CHAPTER 2

CURRENT AND FUTURE DENTAL CARE NEEDS

2.1 The need for quality dental care is an issue that is relevant to all Australians. The cost associated with providing this dental care is likewise a universal issue, affecting individuals in respect of the dental treatment they seek and affecting the whole community in the context of its wider costs. For example:

- national expenditure on dental services in 1994-95 was $1.94 billion;[1]
- it was estimated that in 1983 there were one million days work lost and over three million days of limited activity, associated with oral disease in the Australian population;[2]
- the NSW Dental Health Branch estimated that the cost of oral disease to the NSW community alone in 1995 approached $500million;[3]
- oral disease in Australia ranks among the most frequently experienced illness episodes;[4]
- dental disease is almost entirely preventable and the costs of these preventative measures are insignificant when compared with the costs of providing restorative care;[5]
- dental health is essential for good nutritional status and poor diet is one of the main causes of poor health in Australia (60 per cent of deaths in Australia are diet-related);[6] and
- recent research in the United States of America indicates a strong correlation between periodontal disease and heart attack.[7]

2.2 In quoting oral health statistics here and elsewhere in the report, the Committee notes that, with the exception of some data collected across the years 1994 to 1996 under the Commonwealth Dental Health Program (CDHP), much of the national data dates back to 1983 and the last Australian oral health survey.

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1 *Committee Hansard,* 23.3.98, p.97.

2 National Health Strategy, *Improving Dental Health in Australia,* Background Paper No. 9, 1992, p.11.

3 Submission No.131, p.2.

4 AIHW Dental Statistics and Research Unit, *Dental Care for Adults in Australia,* AIHW, 1993, p.1.

5 Submission No.51, p.1.

6 Submission No.88, p.1.

7 *Committee Hansard,* 6.3.98, p.40.

Oral health and general health

2.3 Oral health is concerned with the well-being of the mouth and its structures including the teeth, tongue, jaws, supporting tissues and salivary glands. Poor oral health has a range of consequences including pain, difficulty in eating and the avoidance of certain foods (which can lead to wider health problems), impaired speech, loss of self esteem, restricting social and community participation, and impeding the ability to gain employment. Generally, a person's overall quality of life is affected.

2.4 Dr Deborah Cole, Director of the Royal Dental Hospital of Melbourne, referred to some of the consequences of poor dental health:

> … It horrifies me that many people, especially decision makers, have no realisation of the dental consequences for the financially disadvantaged. These people with their broken down mouths have their job prospects diminished, are more likely to have problems dealing with landlords, bank managers, the police, doctors, lawyers and many other people they come into contact with in their daily lives. The value judgements that all these people make on a daily basis … come into effect to help these people stay in the poverty trap.[8]

2.5 The Committee was advised that although there are many diseases that affect the mouth, the two most common, and hence those constituting the major public health problem, are tooth decay (dental caries) and periodontal diseases, which affect the gums and tooth supporting structures. While dental caries has decreased in prevalence in the past 20 years (although remaining a major health and social problem), the need for periodontal maintenance programs are becoming more evident as more people retain their teeth. Both diseases are largely preventable.[9]

2.6 Oral disease has traditionally been treated and funded separately from other medical conditions. However, the interrelationship between oral health and the health of the whole body was constantly emphasised in evidence. Oral health should be recognised as an essential and integrated component of general health.[10] Dr Martin Dooland, of Dental Health Services Victoria (DHSV), stated in evidence that the link between oral and general health is most obvious from dentally compromised patients and most dramatic for life-threatening oral conditions. Dr Dooland noted, however, that 'the general health of over five million concession card holders is being damaged in less startling but very real ways by their poor and uneven access to basic oral health care, unlike the access they have to government subsidised medical care for other conditions'.[11]

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8 Submission No.87, p.1.

9 Submissions No.95, p.1 and No.128, p.3.

10 For example Submissions No.37, p.2; No.76, p.1; No.97, p.10; and No.133, p.8.

11 *Committee Hansard*, 23.03.98, p.119.

Groups with particular disadvantage

2.7 While the need for dental care is universal, certain people within Australian society are currently in greater need than others due to a range of barriers preventing them maintaining a desirable level of oral health. This is encapsulated in the finding of the Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit that:

> Research regarding variation in dental health within the adult community has highlighted manifest social inequalities in dental health status and access to basic dental care in the Australian adult population.[12]

2.8 It is important to note that, while rates of dental disease may vary due to factors such as the presence or absence of fluoridated water, low income earners and other disadvantaged groups have similar patterns of dental disease to the general population. The Victorian Government submitted that 'the major difference between these two groups is not so much in the experience of oral disease, but in access to and experience of treatment'.[13]

2.9 People disadvantaged in terms of their experience of dental care can be categorised as belonging to a number of broad groupings within Australian society. It must be remembered, however, that as individuals, they may suffer a range of disadvantages which apply to a number of groupings. For instance, as well as being a low income earner, a person might also live in a remote area and suffer the dental complications of a major illness. In such circumstances, their problems are compounded.

2.10 The most disadvantaged groups, as raised in evidence before the Committee, are addressed below.

Low income earners, including Health Card holders

2.11 The overwhelming weight of evidence before the Committee pointed to low income earners and their dependants as a significantly disadvantaged group in the area of dental health.

2.12 This group was generally seen as including those people who are eligible for health care cards and, therefore, publicly funded dental care. These are people who have a Pensioner Concession Card, Health Benefits Card, Health Care Card or Commonwealth Seniors' Health Card.[14] The Tasmanian Dental Service noted that Health Card Holders are receiving nearly twice as many extractions as the rest of the

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12 AIHW Dental Statistics and Research Unit, *Commonwealth Dental Health Program Baseline Evaluation Report 1994*, AIHW, 1995, p.1.

