



AUSTRALIAN DENTAL
ASSOCIATION INC.

2008-09 PRE-BUDGET SUBMISSION

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EXECUTIVE SUMMARY

The oral health of the Australian population is mixed. Many in the community enjoy good oral health, supported by timely access to high quality dental care. By contrast, others in the community suffer from poor oral health, spending excessive periods – sometimes years – waiting to receive basic dental care in our public system.

Internationally, WHO (2006) ranks Australia 17th among OECD countries for adult dental caries; a relatively poor performance in light of Australia's much better performance on other leading health indicators such as life expectancy.¹ Groups among the adult population whose oral health is particularly poor include older people, Aboriginal and Torres Strait Islander peoples, people living in rural and remote communities and those with special needs.

Conversely, the oral health of Australian children is generally of a high standard. According to a new report, titled *Water Fluoridation and children's dental health: The Child Dental Health Survey, Australia 2002*, children in Australia have better oral health than children in many other countries, due largely to fluoridated water. Of the 44 countries with comparable national data available, Australian 12 year olds have the seventh lowest average number of decayed, missing and filled permanent teeth.² Even so, despite Australian children doing well in the world stakes, locally, oral health problems are still evident.

The Australian Dental Association (ADA) believes that the Commonwealth, States and the Territories should do more to address poor oral health. As the States and Territories appear not to be meeting the needs of large sections of the community, the Commonwealth must take up a leadership role, and work cooperatively with the states to deliver basic dental services to ensure that the minimum standard of dental health is achieved throughout the community.

The Commonwealth Government's current contribution to dental expenditure is largely confined to subsidies through the 30% rebate for private health insurance. The Commonwealth provides no direct expenditure for services for people on low incomes, yet this is the group which has the highest prevalence of dental disease and has the greatest difficulty in accessing dental care. Since the cessation of the Commonwealth Dental Health Program in 1996, the Commonwealth, States and Territories have engaged in a 'blame game', each avoiding responsibility for providing adequately funded dental care for financially disadvantaged Australians.

The ADA hopes that the newly elected Federal Labor Government's recent announcements to re-introduce a Commonwealth Dental Health Program, introduce a Teen Dental Plan and to wind up the Dental EPC scheme will result in funding targeted to improve access to dental care for economically disadvantaged groups.

The National Adult Oral Health Survey and Australia's National Oral Health Plan 2001-2013 have identified where action is required. There is still a long way to go until Australia has the degree of dental health it deserves for a country of its wealth.

The timing is right for the establishment of a clear role for the Federal Government that will see this Government assist in the delivery of effective dental services to the financially disadvantaged. An opportunity exists now for leadership to be shown as to how this can be achieved in a cooperative and effective fashion by Federal, State and Territory governments.

The ADA's pre-budget submission outlines a clear plan to improve the oral health of the Australian population. In some areas we repeat calls made in our 2007-08 submission, while in others we highlight new areas for action. In both cases, this submission identifies areas where investment by the Commonwealth Government would lead to significant improvements in oral health for many in the Australian community.

ADA recommendations for additional expenditure in 2008-09

Item	Additional Funding for 2008-09 (\$)
Dental Workforce and Higher Education	\$5,320,000
Commonwealth Funded National Oral Health Program	\$197,000,000
Indigenous Oral Health	\$2,000,000
Older People	\$10,550,000
Children and Adolescents	\$ 153,500,000
People with Special Needs	\$29,750,000
Department of Veteran Affairs	\$4,500,000
Additional items for Medicare – Anomalies Of The Dentition	\$9,452,000
Oral Health Promotion	\$4,500,000
Federal Dental Advisors	\$335,000
TOTAL	\$416,907,000

INTRODUCTION

The Australian Dental Association (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The primary objectives of the ADA are to promote the practice of evidence-based dentistry and encourage access for all Australians to affordable preventive oral care. There is a Branch of the ADA Inc in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

Submission outline

This submission is broken into four parts:

Part 1: Dental Workforce and Higher Education.

Part 2: Access to Dental Care:

- Commonwealth Funded National Oral Health Program
- Indigenous Oral Health
- Older People
- Children and Adolescents
- People with Special Needs
- Department of Veteran Affairs
- Additional Items for Medicare – Congenital Anomalies of the Dentition.

Part 3: Oral Health Promotion.

Part 4: Federal Dental Advisors.

Additionally, this submission provides a summary on dental health expenditure that was released in a report by the Australian Institute of Health and Expenditure, *Health Expenditure Australia 2005-06*, as well as providing a summary that compares expenditure by each State and Territory (see Appendix).

Part 1:

***Dental Workforce and
Higher Education***

DENTAL WORKFORCE AND HIGHER EDUCATION

Workforce

The five established Australian dental schools have increased the intake of dental students in recent years, and four new schools have been established or announced in the last decade. However the ADA is still concerned that not enough is being done to rectify problems with Australians accessing dental care, particularly in rural and remote areas and in the public sector. This distribution of the current dental workforce is negatively impacting on the delivery of services in areas of need.

According to Australia's National Oral Health Plan³, the impact of this distribution means:

"... [M]any Australians access dental care, if it is available at all, only in emergencies or when advanced oral disease is present. This leaves little opportunity for preventive care and oral health promotion, and treatment tends to focus on extraction rather than restoration of teeth."

Australia's dental workforce is low by international standards, ranking nineteenth out of 29 OECD countries.⁴

In 2003, there were an estimated 9,678 practising dentists which represented a ratio of 48.7 dentists per 100,000 population. Workforce shortages are most acute in outer regional and remote/very remote parts of Australia, for example:

- Major cities – 57.6 dentists per 100,000 population.
- Inner regional – 34.5 dentists per 100,000 population.
- Outer regional – 27.7 dentists per 100,000 population.
- Remote/very remote – 18.1 dentists per 100,000 population.⁵

The impact of workforce shortages is also felt strongly in the public sector. Of the 9,678 practising dentists, 82.0% worked in the private sector compared to 15.5% in the public sector.⁶ A vacancy rate of 20.2% for general dentists and 16.8% for specialist dentist positions has been reported in the NSW public sector.⁷ Such shortages add to the difficulty experienced in accessing care by the reported 650,000 Australians on public dental waiting lists, with an average waiting time of 27 months.⁸

Training

To address current workforce shortages, attention firstly needs to be given to the training of the dental workforce.

Dental schools are facing the immediate difficulty of attracting and retaining teaching staff, a trend that is common in most developed countries.⁹ This is largely due to the gap between academic salaries and remuneration for dentists working in private practice.¹⁰ The recently created dental schools at Charles Sturt University and James Cook University's (JCU) Cairns' campus may assist in increasing the number of practising dentists. However before that can be properly achieved such Universities will need to address the (worldwide) shortage of dental academics. We are concerned that if this issue is not addressed, the schools (both new and existing) will not be able to provide the quality education required to maintain the standards required for Australian dental services.

The simple creation of more dental graduates will not necessarily solve distributional issues in rural areas. The concept of opening schools regionally has been based on the premise that graduates will remain in the area where they are educated and practise there. The ADA feels that unless the dentists are also sourced from these areas there is, in fact, no evidence to indicate that the additional places created will do other than attract students from any region of the country to enter the faculty and on graduation return to metropolitan areas to practise. If, however, this education experience was supplemented by way of provision of some financial incentive to have these students remain in these rural and remote regions then this may go a long way to solving these problems.

The ADA wishes to express concerns about the recent announcements to provide funding to JCU for the creation of a new dental school. The ADA believes that the stated intention of seeking to train students at Cairns and Townsville with a view to them practicing in this area is ill conceived. As indicated there is no evidence to indicate this result will be achieved. Investment of a recurring \$50m p.a. to establish and conduct the School is clearly in excess of what should be spent to achieve the creation of an estimated 20-30 dentists in the area of the university to create parity with population/dentist ratios.

Investment of this funding in existing schools with provision of financial incentives to students to practise in remote areas would seem to be a much more effective long term solution.

In order to estimate future workforce needs and so establish the appropriate education and training resources, the ADA believes a comprehensive dental workforce review is necessary. The review should look at:

- ratios of general dentists/dental specialists/allied dental personnel;
- comparison of rural schools/expanding existing schools with peripheral rural clinics;
- ideal dentists/population ratios, and
- future public patient funding proposals and their impact.

Once such a review is completed, possible modifications to existing training can be undertaken tailored to the needs identified.

Higher education

Today's generation of dental students are graduating with higher debts than previous generations. According to The University of Melbourne's Vice Chancellor, Glyn Davis, funding to Australian universities is one-third less today than in the mid-1970s. For the previous generation, higher education was free while, for today's students, higher education costs are the fifth highest in the OECD. Among OECD countries, Australia is the only country where government funding per student has fallen since 1995.¹¹

The ADA is concerned at the extraordinary cost of dental degrees as revealed in the 2008 Good Universities Guide. According to the latest edition of the Guide there are 111 university degrees this year costing over \$100,000 and 13 degrees costing over \$150,000. Dentistry is in the higher bracket.

