



Australian Dental Association Inc.

Submission

Australian Senate

Select Committee on Health

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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing the majority of Australia's 15,000 registered dentists as well as dentist students. ADA members work in both the public and private sectors as well as in academia and research.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry and to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are ADA Branches in all States and Territories other than in the Australian Capital Territory. Further information on the activities of the ADA can be found at www.ada.org.au.

Introduction

The ADA welcomes the opportunity to provide this submission to the Select Committee on Health. We understand the Committee will inquire into and report on health policy, administration and expenditure. This inquiry is a broad one and thus it is important that oral health policy is considered within its ambit. This is the focus of our submission, however oral health policy is not distinct from health policy overall and it is important that any approach to the development of oral health policy is integrated and coordinated within general health policy.

ADA members work at the coalface of dental care delivery in both the private and public sectors and are committed to improving the oral health of the community. The ADA is therefore well placed to provide advice and work with government to ensure that the oral health of all Australians can be improved and maintained by long term sustainable, effective and economically viable policies. Good oral health is fundamental for optimum overall health which is essential for a productive and cohesive community.



This submission is divided into three parts.

In Part 1, the ADA makes some general observations about Australian's oral health and the importance of oral health to overall health. While it is generally good news, recent trends are concerning.

In Part 2, the ADA suggests an approach to the formulation and development of Australia's overall oral health policy. Five main principles are identified and summarised from ADA's policies and guidelines. Ideally these principles should underpin Australia's oral health policy.

In Part 3, the ADA addresses each of the terms of reference of the inquiry and, where appropriate, refers the Committee to the specific components of the Budget 2014-2015 which are likely to impact upon oral health care delivery. The ADA understands that a significant focus of this inquiry will be informing the Australian Government about the impact of Budget 2014-2015 announcements on health services. In terms of oral health care delivery, there were five significant announcements in the Budget. They are listed below under the heading of the programme to which they relate. Recommendations under each of the terms of reference are also included.

Part 1 - Australian's oral health – a snapshot

Good oral health has been characterised by adequate dentition and the absence of untreated tooth decay or periodontal diseases and a number of other less prevalent oral diseases and disorders.¹ The proportion of expenditure on health represented by oral health is just over 6.3% however, this relates to the direct costs only and in all likelihood understates the importance of oral health as a burden on Australians because there is relatively little public health expenditure on oral health in comparison with other aspects of health. There are also unquantified indirect costs to government and society of dental disease. For example, the Report of the National Advisory Council on Dental Health² estimated that the cost of public hospital admissions due to dental disease for 2008-09 was approximately \$84 million with an additional estimates of anywhere between \$10 and \$300 million per annum expended through Medicare subsidies for visits to general practice related to dental disease. Given that

¹ Report of the National Advisory Council on Dental Health

² Ibid.



on average only two thirds of the population visited a dentist in any 12 month period, the level of untreated oral disease could be significant.³

There is also now strong evidence of the association between oral disease and other non-communicable diseases such as diabetes, cardiovascular disease, certain forms of cancer and respiratory diseases.

Australians more than ever are retaining their natural teeth and overall now enjoy better oral health. This has been achieved primarily by:

- a) access to reticulated water fluoridation;
- b) an improved diet;
- c) reduction in the use of tobacco;
- d) good oral hygiene supported by a greater community awareness, and
- e) regular visits to the dentist.

In addition, oral health benefits have also been achieved through:

- f) an increase in the expertise of Australian dentists and the utilisation and availability of newer dental materials;
- g) the use of applied preparations containing fluoride such as fluoride toothpastes, and
- h) technological advances.

However, there are some worrying recent trends. Recent studies indicate that the oral health of Australian children is particularly at risk. Poor childhood oral health is a strong predictor of poor adult oral health. Despite a significant and steady decrease since the 1970s, dental decay in children has been marred by some increase from late 1990s onwards.⁴ The latest statistics,⁵ reproduced from *Oral health and dental care: key facts and figures trends 2014*, foreshadow a continuation of this trend.

³ Australian Institute of Health and Welfare 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW

⁴ AIHW 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW at p151.

⁵ AIHW 2014. *Oral health and dental care in Australia: key facts and figures trends 2014*. Cat. No. DEN 228. Canberra: AIHW available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548452> accessed 5 September 2014

