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

Key messages:

PHAA will:
1. advocate for Denticare - a universal and equitable dental system for all Australians within Medicare - phased-in and initially targeted.

2. advocate for: a population health approach; integration of oral health within primary health care; and the normalization of prevention oriented, person centred clinical dental care.

3. identify and advocate for programs that will develop the oral health workforce and resources in child and adult public services, aged care, rural and remote areas and other areas of high patient and population need; and identify and advocate for strategies to create a cost-efficient, flexible and multi-skilled oral health workforce.

4. lobby Australian, State and Territory Health Ministers to provide water fluoridation to all communities of 1000 or more population by 2016.

5. lobby for the incorporation of the above policies in the development of the second National Oral Health Plan 2014-2023 and contribute to its implementation.

Summary:
All Australians should have access to high quality, person centred, minimally-invasive, culturally appropriate, safe, affordable, timely and cost-effective oral health care. National and appropriate local oral health promotion and prevention strategies are essential. All clinical and non-clinical activities should promote oral health literacy and enable people to better understand their oral condition and their 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: Australian, State and Territory Governments, policy makers and program managers. Other relevant stakeholder groups in the oral and general health and aged care fields.

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

Date policy adopted: September 2014

Contact: Bruce Simmons, Convenor, Oral Health SIG, simmonsbruce@hotmail.com
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 share risk factors with other chronic diseases (xx).

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 third highest cause of acute preventable hospital admissions (iii).

4. Expenditure on oral care is significant –
   - Annual expenditure on dental care in Australia was $8.34 billion in 2011-12 (iv).
   - 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 28% 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 consistent 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).
   - Health Care Card 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 both private and public oral health practitioners is limited.

8. Around 46 per cent of Australian adults have favourable visiting patterns (attend regularly each year for a dental check-up), 22 per cent have unfavourable visiting patterns (attend only for problem-based care), and 32 per cent have a mixed or intermediate visiting pattern (xvi). People with infrequent dental attendance are 2.7 times more likely to have a tooth extracted when they do attend (xv).

9. Public funding for oral health care is not reaching many of those most in need. Initiatives in the 2012 Federal Budget (Table 1) and in the Dental Health Reform Package announced in August 2012 (Table 2) began to address the key issues but should be seen as no more than initial stages in the creation of a ‘Denticare Australia’ system.

Table 1. 2012-13 Federal Budget dental initiatives ($m)

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<tbody>
<tr>
<td>Public dental waiting list alleviation</td>
<td>70.0</td>
<td>155.8</td>
<td>120.0</td>
<td>0</td>
<td>345.8</td>
</tr>
<tr>
<td>Increasing the capacity of the dental workforce</td>
<td>14.4</td>
<td>51.0</td>
<td>47.3</td>
<td>45.9</td>
<td>158.6</td>
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<tr>
<td>Oral health promotion</td>
<td>0.5</td>
<td>5.0</td>
<td>5.0</td>
<td>0</td>
<td>10.5</td>
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<tr>
<td>Coordinate the delivery of pro bono dental services</td>
<td>0.5</td>
<td>5.0</td>
<td>5.0</td>
<td>0</td>
<td>0.45</td>
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<td><strong>Total</strong></td>
<td><strong>84.9</strong></td>
<td><strong>211.8</strong></td>
<td><strong>172.3</strong></td>
<td><strong>45.9</strong></td>
<td><strong>$515.35m</strong></td>
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Table 2. Impact of the 2014 Budget on the 2012 Dental Health Reform Package 2013-14 to 2017-18

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<tr>
<th>Initiative</th>
<th>Original Budget</th>
<th>2014 Budget</th>
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<tr>
<td>Child Dental Benefits Scheme</td>
<td>$2.7b over six years</td>
<td>No change</td>
</tr>
<tr>
<td>National Partnership Agreement (NPA) for adult public dental services</td>
<td>$1.3b over four years</td>
<td>2014/15 deferral with cut of $390m up to 2017-18</td>
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<tr>
<td>Regional and rural dental services, workforce and indigenous programs</td>
<td>$225m</td>
<td>Ceased</td>
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10. The 2014 Commonwealth Budget reduced dental funding as shown in Table 2. The current National Partnership Agreement (NPA) is due to end in March 2015. Its funds have led to a significant increase in low income patients being treated across Australia. The second $1.3b NPA was originally scheduled to start on 1 July 2014 but the budget proposes its deferral until 2015-16 and cutting $390m over four years.

