Author/s:
Holden, ACL;Hopcraft, MS

Title:
Control, access and professionalism: a qualitative evaluation of Australian dental practitioners attitudes to expanding medicare to include more dental services

Date:
2025-12-01

Citation:
Holden, A. C. L. & Hopcraft, M. S. (2025). Control, access and professionalism: a qualitative evaluation of Australian dental practitioners attitudes to expanding medicare to include more dental services. BMC Oral Health, 25 (1), pp.1283-. https://doi.org/10.1186/s12903-025-06525-x.

Persistent Link:
https://hdl.handle.net/11343/362010

BMC Oral Health

RESEARCH Open Access

Control, access and professionalism: a qualitative evaluation of Australian dental practitioners attitudes to expanding medicare to include more dental services

Alexander C. L. Holden[1,2*] and Matt S. Hopcraft[3]

Abstract

Background Australia benefits from one of the most comprehensive publicly-funded health systems in the world, however, dentistry hardly features at all within the provisions of the scheme. As a result, the majority of dental care in Australia is provided within the private sector, with the States and Territories providing a small eligibility-controlled service. This research examines Australian dental practitioner's attitudes to the conceptual expansion of Medicare to include more dental services.

Methods This research utilises the qualitative methodology of thematic analysis to explore the attitudes and beliefs of dental practitioners in relation to expanding Medicare to include more dental services. Participants were recruited from a pool of dental practitioners who had responded to a survey on Medicare expansion to include dental care. Participants were interviewed using an interview guide, with semi-structured questions. Interviews took place online and were recorded. Iterative rounds of coding allowed constituent themes to emerge for analysis.

Results A total of 12 participants were interviewed before saturation was reached, with three main overarching themes developing through successive rounds of coding. The three themes identified were: Professional Factors; Nature and Organisation of a Potential Scheme; and, Oral Health as Health.

Conclusions Professional attitudes to the expansion of Medicare are not simple or binary considerations. Dental practitioners are highly sensitive to the high cost of dentistry as an impediment to access and would welcome government assistance to help those who struggle with the costs of private dentistry to experience better oral health. However, participants also shared their anxieties in relation to how Medicare increasing its scope in relation to dentistry might herald unwelcome impacts for business models in dental care. Participants also noted the staunch self-interest to opposing comprehensive Medicare expansion from the Australian Dental Association.

Keywords Dentistry, Oral health, Medicare, Public funding, Professionalism

*Correspondence:
Alexander C. L. Holden
alexander.holden@sydney.edu.au
[1]Sydney Dental Hospital and Oral Health Services, Sydney Local Health District, Sydney, NSW, Australia
[2]Faculty of Medicine and Health, The University of Sydney School of Dentistry, Sydney, NSW, Australia
[3]Melbourne Dental School, The University of Melbourne, Melbourne, Australia

Background

Medicare in Australia is world-envied, being highly-ranked for the health outcomes achieved, equity and the efficiency with which the scheme operates [1]. Aside from small, targeted schemes, dentistry has never been part of Medicare's universal scope and this ultimately leaves oral health outside the ambit of wider healthcare in Australia, facing access challenges due to the high cost and unaffordability of care for many [2, 3]. When Medicare (then as its predecessor, Medibank) was established in 1970s, dentistry was not included in the scheme due to a variety of political and economic factors, notable amongst these is the professional resistance from the dental profession advocating against the inclusion of oral health [4, 5]. Contemporary discourse places oral health alongside general health, with dental care being included within concepts of universal health coverage [6]. It is appropriate for the prospect of increasing access within the envelope of Medicare to be discussed in earnest again.

Around 30% of Australian adults are eligible to access public dental services provided by the States and Territories. However, those accessing services can expect long waiting-times due to the rationing of services [7]. Recent research also highlights the frank unaffordability [8] and the impacts of financial hardship [9] on access to dental care. The limited nature of public funding and the high cost of private dental practice means that patients accessing dental care have one of the highest out-of-pocket costs in Australia. This has the impact of patients either deferring recommended treatment or reducing the frequency of their dental visits [10, 11].

Pressure to improve access to dental care through increased public investment is building, with the 2023 Senate Select Committee inquiry report recommending funding reform to establish a universal dental health scheme through Medicare to include greater numbers of dental services [12]. This aligns with contemporary positions from the World Health Organisation (WHO) which advocates for including oral health as part of universal health coverage initiatives [13].

Newly published research demonstrates that dental practitioners in Australia support the principle of expanding Medicare to cover oral health [14]. However, the complex series of professional enablers and barriers that might affect professional perspectives remain unexplored. Greater understanding of reasons why dental practitioners may or may not support expansion of Medicare to include dental care is essential to preparing for a future where great government investment in Australian oral health may occur. The findings of this research have important implications for future policy, as well as adding to the rich discourse already underway in relation to how increased publicly funded dental coverage in Australia might occur.

Methods

Potential participants were identified from those who had taken part in an earlier survey relating to the expansion of Medicare to include dental care. The survey and associated results are reported separately [14]. Participants were invited to take part in in-depth interviews to further explore their views on the subject.

Ethics approval was gained from the Human Research Ethics Committee of the University of Melbourne (2024-31002-60326-3). The conduct of this research complied with the expectations of the Australian National Statement on Ethical Conduct in Human Research which is based on the historical principles of the Declaration of Helsinki. Consent to participate was expressed by all participants and informed through a Participant Information Statement approved by the Human Research Ethics Committee overseeing this research. Interviews were guided by semi-structured questions, developed from the responses to the survey. Interviews were conducted by one researcher (ACLH) and were recorded and transcribed verbatim.

Following data collection, thematic analysis was used to draw out common themes and their component subthemes through successive rounds of reading and analysing the data. With each successive round of analysis, the number of themes condensed to form distinct, linked and overarching categories grouping the data, with themes becoming irreducible through this process [15]. Thematic analysis allows for the deep and rich connections within the data to be identified and further explored [16]. Interviews, coding and analysis took place simultaneously, with data synthesis feeding back into the data collection process, further facilitating the development of richness within the data.

Participants were provided with a copy of the findings with their quotes highlighted to them. This allowed participants to provide feedback on how their comments were interpreted and used within the research. No participants requested changes to how they had been represented.

Findings

A total of 12 participants, all registered dental practitioners in Australia, were recruited to take part in semi-structured interviews, held over teleconferencing software (Microsoft Teams) between February and March 2025. The characteristics of the participants are displayed in the table below. Interviews lasted on average 42 min. Participants were recruited from New South Wales, Queensland, Victoria and the Australian Capital Territory and most had both private and public clinical experience. Table 1 below shows the participant demographics.

