



Prevention Pays: Cutting the cost of dental hospitalisations

NSW Council of Social Service

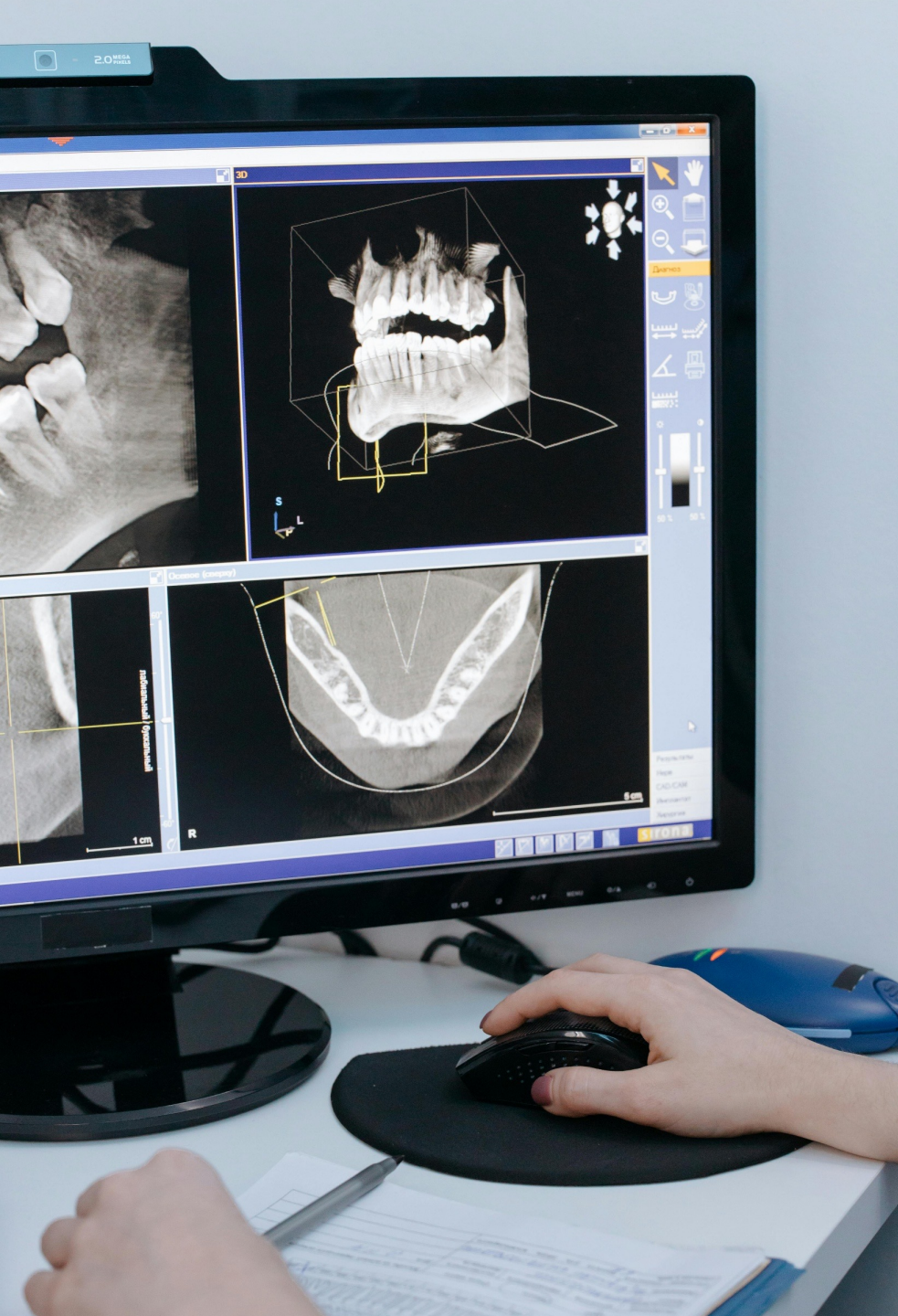
OCTOBER 2025



Dental conditions are the leading cause of potentially preventable hospitalisations (PPH), with preventative care for at-risk groups the most effective solution

Dental conditions are the leading cause of potentially preventable hospitalisations in NSW	A lack of access to and affordability of early intervention and prevention is costing NSW	Targeting priority groups through preventative care uses the finite health budget efficiently to address the groups with the highest rates of potentially preventable hospitalisations
 Dental conditions are now the leading cause of potentially preventable hospitalisations (PPH)¹ in NSW, contributing to 24,300 admissions in 2022	1/3 Personal oral hygiene is an affordable prevention method but one third of children do not meet the recommended frequency of tooth brushing	 On the pathway towards universal preventative dental care, policymakers can begin the expansion of existing programs to children and their parents
 PPH are most prevalent amongst children, older people, Aboriginal and Torres Strait Islander people and those in remote areas	35% Government schemes to make dental care more affordable are underutilised, with only 35% of eligible children using the Child Dental Benefits Schedule (CDBS)	 Launching a one-off voucher for dental care and upskilling professionals to provide preventative care will improve oral health for seniors in the interim before a Seniors Dental Benefits Schedule (SDBS) can be introduced
 Preventable dental conditions such as dental caries² cause PPH, with social determinants of health driving preventable dental conditions	\$147m It could be costing NSW \$147 million per year to manage potentially preventable hospitalisations for dental conditions in the public and private systems, with a likely split of 70:30 between the private and public systems³	 Providing transport support, ensuring fresh drinking water and delivering services through channels which are appropriate for Aboriginal and Torres Strait Islander people and those in remote areas will improve oral health

1 Potentially preventable hospitalisations are defined as conditions that are amenable in some circumstances to primary and community care interventions. These may be acute, chronic or vaccine-preventable conditions.
2 Dental caries are the development of cavities in the teeth that compromise the health and structure of the tooth (commonly known as dental decay).
3 Based on advice from NSW Health.
Sources: AIHW (2024) Potentially preventable hospitalisations in Australia by small geographic areas, 2020-21 to 2021-22; AIHW (2022) Australia's children: Dental health



1

Dental conditions are the leading cause of potentially preventable hospitalisations in NSW

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A lack of access to and affordability of early intervention and prevention is costing NSW

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Targeting priority groups through preventative care uses a finite budget efficiently to address the groups with the highest rates of potentially preventable hospitalisations

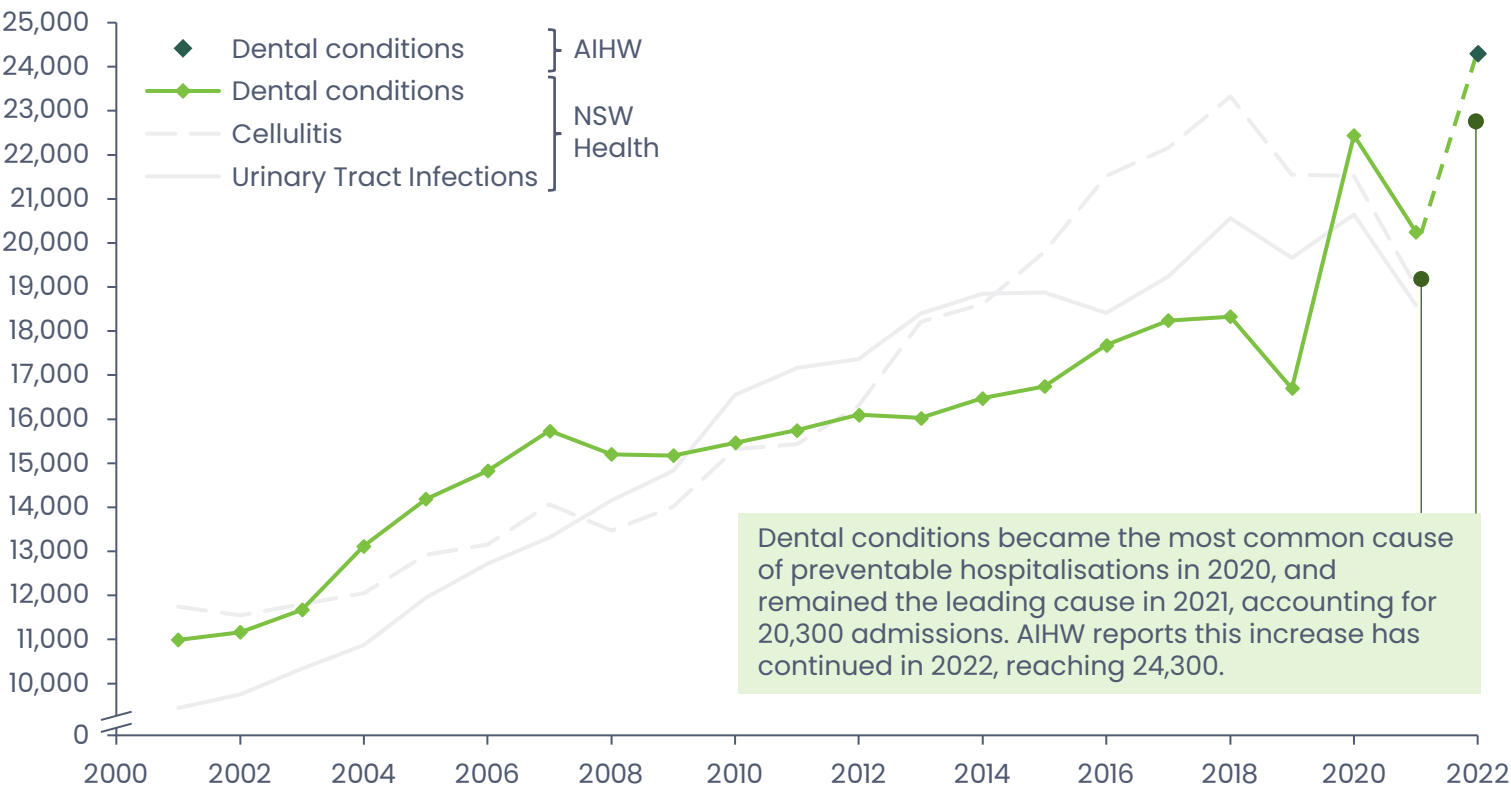
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Appendix

Dental conditions are now the leading cause of potentially preventable hospitalisations (PPH) in NSW, contributing to ~24,300 admissions in 2022

Top three most common causes of PPH in NSW

Number of hospitalisations, historical trend for top three common causes to 2022/23



Dental conditions became the most common cause of preventable hospitalisations in 2020, and remained the leading cause in 2021, accounting for 20,300 admissions. AIHW reports this increase has continued in 2022, reaching 24,300.

