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Hon Jill Hall MP
Chair
Standing Committee on Health and Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600
Email: haa.reps@aph.gov.au

Dear Ms Hall,

We appreciate the opportunity to make a submission to the Commonwealth Parliamentary Inquiry into Adult Dental Services. Our submission addresses Terms of Reference 1–4 and 6.

Our main points are:

1. Both the demographic and epidemiological changes will place significant ongoing pressure on the dental care system for the near future.
2. There are ongoing financial and other barriers to accessing timely, appropriate dental care that fall disproportionately on adults with low income, older, especially frail adults, people with a disability and those living in rural and remote areas.
3. Despite expected rapid growth in the number of dental practitioners, these inequalities in access are expected to persist without active support for services in currently under-served areas.

However, there are a suite of known preventive and dental service actions that can be taken to alleviate these problems and contribute to reduced inequalities in oral health and improved oral health overall. These are outlined in more detail in our attached submission.

Yours sincerely

Professor Kaye Roberts-Thomson
Director,
Australian Research Centre for Population Oral Health

Professor Marco Peres
Director
Australian Research Centre for Population Oral Health

Summary of key issues and recommendations:

Demand

Demand for dental care has increased since 1979 and is projected to continue to do so with ongoing population ageing and increased retention of teeth.

Demand reflects ability to pay and is weaker for those without the means to pay, either directly or through dental insurance.

Coverage

Overall, the majority of dental care costs are borne by the individual, in contrast to medical care costs, which are borne publicly.

People using public dental services have longer waiting times which leads to more problem-oriented visits, and ultimately, greater tooth loss.

Special needs groups

Indigenous Australians, older Australians and those with a disability, all experience both poor oral health and poor access to care.

Regional availability

Australians in rural and remote areas are less likely to visit a dentist, and when they do visit, it is more likely to be for a problem. While urban-dwelling Australians have made gains in dental visiting since 1994, their rural and remote counterparts have not enjoyed significant improvements.

Workforce

The distribution of the dental labour force is heavily skewed in favour of metropolitan areas. Ongoing debate about the appropriate balance between dental professional groups and the best use of their skill mix continues.

Recommendations

Expanded support for oral health promotion, continued progress towards a system of universal dental care and development of workforce options all require attention to address the growing demand for dental care in the future and to address poor oral health outcomes, especially for those dependent on public dental care.

All Australians, but especially those with special needs, can benefit from tailored health promotion efforts and expanded dental care options, including the use of the full skill set of all dental professionals.

Work continuing to support dental professionals to work in rural and remote areas, as well as underserved urban areas, needs to continue and be strengthened. Where professionals do work in these areas, they need to be supported to maximise the use of their skill set.

Submission from Australian Research Centre for Population Oral Health to House of Representative Standing Committee on Health and Ageing Inquiry into Adult Dental Services

Oral health is an integral aspect of general health and good health does not exist without good oral health. Oral diseases are largely preventable, and when they occur, interventions are available to limit their progress, alleviate pain and suffering, and restore function. Therefore, better oral health should be a significant public health goal and good dental care should be a significant health service goal. Inequalities in oral health in Australia are magnified by unequal access to dental care. An urgent priority for improving the oral health of Australian adults and reducing inequalities in oral health among Australian adults is to address the current high levels of inadequate access to dental care. This submission addresses Terms of Reference 1–4 and 6 in relation to this urgent problem.

Terms of Reference 1: Demand for dental services across Australia and issues associated with waiting lists

Demand for dental care reflects people's want or desire for dental care and willingness to pay at market prices. Demand is expressed through the use of dental services and hence can be measured in dental visits made, and services received, in a year.

Total per capita demand for dentate persons increased substantially between 1979 and 2005, from 0.99 to 1.51 dental visits per year. Demand for dental visits by edentulous persons has also increased over this period, from 0.30 visits per edentulous person in 1979 to 0.67 in 2005 (1). There has been a dramatic reduction in the prevalence of edentulism with the percentage of edentulous persons in the population decreasing from 15.4% in 1979 to 5.9% in 2008 (2, 3).

Demand for dental care is also influenced by dental insurance status, with insurance acting as an enabling factor in access to dental care. In 2008, 48.4% of Australians held dental insurance. Insurance coverage was higher among the dentate population than those who were edentulous (50.0% compared to 22.8%). Per capita demand rates for dentate persons were substantially higher for insured persons in all age groups (1).

