



Fact Sheet 16

Oral and dental health

MAY 2009

Tooth and gum diseases are among the most common causes of morbidity in Australia. They can have serious negative effects on both general health and the quality of life. The diseases are more common in rural and remote areas, largely because people there are unable to find or afford a private dentist and there is serious under-investment in public dental services.

Background

Oral diseases are the most common of the chronic diseases and are important public health problems in Australia because of their prevalence, their impact on individuals and communities, and the expensive nature of their treatment.

There is good evidence of links between dental and other chronic disease, for example between periodontal disease and diabetes.

Dental ill-health is not only costly in terms of loss of personal health and wellbeing: it is also expensive in economic terms. Dental decay is the second most costly diet-related disease in the country, costing more than coronary heart disease, hypertension or diabetes.

Despite this, the Commonwealth still separates oral health from general health and to date has provided limited resources for it even though it has the same constitutional powers to fund dental services as it has for medical services. It remains unclear which level of government carries responsibility for oral and dental health, and so it is encouraging that the National Health and Hospitals Reform Commission has proposed strong national leadership and investment in oral health.

In Australia there may still be the general inference that government should largely meet medical services costs because they address potentially life-threatening problems that are subject to chance, while dental services should mostly be personally financed because they are not life-threatening and dental diseases are the consequences of personal lifestyle choices. This attitude is unjustified and unfair as there is strong evidence that most people experience considerable dental disease over their life times, and while some are able to access regular dental care, the majority of Australians cannot. For some years in the 1990s the Commonwealth's involvement through the Commonwealth Dental Health Program (CDHP) demonstrated that a serious waiting list situation could be ameliorated with additional funds. Over the past 10 years inequities have grown large again due to lack of Commonwealth funding.

Economic disadvantage and living in rural areas are two of the greatest risk factors for poor oral health in Australia. These factors have a compounding effect because some of the most socio-economically disadvantaged parts of the country are also the most geographically remote.

Those with very poor teeth and gums are frequently public patients, many of whom live in rural and remote areas. A significantly higher level of edentulism (no teeth) has been reported in the rural population compared with people in metropolitan areas.

Poor oral health, difficulties in accessing care and lack of dental health awareness are major issues for adult Indigenous Australians. Indigenous children have more than twice as many cavities as non-Indigenous children, in both deciduous and permanent teeth. Many Indigenous children don't have a toothbrush. Early childhood caries is particularly common and often acute or severe enough to require treatment in hospital under general anaesthesia.

Public dental health programs need to make much greater use of Aboriginal Health Workers and primary health care professionals more generally to encourage prevention and referral for treatment.

All States and Territories have schemes in place aimed at assisting rural and remote people to access dental care but the facts speak for themselves: oral health is poorer, services are sparser and access to care is more difficult in rural and remote Australia. All jurisdictions provide some public dental health services to individuals who are economically disadvantaged, but there is currently great variation in per capita funding between them and also between geographic areas.



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The shortage of public dental professionals is particularly pronounced in rural areas. About 28 per cent of public jobs were recently unfilled in rural New South Wales and the figure may well be higher in more remote areas.

Private dental services, too, are more easily accessed in major urban centres than in small or moderately large rural towns. As a rule of thumb, the further you live from a capital city the more difficult it is to access both public and private dental care. In 2005 there were 60 dentists per 100,000 people in major cities, 30 per 100,000 in regional areas, and only 20 per 100,000 in remote areas.

Dental specialist care is often much more difficult for rural and remote people to access. In 2003, 87.8 per cent of registered dental specialists worked in 'major city' areas compared to 78.4 per cent of all dentists. There were 7.5 dental specialists per 100,000 people in major cities, compared with 1.8 in outer regional and 0.2 specialists per 100,000 in remote Australia.

What has been achieved?

- Between 2005 and 2014 the number of Australian dentistry and oral health graduates is expected to double to around 600 a year.
- More than 100 overseas trained dentists now qualify and register to practise in Australia each year.
- During the past six years Griffith, Newcastle, La Trobe and Charles Sturt Universities have established both dentistry and oral health courses, while James Cook University now offers dentistry. Each new dental school promotes a strong rural student focus and a rural and Indigenous service focus.
- The coverage of fluoridation is spreading, particularly where it is most needed in Queensland and country Victoria.
- In February 2009 the National Health and Hospitals Reform Commission (NHHRC) handed down an Interim Report that recommended substantial reform in the oral health sector. Disadvantaged people have a great deal to gain from a program such as Denticare, providing it clearly addresses rural and remote inequities through strong policy and funding decisions.

- The national health professional registration and accreditation scheme currently being introduced will enable revised standards and new scopes of practice that will create flexibility and opportunity for reform.

The future

Further strong advocacy is necessary, especially by rural organisations, to convince the Australian Government of the need to adopt and fund major oral health reforms. The aim must be to simultaneously address major inequities in oral health, oral health literacy, access to dental clinics and other oral care, and workforce levels.

Federal funding should be available for the reforms proposed by the Alliance in its submission to the NHHRC to address the major inequities in rural oral health (see 'Submissions' at www.ruralhealth.org.au).

Undergraduate and continuing education programs for Australia's health professionals should be re-shaped to instil and maintain a service culture that focuses on health and wellbeing, health equity and person- and population-centred care.

There needs to be a national strategic effort to recruit and retain greater numbers of dentists, dental hygienists and dental/oral health therapists to rural and remote areas and to public dental services generally.

All Australians should have the opportunity to take measures within their means to prevent tooth decay and gum diseases, rather than waiting until emergency treatment is needed. Increasing the nation's opportunity to enjoy continuing good oral health and wellbeing will produce substantial social and economic benefits over the longer term.

Greater funding is needed for specific programs targeting improved oral health for Indigenous Australians.

Like general health, good oral health is highly dependent on the environmental and social determinants of health. Without healthy communities, good oral health will remain an impossible dream for many.



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