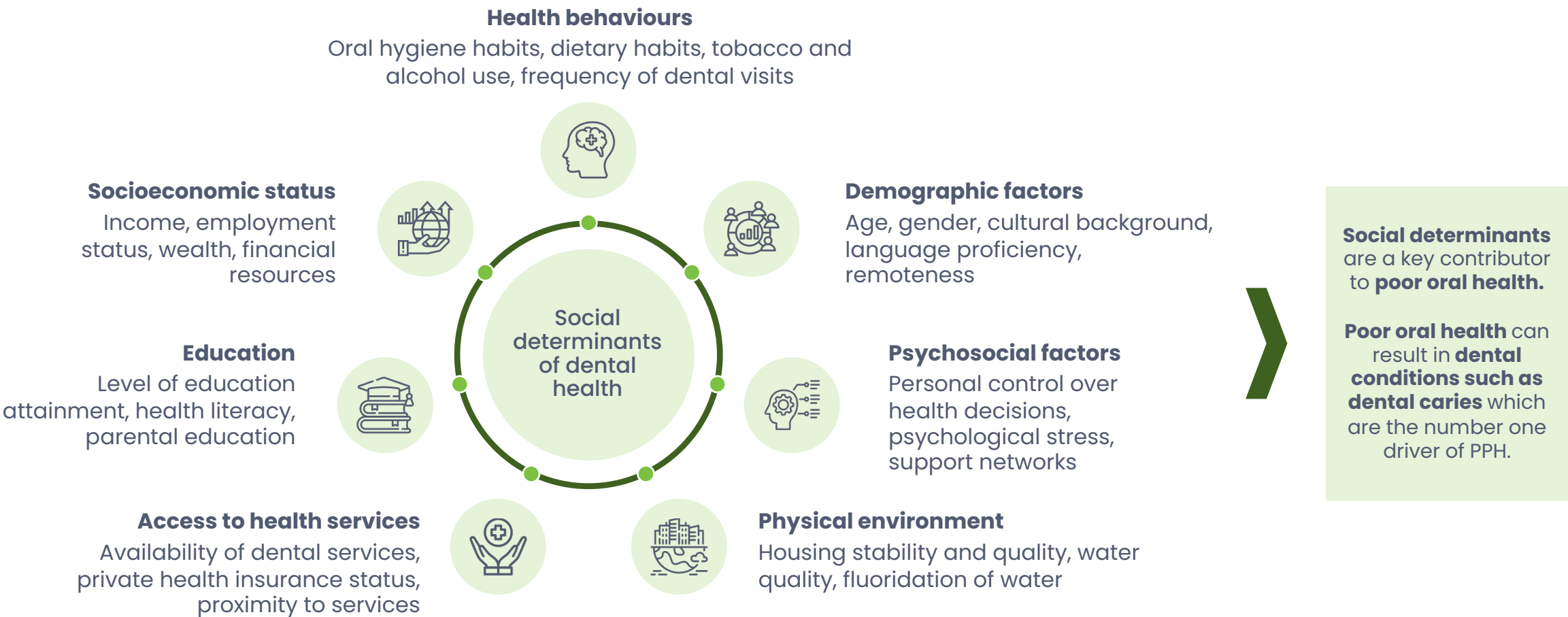
Key points

- PPH are admissions to hospital which could be avoided through timely and adequate health care in the community¹
- Dental conditions which contribute to PPH are tooth decay, gum disease, other tissue diseases, gum and jaw disorders, oral cysts, irritation or lesions to mucous membrane, and tongue swelling²
- Most of these dental conditions are preventable and can be treated in early stages, but some groups have different clinical patterns that affect dental PPH. For example, people aged over 65 years may have co-morbidities that may require planned admissions
- Preventable hospitalisations from dental conditions in NSW have grown at 3% each year, faster than population growth rate of 1% each year.³ While there was a slight decline from 2020 to 2021, it remains to be seen if this trend or the long-term trend of 3% yearly growth continues

1 AIHW (2019) Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18
2 AIHW (2021) National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2021
3 ABS (2024) National, state and territory population
Note: See Appendix slide 30 for full list of dental conditions included in dental PPH statistics. This chart uses data from both NSW Health and AIHW to demonstrate longer term trends in PPH. The remainder of this report uses AIHW data only.
Source: Health Stats NSW (2025) Potentially preventable hospitalisations: Conditions; AIHW (2024) Oral health and dental care in Australia

Social determinants of health are key contributors to preventable dental conditions such as dental caries

Social determinants of oral health



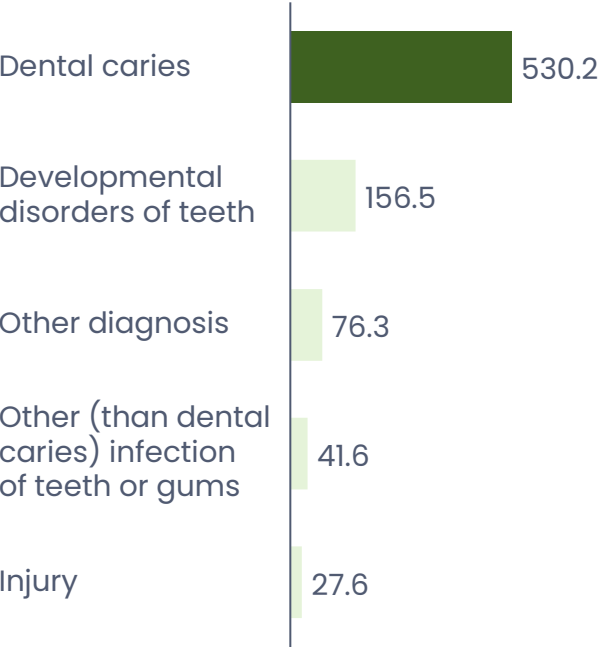
Source: Royal Flying Doctor Service (2015) *Filling the gap disparities in oral health access and outcomes in remote and rural Australia*; Australian Dental Association (2023) *Policy Statement 2.10 – Oral Health and the Social Determinants of Health*; Mandala analysis.

Dental caries are the leading cause of dental hospitalisations among children and those aged over 65

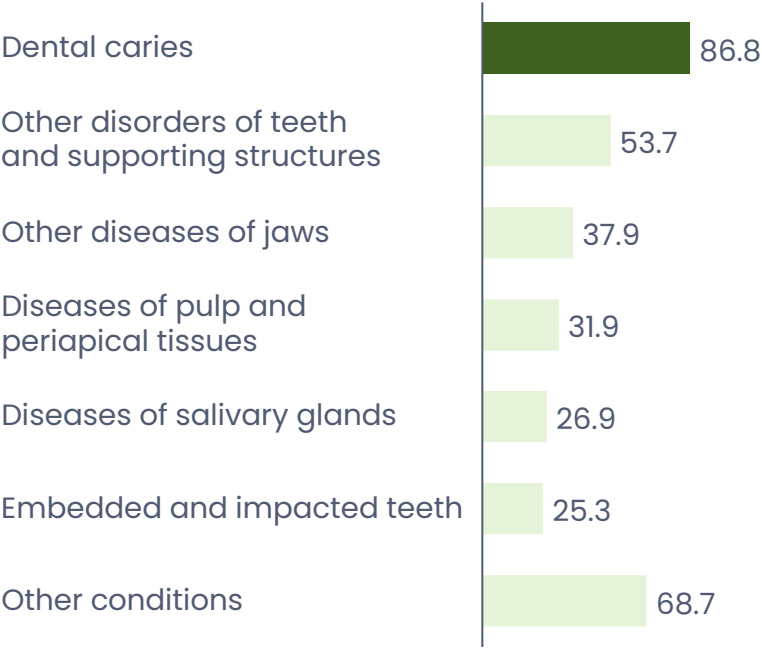
Oral health hospitalisations, by reason for hospitalisation

Rate per 100,000 population, by condition, 0-14 years in 2022/23 (L) and 65+ years in 1998-2019 (R)

0-14 years



65+ years



Key points

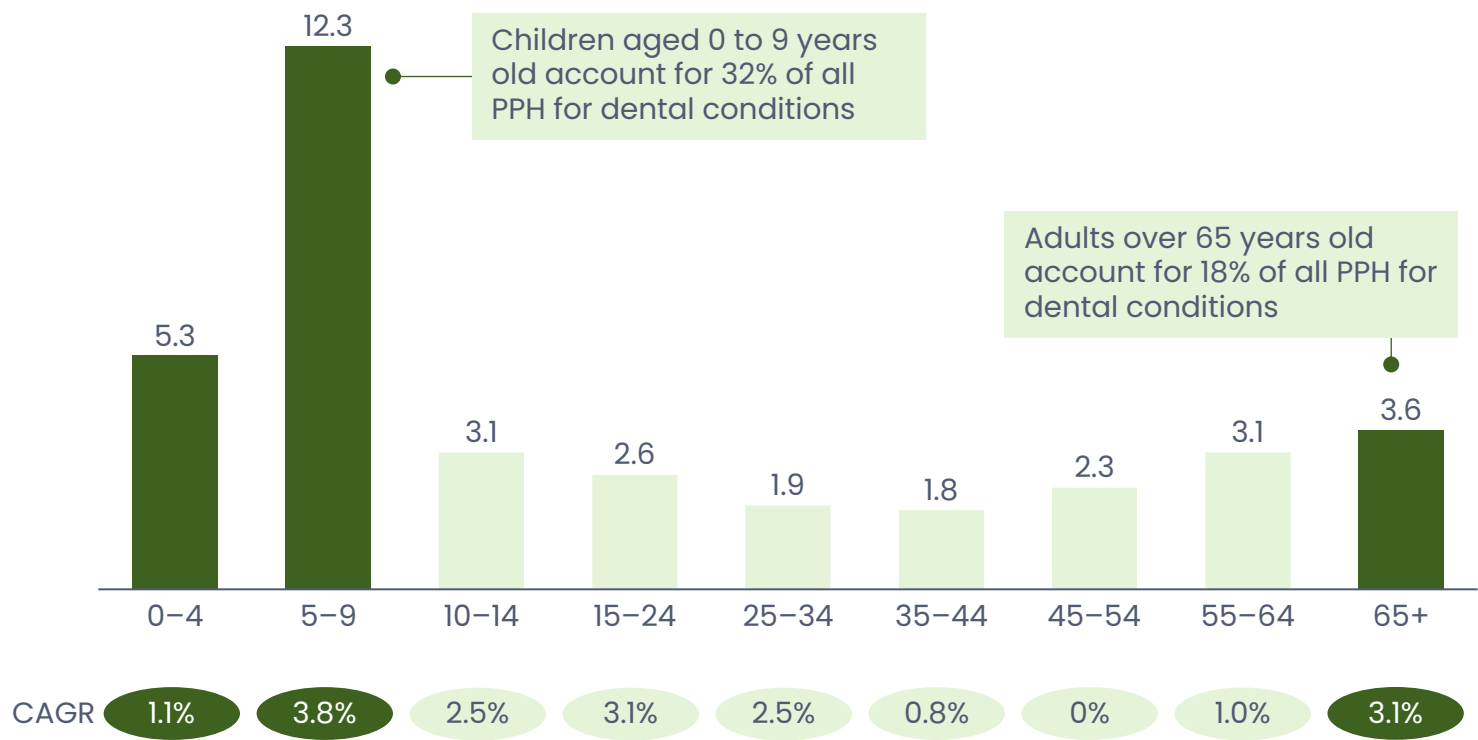
- Dental caries contribute the greatest number of dental hospitalisations among both children and older people
- Dental caries results when plaque forms on the surface of a tooth and converts the sugars from food and drinks consumed into acids that destroy the tooth over time
- A continued high intake of sugar, inadequate exposure to fluoride and a lack of removal of plaque by toothbrushing can lead to caries, pain, and sometimes tooth loss and infection
- For children, prolonged exposure to sugary beverages like fruit juice or milk from a bottle can lead to tooth decay. Dental caries among young children is the most common childhood disease, five times more common than asthma
- In older people, poor oral health can result in a decline in the ability to eat and, as a result, dietary intake is often compromised and the risk of malnutrition increases

Note: Sources use different condition classifications. Other conditions refers to other diseases of lip and oral mucosa, stomatitis and related lesions, diseases of tongue, dentofacial anomalies (including malocclusion), gingivitis and periodontal diseases, cysts of oral region, not elsewhere classified, other disorders of gingiva and edentulous alveolar ridge, disorders of tooth development and eruption and other diseases of hard tissues of teeth.
Source: NSW Ministry of Health (2023) NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI); Kamil, W et al. (2021) Hospitalization for Oral Health-Related Conditions of the Australian Ageing Population: Two Decades of Analysis; World Health Organisation (2025) Oral Health; Mandala analysis.

