# Submission to Senate Inquiry

# Provision of Access to Dental Services in Australia

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## Introduction

Our submission is based on a book that will be published in July - *Looking Back Looking Forward - A history of dental public health in Victoria 1970 to 2022* and beyond (Rogers & Robertson, 2023). We have looked back to propose future steps to improve the oral health of Australians, and particularly reduce inequality in oral health.

The book describes the events, drivers and motives which have led to policy and legislative changes. It reviews successful and failed policies and programs, the stop–start nature of Australian government funding and changes in the dental system. The contents page is attached (Appendix 1).

The aim of the research was to trace the history of oral health and disease alongside the complex interaction of social, political and economic factors that have shaped these over the last 50 years. And to offer a roadmap of how we arrived at the current state of oral health and the present dental system, to propose a future where better oral health is available to all.

A comprehensive literature review was conducted and there were discussions with 35 key players. The literature review was of published articles and "grey literature" eg government and non-government reports, reviews, audits, budget documents, plans, annual reports and media articles. More than 300 documents were sourced[1].

The World Health Organization's framework for health systems in terms of core components or "building blocks" (WHO, 2010) was adapted. The focus was on the building blocks of leadership and governance, workforce, financing, the service system and health information systems including research. Proposals for a future system to enhance access to dental care, prevent oral disease and reduce inequality are framed against the six strategic objectives set out in the WHO Global Strategy on Oral Health (WHO, 2022a).

## Findings

In Victoria but similar for Australia:

### Oral Health

- There have been significant improvements in oral health over the last 50 years but there is still a large unequal burden of preventable disease.
- Inequality has increased. The tooth decay gap between health care card holders and non-card holders rose from three to six teeth in the 12 years to 2018 (AIHW, 2007; ARCPOH, 2019).

[1] The University of Melbourne Dental Alumni Research Foundation, the Melbourne Dental School and the Australian Dental Association Victorian Branch, provided financial support to produce the book. They did not influence our approach nor have editorial control, for both of which the authors bear responsibility.

- More people are retaining their natural teeth for longer (up from a third of older people to 85%) (Sanders et al., 2004; NDTIS, 2013; ARCPOH, 2019) but more people are consequently prone to gum disease and tooth decay. More than half of all older people have moderate or severe gum disease (ARCPOH, 2019).
- While tooth decay has declined, it is still one of the most common health problems, with more than 80% of adults affected and more than 40% of 5–10-year-olds (Do & Spencer, 2016).
- Tooth decay is one of the most expensive disease conditions to treat. Costing $5 billion in Australia in 2018–19, the treatment of tooth decay was more costly than the treatment of falls (AIHW, 2021).
- Tooth decay is the leading cause of preventable hospitalisations in children aged under 10 (Rogers et al., 2018).
- Although oral cancer mortality rates have decreased, the incidence of tongue and oropharyngeal cancer has increased since 2010 (AIHW, 2020a).

### Access to dental care

- Cost as a barrier to seeking dental care has increased (AIHW, 2007; DHHS, 2016; DHHS, 2018; VHIA, n.d)). Fees for most dental services have increased at a higher rate than average weekly earnings (Rogers & Robertson, 2023).
- Dental visits by adults have been relatively stable over the past 40 years, with about half reporting a visit in the previous 12 months (Barnard, 1993; AIHW, 2007 (as referenced in ARCPOH, 2019); DHHS, 2016; DHHS, 2018; ARCPOH, 2019).
- Although access to public emergency dental care has improved, concession card holders face long waiting times for general care and their oral health needs have not been met. The public dental system remains only a tattered safety net.
- Governments cover less than 20% of dental costs, compared with around 65% of other health care costs and more for general practitioners (AIHW, 2020b). Dental care continues as the poor health cousin for government funding.
- Australian government funding has followed a roller-coaster trajectory, with many programs initiated but not maintained. (Duckett et al., 2019).
- Australian government funding has been found to be the most important factor in addressing the oral health needs of the most disadvantaged (Rogers & Robertson, 2023).

A judgement could be made that a moral test of government has not been met in relation to oral health. With the exception of primary school-aged children, Australian governments have fallen short in how they "treat those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in shadows of life, the sick, the needy, and the handicapped". While community support for a national scheme within or beside Medicare has been constant (Cresswell, 2011), the current public dental system could be seen as little more than a tattered safety net.

## Recommendations

It is timely to consider how the *Global strategy on oral health* adopted by the WHO in May 2022 could provide a framework for action in Australia (WHO, 2022a). This strategy espouses a bold vision of universal oral health coverage for all individuals and communities by 2030. It sets out four overarching goals to guide Member States while six guiding principles and six strategic objectives underpin and direct the path for governments towards realisation of the vision.

To develop a world best practice system we should draw on the six WHO strategic objectives to consider possible future directions. We propose a set of high-level recommendations for broad discussion. These suggestions offer a starting point for more detailed development of proposals. Priorities, timelines, funding and implementation responsibilities all need to be determined. We appreciate that this requires making difficult choices among the many options for using resources.