11. In addition, the Government has indicated that it will not proceed with the $229m Flexible Grants Program, which was to provide dental infrastructure in outer metropolitan, rural and regional
areas. Also, changes to Family Tax Benefit A are likely to reduce the number of children eligible for the Children’s Dental Benefit Scheme.

12. Furthermore, the private health insurance rebate of $528 million annually favours those who can afford private health insurance (iv). It should be directed towards people with the greatest dental needs.

13. The findings and recommendations of the 2009 National Health and Hospitals Reform Commission (NHHRC) are strongly supported. The NHHRC found that Australia ranks among the bottom third of OECD countries for rates of dental decay in adults and described major inequities in Australians’ access to oral health care resulting in poor oral health for many (xx). It recommended a ‘Denticare Australia’ system and three further oral health reforms aimed at promoting life-long oral health and making oral health care an integral part of primary health care.

14. It is disappointing that the National Oral Health Promotion Plan developed in 2013 has not been released and the $10m identified for oral health promotion not provided. The recommendations of that report should be implemented. These include -
   • Establishing a prevention system for oral health
   • Developing evidence-based guidelines for the Child Dental Health Benefit Scheme to help ensure that efficient, effective, preventively focused care is provided to children who need care most and avoid over servicing for the worried well.
   • Enabling family based care, integrating the dental care services and oral health literacy of the whole family wherever possible.

15. Fluoridation of drinking water remains the most effective and socially equitable means of achieving community-wide exposure to the caries prevention effects of fluoride (i). However up to 20 per cent of Australians do not have access to fluoridated water (xvii).

16. Demand for dental care is likely to increase because of an increasing and ageing population with more people retaining their natural teeth and increased expectations about oral health. There will therefore be more need for preventive and restorative oral health care over many more years of life.

17. Workforce reforms are needed: The previous longstanding supply shortage of dentists and oral health practitioners has been addressed with the expansion of undergraduate numbers across programs in both the newer regional and established dental schools and the increased registration of international dental graduates through Australian Dental Council assessment. Even so, significant workforce and related service delivery reforms are still needed as there remain many underserviced, disadvantaged population groups as well as opportunities for overall national oral health improvement.

   • Prior to its closure by the Coalition government, Health Workforce Australia was undertaking a project titled HW 2025 - Oral Health to provide intelligence on workforce supply and demand to inform national level oral health policy and investment decisions. The project addressed the central question of “what is the right number and mix in the oral health workforce to best meet changing demographic and policy requirements to 2025?” The final report has yet to be released.
   • A more flexible, multi-skilled oral health workforce, distributed on a patient and population health needs basis is required. Scopes of practice for members of the dental
team need to be standardised across jurisdictions.

- The Dental Board of Australia has delivered its report and recommendations to the Health Minister on the Scope of Practice Review for Oral Health Practitioners. There are many areas of care, notably in public services and aged care facilities, where greater policy flexibility and opportunities for professional development would enable a more cost-efficient, flexible and multi-skilled oral health workforce with meaningful and rewarding jobs.

- The oral health workforce continues to be maldistributed with underemployed oral health professionals choosing to stay in capital cities and look for work while there remains a major undersupply in both private and public dental services across rural and remote Australia and inadequate funding to employ more professionals in public dental services.

- A national strategy is needed to encourage and enable rural students to enter dental schools and for all students to have significant, well-supported undergraduate clinical experiences in rural and remote Australia.

