1 What is your name?

Dr R. Mark Hutton

2 What is your email address?

president@ada.org.au

3 What is your organisation?

Australian Dental Association

4 Do you agree with the vision of the Strategy?

Disagree

The Vision fails to reference prevention and this should rectified. We recommend amending the vision to say: "To improve the health of all Australians at all stages of life, through **prevention**, early intervention, better information, targeting risk factors and addressing the broader causes of poor health and wellbeing."

5 Do you agree with the aims and their associated targets for the Strategy?

Partly

Aim 1.

Aim 1 seeks for all Australians to have the best start in life so it is important that Aim 1 addresses prevention relating to preconception and pregnancy, as prenatal health is an important factor in child health outcomes. [1] Current strategies by the Australian Government relating to prenatal health do not approach prevention as a whole, but rather focus on specific important elements (maternity services and Fetal Alcohol Spectrum Disorder [FASD]).

Oral health also needs to be addressed in this Strategy. The Consultation Paper ignores one of the most common conditions affecting young Australian children, tooth decay. Currently more than 1 in 3 children aged 5-6 years have experienced tooth decay, with this rate increasing to 1 in 2 Aboriginal and Torres Strait Islander children. A large proportion of this decay is untreated (27% of children and 44% of ATSI have untreated decay). Australian children aged 5-9 years followed by 0-4 year olds remain the most likely age groups to undergo potentially preventable hospitalisation due to dental conditions at a rate of 9.5 per 1,000 and 4.9 per 1,000, respectively.

[1] Chedid, R.A. and K.P. Phillips, *Best practices for the design, implementation and evaluation of prenatal health programs.* Maternal and child health journal, 2019. **23**(1): p. 109-119.

This can hardly be seen as giving children the best start in life when this leads to pain, oral swelling, disturbed sleep, inability to eat a nutritious diet and poor self-esteem due to the appearance of their teeth. Parents can experience loss of income and/or productivity when needing to take time off work or other duties to care for these children and attend emergency oral health services. In addition, greater dental disease increases government health expenditure.

Currently, the uptake of the Child Dental Benefits Schedule, which is a Commonwealth funded program for eligible children is significantly underutilised. Reports made in Senate Estimate indicated that utilisation is approximately 38% of those eligible. Participation would be greatly increased if appropriate efforts were made to promote the scheme to parents.

Without accounting for oral health, Australians may not be able to live their first 25 years of life in full health, preventing the Target for Aim 1 from being reached.

The Australian Dental Association (ADA) has a number of strategies to improve oral health for children and would be delighted to meet with you to discuss further, including developing specific education for maternal and child health nurses, midwives, and general medical practitioners on how to identify disease and risk factors in young children.

Aim 2.

Tooth decay and gum disease are two of the most common diseases experienced by elderly Australians, with 25% of Australians aged 75 years and over living with untreated tooth decay, and 70% with moderate to severe gum disease.[2, 3] This can be exacerbated by reduced ability to maintain good oral hygiene due to conditions associated with ageing. Changes in quality of life caused by oral disease impacts in the elderly can be prevented or minimised with earlier intervention.

The Royal Commission into Aged Care Safety and Quality heard evidence of the woeful state of oral health in the elderly population living in residential aged care facilities and the community. Poor oral health in this population can lead to aspiration pneumonia and have detrimental effects on general health conditions such as diabetes, dementia and cardiovascular diseases.

The ADA's proposed Seniors Dental Benefits Scheme (SDBS), as outlined in the Australian Dental Health Plan and supported by Aged Care Royal Commissioners, is an important preventive health measure for older Australians. Supporting dental care and maintenance through access to subsidised services will help to:

- Maintain oral health.
- Support general health.
- Reduce pain.
- Increase ability to maintain proper nutrition.
- Improve quality of life.

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[2] Peres, K.G., D.H. Ha, and S. Christofis, *Trend and distribution of coronal dental caries in Australians adults.* Australian Dental Journal, 2020. **65**: p. S32-S39.

[3] Ha, D.H., et al., *Periodontal diseases in the Australian adult population.* Australian Dental Journal, 2020. **65**: p. S52-S58.