Table 1 Participant demographics

Participant	Gender	Scope	Years of Practice	Public Experience	Private Experience	Employment	State
1	F	Dentist	20 years	3 years	17 years	Fully employed	VIC
2	F	Dental Hygienist	21 years	0 years	21 years	Self-employed business owner	ACT
3	M	Dentist	40 years	5 years	35 years	Self-employed business owner	NSW
4	F	Dentist	38 years	14 years	24 years	Public Dentist	NSW
5	M	Dentist	50 years	0 years	50 years	Self-employed business owner	NSW
6	M	Dentist	4 years	0 years	4 years	Self-employed	NSW
7	F	Dentist	6 years	0.5 years	5.5 years	Self-employed	QLD
8	M	Prosthetist	39 years	37 years	2 years	Fully employed	VIC
9	M	Dentist	45 years	2 years	43 years	Fully employed	NSW
10	M	Specialist Dentist	30 years	6 years	24 years	Self-employed	VIC
11	M	Dentist	44 years	19 years	25 years	Self-employed	ACT
12	M	Dentist	25 years	4 years	21 years	Employed principal	QLD

Table 2 Themes and Sub-themes

Overarching Themes	Constituent Sub-themes
Professional Factors	Professional autonomy and control
	Access and public health considerations
	Concerns relating to professionalism
Nature and Organisation of a Potential Scheme	Costs and sustainability
	Scope of services
	Payment system and value
	Organisation
Oral Health as Health	The importance of oral health
	Pride in oral health

Following data analysis, a total of nine individual themes arose which coalesced into three overarching themes after several rounds of coding and re-coding. This process is demonstrated in Table 2 below.

Following the final twelfth interview, the decision was made to cease recruitment of further participants due to the reduction of new themes and insights emerging as the interviews progressed, indicating that saturation had been reached. An approach of concurrent data collection and analysis was taken, allowing inferences from the analysis to feed back into the collection of further data.

The results are presented by theme and sub-theme below, illustrated by select participant quotes. Participants were asked to review the quotes used within this presentation of the qualitative results of this research to validate the interpretation of their statements and ascent to their use within this analysis.

Professional factors

This theme consists of three smaller sub-themes: Professional autonomy and control; Access and public health considerations; and, Concerns relating to professionalism. These three sub-themes coalesce and interact around how participants reported experiencing and perceiving the professional elements around both support for, and opposition against, the proposal of increasing Medicare involvement within the provision of dental care.

Participants spoke about professional freedom from both the perspective of individual dental practitioners, as well as the collective profession as a whole entity. Within the latter, the views and position of the peak dentist's body in Australia, the Australian Dental Association (ADA) were discussed by many participants. These sub-themes illustrate the tension of the dental profession acting collectively to promote and defend its own interests, with the perceived obligation that participants reported feeling that the profession must act cohesively to promote access to care.

Professional autonomy and control

A common element that participants reported perceiving within their colleagues and wider professional groups, as well as reflecting personally, was the concern that the introduction of greater Medicare involvement in dental care provision would attenuate the profession's control over how dentistry would be provided in Australia.

> *The profession opposed it initially and I don't think it's advanced from that position. I don't think it sees, broadly speaking, how it can make dentistry what it wants it to be with it being part of Medicare. - Participant 6.*
> *I guess there's also a worry about government being the largest stakeholder in private practice that potentially leads to more interference with the way that we practise the industry. - Participant 1.*

Government involvement also equated to increased administrative burden and the risk of oversight was a frequently cited reason for hesitance from participants in relation to the potential introduction of greater coverage of dentistry within Medicare. The other concern that some participants raised pertained to how the evolution of dental care provision within Australia being

predominantly within the private sector has led to an unfettered and free-market model of care, where the profession was able to set its own terms of engagement with the public that were largely determined by economic principles:

> *(dentists) don't want to be controlled. They enjoy the benefits of dentistry being a free market. That's what happening at the moment. If Medicare gets involved, then there is an additional party involved in the financial consent which could potentially mean more audits and paperwork that they have to do, which is a change from what they are currently doing. - Participant 7.*
> *We don't like being told how much we are charge for what we do.– Participant 8.*
> *There's mistrust from a private perspective with regards to Medicare and the government in that we don't have any control over.– Participant 3.*

Some participants reflected on the tension between the profession's desire to avoid government control and price setting as part of a Medicare scheme, and the potential negative consequences for access to care:

> *Dentists didn't want Medicare involved because they saw it as some sort of a threat that they would lose control, maybe of how it runs and costings… it was our profession that stopped us in the beginning which I find a little upsetting to hear because I think if that was the truth, I think the people that made those decisions at that time would maybe have no idea of all the thousands of people in Australia sitting in their homes or in aged care facilities with abscesses…suffering because they can't access.– Participant 2.*

The tension between professional control and accessibility of services was noticeable within participant's responses. The next sub-theme reports how participants felt a Medicare scheme might impact access to oral healthcare.

Access and public health consideration

Some participants interviewed were sensitive to the lack of holistic coverage that the public and private sectors currently provide for dentistry in Australia. The lack of access to care faced by those who are ineligible to attend State and Territory public dental services and yet can ill afford the cost of care in the private sector was discussed by multiple participants:

> *It's all those people who fall into that sort of middle demographic where they sort of fall through the hole and they only access services if they absolutely have to. They don't get any routine care; it's all relief of pain. You know, if there's a problem, they'll get it dealt with, then they'll never darken the door of a dental practice again, so you're really sort of missing that cohort of people. - Participant 11.*
> *I can see that there's still quite a significant number of people that only go to the dentist when they have a problem and quite often, they list cost as a factor as one of the barriers to them seeking dental help so if we could make it accessible like more accessible to all.– Participant 7.*

One participant spoke about how they felt strongly that the public should not have to access their superannuation savings to fund oral health care, and how this was inappropriate due to its impact on their future financial wellbeing:

> *All these people accessing their super for their dental treatment…it's absolutely ridiculous…what have they got later in life?– Participant 8.*

Participants spoke about their belief that the dental profession has a duty to work to improve access to oral healthcare:

> *I think that we have a responsibility to try and make sure that everyone has access to dental care…I do think it may not benefit each individual dentist or they can see a real benefit for themselves, but I think that it will benefit the view that people have of dentists as a profession.– Participant 1.*
> *Everybody, regardless of who they are, should at least have access. I think access is a universal right.– Participant 3.*

Multiple participants highlighted their beliefs that the Australian Dental Association's lack of support for a holistic, universal scheme did not align with the intrinsic mission and purpose of dentistry as a professional pursuit, with business considerations and desire for professional control undermining this central purpose:

> *If you go to the ADA, they have a mantra that they want to have money to look after kids, they want to get money from government to look after old folks and the stuff in the middle should be open slather to them. But it's not about oral health, that seems to be the thing to me.– Participant 9.*
> *I think that they (ADA) are very disconnected from the healthscape and they don't see the true cost of health and they are isolated and not really thinking in a broad enough way. There is suspicion about the*

government being in control and regulating things.– Participant 4.