13 Submission No.127, p.5.

14 AIHW Dental Research and Research Unit, *Commonwealth Dental Health Program Evaluation Report 1994-1996*, AIHW, 1997, p.ix.

community, even though their underlying dental disease rate is not significantly higher.[15]

2.13 Research undertaken into the oral health status of low income earners indicates a significant level of inequality when compared with the rest of the population. In his evidence Professor John Spencer, Director of the AIHW Dental Statistics and Research Unit, summarised the range of factors which are generally accepted as characterising the standard of oral health and treatment. When applied to this portion of the population they become indicators of inequality:

> Certainly in incomes below $20,000 per year, we start to see the highest levels of perceived need: experience of both … toothache and inability to chew and eat all foods – those sorts of issues. We see the higher rate of problem or emergency visiting. We see the higher rate of extractions. We see the lower rate of restorations. We see the groups with longer intervals between their dental visits, including five years or more between dental visits.[16]

2.14 The following statistics illustrate these inequalities:

- People aged 45-64 with the lowest quintile of household income[17] are eight times more likely to have no natural teeth and 1.7 times more likely to wear a denture, than people from the wealthiest quintile.
- Health Card holders aged 45 and over are more than 1.7 times more likely to be edentulous (without teeth) and 1.4 times more likely to wear a denture than non health card holders.
- Dentate Card holders aged 45-64 report having an average of five more missing teeth than non health card holders.
- Dentate people from the lowest income quintile are 2.4 times as likely as those from the highest quintile to have attended a dentist as long ago as five or more years.[18]
- People from disadvantaged backgrounds are more likely to have poor oral health than the general population and are about twice as likely to have lost their natural teeth.[19]
- Among those whose last dental visit was in response to a dental problem, the group with the highest extraction rate – Card holders whose last visit was to a public clinic – had the lowest filling rate. Fillings are restorative whereas

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15 Submission No.41, p.2.

16 *Committee Hansard,* 23.3.98, p.100.

17 Those surveyed were divided into five groups, or quintiles, by level of income.

18 AIHW Dental Statistics and Research Unit and Social and Preventive Dentistry at the University of Adelaide, *A Research Database on Dental Care in Australia: Final Report,* April 1993, p.50.

19 Research Database report, p.5.

> extractions are the equivalent of dental morbidity. The group with the lowest extraction rate – non Card holders whose last visit was to a private clinic – had the highest filling rate. People visiting for a checkup within the private sector were more likely to receive restorative care than those who last visited a public clinic.[20]

2.15 In 1996 it was estimated that of people who went to a private dentist, over 94 per cent of those who went for a checkup and nearly 97 per cent of those who went for a problem, were seen within one month. Public patients had a less favourable outcome. Only 65.9 per cent of those with problems and 47.5 per cent of those going for a checkup were seen within one month. Some 6.2 per cent of those with problems and 21.1 per cent of those seeking a checkup reported that they had to wait for 12 months or longer.[21]

2.16 The Committee also noted compelling evidence that the reason a person visits a dental service influences a person's oral health outcomes. People who present with a pre-existing problem are less likely to receive preventative services and more likely to lose their teeth.[22] Low income earners and their dependants are more likely to be in a situation where irregular, emergency dental treatment and poor oral health predominate.

2.17 Dr Cole, encapsulated the problem of oral health for low income people, stating that:

> Australia is now a country where you can pick the poor by their teeth.[23]

2.18 This assertion was borne out by a survey conducted through the South Australian Council of Social Service (SACOSS). That survey, conducted in October – November 1997, collected information on a range of dental health issues relating to low income clients of financial counselling and emergency relief agencies. Its question 'Do you have any comments about getting dental care?' elicited responses which included the following:

> You can't get any except for emergency and then all they do is pull them out.
>
> It's too expensive.
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> I have given up on my teeth because the waiting lists are so long. I haven't even bothered to get myself on the list, I figure my teeth will have fallen out by then.
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> I live in fear of having a toothache and not being able to afford a dentist. I am also looking for work and trying to look as presentable as possible and

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20 Research Database report, pp.174-175.

21 AIHW, *Australia's Health 1996: Fifth Biennial Health Report of the AIHW*, AGPS, Canberra, 1996, p.177.

22 Submission No.120, pp.2-3.

23 Submission No.87, p.1.

> my teeth have needed cleaning for over 3 years. I would be willing to help with some of the payments if I knew that help was available when required.[24]

2.19 The survey found that nearly 60 per cent of the survey group had experienced toothache within the last twelve months compared with an incidence of about 11 per cent for non health care cardholders. About 25 per cent had visited a dentist in the previous 12 months and 25 per cent had not visited a dentist for more than three years. Some 50.8 per cent of respondents needed dental care urgently, 26 per cent reported associated health problems due to dental problems and 59 per cent of people on waiting lists for dental care had been on the waiting list for more than two years.[25]

2.20 The major barrier to low income earners seeking dental care is its cost. For many Australians the cost of private dental care is prohibitive, as attested to by the many submissions received by the Committee from individuals dependant on the public system. The Shop, Distributive and Allied Employees' Association (SDA) put the widely accepted view that for low income families private health insurance to cover oral health services 'is simply not an option at all'.[26]

2.21 The Victorian Dental Therapists Association noted the higher burden of dental disease suffered by lower socio-economic groups, quoting a study in 1997:

> There is a positive relationship between income and dental visits. Dental practitioners have the highest fees of any ancillary health service for a standard session, and ancillary health insurance returns only half of the cost of dental visits. It does not, therefore, remove the income barrier of out-of-pocket costs to obtaining care, which represents a much higher proportion of a low earner's income.[27]

2.22 Those reliant on the public system, however, are unlikely to receive treatment comparable to that of private patients. Compelling evidence was presented to the Committee reinforcing this claim. At the present time in the public system there is an increasing emphasis placed on meeting the demand for emergency care rather than restorative and preventative care, which would have longer term benefits for patients. Evidence received by the Committee indicated that this emphasis was a necessity resulting from financial limitations. Some patients are only treated for emergency matters as the waiting lists are so long that appointments for checkups are superseded by emergencies. It has been reported that in some areas waiting lists stretch to years rather than months and some have been closed so there is no access to public dental services. Further, public dental services do not provide a full range of dental

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24 Submission No.105, Appendix C, pp.1-2.