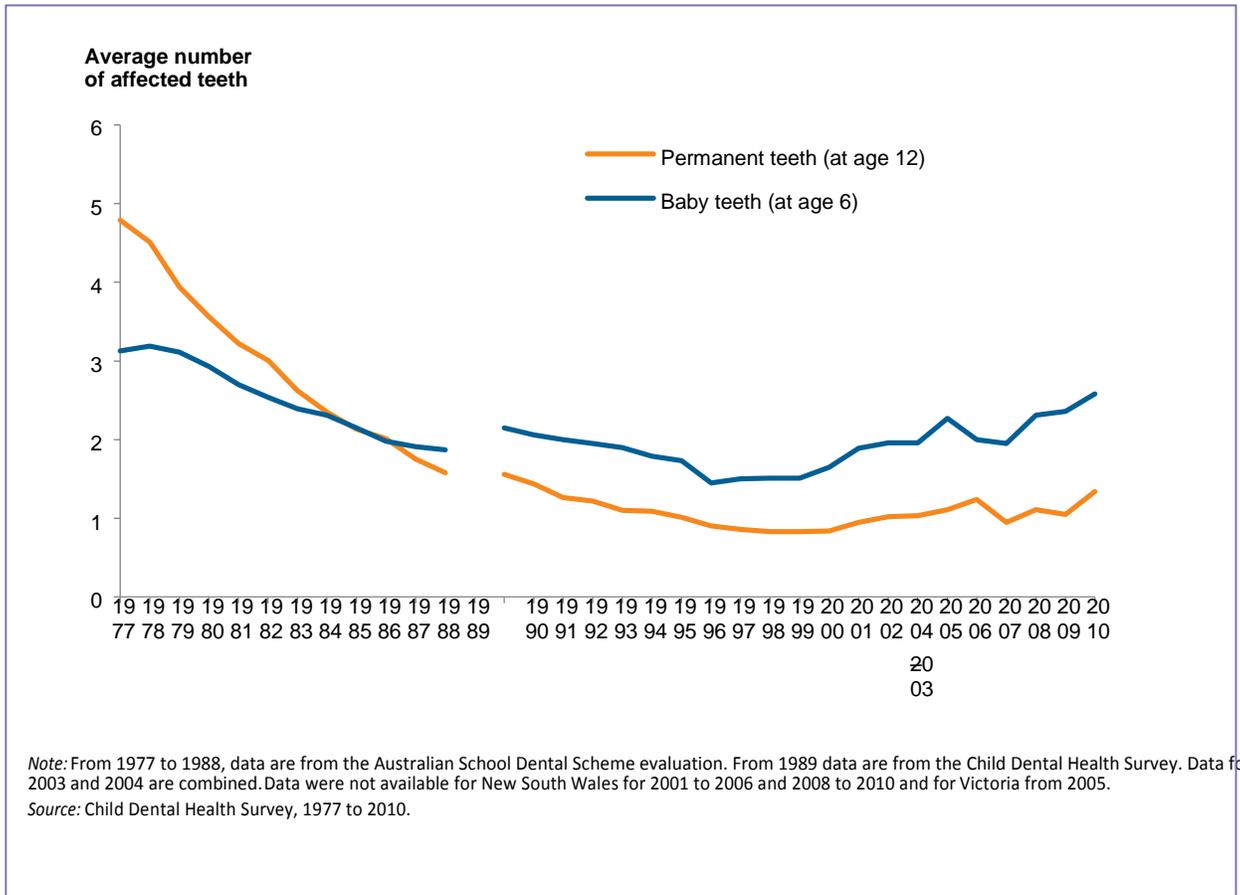


Figure 1: Trends in decayed, missing or filled teeth in children, 1977 to 2010

If dental decay continues to rise, Australians face a future of deteriorating oral health. It is imperative that Australian Governments act. Most at risk are the disadvantaged in our community who generally do not have access to the measures listed at (a), (b) and (d) to (f) above.

The reasons for these trends are complicated and considerable research has been conducted into halting their progress. The ADA, as an organisation of dentists committed to the oral health of all Australians, cannot stress enough the importance of good oral health policy which addresses prevention and education as a priority and operates in an integrated and co-ordinated manner with other health sectors. Regardless of socioeconomic status, age or location, every Australian should have the right to good oral health care.



Part 2 – The focus for Australia’s oral health policy

The ADA has a first-hand insight into the oral health needs of Australians. Our members treat the public every day and have a unique knowledge into the treatment and measures which will be effective in improving oral health and increasing preventive measures. The ADA’s policies and guidelines, available at <http://www.ada.org.au/about/policies.aspx> have been developed as a resource for our members, government, policy makers and the broader public. All interested stakeholders and parties are encouraged to refer to them. It is the ADA’s submission that these policies and guidelines should inform the development, implementation and evaluation of Australia’s oral health policy.

There are five broad principles that underpin ADA’s policies and guidelines. If all policy makers, including the Australian Government, base Australia’s oral health policy on these principles, all Australians will benefit and be in a position to receive optimal oral health care. While it is acknowledged that governments must operate in a fiscally responsible manner, the correct oral health policy will reduce financial burden and improve the oral health and indeed general health of all Australians.

1 – Good Oral health is integral to general health and should be available to all.

Dental disease (including caries and periodontal conditions), is one of the most prevalent yet preventable health conditions in Australia. Oral health must be viewed in a holistic way; it is an important part of an individual’s overall health and must not be treated in isolation. Poor oral health impacts an individual’s general health, wellbeing and quality of life.⁶ At a societal level poor oral health also has economic impacts in terms of ability to obtain work, reduced workforce productivity and additional cost to the health system. The ADA is encouraged to note that, as outlined in *Australia’s health 2014*, dental decay has been recognised for what it is: a chronic disease with a high impact on society.⁷ The Australian Government should support continual research into the oral health of Australians and the prevention of dental disease.⁸

⁶ See ADA Policy Statement 2.1 *National Oral Health* available at http://www.ada.org.au/app_cmslib/media/umlib/policy%20statement%202.1%20national%20oral%20health.pdf

⁷ *Australia’s health 2014* op cit at p 95, see also ADA Policy Statement 2.1 *Oral Health and the Social Determinants of Health* available at http://www.ada.org.au/app_cmslib/media/umlib/policy%20statement%202.1%20national%20oral%20health.pdf

⁸ ADA Policy Statement 2.4 *Research* available at http://www.ada.org.au/app_cmslib/media/umlib/policy%20statement%202.1%20national%20oral%20health.pdf



2 – Early intervention and prevention in oral health is essential and results in long term savings

Broadly speaking, good oral health can be achieved through economically sustainable policies focussing on community oral health promotion and prevention of dental disease, including provision of primary oral health care from dentists. Dental disease shares common underlying causal and risk factors with other chronic diseases. Dental disease may exacerbate other chronic diseases and providing treatment for chronic disease is costly. It makes sense both financially and ethically to invest in primary oral health care. Investing in primary oral care will have a strong preventative effect and addresses some of the behavioural and other risks factors for dental disease.⁹

It is imperative that the public are educated in the importance of good oral health. Good oral health must be given high priority. When prevention and oral health promotion is supported with a strong dental primary care system, it potentiates reduced disease in society and reduced future costs and demand for care.

3 – Government funds should be directed to those with the greatest need.

There are certain groups within the community who continue to suffer from poor oral health. Generally, these groups rely upon the public dental system for dental care and traditionally face long delays and limited treatment options. The high risk groups in our community include:

- Aboriginal and Torres Strait Islander peoples;
- residents in remote areas;
- people with special needs;
- older people, including residents in aged care facilities;
- people on low incomes and socially disadvantaged; and
- children and adolescents.