Comments about the role of professional associations were accompanied by concerns over the anticipated behaviour of a minority of individual colleagues should the inclusion of dentistry within Medicare occur.

Concerns relating to professionalism

While there was strong criticism and skepticism from participants in relation to the behaviour and motivations in opposing dental integration within Medicare by professional associations in dentistry, there was generally a strong indication of support of the professionalism of professional colleagues. This initial strength of support was attenuated by the reported concerns from participants of how a wider public scheme might elicit negative professional behaviours from a small minority of colleagues:

There are some amazingly honourable dentists and professionals out there, but there's just those few and there are a little bit more than a few that will abuse the system. It needs to be checked, and the fee needs to be equitable.– Participant 12.

One participant stated that they felt the nature of fee-for-service attracted an inherent conflict of interest within healthcare and led to overtreatment:

Dentists are all people…I believe most dentists are trying to be good dentists…there is an inbuilt conflict of interest when they're making a treatment plan to somewhat maximise the financial reward for themselves. This is just human nature.– Participant 10.

There was also concern expressed by multiple participants that previous attempts to cover more dental care within Medicare had been poorly organised and administered, leading to abuse and inappopriate professional behaviour. Participants shared their perspectives on the Chronic Diseases Dental Scheme (CDDS), a scheme that ran nationwide from 2008 to 2012 and allowed eligible patients with a chronic disease and a GP referral to access a capped amount of publicly funded dentistry within private dental practice:

The CDDS. Oh my God. The dentists who were involved in ripping that system off should have been dealt with a lot more harshly because they ruined it. The doctors need a good kick in the ass too. They were writing out plans without giving any thought to it. That hasn't been helpful.– Participant 3.

The idea that this particular scheme had damaged both the profession's reputation and the likelihood of dentistry attracting Medicare investment and coverage in the future was strongly shared by multiple participants and will be explored further in other themes within this analysis:

If it's done the wrong way, it would be very financially beneficial for the profession. If it's done the right way, there'll be people that complain about it, but it will overall be better because the profession won't be brought into disrepute.– Participant 10.
I don't want to see something abused and I don't want to see the quality drop and nor do I want to see dentists flogged within an inch of their life.– Participant 12.

One participant shared that they were less concerned about negative professional behaviour, as they had witnessed and experienced collectives of dentists within group practices self-regulating. Their reflection was that individual practices where there was less professional culture of audit and exposure of deviant practise were higher risk environments for poor professional behaviour:

I work with five chairs at the moment and if anyone's over-treating, it's going to be pulled up. It's the solo dentist or maybe a couple who may just see every little scratch and mark in a tooth as an excuse to do a filling.– Participant 12.

Another participant shared their experience that the professionalism of some colleagues was separate from their consideration of any financial benefit to providing particular types of care:

It depends on the ethical consideration of the dentist towards finance. Some people will work to an extremely high standard whether there's money involved…other people are going to cut corners… in the area around me, I know some of the dentists where their work is not ideal and others that will do superb work and it's not related to the money. - Participant 5.

It was clear that participants did not consider colleagues' professionalism to be an isolated component to the likelihood of professional misconduct occurring, with the structure and organisation of any scheme also being an important component in determining professional behaviour.

Nature and organisation of a potential scheme

This theme considers the participants' comments and perspectives concerning how a potential Medicare scheme for dentistry might be structured and organised, both in relation to the scope of services offered, the way a scheme might operate and how this might fit within the broader landscape of clinical care. Four sub-themes are collected within this second overarching theme: Cost and sustainability; Scope of services; payment system and value; and, Organisation. These four constituent themes intersect with each other, but also inter-relate with other thematic elements within the other overarching themes.

Cost and sustainability

Broad support or opposition to a potential scheme for oral health within Medicare was irrelevant to participant concern over whether such a scheme would be affordable and sustainable within the wider political and social context.

Participants universally recognised that a scheme covering dentistry funded within Medicare would be expensive:

> *It's going to be a lot more expensive than they budgeted for– Participant 12.*

Some participants shared concerns around how the scheme would be affordable:

> *Even doctors don't have completely universal coverage, I think that there always needs to be choice as to how people spend their money and how they go, and the government are really spending our money. It's not their money; it's our money so I think there does need to be choice. So now I'd probably have to say no to (universal coverage).– Participant 3.*

Concern was also expressed about how the scheme would need to be resistant to inappropriate claiming behaviour:

> *I think it's a very, very slippery slope to go down and I don't know exactly how Medicare can pay for everything at an equitable rate, which isn't going to be abused– Participant 12.*

Other participants shared that the potential cost of a scheme was a large factor in why politicians had not shown more interest in establishing a universal dental scheme:

> *I just believe that they're scared of how much it's going to cost and it will cost a huge amount of money.– Participant 8.*

Participants expressed a belief that funding for dental services provided through Medicare might be reduced over time, making participation challenging. Some drew parallels between the attrition of dentists working within the NHS in the UK as a lesson to be learned prior to establishing an Australian scheme for dentistry:

> *I think the cost will blow out and then they'll be trying to find a way to keep it low. Unfortunately, quality will be the problem that suffers as it has in many countries that have tried this before.– Participant 12.*
>
> *Rebates will start off as reasonable, but then over time it will be eroded away because the government's not going to fund it to the same extent.– Participant 5.*

Some participants reflected on the risk of structuring business decisions around a scheme that might not be fit for purpose:

> *Before…investments are made, and we start structuring our business models around some sort portable dental service that we're leaving the practice we need to have some sort of confidence that it's going to be financially viable…It's the perception of it being underfunded, and there's a lack of trust to base a private practice business decision on.– Participant 3.*

Other participants shared a belief that a publicly-funded scheme would create the need for unacceptable efficiency and productivity requirements that would compromise clinical care:

> *It can potentially turn into this sort of NHS-style dystopian nightmare that happened where you just have people doing root canal fillings in 20 min and bonding a crown on and doing as many procedures as they can.– Participant 10.*

Although other participants felt that lower rebates would be balanced out by greater numbers of patients, with the end financial outcome for practitioners being neutral or positive:

> *I personally can't see (value of rebate) being a huge problem, because if you can get more people through the door, the numbers should balance themselves at the end of the day.– Participant 7.*

This same participant also shared that, in comparison to other welfare investments made by the Australian Federal

government, universal support for dentistry was very justifiable and represented good value for money:

> *If the government can give a rebate of $1000 for electricity for everybody, why can't you just provide one free dental check-up for everybody? Just imagine the doors that they will open just by investing not a huge amount of money.– Participant 7.*

The cost and sustainability of services was reported by participants to be closely linked to the general scope of care provided.