25 Submission No.107, pp.2-3.

26 Submission No.54, p.2.

27 Submission No.76, p.2. The Association quoted J.M.Lewis, *Interests, Inequity and Inertia: Dental Health Policy and Politics in Australia*, University of Melbourne, 1997.

treatment.[28] The current status of waiting lists in the public dental system is addressed in detail in Chapter 3.

2.23 The Brotherhood of St Laurence (BSL) submitted that its research findings:

> … indicate a strong relationship between income status and dental health status. Whilst a similar relationship may also be found with other health problems, such as heart disease and some cancers, what marks dental health services as different from other health services is that the relationship between income and poor health reflects lack of access to appropriate treatment. Moreover, that lack of access must be seen in longitudinal terms; it is not merely a question of lack of access now but also the effects of lack of access in the past.[29]

2.24 The Committee notes that lack of access now will have a continuing impact on this group's future oral health status and the level of demand for public care. Extended periods of poor access to dental care which could prevent dental disease, will compound their problems in the future. The Brotherhood referred to a 'perpetuation of disadvantage',[30] which, on the basis of the evidence before the Committee, appears to be an apt description of the circumstances in which many low income earners find themselves.

2.25 Evidence was also received which indicated that many doctors report patients attending for dental problems in order to obtain pain relief or antibiotics. According to the Australian Catholic Social Welfare Commission:

> It is doubtful whether the abolition of the programme [the CDHP] is even achieving its fiscal goal, since people with chronic pain due to oral health problems are now going to doctors as their first port of call and receiving prescriptions for pain-killers. The uncapped Medical Benefits and Pharmaceutical Benefits Schemes are therefore picking up much of the cost of the abolition of the CDHP.[31]

2.26 The Committee was informed that some people visited their doctor for pain relief when they had toothache and for antibiotics when they had infections and it was noted that prescription painkillers are cheaper than ones bought over the counter. Such channelling of dental problems into the general medical sphere places a burden on the Medicare and Pharmaceutical Benefits Schemes as well as being, at best, a short term solution. Doctors are only be able to treat the symptoms rather than the problem, so that patients would eventually require dental treatment.[32]

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28 Submission No.100, p.2.

29 Submission No.85, p.3.

30 Submission No.85, p.3.

31 Submission No.80, p.1.

32 Submissions No.85, pp. 5-6; No. 87, p.2; No.50, p.1.

2.27 Without doubt the cost of adequate dental care combined with the limitations of the current public dental system mean that many low income earners and their dependants have a standard of oral health which is inferior in comparison when compared with the general population.

2.28 This is not a problem which will diminish without intervention. Evidence was received from the Consumers' Health Forum of Australia (CHF) that:

> … the number of people on low income relying on publicly subsidised dental health services is likely to increase gradually but substantially in the coming years. Demographic factors behind this increase include not only the ageing of the population, but also trends suggesting that the proportion of the population in the paid workforce may decline, leading to an increase in the number of employed persons on low incomes. Therefore, the number of people unable to access or afford privately funded dental health services is likely to comprise a significant proportion of the population in years to come.[33]

Preschoolers and young adults as specific target groups

2.29 The Committee received evidence that, within the broad grouping of Australians dependant on low incomes, two groups of young Australians were at specific risk of dental problems. These were preschool children and young adults.

2.30 Evidence before the Committee indicated that the dental health of Australian children has improved dramatically in the last 30 years and the average amount of decay in the permanent teeth of twelve year old children has fallen. Nevertheless, 30 per cent of children enter primary school with untreated dental decay and less than a third of 2-4 year olds have visited a dentist. A small but significant proportion of preschoolers suffer very severe and extensive dental decay requiring hospitalisation and treatment under general anaesthetic.[34] Dr Dooland of DHSV gave evidence that this is a nutrition issue:

> It is particularly so with low-income groups, particularly single parents, from pacifying children with sweet liquids, even milk, for extended periods at night-time. That damages the teeth in a very great way. Providing information to young mothers and pregnant mothers, targeted identification of those children and making sure that they get early management are the economical way of handling those peaks of need.[35]

2.31 The BSL referred to the fact that the oral health of young Australians as a group is more comparable than the oral health status of adults due to a range of factors including fluoridation and school dental clinics (ie. there is more commonality across

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33 Submission No.125, p.6.

34 Submissions No.67, p.8 and No.92, pp.2-4. See also Submission No.27 which quoted statistics from the AIHW.

35 *Committee Hansard*, 23.3.98, pp.130-131.

socio-economic groups). The Brotherhood also pointed to the period of transition to adulthood, however, as a period when lack of access, affordability, unemployment or low paid work intervene to undermine these benefits.[36] Lack of regular dental care and changes in lifestyle have led to a deterioration in dental health for some young adults, particularly for low income earners.[37] Professor Spencer, of the AIHW, advised the Committee that:

> Young adults seem to be at risk of using emergency dental services and of receiving extractions when they use dental services, particularly those that are eligible for public sector dental care. The school dental service carries children through to the end of their eligibility in a state of good dental health – among the best in the world… As soon as they leave that service, though, the sorts of problems that exist in the community at large with accessing dental care re-emerge. There is a deterioration in oral health of young adults as lifestyle changes occur. Certainly we find that those who have come from less privileged backgrounds, those that are unemployed, have really quite high rates of dental decay. The problem is carrying forward the gains that have been made among children and adolescents really into young adults.[38]

Aged people

2.32 Many of Australia's elderly people are on low incomes and subject to the disadvantages described above. In addition, older Australians face a range of other problems in accessing dental care, for instance due to illness or restricted mobility.

2.33 The Committee noted that some elderly Australians are entitled to dental treatment due to their status as veterans or war widow/ers. This status gives them access to free treatment for basic services, although there is a financial limit on the provision of some services.