As the table below shows, a Commonwealth supported dental student studying at the University of Sydney will graduate with a debt of \$54,686. The equivalent student, who receives Government support during their undergraduate degree, but then pays the full upfront fee for their graduate dental degree, will graduate with a debt of \$146,154. A dental student who pays the full upfront fee for both their undergraduate and graduate studies would commence their working life with a \$190,176 debt. These figures have increased since last year. The ability to be able to afford this debt is restricting access to Schools to the wealthy. Ability, not wealth, ought to be the real determinant of who can study dentistry.

Student Contribution to Dental Degree – University of Sydney 2007

Year	Commonwealth supported place (\$)	Combined Commonwealth Support and Full-Fee (\$)*	Domestic Full-Fee paying place (\$) (both degrees)
3 year undergraduate Science Degree	\$21,354	\$21,354	\$65,376
4 year graduate BDent Program	\$33,332	\$124,800	\$124,800
Total cost	\$54,686	\$146,154	\$190,176

Source: <http://www.usyd.edu.au/fstudent/undergrad/apply/costs.shtml> accessed 16 August 2007

* These figures are based on the assumption that the student’s first 3-year undergraduate Science Degree was a Commonwealth Supported Place.

While the ADA does not believe that the prospect of these higher student debts will necessarily reduce the number of students applying to study dentistry, it is nonetheless concerned that dental graduates – commencing their professional career with significant student debts – will seek employment in more lucrative areas of dentistry. These will usually be in the big cities in private practice and graduates will be less likely to work in areas of need, such as the public sector, where remuneration is lower than in the private sector. If graduates eschew the public sector in favour of the private sector, trends in the maldistribution of Australia’s dental workforce will widen and public sector waiting lists will continue to grow. This will lead to greater reliance being placed on overseas recruitment; when it is generally accepted that we should be educating Australians to meet our needs and not recruiting dentists from countries less fortunate than ourselves.

A study by Sivla et al¹² found that the decision by recent dental graduates to move into the private sector is motivated by a range of factors, including continuity of patient care, work environment, a broader range of clinical experience and remuneration. In its submission to the New South Wales Parliamentary Inquiry into dental services, the ADA NSW Branch¹³ highlighted the disparity in wages for dentists working in the private sector compared to those in the public sector. As the table below shows, recent graduates who work in the private sector can earn significantly higher wages (up to \$130,000) than those in the New South Wales public sector (\$56,223) or the Queensland public sector (\$65,954).

Remuneration for dentists with two years post graduation experience

NSW public sector	QLD public sector	Private health insurance clinic	Private practice
\$56,223	\$65,954	\$90,000	Up to \$130,000

Source: NSW Legislative Council (2006) *Dental Services*, Standing Committee on Social Issues, p. 58. (Information based on ADA NSW Branch submission to Legislative Inquiry.)

ADA recommendations:

Additional Commonwealth Government funding should be provided to:

- *Undertake a comprehensive dental workforce review.*
- *Provide financial assistance directly to Schools of Dentistry to assist with recruitment and retention of academic staff to alleviate shortages in the current academic dental workforce.¹⁴*
- *Increase funding per dental student at accredited educational institutions.*
- *Create further scholarships for dental students from rural and remote parts of Australia as one measure to address the maldistribution of dentists. (The ADA advocates the creation of RAMUS-type scholarships for dental students.)*
- *Fund rural placement schemes for students from all dental schools.*
- *Extend the existing relocation program available for medical general practitioners and specialists to dentists. (This program offers financial grants for GPs and medical specialists to relocate to areas of medical doctor shortage.) Currently, "doctors can apply for grants of up to \$30,000 to establish a new practice, or up to \$20,000 to join an existing practice in an area of doctor shortage".¹⁵ The ADA believes a similar program should be created to attract dentists from well serviced metropolitan areas to work in regional, rural and remote areas.*
- *Increase the number of Commonwealth-supported (formally HECS) places in the long established dental schools for Australian dental students.*
- *Fund a clinical placement year for graduating dentists (University and overseas trained dentists). This placement year, to be served mainly in the public dental sector (although some private rural placements should be considered in areas of special need) would increase access to dental care for public sector patients and significantly reduce waiting lists. This will also require additional infrastructure and mentors to be provided by the States and Territories. (This may need to be progressed in line with increased numbers of graduates and facilities to take them)*
- *Create a moratorium or debt forgiveness for all dental graduates who in turn agree to provide their services in regional, rural and remote areas or in the public sector. The extent of the moratorium or debt forgiveness should reflect the period of time the dental graduate undertakes practice in these particular areas. The longer the period of guaranteed service in regional, rural or remote areas, the greater the moratorium or debt forgiveness. The HECS*

Reimbursement Scheme and the Medical Rural Bonded Scholarship, available to medical students should be extended to dental students.

- *Introduce rural retention schemes whereby the government provides financial payment to the practitioner as an incentive to remain practising in the remote regions. Such funding might assist the practitioner meet the common concern that many have as to the quality of education that may be available to their children in rural regions. A payment provided might offset boarding school fees that may need to be incurred for the practitioner's child (ren) to achieve the level of education the practitioner considers their child (ren) should receive.*
- *Fund the establishment and ongoing costs of dental school rural clinics and associated student/intern accommodation.*
- *Encourage State and Territory Governments to direct additional funding to increase salary levels for public sector dentists. Such action by these governments should then be linked to the provision of additional financial assistance being made available federally.*

ADA recommendation for expenditure in 2008-09 for dental workforce and higher education

Item	Sub-total	TOTAL
30 additional Commonwealth Supported dental students	\$18,000 per student	\$540,000
25 dental student scholarships	\$25,000 per scholarship	\$625,000
25 dentist relocations	\$25,000 per relocation	\$625,000
3 academic positions per dental school (total 18 positions)	\$150,000 per position	\$2,700,000
Debt forgiveness	10 students – 25% CSP debt discount per year (based on \$32,000 student debt)	\$80,000
HECS Reimbursement		\$250,000
Rural Bonded Scholarship		\$250,000
Rural retention scheme		\$250,000
TOTAL		\$5,320,000

Part 2:
Access to Dental Care

COMMONWEALTH FUNDED NATIONAL ORAL HEALTH PROGRAMS

In its 2007-08 pre-budget submission,¹⁶ the ADA called on the Commonwealth Government to take a leadership role to improve access to dental care for those most disadvantaged in Australia. There are purportedly over 650,000 Australians on waiting lists for general dental care from public dental services and currently the average time on a waiting list is 27 months.¹⁷ In 2004-05 some 50,000 Australians had to go to hospital for acute crisis care arising out of normally preventable dental conditions.

In this submission the ADA repeats the call made in 2007-08. That is, the Commonwealth Government should take immediate and significant steps to improve the delivery of dental care in the community, with a particular emphasis on those who are most financially disadvantaged. The time has long passed where dental professionals and the broader community can accept the Commonwealth and the State and Territories blaming each other for the problem of poor oral health in Australia. Reports of recent COAG activities provide the ADA with encouraging signs that these issues are being addressed.

The need for leadership by the Commonwealth was recently expressed in a 2006 national report on the state of dental care by the Australian Council of Social Service (ACOSS).¹⁸ ACOSS argued:

"The Commonwealth Government's current Budget surplus is in excess of \$10 billion and the Prime Minister and the Council of Australian Governments recently demonstrated how national leadership can drive implementation in the case of mental health policy and cancer services ... [There is] the continuing need for the Commonwealth Government to increase its funding commitment and exercise its leadership in planning a more efficient, sustainable and equitable system of oral health promotion, prevention of disease, and treatment." (p. 3)

A recent survey released by Australia Fair has shown that 75% of people believe the Federal Government must at least share the funding for dental care. Only 5% thought it was a State Government responsibility alone.¹⁹

As the last Budget marked the 10th consecutive year the Budget was in surplus (in excess of \$10 billion²⁰) with a strong economy, it seems only fair that people from financially disadvantaged backgrounds have access, through increased funding, to dental care. Lack of such access experienced by these Australians is of great concern to the ADA. Socio-economically disadvantaged groups rate their oral health poorer than more advantaged groups and report more tooth loss and more problems with their teeth, mouth or dentures than advantaged groups.²¹ The impact of poor oral health is significantly higher for people without private health insurance (who are more likely to be low-income earners) than those with private health insurance.²² People on concession cards are 20% less likely to visit a dentist than non-card holders and are more than twice as likely to have a tooth extracted.²³ People who are disadvantaged by socioeconomic status experience greater levels of oral disease than those from more affluent groups. This has been acknowledged by Australia's National Oral Health Plan²⁴ which argued that "profound disparities exist across socio-economic groups in Australia ... [as] the incidence of caries and periodontal disease increases as socio-economic status decreases." Spencer²⁵ has referred to this as the "polarisation of the burden of [oral] disease".