It is important that Australia's oral health care is targeted at these "at risk groups" in our community in a timely and efficient manner.¹⁰ If financial and infrastructure support is to be provided by the Australian Government, it should be targeted at these groups in the community.

⁹ Ibid.

¹⁰ Ibid.



4 – Australian dentists are vital to ensuring good oral health throughout the community and the development and implementation of good oral health policy.

There are approximately 15,000 registered dentists as well as 3000 dentist students in Australia. ADA members work in both the public and private sectors as well as in academia and research. Providing the full spectrum of contemporary oral health care can be costly, so it makes good economic sense to utilise the existing dental workforce and infrastructure. Australia's dental workforce has the expertise and skills required to provide Australians with the best oral health care. In providing the full spectrum of care, the dentist is the team leader of any dental team providing oral health care to the community.¹¹

5 – Government has a crucial role to play in regulating the role of the Private Health Insurance Industry in the delivery of good oral health.

While some Australians receive dental care through publicly funded government programmes only 18-19% of total dental care is funded by the Australian Government. Many Australians are covered by private health insurance (PHI) general treatment [ancillary] cover. On 30 June 2013, **54.9%** of all Australians were covered by general (including dental) treatment PHI,¹² but PHI cover provided rebates for only some 21-22% of dental services.

In view of the Australian Government's financial incentive and other policy encouraging Australians to take out PHI, it is important to the sustainability of Australia's universal health care system that Australians with PHI continue to receive the best dental coverage. The Australian Government has a fundamental role to play in ensuring that PHI delivers value for money; the cost of PHI remains within the reach of all Australians and that the clinical independence and choice of provider are not eroded.

¹¹Ibid. See also ADA Policy Statement 3.1. *Dental Workforce* available at http://www.ada.org.au/app_cmslib/media/umlib/policy%20statement%202.1%20national%20oral%20health.pdf

¹² Australian Government Private Health Insurance Administration Council *The Operations of Private Health Insurers Annual Report 2012-2013* at page 20 available at <http://phiac.gov.au/wp-content/uploads/2013/12/2012-13-accessible-pdf.pdf> accessed 1 August 2014.



Part 3 - The terms of reference

A The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting.

While the vast majority of Australians receive oral health care from private dentists in private practice, a significant number of Australians receive dental care through publicly funded government programmes. Generally, these services are directed and utilised by Australians who fall within the “at risk” groups previously mentioned. State and territory governments fund public oral health care in partnership with the Commonwealth through the National Partnership agreements. The Commonwealth also fund public dental care through specific funding of programmes.

There are a number of measures in the Federal Budget 2014-2015 which will have a detrimental impact on the provision of public dental care. The effect of reduced Commonwealth funding on public dental care is of concern to the ADA. Whilst the terms of reference have requested information specifically on state and territory government programmes, the Federal Budget 2014-15 also proposes changes to Commonwealth funded programmes which will impact on oral health care delivery. We also refer to these Commonwealth programmes in this part of our submission at point (ii) to (iv) below.

State and territory delivered dental care

(i) National Partnership Agreement for adult public dental services — deferral

The Federal Budget 2014-2015 proposes a deferral of funding for adult public dental services through the National Partnership Agreement (NPA). Budget paper 2 states:

“The Government will achieve savings of \$390.0 million over four years from 2014 -15 by deferring the commencement of the Mid -Year Economic and Fiscal Outlook 2012 -13 measure Dental health reform — National Partnership Agreement for adult public dental services from 2014 -15 to 2015 -16.



The savings from this measure will be invested by the Government in the Medical Research Future Fund.”¹³

In 2012, under the NPA, the Commonwealth provided \$344 million to State and Territory Governments to assist in the delivery of dental services to approximately 400,000 adults on public dental waiting lists. NPA funding has been utilised by state and territory governments to assist in the oral health care of public dental patients the vast majority of whom fall within the “at risk groups” referred to above in Part 2 of this submission.

A recent feature of these government funded dental programmes has been the treatment of public patients in partnership with dentists in the private sector. Some states and territories have issued vouchers or similar to public dental patients enabling them to access dental treatment from private dentists. This utilisation of private dentists and private infrastructure makes economic sense. Outsourcing dental care has proven very successful in reducing the number of patients on public dental waiting lists. For example, in NSW¹⁴, the number of patients on public dental waiting lists has fallen from 68,000 to 53,000.¹⁵ In Queensland the effect on public dental waiting lists has been even more significant. The number of Queenslanders on general public dental waiting lists has been cut in half and the long wait list slashed from 62,513 to 8494.¹⁶

The proposed deferral by the Commonwealth of NPA funding threatens to undermine these significant achievements. It is unlikely that state and territory governments will increase the level of funding to make up the short fall created by the deferral of the NPA funds. It is also unlikely that public dental patients will be in a position to fund their own dental care. The end result will be a return to the days of long waits for public dental care patients.

When there is clear evidence the private sector in dentistry has more than adequate capacity to provide oral health care to public dental patients, the short term financial savings achieved by this budget measure may be at the oral health expense of those who would have been able to access dental care through the voucher schemes.

¹³ Ibid.

¹⁴ In NSW, this operates under the Oral Health Fee for Service Scheme available at http://www.health.nsw.gov.au/policies/ib/2013/IB2013_061.html.

¹⁵ NSW Government *Reductions in the Number of NSW residents waiting for Public Dental Care* available at <http://www.health.nsw.gov.au/oralhealth/Pages/public-dental-care-waiting.aspx> accessed 1 August 2014.

¹⁶ Queensland Government, Media Statement Minister for Health, the Honourable Lawrence Springborg Monday February 10 2014, *Health Sinks its teeth into dental wait lists* available at <http://statements.qld.gov.au/Statement/2014/2/10/health-sinks-its-teeth-into-dental-wait-lists> accessed 12 August 2014.



Recommendation A (i)

The proposed deferral of the funding under the NPA for adult public dental schemes should not proceed. The Commonwealth Government has an obligation to continue with its funding of the adult public dental schemes.

