Public Health Association
AUSTRALIA

Public Health Association of Australia (PHAA) response to the National Health and Hospitals Reform Commission (NHHRC) Interim Report

Proposals for 'Improving oral health and access to dental care'

National Health and Hospitals Reform Commission
PO Box 685
WODEN ACT 2606

Fax: +61 2 6262 7264
Email: talkhealth@nhhrc.org.au

24 March 2009

Contents

Introduction 3

Background 4

Reform directions 1 to 3 – 'Denticare Australia' 4

Reform direction 4 – Internship Scheme 5

Reform direction 5 – National expansion of the pre-school and school dental programs 6

Reform direction 6 – Additional funding for oral health promotion 6

Conclusion 7

Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

The PHAA is a national organisation comprising around 1500 individual members and representing over 40 professional groups concerned with the promotion of health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the government and for the Preventative Health Taskforce and NHMRC in their efforts to develop and strengthen research and actions in this area across Australia.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian New Zealand Journal of Public Health draws on individuals from within the PHAA who provide editorial advice, review and who edit the Journal.

In recent years the PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all aspects of government and promoting key policies and advocacy goals through the media and other means.

This submission has been developed by PHAA's Oral Health Special Interest Group.

Background

The Public Health Association of Australia (PHAA) supports the Commission's proposals for improving Australians' oral health. The PHAA fully agrees with the Commission's key messages in Chapter 11 about –

- The importance of oral health to overall general health,
- The need to incorporate oral health care into primary health care,
- The high cost of dental care being a barrier for many people to access timely preventive oral health care,
- The under-resourcing of public dental services and consequent long waiting times and emergency/extraction focused care.

Inequities among Australians' oral health need to be addressed. As highlighted in the report –

- Oral health is a key indicator of inequality. People who have 'unfavourable' access to dental services are almost four times as likely to have a tooth extracted than those that have 'favourable' access to dental care,
- Whereas 78% of medical services in Australia are funded by government, only 18% of dental services are government funded.

Comments will be made on the six proposed reform directions, followed by recommendations on each.

Reform directions 1 to 3 – 'Denticare Australia'

Comments

- Strong but qualified support.
- A period of phased implementation based on prioritising those groups in greatest need would appear to be required given current workforce shortages and misdistribution. Otherwise more advantaged groups would be likely to be the immediate beneficiaries, thus increasing inequalities.
- There will be a significant increase in demand for public dental services with the proposed increase to public dental eligibility.
- Public dental services will need to be better resourced to ensure that timely and preventively focused oral health services can be provided to the most disadvantaged. Groups with high oral health care needs include:
    - low income individuals and families;
    - Indigenous people;
    - low income pregnant women; and
    - Low income people with further disadvantage or combination of disadvantage, such as disability, mental illness, chronic illness, special needs, or living in residential care services.
- The range of services offered could be marginally broadened for example, to include root canal treatment for anterior (front) teeth to maintain oral function and aesthetics.

- Issues highlighted in the costing report will need to be considered carefully for example, impact on demand (page 29), scope creep (page 12), and price inflation (page 33).
- The experience of jurisdictions that have public dental co-payments could be considered. The relatively low charges (less than 20% of private practice fees) do not appear to have been a barrier to access when there is scope to waive charges in necessitous circumstances. Co-payments would raise revenue to allow more people to be treated.
- Workforce reforms to increase capacity to provide more preventive dental care include:
    - Expanding the scopes of practice of dental therapists, dental hygienists and oral health therapists to better utilise the skills they either already possess or could obtain through appropriate further training; and
    - Creating an expanded dental assistant qualification to support routine preventive oral health services in primary health care and aged care facilities.
- The culture of dental education should focus more on the integration of oral health into primary health care, team work, social justice and the reduction of inequality, and people-centred enabling approaches. Additional funding for dental schools could be tied to such curriculum changes.

Recommendations

- Develop a detailed implementation study prior to the finalisation of the Commission's June Report.
- Incorporate key action items from the 2004-2013 National Oral Health Plan within the detailed implementation study and establish publicly accountable monitoring and reporting processes.
- Increase the number of Commonwealth-supported Bachelor of Oral Health places.
- Increase funding for dental schools that provide a more integrated, people-centred approach.
- Provide more rural oral health scholarships and support more rural education.

Reform direction 4 – Internship Scheme

Comments

- Qualified support.
- Clinical facilities as well as many more experienced public sector staff will be required. Private sector placements may be able to be included. However the experience of the voluntary dental intern scheme that operated in Victoria in the 1990's was that few private practices were able to accommodate interns. There will be about 500 dentist graduates in 2014, plus about 100 accredited overseas trained dentists. Other members of the dental team such as oral health therapists should also be part of the intern scheme.
- The scheme will need to be well funded, with a mentored clinical component, professional development, and options for research and oral health promotion.
- The scheme would need to be phased in as public infrastructure (capital and experienced workforce to mentor graduates) is developed.

- A constant turnover of first year graduates will reduce the public sector's ability to offer continuity of provider to clients. Such continuity is a key factor in client satisfaction with dental care.
- Establishing an attractive voluntary intern scheme that would include greater opportunities for the intern to continue in the same location would be an alternative option to a compulsory scheme.

Recommendation

- Phase in the scheme as public sector infrastructure is expanded.

Reform direction 5 – National expansion of the pre-school and school dental programs

Comments

- Support.
- Programs for children need to have a family focus and be closely integrated with adult dental services and other primary health care services.
- The collection of children's oral health data, particularly in the early childhood period, needs to be standardised and strengthened for enhanced monitoring of oral health and program accountability.

Reform direction 6 – Additional funding for oral health promotion

Comments

- Support.

Recommendations

- Fast track the rolling out of rural/remote town water fluoridation.
- Integrate oral health promotion into general health promotion via a common risk factor approach. For example via diabetes education and smoking cessation.
- Fund community based oral health promotion targeted at populations with a high proportion of people at high risk of oral disease.
- Include the promotion of oral health as a core task for the proposed National Health Promotion and Prevention Agency.
- Include routine oral health screening questions within the health checks undertaken by GPs for groups identified as at risk e.g. Indigenous, aged, chronically ill people, children and pregnant mothers.
- Provide all primary health care workers with training to ensure basic oral health promotion in their work.
- Provide training and funding for primary health personnel including medical practitioners, child welfare nurses and Aboriginal Health Workers to 'Lift the Lip', check for tooth decay,

apply fluoride varnish where appropriate, and provide oral health advice including referral to a dental provider.

- Include oral health professionals within Divisions of Primary Care.

Conclusion

The PHAA is supportive of the Commission's oral health reforms and is willing to meet with the Commissioners to discuss implementation issues. It is important that the opportunity to improve Australians' oral health and to redress inequalities in oral health is not lost.

24 March 2009

Michael Moore BA, Dip Ed, MPH
Chief Executive Officer
Public Health Association of Australia