2.34 There is a strong correlation between age and low income. Private income decreases with age and affordability of dental health services is a critical issue for the elderly. Evidence received from the Council on the Ageing (COTA) indicated that over 70 per cent of Australians aged over 65 (ie. 1.7 million people in 1997) rely on part or full age pensions. This put most single older people on a pension income of between $160 and $199 per week and older married couples on the pension receive an income of $200 to $400 per week. By contrast, a recent survey of COTA members indicated that their members had been quoted costs for dental work ranging from $600 to $2 000 for replacement dentures and a similar range of costs for bridges, crowns and other maintenance work.[39]

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36 Submission No.85, p.2.

37 Submission No.67, p.8.

38 *Committee Hansard*, 23.3.98, p.89.

39 *Committee Hansard*, 23.3.98, p.112.

2.35 Private dental care has become less affordable and the Victorian Government, in its submission, cited the fact that between 1985 and 1996 the cost of an average course of treatment has increased by 25 per cent more than social security payments.[40] Evidence was also received from Aged Care Australia (ACA), that the ability of older people to pay for dental services has diminished due to the introduction of user contributions towards the cost of aged care services and the higher contribution for medications.[41] COTA also noted that older people on a pension have little capacity for saving for large cost items and that their capacity to contribute to the cost of dental care is very limited.[42]

2.36 The distress caused to elderly Australians who may have difficulty affording adequate dental care at an age when oral health affects the quality of life so greatly, was evidenced by some of the anecdotal comments contained in individual submissions to the Committee:

> I am appalled at what I have to pay to have my remaining teeth attended to … Pensioners are being held to ransom by the dentists …[43]
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> … it is humiliating to have to beg our political masters to alleviate our suffering. Perhaps they could … use the hundreds of millions from the National Welfare Fund which we former workers compulsorily contributed to …[44]
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> … I … have fought hard all my life to retain my teeth, by having regular check-ups, etc. Now it seems that at an age when I should be receiving more care, there is much less help available.[45]

2.37 As Australia's population is ageing the needs of the elderly in maintaining a good standard of oral health will require more emphasis. In future, the percentage of older Australians within the total population will continue to grow as will the number dependant on public dental services. At present 13 per cent of the population is over 65 years of age and it is estimated that by the year 2010 this figure will have risen to over 22 per cent.[46] In Victoria, the Metropolitan Hospitals Planning Board estimated in 1995 that Victoria's aged population would increase by 30 per cent in the next fifteen years.[47]

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40 Submission No.127, p.9.

41 Submission No.49, pp.1-2.

42 *Committee Hansard*, 23.3.98, p.116.

43 Submission No.8, p.1.

44 Submission No.10, p.1.

45 Submission No.34, p.1.

46 Submission No.59, p.3.

47 Submission No.127, p.7.

2.38 There is a trend towards increased retention of teeth by older people. This brings with it increased caries (tooth decay) and periodontal disease and an increased need for dental care.[48] An AIHW report has found that:

> … the number of natural teeth in people aged 65 and over in 1994 was 62.1 per cent more than it was in people 65 and over in 1989 (Carter et al. 1995). The combination of changes in age distribution and declines in tooth loss is thus likely to result in an increase in demand for dental care by older Australians.[49]

2.39 The proportion of elderly people who are edentulous is rapidly shrinking and it is estimated that by 2020 only about 20 per cent of the elderly will have full upper and lower dentures.[50] The Committee also received evidence from COTA indicating that the number of people with dementia is increasing and that, in future, more people with dementia will have their own teeth.[51] This will translate into difficulties of care and more people in need of special dental assistance.

2.40 The Australian Dental Association (ADA) submitted that:

> … twenty years ago, dental treatment for the over seventies consisted typically of occasional new dentures and a very quick cleaning of these dentures by the elderly person, the carer or nursing home staff. Due to advances in dental care being enjoyed by today's adults, we are now seeing a dentate elderly population with restorative and preventive needs and many of these requiring treatment for an increasingly complex number of dental problems.[52]

2.41 For the elderly, good dental health, meaning well-maintained natural teeth or well functioning dentures, is a basic pre-requisite of good nutrition. Poorly maintained teeth or badly functioning dentures restrict diet and poor diet is linked to conditions in older people such as cardio-vascular disease and bone thinning as well as contributing to memory loss and poor cognitive functioning. Pain and suffering from untreated dental problems can contribute to depression and other mental health problems and the long term use of pain killers and antidepressants. COTA argued that poor dental health can contribute to the deterioration in the overall health of older people that can lead to premature admission to nursing homes or death.[53]

2.42 Older Australians have a legacy of dental disease and repair which necessitates continuing dental care, particularly in light of dental problems incurred as a result of living through the Depression, world wars and immediate post war years

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48 Submissions No.41, p.5 and No.91, p.2.

49 AIHW, *Australia's Health 1996*, p.79.

50 Submission No.64, p.1.

51 Submission No.97, p.5.

52 Submission No.51, p.3.

53 Submission No.97, pp.1-2.

without the benefit of fluoridation. The ageing process results in the wearing down of the teeth, fillings and gums. Shrinkage of gums exposes teeth roots which are then susceptible to decay. Dr Wendell Evans, Senior Lecturer in Preventive and Community Dentistry at the University of Melbourne, emphasised that:

> As one ages, the consequences for dental needs are that they tend to become more, rather than less, complex UNLESS comprehensive preventive programs are in place.[54]

2.43 Dr Evans stressed the need for regular check ups for preventative and maintenance care in the elderly. Without such check ups previous efforts to maintain functioning teeth could be undermined to the extent that repair may not be warranted or the costs of repair may be prohibitive, leading to a situation of worsening oral health or removal of teeth.[55]

2.44 An important point was also made that while elderly people in nursing homes have access to qualified medical practitioners, their carers and health professionals generally have no oral health training. The Victorian Government submitted that 'one of the barriers to dependant older people obtaining oral health is the lack of dental health knowledge and skill of carers (Berley et al, 1988)'.[56]

2.45 Dr Peter Foltyn, Consultant Dentist at St Vincent's Hospital Dental Department submitted that:

> Oral health care has not been seen as a priority nor has it been fully appreciated by the medical profession and government. Many doctors have a limited working knowledge of oral and dental anatomy and the close relationship between oral health and general health. As we near the year 2000 many of our "baby boomers" will be approaching retirement age. Some will be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns and bridges, unlike the average 50-60 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility… Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled.[57]

2.46 Functionally dependent older Australians, including the homebound and institutionalised, are particularly disadvantaged. They have high requirements for extractions, scaling, oral hygiene instruction and dentures but most States have extremely limited domiciliary services. For example, the Tasmanian Dental Service conceded that the current and future dental needs of the homebound, institutionalised and disabled is a significant problem that is beyond the scope of the dental workforce

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54 Submission No.64, p.1.