Projected demand for dental care between 2005 to 2020

Between 2005 and 2020, the overall population is expected to increase by 16.6% and consequently, per capita demand for dental care is also expected to increase. In addition, with regard to population growth and demographic changes, the number of edentulous persons is expected to decrease by 1.4%, while the number of dentate persons is expected to increase by 18.3%. The increase in tooth retention in an older population will result in a higher prevalence of periodontal disease as well as more teeth with a history of decay that will need to be maintained. In turn, this will result in an intensification of service delivery, particularly for diagnostic, preventive and restorative services (4).

Perceived need

Perceived need for dental treatment is a predictor of the use of dental services. A larger proportion of cardholders reported a perceived need for treatment than non-cardholders, particularly the need for fillings and extractions. The same trend was observed among the uninsured population compared to those with insurance. The number of dentate adults perceiving a need for dental treatment has increased over time, from 21.9% in 1994 to 46.2% in 2008. During this period, an

increased trend in perceived need was observed for cardholders (from 27.7% in 1994 to 52.6% in 2008) and for the uninsured population (from 25.5% in 1994 to 50.9% in 2008) (3, 5).

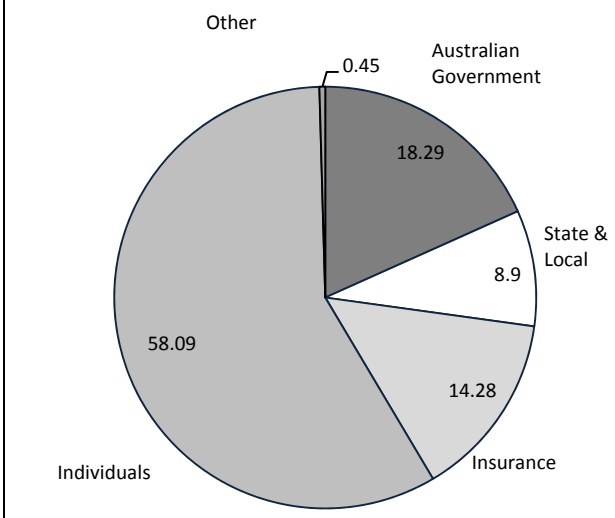
Recommendations:

- Strengthen and support oral health promotion activities that address the twin challenge of epidemiological and demographic change.
- Continue to explore dental workforce options to address the changing oral health needs of the population.
- Continue progress towards the long-term goals of universal dental insurance as recommended by the National Health and Hospitals Reform Commission (6) and the National Advisory Council on Dental Health (7).

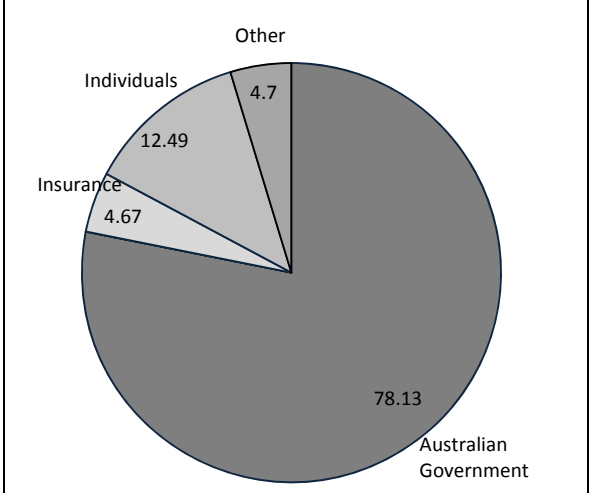
Terms of Reference 2: The mix and coverage of dental services supported by state and territory governments

Despite there being identical constitutional provisions for Commonwealth government financing of dental care as for medical care, paying for dental care in Australia remains largely up to the individual patient. This is in distinct contrast to medical services, for which the bulk of expenditure is borne by the Australian government. Australians who visit a dental practitioner contribute almost 60% of the cost of care out of their own pocket. However, they contribute around 13% of the cost of a visit to a medical practitioner. At the same time, the public subsidy for these visits is almost 80% for medical care, but a mere 25% for dental care.

Dental services 2010–11



Medical services 2010–11



Source: AIHW 2012

When public dental services are available, there are generally long waiting times for care. Even in jurisdictions that have short average waiting times, there are groups who are subject to long waiting times, such as people living in rural and remote areas. These long waiting times drive key inequalities in oral health through high tooth extraction rates (7). People who visit for a problem, or who visit a public dental clinic, are more likely to have an extraction than those who visit for a check-up or attend a private dental clinic. People who visit a public dental service are twice as likely to receive an extraction as those who visit a private practice, and those who visit for a problem are five times as likely as those who visit for a check-up. A key driver of high extraction rates for visits to public dental services is long waiting times leading to increased likelihood of visiting for a problem and receiving an extraction. Even small differences in rates of extraction in any time period can result in large differences in tooth loss over a lifetime. The lack of public support for dentistry, and resultant long waiting times, is a key driver of inequalities in oral health in adulthood, especially regarding inequalities in tooth loss.

