AUSTRALIAN DENTAL ASSOCIATION INC.

NATIONAL DENTAL UPDATE
SEPTEMBER 2006

www.ada.org.au

# SOCIOECONOMIC STATUS AND ORAL HEALTH

Tooth decay and gum disease are significant health problems in Australia. Tooth decay ranks as this country's most prevalent health problem, while gum disease ranks fifth highest.[1]

Poor oral health can be manifested through pain, functional limitation, psychological discomfort, handicap, physical disability, psychological disability and social disability.[2] If left untreated, oral disease can lead to increased rates of hospitalisation. In 2002-03 for example, there were 223 hospitalisations per 100,000 people for dental conditions that were potentially preventable.[3]

## Socioeconomic status

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 Plan[4] which argues that "profound disparities exist across socio-economic groups in Australia … [as] the incidence of caries and periodontal disease increases as socio-economic status decreases." Spencer[5] has referred to this as the "polarisation of the burden of [oral] disease".

Socioeconomically 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.[6] 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.[7] People on concession cards are 20% less likely to visit a dentist than non-card holders and are more than two times as likely to have a tooth extracted.[8]

## Dental behaviour, access to dental care and poor oral health

A significant misconception held by many is that poor oral health behaviour is the reason why people on low incomes experience poor oral health. As the table overleaf shows, contemporary research challenges this notion by showing that people from disadvantaged groups are as equally inclined to practice oral health self-care as those from more affluent groups.[9]

By contrast, access to dental care is closely associated with income. As the table overleaf shows, people from advantaged areas are more likely to visit a dentist than people on low incomes and in turn this positively impacts on oral health.[9]

*"People who are disadvantaged by socioeconomic status experience greater levels of oral disease than those from more affluent groups."*

## Commonwealth leadership

As access to dental care is associated with oral health status, the Australian Dental Association believes that the Commonwealth Government should provide targeted funding to improve access to dental care for financially disadvantaged groups. Such funding could take the form of a modified and improved Commonwealth Dental Health Program and would be jointly funded by the Commonwealth and State and Territory Governments.

## Oral health promotion

Additional Commonwealth (and State and Territory) funding should also be provided to promote good oral health. While basic oral health education is important, the most effective way to improve oral health is to invest in health promotion programs that focus on common risk factors that contribute to poor oral health.

A common risk factor approach recognises that many diseases – such as heart disease, stroke, cancer, diabetes and dental caries – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma.[10,11] Additionally, oral health promotion should consider the social determinants of health as factors as social exclusion, unemployment, stress, and addiction all contribute to poor (oral) health.[12]

**Contacts:** Dr Bill O'Reilly, President Mr Robert Boyd-Boland, Chief Executive Officer

Australian Dental Association Inc. 75 Lithgow Street, St Leonards NSW 2065 PO Box 520, St Leonards NSW 1590
Tel: 02 9906 4412 Fax: 02 9906 4736 Email: adainc@ada.org.au

**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, Slade GD (2006) 'Evaluating the role of dental behavior in oral health inequalities', *Community Dentistry and Oral Epidemiology*, Vol. 34: 71-79.
*Higher IRSD indicate lower levels of disadvantage.
(This table shows that people from areas of socioeconomic disadvantage (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.)

## References


1. 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.
2. AIHW Dental Statistics and Research Unit (2006) *Social Impact of Oral Conditions Among Australian Adults*, Research Report No. 24, Australian Research Centre for Population Oral Health, The University of Adelaide.
3. SCRGSP (Steering Committee for the Review of Government Service Provision) (2005) *Report on Government Services 2005*, Productivity Commission, Canberra, p. 10.43
4. National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Ministers' Conference, p. 27
5. Spencer AJ (2004) *Narrowing the Inequality Gap in Oral Health and Dental Care in Australia*, Australian Health Policy Institute, The University of Sydney, p. 11.
6. Sanders A, Spencer AJ (2004) 'Social inequality in perceived oral health among adults in Australia', *Australian and New Zealand Journal of Public Health*, Vol. 28, No. 2: 159-166.
7. Australian Research Centre for Population Oral Health (2003) *Social Impact of Oral Conditions Among Australian Adults*, AIHW Dental Statistics and Research Unit, Report No. 24, The University of Adelaide
8. Carter KD, Stewart JF (2002) cited in Spencer AJ, Harford J (no date) *Submission to the Senate Select Committee on Medicare*, Australian Research Centre for Population Oral Health, The University of Adelaide, Accessed from http://www.aph.gov.au/Senate/committee/medicare_ctte/fairer_medicare/submissions/sub212.doc on 31 July 2006.
9. Sanders AE, Spencer AJ, Slade GD (2006) 'Evaluating the role of dental behavior in oral health inequalities', *Community Dentistry and Oral Epidemiology*, Vol. 34: 71-79.
10. Watt RG (2005) 'Strategies and approaches in oral disease prevention and health promotion', *Bulletin of the World Health Organization*, Vol. 83, No. 9: 711-718.
11. Sheiham A, Watt RG (2000) 'The common risk factor approach: a rational basis for promoting oral health', *Community Dentistry and Oral Epidemiology*, Vol. 28: 399-406.
12. Newton JT, Bower EJ (2005) 'The social determinants of oral health: new approaches to conceptualizing and researching complex causal networks', *Community Dentistry and Oral Epidemiology*, Vol. 33: 25-34.