

## Policy-at-a-glance – Oral Health Policy

- Key message:** PHAA will:
1. advocate for the government's adoption of a deliberate and phased implementation of 'Denticare Australia' and the other three NHHRC oral health recommendations that address not only the cost but other critical barriers to dental care;
  2. continue its advocacy for government policies which promote equitable oral health outcomes for all Australians in line with the National Oral Health Plan and as appropriate contribute to the work of the National Oral Health Alliance;
  3. identify key opportunities and barriers to incentive schemes for other health professional groups to build their workforces in public services and rural and remote areas in order to inform future oral health workforce policy; and
  4. lobby all State and Territory Health Ministers to -
    - provide water fluoridation to all communities of 1000 or more population by 2015,
    - identify and implement strategies to create a more flexible and multi-skilled oral health workforce.

**Summary:** All Australians should have access to culturally appropriate, safe, affordable, timely and cost-effective oral health care. This should include information about their oral condition, their risk of future oral diseases, and their options for appropriate care and health promoting life styles.

Disadvantaged groups such as Aboriginal and Torres Strait Islander peoples, low-income earners, people with special needs, dependent older people and newly arrived migrants and refugees should be given priority in public oral health care programs.

This policy seeks to outline a series of tangible actions designed to achieve these goals.

**Audience:** Australian, State and Territory Governments, policy makers and program managers. Other relevant stakeholder groups in the oral health field.

**Responsibility:** PHAA's Oral Health Special Interest Group (SIG)  
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## ORAL HEALTH POLICY

### The Public Health Association of Australia notes the following:

1. Oral health is fundamental to overall health, well-being and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment (i).
2. Oral diseases have similar risk factors to other chronic diseases (xix).
3. Oral diseases place a considerable burden on individuals, families and the community -
  - Dental caries is Australia's most prevalent health problem, edentulism the third most prevalent and periodontal disease the fifth most prevalent (i).
  - Over 600 Australians die of oral cancer each year (ii).
  - Dental admissions are the highest cause of acute preventable hospital admissions (iii).
4. Expenditure on oral care is significant –
  - Annual expenditure on dental care in Australia was \$5.74 billion in 2006-07 (iv) and is likely to reach over \$6 billion in 2008-09.
  - Oral health is the second most expensive disease group, just below cardiovascular disease (v).
  - Unlike general medical services which are 78% funded by government, only 18% of dental care costs are funded by government (iv).
5. A range of health conditions are associated with oral disease –
  - Periodontal infection has an adverse effect on glycemic control and the incidence of diabetes complications (vi).
  - There is a likely association between periodontal disease and both adverse pregnancy outcomes (vii, viii) and coronary heart disease (ix, x).
  - Poor oral health is associated with poor diet (xi, xii), aspiration pneumonia and infective endocarditis (xiii).
6. There are significant inequalities in oral health. Oral disease is a key marker of disadvantage. Greater levels of oral disease are experienced by Aboriginal and Torres Strait Islander peoples, people on low-incomes, people in rural and remote areas, some immigrant groups from culturally and linguistically diverse backgrounds (particularly refugees) and dependent older people -
  - Young children in low socio-economic groups experience almost twice as much dental caries as those in high socio-economic groups (xiv).
  - Concession card holders have on average 3.5 less teeth and are 6 times more likely to have had all their teeth extracted than non card holders (xv).

7. There are many barriers to accessing oral health care - people on middle and low incomes experience financial barriers, users of public dental services face long waiting times, and in rural and remote areas access to oral health practitioners is limited. People with infrequent dental attendance are almost four times more likely to have a tooth extracted when they do attend (xv).
8. Public funding for oral health care is not reaching those most in need. The Senate has blocked the Labor Government's introduction of a Commonwealth Dental Health Program for concession card holders (\$290 million over 3 years). Meanwhile two more expensive programs are benefiting those who are better off. The dental Enhanced Primary Care (EPC) program within Medicare is being used more by those with a private dentist (expenditure will be approximately \$350 million in 2008-09) ; and the private health insurance rebate (over \$414 million annually) is favouring those who can afford private health insurance.
9. The National Health and Hospitals Reform Commission (NHHRC) has recommended a 'Denticare Australia' system and three further oral health reforms. These should be seen as an integral part of primary health care and supporting the NHHRC's findings that the major inequities in Australians' oral health need to be addressed, especially with mounting evidence of links between oral and overall health (xx).
10. Fluoridation of drinking water remains the most effective and socially equitable means of achieving community-wide exposure to the caries prevention effects of fluoride (xvi). However up to 20 per cent of Australians do not have access to fluoridated water (xvii). Demand for dental care is likely to increase because of an increasing and ageing population with more people retaining their natural teeth. With increased expectations about oral health there will be more need for preventive and restorative oral health care over many more years of life.
11. Workforce reforms are needed -
  - There are insufficient oral health practitioners (general and specialist dentists, dental/oral health therapists, dental hygienists, and dental prosthetists) to meet current and projected demand (xiii). The supply shortage of oral health practitioners is being partially addressed with the expansion of oral health training in regional universities. However, the major shortages of academics to support tertiary dental training, the very low numbers of students from rural backgrounds and the appropriateness of the mix of professionals being trained have not been addressed.
  - There is potential to develop a more flexible and multi-skilled oral health workforce. Currently, scopes of practice for members of the dental team vary markedly across jurisdictions.
12. Further data on oral health status is required for planning and monitoring. Data for the general Australian adult community has been collected through the 2004-06 National Survey of Adult Oral Health (xv). However, data for marginalised groups such as Aboriginal and Torres Strait Islander peoples, homeless people and those living in shelters/hostels has not been systematically collected. Data on children's oral health is collected but the representativeness and sample yield of the data is inconsistent due to differences in data collection by jurisdictions.
13. There is no public reporting of monitoring and evaluation of the National Oral Health Plan 2004 – 2013.