Recommendation:

- Continue progress towards the long-term goal of universal insurance for dental services as recommended by the National Health and Hospitals Reform Commission (6) and the National Advisory Council (7).

Terms of Reference 3: Availability and affordability of dental services for people with special dental health needs

A number of groups have been identified as having either greater or particular needs for oral health services. These needs are related to the issues such as disability, social disadvantage, social isolation and life stage.

3.1 Indigenous Australians

Aboriginal and Torres Strait Islander Australians face multiple disadvantages which lead to poor oral health, and also to poor access to dental care. Indigenous Australians have around five times the prevalence of dental disease experience than non-Aboriginal Australians (8, 9), and profound oral health inequalities have been noted (10) There are high levels of periodontal disease (11), particularly given the links between periodontal disease and a range of chronic conditions such as diabetes, cardiovascular disease and kidney disease. Whilst improvements in many areas of Aboriginal health have been noted, the oral health of this vulnerable population is decreasing (12).

For the most part, oral health services tend not to be culturally appropriate and often ignore the Indigenous understandings of health. The current lack of Indigenous dental professionals, poses a problem given many Indigenous people may be more likely to visit an Indigenous dentist (13). Currently, training in cultural sensitivity is not comprehensive and there is limited support in providing a more appropriate service for Indigenous patients (13); however, culturally sensitive services have increased acceptance and improved attendance rates (14).

Recommendations:

- Better working professional support, long-term sustainable funding, professional development opportunities, and accommodation support for those working in rural and remote areas.

- Making services more culturally appropriate (or making staff more culturally competent).
- Expanding community–level fluorides including water fluoridation.
- Mandatory inclusion of oral health screening in diabetes, obesity, maternity, alcohol and drug programs.
- Support for preventive measures – affordable healthy food, toothbrushes and toothpastes.

3.2 Older people in the community and residential care

The Australian population is ageing. It is projected that the Australian population will continue to age rapidly until 2021. Many older adults are in poor oral health with high rates of inadequate natural dentition (less than 21 teeth), untreated decay and periodontitis (15).

The oral health among older adults in residential aged care facilities (RACFs) is even poorer than their community-dwelling peers (16). With high levels of uncontrolled oral diseases and conditions, including denture-related oral mucosal infections, and exceedingly high levels of dental plaque, dramatically increases the risk of aspiration pneumonia, periodontal disease (gum disease), caries (tooth decay) on the coronal and/or root surfaces and xerostomia (17-20).

It is estimated that 90% of frail community-dwelling older people had unmet dental care needs with an average cost of needed care of $1,069 per person 'Improving Oral Health for Frail Community Living Older People' (21). A high level of need is also evident in nursing home residents (18).

Despite their high dental needs, older adults have great difficulties in accessing affordable and timely dental care. Population ageing will cause a rapid growth in people eligible for public dental care. As those who become eligible are carrying a lifetime of accumulated dental problems, the average need of public dental patients will increase. Even those who are eligible for public dental care face barriers, such as long waiting times. Community-dwelling older adults have low rates of dental visiting and high rates of visiting for a problem rather than a check-up (22). While some of this is accounted for by lack of affordability, other barriers also play a role.

Recommendations:

- Wider use of all dental practitioners in home and aged care facilities.
- Multidisciplinary collaborations with the non-dental health workforce especially in prevention and screening.
- Support for aged sector-wide adoption of the 'Oral Health Assessment Tool', which has been demonstrated to improve oral health outcomes, but is not widely used.
- Strengthening current accreditation standards to support assessment and care planning for oral health and the implementation of these care plans in aged care facilities.
- Greater employment of mobile dental clinics and dental equipment in providing services to aged care residents with mobility and transport issues.
- Support for multi-purpose treatment facilities in residential accommodation that can support dental care as well as a range of other treatment needs.
- A strategy to educate the dental and non-dental workforces in managing aged care.

3.3 Homelessness

There are many causes of homelessness affecting a range of people. Homelessness includes: those without shelter; people that are forced to stay with friends, relatives and in hotels; and those who

live in boarding houses and caravan parks with no private facilities or lease. These circumstances make it very difficult for people to be employed or lead a healthy and stable life. Dental survey data does not collect visiting patterns and oral health status on homeless Australians. Given the broader concession card holder arrangements and the large eligible population, homeless people are likely to be eligible for these services. However, it may be difficult for dental services to reach these people for a range of reasons, including the lack of a fixed address.