55 Submission No.64, p.2.

56 Submission No.127, p.21.

57 Submission No.59, p.5.

in Tasmania',[58] while in Victoria there are only two publicly funded domiciliary vans and few private dentists to provide domiciliary care to this group.[59] The Victorian Government noted that 'people in institutions require sound dental health to ensure that their level of dependency does not increase'.[60]

2.47 Dr Jane Chalmers informed the Committee that the AIHW Dental Services Unit in conjunction with the ADA (SA Branch) was conducting an investigation of the oral health of the increasingly dentate nursing home population. The study was providing many insights into the problems encountered by nursing home staff and dental staff when organising dental care for nursing home residents. Dr Chalmers was hopeful 'that the data from this and other geriatric dental investigations will be used to assist both the government and private sector with the development of appropriate and effective dental services for older Australians'.[61]

2.48 The following needs of the elderly were identified in evidence before the Committee:

- access to affordable care which includes regular oral health assessments and the provision and maintenance of dentures;
- services that minimise travel requirements, including visiting dental services for the institutionalised and homebound;
- specialist services that cater for people with dementia, who are less able to communicate if they have a dental problem;
- the education of carers in oral health issues; and
- a co-ordinated, interdisciplinary approach between dentists, other health care providers and dieticians.

Rural and remote Australians

2.49 Evidence before the Committee suggested that 'there is a marked inequity of dental services depending on where one resides'.[62] There was widespread acknowledgment among those providing evidence that Australians dwelling in rural and remote areas were subject to particular disadvantage.

2.50 The Australian Council of Social Service (ACOSS) drew attention to the spread of dental practitioners. The Australian average is 43 per 100 000 people. Capital cities average 51.2 per 100 000 compared with 28.7 per 100 000 outside capital cities. In some rural areas the rate is much lower, for example in some rural

58 Submission No.41, p.5.

59 Submission No.127, p.21.

60 Submission No.127, p.21.

61 Submission No.62, p.2.

62 Submission No.90, p.2.

areas of Western Australia there are only 5.9 practitioners per 100 000 people.[63] The Committee also noted evidence that in some rural areas no dental service is available.[64]

2.51 The National Rural Health Alliance (NRHA) cited a range of reasons for dentists not taking up rural practice, namely lower earning capacity, lack of professional support, lack of continuing education, and lack of employment, health and educational opportunities for their families.[65] In Queensland, strategies such as a rural incentive scheme where above award payments are made to dentists and a Dental Scholarship scheme that commits a few graduates to rural locations, have been successfully used to attract dentists to rural practice.[66]

2.52 The Committee received evidence that in some areas of Australia there was no opportunity for public adult dental care 'due to the complete absence of public facilities and the inability of provision of adequate financing for treatment through private facilities'.[67] The lack of access to dental services and the costs of transport to services from rural and remote areas compound the disadvantage of this portion of the population. Mobile dental services are generally regarded as the most viable way to service remote communities, although they are costly to establish, operate and maintain. Case studies were provided to illustrate the disadvantage of people living in remote areas.[68]

2.53 The NRHA cited longer waiting times for routine services at both public and private surgeries in rural areas: up to 2.5 years wait in rural New South Wales as opposed to 7.5 months in Sydney. The Alliance also made the point that long distances may be travelled to access specialist services.[69] This lack of access to care has an impact on the dental health of people in rural and remote areas, as does the decreased likelihood of them having a fluoridated water supply and their often more limited range of affordable fresh produce with its concomitant problems for nutrition.

2.54 An AIHW report in February 1997 identified a higher proportion of decayed, missing or filled teeth for rural patients compared to urban patients from all age groups except those aged 55-64 years. The highest rates of decayed teeth were for rural patients aged 25-34 years.[70] DHSV informed the Committee that, according to its data, children in rural areas had 60 per cent more dental decay than children in urban areas.[71] Reduced access to services has long term effects as children and young

63 Submission No.120, p.3. ACOSS cited AIHW, *Dental Practitioner Statistics Australia, 1994*.

64 Submission No.128, p.3.

65 Submission No.129, p.4.

66 Submission No.128, p.13.

67 Submission No.51, p.3.

68 *Committee Hansard*, 6.3.98, pp.34, 56.

69 Submission No.129, p.3.

70 Submission No.128, p.4.

71 Submission No.67, p.11.

people, in particular, may not receive preventative and early treatment which would improve their oral health status for the future.

2.55 Mr Gordon Gregory, Executive Director of the NRHA, expressed the view that:

> Overall, the status of rural health is worse than in the major cities. In general, the more remote the individual, the worse his or her health is likely to be. This situation is exacerbated by relatively poor access to health services, few options, higher costs and an adverse cultural approach to health matters in country areas.[72]

Indigenous Australians

2.56 The Fifth Biennial Health Report of the AIHW in 1996 noted that:

> As early as 1925 Aboriginal groups were reported as having a substantial advantage over other Australians with regard to dental health (Campbell & Moore 1930). Although there is little published information specifically comparing the dental caries experience of contemporary Australian Aboriginal people with that of other Australians, the existing literature indicates a loss of this historical advantage. For instance, while there has been a major decrease in caries experience in other Australian children since the 1970s … there has been an increase in caries experience in Aboriginal children (Schamschula et al. 1980).[73]

2.57 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that indigenous Australians now suffer greater levels of dental disease than non-indigenous Australians generally. NACCHO drew attention to the high level of diabetes in the Aboriginal population, which may lead to the development of severe periodontal disease and to the greater number of Aboriginal people who are ill and have a greater risk of severe dental infection. NACCHO cited the National Aboriginal Health Strategy (1989) as identifying dental health as a major problem in Aboriginal communities due to factors such as limited access to services, high costs, lack of awareness and fear.[74] Other relevant factors include poverty, diet and lack of fluoridated water.[75]

2.58 The Northern Territory Government indicated that in the Territory the impact of poor dental health is particularly evident among Aboriginal people, who comprise about 27 percent of the population, the majority of whom are resident in remote locations. The Territory Government also noted that dental health is one among a complex of problems related to diet and other living situation factors. These include chronic diseases such as diabetes, heart and renal disease, which are more prevalent

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72 *Committee Hansard,* 6.3.98, p.57.

