Public Health Association
AUSTRALIA

Public Health Association of Australia submission on the Provision of and Access to Dental Services in Australia

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Introduction

PHAA welcomes the opportunity to provide input to the Senate Select Committee for an inquiry into the Provision of and Access to Dental Services in Australia. Many of the issues regarding oral health are stated in our Oral Health Policy (attached). Therefore, our response will address specific topics from the Terms of Reference.

PHAA response to the Inquiry on the Provision and Access to Dental Services in Australia

Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services.

The PHAA recognises that the COAG Health Council's National Oral Health Plan 2015-2024 made recommendations regarding national leadership. It articulated that:

"National leadership is required to guide and inform the development, implementation and evaluation of oral health policy and programs and to oversee the integration of oral health and general health programs across sectors, jurisdictions, and delivery settings. The promotion of inter-sectorial collaborations at policy, program and care delivery levels will be particularly important across the four Priority Population groups. Examples include the disability, mental health, and aged care sectors as well as Aboriginal and Torres Strait Islander communities. The appointment of an Australian Chief Dental Officer who is supported by a broadly representative National Oral Health Advisory Committee could take on the responsibility for providing this leadership and overseeing this work.[1]"

The four Priority Populations include1:

- People who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander People
- People living in regional and remote areas
- People with additional or specialised health care needs

It is, therefore, imperative that directions to improve oral health are supported by national leadership through the appointment of Australia's first Commonwealth Chief Dental Officer.[2] As an example, dental services to meet consumer needs can only be provided when the regional and remote areas oral health workforce is adequate. However, there is no determination from the federal or state governments to support the training of the rural oral health workforce. Ironically, metropolitan dental schools receive the Dental Training Expanding Rural Placements funding to provide rural placements to metropolitan-based students who are less likely to live and work in rural areas, while rural dental schools do not get funding through the Dental Training Expanding Rural Placements when their placements are predominantly rural. Some people might argue that rural schools that have University Departments of Rural Health receive RHMT funding, but Rural Health Multidisciplinary Training funding is for all allied health disciplines and is not dentistry specific.

The PHAA is an active member of the National Oral Health Alliance and has provided leadership in matters related to national oral health policy. This has included four key recommendations:

- Appoint Australia's first Commonwealth Chief Dental Officer,
- Implement the oral health recommendations by the Royal Commission into Aged Care Quality and Safety, including the establishment of the Seniors Dental Benefits Scheme,
- Commit to increased funding by the Commonwealth government for public dental services (initially $500 million annually), and
- Engage NOHA with Australia's National Oral Health Plan 2025-2034.

It remains illogical and unreasonable that essential oral healthcare remains separate from Medicare. This disconnect continues to exacerbate barriers to innovation in healthcare reform and the importance of oral health from a common risk factor approach articulated in the National Preventive Health Strategy 2021-30.[3] Dental practitioners can take a significant role within primary healthcare such as conducting general health screening and vaccination programs. Likewise, registered non-dental professionals with appropriate training, can provide preventive oral healthcare services and oral health screening programs to facilitate high-quality, person-centred and values based, culturally appropriate, safe, affordable, timely and cost-effective oral health care.

Non-registered non-dental professionals can also play a pivotal role in achieving the goal of improving oral health outcomes in Australia. This is recognised by the Royal Commission into Aged Care Quality and Safety by the recommendations made regarding oral health. The five recommendations include:[4]

- Recommendation 19: Urgent review of the Aged Care Quality Standards, in particular best-practice oral care, with sufficient detail on what these requirements involve and how they are to be achieved.
- Recommendation 38: Residential aged care to employ or retain at least an allied health professional, including oral health practitioners.
- Recommendation 60: Establish a Senior Dental Benefits Scheme (SDBS) for people who live in residential aged care or in the community.
- Recommendation 79: Review Certificate III and IV courses to consider including oral health as a core competency.
- Recommendation 114: Immediate funding for education and training to improve the quality of care, including oral health.

Of particular note, the PHAA acknowledges that Recommendation 60, which is to establish the SDBS, is being considered by the Australian government. To that end, the PHAA has sought consultation with regards to a proposed framework for universal access to affordable oral healthcare, which is applied to the recommendation on the SDBS, noting it would be practical for a staged approach required to achieve it.

The proposed framework for SDBS is designed within the context of the Australian healthcare system and adheres to international oral health policy directions. Although it does not specify the exact funding requirements to implement it, the proposal articulates important components that are necessary for funding considerations. Emphasis is given to timely prevention and early intervention, and effective and cost-effective oral health interventions. Broadly, additional funding sources to support the roadmap towards universal access to affordable oral healthcare would consider:

- Raising the Medicare levy, perhaps by 0.75% of the taxable income as previously suggested by the National Health and Hospitals Reform Commission,[5]

- Redirected revenue generated from the implementation of a sugar-sweetened health levy, which has shown direct reductions in obesity[6] and dental caries (tooth decay)[7] and promotes health equity,[8] and/or
- A staged withdrawal of $775 million spent on private health insurances subsidisation for dental services.[9]

Proposed Framework for the Universal Access to Affordable Oral Healthcare an example applied to the recommendation on the SDBS

Good oral health is fundamental to overall health and wellbeing at all stages of life. Oral diseases and conditions are mostly preventable or treatable, yet older people often do not receive the necessary routine care to maintain good oral health, particularly those living in residential aged care facilities. The neglect of oral health constitutes a failure of global health policy and a failure to deliver the basic human rights of older people.[10]

