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Evaluation action and reaction: a case study in public dental health services

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1. Abstract

In October 2002, the Auditor-General of the State of Victoria, Australia, tabled a report in the Victorian Parliament which reviewed the provision of public dental health services across Victoria[2]. The service system was found to be under stress. Access to treatment was inadequate with long waiting lists and waiting times, with a focus on emergency rather than preventative care. Clinics were not providing services in a timely or efficient manner and infection control practices and physical conditions were variable.

Reactions to the report began even before the report was completed, including addressing infection control issues and program management arrangements. At a political level, commitments were made for increased resources and a review of fluoridation issues in rural areas. Through this case study of a performance audit, the authors explore the importance of topic relevance, stakeholder involvement and timing to maximising the impact of evaluation studies, especially given the constraints of performance auditing.

2. The study

2.1 Performance audits

The study was a performance audit, i.e. a study to evaluate whether an organisation is effectively meeting its objectives, and using its resources economically and efficiently. The Auditor-General of the State of Victoria, Australia, undertakes such audits in accordance with the provisions of section 15 of the Victorian *Audit Act* 1994.

Performance audits have several features which distinguish them from most evaluation studies:

- They are an independent assessment of an area of public sector activity. The Auditor-General is required to identify areas of public sector activity for assessment and agencies are required to provide all requested information and assistance. The agency does not request, and cannot refuse to participate in, the study;
- The primary client for the study is not the agency or those receiving its services, but the Parliament of Victoria. The Auditor-General seeks to improve resource management and add value to an agency through recommendations on improving operations and procedures. These recommendations are reported to the Parliament which is then able to take any necessary action through Parliamentary processes to ensure the recommendations of the report are implemented. The Auditor-General cannot directly require action on his recommendations; and
- The Auditor-General by legislation is not permitted to question the merits of government policy. While he focuses on recommendations which will improve the implementation of government policy, the Auditor-General must accept the policy framework of the Government.

These features of performance audits might be regarded as limiting their capacity to result in improvements to resource management. This paper provides an example where the relevance of the topic, timeliness of the study and attention to stakeholder involvement has contributed to its impact, despite the constraints of performance auditing.

2.2 Genesis and nature of the study

The study topic was identified in December 2000 through environmental scanning which identified that government-funded community dental services were unable to meet demand. Waiting lists and waiting times were growing and there were severe workforce shortages. This was an issue not only in Victoria but in other Australian States, several of whom had been attempting to improve the way in which they managed the provision of community dental services[3]. It was likely therefore that the study might clarify the causes of stress in the Victorian system and identify recommendations for improvement. After consultation with the Victorian Parliament's Public Accounts and Estimates Committee, the topic was incorporated in the annual program of audits for 2002-03.

The objective of the study was to examine the economy, efficiency and effectiveness of community dental services in Victoria. The study examined whether:

- access to community dental services met the Government's objective of improving oral health for vulnerable groups, in particular, children and the disadvantaged;
- timely, efficient and effective community dental services were provided;
- funds (recurrent and capital) allocated to public dental services were distributed according to need; and
- an effective framework was in place to plan, manage, measure and monitor the effectiveness of community dental services at a Statewide and program level.

The examinations were largely undertaken within the Dental Health Unit of the Department of Human Services [the funder], Dental Health Services Victoria (DHSV) [the purchaser and part-provider], and in 5 DHSV-managed clinics and 8 community dental clinics managed by community health centres and rural hospitals [the providers]. The study included the analysis of administrative data from the service, fieldwork in clinics, and surveys of clients. The study was guided by a Reference Group of key stakeholders and was directly advised by specialists in community dental health research, practice and administration.

The study had been identified in December 2000, incorporated in the 2002-03 Annual Plan for the Auditor-General in January 2002, commenced in January 2002 and was tabled in Parliament in October 2002.

2.3 The findings and recommendations from the study

2.3.1 Service access

For the Community Dental Program, at December 2001 there were 185 290 people on the waiting list for general dental care (average waiting time of 22 months); and 25 085 people on the waiting list for dentures (average waiting time of 24 months).

