Public Health Association of Australia: Policy-at-a-glance – Oral Health Policy

Key message: PHAA will –
1. Advocate for the prevention of oral diseases through a population health approach; integration of oral health within primary health care; and the normalisation of prevention oriented, person centred dental care utilising a more flexible and multi-skilled workforce.
3. Lobby for State and Territory Health Ministers to provide water fluoridation to all communities of 1000 or more population by 2020.
4. Advocate for integration of oral health into all relevant policies and public health programs, including policies related to Non-Communicable Diseases (NCDs) and Sustainable Development Goals (SDGs).
5. Advocate to enhance the effectiveness of the Child Dental Benefits Schedule (CDBS) by including evidence-based guidelines, and by monitoring treatment services and access by high needs groups.
6. Contribute to the implementation of the National Oral Health Plan 2015-24 and to the work of the National Oral Health Alliance.

Summary: Population and targeted health promotion and prevention strategies are essential to reduce inequalities in oral health in Australia. All Australians should have access to high quality, person-centred, culturally appropriate, safe, affordable, timely and cost-effective oral health care. Oral health literacy should be enhanced to promote the understanding of oral conditions and the options for appropriate care and health promoting lifestyles. Disadvantaged groups have a higher burden of oral disease and should be given priority in public oral health care programs.

Audience: The Australian community, particularly Australian, State and Territory Governments, policy makers, program managers, and stakeholder groups in the oral and general health fields.

Responsibility: PHAA’s Oral Health Special Interest Group (SIG).

Date policy adopted: October 2017

Contacts: Bruce Simmons, Convenor, Oral Health SIG
Oral Health Policy Statement

The Public Health Association of Australia notes that:

1. Oral health is fundamental to overall health, well-being and quality of life. A healthy mouth enables individuals to eat, speak and socialise without pain, discomfort or embarrassment.¹

2. While there have been some improvements over the last decade, oral diseases place a considerable burden on individuals, families and the community. Tooth decay is the most prevalent health condition in Australia.¹ More than 90% of adults and around 50% of disadvantaged children have experienced tooth decay, with a third having untreated decay.¹ Almost half of older people have moderate or severe gum disease² and oral cancer is among the top 10 cancers for mortality.¹ Potentially preventable dental hospitalisations are the highest of all potentially preventable hospitalisations for young children.³

3. Poor oral health is a marker of disadvantage. Significant inequalities exist with greater levels of oral disease experienced by Aboriginal and Torres Strait Islander peoples, people on low-incomes, those living in rural and remote areas, some immigrant groups from culturally and linguistically diverse backgrounds and dependent older people.¹

4. A range of health conditions are closely associated with oral disease. Gum disease exacerbates diabetes by making it harder to manage sugar levels,⁴ and is associated with adverse pregnancy outcomes⁵, ⁶ and coronary heart disease.⁷ Poor oral health can also lead to a poor diet, ⁸, ⁹ aspiration pneumonia and infective endocarditis.¹⁰

5. Barriers to accessing oral health care include the high cost of private dental treatment, long public dental waiting times, low oral health literacy, transport problems and the maldistribution of the dental workforce particularly in rural and remote areas.¹

6. Only 44 per cent of all adults aged over 18 have favourable dental visiting patterns (visiting once or more per year).¹¹

7. Dental care is second to cardiovascular disease as the most expensive disease group.³ Per capita public dental funding varies markedly between states and territories and federal funding has varied markedly each year. Out-of-pocket expenses equate to 58.2% of total dental costs, about four times the average for all other health care.³

8. The private health insurance rebate supports those who can afford private health insurance and does little for those with greatest dental needs. In 2012-13 the rebate was $606 million.¹¹
Oral diseases are amenable to prevention. They share common risk factors with other chronic diseases, for example high intake of sugary food and drinks, tobacco use, and the excessive intake of alcohol. Prevention interventions are necessary to target these risk factors.\textsuperscript{12}

10. Fluoridation of drinking water remains the most effective and socially equitable means of achieving community-wide exposure for preventing tooth decay. However, only 82.2\% of the national population have access to fluoridated water.\textsuperscript{13}

11. The Child Dental Benefits Schedule (CDBS) has increased access for children but there are insufficient data collected to be able to monitor effectiveness.