A significant misconception held by many is that poor oral health behaviour is the reason why people who are disadvantaged by socio-economic status experience poor oral health. As the table below shows, contemporary research challenges this notion by showing that people from disadvantaged groups are as equally inclined to practise oral health self-care as those from more affluent groups. By contrast, socio-economic status is strongly associated with access to dental care (obtaining dental visits). People from advantaged areas are more likely to visit a dentist than people from disadvantaged areas. In turn, this has a positive impact on oral health.²⁶

Mean scores for dental visiting and dental self-care according to levels of socioeconomic disadvantage of areas (grouped as quintiles) – adjusted for age in years

Index of Relative Socioeconomic Disadvantage (IRSD) quintiles*	Dental visiting – adjusted for age	Dental self-care – adjusted for age
Low	2.36	2.39
Low to moderate	2.49	2.39
Moderate	2.48	2.39
Moderate to high	2.54	2.30
High	2.73	2.51

Source: Sanders AE, Spencer AJ and Slade GD (2006) 'Evaluating the role of dental behavior in oral health inequalities', *Community Dentistry and Oral Epidemiology*, 34: 71-79.

* Higher IRSD indicate lower levels of disadvantage.

(This table shows that people from areas of socioeconomic disadvantaged [low IRSD] are as equally inclined to practice oral health self-care as those from more affluent groups, however, are less likely to visit a dentist than people from areas of socioeconomic advantage.)

The ADA notes that Federal Labor's recently announced **Commonwealth Dental Health Program** will fund up to 1 million consultations and treatments through public dental services, which will benefit the many rural communities who do not always have private dental services. Prime Minister Kevin Rudd pledged to invest up to \$290 million, over three years for a Commonwealth Dental Health Program. This initiative was cautiously welcomed by the ADA, recognising that the Plan has only been very briefly outlined to date.

It has the following features that are supported by the ADA as it :

- Will in part address the dire state of dental waiting lists.
- Provides and confines access to dental care under the Plan to those who are economically disadvantaged.
- Provides access to dental care for those who are located in rural and remote communities that have been unable to access public services.
- Fits within the *National Oral Health Plan 2004*.
- Incorporates a federal requirement for accountability from States and Territories which will mean its contribution will supplement States and Territories' investment and not be a substitute for their contributions.

- Could facilitate treatment to patients previously on the EPC Medicare Scheme (to be disbanded) but who would now be eligible under the means tested criteria created under the Plan.

However, the ADA sees deficiencies in the proposal, some of which are as follows:

- It will be susceptible to State and Territory intervention in identifying those to whom federal assistance will apply.
- There will be difficulty in ensuring accountability from States and Territories – there is a need to ensure no corresponding drop in funding by States and Territories.
- The proposed expenditure equates with expenditure provided in 1996 under a similar Plan. The funding proposed therefore has taken no account of the increased demand now in existence due to population increases nor increased costs of treatment since 1996. Funding must be increased to account for this.
- Such funding ought to have built in factors to enable the funding allocated to increase due to increased population, increased demands and increased costs of dental care provision.

In addition to the introduction of the Commonwealth Dental Health Plan, the ALP also announced the introduction of a **Teen Dental Plan** that will provide \$150 towards the cost of a preventative dental health check-up for 12 to 17 year olds in families eligible for Family Tax Benefit (A).

Again, the ADA cautiously welcomed this announcement but sees some deficiencies that will need to be addressed.

Features of this Plan that the ADA supports are that it :

- Is a means tested facility.
- Provides access to a check-up to the financially disadvantaged who, according to studies, have a higher incidence of poor dental health²⁷.
- Will provide access to private sector dentists where required.
- Indicates a co-payment will be available.
- Will improve the oral health for this group which, in turn, will assist in ensuring good general health due to the established relationship between dental health and general health.

Features of the Plan that concern the ADA and which must be addressed are:

- The \$150 rebate would not cover all services in a preventively oriented check-up to a teenager who had not visited a dentist for some time. The rebate level provided ought to be increased in relation to the time since the patient was last dentally examined. For example if a dental examination has not been conducted for over 2 years, though no fault of the patient, the rebate level ought to be increased by one third. Loss of entitlements should however be imposed where no attendance or treatment occurs.

- The perception that, as it is means tested, it will be required to be bulk billed. This is unlikely if the fee scale used in the revised EPC is adopted.
- A dental service of \$150 may do little more than provide basic information to the patient as to the state of the patient's dental health. Such a service may only serve to alert a patient of problems. If a dental problem is revealed, then the patient may well not have access to any other rebated dental services. It therefore creates potential for discontent. The Plan must be linked to other available public dental services.
- The patient would, if in need of treatment, be required to join the public sector waiting lists. Lengthy delays in receipt of remedial treatment are likely.
- The target group may be too narrow as statistics indicate that caries is on the increase in young children. Persons in their twenties also need incentives to attend the dentist. The incentives for PHI cover are not available until aged 30 - so many in this age-group are uninsured and not accessing care. 13-19 yos will have had access to school dental services in many cases.
- The Teen Plan constitutes a separate Plan to the CDHP when it could be co-ordinated into the CDHP as a specific target group. See recommendations made below.

ADA recommendations:

As access to dental care is associated with oral health status, the ADA believes that the Commonwealth Government should provide targeted funding to improve access to dental care for financially disadvantaged groups.

The Proposed Commonwealth Dental Health Plan announced needs to take account of the following issues:

- *Funding should be provided to the States and Territories on a measured basis - calculated on dental health information, waiting list demand, requirements to meet designated targets and general population.*
- *Eligibility for the Scheme must be confined to the financially disadvantaged, e.g. Concession card holders.*
- *States and Territory Dental Services should select patients who will be eligible to receive benefits. Triage requirements to deliver services need be directed to those who are in pain or have been longest on the waiting lists.*
- *Due to shortages in the dental labour force, the ability should be given to the States and Territories to utilise private sector dentists to deliver services.*
- *States and Territory Services should provide a patient with a "voucher" identifying the dollar amount of service available to be received. These fees should be based on a nationally agreed "charity" scale, reviewed and adjusted annually in line with health CPI.*
- *The dentist would then advise the States and Territory dental service of treatment provided and claim payment of the "voucher".*
- *There would be a need to set clear parameters to States and Territories to ensure the level of funding provided to dental services by States and*

Territories was increased in proportion to level of increased funding by the Federal Government. Conditions upon supplementary funding need to be clear and measurable.

- *It would provide incentives for dental students and dentists to practise in the public sector or in rural and remote communities.*
- *There needs to be a significant increase in funding over and above that announced in order to accommodate increased demand for services and costs of treatment since 1996. The ADA calculates that,, as the Australian population has increased by approximately 20% since 1996 and as CPI increases since then would have been in the order of 29%, the requisite funding that should be provided under this scheme should be increased by \$142m to provide an equivalent level of funding to that provided in 1996. As waiting lists have also increased dramatically from the levels faced in 1996, a further funding increase to account for that of \$50m is strongly suggested. This indicates that additional CDH Plan funding of \$192m over and above that announced should be provided to create an overall provision of \$482m.*
- *To properly supervise and enhance the delivery of dental services under the proposed scheme the ADA feels the Government needs to obtain dental expertise and, as such, needs to incorporate dental advisors to help oversee the Scheme. (See Part 4 of this Submission.)*

In relation to the Teen Dental Plan, the ADA recommends that:

- *Provision be made for an increased rebate for those patients who require a more comprehensive dental check due to the length of time since last dentally examined. Assuming 25,000 such patients are seen in any year, a further provision of $\$150 \times 1/3^{\text{rd}} \times 25000 = \1.25m is needed.*
- *Extension of the age range for persons eligible for dental examination. Assuming an extension of the age group means an additional 25,000 examinations are available then a provision of an additional \$3.75m per annum would be required.*

In relation to the integration of the Commonwealth Dental Health Plan (CDHP) and the Teen Dental Plan, the ADA strongly recommends that:

- *The CDHP ought be the primary Plan for delivery of public dental care by the Federal Government. This Plan would introduce a scheme of delivery of dental care through the voucher type system outlined above. A set of uniform practices for delivery of Federal funding would then be created. Specific targetted projects of dental care would then form additional sub-sets of this Plan. The Teen Plan, for example, would be brought within the CDHP program. It would then represent one specific targetted group eligible for care. Other targetted funding to specific groups with their own sub-set of eligibility could then be created. Dental service delivery funding to other groups such as the indigenous populations of Australians or the elderly could be added.*
- *Integration within the one Plan would ease the administrative and budgetry burden of State and Territory Dental services, as delivery of care provided by Federal funding will be able to be coordinated through the one Scheme.*
- *Integration will avoid duplication of schemes and avoid confusion. For example it would aid in the transfer of a teen identified (under the Teen Plan) with significant dental disease from teen list to general list to access care.*

- *The same "voucher" system to that outlined above could be utilised. Similarity in administration of the Teen Plan with that of the CDHP would encourage use, due to familiarity of the Scheme operation. Uniformity of funding for delivery of all public dental services would therefore be created.*
- *Statistical data obtained through the provision of services under the Plans could then be used as the basis for future oral health campaigns. As announced by the ALP, prevention programs are a worthwhile investment as such campaigns will reduce long term financial health burden. General health would be likely to improve as there is demonstrable evidence to relate oral health and general health.*

ADA recommendation for expenditure in 2008-09

ADDITIONAL FUNDING REQUIRED (over and above announced increases):

Recommendation	Sub-total	TOTAL
1. CDHP funding required to meet additional demand and cost since 1996 (over 3 years)		\$192,000,000
2. Extension of Teen Dental Plan (per annum)		\$ 5,000,000
TOTAL		\$197,000,000

INDIGENOUS ORAL HEALTH

Health outcomes for Aboriginal and Torres Strait Islander people are much worse than for the general population. Aboriginal and Torres Strait Islander people experience greater levels of disease and disability, die much younger and experience a poorer quality of life due to ill health.²⁸

For Indigenous males, life expectancy is 59.4 years compared to 76.6 years for non-Indigenous males. For Indigenous females, life expectancy is 64.8 years compared to 82.0 years for non-Indigenous females. For all age groups, mortality rates for Indigenous Australians are almost three times higher than non-Indigenous Australians.²⁹

The oral health of Aboriginal and Torres Strait Islander people is consistent with their poor general health. In 2003-04, for example, there were approximately 2,000 hospital admissions for Aboriginal and Torres Strait Islander people due to oral conditions.³⁰

Until the 1980s Aboriginal children were recognised as having better oral health than non-Aboriginal children. During 1998-2000, tooth decay and the number of missing teeth doubled for Aboriginal adults aged 35-44 years, while the number of filled teeth grew three-fold. Complete loss of all natural teeth (edentulism) was higher for Aboriginal people of all age groups (16.2%) compared to non-Aboriginal people (10.2%).³¹

According to a new report *The Oral Health of Aboriginal and Torres Strait Islander Children*, poor dental health, including dental decay, is more common among Aboriginal and Torres Strait Islander children than other Australian children, and that those Indigenous children who are less well off and those in rural and remote areas are most affected. Less than 5% of remote Aboriginal and Torres Strait Islander pre-school children brush their teeth regularly.³²

Another recently published Western Australian study of pre-school children found only 26% of Aboriginal children were caries-free compared to 51% for non-Aboriginal children. The same study also showed that the average number of decayed, missing and filled teeth for Aboriginal children was 4.29 compared to 1.89 for non-Aboriginal children.³³

The ADA has recently been in discussions with the DoHA on indigenous oral health as part of the Howard government's initiatives.

Factors that contribute to the poor oral health of Aboriginal and Torres Strait Islander people include:

1. Poor access to dental care – many Aboriginal and Torres Strait Islander people live in remote parts of Australia. In these communities there are fewer dental services and people are required to travel further to obtain care.^{34, 35}
2. Lack of access to fluoride – fluoridation of drinking water is a highly successful public health measure that prevents dental decay.³⁶ Despite this, rural and remote areas of Australia are less likely to be fluoridated than metropolitan areas, reducing access for many Aboriginal communities.³⁷ In 2005, Armfield³⁸ found that decayed, missing and filled teeth (dmft) in 5-6 year-olds was between 47% and 75% higher in non-fluoridated areas compared to fluoridated areas.

3. Greater exposure to risk factors such as smoking, poor diet, alcohol, stress and trauma that contribute to dental caries, as well as a range of other health problems such as heart disease, stroke, cancer, diabetes.^{39,40,41}
4. Social exclusion, unemployment, stress and addiction, all of which contribute to poor health, including poor oral health.^{42, 43, 44}
5. Changing lifestyle patterns – a change from a traditional diet (high in fibre and low in saturated fats and sugar) to one high in sugar, saturated fats and refined carbohydrates is reflected in the poor oral health of Indigenous Australians. Additionally, access to fresh fruit and vegetables is particularly difficult for many living in remote communities.^{45,46}

The problems identified are only exacerbated when the issue of Indigenous oral health is considered for indigenous children. They are at an extreme risk of tooth decay with older children also at high risk of periodontal disease.

Historically, the uptake of dental services by these children has been spasmodic due to staffing issues, low school attendance, difficulty in gaining consent to treatment, infrequent service to clinics, and no services to some of the more remote homeland communities.

The dental checks by Australian Government Intervention (AGI) teams have been performed under much less than ideal examining conditions and have been carried out by non-dental health professionals who are very likely to have considerably underestimated the prevalence of dental diseases. Furthermore, the AGI teams have not provided any details on the burden (extent and severity) of the diseases.

The only sure way to ensure that the burden of dental diseases is lifted from the child population is to institute a comprehensive examination followed by preventive and restorative services targeting ALL remote Indigenous children.

ADA recommendation:

Initiatives in the areas of Indigenous health should focus on the provision of primary care, particularly through the involvement of Aboriginal health workers. In the short to medium-term, this necessitates the need for Aboriginal health workers to receive oral health training which focuses on oral health promotion. In the long-term, additional vocational and higher education places should be set aside to increase the number of Aboriginal and Torres Strait Islander people working in oral health.

Immediate effort is required to reduce risk factors – such as poor diet, alcohol misuse, poor living conditions, and poverty – associated with the poor oral health of Aboriginal and Torres Strait Islander people.

In respect of the issue identified above for indigenous children the ADA suggests:

1. *A collaborative partnership agreement is needed between DoHA and State and Territory services to determine division of service delivery and funding and to ensure accountability.*
2. *For improvements in oral health to be maintained, any Follow-Up Program must initiate strategies for long-term sustainability.*

3. *Provision for a comprehensive examination of all remote Indigenous children aged from 2-15yrs.*
4. *Support for the roll-out of the new information management system to collate comprehensive oral health data on each child and to monitor and evaluate the progress of the follow-up services.*
5. *Delegate the responsibility for examining and treating all 2-4yr olds other than those living in remote homeland communities to State and Territory remote dental teams.*
6. *Delegate the responsibility for services to all 5-15yr olds and 2-4yr olds living in remote homeland communities to AGI Dental Teams.*
7. *Set up an appropriate number of AGI Dental Teams to complete the Follow-Up Program by end of 2008.*
8. *Equip AGI Dental Teams with mobile equipment and all necessary support systems.*
9. *AGI Dental teams would comprise of a dentist, dental hygienist or dental therapist, dental assistant, an administrator and a local Indigenous community liaison worker.*
10. *Provision will need to be made for substantially increasing access to general anaesthetic procedures.*
11. *Investigate fluoridating the water of small communities and/or introduce school based preventive programs*

For long term maintenance of the improvement of indigenous child oral health it is suggested that after these short term solutions are progressed, a service agreement be implemented to ensure the continuation of a sustainable oral health service to the Indigenous children in remote communities. A comprehensive primary health care program must also be implemented to complement the clinical services.

Steps are also required to improve diet, access to dental care and to increase access to fluoridated water supplies.

ADA recommendation for expenditure in 2008-09

Recommendation	Sub-total	TOTAL
Oral health training for Aboriginal health workers	\$1,000,000	\$1,000,000
Vocational training assistance for Aboriginal dentists	\$700,000	\$700,000
Fluoridation facilities		\$300,000
Creation of 15 AGI Dental teams for equivalent of 6 months each year		*
TOTAL		\$2,000,000 plus

*Not able to be quantified. Further funding would be required in future years for the long term sustainability of this initiative.

OLDER PEOPLE

For people aged over 65 years, the prevalence of tooth decay, gum disease and oral cancer is higher than for the general population. Access to dental care can become more difficult as people get older with influences such as decreased mobility and reduced income having an impact on them. Oral diseases have the potential to affect older people's general health and social functioning.