The rate of preventative dental hospitalisations is highest amongst children aged 5 to 9, lowest in the working age groups, and increases again as people approach 65+

Potentially preventable hospitalisations for dental conditions by age group

Population rate per 100,000 of potentially preventable hospitalisations, 2022/23; CAGR 2016/17 – 2022/23



Key points

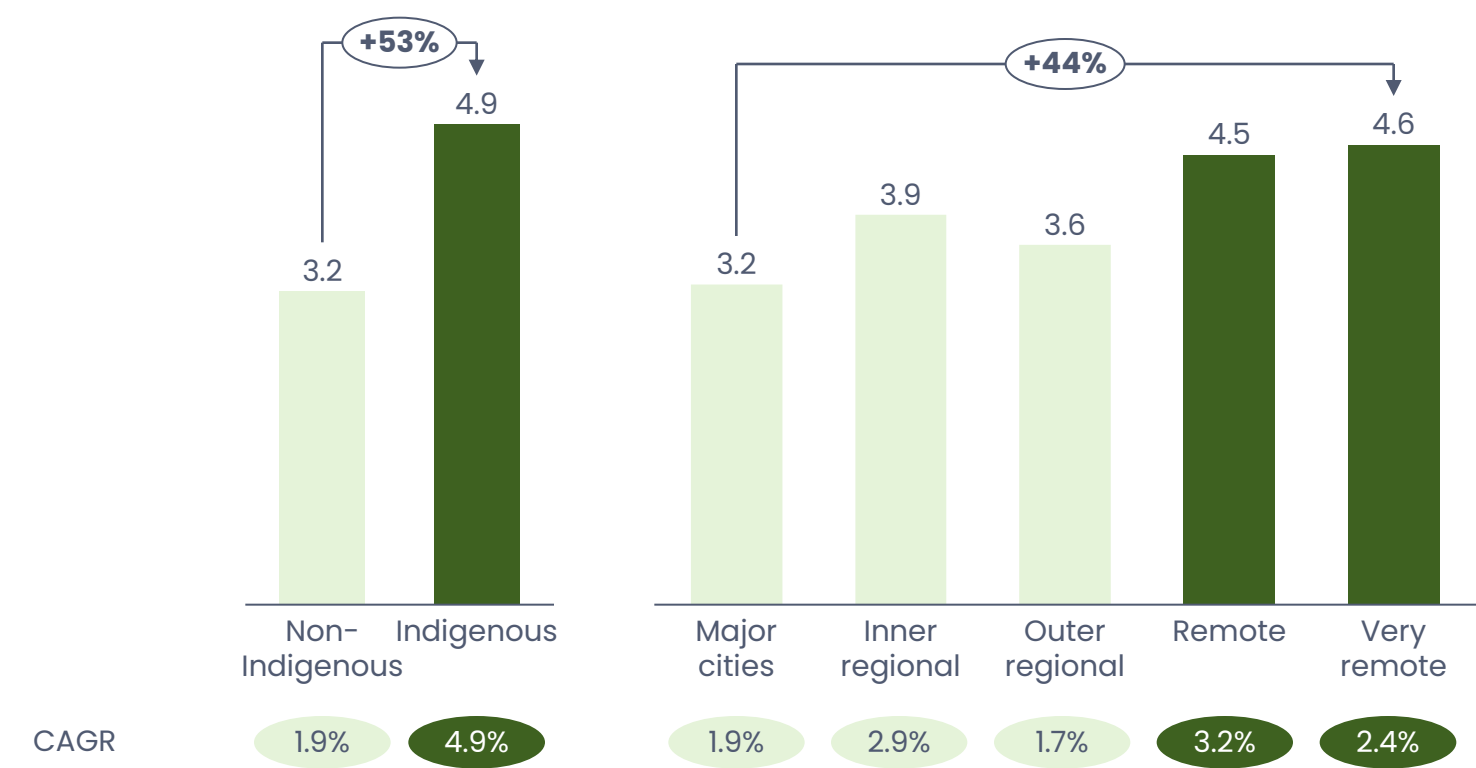
- Poor oral health is highly concentrated amongst children, with those 5 to 9 years old experiencing the highest rates of PPH per 100,000 people at 12.3. This is more than double the next most vulnerable cohort, children between 0 to 4 years old (5.3)
- While PPH are most prevalent amongst children, there is a decline in PPH over middle age before an upward trend towards another peak amongst those aged 65 and over
- PPH for aged 65 and over are increasing at a rate of 3.1% year on year, with 5 to 9 age cohort the fastest growing at 3.8%
- Children with poor oral health become adults with ongoing dental problems, creating lifelong demand for healthcare services and repeated hospitalisations
- Tooth loss in older adults leads to malnutrition and increased infection risk, resulting in greater reliance on the health system and higher hospitalisation rates

Note: Potentially preventable hospitalisations related to dental care are defined as the following ICD-10-AM Principal diagnosis categories: K02 Dental caries, K03 Other diseases of hard tissues of teeth, K04 Diseases of pulp and periapical tissues, K05 Gingivitis and periodontal diseases, K06 Other diseases of gingival and edentulous alveolar ridge, K08 Other disorders of teeth and supporting structures, K09.8 Other cysts of oral region, not elsewhere classified, K09.9 Cyst of oral region, unspecified, K12 Stomatitis and related lesions, K13 Other diseases of lip and oral mucosa, K14.0 Glossitis.
Source: AIHW (2024) Oral health and dental care in Australia; Mandala analysis.

Aboriginal and Torres Strait Islander people and those who live in remote areas have high rates of preventative dental hospitalisations

Potentially preventable hospitalisations for dental conditions, by demographic characteristic

Population rate per 100,000 of potentially preventable hospitalisations, 2022/23; CAGR 2016/17 – 2022/23



Key points

- People who live in remote and very remote areas as well as Aboriginal and Torres Strait Islander people have higher rates of PPH per 100,000
- These cohorts have seen the rates of PPH per 100,000 increase at a higher rate since 2016/17, with the rate of PPH for Aboriginal and Torres Strait Islander people growing the fastest at 4.9% year-on-year
- Those who live in remote and very remote parts of NSW and Aboriginal and Torres Strait Islander people are over-represented in PPH for dental conditions
- People who live in remote and very remote areas account for 3% of dental PPH but make up only 0.4% of the NSW population
- Aboriginal and Torres Strait Islander people account for 6% of dental PPH, despite only making up 3.4% of the NSW population

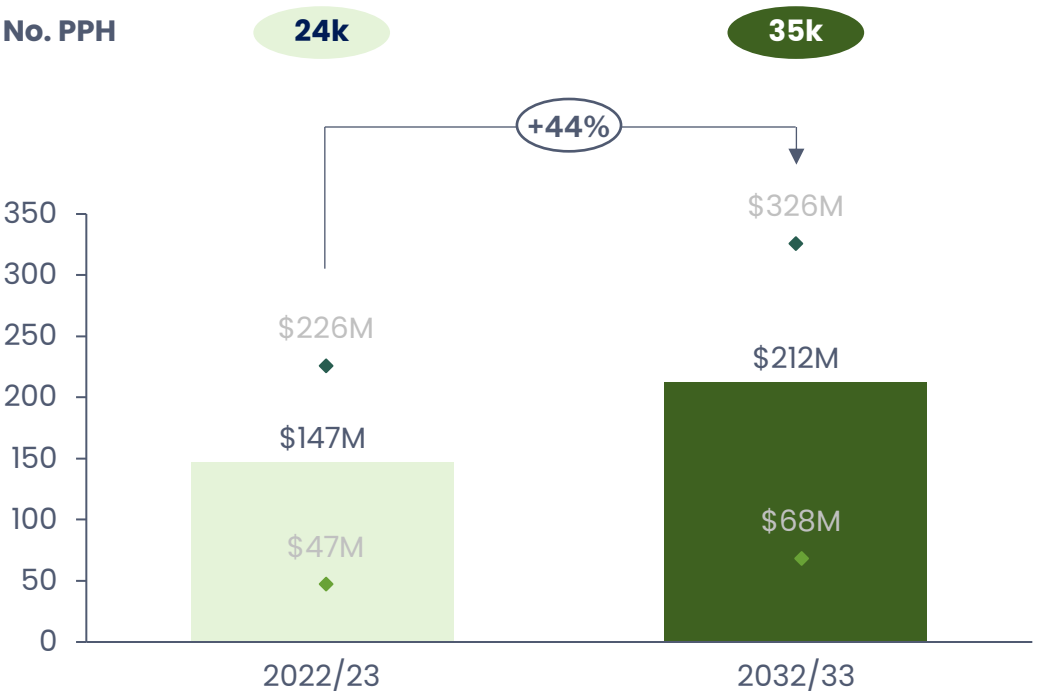
Note: Study covered people 15 years and older. Adult dentate population refers to the sub-group of the adult population who have natural teeth, which excludes those who have no teeth.
Source: AIHW (2024) Oral health and dental care in Australia; Do, L and Luzzi, L (2019) Australia’s Oral Health: National Study of Adult Oral Health 2017–18; Parliament of Australia (2023) A system in decay: a review into dental services in Australia – Chapter 4 – Filling the gaps: improving access for priority groups; ABS (2022) New South Wales: Aboriginal and Torres Strait Islander population summary; ABS (2021) Census; Mandala analysis.

Dental PPH could cost the NSW public and private health system \$147M each year, and could reach \$212M by 2033 if no action is taken to slow growth

Estimated cost to the NSW health system in PPH for dental conditions

\$ millions per year, 2022/23 to 2032/33 (including estimated range)

2022/23 2032/33 Lower bound Upper bound



- Cost estimates include overall annual figure and possible range
- These costs represent only the direct costs to hospitals (public and private) from individuals with dental PPH
- They do not account for the direct costs of non-hospital dental conditions or the indirect impacts on the economy from lost productivity due to dental conditions

Key points

- Dental PPH represent 13% of all PPH in NSW at a direct cost to hospitals of \$147M in 2022/23 (estimated range between \$47M and \$226M)
- If no actions are taken to slow the growth of PPH for dental conditions in NSW, the cost will grow to \$212 million by 2032/33, which represents a 44% increase in the cost over the decade¹
- This would represent an increase in the number of PPH in NSW from 24,300 (in 2022) to 35,100 in 2033
- While this analysis does not separate private and public distribution of costs, it is estimated that the split is approximately 70:30, according to advice from NSW Health

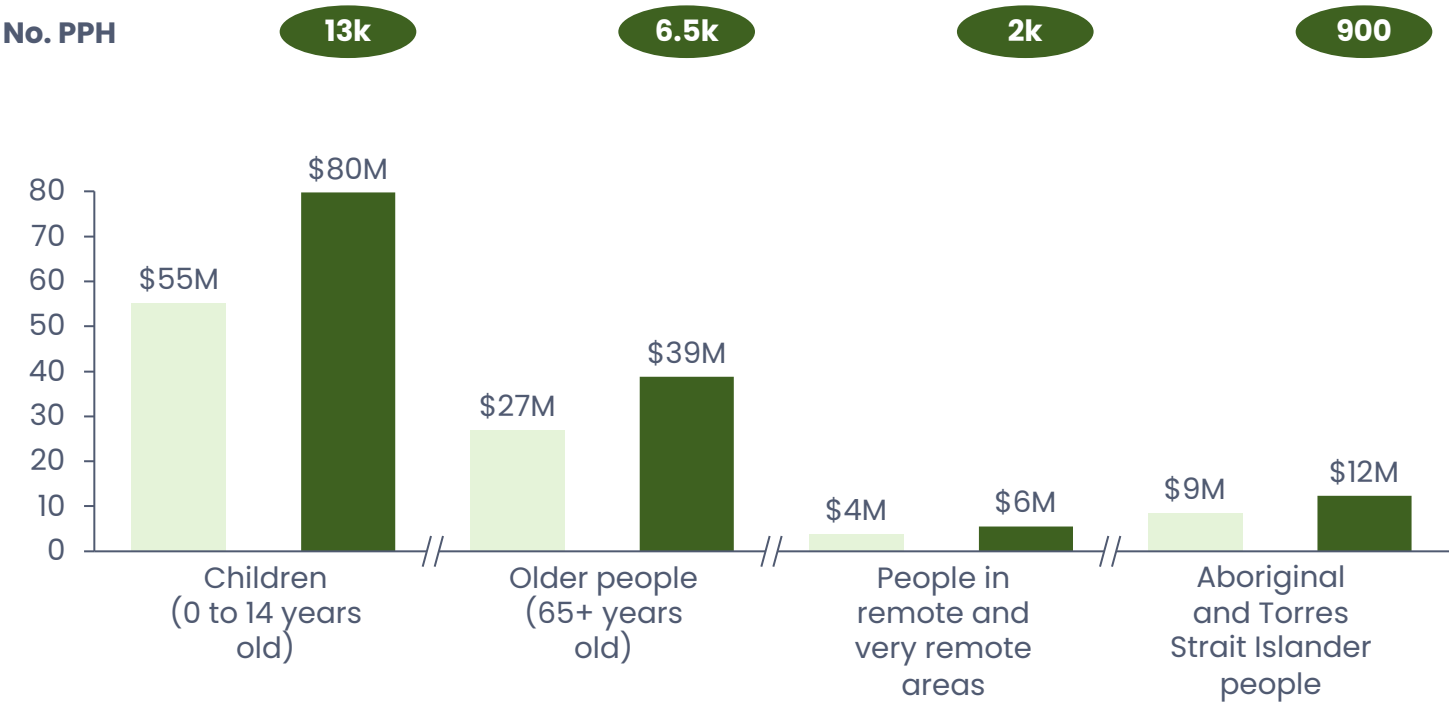
¹ Assumes the compound annual growth rate of dental PPH in NSW from 2013/14 to 2022/23 (3.7%) continues to 2032/33.
Source: AIHW (2024) Oral health and dental care in Australia; AIHW (2021-22) Admitted patient care 2021-22 7 Costs and funding, Table 7.4 via DCJ (2024) DCJ Benefits Database; AIHW (2022) Potentially preventable hospitalisations in Australia by small geographic areas, 2020-21 to 2021-22; AIHW (2024) Health Expenditure Australia; IHACPA (2025) National Efficient Price Determination 2025-26; IHACPA (2025) NWAU calculators; NSW Health; Mandala analysis.