There is no national data on the oral health of homeless persons; however, a recent Adelaide study showed that homeless adults reported poorer oral health and higher rates of smoking than the general population. They also have lower rates of dental visiting, fewer check-ups and very high rates of avoidance of dental care due to cost, as well as a very high perceived need for fillings or extractions. Three times as many homeless adults rated their oral health as 'fair' or 'poor' (23).

Recommendations:

These population groups not only face barriers accessing dental services but also have difficulty accessing other health services. This will require strategies for marshalling social assets in the community, e.g. the Medicare Locals, the Local Hospital Networks, Community Health Services, and non-government organisations. It is suggested that incorporating oral health promotion, and preventive and treatment programs within broader health programs designed specifically for this marginalized population, will have the most impact.

3.4 People with disabilities

There is no national data on visiting patterns and oral health status of Australians with disabilities. However, people with disabilities in the community face significant access barriers which vary greatly in scope and complexity, including lack of dental professionals skilled in caring for patients with these special needs; the cost of dental treatment; inconvenient location of dental clinic; lack of dentists willing to treat people with disabilities; and transport difficulties. These problems are most acute for people living in the care of their families (24).

Recommendations:

- Develop specific programs designed to meet needs of this group, including co-ordination of services through new and existing social assets and systems of service.
- Wider use of all dental practitioners in family homes, community housing and institutions for disabled people.
- Development of education and information to assist dental practitioners in working with various disabled people.
- Ongoing support for carers to deliver oral hygiene care for disabled people.
- Support for multi-purpose treatment facilities in residential accommodation that can support dental care as well as a range of other treatment needs.

Terms of Reference 4: Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

The distribution of the dental labour force in Australia is heavily skewed in favour of metropolitan areas (See Terms of Reference 6). Across remoteness areas, adults who live in a major city are more

likely to visit a dentist, more likely to visit for a check-up and more likely to visit a private practice than those in other areas (25). Overall, they are more likely to have a favourable dental visiting pattern (usually visit at least once a year), usually visit for a check-up, and have a regular source of dental care, than in other areas (25). At the same time, living in a major city means having more preventive services than living in other areas (25). These current differences are not explained by reported experience of financial barriers to dental care, however, adults who live outside of major cities are less likely to have private dental insurance, and the gap between urban and rural/remote dwellers insurance coverage increased between 1994 and 2008 (26). In addition to falling behind on insurance coverage, rural and remote dwellers have not made other gains in dental visiting than their urban counterparts have enjoyed. Urban-dwellers have had a 20% increase in visiting for a check-up between 1994 and 2008, and non–urban-dwellers experienced a 90% increase in reporting that dental visits were a large financial burden (26).

The disadvantage in visiting for rural and remote adults is reflected in their oral health. Adults who live outside capital cities are more likely at all ages except the oldest to have had all of their teeth extracted, and more likely to have insufficient teeth for good oral function (27). They are also more likely to have dental care needs unmet; for example, almost 50% more likely to have untreated dental decay (27).

A key challenge for addressing the urban rural gap is to continue the work of improving availability of dental care in rural areas. In addition, lower rates of insurance coverage in rural areas means that there is a need for financing mechanisms for dental care so that affordability does not become a growing barrier for rural dwellers.

Terms of Reference 6: Workforce issues relevant to the provision of dental services

There are two key workforce issues that reduce the impact of the dental labour force on the oral health of Australians:

6.1 Despite the projected growth in the overall dental labour force, an unequal distribution of dental professionals that currently exists is unlikely to be ameliorated without significant policy action. The supply of all registered dental professionals is unevenly distributed across geographic regions. The supply of dental practitioners is highest in major cities (64.1 per 100,000) and lower in all other areas. The pattern is similar for dental hygienists, but less pronounced for dental prosthetists and oral health therapists. The exception is dental therapists, where major cities have the lowest number per 100,000 (28).

In addition to the geographic imbalance, there is an imbalance between the public and private sectors with public dental services unable to recruit and retain practitioners in proportion to the size of the eligible population.

6.2 There is an ongoing debate about the appropriate balance between registered dental professional groups and best use of skill mix they possess. In particular, little is understood about the practice patterns of the emerging oral health therapist group. As the non-dental oral health professions have been identified as key in addressing the oral health needs of Australians, particularly people with special needs, better understanding of the potential roles of these groups and the appropriate skill mix for these roles is essential.

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