Long-term oral health trends highlight good and bad news for Australia's ageing population. On the positive side, older people are retaining their natural teeth in greater numbers than before. In 1979, 60% of older people had no natural teeth. By 1989, this had fallen to 44% and is expected to drop to 20% by 2019.⁴⁷

The bad news is that older people experience a range of oral health problems at greater rates than the general population. Prominent amongst these are dental decay, gum disease, dry mouth and oral cancer. Teeth extractions associated with gum disease increase with age.⁴⁸ As the table below shows, people aged over 65 years have higher rates of edentulism (missing teeth), fewer sound teeth and more filled and decayed teeth than the general population.

Edentulism rates and mean numbers of sound, filled and decayed teeth for older Australians, 1988-97

	All Australians aged 5+ (1988-89)	Adults aged 65+ (1996)	Nursing home residents (1997)
Edentulous (%)	16%*	38%	66%
Sound teeth	13.1	8.7	7.0
Filled teeth	5.6	8.3	3.8
Decayed teeth	1.1	0.3	1.1
Total number of teeth	19.8	17.3	11.9

Source: Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement*, Final Report, Steering Committee for National Planning for Oral Health, p. 36.

* Data only available for people aged 20 years and older

These problems are not specifically related to old age but, as the Australian Health Ministers' Advisory Council⁴⁹ stated:

"The cumulative effects of oral disease throughout life become apparent in old age. In addition, the many chronic and systemic diseases that have been associated with poor oral health become more prevalent".

Older people living in residential accommodation and older people with dementia have particular oral health problems. These include declining cognitive status, poorer general health, declining physical functioning, difficulties with swallowing, and nutritional problems. Oral diseases and related conditions can lead to pain, problems with speech, discomfort when eating certain foods and concerns about self appearance.⁵⁰

Despite a body of research highlighting the relatively poor oral health status of Australia's older population, too little is being done to redress the issue. The ADA believes that the Commonwealth Government should provide leadership to implement the range of initiatives outlined in Australia's National Oral Health Plan to improve older people's oral health. Amongst a number of key points, the Plan calls for:

- Improved oral health assessments through the Home and Community Care program and the Aged Care Assessment Service.
- Improved oral hygiene programs to assist older people to live independently in the community.
- Ensure that oral health is taken into account when developing a care plan for people in residential accommodation.
- More affordable transport to enable older people to attend dental appointments.
- Greater funding for public dental care.

The ADA has recently undertaken 2 very effective pilot programs in South Australia and Queensland. Any approach adopted should only be developed after review of these programs⁵¹.

As the proportion of older Australians increases – figures cited in Australia’s National Oral Health Plan show that the number of people aged over 65 years is projected to rise from 2.2 million in 1997 to 4 million by 2021 - the oral health needs and costs for these people will continue to increase in the 21st century. More Australians are retaining their natural teeth; this will lead to even higher levels of dental disease in the future. The need for greater prevention and care must therefore be addressed as a matter of priority.⁵²

ADA recommendations:

Analysis of the above data and the results of the studies referred to in the footnote⁵³ indicate that the Commonwealth Government should provide leadership to implement the range of initiatives outlined in Australia’s National Oral Health Plan to improve older people’s oral health. Amongst a number of key points, the Plan calls for:

- *Mandatory and uniform oral health assessments through the Home and Community Care program and the Aged Care Assessment Service.*
- *Improved oral hygiene programs to assist older people to live independently in the community.*
- *Secure sufficient resources to ensure that oral health is taken into account when developing a care plan for people in residential accommodation.*
- *More affordable transport to enable older people to attend dental appointments.*
- *Greater funding for public dental care.*
- *Development of additional professional education for dentists and allied dental personnel in the oral health needs of older people and in the training of carers and nursing home staff.*
- *Initiate appropriate regulatory changes to enable dental hygienists under dentist oversight to provide services to eligible older persons through Home and Community Care programs and aged care assessment.*

ADA recommendation for additional spending in 2008-09

Recommendation	Sub-total	TOTAL
Oral health examination for residents in aged care accommodation (assuming 60,000 examinations annually)	\$100 per examination	\$6,000,000
Development of oral health plan for each person in residential accommodation	\$2,000,000	\$2,000,000
Oral health training manual	\$250,000	\$250,000
Portable dental equipment	\$2,000,000 plus \$300,000 per year to support	\$2,300,000
TOTAL		\$10,550,000

CHILDREN AND ADOLESCENTS

Dental decay has been estimated to be Australia's most expensive diet-related disease⁵⁴ and dental caries is the single most common chronic disease among children.⁵⁵

The oral health of Australian children is generally of a high standard. According to a new report released by the Australian Institute of Health and Welfare (AIHW), titled *Water Fluoridation and children's dental health: The Child Dental Health Survey, Australia 2002* children in Australia have better oral health than children in many other countries, due largely to fluoridated water. Of the 44 countries with comparable national data available, Australian 12 year olds have the seventh lowest average number of decayed, missing and filled permanent teeth.⁵⁶

Whilst Australians are doing well in the world stakes, locally oral health problems in children are still evident. In 2002, over 47% of six year olds had cavities in their baby teeth. On average, for every six year old child in Australia there were approximately two decayed, missing or filled baby teeth. At the same time, over 42% of 12-year-olds had cavities in their permanent teeth. For every 12 year old in Australia, there was approximately one decayed, missing or filled permanent tooth.⁵⁷

Trends showing a decline in childhood oral health status were also reported in a national survey, *The Child Dental Health Survey, Australia 1999: Trends across the 1990s*.⁵⁸ It was evident that decay rates of primary teeth (baby teeth) across children of all age groups increased during the period from 1996-1999, reversing the trend which saw a decline in rates of decay during 1991-1996. The trend since 1996 was most significant for five-year old children who experienced a 21.7% increase in decay during this period.⁵⁹

A surge in hospitalisations and general anaesthetic procedures for young children requiring dental treatment has also been evident. A study examining the dental general anaesthetic (DGA) trends among Australian children aged 0-9 years has shown that there was a 3-fold increase in DGA rates from 1993-1994 (215.8 per 100,000) to 2003-2004 (731.4 per 100,000).⁶⁰

Indigenous children are a significant population group with poor oral health. According to a recent report released by the Australian Institute of Health and Welfare's (AIHW) Dental Statistics and Research Unit, levels of dental decay have increased among Aboriginal and Torres Strait Islander children in recent years, particularly among those aged less than seven years.⁶¹

The report, *Oral Health of Aboriginal and Torres Strait Islander Children*, shows that poor dental health, including dental decay, is more common among Aboriginal and Torres Strait Islander children than other children, and that Indigenous children who are less well off and those in rural and remote areas are most affected. Hospitalisation for treatment of dental decay also occurred at higher rates among Aboriginal and Torres Strait Islander children than among other children. This is partly related to more dental disease and partly related to lack of timely access to dental services. Diet is also an issue. Sugar, particularly in the form of soft drinks, which are readily accessible even in the remotest of communities, is a factor in the poorer oral health of Indigenous children.⁶²

These statistics make it clear that something urgently needs to be done to redress the disturbing trends shown. The ADA notes the ALP announcement regarding the introduction of the Teen Dental Plan. As indicated elsewhere in this

submission (see Commonwealth Funded National Oral Care Program), the ADA is cautiously supportive of the concept announced. Reference should be made to the recommendations made by the ADA in dealing with this Plan in the Commonwealth Funded National Oral Care Program section of the submission.

The federal Government needs to work with the State and Territory governments to address these issues and help contribute to provision of funding to aid in delivery through the State and territory services.

ADA recommendation:

Additional government funding should be allocated to:

- *Ensure adequate funding is provided so that all children below 12 years of age, who come from families which suffer economic hardship, can access and receive an oral examination and treatment. Based upon the ALP's calculations of the usage of the Teen Dental Plan, the ADA estimates that an amount of \$290 million is required to provide up to 1 million additional dental consultations and treatments for persons in the age groups 1 to 11 years. This is based upon the same rebate level being available as is available in the Teen Dental Plan. The budget recommendation made below proposes the Federal Government contribute equally with the State and territory governments to fund this.*
- *Provide additional funding for the increase in incidence of school dental services throughout the country. A similar proportionate contribution is suggested as in the previous paragraph.*
- *Oral health promotion that targets adolescents should be developed in conjunction with the ADA which has considerable experience in such campaigns. It should take into account risk factors – such as poor diet, eating disorders, soft drink consumption, obesity and smoking – which contribute to poor adolescent oral health.*

ADA recommendation for additional spending in 2008-09

Recommendation	Sub-total	TOTAL
Provision of additional funding to supplement school dental services-estimate only	\$290,000,000 (Federal government to contribute 50%)	\$145,000,000
Funding for oral health promotion activities-estimate only	\$2,500,000	\$2,500,000
Additional funding for the increase in incidence of school dental services	\$12,000,000 (Federal government to contribute 50%)	\$6,000,000
TOTAL		\$153,500,000

PEOPLE WITH SPECIAL NEEDS

Whilst the oral health across the Australian general population over the last 20 years has seen overall improvements, the gap between the oral health status of the advantaged and the disadvantaged is substantial and increasing. People with special needs experience much higher levels of oral disease, with considerably less access to treatment - yet it seems little is being done by Governments to redress this.⁶³

"*Special needs*" refers to people with intellectual or physical disability, or medical or psychiatric conditions, which increase their risk of oral health problems or increase the complexity of their oral health care.⁶⁴

As special needs patients often lack the resources to obtain appropriate dental treatment, Governments must ensure that these patients are targeted for publicly funded services as this group deserves and requires the best possible health and dental care.