Children with dental PPH could be costing the NSW public and private health system \$55M each year

Estimated cost to the NSW health system in PPH for dental conditions

\$ millions per year, 2022/23 to 2032/33 (estimated)

2022/23 2032/33



Key points

- Children drive the largest portion of dental PPH in NSW, so programs targeting children have the potential to save the most money
- Targeted interventions are important for equity and for achieving universal health outcomes
- If no actions are taken to slow the growth of PPH for dental conditions in NSW, the cost of PPH for children grow to \$80 million and the cost of PPH for older people grow to \$39 million
- These costs do not account for additional comorbidities that individuals in these groups may experience
- While this analysis does not separate private and public distribution of costs, it is estimated that the split is approximately 70:30, according to advice from NSW Health

1 Assumes the compound annual growth rate of dental PPH in NSW from 2013/14 to 2022/23 (3.7%) continues to 2032/33. The cost of PPH for priority groups cannot be added together as priority groups are not mutually exclusive. See appendix for upper and lower bounds for subgroups.
Source: AIHW (2024) Oral health and dental care in Australia; AIHW (2021-22) Admitted patient care 2021-22 7 Costs and funding, Table 7.4 via DCJ (2024) DCJ Benefits Database; AIHW (2022) Potentially preventable hospitalisations in Australia by small geographic areas, 2020-21 to 2021-22; AIHW (2024) Health Expenditure Australia; IHACPA (2025) NWAU calculators; Mandala analysis.



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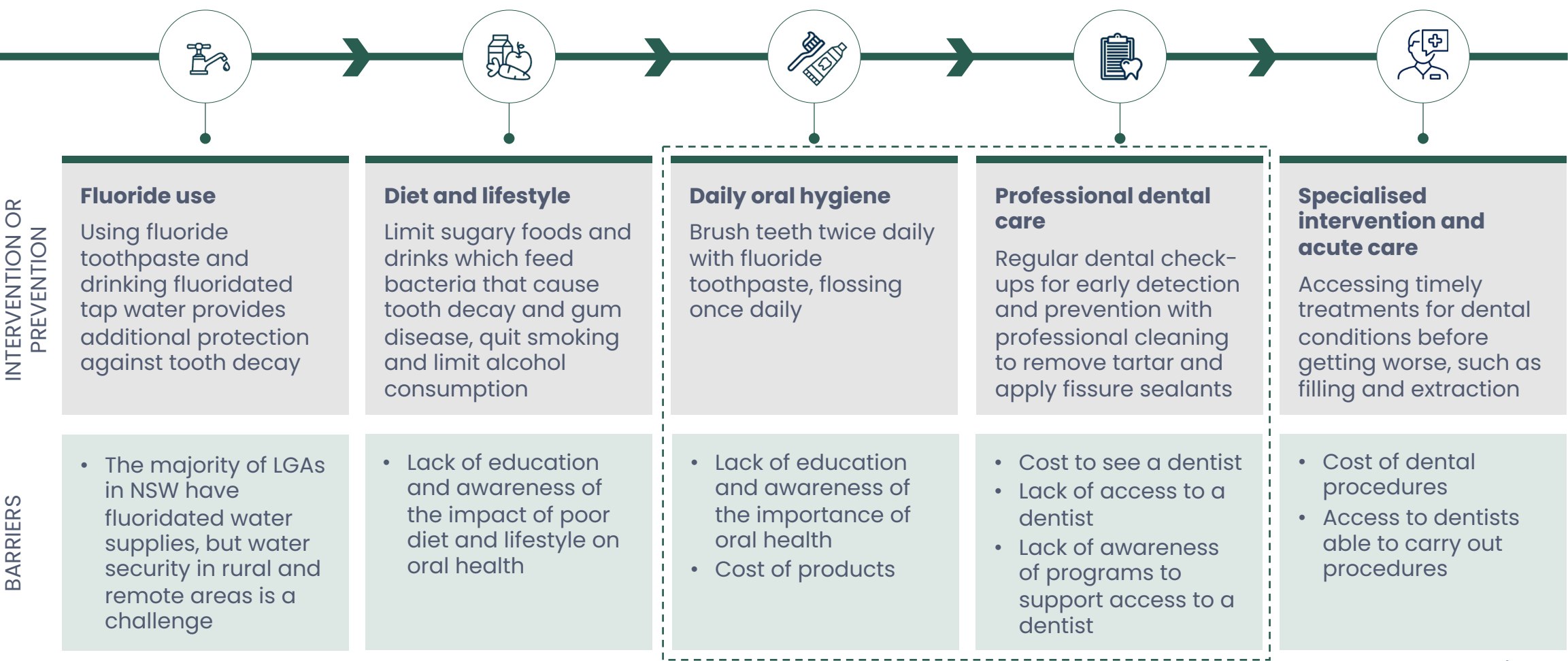
Targeting priority groups through preventative care uses a finite budget efficiently to address the groups with the highest rates of potentially preventable hospitalisations

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Appendix

Improving oral hygiene education and access to professional dental care would prevent poor oral health progressing to the point where hospitalisation is required

Points of prevention or intervention



Note: Fissure sealants are a dental treatment applied to prevent tooth decay

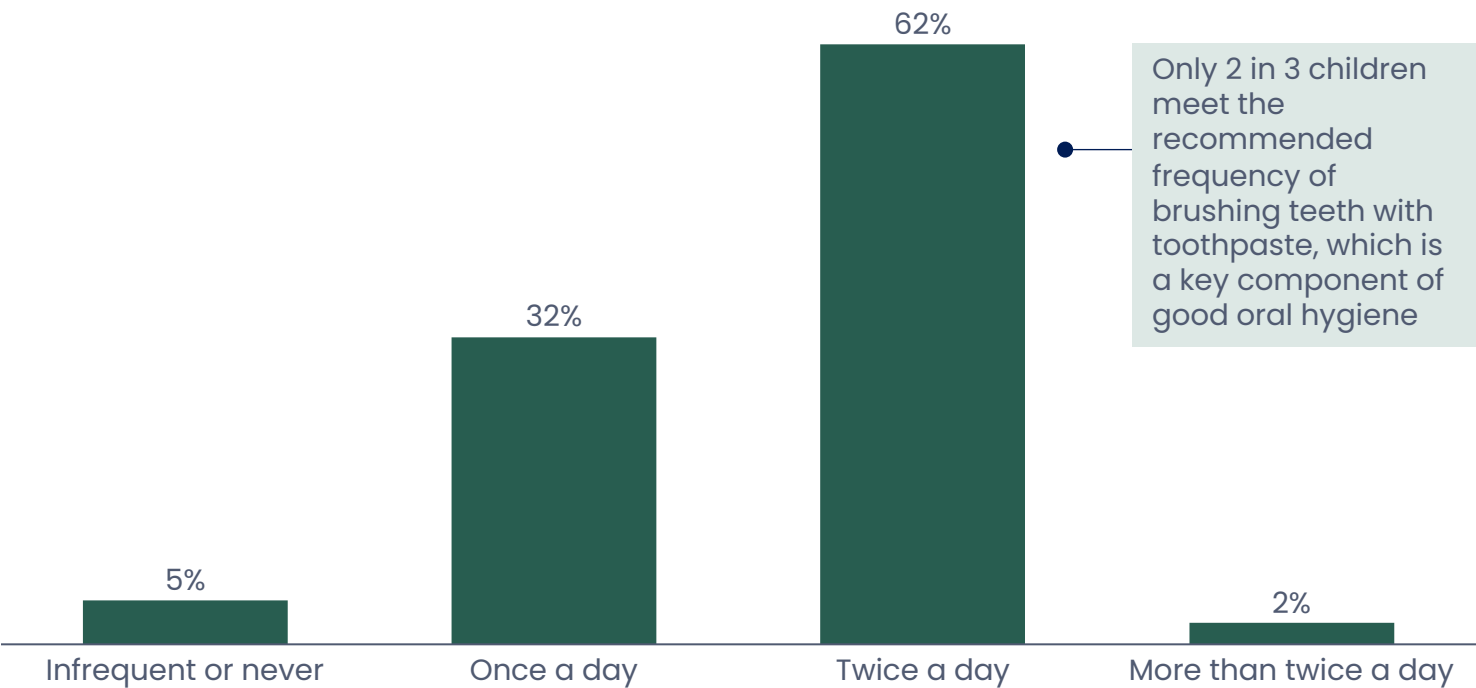
Areas of focus for recommendations for improving preventative care, see next section for details



One third of children do not meet the recommended frequency of brushing teeth with toothpaste, despite it being an affordable preventative care method

Frequency of children brushing teeth with toothpaste

Percentage of children aged 5 – 15 years old, 2022/23



Key points

- Good oral health habits need to start early and be maintained during childhood to ensure health and well-being into adulthood
- All children need to brush their teeth, gums and tongue twice a day
- At a national level, children from high-income households (78%) were more likely to brush their teeth twice daily than children from low-income households (59%)¹
- Aboriginal and Torres Strait Islander children (54%) were less likely to brush their teeth twice daily with toothpaste than non-Indigenous children (70%)¹
- One in eight parents (13%) held the misbelief that children only need to brush their teeth if they eat sugary foods and 9% incorrectly felt that children don't need to brush their teeth after dinner if they eat fruit²

¹ AIHW (2024) Oral health and dental care in Australia

² Rhodes, A (2018) Child oral health: Habits in Australian homes

Source: HealthStats NSW (2023) Frequency of children brushing teeth with toothpaste; NSW Health (2024) Advice for children and young people 6-17 years



Private dental is unaffordable for many Australians, with 21% of people delaying seeing a dentist due to cost