Commonwealth funded programmes

(ii) Department of Veterans' Affairs

Budget paper 2 states:

“Dental and Allied Health Provider Fees — defer and align indexation.

The Government will achieve savings of up to \$35.7 million over four years by deferring indexation of Department of Veterans' Affairs (DVA) dental and allied health provider payments to 1 July 2016. This measure will align indexation of payments to dental and allied health providers with the indexation arrangements for DVA medical services.

The savings from this measure will be invested by the Government in the Medical Research Future Fund.”¹⁷

The proposed deferral and aligning of indexation rebates payable for dental services provided to veterans has the potential to reduce availability of oral health care to this group of Australians.

There has always been a significant discrepancy between the fee levels established by the *Treasury Scale of Fees-Department of Veterans' Affairs Schedule (DVAS)* and the mean fee identified by the *ADA Fee Survey* which collects the customary fees charged for services by dentists. Dentists have always ensured that their fees are reasonable. Indeed dentists' customary fees over the last seven years have been maintained at levels *below* the Health Index. However, DVA's scale increases have not kept pace with dentists' customary fees. The result is an increasing discrepancy between dentist fees and DVA's scale fees. Research compiled by the ADA and shown at figure 2¹⁸ illustrates that on average this discrepancy is nearly 20% and in some individual cases it has been as high as 60%.

¹⁷ Australian Government Budget Paper No. 2: Budget Measures 2014-2015 Part 2 Expense Measures available at http://www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-23.htm accessed 1 August 2014.

¹⁸ Compiled from internal ADA data

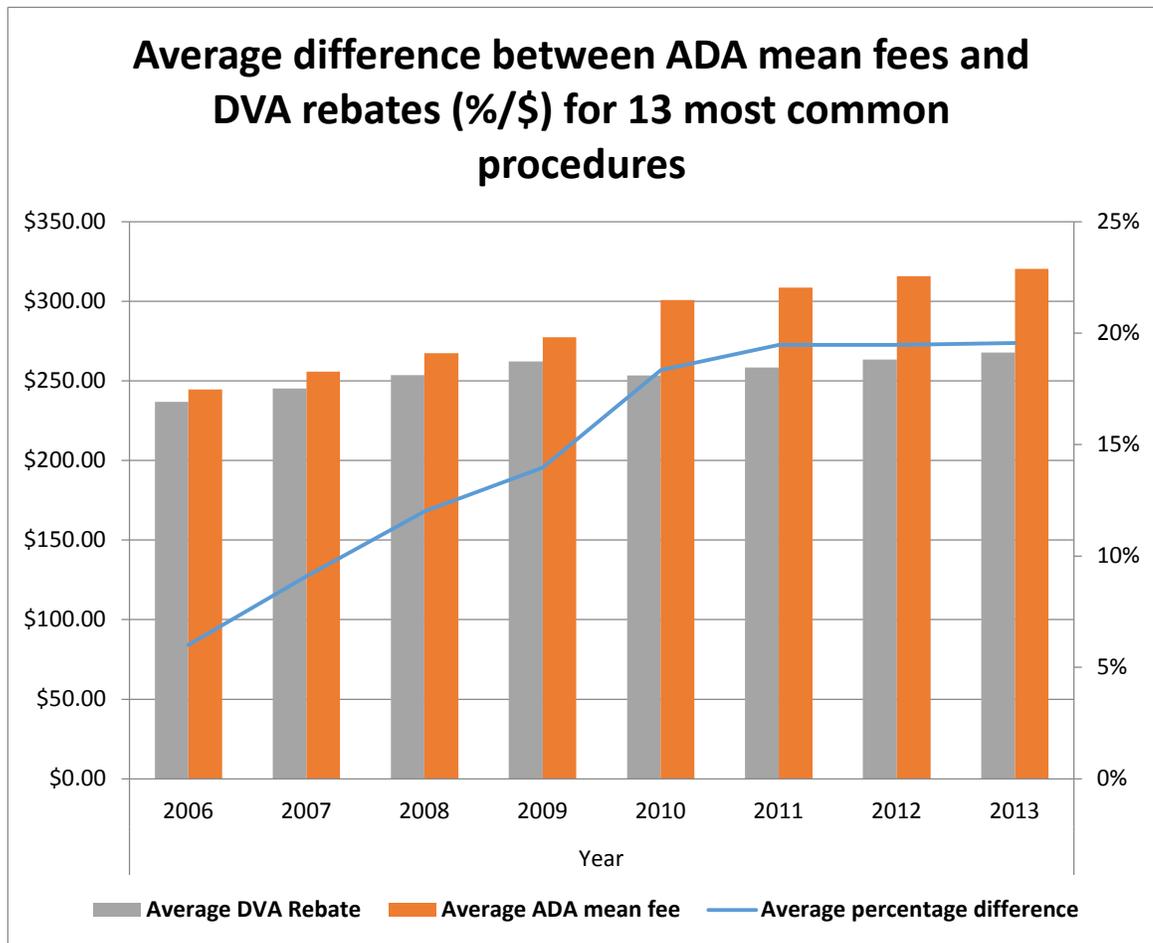


Figure 2: Comparison of DVA and ADA mean fees for most common procedures

The ADA has regularly brought this issue to the attention of the Australian Government most recently in our submission to the Australian Senate *Inquiry into out-of-pocket costs into Australian healthcare*.¹⁹ In an environment where the Australian Taxation Office has estimated about 70% of any dental fee is overhead costs, it is apparent that there is no or minimal return for a dentist that performs these essential DVA services.

The impact of this budget proposal on DVA eligible patients and their families is obvious. Dentists already find it increasingly difficult to treat DVA patients at the current rebate amount and a freeze in indexation of those fees will make the provision of services to DVA patients all the more difficult.

¹⁹ Australian Dental Association: Submission to Standing Committee on Community Affairs *Inquiry into the out-of-pockets costs in Australian healthcare* 12 May 2014 available at http://www.ada.org.au/App_CmsLib/Media/Lib/1405/M769771_v1_635355802511720971.pdf.