### 1 Oral health governance

The first of the WHO strategic objectives is to improve the political and resource commitment to oral health, strengthen leadership and create partnerships. Three actions, all relevant to Victoria and Australia, are proposed: namely, integrate oral health into all relevant policies and public health programs strengthen the capacity of the national oral health unit and create sustainable partnerships within and outside the health sector. The governance of the workforce is also relevant.

In summary, the way forward to improve oral health governance and leadership in Victoria and Australia would include the following actions:

- Further integrate oral health into all relevant policies and public health programs
- Enhance population oral health skills and experience in the Australian Department of Health to improve national planning
- Include the prevention of oral disease and oral health promotion in the remit of the Australian Centre for Disease Control that is currently being established[2]
- Subject Ahpra to triennial or quinquennial reviews but give it more resources to respond faster to notifications about oral health practitioners who place the public at risk of harm. Ahpra should also have more pro-active power and not simply wait to react to a notification.

### 2 Oral health promotion and oral disease prevention

The WHO call under this strategic objective is for evidence-based, cost-effective and sustainable interventions to promote oral health and prevent oral diseases.

[2] https://www.health.gov.au/our-work/Australian-CDC

As explored in the book, it is apparent that while there have been successful prevention programs in Victoria over the last 50 years, often they have been at a relatively small scale. Community water fluoridation has been a standout example but broader opportunities for prevention of oral disease and reduction of inequity have not been realised. Budgets for prevention have been small and successful pilot programs have often not been funded more broadly. From a macro perspective, funding for oral health care is considerably misaligned in favour of post disease treatment, rather than prevention.

A public health approach, the first of the WHO Global Strategy's guiding principles, requires an emphasis on preventing disease by analysing its distribution and determinants; establishing health promoting environments; enabling people to increase control over, and to improve their health; and reducing inequities in access to care. There must be upstream action on important factors, including legislation and improving social, economic, educational and environmental determinants. The more conducive to good health these factors are, the easier it is to live a healthy life – making the healthy choices the easier choices.

The social, economic, political and environmental determinants of poor oral health – "the causes of the causes" such as income, education and housing – largely lie outside the health system but can be influenced by health policy and practice. Health policy can help to promote healthy environments, influence early childhood development and provide access to affordable health services of decent quality. These are all social determinants of health (PAHO & WHO, 2023).

One key shortfall has been the lack of use of fiscal measures such as a sugar levy to reduce consumption of sweetened drinks. Such fiscal measures have been successful in reducing the consumption of tobacco and alcohol and have proven effective in reducing sugar consumption internationally (Park & Yu, 2019; WHO, 2022b). It has been estimated that a 20% tax on sugar-sweetened beverages in Australia would prevent 3.9 million decayed-missing-filled teeth over 10 years and save $666 million over that time (Sowa et al., 2019).

There are successful oral health promotion programs in Victoria and other jurisdictions, that are integrated with health promotion programs using a common risk factor approach. However, they are being implemented on a relatively small scale (Rogers & Robertson, 2013). Also, not all prevention interventions have been sufficiently funded to allow for robust economic evaluation, thereby limiting their utility in terms of informing policy.

The way forward for prevention of oral health problems in Victoria and Australia would include these actions:

- Expand community water fluoridation
- Scale-up prevention programs that have been evaluated to be cost effective. For example:
    - Collaborate with health, education and welfare professionals who interact with young children and their families
    - Create oral health promoting environments in pre-school, school, and aged care settings
    - Extend preventive value-based dental care by employing minimal intervention approaches such as fissure sealants, Hall crowns, silver diamine fluoride and community-based fluoride varnish programs

  - Trial the involvement of other health professionals in applying fluoride varnish
  - Support peer-led oral health promotion programs
  - Mandate oral health assessment on entry into residential care such as aged care and disability facilities; develop oral health care plans and provide support to residents in these settings
- Enhance access to preventive and value-based dental care through secure, ongoing national government funding
- Advocate for inclusion of oral health in all health plans, including in local government Public Health and Wellbeing plans and in the implementation of the *National preventive health strategy 2020-2030* (DH-A, 2021)
- Consider implementing evidence-based interventions that have not yet been tried in Victoria and
  - further restrict advertising of sugar-rich foods to children: for example, remove the advertising of unhealthy food from government-owned property;
  - introduce a national sugar levy; and
  - include oral health prompts in routine health checks.
- Implement a national oral health literacy campaign.
- Include the prevention of oral disease and oral health promotion in the remit of the Australian Centre for Disease Control that is currently being established
- Include a focus on prevention in oral health information systems
- Undertake prevention research, monitoring and evaluation focussing on addressing oral health inequalities (Tsakos et al., 2022), economic evaluation, community-based participatory research, and interdisciplinary research.

## 3 Health workforce

The WHO health workforce strategic objective is to develop innovative workforce models to respond to population oral health needs. Three main actions have been proposed: to develop the appropriate composition and size of the dental workforce; to work with other relevant health professionals; and to expand workforce education to respond to population oral health needs. The book considers these three actions in more detail.