Oral health needs to be accepted as an intrinsically important aspect of health, particularly among older adults due to higher unmet needs. The World Health Organization (WHO) defines healthy ageing as, "the process of developing and maintaining the functional ability that enables wellbeing in older age".[11] An appropriate framework and implementation of the SDBS would help to meet the WHO requirements for healthy ageing and facilitate steps towards the achievement of universal access to affordable oral healthcare in Australia. The SDBS should conform to the Principles of Care[12] articulated by the Australian Commission on Safety and Quality in Health Care under the four pillars of focus:

- Person-centred care
- Multidisciplinary care
- Carers and family members
- Integrated approach to care

The provision of oral healthcare has historically been an implied joint responsibility of the Commonwealth government and the state/territory governments. However, it is ultimately a Commonwealth responsibility for health, including oral health, and therefore Commonwealth leadership needs to appropriately fund medically necessary, clinically appropriate and cost-effective oral healthcare. It must consider the current policy environment of government subsidisation of private health insurance and the Federal Financial Agreement for public dental services with the state/territory jurisdictions. Although subsidisation of private health insurance for dental services may be beneficial, it does not target populations with the highest oral health needs. Redirected funding from this Government funding pool would directly support approximately 775,000 Australians with the highest oral health needs.

The WHO defines essential oral healthcare as 'a defined set of safe, cost-effective interventions at individual and community levels that promote oral health and prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral.[13]'

Essential oral healthcare, which should be made available for everyone regardless of the ability to pay, should be funded and implemented under the Health Insurance Act 1973. This formally recognises the importance of oral health in primary healthcare and offers strategic opportunities to strengthen and integrate oral health with the broader non-dental health profession. In addition, funding essential oral healthcare within the Health Insurance Act 1973 facilitates the same rigorous process of health technology

assessment, which is applied to the Medical Services Advisory Committee and the Pharmaceutical Benefits Advisory Committee, to be applied to dentistry. It also allows for consumer financial protection for health benefits under the Medicare Safety Nets to facilitate ongoing preventive oral healthcare, which currently is a limitation for the Child Dental Benefits Schedule. Under the Health Insurance Act 1973, dental services should include:

1. An oral health assessment conducted by a registered dental practitioner for every resident entering residential care to inform and optimise their oral hygiene measures. All older adults should have an appropriate oral health care plan and referral pathway identified for them, whether they are community-dwelling or living in residential care.
2. Routine and preventive oral healthcare to promote timely and early detection of oral disease and cost-effective interventions to stabilise or prevent oral disease progression, at least once every two years.
3. Additional loading for essential oral healthcare to encourage access and uptake to dental services in regional and remote areas.

The costs for dental treatment are significant and would require a fiscal economic approach to ensure dental services provided are timely, clinically relevant, and appropriate. These dental services can be funded under the Dental Benefits Act 2008, which is reviewed every three-years to ensure the scope of dental services meet the dynamic community oral health needs. The following should be funded via the Dental Benefits Act 2008:

1. Limited essential curative oral healthcare to promote best practice approaches to manage and treat more severe stages of oral disease, including urgent and timely access to dental treatment for causes of oral pain and discomfort.
2. Limited rehabilitation oral healthcare to preserve or to improve oral function and quality of life, for example through the fabrication of a removable prosthesis (partial or full dentures).

It is important to note that there are individuals who have greater oral health needs, especially those living with disabilities and/or complex health conditions. Any additional oral health needs should be provided by the state/territory jurisdictions through care co-ordination, which can include more complex clinically relevant and appropriate oral healthcare, including but not limited to:

1. Surgical management of severe gum disease
2. Surgical removal of teeth
3. Root canal treatment
4. Fixed prosthesis (crown, bridge, or dental implants)
5. Orthodontics

National Disability Insurance Scheme (NDIS) participants who are eligible for the NDIS, which applies to populations not exclusive to older Australians, would also consider applying for specific funding to support their oral health needs, but not clinical dental services. Rather than duplicate existing funding mechanisms for dental services, the NDIS and other Commonwealth or state/territory support programs would be complementary. This includes approved funding to have registered dental practitioners to train their carers to optimise and support oral hygiene practice, travel allowances to attend dental appointments, or extended dental consultations to understand and manage oral health issues in person-centred and value-based approach to care.

It is envisioned that Medicare funded dental services under the SDBS, via the Health Insurance Act 1973 and the Dental Benefits Act 2008, would reduce the demand for oral healthcare by individuals with lower oral health needs, and dental emergency presentations. This generates substantial additional capacity for the state/territory public dental services to provide comprehensive coordinated approaches to individuals with greater oral health needs and outreach dental programs. In addition, it will enable the stage/territory governments to focus on local oral health issues and their oral health plans, which are aligned with the national oral health plan.

Conclusion

PHAA supports the need to prioritise oral health as integral to overall health and wellbeing within the Australian healthcare system. However, we emphasise that a roadmap towards universal access to affordable oral healthcare can only be realised by augmented national leadership for oral health within the Department of Health and Aged Care in line with this submission. We are particularly keen that the following points are highlighted:

- Appointing Australia's first Commonwealth Chief Dental Officer is required to provide national leadership for oral health.
- Medically necessary essential oral healthcare should be the goal of universal access to affordable oral healthcare, starting first with Priority Populations
- Medicare should recognise and enable innovation by allowing for dental practitioners to provide primary healthcare beyond clinical dentistry. Additionally registered non-dental professionals with appropriate training, should be enabled to provide preventive oral healthcare services under Medicare.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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