Australia's National Oral Health Plan highlights the following points:⁶⁵

- Approximately 2.4 million people are aged less than 65 years of age in Australia with at least one disability or long-term health condition.⁶⁶
- 6% of Australians are reported to have severe/profound disabilities.⁶⁷
- Whilst there is no published data to support accurate estimates of the numbers whose disability would increase the risk of oral health problems or the complexity of oral health care, expert opinion estimates that around 1 million people would be in the "special need" category for oral health.
- People with special needs experience higher levels of oral health disease and poorer access to oral health care than the general population.
- For many people with special needs, socio-economic disadvantage adds to their risk of oral disease and difficulties in accessing dental care.
- Access to dental care is difficult for those with special needs, particularly for those in community based housing.
- Treatment can also be more difficult when care is obtained – due to complex medical conditions, physical and behavioural barriers to oral health.

Special needs patients have been currently identified as having inequity in access to oral health care and these barriers have been established. The dental profession's limited ability to provide care to certain special needs groups exacerbates this inequity in access to care in so far as, currently, special needs groups are receiving predominantly emergency care, not general dental care.

The situation is further aggravated as treatment required by many special needs patients is beyond the capacity of the private surgery setting of dental practitioners. More patients are therefore requiring treatment through hospital admission or under general anaesthesia (GA). Public sector health services information has revealed there is limited access to GA facilities/theatre sessions/specialist anaesthetist staff often required to provide such treatment.

Public sector oral health services are state funded, with no dedicated funding for special needs patients. The ADA supports the winding up of the very limited reimbursement that is currently available for patients with chronic conditions or complex care needs through the federally funded Enhanced Primary Care Scheme.

Special needs patients, whose needs to access dental care are greater and who are already finding it increasingly difficult to receive the complexity of treatment required, must be eligible for benefits under this Scheme.

ADA recommendation:

There are many special needs patients who are best treated in a hospital setting or a dedicated clinic. There is a need for both the public and private sectors to work together to improve access to care for these patients.

To ensure people with special needs can enjoy improved oral health government funding must be directed to the delivery of dental care to this group by:

- *Training carers/health workers in oral hygiene and diet for people with special needs.*
- *Funding dentists and hygienists to provide dental services for people with special needs in clinics, institutions and in their homes.*
- *Subsidising such dental treatment in private practice.*
- *Building special facilities in public clinics.*
- *Educating and developing the capacity of the dental workforce (including fostering of a multidisciplinary approach) to provide care to people with special needs.*
- *Provision of services to this group could form an additional subset to the CDH Plan outlined earlier in this submission.*

ADA recommendation for expenditure in 2008-09

Recommendation	Sub-total	TOTAL
Training carers/health workers	\$2,000,000	
Funding for provision of services (Estimating provision of services to the value of \$450 per patient and provision to 50,000 patients per year)	\$22,500,000	
Subsidising dental treatment in private practice (\$175 per patient to 10,000 patients per annum)	\$1,750,000	
Building special facilities in public clinics	\$2,500,000	
Educating and developing the capacity of the dental workforce	\$1,000,000	
TOTAL		\$29,750,000

DEPARTMENT OF VETERANS' AFFAIRS

The ADA is cognisant of the very important and special contribution which has been made by our Veterans. Dentists respect the contribution made by Veterans to our country and are proud to be able to provide their services to them.

The concern of the ADA is that, as the current level of fees payable for dental services by the Department of Veterans' Affairs (DVA) for Veterans and their entitled dependants is so grossly inadequate, dentists may no longer be able to afford to provide services to these people thus depriving them of adequate dental care. The ADA does not understand why this deserving group of Australians are made reliant upon dental services that are provided at a discount fee. It maintains that the DVA exploits the benevolent nature of the dental profession and other health providers that provide services to this group. Fees for services to veterans and their families should be at normal fee levels.

Recent increases in the level of fees paid for DVA dental services addressed some of the ADA's concerns. However, this year announced increases in the scale of fees payable was 2.2% only as compared to CPI and health index increase of at least twice that rate. Again the benevolence of the profession is being exploited.

Most dentists treating Veterans do so at a significant reduction to their normal fee levels. For many, it is increasingly uneconomic to treat DVA patients and already, unfortunately, some dentists have reduced their Veteran client list or ceased to perform work for Veterans. Members of the ADA (comprising 95% of Australian dentists) have expressed their concern.

ADA Recommendations

A regular review of fees paid for DVA services be undertaken with the review recommending variation of the fees payable at a level commensurate with other health index variations and the ADA Fee Survey results.

ADA recommendation for additional spending in 2008-09

A general increase in fee levels of approximately 6% on the existing scale, requiring an additional allocation of approximately **\$4,500,000**.

Review of fees in years following the 2008-2009 period should then equate to customary fee levels charged by dentists.

ADDITIONAL ITEMS FOR MEDICARE – CONGENITAL ANOMALIES OF THE DENTITION

Disturbances in both the form and structure of tooth development may be genetic in aetiology. Some of these inherited disorders occur in isolation whilst others are associated with various additional systemic disorders. The more common of these disorders is Amelogenesis Imperfecta (AI) which is a group of inherited disorders of tooth enamel (recent estimations suggest a prevalence of 1:4000 births). Defects in the structure and function of dentine also exist. Whilst this latter condition, Dentinogenesis Imperfecta (DI), is less common (approx 1:8000 children), the effect on the dentition is catastrophic structurally, functionally and aesthetically.

As a result of their genetic aetiology these conditions create a disproportionately high burden of care for a small number of families. In addition to being at increased risk of dental caries, tooth wear and periodontal disease, individuals with these anomalies are reported to have reduced quality of life, self esteem and social functioning. Anxiety and cost are the two main barriers to these families in seeking appropriate treatment. Outcomes are significantly improved if preventive and restorative care is implemented early. In the long term, most of these individuals will require comprehensive full mouth rehabilitation, the outcomes of which are optimized by good paediatric oral healthcare.

ADA recommendations:

That the Commonwealth Government provides funding through additional MBS items for treatment for the following groups: (Prevalence and cost based on those for the State of Victoria in 2005, then extrapolated for Australia).

Pre-school

- Total number of affected individuals aged 1–5 years in Victoria = 15.
- Estimated total number for Australia = 50
- Mean cost per child of treatment = \$2500 per child.
- Sub-total = **\$125,000.**
- Nature of treatment required – Principally preventive and protective restorative treatment. For example, stainless steel crowns and anterior strip crowns to prevent tooth tissue loss, sensitivity and caries whilst simultaneously improving aesthetics.

Primary School

- Total number of affected individuals aged 6-10 years in Victoria = 32.
- Estimated total number for Australia = 90
- Mean cost per child of treatment = \$4,300 per child.
- Sub-total = **\$387,000.**
- Nature of treatment required – Principally preventive and protective restorative treatment. For example, fissure sealants, cast onlays on first permanent molars and minimal preparation anterior veneers to prevent tooth tissue loss, sensitivity and caries whilst simultaneously improving aesthetics.

High School

- Total number of affected individuals aged 11-16 years in Victoria = 87.
- Estimated total number for Australia = 200
- Mean cost per child of treatment = \$15,000 per child.
- Sub-total = **\$3,000,000.**

- *Nature of treatment required – Principally orthodontic with ongoing preventive and some protective restorative treatment E.g. Many of these children require routine orthodontic treatment prior to final full mouth rehabilitation. For certain types of AI, late orthodontic treatment and orthognathic surgery is required to manage the associated significant skeletal discrepancies. Ongoing minimal preparation of composite restorations is required for both prevention of wear and maintenance of aesthetics.*

Young adulthood

- *Total number of affected individuals aged 17-22 years in Victoria = 76.*
- *Estimated total number for Australia = 180*
- *Mean cost per child of treatment = \$33,000 per child.*
- *Sub-total = **\$5,940,000.***
- *Nature of treatment required – Principally prosthetic rehabilitation with some late orthodontics and orthognathic surgery. In some cases of AI, removal of the severely worn dentition and replacement of missing teeth using implants would optimize the outcomes. However this scenario will be limited to the most severely affected cases*

Adulthood

Ongoing maintenance will be essential particularly for those individuals with full mouth rehabilitation requirements.