73 AIHW, *Australia's Health 1996,* p.28.

74 Submission No.78, pp.2-3.

75 *Committee Hansard,* 6.3.98, p.66.

among Aboriginal people as a group, and which have compounding adverse effects on health outcomes.[76]

2.59 Most indigenous people cannot afford private dental care and are dependent on public services. For Aboriginal people resident in remote communities, private treatment is simply not an option because these communities do not have resident private sector dentists.[77] The size of waiting lists for public dental treatment at the present time precludes optimal dental care for those reliant on the public system. This is addressed in detail in Chapter 3. NACCHO submitted that:

> The result is that in many regions any dental care comes down to a "relief of pain" basis, usually an extraction, with no coordinated care or education being provided. It also means that the dental services that do exist in ACCHSs [Aboriginal Community Controlled Health Services] are providing dental care for people outside of their communities. Many urban services are seeing people who have travelled long distances from rural and remote areas, because they cannot access appropriate dental care locally or regionally.[78]

2.60 NACCHO also stated that in remote and rural communities 'we are approaching the situation where they will have no services at all' and that 'in many areas Aboriginal children *do not* receive dental care at school'.[79] The Territory Government commented that the extended nature of Aboriginal families, and cultural obligations, mean that Aboriginal people may move between a number of different locations during the year. This contributes to difficulties with service delivery and the completion of treatment programs.[80]

2.61 The AIHW provided evidence that indigenous Australians had a higher rate of edentulism than non-indigenous Australians (16.3 per cent versus 10.9 per cent). They also have a higher percentage of patients who usually visit dentists for a problem than non-indigenous Australians (63.7 per cent versus 49.7 per cent).[81]

2.62 The AIHW's Fifth Biennial Health Report in 1996 referred to data from the Children's Dental Service in the Northern Territory that provides a program for school age children. This data indicated that Aboriginal children had a greater number of infant teeth affected by dental caries than other Australian children and that there was nearly a threefold variation in the mean number of decayed teeth between other Australian born children and Aboriginal children. It concluded that 'Aboriginal

76 Submission No.133, pp.2-5.

77 Submission No.133, p.2.

78 Submission No.78, p.5.

79 Submission No.78, p.6.

80 Submission No.133, pp.3-4.

81 Submission No.61A, p.2.

children thus have a double disadvantage: more disease experience and a higher ratio of disease experience being untreated'.[82]

2.63 The AIHW's Report noted that tooth extraction is counter to the desired goal of maintaining functional natural dentition for life and to the advocated treatment which emphasises monitoring and prevention. Figures indicated that a higher percentage of Aboriginal and Torres Strait Islander (ATSI) patients received extractions than other patients. In some age groups the difference was significant. For example, in the 25-44 year age group at non-emergency visits, 25.7 per cent of ATSI people received extractions, compared with 6.4 per cent of other patients.

2.64 The report also noted that in some instances ATSI people had a lower rate for fillings. Fillings are viewed as attempts to restore damaged teeth and prevent further deterioration which may lead to the need for extraction. At emergency visits 23.4 per cent of ATSI patients received fillings, compared with 40.5 per cent of other patients. For both emergency and non-emergency visits, the trend across age groups was for the percentage of people receiving fillings to decrease for ATSI patients, whereas for other patients the percentage receiving fillings remained high. The report found that:

> Older Aboriginal and Torres Strait Islander patients… receive a pattern of dental care which involves more extractions and fewer fillings. This pattern indicates less favourable treatment processes.[83]

2.65 Indigenous Australians, whether or not they live in rural and remote areas, are recognised as being a significantly disadvantaged group. Their needs include access to affordable services, oral health education and prevention programs and services which are delivered in a way which ATSI people can feel confident in accessing.

Medically compromised patients

2.66 Evidence was received by the Committee that there was a small yet significant group of Australians whose illnesses put them in greater need of dental care than the general population and who, often, were disadvantaged in respect of that need.

2.67 Many medically compromised patients are affected by their illness to such an extent that they cannot continue working and, due to financial pressures, must rely on public dental services. In rural and remote areas there are often inadequate accessible public dental facilities and in cities the public facilities are over-burdened. The Committee was informed that:

> Some facilities have 2-3 years waiting lists whilst others have closed their waiting lists altogether citing inadequate resources and only providing relief

82 AIHW, *Australia's Health 1996*, pp.28-29.

83 AIHW, *Australia's Health 1996*, pp. 178-179.

> from pain and are certainly unable to provide preventative dental care or a meaningful treatment plan for patients requiring more extensive treatment.[84]

2.68 A range of illnesses and treatments have implications for the oral health of the patient. These include heart disease, oral cancers, immunological conditions and organ transplants.[85] In such cases routine oral examinations are necessary. Often dental treatment is required before a patient can proceed with surgery, including heart valve replacement, organ transplant surgery, or radiotherapy to the head and neck. Patients with immune deficiencies such as AIDS often require biopsies of oral lesions and management of xerostomia (dry mouth). It is also noteworthy that the symptoms of a wide range of illnesses, including HIV, are often evidenced in the mouth.

2.69 Dr Foltyn gave evidence regarding the case of:

> People with specific medical problems that impact on oral health; or the reverse – the oral health complicates their medical management. For patients with head and neck cancer, very often the oral health is an integral part of their medical management; and unless you get it right with removal of teeth or cleaning the mouth up in patients who are having specific heart surgery, patients die. The mouth has to be clean.[86]

2.70 People with HIV/AIDS have a higher incidence of gingivitis, cavities, and dental disease than normal. Advances in HIV drug treatment have also been linked to more rapid deterioration in dental health by increasing the prevalence of xerostomia.[87] The early detection of oral symptoms of HIV by dentists can help save lives as preventative treatments may be possible.