Preventive care can also lead to significant cost savings in the long term for both individuals and government. Implementation of the SDBS by the Australian Government will also help to address Aim 3 and Aim 4.

The ADA has identified an existing mechanism that could assist in this area. Health Assessments covered under MBS item **701 (brief), 703 (standard), 705 (long) or 707 (prolonged)** do not include a compulsory assessment of the dentition and oral health. Medical practitioners can choose to include these however many do not. To incorporate a compulsory oral check would require no additional funding but could identify serious disease including oral cancers in the community. The ADA would be willing to develop educational material to upskill GPs to feel confident in performing these checks to assist in the roll out of such a program.

Aim 3.

Reducing inter-generational health disadvantage is crucial to break the cycle of poor health. This could be separated from the overarching aim, to further reduce health inequity and ensure the appropriate level of focus. Also see Aim 1.

There is a plethora of evidence demonstrating that oral health inequities exist. People with poor oral health include frail and older people, rural residents, Indigenous Australians, Australians with physical and intellectual disabilities and people of low socio-economic status. This list looks similar to what you would expect to find for general health inequality and suggests that when focussing health policies on at-risk groups, oral health should be included.

Without investment to improve access to oral health services for patients with greater needs, there is currently no way to achieve this aim for oral health care. Public oral health services these individuals is so critically under-funded that the gap between those who can afford to access private dental services and those who cannot is ever widening.
Many adults are unable to pay for dental care but are not eligible for public dental services. This group are falling between the cracks when it comes to their oral health. The ADA's Australian Dental Health Plan provides the framework to improve access to care for this vulnerable group. A copy of the plan is attached.

Aim 4

Currently, there is almost no investment in public oral health preventive services, advocacy, public education, and health promotion.

Healthcare maintenance and engagement with primary healthcare providers (medical/ dental checkups, screening for conditions) is an important element of preventive health. Reducing barriers to accessing preventive services in primary care settings is important to help achieve Aim 4 and Goal 2 (Prevention will be embedded in the health system). Out-of-pocket costs for many private healthcare services as a result of poor private health insurance rebates can prevent those ineligible or unable to access timely public sector care from seeking preventive healthcare.

The majority of the government-funded oral health services in Australia are not set up to provide preventive treatment due to the gross lack of funding. Most of these services can only provide emergency oral care and relief of pain for eligible patients. The Grattan report highlights that about 2 million Australians miss out on the dental care they require each year due to cost (p 11). Since the

restrictions on dental services during COVID-19 the waiting lists for treatment in most areas of Australia has risen dramatically. (eg. NSW https://www.health.nsw.gov.au/oralhealth/Pages/waiting.aspx)

These waiting lists for treatment preclude any meaningful attempts at prevention. Further, the Government-funded Schemes (CDBS and even DVA) work on a fee-for-service structure with little or no possibility of preventive approaches. In fact, there is no item within the CDBS that allows for oral health education (the discussion of preventive strategies for children and their parents/carers to follow at home, which make up the basis of a routine oral health regimen) or mouthguard fabrication to protect against dental trauma, which can result in life-long consequences.

It is important to address these barriers through:

- Private health insurance benefits available for all preventive health services
- Appropriate funding for access to services targeted at those most in need
- Strategies to minimise waiting times for preventive services in public agencies through sustainable funding agreements between Commonwealth and State governments.

These measures complement other strategies to build preventive capacity for all individuals.

6 Do you agree with the principles?

Agree

Enabling the workforce

This is an acceptable principle but must commit to education students and already registered health professionals in order to effectively enable the embedding of prevention.

Empowering and supporting Australians

To effectively empower and supporting Australians from diverse cultural backgrounds, compulsory training of health professionals in cultural safe practices should be considered to improve the outcomes able to be achieved.

7 Do you agree with the enablers?

Agree

Information and health literacy

To reorientate health services in order to promote health, consideration for health practitioner education is necessary as health promotion education is not included as core learning, for example, in all Australian tertiary dental courses.

