



PUBLIC HEALTH ASSOCIATION
of Australia Inc

ORAL HEALTH POLICY

The Public Health Association of Australia notes the following circumstances regarding oral health:

1. Oral health is fundamental to overall health, well-being and quality of life.ⁱ
2. Oral diseases, in particular dental caries and periodontal disease, are a significant and costly burden to the Australian public. Oral Health expenditure in Australia is the sixth highest health cost and accounted for 7% of total allocated health expenditure (\$3.4 billion).ⁱⁱ Unlike general health costs, dental health is mostly funded by private funding (85%).ⁱⁱⁱ
3. Dental admissions are the highest cause of acute preventable hospital admissions in children.^{iv}
4. Greater levels of oral disease are experienced by Aboriginal and Torres Strait Islander peoples, people on low-incomes, people in rural and remote areas, some immigrant groups from non-English speaking backgrounds (particularly refugees) and dependent older people. This equates to inequitable distribution of need for oral care.^v
5. Oral cancers are responsible for a significant number of deaths and disability.
6. People on low-incomes experience financial barriers, users of public dental services face long waiting lists, and in rural and remote areas accessibility and availability of dental practitioners is limited.^v
7. As more people retain their natural teeth, there is a consequent increase in the need for preventive and restorative dental treatment over many more years of life. More than 60% of population over 65 years now have one or more natural teeth.
8. There is a growing shortage of dental clinicians, aggravated by the ageing of the dental workforce, which continues to reduce the capacity to provide services. Rural and remote areas, public dental services and Aboriginal Health Services are finding it increasingly difficult to attract and retain staff, resulting in declining access for people on low incomes and in non-urban settings.
9. Fluoridation of reticulated water supplies is the most effective socially equitable and safe method of prevention of dental caries. However, access to water fluoridation varies with 75% or more of the population in most state and territories but only 5% access in Queensland.
10. There is no direct Commonwealth funding for dental care for low income Australians. The Commonwealth Government subsidises dental care through the private health insurance rebate of approximately \$380 million. This mainly benefits middle and high income Australians. The rebate for private health insurance on ancillary services should be abolished and the funding redirected to oral health services for Australians on low incomes.

11. The introduction of Medicare Plus has resulted in minimal improvement in access to oral health care for people with chronic illnesses, due to the reluctance of dentists to participate because of the amount of documentation required.
12. Data for the general Australian adult community has recently been collected through the Australian Adult Oral Health survey however data for marginalised groups such as Aboriginal and Torres Strait Islander people, homeless people and those living in shelters/hostels has not been systematically collected. Data on children's oral health is collected but the representativeness and sample yield of the data is inconsistent due to differences in data collection by varying jurisdictions. Quality standardised data collection is essential to detect emerging trends and to enable national and international comparisons.

The Public Health Association of Australia supports the key action areas set out in Australia's National Oral Health Plan 2004-2013, Healthy Mouths Healthy Lives,ⁱ and affirms the following principles:

1. All members of the Australian public should have access to culturally appropriate, safe, affordable, timely and cost-efficient oral health care and dental services. This should include the provision of information about their oral condition, their risk of future oral diseases, and their options for appropriate care.
2. The needs of specific disadvantaged groups such as Aboriginal and Torres Strait Islander communities, low-income earners, dependent older people and newly arrived refugees should be given priority in existing public health care programs.
3. The fluoridation of reticulated water supplies should be continued and extended to all communities across Australia of 1000 or more people.
4. Given the common risk factors to oral health and general health, oral health promotion should be integrated into general health promotion, planning, program implementation and evaluation.
5. The declining supply of dental practitioners should be addressed as a matter of urgency by Committee of Heads and Deans of Dental Schools, AHMAC, DEET and the Australian Vice Chancellors committee.
6. The identification and development of a more flexible and multi-skilled oral health workforce should be explored by State and Territory oral health services.
7. The monitoring, evaluation and reporting on the implementation of the National Oral Health Plan is crucial to the successful incorporation of the Plan Nationally.

The Public Health Association of Australia resolves to undertake the following:

1. The Oral Health Special Interest group will draft a letter for the Association to send to NHMRC requesting that a statement on the oral health benefits that are gained through the implementation of water fluoridation be re-established.
2. The Oral Health Special Interest group will draft a letter for the Association to request that the Commonwealth

- a. take a more active role in the development of an oral health promotion clearing house (Action Area 1.5) to ensure that this key national initiative is progressed and not blocked due to jurisdictional barriers.
 - b. make available to oral health workforce in rural and remote areas incentives that apply to medical and allied health to recruit and retain staff.
 - c. increase oral health workforce through Commonwealth funded tertiary places.
3. The Oral Health Special Interest group will draft a letter for the Association to send to all State and Territory Health Ministers asking that:
 - a. water fluoridation be provided to all communities of 1000 or more population by 2010.
 - b. strategies to identify and develop a more flexible and multi-skilled oral health workforce be implemented.
4. The Oral Health Special Interest group will draft a letter for the Association to send to AIHW DSRU to request that information on fluoride access to populations over 1000 in each state and territory be placed on their website and updated biennially for easy reference.
5. The Oral Health Special Interest group will draft a letter for the Association to send to all State and Territory Oral Health Managers to request a review of current data collection processes to identify opportunities to enhance data systems nationally.

REVISED AND ADOPTED 2006

First adopted at the 1994 Annual General Meeting of the Public Health Association of Australia, revised 1995, 2003 and 2006.

ⁱ National Oral Health Plan 2004-2013. Prepared by the National Health Advisory Committee on Oral Health. A committee established by the Australian Health Ministers' Conference.

ⁱⁱ Australian Institute of Health and Welfare 2004. Australia's Health 2004. Canberra.

ⁱⁱⁱ Australian Institute of Health and Welfare 2004. Australia's Health 2004. Canberra.

^{iv} Australian Institute of Health and Welfare. Australian Hospital Statistics 2002-2003. AIHW Cat. No. HSE 25. Canberra; AIHW Health Services Series No 20. (2004).

^v AHMAC Steering Committee for National Planning for Oral Health. 2001 Oral Health of Australians: national planning for oral health final report. South Australian Department of Human Services.