Public Health Association
AUSTRALIA

Public Health Association of Australia submission to the Inquiry into Adult Dental Services in Australia

House of Representatives
Standing Committee on Health and Ageing
Inquiry into Adult Dental Services in Australia
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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.

Public Health

Public health 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.

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

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. PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the Australian Government and for the Preventative Health Taskforce and National Health and Medical Research Council (NHMRC) in their efforts to develop and strengthen research and actions in this area across Australia.

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 public events 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 and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

Advocacy and capacity building

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government

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and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

PHAA submission to the Inquiry into Adult Dental Services in Australia

The PHAA believes that all Australians should have access within Medicare to person-centred, culturally appropriate, safe, affordable, timely and cost-effective evidence-based 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.

A much greater focus on prevention is imperative but there would remain substantial backlog requirements for care, possibly for generations.

Rights to oral health are not just a dental issue but an ethical and social justice issue – one of human rights and dignity.

1. Demand for dental services across Australia and issues associated with waiting lists

PHAA advocates for the deliberate and phased implementation of 'Denticare Australia', a universal access system for dental care. We believe the current dental system is highly inequitable and performs poorly in terms of access to care and oral health outcomes.

Public dental service waiting lists stretch to a year in many parts of Australia, reflecting a lack of infrastructure and the workforce to meet demand. In rural Australia, many midsize to small towns are poorly supplied with private and public dental practices resulting in even longer wait times and difficult access to both acute and general care. Often by the time people receive care the problem has worsened and they require more invasive and/or extensive treatment. Little attention is paid to the morbidity caused by such waiting lists, and unfortunately there is often an acceptance of both pain and dental disease as a normal part of life, particularly in disadvantaged communities.

The National Survey of Adult Oral Health 2004-06 demonstrated that eligible users of public dental services face such long waiting times that 63 per cent chose to visit a private practice, very often for problem based care only. People who attend a dentist infrequently (i.e. for problem based care only) are almost four times more likely to have a tooth extracted when they do attend (1). This pattern of care results in greater pain, infection and loss of function over time, and may result in difficulty eating and lack of self-esteem. People with poor attendance are far more likely to be the disadvantaged.

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Dental diseases are largely preventable conditions. Oral health promotion, prevention and early intervention policies and programs can prevent problems and reduce demand for services. Prevention is the most cost-effective way of improving oral health and the best means of reducing the pain and suffering associated with dental disease. Programs can be provided through population oral health, primary health care and/or clinical care services.

Fluoridation of drinking water remains the most effective and socially equitable means of preventing caries (2); however up to 20 per cent of Australians do not have access to fluoridated water (3). PHAA strongly supports providing water fluoridation to all communities of 1000 or more population by 2015.

Demand for dental care is likely to increase in coming years because our ageing population are retaining their natural teeth (which require more maintenance care than dentures) and have higher expectations for their oral health. Demand for preventive and restorative oral health care will therefore continue to increase.

Government also has an imperative to recognise and address the social determinants of health (eg poverty and educational attainment) to enable progress in preventing dental diseases and reducing oral health disparities. This is required alongside the other proposed changes.

2. The mix and coverage of dental services supported by state and territory governments, and the Australian Government

The PHAA supports a universal system of oral health care, available to all Australians. The system should sit within Medicare and be phased-in and initially targeted. It should incorporate a population health approach; integration of oral health within primary health care; and be prevention oriented (4).

In the meantime, jurisdictions and other sectors have particular roles and responsibilities in the funding and delivery of oral health services; the Commonwealth through leadership and funding; the states and territories through funding and public sector service delivery, training and education; and the private and non- government sectors through service delivery (1).

Currently there are major differences in the mix and coverage of dental services supported by state and territory governments. To help address these differences the Commonwealth will need to provide sufficient additional funding to states and territories on an eligible persons per capita basis to effectively minimise the current inequities. At the same time it must require states and territories to maintain their current effort or the potential gains will be minimised by cost shifting.

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3. Availability and affordability of dental services for people with special dental health needs

PHAA considers that disadvantaged groups such as Aboriginal and Torres Strait Islander peoples, low-income earners, rural and remote dwelling Australians and dependent older people have a higher burden of oral disease and should be given priority in public oral health care programs.

Young children in low socio-economic groups experience almost twice as much dental caries as those in high socio-economic groups (5), and 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 (6).

PHAA considers that all Australians should have access to high quality, person centred, culturally appropriate, safe, affordable, timely and cost-effective oral health care, oral health promotion and prevention strategies.

4. Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

The oral health workforce continues to be maldistributed with supply exceeding demand in urban private practices and a major undersupply in public dental services and in rural and remote Australia. People in rural and remote areas are more likely to have no teeth and less likely to have a recent dental visit.

5. The coordination of dental services between the two tiers of government and with privately funded dental services

Unfortunately the current two tiered government system has often resulted in no one taking responsibility for dental care. For example, in aged care the combined complexity of aged care and dental care has often resulted in poor or no services for those in serious need.

The PHAA commends the Commonwealth for tackling the public dental waiting lists with the current National Partnership Agreements with states and territories. However PHAA urges the Commonwealth to implement a stepped approach to the introduction of a system that enables more people to access timely, person centred preventive dental care.

Currently, the majority of dental services in Australia are provided in the private sector. In addition the public dental sector in several state use vouchers systems to pay private providers where staffing levels are inadequate or when demand exceeds service availability.

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It is essential that there is a coordinated population oral health approach to deliver equitable dental services and access.

6. Workforce issues relevant to the provision of dental services

The oral health workforce continues to be maldistributed with supply exceeding demand in urban private practices and a major undersupply in public dental services and in rural and remote Australia

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.

A more flexible, multi-skilled oral health workforce, distributed on a patient and population needs basis is required. Currently, scopes of practice for members of the dental team, including dental assistants, are unduly restrictive. All members of the dental workforce, as well as other primary health care workers, should be enabled by legislation to provide dental care services in line with their training either as undergraduates or through continuing professional development.

Areas of substantial need such as working with the disabled or working in aged care are often not seen as attractive options for dental professionals hence even if we provide adequate numbers of professionals for overall population – care for such disadvantaged groups is likely to remain inadequate.

Aboriginal and Torres Strait Islander people are under-represented in the dental health workforce. PHAA believes that more Indigenous people working in relevant professions such as dentistry and other oral health professions can reduce barriers for other Indigenous people seeking dental care by helping to ensure the provision of culturally appropriate dental care.

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Conclusion

The PHAA believes that all Australians should have access within Medicare to person-centred, culturally appropriate, safe, affordable, timely and cost-effective evidence-based oral health care. This submission outlines key issues related to achieving this goal.

The PHAA appreciates the opportunity to make this submission to the Inquiry into Adult Dental Services in Australia.

Please do not hesitate to contact PHAA should you require additional information or have any queries in relation to this submission.

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