To ready the oral health workforce for the future, the following steps need to be taken:

- Develop and test workforce models of the optimal mix of practitioner types to meet community needs, and refine these for population subgroups in private, public and corporate environments.
- Scale up the two most promising candidates for trial across Australia, recognising that more than one model may be needed.
- Maximise the use of all members of the dental team.
- Develop and strengthen partnerships with other health and welfare workers to enhance oral health promotion as part of their practice (WHO Strategic objective 2).

- Prepare health workers to manage and respond to the public health aspects of oral health and address the environmental impact of oral health services.

## 4 Oral health care

This strategic objective is aimed at increasing access to essential oral health care – safe, effective and affordable – for the whole population. Action is required to enhance access to value-based oral health care that is integrated into general primary health care.

In a blame game between the states and Australian governments, public funding for dental services has often fallen between the cracks. As mentioned earlier, governments have covered less than 20% of dental costs, compared with 65% of other health care costs (AIHW, 2020b). Public dental performance has fluctuated subject to the ebb and flow of budgets, most markedly in Australian government funding (Duckett et al., 2019; Rogers & Robertson, 2013). Considerable additional recurrent resources from the Australian government would be required if Australia is to meet the WHO vision of UHC in oral health for all individuals and communities by 2030.

Further detail is included in the book on the need to consider value-based oral health care, integrating oral health care into primary health care and exploring dental health technology

For enhanced access to people-centred oral health care for all, the following are needed:

- Sustained Australian government funding for public dental services to improve access to preventively focused value-based care
- Phased integration of basic dental care into Medicare, starting with a Seniors Dental Benefit Scheme as recommended by the Royal Commission into Aged Care Quality and Safety (RCACQ&S, 2021). With monitoring, evaluation and adjustments this could subsequently be extended, for example, to people with certain chronic health conditions such as endocrine and cardiovascular disorders and to people who are currently eligible for public dental services (Duckett et al., 2019; Maskell-Knight, 2022)
- Funding systems that focus on oral health outcomes that matter to people
- A new public–private partnership model that includes value-based care with strong governance, monitoring and evaluation arrangements
- More compatible dental and medical record systems which bring together health information and are linked to Medicare
- Innovation in modalities and programs to take dental care to people who are unable to travel to clinics either because of infirmity or remote geographical location

## 5 Oral health information systems

Planning for provision of whole-of-life care requires surveys of oral health status at regular intervals and, if oral health status and disease trends in populations are to be understood, reliably assured funding to conduct these surveys will be needed (Chattopadhyay et al., 2022). Such knowledge is essential for strategic planning of disease management and associated workforce requirements.

To improve policy planning for care and workforce deployment there is a need to:

- Enhance the surveillance and information capability of oral health information systems to support evidence-based policy development: in particular, to establish a system to measure and monitor oral health equity, use data from private dental practices and dental insurers, and enable linkages with broader health data systems
- Progress and further utilise ehealth (for example, teledentistry) as a means to overcome lack of access to services, promote oral health education to disparate groups, and as an additional modality for professional education
- Conduct national oral health surveys regularly, every five years at a minimum, alternating between child and adult oral health, as proposed in the *National oral health plan 2015–2024* (COAG, 2015); also ensure that qualitative surveys supplement existing quantitative surveys to gain more information for policy development

### 6 Oral health research agenda

Oral health research is inadequately funded in Australia. Less than 1% of National Health and Medical Research Council research funds are provided for oral health research (Ghanbarzadegan, 2023).

Necessary improvements include:

- Research addressing the public health aspects of oral health, such as investigations of upstream interventions; oral health inequalities (Tsakos et al., 2022); primary health care interventions including community-based participatory research; the impact of oral health on general health; minimally invasive interventions; learning health systems; workforce models; digital technologies, and environmentally sustainable practice
- Economic analyses to identify targeted cost-effective interventions
- Increased funding for oral health research
- Research into the barriers and enablers for the translation of research into policy and practice

## Conclusion

Improving oral health and reducing longstanding inequities requires action at all levels of government and in all sectors of civil society. The WHO *Global strategy on oral health*, adopted by the World Health Assembly in May 2022, provides a useful framework for identifying actions required to achieve the WHO vision in Victoria and Australia. The overall vision is universal health coverage in oral health for all individuals and communities by 2030.

Based on the findings of our look back to 1970, we have recommended areas for action on oral health under each of the six strategic objectives of the WHO global strategy. To progress this ambitious reform agenda, substantial discussion and policy attention are needed to determine priorities, timelines, funding and implementation responsibilities.

Universal oral health care for all individuals and communities would enable Australians to enjoy the highest attainable state of oral health and contribute to healthy and productive lives. The tattered safety net needs repair. The mouth should be brought back into the body.

We must consider every option carefully and, if the path to UHC is a long one, along the way we must tackle the unequal burden of poor oral health experienced by those who already bear the burden of social and economic inequality.

We hope that the findings of this study and the proposals put forward will contribute to an important national conversation about how to achieve the WHO vision.

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## Appendix

Looking Back Looking Forward
Oral health in Victorian and Australia 1970 to 2022 and beyond

Contents