Scope of services

Participants were asked to reflect on what they would imagine a scheme should and should not cover. The participants varied in their perspectives, with most expressing a view that balanced the considerations of affordability with opportunity to provide treatment that would create the best social good for patients.

Some participants took a view that a scheme would need to be universal to ensure that payment considerations wouldn't interfere with clinical best practise:

> *I think a comprehensive scheme is what needs to be supported as soon as you don't support everything, people will always choose the free option.– Participant 12.*

One participant spoke about their wish for a Medicare-supported scheme to allow clinical care to take a position of primacy over dealing with financial considerations:

> *In an ideal world, the scheme that I would like is: I can discuss patient care without having to be concerned about discussing money. That would be my gold standard. I'd love to be able to discuss an implant overdenture, which is, depending on what literature you agree with, the minimum standard of care for a lower fully edentulous arch. I'd love to be able to discuss that without discussing money. I recognise that whatever funding model comes in, that not likely to be part of it. You know anything is better than nothing and anything is probably better than private health.– Participant 6.*

The affordability of universality concerned many participants as they discussed scope of services:

> *I'd like to see more of a universal dental care package delivered rather than only targeting high risk groups, but there's not an infinite amount of money that the government is going to be able to spend, so probably a phased approach of potentially people having access to a fixed amount of money to be able to spend on a dental service.– Participant 1.*
> *Originally it should be limited because you don't want to break the bank.– Participant 5.*

Access to basic services, such as a dental examination and management of acute dental issues was expressed to be low cost and represented a good investment in public health and well-being:

> *I think it would be terrific if every single person could at least have an examination to become aware of what is going on in their mouth…If anyone in Australia was able to go to a general dental practice for relief of pain and infection, which might include an extraction or a pulp extirpation, that would be relatively low cost, I believe and efficient and deliver a lot of benefit to the society.– Participant 10.*

The concept of scope of the service and the structure of payment systems within the scheme was a joint consideration for some participants who stated that would be concerned that a holistic and free scheme might lead to a lack of public value in oral health:

> *I think the ideal model for dental care is a joint responsibility between Medicare and the individual. So Medicare will provide annual check-up for everyone under the sky and preventative services such as your fluoride treatment, scaling, clean and maybe some basic fillings. And whatever that is on top of that, the patient will fund it themselves or there is certain type of waiting period before higher treatment can be performed because the concern, I personally have about Medicare including dental is overservicing. Having said that overservicing within the Medicare system is already a present issue.– Participant 7.*

The majority of participants were not supportive of higher value and complex treatment being covered by a potential scheme:

> *I'm thinking a lot of the crown and bridge stuff is obviously on the periphery, but things like removable dentures and things like that are absolutely critical to giving people a decent stab at life. So I'm basically going to say that it's mainly the more advanced crown and bridge, and some of the implant stuff (that wouldn't be included).– Participant 9.*

As previously stated, participants did have concerns about how a potential scheme might facilitate or discourage over-servicing and financially driven clinical practice.

One participant was critical of the ADA's advocacy efforts to include crowns within the scope of the ADA's proposed scheme (targeting the 2025 Federal Election) which is a limited scheme for seniors:

> *To put the crown in there, I think it was a big mistake and it just plays to the tune of you know, dentists are just this muddy, bloody, rich, money-grabbing, "all I want to do is crowns" type thing and you know I don't think it was the right message.– Participant 3.*

This comment links with similar comments reported in other themes made about how potential schemes might encourage inappropriate clinical practice and the subsequent consequences of this on the wider profession's public standing.

Payment system and value

This sub-theme captures participants comments on how any potential scheme might be set-up to include a patient co-payment or not, and how value for money might be assured for the government funding the care provided.

One participant was adamant that introducing a system where a co-payment might be voluntary for providers to charge would create a financial challenge for anyone who then decided to charge this co-payment:

> *The competition at the moment is so horrendously high that everyone will be doing rebate only… Co-payment is not going to work if patients will always find the bulk billing dentist and there will always be a dentist that will bulk bill– Participant 12.*

This participant also detailed their perception of the challenge that would be introduced by patients being motivated by treatment that was covered by the scheme, versus treatments that were not funded by Medicare:

> *It we have a situation where someone is offered a free filling for $400, or a better crown…if they don't pay for their $400 filling but have to pay for a crown for $1600 (which is the better option) they will choose the cheaper option. That's what human nature is.– Participant 12.*

Participants also shared their caution on how payment systems would likely be influential on dentists' professional behaviour:

> *(in reference to CDDS) Last time it was $4,500 of whatever work you wanted to do, so naturally, everybody ran it up to $4,500 as quick as they could– Participant 8.*
>
> *The more you did, the more you got paid. Well, that in itself is going to be an issue because there'll always be somebody at that end of the curve who's going to try and milk the system a bit.– Participant 11.*

Participants viewed the inclusion of co-payments within the scheme as an important component of public value for dental care and as a way to ensure accountability for engagement in their treatment:

> *I think if it's totally free, the problem is that the services tend not to be valued and that's always a big issue because generally speaking, even in private practice, people don't really understand the costs that you're dealing with in terms of delivering service.– Participant 11.*
>
> *I think there needs to be a gap payment just to make people publicly accountable for their appointments and because we can book patients in and they just don't turn up, and then they're taking time off everyone else.– Participant 8.*

The structure of any proposed scheme was of great interest to all participants, with many of the concepts linking with the sub-theme concerning the overall organisation of how dentistry might be provided by Medicare.