There is no doubt in the ADA's mind the Australian Government is seeking to further exploit the generosity of dentists who continue to willingly provide treatment to these patients.

Recommendation A (ii)

The proposed deferral and aligning of indexation of DVA fees should be rejected. There should be greater correlation between customary fees charged by dentist for services and the level of 'fee for services' paid under the DVA scheme. Annual review of DVA's fee scales should be conducted at the very least in line with health CPI indices.

(iii) Charles Sturt University

Budget Paper 2 states:

The Government will achieve savings of \$15.2 million over three years by not proceeding with the Charles Sturt University — dental and oral health clinic developments in New South Wales measure which was announced in the 2013 Economic Statement.

The savings from this measure will be invested by the Government in the Medical Research Future Fund.²⁰

The proposal to withdraw funding from this University has the potential to increase out of pocket costs for rural residents in Australia and impact upon the oral health of central west NSW residents.

Charles Sturt University provides dental services to residents in the vicinity of its dental clinic. These services are either provided free or at a discount to the customary fee charged by dentists. Removal of the funding will mean:

- Residents are not able to access care through the University clinic;
- To access services, residents will need to access the public or private sector for services. Public patients will face a long wait for treatment which will potentially cause deterioration of the patient's oral health and thus the need for further services. Patients who seek care through the private sector will be required to meet the cost of

²⁰ Ibid.



care themselves possibly incurring additional costs such as transport. Either way the cost of treatment will increase.

- The Dental faculty was established in the expectation that upon graduation, students would remain in the area to practise. There is strong evidence to suggest that the programme provides high rural vocation retention, benefiting one of the areas of need and patients at high risk. Students at Charles Sturt University who previously had access to this clinic as an important part of their training will miss out of this valuable educational tool. This could result in a reduction in student numbers or abandonment of the dental school. This in turn will reduce the number of rural dentist. This will mean residents will need to travel longer distances to access treatment and thus increase the cost of care.

Recommendation A (iii)

In the interests of Australians living in the central west region of NSW, the proposal to withdraw funding from Charles Sturt University should be rejected.

(iv) Dental flexible grants

Budget Paper 2 states:

“The Government will achieve savings of \$229.0 million over four years by ceasing the Dental Flexible Grants Programme.

The savings from this measure will be invested by the Government in the Medical Research Future Fund.”²¹

The withdrawal of this funding may also reduce the ability of rural residents to access dental care. If the funding had been granted, the result could have been to encourage dentists to practise in the more remote regions of Australia. Easier and improved access to care would have resulted in a saving to those residents accessing services through these practices.

Recommendation A (iv)

In the interests of Australians living in rural and regional areas, the proposal to withdraw dental flexible grants funding should be rejected.

²¹ Ibid.

B The impact of additional costs on access to affordable healthcare and the sustainability of Medicare

Access to affordable dental care is essential to the improvement and maintenance of Australian’s oral health. In this part of our submission, we would like to raise the ADA’s concerns about the challenges faced by privately insured Australians who despite paying high premiums for their PHI, are facing larger out-of-pocket costs due to decreasing rebates on dental care.

Figures released by the Australian Institute of Health and Welfare show that for the period 2011-2012 individuals were by far the biggest contributors to the cost of dental care.²²

Figure 3 shows a percentage breakdown in the contributions of government, the PHI industry and individuals to the cost of dental care. In 2011-12, total expenditure on dental health care was estimated at \$8.336b. Governments (Federal and State) contributed \$2.3b of this amount with \$6.03b coming from either the PHI industry or individuals. Notwithstanding the level of premiums paid by Australians for PHI, the industry contributed only \$1.26b to the cost of dental care while individuals contributed **\$4.736b**. Indeed with the exception of medication expenses, dental care is an individual’s largest health expense.



Figure 3: Dental Expenditure in Australia 2011-12

²² Australian Institute of Health and Welfare *Health expenditure Australia 2011-12* Table A3 available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544656> accessed 1 August 2014.



The ADA has made a submission to the Senate Community Affairs References Committee inquiry into out of pocket (OOP) costs in Australian healthcare. In that submission the ADA addressed the financial challenges faced by Australians in covering the cost of their dental care. Research undertaken by the ADA indicates an increasing discrepancy between customary fees charged for dental services and the rebate levels paid by the PHI industry. Australians with PHI are required to meet the difference or gap. This increasing gap has an adverse impact upon insured patients accessing dental care. This in turn results in less than optimal care being obtained. This submission is available at www.ada.org.au.²³

The Australian Government should be concerned about the provision of private dental care in Australia and the impact of the additional cost of dental care on Australians. It is important that the PHI industry, which is supported by Australian Government financially and through other policy measures, meet their obligations to the Australian public. If private dental care becomes too costly and Australians get less value for their PHI, in an environment where premiums are increasing, there is the potential for Australians to abandon dental PHI. This is not in the interests of optimal oral health outcomes for Australians. There are 3 possible scenarios:

- (a) Uninsured Australians pay the full cost of their dental care. With increasing cost of living pressures, many Australians may simply neglect their oral health as an expense they can't afford or delay treatment until their dental problems require more complex and costly treatment. Some view dental expenditure as discretionary but early intervention can keep people with oral disease out of hospital. Research has also shown that when Australians cannot access dental care, they seek assistance from other parts of the health sector including general practitioners.²⁴
- (b) Uninsured Australians may seek dental care through public dental programmes. Adding to the number of Australians who are currently seeking public dental care is not, without a substantial overhaul of dental care delivery, in the long term interests of the oral health of all Australians.

²³ Australian Dental Association: Submission to Standing Committee on Community Affairs *Inquiry into the out-of-pockets costs in Australian healthcare* 12 May 2014 available at http://www.ada.org.au/App_CmsLib/Media/Lib/1405/M769771_v1_635355802511720971.pdf.