NSW population who delayed seeing or did not see a dentist due to cost

Percentage, 2024



Key points

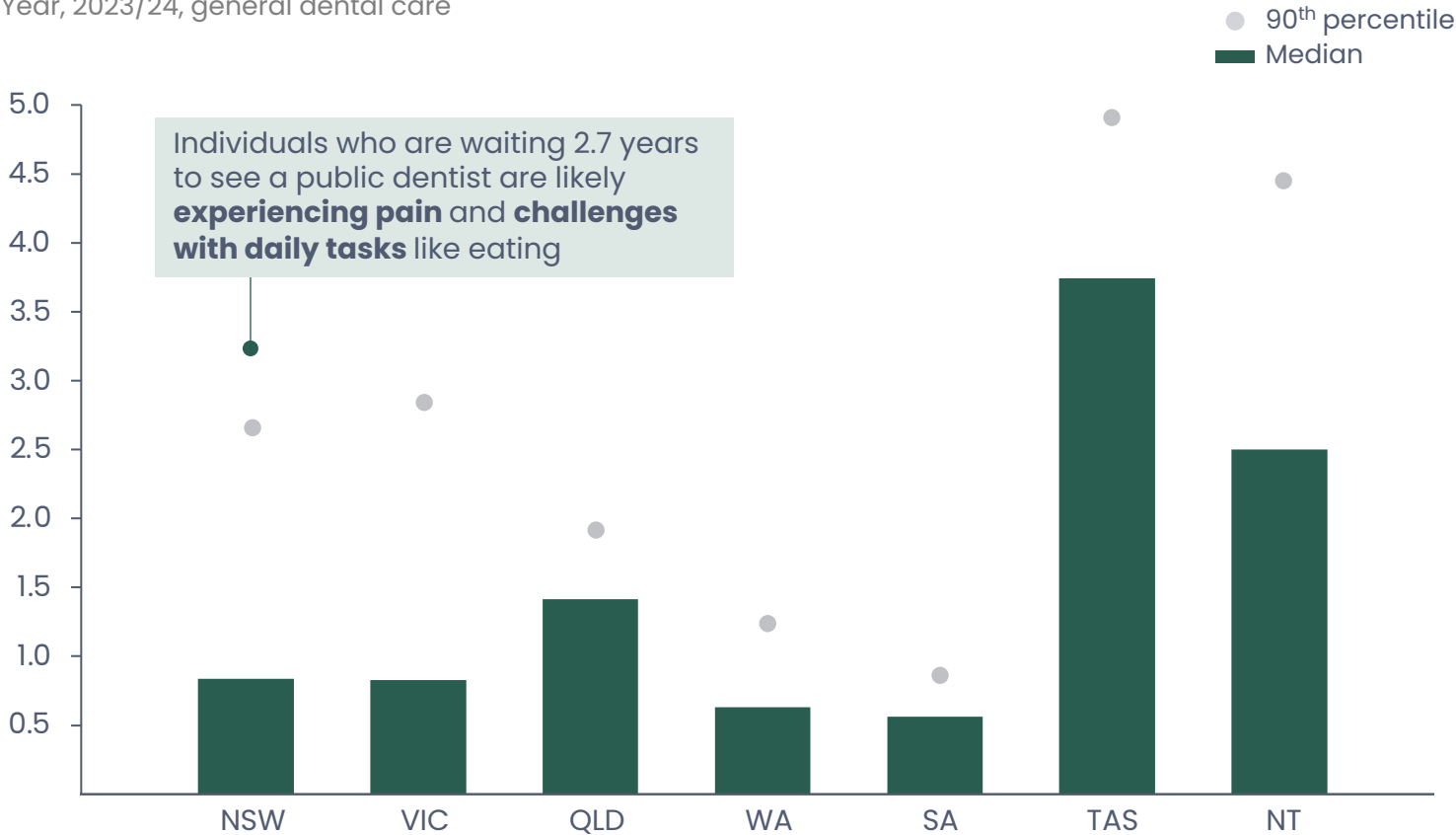
- Across NSW, 21% of people delayed seeing or did not see a dentist due to cost in 2024
- The cost of dental care is a greater concern for those who live in regional NSW and those on lower incomes
- Almost twice as many people in regional NSW (30%) delayed seeing or did not see a dentist due to cost, compared to those who live in greater Sydney (17%)
- 31% of those on low incomes delayed seeing or did not see a dentist due to cost, compared to 21% of those on medium or high incomes
- When both factors are combined, almost half (42%) of individuals who are low-income and live in regional NSW delayed or did not see a dentist
- People with Private Health Insurance (PHI) have access to dental care through their extras on their policy, but those without PHI must pay out of pocket
- Those on lower incomes are less likely to have PHI, meaning they are required to cover the cost of private dental care themselves



While public dental care is available in Australia, individuals can wait up to 2.7 years in NSW to see a dentist

Wait time for first visit to receive public dental care, by state and territory³

Year, 2023/24, general dental care



Key points

- Dental care through the public system is based on eligibility and involves lengthy wait periods¹
- In NSW, eligibility for adults requires either a Health Care Card, Pensioner Concession Card or Commonwealth Seniors Health Card²
- People in NSW experience a median wait time of 0.8 years to see a public dentist, with some waiting up to 2.7 years
- Some Aboriginal and Torres Strait Islander people and those who live in very remote areas are waiting the longest to access public dental care, with 90% of cases waiting up to 3.4 and 4 years respectively
- Long wait periods can result in treatable dental health issues becoming severe and requiring greater interventions to treat oral health issues
- Public dental wait periods are driven by rising costs of private dental care and limited supply of public dental resources

¹ Access to public dental care in NSW is administered through local health district-operated public dental clinics, usually located in public hospitals and community health centres

² NSW Health (2025) *Public dental services – information for patients*

³ Data not available for the ACT

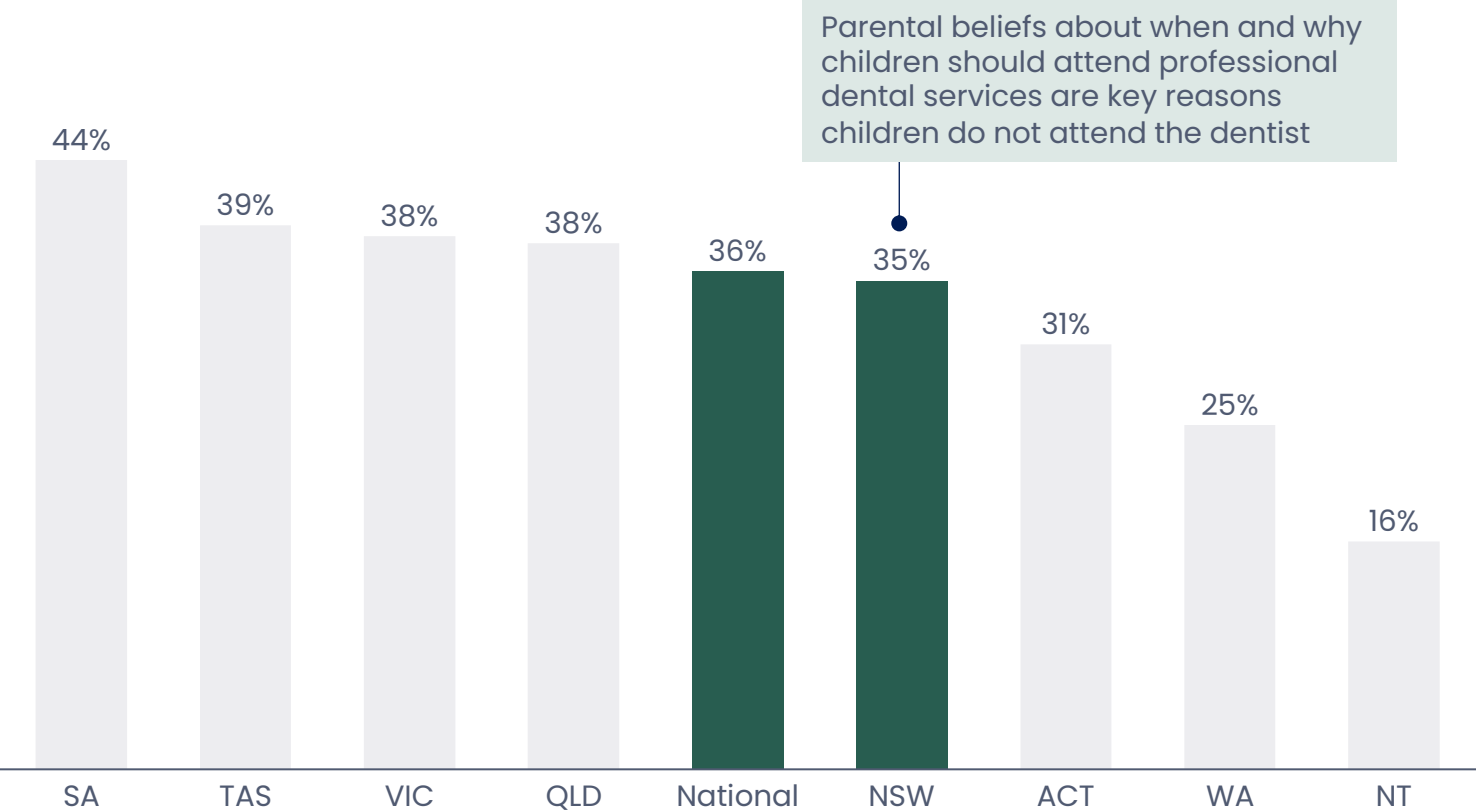
Source: Productivity Commission (2025) *Report on Government Services 2025 – 10 Primary and community health*



Only 35% of eligible families in NSW use the Child Dental Benefits Schedule

Utilisation of the Child Dental Benefits Schedule (CDBS)

Proportion of eligible children, by state and territory



Key points

- 45% of children in NSW are eligible for dental care under the CDBS of up to \$1,132 over two consecutive calendar years¹
- Uptake is low, with only 35% of eligible children using the initiative, just below the national average of 36%
- Utilisation of CDBS by eligible children in NSW has declined by 3.2% between 2018 to 2021, a more significant drop than the national decline of only 1.8% over the same period
- Non-operative appointments (diagnostic and preventive) are more common under the CDBS
- 43% of appointments in remote and very remote areas are operative compared to 29% in cities
- There is a higher proportion of operative appointments (fillings and extractions) in remote and low-socioeconomic areas, which could be driven by a combination of a lack of availability or accessibility of dental services, a lack of awareness of the CDBS and their eligibility, or families choosing to save money for more serious dental concerns

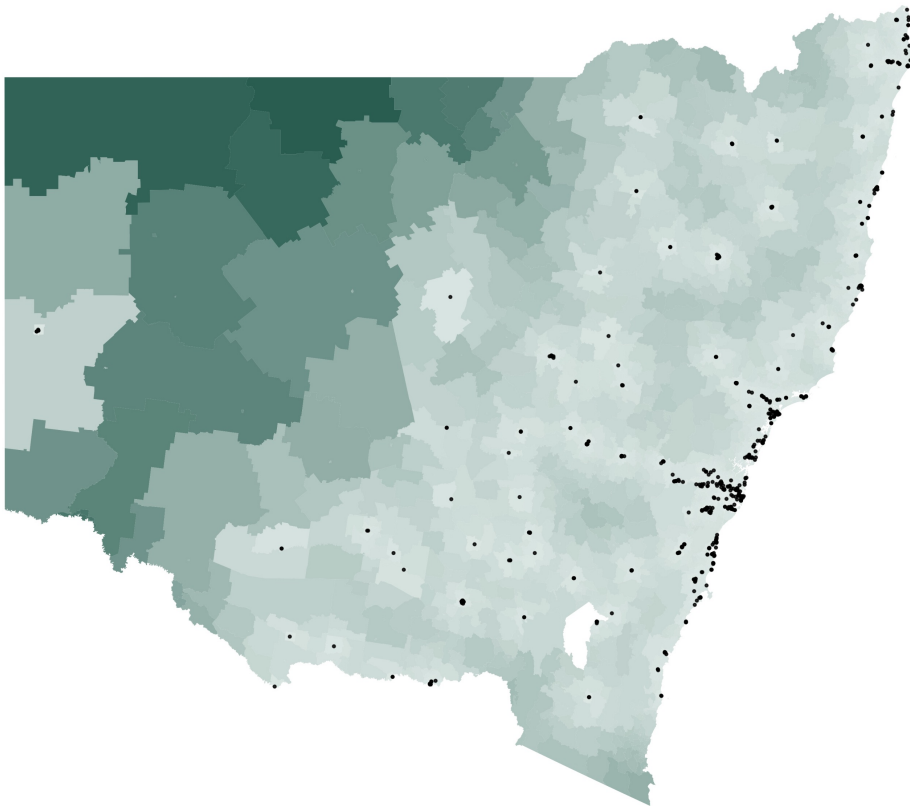
¹ Children are eligible for the CDBS if aged between 0 and 17 and receive (or their parent or guardian receives) certain Centrelink payments, such as family Tax Benefit Part A, Parenting Payment, ABSTUDY, the Disability Support Pension, and other payments
 Source: AIHW (2021) Oral health and dental care in Australia – Dental Care; Aminian, P et al. (2023) Effects of the Child Dental Benefits Schedule on dental hospitalisation rates in Australian children; Department of Health and Aged Care (2025) Guide to the Child Dental Benefits Schedule (CDBS)

Individuals travel close to 300km to visit a dentist in parts of NSW, increasing the risk of missing regular dental check-ups

Distribution of dentists by SA1 in NSW

Proximity to a dentist, shading represents the distance of a dental practice to the centre of the SA1

Near a dentist  Far from a dentist ● Dental practice



Key points

- Individuals living in Bourke, in the north-west of NSW, have the greatest distance to a dentist of 298km. The second furthest distance to a dentist, 283km, is in Far West, which is the western most part of NSW
- Many places with the fewest dentists are in remote and very remote areas, meaning people must travel considerable distances to access a dentist
- In greater Sydney, there are pockets with limited accessibility to dentists. The greatest distance to a dentist is 24km which is in Bargo, Macarthur Region of Greater Sydney, followed by Douglas Park, with 21km to a dentist

Note: The data set of dental locations may not be complete as it is based on data from Google Maps. Not all services may advertise themselves on Google Maps as a dental service. SA1 (Statistical Areas Level 1) are small geographic areas defined by the ABS, commonly representing a population of between 200 and 800 people.
Source: Google Maps; ABS (2021) Digital boundary files; Mandala analysis.