Between 1997-98 and 2001-02, the number of individuals who received emergency care under the Community Dental Program increased by around 31 per cent, compared with an increase of around one per cent in the number of individuals who received general care. This focus on emergency care prevented sufficient attention to general care and placed additional pressure on future dental care needs.
The School Dental Service Statewide participation rate increased from 37 per cent in June 1997 to 52 per cent in June 2002. Eighty per cent of child dependents of concession card holders used the Service, compared with 31 per cent of children of non-concession card holders. The recall cycle target of 12 months for high risk children had been achieved, but the targets for low risk children were increasingly not achieved over the 5 years to June 2002. The Service was appropriately placing priority on economically disadvantaged and high risk children, but at the expense of low risk children.

Recommendation

We recommended that the Government address the increasingly low levels of effective access to public dental services, either through a reduction in the eligibility for, and/or nature of, service offerings or increased resourcing, or both.

2.3.2 Service delivery

Targets for average waiting times for restorative care and dentures had not been met in 4 of the 5 years to June 2002. However, the gap had reduced over the latter 3 years, partly as a consequence of increased targets.

Insufficient attention had been given to the issue of service efficiency, reflecting a focus on managing the increasing demand.

Over 2001-02, 4 major infection control breaches had been reported to DHSV, and dealt with appropriately. Examinations in clinics identified some non-compliance with standard infection control precautions and, in some clinics, a lack of infection control audits and use of infection control consultants. The matters raised did not represent a significant immediate risk to public health and we were satisfied that DHSV would take appropriate action, within the limits of the physical environment of clinics.

Recommendation

We recommended that:

- DHSV undertake a review of the efficiency of clinics to establish the reasons for varied performance and to develop strategies to improve the efficiency of service delivery, commencing with improved monitoring and benchmarking of dental clinics;
- DHSV increase its ongoing support and training for staff of all dental clinics, particularly for critical practice issues and areas of non-compliance and inconsistent practice, such as infection control;
- Continued emphasis be given to investing in equipment for occupational health and safety and clinical requirements;
- An audit of equipment be undertaken to enable development of an equipment replacement strategy for the entire service system; and
- A review of the efficiency of the DHSV workshop be undertaken in response to criticisms of slow response times and excessive cost.

2.3.3 Work force

There is an oral health work force shortage in Victoria. The shortage is not uniform, being most problematic in rural areas and in the public sector. This shortage is exacerbated in the community dental services by high attrition rates.

The Department had had ongoing discussions with The University of Melbourne about ways to increase the number of dentistry students and to encourage them to work in the public sector.

In 2000-01, 15 per cent of public dental patients were treated by private dentists under 3 voucher schemes. There was potential for greater utilisation of private dentists if additional funding for these schemes was available and they proved to be cost-effective.

Recommendations

We recommended the development and maintenance of a work force database by DHSV to enable accurate and ongoing monitoring of the oral health work force for the School Dental Service and the Community Dental Program.

We recommended that the Department, in collaboration with DHSV and key stakeholders, take strategic action to address the current and future shortages in the oral health work force, including:

- immediate and long-term initiatives to increase the supply of oral health workers, targeting areas of greatest need including the public sector and rural regions;
- a review of the potential for widening the role and scope of practice by dental auxiliaries, as a means of addressing the increasing demand for dental services; and
- specific initiatives aimed at improving the perception of public dentistry and the quality of the work environment in order to attract a greater number of oral health graduates and to increase the re-entry and retention of experienced oral health workers.

2.3.4 Program management

Differing understandings and expectations about roles and responsibilities impacted on how the Department (the funder) and DHSV (the purchaser and part-provider) interacted with the service system, e.g. the way in which DHSV engaged with non-DHSV clinics in relation to standards setting, infection control and complaints handling, and the degree of accountability by DHSV to the Department.

The physical environment of some clinics was deficient and the equipment available was in need of an upgrade to meet current occupational health and safety and infection control requirements. The progressive decommissioning of School Dental Service vans will address some problems identified, as will continued investment in equipment. However, we believe that the approach to capital provision needed to be revisited.

Following a substantial increase in 1999-2000, increases in government funding for community dental services to 2001-02 had been small, and co-payments collected in the School Dental Service and the Community Dental Program had decreased.

The Department advised that it was reviewing the funding systems for community dental services. Draft Terms of Reference of the review covered some, but not all, of the issues relating to funding rates and the funding formula identified in the study audit.

The level of usage of voucher schemes was not determined on the basis of their relative cost-effectiveness. Systems and information necessary to identify the true cost of treatments provided by DHSV and non-DHSV clinics were not available.