²⁴ National Advisory Council on Dental Health *Report of the National Advisory Council on Dental Health* 23 February 2012 at p 18 available at [http://www.health.gov.au/internet/main/publishing.nsf/Content/C10065B9A8B6790FCA257BF0001BDB29/\\$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20\(PUBLICATION\).pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C10065B9A8B6790FCA257BF0001BDB29/$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20(PUBLICATION).pdf) accessed 12 September 2014.



- (c) Research shows that uninsured Australians are more likely to have an unfavourable visiting pattern with their dentist. Unfavourable visiting patterns as demonstrated in point (a) have serious long term complications.

Recommendation B

That the Australian Government enact policy measures which as far as possible limit the continuing increase in the out-of-pocket costs faced by Australians in obtaining oral health care. In this regard reference is made to the submission to the Senate Community Affairs Reference Committee inquiry into out-of-pocket (OOP) costs in Australian healthcare.²⁵ The ADA has suggested a number of measures which could be utilised to reduce the exposure of Australians to increasing out-of pocket costs when accessing dental care. This submission is available at www.ada.org.au but for ease of reference the following recommendations from that submission are transcribed below:

- 1. Greater correlation be created between customary fees charged for services and the level of fee for service paid under government schemes.*
- 2. In the formulation of government schemes input be obtained from dental experts to ensure that the scheme created provides effective services for the targeted group so as to best meet their dental needs.*
- 3. Discriminatory conduct relating to the payment of rebates based on the provider of the services affiliation with a PHI be declared anti-competitive, as it is against the health interest of the patient. Where the same contribution (premium) rate is paid, the contributor must be entitled to the same rebate for the same itemised procedure regardless of which dentist provided the service. Economic fairness and equality must be maintained.*
- 4. Health funds should be banned from actively and directly attempting to influence their members to receive treatment from the health funds' contracted providers as it interferes with the patient/dentist relationship and substantially lessens competition.*
- 5. The need for health funds to be brought to account to provide justification for the effective decline in rebated benefits compared to premium increases and, if suitable explanation is not provided, then remedial action be imposed through legislation to rectify this decline.*
- 6. Health funds be obligated to provide full and clear disclosure of policy terms in plain English so that consumers can be made fully aware of all nuances contained in policies that might otherwise restrict policy holders from receiving cover for*

²⁵ See FN 21



services. Clear explanations of Dental rebates for all services; Annual limits for all services; Rebates per item/service and Qualifying periods must be specified without ambiguity.

C The impact of reduced Commonwealth funding for health promotion, prevention and early intervention

The *Australian National Oral Health Plan 2004-2013*²⁶ noted the importance of oral health promotion in improving oral health and the ADA endorses that statement. Health promotion, prevention and early intervention in oral health care are very effective when tailored to meet the needs of particular groups within the community and are population and scientifically based. For example in line with current research,²⁷ the ADA has always advocated that the public needs better information on the oral health risks of sugary foods and drinks as well as tobacco and alcohol use. The ADA's position is that dietary and lifestyle education, a major preventative measure in oral health care, should be targeted to specific high risk groups such as parents of infants and babies, children and young adults, and the elderly. This is and should be a focus of oral health campaigns.

Another essential aspect of improving oral health is early intervention. Studies support the efficacy of oral health promotion, particularly among expectant mothers and parents of infants.²⁸ Parents should be encouraged to take their infants and young children to the dentist. The ADA recommends that the first dental visit should occur when a baby's first tooth becomes visible or they reach 12 months of age.²⁹ It is essential that the community is well informed about the importance of early intervention and primary care from a dentist in maintaining good oral health.

The addition of fluoride to reticulated water systems is also an essential feature of Australia's prevention against poor oral health. Fluoridation of reticulated water supplies is the most cost effective, equitable and efficient measure for controlling dental disease. This simple and cost effective preventative measure must be a fundamental and integral part of Australia's

²⁶ National Advisory Committee on Oral Health: *Healthy mouths Healthy lives: Australia's National Oral Health Plan 2004-2013* available at <http://oralhealthplan.com.au/sites/default/files/oralhealthplan-1.pdf> accessed 13 August 2014

²⁷ Moynihan, P.J. and Kelly, S.A.M. "Effect on Caries of Restricting Sugars Intake. Systematic Review to Inform WHO Guidelines" *Journal of Dental Research* January 2014 vol.93no. 1 (8-18)

²⁸ Plutzer, Kamila and Spencer, A. John. "Efficacy of an oral health promotion intervention in the prevention of early childhood caries" *Community Dentistry and oral Epidemiology* Vol36 (4) (August 2008) p 335-346

²⁹ Australian Dental Association Babies and Toddlers *When should my child first see the dentist?* available at http://www.dentalhealthweek.com.au/downloads/DHW_factsheet_BabiesandToddlers_Seeingthedentist.pdf



oral health policy. Legislation should be introduced which requires local Councils to introduce and maintain fluoride levels in reticulated water.

As announced in the Budget 2014-15, essential functions of the Australian National Preventative Health Agency (ANPHA) have been transferred to the Department of Health. The ANPHA was established on 1 January 2011 to provide a national driver of preventative health policy and programs. The ADA is unsure at this stage what the effect of this change will be on health promotion, prevention and early intervention and is concerned about the potential loss of a united message on oral health promotion. However, it is encouraging that many States and territories already have in place strong oral health promotion resources and strategies.³⁰

The ADA supports the idea of a specialised Commonwealth agency driving health promotion, prevention and early intervention. However in regard to ANPHA, the ADA was concerned that it did not adequately incorporate oral health messages into its initiatives. An expert in oral health was not included on any of the expert reference groups established by ANPHA and generally there was a lack of oral health messages in ANPHA initiatives. It was and remains a concern to the ADA that previous requests to partner with Australian Government on oral health promotion campaigns have been ignored.

Further, it is a concern to the ADA that previous funding and promotional plans have been unallocated or simply not acted upon. An example is the *National Oral Health Promotional Plan*. The previous Australian Government allocated \$15m for a period of three years from the 2012-2013 Budget towards national oral health promotion activities.³¹ A committee of experts was established to formulate plan to allocate the funding. The *National Oral health Promotional Plan* was prepared however this plan was never released and the funding never allocated.