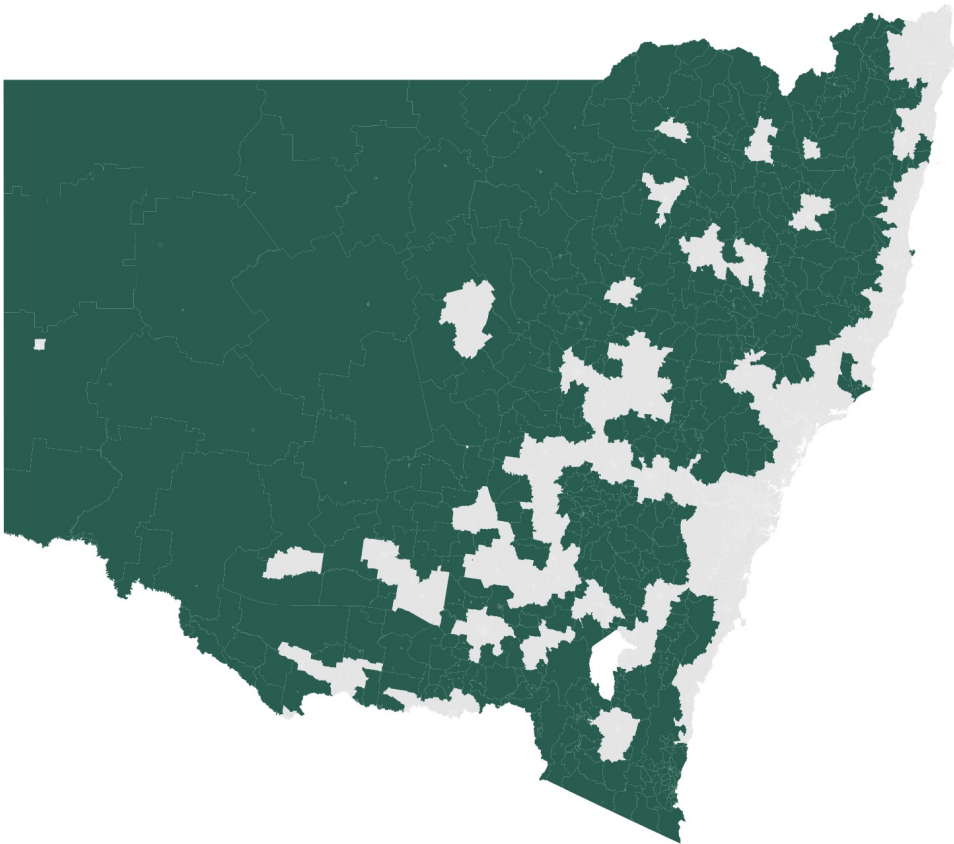


'Dental deserts' are concentrated in very remote, remote and outer regional areas of NSW, with 287,000 individuals living more than 25km from a dentist

Dental deserts, where there is no dentist within 25km, in NSW

Distance to a dentist, km

Dentist within 25km *No dentist within 25km*



Key points

- Approximately 4% of the population in NSW are 25km or more from a dentist
- This represents 287,000 individuals who must travel more than 25km to visit a dentist
- Most areas are in very remote, remote and outer regional areas of NSW
- Dental deserts form distinct corridors along the western inland regions, creating significant access barriers for rural communities
- The largest continuous dental desert spans from the Murray River region through central-west NSW to the Queensland border
- Many residents must travel to major regional centres like Dubbo, Orange, or Albury for dental services
- Travel costs and time away from work create additional barriers beyond distance alone

Note: 'Dental desert' here is defined as an SA1 which is more than 25km from a dentist.
Source: Google Maps; ABS (2021) *Digital boundary files*; Mandala analysis.

Outreach services exist and attempt to support people who fall through the gaps of other services, but coverage is incomplete

Outreach services for target groups

Target group	Program	Limitations
Children	NSW Health Primary School Mobile Dental Program use dental vans to provide examinations, dental x-rays, clinical photographs, cleaning, fluoride varnish and fissure sealants	Not available to all children: For example, the Mobile Dental Vans operates in 11 local health districts out of 15 in NSW and services 136,000 primary school children each year
	My School Dentist use dental vans to provide dental check-ups, and where necessary, x-rays, cleans, fluoride treatment, dietary advice and oral hygiene instruction	
Aboriginal and Torres Strait Islander people	NSW Health assists Aboriginal Community Controlled Health Organisations (ACCHOs) to provide dental care for their patients	Limited ACCHO dental services: Over 50% of Aboriginal and Torres Strait Islander people prefer to attend an ACCHO over a non-Indigenous practice but limitations on available appointments result in people being turned away
	Smiles not Tears dental education program trained and supported Aboriginal Health Workers to educate parents and guardians about oral health	
Low-income adults	Filling the Gap provides pro bono dental treatment for vulnerable people who are unable to access mainstream oral health services	Relies on volunteers: The program relies heavily on volunteer dentists and limited resources, which can impact the scope and reach of the treatment provided
People in rural and remote areas	Royal Flying Doctor Service (RFDS) provide regular oral health services through a specialist dental van and fly-in fly-out clinics	Limited capacity: The RFDS does not have the capacity to reach all rural and remote at the frequency required
Older Australians	Aged Care Dental Program provided through the Australian Dental Foundation, which provides dental services for individuals living in residential aged care facilities	Excludes home care: Home care is increasing in popularity, and existing dental programs do not service this segment of the ageing population
	Senior Smiles provides dental care in residential aged care facilities in NSW	

Source: NSW Health (2024) *NSW Health Primary School Mobile Dental Program*; NACCHO (2023) *Provision of and Access to Dental Services in Australia*; Filling the Gap (2023) *Filling gaps, changing lives*; Senior Smiles (n.d.) *About Us*; Mandala analysis.

Early intervention and prevention are well-supported by public health literature as the most effective way to prevent dental caries

Select public health literature demonstrating the effectiveness of early intervention and prevention in oral health

 Jurisdiction of study



Fluoride is a cost-effective prevention strategy for dental caries

Biannual professional application of fluoride varnish is a highly cost-effective strategy for preventing dental caries in permanent teeth, with incremental cost-effectiveness ratios well below commonly accepted thresholds¹



Preventative care delivers a positive return on investment

Economic analysis shows that both eliminating gingivitis using home care prevention techniques and increasing the rate of diagnosis and management of periodontitis to 90%, has a positive return on investment in all the European countries in the study²



Benefits of intervention outweigh cost of treatment in long-term

The study found that over a 12-year period, school-based fluoride varnish programs are highly cost-effective for preventing dental caries in low-income Australian children, but this positive cost-benefit is only clear when long-term and broader healthcare savings are considered³



Educating parents generates patient benefits and cost savings

A telephone-based education program for parents of young children prevented an estimated 43 carious teeth per 100 children and saved substantial healthcare costs by age six, proving highly cost-effective in disadvantaged communities⁴



School-based dental check-ups save money and improve outcomes

An economic evaluation of a pilot Australian school-based dental checkup program found it was less costly and more effective than standard care, resulting in cost savings per child and improved oral health outcomes, particularly for children from low socioeconomic backgrounds⁵



Oral care education saves money on dental treatments in the future

A 30-minute conversational intervention, focused on setting goals and supporting healthy routines, was more effective than standard care alone. Over two years, children whose families received the intervention had fewer dental problems, and reduced costs for the NHS on dental treatments⁶

1 Nguyen, T.M et al. (2019) A Markov cost-effective analysis of biannual fluoride varnish for preventing dental caries in permanent teeth over a 70-year time horizon

2 The Economist Intelligence Unit. (2021). Time to take gum disease seriously: The societal and economic impact of periodontitis

3 Nguyen, T.M et al. (2025) Economic evaluation on dental caries preventive interventions for Australian children using a priority-setting approach

4 Pukallus, M et al. (2013) Cost-effectiveness of a telephone delivered education programme to prevent early childhood caries in a disadvantaged area: a cohort study

5 Nguyen, T.M et al. (2017) Economic Evaluation of a Pilot School-Based Dental Checkup Program

6 Victory, E et al. (2022) Cost-effectiveness Analysis of the Dental RECUR Pragmatic Randomized Controlled Trial: Evaluating a Goal-oriented Talking Intervention to Prevent Reoccurrence of Dental Caries in Children



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Appendix

Improving dental health outcomes for priority groups through improved preventative care can reduce PPH and address inequitable dental health outcomes

Key outcomes for target groups and recommendations to support achieving them

GROUP	RECOMMENDED OUTCOME	SUPPORTING RECOMMENDATIONS	ESTIMATED COST TO NSW
 Children	More children are receiving dental care, including through the Child Dental Benefits Schedule (CDBS)	1.1 Awareness of the CDBS 1.2 Primary school dental programs 1.3. Education for parents	\$3 million \$17 million \$3 million
 Older people	Older Australians in NSW have access to financial and other supports needed to maintain good oral health	2.1 Seniors Dental Benefits Schedule 2.2 Voucher scheme 2.3 Aged care staff training	\$0¹ \$65 million \$20 million²
 People in remote areas	People living in remote areas in NSW are supported to access preventative dental care	3.1. Expand the IPTAAS³ 3.2 Outreach services	\$20 million \$37.5 million
 Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people can access culturally-sensitive care and have the same right to clean drinking water as other citizens	4.1 Funding for ACCHOs 4.2 Ensure clean drinking water	\$4.6 million \$7 million per community²

These policies represent starting points for funding and different combinations can be implemented over time. They can be prioritised based on their likely impact, and feasibility (including cost to deliver), rather than implemented all in one step.

Discussed in more detail on following pages

More detailed assumptions and sources in appendix

¹ Cost of implementing a SDBS would be 0 for NSW as it would fall to the Commonwealth government to implement
² Costs could be shared with the Commonwealth government
³ Isolated Patients Travel and Accommodation Assistance Scheme

Targeting groups with high PPH is the most effective at reducing overall PPH rates in NSW, given funding limitations prevent introduction of universal programs

Overview of recommendations to address PPH from dental conditions

Children	Older people	People in remote areas	Aboriginal and Torres Strait Islander people
1.1 Run an awareness campaign for the Child Dental Benefits Schedule (CDBS) to increase uptake of the CDBS for preventative dental check-ups	2.1 Advocate to the Commonwealth government to introduce the Seniors Dental Benefits Schedule (SDBS), a similar program to the CDBS	3.1 Include general dental in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to support dental care access	4.1 Increase dedicated funding to Aboriginal Community Controlled Health Organisations (ACCHO) for dental care
1.2 Expand the reach of primary school dental programs through the NSW Health Primary School Mobile Dental Program	2.2 Launch a one-off voucher through a pensioner's Service NSW account to support a visit to the dentist, as an interim measure before universal dental care can be achieved	3.2 Increase funding for public dental outreach services to address shortages across NSW, prioritising areas of highest need and most disadvantage to reach an extra 7,500 people	4.2 Work towards ensuring access to fresh drinking water in all First Nations communities, including fluoridation where possible, to ensure water security
1.3 Educate parents on the importance of preventative dental care for children to overcome misconceptions about professional dental attendances	2.3 Provide education and training to staff in residential aged care facilities to provide preventative oral hygiene measures		

 Initially, priority groups with the greatest need for dental prevention and early intervention should be the focus to reduce preventable hospitalisations. These measures should be seen as steps towards universal dental care in the future.