Recommendations

We recommended that:

- The Statewide strategy for public dental health be reviewed to ensure that priorities for dental health are being properly identified and met, and that responsibilities for policy and operational activities are appropriately assigned and understood between the Department and DHSV. Specifically, DHSV as a purchaser of community dental services must ensure required standards are met, regardless of whether services are delivered by DHSV or non-DHSV clinics;
- A Statewide service plan be developed by DHSV, including a re-assessment of the appropriateness of the service planning principles in place, and whether the location and scale of dental clinics established meet the needs of the eligible population;
- The dental health capital plan be revisited to determine the appropriateness of the current approach to capital provision for dental services, i.e. promoting the integration of dental health services with primary health services; and
- The Department and DHSV support, and participate in, national initiatives aimed at collecting data on the oral health of adults, including data relating to the oral health of, and services used by, adults receiving treatment through public dental services.

We recommended that:

- The Terms of Reference for the Department's proposed review of the funding formula be expanded to include consideration of the matters regarding the funding rates and funding formula raised by this audit; and
- A clinical costing study be undertaken and appropriate systems introduced at DHSV, to ensure the costs of service delivery are adequately identified and clinics are equitably funded to meet those costs, while incorporating incentives for efficient service provision. Such information would ensure a more rigorous basis for decisions on whether to provide services in-house, through contracted clinics or through the voucher schemes.

We recommended that external reporting by the Department be expanded to address achievements against program objectives, and that reporting by DHSV to the Department under the Health Service Agreement provide sufficient relevant information to the Department to inform its policy development role, and to enable it to monitor the effectiveness and efficiency of DHSV's management of the service system, including both DHSV and non-DHSV managed clinics.

3. Action since the study

3.1 The impact for clients

To date there has been little improvement for clients:

- waiting lists and waiting times are continuing to increase;
- demand for emergency care continues to rise at a greater rate than demand for general care; and
- shortages across the dental workforce remain, with vacancies still greater in rural areas than in the city.

However, there are signs that improvements are beginning:

- there has been an increase of 11 EFT dentists in the public sector between December 2002 and June 2003; and
- the Government recently announced a $750 000 Waiting List Strategy designed to streamline the system to ensure priority patients are assessed on the basis of their individual needs, to co-ordinate waiting lists across the State so that patients in need may be offered treatment at another location with a shorter waiting time, and to target funding for the voucher schemes to clinics with the greatest demand.

3.2 The reactions from stakeholders

Up to September 2003 (almost a year after the publication of the Report), the reactions to, and actions resulting from, the study have been varied, as set out below:

Stakeholder	Reaction/action
Executive government	There has been a budget increase for dental health; and increased focus on fluoridation and work force issues.
Members of Parliament	The Australian Labor Party [state level] policy statement of November 2002 included commitments to increased expenditure in dental health: $21 million over 4 years to reduce dental waiting times by training more dental therapists, opening more dental chairs, expanding the school dental service to preschools and providing funding to private contractors to make dentures; $3 million in capital investment for dental services including establishment of a rural dental clinical school at Shepparton. The Liberal Party [state level] policy statement of November 2002 also included funding commitments: $40 million to decrease waiting times for restorative and denture care for those most in need, fluoridation of all Victorian water supplies by 2010 where there was community support for the process, improved mobile dental technology and provision of personnel for improved dental services for rural and regional Victoria.