It is hoped that within the Department of Health, the focus upon health promotion, prevention and early intervention will be renewed and continued.

³⁰ Rogers, J.G. *Evidence-based oral health promotion resource*. Prevention and Population Health Branch, Government of Victoria, Department of Health, Melbourne 2011 available at [accessed 13 August 2014](#). Centre for Oral Health Strategy: *Oral health 2020: A Strategic Framework for Dental Health in NSW* available at <http://www.health.nsw.gov.au/oralhealth/Publications/progress-on-oral-health-2020.pdf> accessed 13 August 2014. SA Dental Service *South Australia's Oral Health Plan 2010-2017* available at <http://www.sadental.sa.gov.au/Portals/57ad7180-c5e7-49f5b282-c6475cdb7ee7/state-oral-health-plan-2010-2017.pdf> accessed 13 August 2014.

³¹ Australian Government Health and Ageing 2012-2013 Budget at a Glance available at <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2012-glance.htm> accessed 5 September 2014.



Recommendation C

It is noted that ANPHA has now been disbanded and essential features have been transferred to the Department of Health. The Australian Government should undertake a review to ensure that the Department of Health has:

- (i) capacity to assume the role of ANPHA;***
- (ii) an appropriate strategy to ensure a united voice on health promotion, prevention and early intervention; and***
- (iii) an appreciation of the importance of oral health in in all aspects of overall health promotion, prevention and early intervention.***

D The interaction between elements of the health system, including between aged care and health care

The elderly comprise one of the groups “at risk” from oral disease, particularly those resident in aged care facilities. While the elderly are today less likely to be edentulous (complete tooth loss)³² and more likely to retain their natural teeth,³³ the incidence of oral disease is a serious concern. The elderly face considerable challenges when it comes to receiving routine dental care. The elderly can have teeth with large fillings, teeth which are covered in crowns or bridges or teeth which are generally badly broken down. Natural teeth require more care than dentures, though dentures also pose problems for the elderly. Poor oral health can lead to difficulty in maintaining a nutritious diet, exacerbate other chronic medical conditions and impact upon the overall enjoyment of life. The issue of the access to oral health care is one that will affect a growing number of people.

The oral health care of the elderly requires a multifaceted approach from the health sector. While some elderly Australians reside in aged care facilities, the majority of Australia’s elderly reside in the community and with support wish to remain living independently. The oral care which is delivered to the elderly therefore needs to be tailored to specific circumstances, including the financial circumstances of the elderly concerned.

³² Overall there has been a significant decrease in the number of Australians who are edentulous. In 2010 the proportion of people over 15 years who were edentulous was 5.2%, down from 14.4% in 1988. Those aged 65 years and over had the highest proportion of complete tooth loss at 21.1%. See further: Christopoulos S & Harford JE 2013. *Oral health and dental care in Australia: key facts and figures 2012*. Cat. no. DEN 224. Canberra: AIHW.

³³ In 1979, 40% of Australians 75 years and older had retained some natural teeth. In 2004-2006 this proportion had increased to 64%. AIHW Dental Statistics and Research Unit 2007. *Australia's dental generations: the National Survey of Adult Oral Health 2004-06*. Dental statistics and research series 34. Cat. no. DEN 165. Canberra: AIHW. Available at <http://www.aihw.gov.au/publication-detail/?id=6442467953> accessed 14 August 2014.



Approximately 72% of Australians aged 65 years and over hold a concession card and are eligible for public dental care. Public dental programmes must be funded to ensure timely and adequate access. Without proper funding, appropriate care is simply not available to many elderly, particularly in regional and remote areas and otherwise preventable conditions significantly worsen. As a group, the elderly comprise one of the highest groups of Australians being admitted to hospital due to dental issues.³⁴

The Australian Government should formulate health policy concerning the care of the elderly which promotes an integrated approach across all areas of the health sector. Doctors and dentists should be encouraged to work together as team leaders to ensure optimal health for the elderly. All healthcare professionals should be adequately trained in the specific health needs of the elderly including in particular carrying out screening and educating the elderly to carry out at home maintenance of teeth and gums.

Recommendation D

The Australian Government must provide enhanced levels of funding to ensure that timely and adequate access to public dental care programmes are available for the aged.

As far as residents in aged care facilities, it is suggested that the following procedures should be instituted to assist in the care of the elderly:

- i. where possible, oral health care delivery should take place in dedicated dental surgeries;***
- ii. alternatively, specialised treatment rooms including x-ray machines and other complex and non-transportable equipment should be made available for health practitioners including dentists to treat patients in aged care facilities;***
- iii. oral health education should be compulsory for all professionals treating the aged and this should include:***
 - an oral health assessment on admission;***
 - oral health screening at regular intervals thereafter; and***
 - a daily mouth care plan.***

³⁴ Oral health and dental care in Australia: key facts and figures trends 2014. op cit



- iv. *oral health plans recognising the importance of early intervention in oral health care of the elderly should be developed at all aged care facilities;*
- v. *under graduate dentistry should include a specialised unit on the oral health requirements of the elderly in aged care facilities.*

The oral health care of the elderly in the community should also be a special focus for policy makers. All health care professionals should be adequately trained in the specific needs of the elderly. Oral health screening should be carried out as an important part of general health checks. Funding should be provided for fully equipped, comprehensive mobile dental teams to provide screening and treatment for the elderly or where practical, transport to local dental facilities.

The ADA has formulated policies on the delivery of oral health care to the elderly. They are available at www.ada.org.au.³⁵

E Improvements in the provision of health services, including Indigenous health and rural health

Oral health amongst Indigenous Australians in remote and very remote communities is significantly worse than in regional and metropolitan areas. As Australians in these communities tend to be from a lower socioeconomic background, governments should provide more resources into ensuring that adequate levels of funding are available to operate public dental programmes. Unfortunately past government policies and programmes have not always been given consistent and continued levels of funding. This is not a policy approach which will deliver optimal oral health outcomes.