ADA recommendation for expenditure in 2008-09

Recommendation	Sub-total	TOTAL
As outlined above:		\$9,452,000

Part 3:
Oral Health Promotion

ORAL HEALTH PROMOTION

While reports continue to be publicised on Australia's growing dental crisis, Government support for Oral Health Promotion would have a very positive effect on the long term dental health of all Australians.

Oral health promotion recognises the link between oral disease and the broader social and economic determinants of oral health, taking into account the underlying cause of illness and disease.⁶⁸

Common oral diseases such as tooth decay, gum disease and oral cancers are largely preventable. Early detection and interception greatly improves the outcome. If individuals can be educated as to the importance of oral health and thus avoid the serious consequences of these conditions, it would represent a worthwhile investment and achieve significant savings in the future recognising that 90% of dental disease is preventable.

The link between oral health and disease and general health and disease – referred to as a 'common risk approach' – is an important aspect of contemporary oral health promotion.⁶⁹ Rather than focusing on single diseases, a contemporary oral health promotion recognizes that many diseases – such as heart disease, stroke, cancer, diabetes, periodontitis and tooth decay – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma and common health factors such as improved diet and exercise.^{70 71}

Research examining the social determinants of oral health has shown that social class, education, income, lifestyle, environmental factors, psychological stress and oral health behaviour are associated with variables of oral health status.⁷²

Over the past two decades, Governments throughout Australia have achieved success in delivering health promotion messages. Successful campaigns have included *Sun Smart*, QUIT smoking, injury prevention and the national alcohol campaign. Successful screening programs have also raised awareness and promoted the benefits of early detection through screening for breast, cervical and bowel cancer.

The ADA notes there is recognition given by the ALP of the importance of preventive programs for dental health care in its pre-election announcements. This is welcomed by the ADA as it has long held the view that investment in such programs will lead to enhanced oral and general health for Australians and result in greater long term savings in expenditure for future care.

Reference should be made to the oral health promotional activities of the ADA by visiting the ADA website at www.ada.org.au and specifically on such links to its Dental Health Week campaigns and to the recent Infants and Toddler campaign.

ADA recommendation:

The most effective way to improve health and reduce long term health costs is to invest in health promotion programs which focus on risk factors that contribute to poor oral health. The impact of a stronger focus on oral health promotion has the potential to be significant both from a health and financial perspective.

The benefits of fluoridation should also be promoted. Clear solid scientific evidence exists that water fluoridation has proven to be an efficient, effective and

equitable public health measure for reducing the prevalence of dental decay in all age groups. The recent report by the AIHW, 'Water fluoridation and children's dental health – The Child Dental Health Survey, Australia 2002' shows that children in Australia have better oral health than children in many other countries, due largely to fluoridated water.⁷³ Likewise the publication of the 2004-06 National Adult Oral Health Survey has shown that members of the 'fluoride generation' (those born after 1970) had about half the level of decay that their parents' generation had developed at about the same age.⁷⁴ Water fluoridation should be adopted as part of a Government's health policy and should be implemented in non-fluoridated communities. (The ADA notes recent initiatives in Queensland and Victoria indicate strong leadership can ensure that all Australians using reticulated water can have access to fluoride).

To coincide with the proposed introduction of the Teen Dental Plan, the ADA suggests that the government fund the delivery of oral health messages to the age group to which this Plan relates. This would include a simple message (e.g. floss, rinse, brush,) with website links. Oral health promotion activities should be linked to check ups.

To ensure broader circulation of the messages, schools ought to be provided with similar information to be disseminated to students. In view of the lack of dental expertise in the Department of Health and Ageing, the ADA would be happy to collaborate with Government on the information needed to be provided.

ADA recommendation for additional spending in 2008-09

Recommendation	Sub-total	TOTAL
Funding for initial roll out of dental health information to 12-17 year olds		\$4,500,000
TOTAL		\$4,500,000

Part 4:

Federal Dental Advisors

Federal Dental Advisors

One of the major flaws, historically, in the approach taken by the Federal Government in relation to its role in dental care delivery is that it is fragmented. Currently, it participates in direct funding for dental services for Veterans and the armed forces, funding assistance for some Australians through the 30% rebate, provision of acute hospital care for dental emergencies, some funding to the States and Territories and the recent Enhanced Primary Care Scheme.

A more coordinated and sophisticated approach is required. The Federal Government has assumed a responsibility in delivery of medical care to the community. With ever increasing evidence of there being a clear relationship between good general health and good dental health, a level of responsibility should extend to dental care delivery.

The Federal Government ought to provide leadership on dental delivery by setting national standards for oral health. The ADA is not calling for the Federal Government to assume the role of the major provider of dental care but rather the assumption of a cooperative role with the States and Territories, to ensure that an appropriate level of service is assured for all Australians.

Elsewhere in this submission the ADA has provided information about the poor status of oral health in this country and the ADA says that this status has to be improved and that a level of general dental health be achieved as befits our economic and social status within the world.

All governments have a responsibility to their constituents to provide basic services and, in the Australian community; this extends to ensuring basic health services are provided including dental care. Governments must work together to ensure that this delivery is achieved.

It is no answer for the Federal government to point blame in the direction of others. If basic services are not provided then it is the responsibility of all governments, including the Federal Government, to ensure that they are provided.

The Federal Government must monitor dental care delivery and, if such delivery is found wanting in any State or Territory sphere, it must intervene to ensure this is rectified.

This can be done by either calling on the State or Territory government to immediately respond and deliver requisite services or by the imposition of some economic or funding sanction being imposed on the State or Territory government until the required level and standard of care reaches the level dictated by the Federal Government.

The National Adult Oral Health Survey and Australia's National Oral Health Plan 2004-2013 have analysed how Australia is faring in relation to its oral health and has identified where action is required.

CDHP and DVA schemes these advisors should be empowered to review the National Oral Health Plan and the results of the National Adult Oral Health Survey to then determine what steps need to be taken in Australia to achieve a level of oral health care delivery that the Government considers befits Australia's status within the world. The ADA would be happy to add its expertise to any such review.

A national set of standards for oral health delivery would be determined and a program devised nationally for delivery of those services. The delivery program would be implemented as decided by all levels of government, with the Federal Government taking a leadership role in determining if all levels of government are delivering the services in accordance with the agreement reached.

ADA Recommendations:

1. *The creation of the position of Federal Dental Advisors.*
2. *The creation of standards that have to be achieved in Australia to ensure that a minimum standard of dental health is achieved.*
3. *The designation of responsibility for delivery of dental care between governments.*
4. *The monitoring of the quality of oral health delivery by governments.*
5. *If necessary, the implementation of sanctions upon those sectors of government which have not delivered services in accordance with the agreement reached.*

ADA Recommendation for additional spending in 2008-09

Recommendation	Sub-total	TOTAL
Creation of an advisory group		\$185,000
Supporting staff		150,000
TOTAL		\$335,000



Dr J E Matthews
Federal President
Australian Dental Association Inc.

APPENDIX

Dental Health Expenditure

According to a new report released by the Australian Institute of Health and Welfare, *Health expenditure Australia 2005-06*, growth in health expenditure is slowing.

The total health expenditure in Australia grew by over 7% between 2004-05 and 2005-06 to \$87 billion or \$4,200 per person.

Health expenditure as a proportion of gross domestic product (GDP) was 9%, down slightly from 9.05% the previous year, and up from 7.5% in 1995-96.

The report shows that after adjusting for inflation, total health expenditure increased 3.1% in 2005-06, compared to annual average growth in the decade to 2005-06 of 5.1%.

The areas of expenditure that showed relatively high real increases (after allowing for inflation) were research (7%), public hospital services (6%), community health (5%), aids and appliances and other health practitioners (4% each).

For the period 2003-04 to 2005-06, real growth in dental services expenditure averaged 1.9% per year—1.9 percentage points below the annual real growth in total recurrent health expenditure of 3.8%. In nominal terms, average annual growth for dental services expenditure was 7.2% during this period, 1.0 percentage points lower than the growth for total recurrent health expenditure of 8.2%

The report showed the majority of spending in health was funded by governments (68%), with the Australian Government contributing 43%. State, Territory and local governments contributed 25%. The non-government sector (individuals, private health insurance and other non-government) funded the remaining 32%.