2.71 The Australian Federation of AIDS Organisations (AFAO) reported difficulties in finding dentists with experience of dealing with HIV as well as extended waiting times at some HIV clinics. AFAO stated that people with HIV in rural areas were 'among the most marginalised groups in the country'. AFAO referred to breaches of confidentiality regarding the HIV status of people in rural areas and the preference by many for the anonymity of the city, despite the transport costs involved. AFAO also noted that, as people with HIV/AIDS are living longer and many have allowed dental problems to worsen as they thought they would not live long, there is a need to extend the level of dental work undertaken at clinics (for example, to include crowns) in order to restore their appearance and possibly assist them to re-enter the workforce.[88]

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84 Submission No.59, p.3.

85 *Non dental pathology and systemic diseases with oral symptoms*, List tabled at hearing on 23.3.98 (DHSV).

86 *Committee Hansard*, 6.3.98, p.36.

87 Submission No.124, p.2.

88 Submission No.124, pp.3-5.

2.72 For many medically compromised patients, treatment or routine dental assessments are required on medical grounds and failure to provide treatment may further compromise their general health. Dr Foltyn gave the example of an elderly pensioner with a cancer in the mouth who required modification to her dentures and must pay for the service even though it is needed in order to assist her medical treatment.[89]

2.73 Dr Mark Schifter, of the Westmead Hospital Dental Clinical School, submitted to the Committee that the number of people who are economically disadvantaged due to significant ill-health, whether chronic debilitating medical problems or acute, major and devastating illnesses, is an ever increasing proportion of the population as a result of our ageing community and progress in interventional medicine. In his opinion:

> This group is badly disadvantaged for several reasons: this issue remains under-recognised; secondly, largely because of historical necessity, the main focus of public dental services, and its present workforce is to treat dental caries and its effects, for the relatively healthy, ambulatory, but economically deprived segment of the population.[90]

The homeless

2.74 The Committee received evidence that people who are homeless find it very difficult to access mainstream services and that homeless-specific services were vital to ensure fair access for this disadvantaged group.

2.75 The Council for Homeless Persons Australia cited a report it had produced which documented a 'deplorable' and 'appalling standard of oral hygiene' among the homeless and largely untreated dental decay and disease.[91] Statistics provided to the Committee by the Council included:

- of homeless people surveyed, more than half had tooth decay, 80 per cent had some form of disease and of those, 62 per cent had severe periodontal disease with advanced, irreversible damage;
- 37 per cent of the sample group had no teeth and of these, 30.6 per cent had no dentures. Of those with dentures, nearly half had been wearing them for more than 30 years, compared with an accepted norm of five years; and
- in the 12 months to June 1997, an estimated 147 000 people (of whom 31 per cent were children) used homeless services and a further estimated 304 000 requests for support or accommodation could not be met.[92]

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89 *Committee Hansard*, 6.3.98, p.34.

90 Submission No.74, p.2.

91 Submission No.48, p.4.

92 Submission No.48, pp.2, 5.

2.76 The Committee noted with concern the evidence of Dr John Wilkinson of the Sydney United Dental Hospital (UDH), regarding the fact that many young homeless people have open wounds in the mouth which leave them open to contracting a range of diseases including Hepatitis A, B and C and HIV.[93]

2.77 The homeless face barriers to access in the form of costs both of treatment and transport, waiting periods, substance dependencies and mental illness. Their transient lifestyle makes continuity of care difficult. Nevertheless, the Committee also received evidence that, despite the difficulties in meeting the needs of the homeless, there had been some success in using specially targeted programs.[94]

The mentally ill

2.78 Another disadvantaged group identified in evidence was the mentally ill. The Canberra Schizophrenic Fellowship informed the Committee that many of the people who develop mental conditions, such as schizophrenia or bi-polar disorder are too ill to work and are dependent on public dental care. The Fellowship advised that the onset of major mental illness often occurs in the late teens or early twenties and dental problems dealt with inappropriately in young people may subsequently become a source of major difficulties.[95]

2.79 The Fellowship noted that though there is access to public emergency dental care:

> it is almost impossible for most people with a mental illness to negotiate the methods for accessing emergency treatment… The effects of medication and of illness often make it difficult for people with a mental illness to make a phone call early in the morning. If they do manage to reach a phone, the lines are often engaged and the whole business becomes so frustrating that it is just too much for people who are already ill… It is not easy for many people who have a mental illness to wait for long periods of time. They may not always understand the consequences of leaving when they cannot stand any longer to be in a confined space.[96]

2.80 The UDH in Sydney referred to the mentally ill as one of the groups which had specific difficulties in accessing mainstream dental services. It submitted that this group needs transport, accompanying health workers and resource intensive preventative interventions in order to ensure appropriate and timely dental care.[97]

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93 *Committee Hansard*, 6.3.98, p.41.

94 Submission No.48, p.6.

95 Submission No.11, p.1.

96 Submission No.11, p.2.

97 Submission No.91, p.4.

Overseas-born, Language Other Than English (LOTE) speakers, including refugees

2.81 Members of this group suffer the obvious difficulties associated with language barriers to accessing services. Often they lack information on what services are available to them. There were almost 100 000 settler arrivals in Australia in 1995-96 and many settlers would find cost a barrier to good dental care.