Running an awareness campaign for the CDBS and increasing outreach funding are the most feasible and impactful recommendations

Recommendations ranked based on assessment of feasibility and impact

Recommendations		Feasibility	Impact	
3.2	Increase funding for public dental outreach services to address shortages across NSW, prioritising areas of the highest need and most disadvantage to reach an extra 7,500 people	High	High	Priority 1 for implementation
1.1	Run an awareness campaign for the Child Dental Benefits Schedule (CDBS) to increase uptake of the CDBS for preventative dental check-ups	High	Medium	
1.2	Expand the reach of primary school dental programs through the NSW Health Primary School Mobile Dental Program	High	Low	Priority 2
2.1	Advocate to the Commonwealth government to introduce the Seniors Dental Benefits Schedule (SDBS), a similar program to the CDBS	Low	High	
2.2	Launch a one-off voucher through a pensioner's Service NSW account to support a visit to the dentist, as an interim measure before universal dental care can be achieved	Medium	Medium	Priority 3
4.2	Work towards ensuring access to fresh drinking water in all First Nations communities, including fluoridation where possible, to ensure water security	Medium	Medium	
3.1	Include general dental in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to support those in rural and remote areas to access dental care	Medium	Medium	
4.1	Increase dedicated funding to Aboriginal Community Controlled Health Organisations (ACCHO) for dental care	Medium	Medium	
1.3	Educate parents on the importance of preventative dental care for children to overcome misconceptions about professional dental attendances	Medium	Low	Priority 4
2.3	Provide education and training to staff in residential aged care facilities to provide preventative oral hygiene measures	Medium	Low	

Notes: See appendix for more detailed information on feasibility and impact assessments

Expanding the reach of preventative dental programs and targeting parental awareness can improve the oral health of children and reduce PPH

Children

Policy options	1.1 Run an awareness campaign for the Child Dental Benefits Schedule (CDBS) to increase uptake of the CDBS for preventative dental check-ups	1.2 Expand the reach of primary school dental programs through the NSW Health Primary School Mobile Dental Program	1.3 Educate parents on the importance of preventative dental care for children to overcome misconceptions about children attending professional dental care
Context	- Low utilisation rates can be attributed to a general lack of awareness of the CDBS and a lack of understanding of the benefits for children in visiting the dentist regularly from an early age - Awareness campaign should focus on increasing the uptake of the CDBS for preventative dental check-ups - Cost will still be a barrier with parents concerned about out-of-pocket costs if dental care exceeds CDBS cap of \$1,132 over two years	1,000 schools have been visited, offering free dental care to 300,000 children since 2019 - Expansion of this program into more schools will increase the impact - Ensuring regular follow up services are provided across all schools will ensure continued preventative care	- Parental beliefs are a key reason children do not attend the dentist, with the top three beliefs not to attend being the child's teeth were healthy, they were not old enough to go to the dentist, or they would be scared to go to the dentist - Parents are unaware that children should have their first dental visit at 12 months, and most children miss out on essential early health promotion - Educating parents will ensure children develop healthy habits early in life
Feasibility	High	High	Medium
Impact	Medium	Low	Low

Source: Moloney, G et al. (2024) Socially constructed beliefs and the uptake of the Child Dental Benefits Schedule; Trinh, M-V et al. (2022) Dental visits in early life: patterns and barriers among Australian children; NSW Government (2024) Free dental check-ups provided to more NSW children; Department of Health and Aged Care (2023) Report on the Fifth Review of the Dental Benefits Act 2008; Mandala analysis.

Introducing programs to increase accessibility of dental care and upskilling professionals to provide preventative care will improve oral health for seniors

Older people

Policy options	2.1 Advocate to the Federal Government to introduce the Seniors Dental Benefits Schedule (SDBS), a similar program to the CDBS	2.2 Launch a one-off voucher through a pensioner’s Service NSW account to support a visit to the dentist, as an interim measure before universal dental care can be achieved	2.3 Provide education and training to staff in residential aged care facilities to provide preventative oral hygiene measures
Context	- As the population ages, the goal should be universal dental care for older people - The Parliamentary Budget Office calculated the cost to be \$1.143 billion a year in 2025–26 for 2.8 million eligible seniors - The Schedule would cover a maximum of \$1,132 worth of free dental care for qualifying seniors every two years - A proof of concept for the SDBS is operating in Maroubra Medical & Dental Centre in Sydney	- The voucher’s value should fully cover the cost of a standard dental check-up, in line with the schedule of fees set by the NSW Oral Health Fee for Service Scheme (OHFFSS) - Integrate the voucher scheme into the existing Service NSW digital platform, ensuring simplicity and efficiency - Provide support and alternative access options (such as phone or in-person assistance) to those without an account or digital access	- The <i>Royal Commission into Aged Care Quality and Safety Final Report</i> found dental and oral health are not treated as a priority in residential aged care - Staff in residential aged care facilities should have appropriate training and understanding of the need for dental care of older people - Training should include the provision of daily preventative oral hygiene for individuals with more complex needs such as dementia
Feasibility	Low	Medium	Medium
Impact	High	Medium	Low

Source: Australian Dental Association (2025) *Why does Australia need a Seniors’ Dental Benefits Schedule now?*; Parliament of Australia (2023) *A system in decay: a review into dental services in Australia – Chapter 4 – Filling the gaps: improving access for priority groups*; Australian Dental Association (2025) *Pilot aims to transform oral health of millions of Australian seniors*

Supporting transport and increasing service provision in areas experiencing shortages will support access to dental care in rural and remote areas of NSW

People in remote areas

Policy options	3.1 Include general dental in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to support those in rural and remote areas to access dental care	3.2 Increasing funding for public dental outreach services to address shortages across NSW, prioritising locations with the highest need and most disadvantage to reach an extra 7,500 people
Context	- Limited access to a dentist in a rural or regional area means individuals are required to travel significant distances for care - General dentistry is not an eligible dental service under the IPTAAS guidelines - Adding general dentistry to IPTAAS will enable individuals to receive financial support for travel and accommodation to receive general dental services, removing a barrier to preventative care	- Public dental outreach services in NSW are currently underfunded relative to the significant need in rural and remote areas, creating barriers to preventative and basic dental care - Rural and remote communities face compounded challenges with both limited local dental services and financial barriers to accessing care in urban centres - Enhanced outreach services can deliver early intervention and preventative care, potentially reducing the need for more expensive emergency dental treatments later - Increasing funding by \$37.5 million would see an additional 7,500 individuals accessing dental care who would otherwise miss out
Feasibility	Medium	High
Impact	Medium	High

Source: Veginadu, R (2024) Integrating oral health into primary healthcare for improved access to oral health care for rural and remote populations; National Aboriginal Community Controlled Health Organisation (2023) Provision of and access to dental service In Australia; NSW Government (n.d.) Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) Assessment Guidelines; B.M.J. Kalpana Balasooriya et al. (2023) A review of drinking water quality issues in remote and indigenous communities in rich nations with special emphasis on Australia; McAuliffe, A et al. (2020) Addressing the oral health needs of Indigenous Australians through water fluoridation; NSW Government (2025) NSW budget 2024–25 Budget Paper No.01 Budget Statement; Mandala analysis.

Providing services through channels which are appropriate for Aboriginal and Torres Strait Islander people will improve oral health

Aboriginal and Torres Strait Islander people

Policy options	4.1 Address gaps in the provision of dental services by Aboriginal Community Controlled Health Organisations (ACCHOs) to increase access to this essential care for Aboriginal communities	4.2 Work towards ensuring access to fresh drinking water in all First Nations communities, including fluoridation where possible, to ensure water security
Context	- Over 50% of Aboriginal and Torres Strait Islander people prefer to attend an Aboriginal Community Controlled Health Service over a non-Indigenous practice, but limited availability results in individuals missing out on care - Community-controlled models have proven to improve engagement and outcomes - Greater funding will enable more Aboriginal Community Controlled Health Services to provide dental care alongside other health care services which may be available currently	- Water fluoridation is one of the most effective public health interventions, and has been linked to a decrease in prevalence and severity of tooth decay - Many Aboriginal communities do not have access to clean, safe drinking water which is fluoridated - Inadequate fresh water supplies can lead individuals to consume sugar-sweetened beverages due to cost, which are harmful to oral health
Feasibility	Medium	Medium
Impact	Medium	Medium

Source: Veginadu, R (2024) Integrating oral health into primary healthcare for improved access to oral health care for rural and remote populations; National Aboriginal Community Controlled Health Organisation (2023) Provision of and access to dental service In Australia; NSW Government (n.d.) Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) Assessment Guidelines; B.M.J. Kalpana Balasooriya et al. (2023) A review of drinking water quality issues in remote and indigenous communities in rich nations with special emphasis on Australia; McAuliffe, A et al. (2020) Addressing the oral health needs of Indigenous Australians through water fluoridation; Mandala analysis.



1

Dental conditions are the leading cause of potentially preventable hospitalisations in NSW

2

A lack of access to and affordability of early intervention and prevention is costing NSW

3

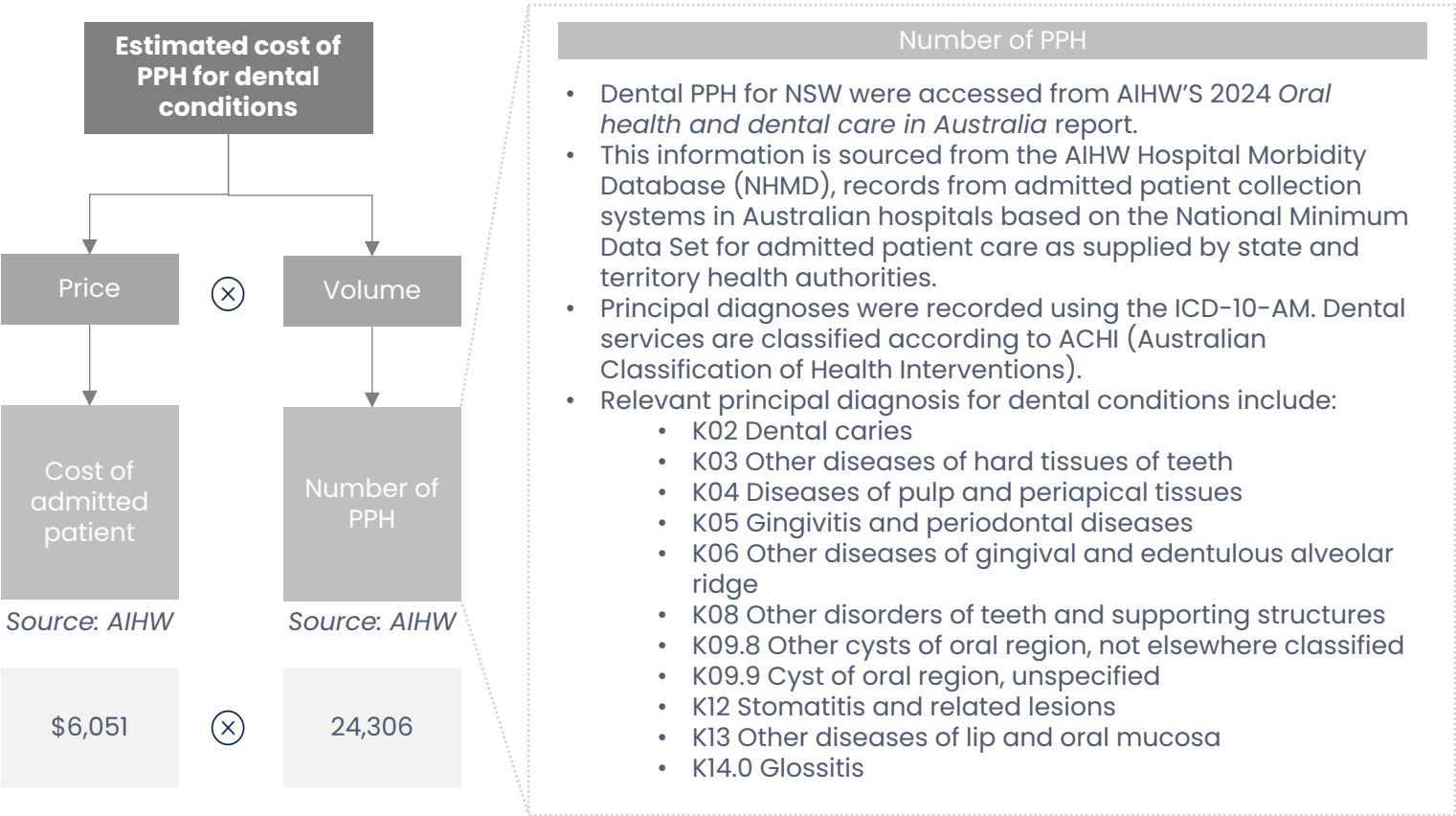
Targeting priority groups through preventative care uses a finite budget efficiently to address the highest rates of potentially preventable hospitalisations

4

Appendix

The cost estimate of PPH in NSW is based on the cost of admitted patient care and dental PPH volumes from AIHW

Method for estimating the cost to NSW from PPH for dental conditions



Key assumptions

- The price estimate used here is based on AIHW's generic cost of admitted patient care as referenced by the NSW Department of Communities and Justice *Benefits Database* as the cost of an avoided admission to hospital, adjusted to 2024 dollars of \$6,051.
- In the past, estimates of cost per dental PPH have varied from \$4,660 (in 2008-09 dollars)¹ to \$3,733 (in 2013-14 dollars)^{2,3}
- This benefit, measured per day, is applicable to when it can be demonstrated that an initiative has resulted in fewer hospitalisation days as compared to a comparison group.