Stakeholder	Reaction/action
Audited agencies	Agencies were supportive in comments published in the report, and commented favourably about the quality of the report and the audit process in our post-audit agency surveys. The report is being used as an input to decision-making: • DHSV Board receives regular updates on progress with implementation of the recommendations; • the Department is using the recommendations in developing submissions for the 2004-05 Budget and Cabinet submissions and for Ministerial Briefings. The recommendations provided support for some actions being undertaken and/or planned by DHSV, giving assurance to management about the direction it was taking. The report has assisted in improving resource management: • DHSV has increased its focus on efficiency in clinics and has introduced benchmarking across clinics and regular reporting to enable managers in individual clinics to compare performance; • DHSV has used the report in discussions with the Department about funding rates and the counting unit upon which funding levels are determined; and • Feedback on findings to DHSV management during the audit helped the Board to recognise the need for an organisational restructure. Funding and service agreements between clinics and DHSV have been updated to address a range of quality issues including clinical indicators, infection control standards, complaints reporting and management, accreditation action plans and standards for record keeping. The Department and DHSV have continued to work with stakeholders to address work force issues: negotiating awards for dentists, dental specialists and other oral health workers, investigating the expansion of duties of dental auxiliaries, introducing scholarships for dental students requiring a commitment to rural employment following completion of studies, implementing a strategy to emphasise the advantages of working in the public sector, undertaking an international recruitment campaign and commissioning a consultancy to determine professional development needs and gaps for the oral health workforce as a whole to assist strategy development.
Dental profession	Workforce issues are being increasingly taken up by academics and dental professional groups. There was reference to the report in the Australian Dental Association (ADA) periodic dental update and its pre-election press release seeking the commitment of the major parties for funding action to address waiting lists. The report was cited as one of the 5 reasons for the timing of the Victorian Branch of the ADA's November 2002 fact sheet on *Dental waiting lists and dentist shortages*.

Stakeholder	Reaction/action
Interest groups	The fluoridation debate has been revived particularly in rural/regional areas; for example the Geelong Community Forum has held public forums to discuss fluoridation; support for fluoridation has come from Ballarat Trades Hall; and the Anti-Fluoride Association of Victoria has made several public announcements.
Media	A number of references to waiting lists and waiting times were made leading up to the announcement of the 2003-04 State Budget and again in August 2003, particularly in rural/regional press (Mildura, Leongatha, Lakes Entrance, Warrnambool, Portland). The fluoridation debate was picked up in regional/rural press (Ballarat, Wangaratta, Warrnambool) and in metropolitan Melbourne media.
Victorian Auditor-General's Office	The audit contributed to the corporate goal of improving resource management in government and the output targets of the Office. This was another example of a performance audit of a human service program, deepening our knowledge of the relevant issues and methodologies for consideration of such programs.

It can be difficult at times to determine whether action taken by agencies directly results from the audit or was already planned. However, even when the latter is the case, the audit process, which provides for regular feedback during the audit about findings and emerging issues, can provide useful input for putting in place, or refining those plans. Even where action is already underway, the audit can be beneficial. For example, we believe that the restructure of DHSV during the audit benefited from discussions with the audit team, particularly about how to achieve consistent service quality and performance of clinics across the State.

4. The lessons from the study

4.1 Timing

Timing is fundamental to maximising impact:

- Dental health was already an issue, but had limited focus (overshadowed by acute health, drugs, etc);
- The audit coincided with the appointment to DHSV of a new CEO who was open to change;
- Substantial lead times need to be taken into account. The timeframe for this study from genesis (topic identification) to substantial action (commencement of the audit planning phase) was just over 2 years, while the study itself took 9 months; and
- The audit was undertaken in the period leading up to an expected election, and at the time when budget submissions were being prepared. Because of this it should have been well placed to provide an up-to-date and independent assessment of the operations of community dental health services to the public and other stakeholders, including the Government. However, the tabling of the report coincided with the announcement of the November 2002 State election and the report received little media coverage or government attention at that time.

The following chronology of the study and major events/activity up to and beyond the audit shows how action can start some time after a performance audit report is tabled.

Quarter ended	**VAGO activity**	**Major events/activity by other players**
Dec 2000	Topic identified in forward planning, but not placed as highest priority	
Sept 2001		New CEO appointed to DHSV.
Dec 2001	Audit topic clarified, priority reconsidered and more specific audit proposal developed	Broad government objectives clarified in a publication entitled *Growing Victoria Together*, which included specific reference to dental health.
March 2002	Audit commenced	Agencies and the Parliament's Public Accounts and Estimates Committee advised of topic and consulted on audit specification.
June 2002	Annual plan, incorporating topic, published and fieldwork commenced	Agencies involved in the provision of data to the audit team and provided with on-going feedback on the findings of the audit.
Sept 2002	Fieldwork completed and report drafted	DHSV restructured along lines being considered by the audit team.
Dec 2002	Report tabled	Agencies' responses to the findings and recommendations incorporated in report. Report receives little immediate press coverage as its tabling coincides with announcement of the State election. Major political parties announce pre-election polices and lobby groups make press releases seeking commitments from the parties.
March 2003	Survey of agencies on their perspectives of the quality of the report and the processes	Public debate on fluoridation in regional areas revisited, with input from dental professional and lobby groups and Minister; reference made to Auditor-General's report in debate.
June 2003		Report receives media coverage leading up to 2003-04 Victorian State Budget. Budget includes an additional $2.5 million for dental health, and further commitments for the following 3 years (total of $21 million over the 4 year period).