2.82 The Committee received evidence that the dental needs of people from many immigrant communities have been found to be greater than those of locally born residents.[98] Information provided to the inquiry by the AIHW indicated that:

- Overseas-born, LOTE speakers had a higher percentage for whom dental visits were a large financial burden (15.8 versus 9.8 per cent) and who would have a lot of difficulty in paying a $100 dental bill (20.3 versus 13.5 per cent) than Australian-born, English speakers.
- Among those receiving publicly funded dental care, overseas-born, LOTE speakers had a higher percentage reporting emergency dental care than Australian-born, English speakers (67.9 versus 49.2 per cent).
- Among those receiving publicly funded dental care, overseas-born, LOTE speakers had a higher percentage with advanced periodontal attachment destruction (15.6 versus 6.1 per cent), yet they received a lower rate of preventative services (0.13 versus 0.23 services) and a lower rate of periodontal services (0.13 versus 0.24 services/courses of care) than Australian-born, English speakers.[99]

2.83 The Refugee Resettlement Committee in the ACT, informed the Committee that newly arrived refugees have, prior to arriving in this country, been in stressful situations where there were nutrition and hygiene problems and an almost total lack of dental health services. On arrival they usually have a great need for urgent and extensive dental treatment. The Resettlement Committee also submitted that, though provisions were made to assist refugees in accessing services, financial and staffing pressures often result in less than adequate treatment. Many migrants exist on low incomes, particularly if they must wait two years before being eligible for social security benefits.[100]

Forms of disadvantage

2.84 Just as a range of groups suffering disadvantage in dental care has been identified, so there are a number of forms of disadvantage that must be addressed if the inequalities in oral health are to be rectified. These are inter-related and it is common for more than one of them to affect those who are disadvantaged.

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98 Submission No.91, p.3.

99 Submission No.61A, pp.3-4. These results are from the analysis of data collected during 1994-96.

100 Submission No.72, pp.1-2.

2.85 As has been noted earlier, the cost of private dental care inhibits many Australians from seeking or maintaining a good standard of oral health. This fact was reinforced by the numerous submissions from members of the public as well as from comments in submissions by community organisations. The significant barrier which cost represents to many consumers was highlighted by the call made by COTA for an inquiry into the costs of dental care to create greater transparency regarding the costs of dentists' services,[101] as well as by the Health Issues Centre in Melbourne which sought a referral of the cost and pricing structures of dental services to the Australian Competition and Consumer Commission.[102] A significant number of submissions also called for some form of improved, subsidised dental system for the disadvantaged.

2.86 The relationship between dental treatment and income level indicates that those without the funds for private dental care have generally received treatment that has focused on emergency procedures rather than preventative and restorative care. Evidence referred to earlier in this chapter indicates that many disadvantaged Australians are caught in a cycle of emergency care, receiving dental treatment that eases the immediate burden of pain, but which is clearly second best in terms of their long term oral health.

2.87 Waiting lists in the public dental system are a factor directly affecting the type of care received. Evidence presented to the Committee painted a disturbing picture of waiting lists for public dental care ranging from months to years and, in some cases, closed lists. The dental problems of those waiting for treatment would usually have worsened by the time they receive treatment and several service providers indicated that, increasingly, they were forced to bring forward for treatment those patients whose oral health had reached emergency status. Such waiting times, which are far beyond that normally experienced by patients in the private system, clearly mitigate against a continuing program of care which focuses on prevention and longer term oral health.

2.88 Physical access to services is, without doubt, a significant issue for many Australians, particularly those living in rural and remote areas. Evidence already cited indicates that, in certain areas of this country, dental services are difficult to access and patients must travel considerable distances to receive care. Less obvious, though no less important, is the need to ensure that suitable services are accessible to other groups including the home bound and the institutionalised members of the community.

The use of private and public services in addressing disadvantage

2.89 It is clear to the Committee that in their current state, neither the public nor private dental systems are effectively meeting the needs of all Australians.

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101 Submission No.97, p.16.

102 Submission No.98, p.2.

2.90 A large number of Australians are unable to access private dental care and the experience of those reliant on the public system is that it cannot currently deliver services to meet the needs of all its clients. Burgeoning waiting lists, the increasing focus on emergency rather than maintenance or preventative work and cuts to services mean that, for many, the likelihood of accessing appropriate care is diminishing. Yet the need for public dental care is growing. The Committee also notes that, the longer members of the community have inadequate dental care, the more their problems will compound and the more difficult and expensive it will be to rectify those problems.

2.91 As previously noted, annual expenditure in Australia on dental services is nearly $2 billion. In 1994-95 the Commonwealth Government spent $105 million and State Government expenditure was approximately $141 million in this field.[103] Over the five financial years 1990-91 to 1994-95 Commonwealth Government expenditure grew from $33 million to $105 million. Its expenditure has since dropped as a result of the CDHP's cessation. State Government expenditure over the same period increased from $117 to $141 million and, according to Professor Spencer of the AIHW, there is little evidence of a withdrawal of funding by State Governments with the implementation of the CDHP.[104]

2.92 The Committee received evidence regarding the fact that dental services are the least subsidised area of health services and that its situation is atypical when compared with other areas of health service which the Commonwealth is enabled by the Constitution to fund. In 1994-95 two thirds of the total expenditure on health services was subsidised by government. Government subsidises 74 per cent of expenditure on institutional services, 83 per cent of expenditure on medical services and just under half of expenditure on pharmaceuticals. By comparison, dental services received only a 13 per cent government subsidy and that was in the year the Commonwealth made a substantial contribution through the CDHP.[105] This differentiation between dental and general health was an issue which received widespread unfavourable comment in evidence to the Committee.

2.93 Although there is an undersupply of dental professionals in certain rural and remote areas, there was no evidence put to the Committee that as a nation, we are undersupplied with professionals to service Australia's population or that Australia lacks the capacity to meet the needs of those who are disadvantaged under the current arrangements.

2.94 While there is no single solution to the problems described above, the Committee is of the view that vast improvements can be made to meet the needs of the disadvantaged by better utilising the capacities of both the private and public sectors. As the South Australian Dental Service stated:

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103 *Committee Hansard*, 23.3.98, p.97.

104 Submission No.61, Attachment, *Policy Options for Public Funded Dental Care*, p.2.

105 Submission No.61, Attachment, p.3.

> The capacity of the private and public dental services to meet the current and future needs of low income and other disadvantaged groups was well demonstrated during the life of the Commonwealth Dental Health Program. That willingness and capacity continues to exist.[106]

106 Submission No.86, p.26.