Organisation

Most participants expressed their belief that the Department of Veterans Affair's scheme for dentistry was established well, with sufficient longevity for most operational challenges to have been addressed:

> *I believe that after many, many years of DVA, understanding how dentists work and humans work, they have actually got a very good system which does not get rorted.– Participant 12.*

This participant was skeptical of the notion of a comprehensive dental scheme as part of Medicare. However, if such a scheme was based on the extant DVA scheme, they stated feeling more comfortable with an expansion of publicly-funded dental care:

> *I'd be much less concerned. The DVA system is quite good.– Participant 12.*

Other participants were supportive of the broad scope that the DVA scheme offers those receiving care:

> *I think that the DVA model in terms of what they will fund in terms of more comprehensive treatment or more complex treatment are probably worth looking at– Participant 6.*

In contrast, and as previously noted within this analysis, the CDDS was held in comparatively low regard by participants:

> *(the CDDS) was an absolute disaster because it was so poorly implemented.– Participant 4.*
> *(in reference to CDDS) The whole administrative setup for that was very, very clunky– Participant 11.*

One participant suggested that a future scheme would benefit from being established following appropriate stakeholder engagement, so that the administrators of the scheme would be able to ensure that oral health might be better integrated within the wider health ecosystem:

> *I think that unless this scheme is co-designed, if it's thought up in someone's head with perhaps one person's view of dentistry or a couple of people's views of dentistry, it will really be unfit for purpose. We know our profession is disconnected from each other and being alone and disconnected from the health sector.– Participant 4.*

Participants were keen for a prospective scheme to be able to promote the position of dentistry as part of health, and not further oral health's current disconnect from the rest of healthcare services. The structure of a scheme needs to be considered from the wider strategic perspective of better health integration and wider health promotion.

Oral health as health

The third and final overarching theme considers how participants valued the opportunity for oral health to be included within Medicare and in doing so, for dentistry to be valued in the same way that other branches of medicine and allied health are viewed to be essential components of wellbeing.

This overarching theme is split into two comparatively small sub-themes in relation to the other sub-themes that emerged within this research: The importance of oral health; and, Pride in oral health. Despite their size, their distinctiveness, relevance and the poignancy of the participants' comments justify their inclusion as a separate dyad of sub-themes.

The importance of oral health

It is perhaps of little surprise that a collective of oral health professionals would make statements relating to their views that oral health was an important component of a person's general wellbeing and health. However, comments participants made around the apparent exclusion of dentistry from the rest of medicine and allied health highlight an absurdity to the inclusion of some services and the absence of oral health:

> *If somebody has a car accident or has some sort of medical issue, and they're in a hospital because that's where they've ended up. Then if a doctor says, "well, we need to have physio and occupational therapy and a dietician", that's all very normal. But if somebody was in hospital for three or four months, they wouldn't be expecting to say, "we'll have a dentist come in and clean your teeth for you every week". That would be considered to be abnormal.– Participant 3.*

The absence of oral health within Medicare was noted by other participants who felt that the exclusion of dentistry did not align with the otherwise comprehensive nature of Medicare:

> *It would be a good initiative to include dental in Medicare because oral health is a very important part of one's overall physical and mental health and it is almost kind of ridiculous to just exclude that part from the Medicare system.– Participant 7.*
> *The reason I think it could and should happen is there are a large group of people…with infection and pain that currently can't pay to go to a suburban general practice to have that managed. So, to think that someone can go to a general practitioner with a sore throat and have that looked at, but someone with an abscess in their jaw in pain can't have that relieved is unusual.– Participant 10.*

Participants expressed frustration that the public and political community did not appear to value oral health and its contribution to wider health to the same level that they did, citing a need for greater advocacy and education:

> *We talk as dentists about connecting oral health to general health; I don't think that the case has been made in either the politician's mind of the public's minds.– Participant 4.*
> *There needs to be a lot of education with regards to the oral health, general health issue, because the reality is that we don't have people marching in the streets arguing for higher levels of dental services… there just doesn't seem to be the same degree of anger there.– Participant 3.*

The lack of integration of oral health was also seen by participants to represent an attenuation of the importance of oral health and its place within the health system. The connected sub-theme below further explores

how participants felt the inclusion of oral health in Medicare would impact the profession's ability to promote the importance of oral health.

Pride in oral health

Within this analysis, there is a strong thread throughout relating to the anxiety participants shared over how the inclusion of dentistry within Medicare might negatively impact the professional mission of dentistry in relation to poor professional behaviour. This sub-theme looks at the other extreme; how participants reported the inclusion of dentistry might enhance the status of dentistry and meaningfulness of their role within the health system. For one participant, it was the simple aspect of inclusion within Medicare that would assist in the collaborative efforts of professional dentistry to promote oral health and clinical outcomes:

> *At some level it would be good for our profession in that it sees us as part of the broader health picture. We can't sit around and say the mouth isn't attached to the body if we get invited into Medicare which is general health and we'll be connecting with all of our allied health, nursing and medical colleagues.– Participant 3.*

For another, the inclusion of dentistry in Medicare represented recognition from the government as to the contribution dentistry makes to the health and wellbeing of the community.

> *(Expanding Medicare to include dental care) would be good for the profession. I think on one end we'll feel a bit more validation and also that the work that we do is appreciated and valued from a government point of view, and if there are more people going to the dentist in general, there will be a higher level of satisfaction, in terms of job satisfaction and being able to make a bigger impact. - Participant 7.*

These comments demonstrate the commitment to oral health and the professionalism felt by participants around their professional role and their obligations around the promotion of oral health and the professional pursuit of dentistry.

Discussion

The results of this research demonstrate that whether dental professionals support the expansion of Medicare to cover dental services is not a simple binary consideration. Participants in this research gave largely similar responses regarding their considerations of the central and surrounding issues to the establishment of such a scheme. However, they drew contrasting positions as to their overarching support or opposition to such a scheme becoming a reality. The themes explored in the results reveal tension between participants' recognition of the importance of oral health and the professional duty to promote this importance, and the desire of the dental profession to retain autonomy of their practise and ensure the future viability of the private model of dental care.

Autonomy vs. justice

In principle-based ethical arguments, typically the principle of autonomy would over-rule arguments relating to justice. However, this only rings true when considering the autonomy of patients who are disempowered by knowledge and dependency imbalances, rather than the autonomy of dental practitioners in protecting their professional interests. In this instance, dental professionals face tension in their recognition of the importance of promoting oral health through enhanced access to their services, and the simultaneous desire to remain in control of how dentistry is provided and to whom.

Many of the participants shared their belief in a lack of affordability of a Medicare-style scheme to support dentistry. This belief is reflected by the ADA's advocacy for a targeted scheme for seniors, advocating for funding only towards specific disadvantaged groups. The ADA is well documented in its position that universal dental coverage in Australia is unaffordable [17], with modern day messaging hiding a stronger narrative espoused in the past that such a policy position would represent fiscal irresponsibility on behalf of any government that implemented it [12].