8 Do you agree with the policy achievements of the enablers?

Disagree

Prevention in the health system - *The inherent preventive health capabilities of primary health care professionals, including GPs, allied health, pharmacists and nurses, are better supported and integrated within health services.*

The ability to provide oral health preventive services needs to be recognised and included. The Australians Governments own child dental scheme, the Child Dental Benefits Scheme, does not allow for preventive services including oral health education (the discussion of preventive strategies for children and their parents/carers to follow at home, which make up the basis of a routine oral health regimen) or mouthguard fabrication to protect against dental trauma, which can result in life-long consequences.

Additionally, the Government-funded DVA Scheme is based on a fee-for-service structure with little or no possibility of preventive approaches.

9 Do you agree with the seven focus areas?

Disagree

The strategy has continued to ignore the importance of oral health, not just regarding retaining teeth throughout life with no pain or impact on quality of life, but also the links to general health. Poor oral health can have detrimental effects on general health conditions such as diabetes, dementia, and cardiovascular diseases, as well as impact daily functions such as eating, speaking and socialising. It can also cause aspiration pneumonia in elderly populations living in residential aged care facilities and the community. Good oral health is important in itself. However, it's not until the links between oral and systemic health are explained that some people, can understand the importance of oral health.

Tooth decay is one of the most common and costly chronic diseases in Australia. According to the AIHW report, *Health Expenditure in Australia 2017–18*, total expenditure on dental healthcare in 2017–18 was estimated at $10.5 billion.
It is not enough to only relate a healthy diet to oral health by stating *there is also a bidirectional relationship between the food we consume and oral health; increased free sugar intake is strongly linked to increased oral disease which in turn affects an individual's ability to consume adequate nutrition.* Diet is related to dental conditions such as tooth decay and tooth erosion but there are additional diseases of the mouth where instigating factors are unrelated to diet.
Periodontal disease, one of the most common dental conditions that can ultimately result in pain, tooth loss, and affect quality of life, is associated with tobacco smoking, diabetes, and poor oral health. Additionally, oral cancer rates are increasing, with a rise in young females in the past years. The use of betel nut, which is a risk factor for oral cancer, is increasing in Australia.

Fluoridation of community water supplies for of towns with 1,000+ populations should be an area of focus. Water fluoridation is the most cost-effective way of ensuring better and equitable oral health outcomes.

Australian children aged 5-9 years followed by 0-4 year olds remain the most likely age groups to undergo potentially preventable hospitalisation due to dental conditions at a rate of 9.5 per 1,000 and 4.9 per 1,000, respectively. Children who have required dental treatment in a hospital are likely to need repeat general anaesthetic dental treatment in future years.

10 Do you agree with the targets for the focus areas?

Agree

Targets for the included focus areas are appropriate. This could be improved by including oral health targets as the eighth focus area.

11 Do you agree with the policy achievements for the focus areas?

Disagree

Increasing cancer screening and prevention

Oral cancer screening is routinely completed by dental practitioners at each examination appointment. General medical practitioners are unlikely to screen for oral cancers unless based on patient complaint, however pain is often only present from oral cancers when they are in advanced stages. Without acknowledging the importance of oral health prevention in this report or having it as a focus area, particularly as it is closely related to the other 7 focus areas, early detection of oral cancers may not be routine, resulting in healthy years of life lost, significant permanent disability, or ultimately loss of life.

Continuing Strong Foundations

12 Do you agree with this section of the Strategy?

No opinion

This appears to be an area of acknowledgement and appears to add little to the Strategy.

FEEDBACK

13 Please provide any additional comments you have on the draft Strategy

This Strategy has failed to integrate oral health despite the World Health Organization (WHO) recommending *health policies should be reoriented to incorporate oral health.* The WHO state *the compartmentalization involved in viewing the mouth separately from the rest of the body must cease because oral health affects general health by causing considerable pain and suffering and by changing what people eat, their speech and their quality of life and well-being.*

It has been very disappointing that a National Preventive Health Strategy fails to seriously consider oral health as part of overall health. Poor oral health is a subset of poor systemic health and has the same social determinants. We welcome the opportunity to become further involved in the continued development of this strategy.