Quarter ended	VAGO activity	Major events/activity by other players
Sept 2003	Research for AES Paper Presentation of AES Paper	Minister announces $750 000 action plan to address public dental waiting lists. Funding debate between State and Commonwealth governments revisited. *Minister for Finance's formal response to the findings and recommendations in the report to be tabled.*
Dec 2003		*On-going consideration by government of dental health issues (informed by the report), in the context of the 2004-05 State Budget process.*
June 2004		*2004-05 Victorian Budget pre-commitments for $6.5 million additional funding for dental health and $6.0 million for the following 2 years.*
Sept 2004	*Request from Auditor-General to agencies regarding progress on recommendations*	*Agencies to advise Auditor-General on progress of implementing recommendations*
Dec 2004	*Report to Parliament by Auditor-General on status of progress in implementing recommendations to be tabled*	

Italics = expected activity

As the above shows, performance audit reports do not necessarily have an immediate impact. The cycles of government (elections and budget cycles) and the intervention of other factors (for example, changed priorities resulting from the needs of other programs) mean that action can occur some time after a report is tabled. Because an audit report is an independent view from outside, it is essentially a resource to be used by stakeholders to inform and support their actions.

4.2 Stakeholder involvement

Stakeholder involvement in, and support during, the conduct of the study is crucial to both the credibility of the study and the potential for the findings and recommendations of the study to be taken up by the relevant agencies. The study involved stakeholders and ensured that their views were incorporated in the following ways:

- The agencies funding, purchasing and providing community dental services were kept informed of the conduct of the study;
- Key stakeholders were consulted, including the Australian Dental Association (Victorian Branch), the Dental Practice Board, the Commonwealth Departments responsible for Health and Veterans' Affairs and community dental clinics;

- A reference group was established, drawing together people to advise the audit team about the perspectives of dentists and dental auxiliaries and those involved in rural health service delivery and community service;
- Three specialists were directly involved in the study: an experienced community dental health clinician and academic, a community dental health program manager from another State, and the country's most respected dental health researcher. This assisted in establishing the credibility of the study; and
- Consultants with extensive, widely acknowledged experience in the conduct of government funded community services were employed to undertake part of the fieldwork. They included in their team 2 experienced clinicians to assess standards and infection control practices in clinics.

4.3 Appropriateness of the methodology

Performance audits are required to be undertaken in accordance with the Office's performance audit methodology (VPAM) and the relevant Australian Audit Standards *AUS 806: Performance Auditing* and *AUS 808: Planning Performance Audits*. The Office periodically reviews the audits completed to determine whether these standards have been met.

The Community Dental Service study was recently subject to a review undertaken by a member of the United Kingdom National Audit Office, under the supervision of an Associate Professor from a leading Victorian university. In his draft report, the reviewer observed that the audit complied with both the Office's methodology and the Australian accounting standards, and noted that the methodology used was comprehensive and relevant to the issues under examination. He also reported that the use of specialists and consultants provided additional support to the team and enhanced the audit team's credibility with the audited agencies.

4.4 Usefulness of the study's recommendations

The purpose of making recommendations in a performance audit is to encourage improved resource management and transparency in government operations. The Auditor-General does not have the power to require agencies to implement recommendations made in audit reports: action taken is the prerogative of the Parliament and the Government. Therefore, as well as ensuring that the recommendations if implemented would improve agency operations, it is also important that the recommendations maximise the likelihood that that prerogative will be exercised.

As part of our post-audit practices, the Office routinely surveys client agencies about the value of the audit to them and asks about their acceptance of, and plans to implement, recommendations. In their responses to the post-audit survey, both the Department of Human Services and DSHV agreed that the implementation of the recommendations would contribute to improving the management of their agency. The surveys showed that the agencies accepted most of the recommendations. Those not fully accepted were accepted with qualification. None were rejected.