The lack of support from the ADA for comprehensive and universal oral healthcare access in Australia appears to be at odds with the ADA's statement of its primary objectives which are given to be: "(T)o encourage the improvement of the oral and general health of the public, promote the ethics, art and science of dentistry and support members to provide safe, high quality professional oral care." [18] These objectives also form the underpinning for, and are referenced in, the association's code of ethics. Misalignments between codes of practice and ethics and the actual behaviour and statements of professional associations have been noted elsewhere in academic literature; "Not all the planks of a professional association's code of ethics are meant to be taken in the same spirit. Some are merely costumes the profession puts on to impress outsiders. Some are preachments to be honoured, but not necessarily obeyed." [19] As the participants demonstrated, there are some significant issues that previous experience with public dental schemes that are delivered using private practice infrastructure that urge caution with how the administration of a future scheme might be set up. However, for

the peak professional dental association in Australia to take an unsupportive and cynical position towards universal access for all to oral health, does not portray professional values that are publicly-focused and altruistic. Such opposition has little to do with the public good, and everything to do with serving professional and financial interests. By contrast, the World Dental Federation (FDI), of which the ADA is a member, univocally supports the principle of integrating oral health within universal health coverage as promoted by the WHO [20, 21]. Previous analysis of the Association's values statements through the codes of ethics of a state branch demonstrated the association's alignment to the notion that oral health is a matter of personal responsibility and not an issue that warranted government taking responsibility for health conditions caused by personal choice [22]. An emphasis on personal responsibility may explain the reluctance of the ADA to support the responsibility of funding oral healthcare to be taken on by government. The results demonstrated that some participants also felt oral health was important, but similar to other research findings [23, 24], some shared a belief that the nature of oral health being a matter of personal accountability did not justify the perceived expense of establishing enhanced funding from the public purse.

Through the narrative of its advocacy, the association places the consideration of affordability and budgetary prioritisation ahead of its own association objectives of improving the oral health of the public, taking on the responsibility of government and in the process, becoming unambitious for the possibility of furthering oral health access and improving oral health outcomes across the whole community. This lack of ambition and focus on financial responsibility may be better understood to be a concern for professional control and autonomy, thinly veiled as an argument for the betterment of the public purse. Previous exploration on the role of professional associations in oral health suggested that such self-interested behaviour which actively places the profession's aspirations to maintain professional positions of power over the interests of the public to equitably access oral healthcare are in breach of the social contract between the profession and those it exists to serve [25]. A professional organisation must enhance the ability of its collective of members to act on issues of advocacy that no one member could act upon effectively alone. In this way, the ADA fails in its duty to both its members and the public through lack of support and advocacy for universal access to dental care. As a member-driven association, the ADA should ensure that its position statement accurately reflects the attitudes of both its members and the profession as a whole. This in-depth qualitative exploration shows that dental practitioners do have wide support for dentistry's inclusion into Medicare, attitudes supported more broadly by previously published work with greater numbers of participants. It is of note that the publicly-spirited and altruistic attitudes shared by individual practitioners participating in this research are at odds with the narrative from the ADA.

Structural and organisational concerns

While this analysis is critical of the ADA for not philosophically supporting universal oral health coverage, it is clear for the participants in this study that there are pragmatic and legitimate considerations which might validate individual practitioners being hesitant and concerned about the introduction of a Medicare scheme for dentistry. Chief amongst these illustrated in the results are the impacts of such a scheme upon existing private practice structures, especially if a prospective scheme was poorly conceived or underfunded. Participants stated that, while they supported the idea and intention of a Medicare-style scheme, their vicarious experience of the NHS dental service in the UK made them distrustful and cautious in the face of a similar scheme being established in Australia.

Assessment of the current state of the NHS's provisions for dental care find these concerns to be justified. A recent independent report detailed that; 'NHS-funded dental services in England are in near-terminal decline: nearly six million fewer courses of NHS dental treatment were provided last year than in the pre-pandemic year; funding in 2021/22 was over £500m lower in real terms than in 2014/15; and there are widespread problems in accessing a dentist' [26]. The phenomenon being witnessed in England is the waning support of the NHS public dental services, which are predominantly provided through private dental practices, due to issues with the sustainability of business costs of providing care as part of the service [27]. In Australia, the Grattan Institute advocated for the introduction of a Medicare-style system for dentistry in a gradual and incremental manner to assist with managing workforce shortages, as well as assisting with the assessment of the costs that such a scheme might represent to the Australian taxpayer [28]. Despite the Nuffield Report [26] supporting in-principle the idea of dentistry in the UK as a universal service, it suggests dentistry will not likely be a universal service due to the cost of covering an increasingly complex and expensive offering. Projections suggest that the future complexity of dentistry will reduce due to the oral health of younger generations being better than their predecessors. How Medicare could learn from the experiences of the NHS dental system in England, with a structure that is less interventionist and more preventive in focus and operation, is the real challenge to establishing dentistry within Medicare. Activity focused payment systems are easy to implement and measure, with prevention being

harder to recognise and remunerate. Despite this, with lower levels of disease experience for many members of the community, spending time establishing a scheme that properly and appropriately recognises prevention over pure clinical activity would be both world leading and future proofed.

Within this research, a clear preference was given by most participants to the DVA dental scheme due to its comprehensive nature and the perception that it is well-organised. Comments from participants in relation to the scope of public schemes being restricted to simple, more basic treatments were often less about the clinical need of the population, and more about restricting the opportunity of unscrupulous dentists to engage in over-servicing and in doing so, damage the reputation of the profession. One of the key differences between the DVA scheme and the CDDS is the perception that the CDDS was vulnerable to abuse through a lack of checks and balances.

Alongside the view that the CDDS had been abused and was poorly administered, was an accompanying view that the scheme had disproportionately provided complex treatment such as crowns and dental implants. This assessment is supported by multiple analyses of the CDDS that demonstrate that these treatments were indeed overrepresented [29–31]. Despite one analysis showing complex treatment to be the main expense of the CDDS [30], analysis of the number of services shows that diagnostic, preventive and simple restorative care to be more numerous in number of claims than complex crown and bridge and implant care [29]. There was suggestion from participants that the CDDS was used inappropriately where individual patient allowances were maxed out for clinician benefit. However, the data show that the average spend per patients was $1,808 out of a potential capped amount of $4,250, and that for most patients the cap was not met [29].