12. There is an oversupply of dentists and an undersupply of dental therapists in Australia.\textsuperscript{14} The roles of dental therapists, oral health therapists, dental hygienists and dental assistants are underutilised in oral health prevention initiatives.

13. Oral health curricula have limited focus on population needs, person centred care and evidence based practice. Masters of Public Health courses do not address oral health issues. There is no pathway to registration as a public health dentist for locally trained dental personnel.

14. The suite of indicators being used to monitor the implementation of the National Oral Health Plan 2015-2024 is a good foundation to develop a national oral health surveillance system.

15. Although oral disease is the second most costly disease group in Australia, from 2003 to 2012 less than 1\% of the NHMRC grant funding was allocated to oral health research.\textsuperscript{15} There is little research on the Australian causes of, and solutions for, oral health inequalities.

The Public Health Association of Australia affirms the following principles:

16. Oral health inequalities are caused by the conditions of daily living, the political, social, cultural and physical environments which in turn dictate the choices and options open to people.\textsuperscript{12} Oral diseases are amenable to prevention if there is a proportionate universalism approach. ‘Upstream’ changes that address the social determinants of health are required as well as targeted initiatives including community-based health promotion and clinical prevention services.

17. Inequalities in access to oral health care and oral health outcomes should be addressed through a universal, equitable dental system that has a focus on person centred, culturally appropriate, safe, affordable, timely and cost-effective oral health care.

18. Disadvantaged groups including 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.
PHAA Policy Statement on: Oral Health Policy Statement

19. Programs will be more effective if they enhance oral health literacy and self-efficacy, contributing to empowering individuals and communities to enable more control over their lives and thereby health. People should be provided with information about oral conditions, risk of future disease and options for care and health promoting lifestyles.

The Public Health Association of Australia supports the key action areas set out in Australia’s National Oral Health Plan 2015-2024 and believes that the following steps should be undertaken:

20. Promote fluoridation of water to all communities with populations of 1000 or more.

21. Integrate oral health promotion and disease prevention in general health promotion policies following a common risk factor approach and promoting oral health environments in key settings.

22. Implement Denticare with Medicare – a phased in and initially targeted universal and equitable dental system for all Australians.

23. Abolish the rebate for private health insurance on dental services and redirect the funding to oral health services for Australians on low incomes.

24. Train and develop an appropriate multi-skilled, multi-disciplinary, flexible workforce to provide affordable, safe, quality oral health care for all Australians. This will require strengthening training on population needs, person-centred care and evidence-based practice for effective clinical and community care decisions to be made. Oral health subjects should be included in public health courses to increase the capacity of public health practitioners to promote oral health. There is a need to develop a pathway for the training and recognition of dental public health specialists. Dental public health specialists are a key group needed to support the improved oral health of the Australian community as a whole and disadvantaged groups within the community.

25. Develop a national oral health surveillance system based on the suite of indicators used in the reports prepared by the Oral Health Monitoring Group on the implementation of the National Oral Health Plan 2015-2024. The monitoring reports should be publically released.

26. Increase funding for oral health research and bring together researchers, policy makers and practitioners to enhance oral health translation into policy and practice. Establish a national strategy to inform research investment decisions and facilitate equitable allocation of research funding.
The Public Health Association of Australia resolves to undertake the following actions:

27. Advocate for the prevention of oral diseases through a population health approach; integration of oral health within primary health care and the normalisation of prevention oriented, person centred dental care utilising a more flexible and multi-skilled workforce.


29. Lobby State and Territory Health Ministers to provide water fluoridation to all communities of 1000 or more population by 2020.

30. Advocate for integration of oral health into all relevant policies and public health programs including policies related to NCDs and SDGs.

31. Advocate to enhance the effectiveness of the CDBS by including evidence-based guidelines, and by monitoring treatment services and access by high needs groups.

32. Contribute to the implementation of the National Oral Health Plan 2015-2024 and to the work of the National Oral Health Alliance.

33. Advocate for the development of a pathway for the training and recognition of dental public health specialists to support the improved oral health of the Australian community.

34. Advocate for the creation of a Chief Dental Officer position within the Department of Health to support the integration of oral health within the Department and proportionate funding of oral health research by the NHMRC.


First adopted at the 1994 Annual General Meeting of the Public Health Association of Australia. The latest revision has been undertaken as part of the 2017 policy review process.
References