During 2002-03, the Office developed a self-evaluation guide for analysing audit recommendations, in terms of their value-added and their chance of acceptance. The guide is based on analysis of literature from other performance audit practitioners and experts in evaluation, in particular the United Kingdom National Audit Office and the United States General Accounting Office.[4]

Our criteria for evaluating recommendations are:

- *Are they clear calls to action?* That is, the recommendations use simple and direct language, set out what needs to be done, where and when it needs to be done and by whom.
- *Are they based on the evidence presented, clearly indicating why action should be taken?*
- *Are they meaningful for the agency itself and within its wider context?* Note that the wider context can be difficult to include within a performance audit, which is focused on an area of public sector activity and does not attempt to question the fact, or relative priority, of that activity, since that might be regarded as questioning government policy.
- *Do they set out how action is to be taken?* Note that this criteria is controversial in the context of a performance audit. There is a view that the Auditor-General should not direct how improvements should be made, since that is the role of the agency as the program manager. However, it can be difficult to frame a useful recommendation without incorporating some elements of how the action can be implemented or how the recommended outcomes can be achieved.
- *Are they likely to be implemented?* Recommendations relating to services, processes and rules have a greater chance of acceptance compared to those relating to goals, strategies, transparent disclosure and accountability.

The recommendations were made in the report prior to development of our criteria and self-evaluation guide. However, an analysis of the 15 recommendations against the 5 criteria showed that the recommendations at least partially met each of the criterion. The recommendations:

- Were generally clearly written (although using bureaucratic language) and set out what needed to be done and by whom, but did not set a time frame for implementation. To some extent this reflects the position of the Auditor-General, who cannot require the implementation of recommendations but relies on others;
- Resulted from the analysis which preceded them, although in a few cases audit was unable to gather data beyond the views expressed by key stakeholders, so the recommendations sought the collection of such data;
- Were meaningful in that they were focused on improving the program. However, they tended not to focus beyond the program to the place of community dental health in the broader health sector. This partly reflects the need to limit the focus of any research study and the requirement for the performance auditor not to question government policy;
- Did not always provide clear guidance on how action should be taken. This reflects the view of the Auditor-General that managers should make their own decisions about how to effect change within their agencies; and
- Varied in their likelihood of implementation. Nine of the recommendations related to services, processes and rules, so had a greater chance of acceptance compared to the 6 which related to goals, strategies, transparent disclosure and accountability. However, as noted above, the relevant agencies did not reject any of the recommendations.

4.5 Measuring success

Measuring the success of a study has a number of dimensions:

- *What to measure?*
  - Success needs to be measured using both broad outcome measures (such as changes in the dental status of the client group), and more specific output and process measures (such as changes in waiting lists and times and specific actions on recommendations);
  - Causality may be unclear in 2 respects. First, actions may be a reaction to the study or agencies may have been already considering addressing the issues raised in the study. The latter is usually claimed by the agency subject to the study. Second, any improvements in client outcomes may result from a myriad of factors unrelated to the study (eg. demographic change which can impact on the proportion of the population who were previously denied access to fluoridation).
- *When to measure?* As shown above, even short-term responses can take many years, and long-term change takes longer. The pressure from politicians and clients for immediate results could in some cases distort appropriate action.
- *Who should measure?* In most cases those who report on actions from a study have a vested interest in apparently successful implementation and are likely to attribute any change to the study. An independent follow-up of action can provide greater transparency. In the case of performance audits, the Parliamentary Public Accounts and Estimates Committee can play a valuable role in continuing to monitor and encourage action by agencies as a consequence of an audit report.

5. Conclusion

The reaction to, and action resulting from, a performance audit can be variable. It can be affected by factors such as election and budget cycles, and limits on the power of the Auditor-General to require agencies to act and to question government policy. Where action does take place, it may not do so until some time after the study has been completed.

Despite limited action to date, there are signs that the Victorian Auditor-General's report on Community Dental Services will make a valuable contribution to the implementation of an important social service. The key to its value has been:

- the relevance of the topic and timing of the study;
- the credibility of its methodology and approach to stakeholder involvement; and
- the practical nature of its recommendations.

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[2] Victorian Auditor-General's Office, *Community dental services*, October 2002.

[3] Jones K., et al, *A multi-method model for evaluating an innovative NSW priority oral health program - A case study*, presented at the Australasian Evaluation Society International Conference, Canberra,

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