Specifically, in relation to Indigenous health, the former Prime Minister's *Closing the Gap Report* 2013 outlined many of achievements in the oral health of Indigenous Australians.³⁶ It demonstrates that tangible approaches can result in improvements in oral health. These measures included the placement of an additional 137 dental staff in remote communities, the increased delivery of dental services to Indigenous children and the implementation of the *Stronger Futures* programme which focused on prevention measures, namely the use of

³⁵ Specifically refer to ADA Policies and Guidelines: Policy Statement 2.3.3 *Delivery of Oral Health Care: Special Groups: Aged Persons* available at http://www.ada.org.au/app_cmslib/media/lib/1401/m725890_v1_policystatement_2.3.3_agedpersons.pdf

³⁶ *Closing the Gap: Prime Ministers Report* 2013 available at http://www.dss.gov.au/sites/default/files/documents/02_2013/00313-ctg-report_fa1.pdf accessed 26 August 2014



fluoride varnish and fissure sealants. The ADA supported these and other measures, however we urged the then Australian Government to ensure a more comprehensive level of treatment to Indigenous Australians and also recommended the funding of fully equipped, skilled, trained and experienced mobile dental teams to ensure access for indigenous Australians.

These recommendations remain as the ADA's preferred option. In addition, ADA's policy on the delivery of oral health care to Indigenous Australians calls for a Australian Government approach focused broadly on three main areas:

- i. **research** is essential to Indigenous oral health and it must always seek a better understanding of the issues;
- ii. **oral health promotion and prevention strategies** including primary oral health care need to be integrated within targeted community controlled health services; and
- iii. **the delivery of oral health care** needs to be affordable, culturally and emotionally appropriate including an increase in the recruitment and training of Indigenous Australians in oral health delivery.

Policy focused on the above areas will result in improvements in the provision of oral health services to Indigenous Australians.

In relation to Australians living in rural communities, ADA has two policies which are available to guide optimal oral health delivery in remote and very remote areas.³⁷ While Australians living in these communities may have some difficulty in accessing oral health care due to distance, transport or financial difficulties, with Australian Government support these challenges can be overcome and improvement in oral health delivery will result. The ADA suggests oral health policy for remote Australians which focus on the following:

- i. **oral health promotion including preventative measures** most importantly an increase in the fluoridation of remote and regional water supplies;
- ii. **delivery of oral health care** including specifically formulating and properly funding programmes, including if necessary mobile dental teams, which provide fair access to

³⁷ ADA Policies and Guidelines: Policy Statement 2.3.4 *Delivery of oral health Care: Special groups: Individuals in Regional and remote areas* available at http://www.ada.org.au/app_cmslib/media/lib/1401/m725894_v1_policystatement_2.3.4_individualsinregionalandremotearreas.pdf and Policy Statement 2.3.7 *Delivery of oral health care: Special groups: Individuals unable to visit dental clinics* available at http://www.ada.org.au/app_cmslib/media/lib/1401/m725894_v1_policystatement_2.3.4_individualsinregionalandremotearreas.pdf



dental care to Australians living in remote communities and encouraging dentists to locate their practices in these communities;

- iii. **research** on the oral health and oral health needs of Australians living in remote and very remote areas.

Recommendation E

In order to achieve improvements in oral health care delivery to Indigenous Australians and Australians living in remote and very remote communities, ADA's recommendation can be summed up in three words; research, promotion and delivery. Research must guide every programme and results should be regularly evaluated. Oral health promotion is essential, particularly emphasising increased fluoridation in remote water supplies. Finally, delivery is the next essential focus. Qualified dentists must be supported to provide early and regular primary dental care wherever needed and Australians must be supported to access it.

F The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

The integration and coordination of the various components of the health sector is essential to the treatment of chronic disease in Australia. Risk factors for oral disease are also risk factors for other medical conditions. Adopting a collaborative approach is more rational than one that is disease specific. The recommendations that have been made at point D above, also apply to the better integration and coordination of health care delivery.

G Health workforce planning

Ensuring that the health workforce is of appropriate size and mix and adequately distributed is critical to achieving a sustainable health system. To do this, Australia needs a coordinated, national approach to educate, train, recruit and retain a sufficient number of health workers to meet the needs of an ageing population with increasingly complex health problems.

Under the auspices of Health Workforce Australia (HWA), a national workforce statistical data base was set up to capture health workforce data on all registered health professions to improve workforce planning capability. However with the abolition of HWA, national health workforce planning has been put at risk.



Before they closed, HWA had been undertaking a comprehensive supply and demand study of the oral health workforce.³⁸ While the report is not yet released, it indicates that there will be an increasing projected oversupply of the oral health workforce to 2025 which was as far as HWA projected.

There is evidence from around the world that demand for oral health care has been falling. In the absence of public funding to assist deserving target populations the dental workforce will wither and many practices will collapse. This will compromise the opportunity and ability of the high workforce capacity available to improve the oral health of the Australian Community any further. Urgent action is also necessary to restrict overgrowth of the dental workforce particularly through overseas qualified dentists. The occupation of dentist must be removed from the Skilled Occupation List as a matter of urgency. It has become very difficult for Australian graduates to find fulltime employment in dentistry.

In the absence of reports as the HWA report, reactive government policy decisions are being made based on out- of- date workforce data. It is therefore essential that every effort be made to ensure that the progress made by HWA on national health workforce planning capacity not be lost.

Recommendation G

Australian Government undertake a review to ensure that suitably qualified policy makers are aware of the importance of policy workforce data being used as a basis for the formulation of health workforce.

Recommendation H

That the occupation of dentistry be removed from the Skilled Occupation List.

³⁸ Health Workforce Australia defined the oral health workforce as including dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists.



Conclusion

The ADA is happy to expand on any of the matters raised in this submission. Please do not hesitate to contact Mr Robert Boyd Boland at _____ should you have any queries.

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15 September 2014