

# Health Reform - Note 8

*October 2009*

## Improving oral health and oral health care for all Australians

### The importance of oral health care

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Oral diseases, particularly those affecting the teeth and gums, are among the most common health problems experienced by Australians. Yet poor oral health is largely preventable through a combination of professional and home-based oral health care.

There is a powerful case to improve Australia's oral health through an expanded and more accessible oral health program. Australia has the second worst adult oral health of all OECD countries, and there are 650,000 people on public dental health waiting lists with an average 27 month wait time. Over 50 per cent of the adult population do not or cannot access regular dental checkups and care.

The position is worse in rural Australia. Rural people aged 25-44 are half as likely to visit a dentist as city dwellers. The National Survey of Adult Oral Health 2004-2006 found that 39.4 per cent of Indigenous people surveyed avoided some foods because of dental problems and 17.4 per cent of all rural adults were similarly affected. A 2001 Child Dental Health Study showed that oral health, as assessed by numbers of decayed, missing and filled teeth, was significantly worse with increasing remoteness from major cities. Lack of access to fluoridated water is one contributing factor.

Oral health care comprises preventive, diagnostic and restorative services provided by a trained professional and relating to the health of an individual's mouth, teeth and gums. It includes what have been described as elective services such as teeth crowns, implants, bridges, teeth straightening and cosmetic procedures. (The boundaries between 'basic oral health care', 'elective procedures' and 'cosmetic procedures' are contestable.)

In both the private and public sectors, dental specialists, dentists, dental hygienists, oral health therapists and dental prosthetists provide oral health care within the limits of their differing scopes of practice.

## **The current proposals**

The Health and Hospitals Reform Commission has recommended that all Australians should have access to basic preventive and restorative dental health care, regardless of ability to pay. The Commission's proposal, 'Denticare Australia', would provide everyone the choice of getting a range of dental services paid for either through a private health insurance plan or through public dental services. The services included under the scheme would be prevention, restoration and the provision of dentures. Denticare would pay the insurance premiums for those who chose private dental health insurance and would pay the costs for people using public dental services. Additional funding would be raised by an increased Medicare levy. Those who chose the private dental plan would be required to make a co-payment, while those who use the public services would "probably have to wait for some services".

The Commission also proposes expansion of the preschool and school dental health programs and the introduction of a one-year internship for dentists, hygienists and therapists to ensure clinical quality and to boost the capacity of public dental health services. To boost the dental health workforce and to support the internship program, it proposes major investment in five new dental teaching hospitals and 50 connected academic oral health service centres.

In addition, the Commonwealth Government has proposed augmenting public dental health services through a Commonwealth Dental Health Program and reducing the more expensive and less targeted dental procedures being provided under the existing Medical Benefits Extended Primary Health Care Scheme.

## **The Alliance position so far**

The Alliance strongly supports the establishment of a mix of private and public oral health care services that provides universal access to basic care. Universal basic oral health care is seen as an essential element of a national comprehensive primary care system. Because this is the long term objective, the Alliance also supports a narrowing of the focus of the existing MBS Dental program and the establishment of a Commonwealth Dental Health Program as soon as possible.

The major beneficiaries of such reforms should include people on low incomes, Indigenous people and those in rural and remote areas - most of whom currently have very poor access to dentists and oral health care.

A strengthened public dental health system, the routine incorporation of dental services within Aboriginal Medical Services and better access to private practitioners would help ensure that regular and more frequent dental care is available for Aboriginal and Torres Strait Islander people, including those living in more remote areas. Preventive dental care must also be included in holistic primary healthcare as a part of a broader approach to oral healthcare for Aboriginal and Torres Strait Islander people.

Poorer oral health and lack of access to care follow not only a person's age, but also their socio-economic status, their degree of rurality and their Indigeneity. It appears critical to

Denticare's successful implementation that the actuarial risk adjustment takes into account these four factors, thereby making services to more disadvantaged people more financially rewarding for those providers who are willing to go where the need exists. In the longer term, Denticare provides a sound opportunity to help bring about a needs-based distribution of the dental health workforce. For these reasons, the Alliance sees much merit in the spirit of the proposed Denticare scheme, which would improve access and affordability and focus on basic services within the limits set by an insurance scheme.

We are not confident that Denticare can work in the short term, however, because of the currently entrenched and substantial maldistribution of the dental and oral health workforce. Its immediate implementation would be more likely to benefit those already receiving care than the disadvantaged.

The Government therefore needs a detailed, staged transition in order to create the service delivery environment in which Denticare can produce the desired outcomes.

It is critical in the short-term that workforce programs be put in place to bring about, as soon as possible, an equitable needs-based distribution of the dental health workforce. This will take a considerable time and programmatic response by Government. Over 83 per cent of dentists practise privately and will continue to make their location decisions on the basis of commercial realities and other personal factors. Under these circumstances, universality of access to dental care seems a long way off.

The Alliance is therefore promoting a range of urgent interim measures. It strongly supports the Commission's proposal for expansion of the pre-school and school dental health service. The goal must be a nationally consistent program that is well-distributed, well-targeted, run from infancy to end of secondary schooling and has a strong preventive focus. Currently the programs are highly variable and even the better programs have been hampered by the loss of therapists to retirement and private practice, and by redistribution of limited public funding into adult services.

The Alliance is also providing strong support for the proposed one-year internship for dentists, hygienists and therapists. It has been estimated that this proposal would double the capacity of the public dental health services, improve clinical quality and provide stronger linkages between the tertiary education sector and public oral health. This proposal includes the creation of 5 new dental teaching hospitals (hubs) and 50 oral health centres (spokes). There is a good argument to have some dental teaching hospitals in rural areas and to ensure that the so-called 'spoke' oral health centres have further outreach capacity, since there are 180 towns with a population of between 5,000 and 48,000.

The intern program will need to be phased in as many more public clinical facilities and mentors are needed. The Government will have a critical role in the recruitment and retention of suitably experienced and motivated dentists to rural areas to provide the mentoring and support required by new graduates.

Implementation of the NHHRC's proposals would make the Federal government clearly responsible for ensuring a fair and workable oral health care system. Oral health care would be placed firmly within the primary care system.

## Your input is invited

Do you support the immediate implementation of Denticare, as proposed in the NHHRC report?

Would rural and remote people be better served if Denticare was rolled out in a staged way as access to dental health professionals grows?

What are your views on the existing Medicare program offering dental care for people with chronic diseases? Do you support the proposal for a Commonwealth Dental Health Program?

Do you have information about the capacity of the universities to train additional dental and oral health students and the funding currently being provided for this?

Should the Patient Assisted Travel Schemes (PATS) be extended to cover costs associated with emergency and/or basic oral health care?

If you have a comment, let us know at [nrha@ruralhealth.org.au](mailto:nrha@ruralhealth.org.au) or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.