As Palfreeman and Zoellner identify [29], these analyses demonstrate a clear need for increased access to dental services through the high rate of utilisation of the scheme to receive treatment. The fears of over-servicing and greater than expected expenditure on any such scheme could both be mitigated relatively simply by having either a restricted scheme to begin with (focusing on diagnostic, preventive and simple therapeutic procedures), or a fully comprehensive scheme with inbuilt approval processes for more complex care than would introduce accountability and enforcement of evidence-based practice into the scheme.

Participants expressed concern in relation to how the arrangement of a scheme might impact the behaviour of colleagues. There were multiple references to clinicians 'rorting' payment systems or engaging in overtreatment, abusing public money and trust through engaging in unprofessional or fraudulent behaviour. Participants were keen to qualify their comments in stating they felt that the majority of colleagues would meet any publicly funded scheme with professionalism and as any business rules intended. However, they expressed concern that the minority of colleagues who didn't behave within expectations would bring the profession into disrepute. This perception has not developed without grounds, with examination of the phenomenon of overtreatment showing that dentists experience pressure to react to commercial and market forces [32, 33] and that dentists report manipulating clinical need in order to meet their financial demands and pressures [34]. In Australia, there is very visible and well-publicised experience of public schemes being exploited by professionals and groups within dentistry. In a particularly shocking example, one dentist was found guilty of assaulting patients in an aged care setting; providing inappropriate and unnecessary dental crowns with no consent, funded through the CDDS [35]. In 2021, a public health warning was issued by the NSW Health Care Complaints Commission in relation to a mobile dental services provider (SDS) engaging in unacceptable clinical practices which included, amongst others, overtreatment of child patients. The public warning stated; "SDS and its sole director took advantage of the inexperience of staff to assert a degree of influence and coercion to create a culture of the provision of unnecessary and excessive treatment to vulnerable patients. The sole aim of SDS was to generate increased billing to the CDBS scheme. It was not possible for parents to provide financial consent to such levels of over servicing." [36]. Participants stated that they felt a robust infrastructure would be needed to reduce the risk of aberrant behaviour occurring any future Medicare scheme for dentistry. One possible mechanism would be to include the use of Patient Reported Outcome Measures (PROMs) as an adjunct to assess the impact of interventions on the patient and alleviate concerns raised regarding the quality of care provided. It is questionable how realistic or pragmatic this could be in the Australian context given the lack of oral health leadership at the Commonwealth level and a lack of experience implementing sophisticated oral health surveillance systems. Nonetheless, there will be a need for mechanisms to ensure quality of care and minimise the risk of aberrant behaviour.

Two phenomena well-explored in this research of overtreatment in dentistry and the financial aspects of providing care, would be addressed through the expansion of Medicare. While participants in this research worried about overtreatment, research investigating this phenomenon suggests that over-saturation of dentists and a lack of genuine clinical work to do, are significant contributors to the likelihood of dentists engaging in overtreatment [32–34, 37]. It is well documented that were Medicare to be expanded, there would be a paradigm

shift from Australia having a perceived over-supply of dental practitioners in some areas, to a situation where there would be too few dental professionals to manage demand for care [28]. With Medicare funding dentistry for all, it is likely that unaffordability would also cease to be the main barrier to care [8, 9, 38].

This research represents the first in-depth qualitative analysis of how Australian dental practitioners perceive and assess the opportunity to expand Medicare to include oral health. As with all qualitative analysis, the findings presented here are bound within the time and space that the research was conducted within. The findings here are specific to the participants who gave their perspectives and commentary to the research, as well as the researchers who conducted the analysis. Although all participants were broadly supportive of expanding Medicare in principle, we did not demand a definitive statement of support or opposition, since it is clear that on the range of issues explored the level of support was weighed with concerns about consequence. It is possible that with an alternative research team examining the same data, different themes might emerge. Equally, a different set of themes may emerge with participants who are overtly opposed to expanding Medicare. The analysis detailed here is supported by a well-described methodology and analytical approach which allows transparency to how inferences have been drawn [39].

Conclusions

The participants acknowledged the importance of oral health and the work of the dental profession, however, a hesitation was apparent in relation to the prospect of increasing the scope of Medicare to include dentistry due to the inevitable cost of the scheme, the impact on professional behaviour and the sustainability of dental business models, and whether the government's commitment to such a scheme would be sustained. There was acknowledgement that the establishment of further funding for dentistry would be a good thing for the Australian public, but it remained to be seen whether this would lead to a positive outcome for the profession.

This research highlights the need for co-design of any future publicly funded dental scheme to ensure that it is fit for purpose and is able to meet the needs of dental practitioners providing care as part of any initiative, as well as the public the scheme would be intending to help.

Abbreviations

ADA	Australian Dental Association
CDBS	Child Dental Benefit Schedule
CDDS	Chronic Diseases Dental Scheme
DVA	Department of Veterans' Affairs

Acknowledgements

Not applicable.

Author contributions

Both ACLH and MSH contributed to the conception, design and data analysis involved in this research. ACLH completed the data collection and drafted the main manuscript text. Both ACLH and MSH were involved in reviewing and refining the manuscript.

Funding

The work was supported by the Centre for Oral Health Strategy, NSW Ministry of Health.

Data availability

The datasets used and/or analysed during the current study are reported within the paper. The full research interview transcripts are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval was gained from the Human Research Ethics Committee of the University of Melbourne (2024-31002-60326-3). The conduct of this research complied with the expectations of the Australian National Statement on Ethical Conduct in Human Research which is based on the historical principles of the Declaration of Helsinki. Consent to participate was expressed by all participants and informed through a Participant Information Statement approved by the Human Research Ethics Committee overseeing this research.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Received: 2 May 2025 / Accepted: 30 June 2025
Published online: 31 July 2025