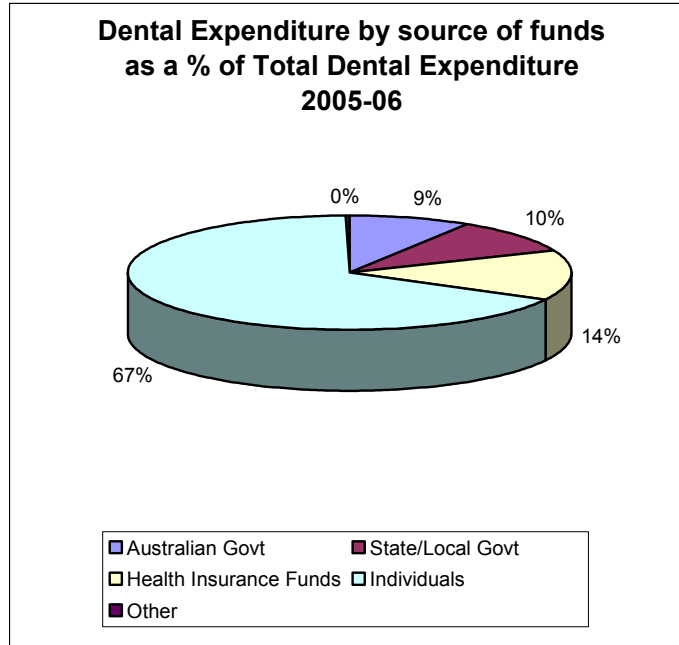
In real terms, the Australian Government's funding grew by 0.7% in 2005-06. State, Territory and local governments funding grew by 7.6% and non-government funding by 2.9%.

In 2005-06, public hospital services and medical services received the highest amounts of government funding for recurrent expenditure (\$22.5 billion and \$12.2 billion respectively). In contrast, dental services received \$995 million (comprised of \$480 million from the Commonwealth Government and \$515 million from State, Territory and local government.)

In 2005-06, medications and dental services received the highest amounts of non-government funding for recurrent expenditure (\$5.4 billion and \$4.3 billion respectively). The dental component being made up of \$760 million from health insurance funds, \$3,573 billion from individuals and \$10 million from others.

The total amount spent on dental services in 2005-06 was \$5,337 billion. This represents 6.1% of the total recurrent health expenditure.

A breakdown of dental expenditure by source of funds as a percentage of total dental expenditure is shown in the table below.



State and Territory Oral Health Budgets 05/06 and 06/07

	2005/2006 dental expenditure (\$)	Population as at December 2005 ¹	Per capita dental expenditure (\$)
Northern Territory	\$7,792,000 ²	204,500	\$38.10
Queensland	\$132,400,000 ³	4,001,000	\$33.09
South Australia	\$47,200,000 ⁴	1,546,300	\$30.52
Tasmania	\$14,500,000 ⁵	487,200	\$29.76
Western Australia	\$56,110,000 ⁶	2,028,700	\$27.66
Victoria	\$126,300,000 ⁷	5,052,400	\$25.00
Australian Capital Territory	\$7,585,500 ⁸	326,700	\$23.22
New South Wales	\$120,000,000 ⁹	6,803,000	\$17.63
Australian Total¹⁰	\$511,887,500	20,452,300	\$25.03

	2006/2007 dental expenditure (\$)	Population as at June 2006 ¹¹	Per capita dental expenditure (\$)
Northern Territory	\$8,266,000 ¹²	206,700	\$39.99
Tasmania	\$16,800,000 ¹³	488,900	\$34.36
Queensland	\$137,700,000 ¹⁴	4,053,400	\$33.97
South Australia	\$52,000,000 ¹⁵	1,554,700	\$33.45
Western Australia	\$58,226,000 ¹⁶	2,050,900	\$28.39
Victoria	\$129,800,000 ¹⁷	5,091,700	\$25.49
ACT	\$8,227,000 ¹⁸	328,800	\$25.02
New South Wales	\$129,000,000 ¹⁹	6,827,700	\$18.89
Australian Total	\$540,019,000	20,605,500	\$26.20

¹ Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, December 2005 (released 2 June 2006)

² Source: Jill Davis (Program Director) Northern Territory Oral Health Branch

³ Source: Penny Slater, Manager (Planning and Evaluation) Queensland Oral Health Unit

⁴ Source: Source: Martin Dooland (CEO) South Australian Dental Service

⁵ Source: Daniel Longstaff (Business Support Consultant) Primary Health, Department of Health and Human Services

⁶ Source: Western Australian Department of Treasury and Finance Budget 2006/07 available at

http://www.dtf.wa.gov.au/cms/uploadedFiles/200607_09%20Part%207%20Health.pdf

⁷ Source: Parliament of Victoria, Public Accounts and Estimates Committee, Report on the 2006-2007 Budget Estimates, September 2006, p.155.

⁸ Source: Larry Vaughan, Director Dental Health Program, ACT Health

⁹ Source:

¹⁰ Includes Other Territories comprising Jervis Bay Territory, Christmas Island and the Cocos Islands.

¹¹ Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, June 2006 (released 7 December 2006)

¹² Source: Jill Davis (Program Director) Northern Territory Oral Health Branch, 16 January 2006

¹³ Source: Cheryl Willis Business Support Unit Oral Health Services, 18 January 2007.

¹⁴ Source: Dr Penny Slater A/Director Oral Health Unit Statewide Health and Community Services, 6 June 2006

¹⁵ Source: Source: Martin Dooland (CEO) South Australian Dental Service (Note: this is offset by \$4.9 m revenue, mostly co-payments), 16 January 2006.

¹⁶ Source: Western Australian Department of Treasury and Finance Budget 2006/07 Budget Paper No. 2 Volume 2, 11 May 2006, p. 452.

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⁵³ The ADA has recently participated in a pilot project in South Australia entitled 'Oral Health for Older People'.

Information about past patterns of dental care, chewing capacity, oral health related quality of life and general health related quality of life was collected by interview and questionnaire from 253 community dwelling elderly people who attended the SA Dental Service Somerton Park Dental Complex between July 2003 and September 2004. Six-month follow-up information was collected from 198 of those patients, whose dental treatment was completed by April 2005.

Six months after they completed their course of general dental care, there were statistically significant improvements in patients' average ratings of oral health and quality of life. Specifically:

- The percentage of patients rating their oral health as 'good', 'very good', or 'excellent' increased from 53% at the pre-treatment interview to 83% 6 months after completion of treatment. The number of adverse impacts on quality of life due to dental problems more than halved, from an average of 1.9 impacts per person (approximately four times the population norm for elderly Australians) to 0.7 impacts per person 6 months after completion of treatment.
- Patients' rating of the extent to which they had achieved their own nominated goal for oral health improved significantly between pre-treatment and 6-month post-treatment interviews, equivalent to moving up 1.4 rungs on a 'goal attainment ladder' that had 7 rungs.
- One aspect of patients' quality of life, measured using the 'role-emotional' subscale of the Short-Form 12 (SF-12) health survey, improved significantly from a pre-treatment level that was below the South Australian population norm for people aged 75+ years to a post-treatment level that was similar to the population norm.
- Improvements in both oral health related quality of life and treatment goal attainment were most pronounced for patients who had the highest priority for care based on their in-home screening, suggesting that the six-question screening tool is effective in identifying those most likely to benefit from dental treatment.

Source: Slade, GD (2007) *Oral Health for Older People – Evaluation of the South Australian Dental Service project*, AIHW cat. No. POH 6, Population and Oral Health Series No. 6, Canberra.

Also as part of the Oral Health for Older People project in SA, under the Aged Care Dental Scheme, private dentists are funded to provide oral health care to residents of aged care facilities. The dentists involved are supplied with portable equipment and reimbursed by the SA Dental Service for most of the costs of delivering the care. The equipment used in the scheme is maintained and sterilised by the staff at the Adelaide Dental Hospital.

The innovative program has run since 2003. The scheme reduces the costs for residents and gets around the previous situation where some could not afford the fees of private visiting dentists. Residents, who must have a current Pensioner Concession Card or Health Card to be eligible for the scheme, are not charged for the initial assessment but pay a small amount (known as a co-payment) if they have work done.

The scheme has been successful and valuable in reducing pain and subsequently reducing behavioural problems in dementia patients.

Facts and figures from the Aged Care Dental Scheme:

- 8 private dental teams have been involved,
- almost 3,000 residents of aged care facilities have been treated since 2003,
- in 2005/06 more than 50 residential aged care facilities were visited by dentists to provide oral health services,

- treatments included preventative oral hygiene services (45 services per 100 people), extractions (18 per 100), restorations (29 per 100), and denture services (57 per 100)

Originally the project was conceived as a 2 year project but will now continue until 2010. With government support the scheme could be modelled in other states.

Source: Cooper Jo (2007) 'Something to smile about', *MX Sydney*, 1 December.

The delivery of oral health care to older people is a necessary investment and oral health treatment should be provided using the model successfully trialled in South Australia which has shown vast improvements in patients overall health and quality of life.

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