Limitations

- There is likely to be variation in the costs attributable based on which admission cost is used to calculate PPHs.
- This cost estimation does not include all the additional costs and resources associated with a preventable dental hospitalisation, nor does it adjust for the range of complexities that could be involved due to limitations in the available data.

1 Richardson and Richardson (2011) *End the decay. The cost of poor dental health what should be done about it*
2 Rogers (2016) *Dental hospitalisation of Victorian children and young adults – prevalence, determinants, impacts and policy implications*
3 Productivity Commission (2017) *Introducing competition and informed user choice into human services: reforms to human services*
Source: AIHW (2021-22) *Admitted patient care 2021-22 7 Costs and funding, Table 7.4* via DCJ (2024) *DCJ Benefits Database*; AIHW (2024) *Oral health and dental care in Australia*; Mandala analysis.

Upper and lower bound costs of PPH for NSW are based on IHACPA’s National Efficient Price (NEP) determination (2025–26)

Upper and lower bound estimates

Year	Segment	Lower bound	Upper bound
2022/23	Total	\$47,400,000	\$225,900,000
	Children (0 to 14 years old)	\$17,800,000	\$84,800,000
	Older people (65+ years old)	\$8,600,000	\$41,200,000
	People in remote and very remote areas	\$1,200,000	\$5,900,000
	Aboriginal and Torres Strait Islander people	\$2,800,000	\$13,200,000
2032/33	Total	\$68,400,000	\$326,000,000
	Children (0 to 14 years old)	\$25,700,000	\$122,500,000
	Older people (65+ years old)	\$12,500,000	\$59,500,000
	People in remote and very remote areas	\$1,800,000	\$8,600,000
	Aboriginal and Torres Strait Islander people	\$4,000,000	\$19,000,000

Key assumptions

- Upper and lower bound estimates are based on the National Efficient Price (NEP) determination (2025–26) admitted acute price for oral and dental disorders, low complexity for lower bound values, and oral and dental disorders, high complexity for upper bound values.
- These values are intended to demonstrate the absolute minimum and maximum potential costs for dental PPH.

Limitations

- The analysis does not capture hospitalisations where comorbidities were present or an unavoidable factor.
- We also do not separate public and private hospital costs. Advice from NSW Health suggests that approximately 30% of dental PPH are in public hospitals.
- Future analysis could include more granular modelling around comorbidities, clinical interpretations or other factors that would produce more detailed estimates, and also consider the broader economic impact to NSW, rather than limiting to hospital costs.

Source: IHACPA (2025) NWAU calculators; IHACPA (2025) National Efficient Price Determination 2025–26

Assessment of recommendations

Assessment framework

	Feasibility	Impact
Low	• More expensive and / or more complex to deliver	• Will impact a small portion of the cohort; or • Will impact administrative aspects of dental services; or • Recommendation is for the extension of an existing program rather than a new program
Medium	• Not currently being considered by NSW Government and aligns with their existing prioritise; or • Moderate cost and / or moderate level of complexity to deliver	• Will impact a part of the cohort; or • Will indirectly impact individuals' oral health; or • Recommendation is delivered for a limited time such as one year
High	• Already being discussed or proposed to the NSW Government with a positive response; or • Less expensive and / or less complexity to deliver	• Will impact most of the cohort; or • Will have a direct tangible impact on individuals; or • Recommendation will be delivered in an ongoing way

Key points

- Qualitative assessment of the feasibility and impact have been conducted
- Assessment of feasibility is relative to the other proposed recommendations rather than independently assessed
- Assessment of impact is based on either the nature of the impact or the scale of the group who is impacted

Justification of the assessment of recommendations (1 of 2)

Recommendations	
1.1	Run an awareness campaign for the Child Dental Benefits Schedule (CDBS) to increase uptake of the CDBS for preventative dental check-ups • High feasibility: This is an awareness campaign of an existing program which is funded by the Commonwealth government. This would be attractive to the NSW Treasury as the cost to implement would be lower than a new program. • Medium impact: This is not providing a direct service to individuals and requires individuals to go and seek out dental services because of the awareness campaign. It also doesn't address any cost side pressures limiting uptake.
1.2	Expand the reach of primary school dental programs through the NSW Health Primary School Mobile Dental Program • High feasibility: This program is already run in most primary schools in NSW, meaning expanding to more schools or more frequent visits to existing schools would cost less than a new program and would be straightforward to justify • Low impact: Given this program is already in most schools the incremental impact would be low
1.3	Educate parents on the importance of preventative dental care for children to overcome misconceptions about children attending professional dental care • Medium feasibility: An awareness campaign would be lower cost relative to introducing a new program • Low impact: This is not providing a direct service to individuals and requires parents to improve the oral health practices at home and seek out dental services
2.1	Advocate to the Federal Government to introduce the Seniors Dental Benefits Schedule (SDBS), a similar program to the CDBS • Low feasibility: The SDBS would be more costly relative to the other programs and has been recommended by other groups without success, resulting in a low likelihood of the Commonwealth government introducing this recommendation in the near term • High impact: The SDBS would provide dental care to older Australians which would directly impact their oral health
2.2	Launch a one-off voucher through a pensioner's Service NSW account to support a visit to the dentist, as an interim measure before universal dental care can be achieved • Medium feasibility: This program would be costly for NSW Treasury, but the one-off nature makes it more feasible than a recurrent program • Medium impact: Program is a one-off, year long program which has a lower impact in comparison to the potential impact of the SDBS
2.3	Provide education and training to staff in residential aged care facilities to provide preventative oral hygiene measures • Medium feasibility: Education and training would be lower cost than other programs, but other areas of age care reform are likely seen as higher priority • Low impact: This indirectly impacts residents in aged care facilities, and does not impact those in home care or living independently

Justification of the assessment of recommendations (2 of 2)

Recommendations	
3.1	Include general dental in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to support those in rural and remote areas to access dental care • Medium feasibility: The inclusion of general dental in IPTAAS would be relatively straightforward implementation exercise and can be costed relatively quickly • Medium impact: Supporting transportation would make attending preventative dental care more affordable, but it still requires individuals to take time off work and school to travel to attend a dentist appointment
3.2	Increase funding for public dental outreach services to address shortages across NSW, prioritising locations with the highest need and most disadvantage • Medium feasibility: Increasing the funding is estimated to cost \$37.5 million. It is an expansion of an existing system meaning the implementation would be straightforward compared to a new program. Feasibility is comparable to the feasibility of expanding IPTAAS in 3.1. • High impact: Increasing the funding for public dental outreach services will provide more services to 7,500 people who previously were not be able to receive public dental services in rural and remote areas
4.1	Work towards ensuring access to fresh drinking water in all First Nations communities, including fluoridation where possible, to ensure water security • Medium feasibility: Recently made a \$21.5 million commitment for clean drinking water in Far West NSW, so this could be expanded to include more Aboriginal communities¹ • Medium impact: Fresh drinking water is a key component to good oral health, but works in combination with other preventative care measures such as regular tooth brushing and attending a dentist for check-ups
4.2	Increase dedicated funding to Aboriginal Community Controlled Health Organisations (ACCHO) for dental care • Medium feasibility: Extension of funding through exiting ACCHO is more feasible than introducing a new program • Medium impact: Increasing funding will directly increase the number of dental services ACCHO can provide, but there may be limitations on impact based on dental practitioner availability and the number of dental practitioners trained to deliver culturally appropriate care

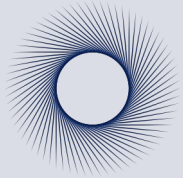
¹ Plibersek, T et al. (2024) Joint media release: Over \$21.5 million for clean drinking water in Far West NSW

Estimated cost of delivering each recommendation

Recommendations	Responsible	Estimated cost	Time period	Assumptions
1.1 Run an awareness campaign for the Child Dental Benefits Schedule (CDBS) to increase uptake of the CDBS for preventative dental check-ups	NSW	\$3 million	One-off*	Based on the cost to deliver major road safety awareness campaigns run by the NSW government ¹
1.2 Expand the reach of primary school dental programs through the NSW Health Primary School Mobile Dental Program	NSW	\$17 million	Annual	Double access from current levels, at a cost of \$130 per child for an extra 136,000 children ²
1.3 Educate parents on the importance of preventative dental care for children to overcome misconceptions about children attending professional dental care	NSW	\$3 million	One-off*	Based on the cost to deliver major road safety awareness campaigns run by the NSW government ¹
2.1 Advocate to the Federal Government to introduce the Seniors Dental Benefits Schedule (SDBS), a similar program to the CDBS	C'with	\$1.143 billion	Annual	Based on ADA estimates in 2025-26 for 2.8 million eligible seniors nationally ³
2.2 Launch a one-off voucher through a pensioner's Service NSW account to support a visit to the dentist, as an interim measure before universal dental care can be achieved	NSW	\$65 million	One-off	Based on the cost of services involved in a scale and clean (oral examination, removal of plaque and calculus) which is \$227 for the reported 817,000 aged pensioners in NSW, assuming the same uptake rate (35%) as the CDBS ⁴
2.3 Provide education and training to staff in residential aged care facilities to provide preventative oral hygiene measures	Both	\$20 million	One-off	For 44,742 residential aged care workers to undertake oral health training at a cost of \$450 each ⁵
3.1 Include general dental in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to support those in rural and remote areas to access dental care	NSW	\$20 million	Annual	Conservatively assuming the number of scheme participants doubles at an average payment \$482 ⁶
3.2 Increase funding for public dental outreach services to address shortages across NSW, prioritising locations with the highest need and most disadvantage	NSW	\$37.5 million	Annual	Based on 2025-26 NSW Budget announcement to expand program to an additional 7,500 people ⁷
4.1 Address gaps in the provision of dental services by Aboriginal Community Controlled Health Services to increase access to this essential care for Aboriginal communities	NSW	\$4.6 million	Annual	Based on the midpoint advertised salary (\$118,117) for a Dental Officer (Level 1) in NSW Health, multiplied by 39 ACCHOs in operation in NSW
4.2 Make a commitment to guaranteeing access to fresh drinking water in all Aboriginal communities to ensure water security	Both	\$7 million per community	One-off	Per at-risk community based on recent Commonwealth announcements ⁸

* Repeat as necessary when awareness declines

1. Audit Office of New South Wales (2024) *Tabling report Government advertising 2022-23*. 2. Balasubramanian et al (2023) *Primary school mobile dental program in New South Wales, Australia: protocol for the evaluation of a state government oral health initiative*. 3. Australian Dental Association (2025) *Why does Australia need a Seniors' Dental Benefits Schedule now?* 4. NSW Health (2025) *Oral Health Fee For Service Scheme (OHFFSS) schedule of fees, DSS (2025) DSS Benefit and Payment Recipient Demographics - March 2025*. 5. Department of Health (2021) *2020 Aged Care Workforce Census Report, Ageing Australia (2025) Oral Health Care for Seniors masterclass*. 6. NSW Ministry of Health (2025) *Regional Health Strategic Plan 2022-32 Progress Snapshot*. 7. NSW Treasurer, Minister for Health (2025) *NSW budget investing in healthier families and communities*. 8. Plibersek, T et al. (2024) *Joint media release: Over \$21.5 million for clean drinking water in Far West NSW*



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NSW Council of Social Service

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Note: All dollar figures are Australian dollars unless indicated otherwise.