- Undergraduate training does not sufficiently emphasise and integrate the three domains essential for making effective clinical and community health decisions. The Australian Dental Council’s review of Accreditation Standards for Dental Practitioner Programs needs to ensure that courses deliver new graduates with the attributes and competencies to-
  1: recognise population needs
  2: perform person centred care and assess the patient’s/population’s biology/ies, history, needs, symptoms, findings, preferences, values and expectations, social and financial circumstances
  3: practice based on the best available evidence (xxi).

18. Oral health academia requires considerable strengthening and scholarly integration. National infrastructure and professional clinical support is required to facilitate training in evidence-based clinical practice across Australia.

19. Enhanced training pathways for specialists in Public Oral Health are required.

20. Ongoing and timely collection of, and access to, data on oral health status is required for population planning and monitoring. It is positive that the first National Child Oral Health Survey is currently being conducted by jurisdictions with the support of ARCPOH. However other national data are outdated - Australian adult data were last collected through the 2004-06 National Survey of Adult Oral Health (xv), while data for marginalised groups such as Aboriginal and Torres Strait Islander peoples, homeless people and those living in shelters/hostels have not been systematically collected.


The Public Health Association of Australia affirms the following principles:

1. Inequalities in access to oral health care and oral health outcomes should be addressed through a universal, equitable dental system.

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 – the social determinants of health (political, social, economic and environmental factors) are crucial and need to be addressed.

4. Person centred oral health care is the first dimension required for a safe and high-quality oral health system (Australian Commission on Safety and Quality in Healthcare (xxii)).

5. Oral health programs will be most effective if they enhance oral health literacy and self-efficacy, contributing to the empowerment of individuals and communities so that people are able to take more control over their own lives and thereby their health.

6. 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 lifestyles.

7. 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.

8. Quality standardised data collection is essential to monitor and evaluate public dental programs and policies, detect emerging trends (such as the impact of bottled water use on oral health) and to enable national and international comparisons.

9. Provision of oral health care is a cost-effective public health measure

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:

1. Promote fluoridation of water as an effective public health measure.
2. Extend the fluoridation of drinking water to all communities with populations of 1000 or more.
3. Integrate oral health promotion and disease prevention activities into general health promotion following a common risk factor approach.
4. Implement the recommendations of the National Oral Health Promotion Plan.
5. Implement Denticare - a phased and initially targeted universal and equitable dental system for all Australians within Medicare
6. Abolish the rebate for private health insurance on dental services and redirect the funding to oral health services for Australians on low incomes.
7. Train and develop an appropriate multi-skilled, flexible workforce to provide safe, quality oral health care for all Australians. This 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.
8. Strengthen undergraduate training by ensuring curricula integrate—
   • patients’ biologies, preferences, values and expectations and the oral health needs of population groups
   • the clinician’s knowledge, skills, attitudes and preferences (xxi)
   • utilization of the best available research evidence on health promotion, prevention, diagnosis and treatment


11. Increase funding for oral health research and strengthen processes to bring together researchers, policy makers and practitioners to enhance the translation of research into policy and practice.

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

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.
   a. Lobby Australian, State and Territory Health Ministers to provide water fluoridation to all communities of 1000 or greater population by 2018.
   b. Identify and implement strategies to create a more flexible and multi-skilled oral health workforce.

3. 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.

4. Lobby all State and Territory Oral Health Managers to review current data collection processes and identify opportunities to enhance data systems and access nationally.

5. The Oral Health Special Interest Group (OHSIG) and PHAA will explore and identify other PHAA Special Interest Groups and policies with which the OHSIG can develop strategic links and develop shared policy statements and linked resolutions.


References:


xvii National Health and Medical Research Council 2007. A systematic review of the efficacy and safety of fluoridation. Canberra: NHMRC.

xix World Health Organisation EB120.R5 Oral health: action plan for promotion and integrated disease prevention


xxii Australian Commission on Safety and Quality in Healthcare 2011. Patient-centred care: Improving quality and safety through partnerships with patients and consumers Sydney NSW