References

1. Commonwealth Fund. Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System. Comparing Performance in 10 Nations. In.; 2024.
2. Ghanbarzadegan A, Balasubramanian M, Luzzi L, Brennan D, Bastani P. Inequality in dental services: a scoping review on the role of access toward achieving universal health coverage in oral health. BMC Oral Health. 2021;21(1):404.
3. The Australian Research Centre for Population Oral Health. Australia's Oral Health. National Study of Adult Oral Health 2017-18. In.; 2019.
4. Akers HF, Weerakoon AT, Foley MA, McAuliffe AJ. The medicare chronic disease dental scheme: historical, scientific, Socio-political origins. J Hist Dent. 2017;65(2):46–62.
5. Clarke P, Cutler H. A proposal to extend universal insurance to dental care in Australia. Aust Econ Rev. 2024;57(2):168–73.
6. Benzian H, Beltrán-Aguilar E, Niederman R. Essential oral health care and universal health coverage go hand in hand. J Am Dent Assoc (1939). 2022;153(11):1020–2.
7. Sloan AJ, Wise SL, Hopcraft M. Primary care dentistry: an Australian perspective. J Dent. 2024;145:104996.
8. Kaur G, Tsakos G, Yap T, King T, Mathur MR, Singh A. The case for affordable oral health care: the public voice. Public Health Res Prac. 2025;35(2) PU24009. https://doi.org/10.1071/PU24009
9. Kaur G, Tsakos G, Yap T, Karahalios A, Chen Z, Singh A. Effect of Becoming Unemployed on Affordability of Oral Health Care among Australian Adults. JDR Clin Transl Res. 2025;0(0). https://doi.org/10.1177/23800844241311843
10. Crocombe LA, Chrisopoulos S, Kapellas K, Brennan D, Luzzi L, Khan S. Access to dental care barriers and poor clinical oral health in Australian regional populations. Aust Dent J. 2022;67(4):344–51.
11. Angeles MR, Crosland P, Hensher M. Challenges for medicare and universal health care in Australia since 2000. Med J Aust. 2023;218(7):322–9.
12. Australian Dental Association. (Inc.): Submission to the senate Select Committee on Medicare. In.; 2003.
13. Assembly UNG. Political declaration of the high-level meeting on universal health coverage. Seventy-Fourth United Nations Gen Assembly 2019:1–12.

14. Hopcraft, M. and Holden, A. (2025), Australian dental practitioner attitudesto expanding Medicare to include more dental services. Aust Dent J. https://doi.org/10.1111/adj.13073
15. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nurs Health Sci. 2013;15:398–405.
16. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Res Psychol. 2006;3(2):77–101.
17. ADA responds to. the Green's dentistry in Medicare proposal [https://ada.org.au/ada-responds-to-the-greens-dentistry-in-medicare-proposal]
18. Australian Dental Association. (Inc.) website [https://ada.org.au/]
19. Gilb CL. Hidden hierarchies: the professions and government. New York: Harper and Row; 1966.
20. Improving Access to Oral Healthcare. Adopted by the FDI general assembly: 27–29 September 2021, sydney, Australia. Int Dent J. 2022;72(1):2–3.
21. Fisher J, Selikowitz HS, Mathur M, Varenne B. Strengthening oral health for universal health coverage. Lancet (London England). 2018;392(10151):899–901.
22. Holden ACL. What do dental codes of ethics and conduct suggest about attitudes to Raising concerns and self-regulation? Br Dent J. 2018;224(4):261–7.
23. Leadbeatter D, Holden ACL. How are the social determinants of health being taught in dental education? J Dent Educ. 2021;85(4):539–554.https://doi.org/10.1002/jdd.12487. Epub PMID: 33197045.
24. Holden ACL, Adam L, Thomson M. Private practice dentists' views of oral health injustice. Community Dent Health. 2021;38(4):268–74.
25. Holden ACL, Quiñonez CR. Is there a social justice to dentistry's social contract? Bioethics. 2021;35(7):646–51.
26. Williams W, Fisher E, Edwards N. Bold action or slow decay? The state of NHS dentistry and future policy actions. Policy briefing, Nuffield Trust, 2023. Available at: https://www.nuffieldtrust.org.uk/research/bold-action-or-slow-decay-the-state-of-nhs-dentistry-and-future-policy-actions (accessed January 2025).
27. Campbell D. English dentists 'walking away' from NHS work as fees fail to cover costs. In: *The Guardian.* 2025.
28. Duckett S, Cowgill M, Swerissen H. Filling the gap: a universal dental care scheme for Australia Carlton. Victoria: Grattan Institute; 2019.
29. Palfreeman V, Zoellner H. Description of comprehensive dental services supported by the medicare chronic disease dental scheme in the first 23 months of operation. Aust N Z J Public Health. 2012;36(1):69–75.
30. Crocombe LA, Kraatz J, Hoang H, Qin D, Godwin D. Costly chronic diseases: a retrospective analysis of chronic disease dental scheme expenditure. Aust Health Rev. 2015;39(4):448–52.
31. Lam R, Kruger E, Tennant M. Experiences in the implementation of a National policy: A retrospective analysis of the Australian chronic dental disease scheme. Australas Med J. 2012;5(10):551–9.
32. Holden ACL, Adam L, Thomson WM. Overtreatment as an ethical dilemma in Australian private dentistry: A qualitative exploration. Community Dent Oral Epidemiol. 2021;49(2):201–8.
33. Holden ACL, Adam L, Thomson WM. Dentists' perspectives on commercial practices in private dentistry. JDR Clin Trans Res. 2022;7(1):29–40.
34. Grytten J, Listl S, Skau I. Do Norwegian private dental practitioners with too few patients compensate for their loss of income by providing more services or by Raising their fees? Commun Dent Oral Epidemiol. 2023;51(5):778–85.
35. Health Care Complaints Commission v Istephan. (2) (2017) NSWCATOD 116.
36. Health Care Complaints Commission. Public warning under s94A of the health care complaints Act - dental services to child care facilities provided by Sydney dental services. https://www.hccc.nsw.gov.au/public-warnings/public-warning-under-s94a-of-the-health-care-complaints-act-dental-services-to-child-care-facilities-provided-by-sydney-dental-services
37. Holden ACL, Adam L, Thomson WM. The relationship between professional and commercial obligations in dentistry: a scoping review. Br Dent J. 2020;228(2):117–22.
38. Australian Institute of Health Welfare. Oral health and dental care in Australia. In. Canberra: AIHW; 2024.
39. Chapman S, Lupton D. Freaks, moral Tales & medical marvels: health & medical stories on Australian television. Media Inform Australia. 1994;72(1):94–103.

Publisher's note

Alexander C. L. Holden is a specialist in public health dentistry and a general dentist. He is currently a senior clinical specialist and clinical executive (Head of Specialist Services) at Sydney Dental Hospital, as well as holding a position at the University of Sydney as a Clinical Professor. He currently also is a private dental practice owner in Sydney. Alexander has held positions as a Director of both the NSW state branch and the Federal branch of the Australian Dental Association as well as other governance and leadership roles within both organisations. He is currently not a member of the Australian Dental Association.

Matt Hopcraft is Associate Professor in Professional Practice at the Melbourne Dental School, University of Melbourne. He is previously the Chief Executive Officer of the Australian Dental Association Victorian Branch, and has held positions as a Director of both the Australian Dental Association Victorian Branch and Australian Dental Association Inc. He is not currently a member of the Australian Dental Association.