**The Public Health Association of Australia affirms the following principles:**

1. Inequalities in oral health should be addressed.
2. Oral health promotion and disease prevention should be strengthened as most oral diseases are amenable to prevention.
3. Oral health is influenced by more than genetics, individual lifestyles and provision of health care – political, social, economic and environmental factors are crucial.
4. Oral health programs should contribute to the empowerment of individuals and communities so that people are able to take more control over their own lives and thereby their health.
5. All Australians should have access to culturally appropriate, safe, affordable, timely and cost-effective oral health care. This should include information about their oral condition, their risk of future oral diseases, and their options for appropriate care and health promoting life styles.
6. Disadvantaged groups such as Aboriginal and Torres Strait Islander peoples, low-income earners, people with special needs, dependent older people and newly arrived migrants and refugees should be given priority in public oral health care programs.
7. Quality standardised data collection is essential to monitor and evaluate public dental programs, detect emerging trends and to enable national and international comparisons.

**The Public Health Association of Australia supports the key action areas set out in Australia's National Oral Health Plan 2004-2013 (i), and believes that the following steps should be undertaken:**

4. The fluoridation of drinking water should be extended to all communities with populations of 1000 or more.
5. Oral health promotion should be integrated into general health promotion following a common risk factor approach.
6. The dental EPC program should be targeted to disadvantaged groups and limited to a prescribed scope of general services.
7. The Commonwealth Dental Health Program as promised in the 2007 election should be introduced.
8. The government should adopt a deliberate and phased implementation of 'Denticare Australia' and the other three NHHRC oral health recommendations that address not only the cost but other critical barriers to dental care.
9. The rebate for private health insurance on dental services should be abolished and the funding redirected to oral health services for Australians on low incomes.
10. Workforce shortages, the low numbers of students from rural backgrounds, the appropriateness of the mix of professionals being trained, and scopes of practice should be addressed as a matter of urgency by the Australasian Council of Dental Schools (ACODS), Australian Health Ministers Conference (AHMC), Australian Government Department of Education, Employment and Workplace Relations (DEEWR), the Australian Vice Chancellors Committee, and Health Workforce Australia.
11. A National Child Oral Health Survey should be conducted.
12. There should be public annual reporting on progress in implementing the action items in the National Oral Health Plan.

**The Public Health Association of Australia resolves to undertake the following:**

**PHAA will -**

1. Continue its advocacy for government policies which promote equitable oral health outcomes for all Australians and as appropriate contribute to the work of the National Oral Health Alliance.
2. identify key opportunities and barriers to incentive schemes for other health professional groups to build their workforces in public services and rural and remote areas in order to inform future oral health workforce policy.
3. request that the Australasian Council of Dental Schools (ACODS) provide advice on the adequacy and appropriateness of, firstly, Commonwealth funded tertiary places, and secondly, the academic workforce needed to meet oral health workforce requirements over the next two decades.
4. lobby all State and Territory Health Ministers to -
  - Provide water fluoridation to all communities of 1000 or more population by 2015.
  - Identify and implement strategies to create a more flexible and multi-skilled oral health workforce.
5. lobby for the Australian Institute of Health and Welfare's Dental Statistics and Research Unit (DSRU) to provide information on fluoride access to populations over 1000 in each state and territory on their website and update it biennially for easy reference.
6. lobby all State and Territory Oral Health Managers to review current data collection processes and identify opportunities to enhance data systems nationally.
7. The Oral Health Special Interest Group (OHSIG) and PHAA will explore and identify other PHAA Special Interest Groups and policies with which the OHSIG might develop strategic links and develop shared policy statements and linked resolutions.

**ADOPTED 1994, REVISED AND RE-ENDORSED IN 1995, 2003, 2006, 2007 AND 2009**

***First adopted at the 1994 Annual General Meeting of the Public Health Association of Australia, revised and re-endorsed in 1995, 2003, 2006, 2007 and 2009.***

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