Public Health Association AUSTRALIA

Oral Health

Policy Position Statement

Key messages:

Oral health is integral to overall health, wellbeing, and quality of life.

The implementation of universal and targeted population preventive interventions is crucial to reduce the burden of oral diseases and address the oral health disparities in Australia.

All Australians should have access to high-quality, person-centred and value based, culturally appropriate, safe, affordable, timely, effective, and cost-effective oral healthcare.

Promoting efforts towards increasing oral health literacy will enable an enhanced understanding of oral conditions and have an impact on healthier lifestyles and uptake of timely and appropriate access to affordable oral healthcare.

Oral health inequities experienced by priority populations are evident and should be given the highest priority in publicly funded oral healthcare programs.

Key policy positions:

1. Advocate for the appointment of a Commonwealth Chief Oral Health Officer to provide national clinical leadership for oral health.
2. Advocate for universal equitable access to affordable oral healthcare within Medicare.
3. Advocate for the implementation of Australia's National Oral Health Plan

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Oral Health Special Interest Group

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Oral Health

Policy position statement

PHAA affirms the following principles:

1. Oral health inequities can be attributed to the daily living conditions, and the political, social, cultural, physical, and environmental contexts, which in turn has significant impacts on an individual's health and wellbeing and society.[1]
2. The inequities of chronic oral diseases are amenable to prevention and timely early intervention strategies if there is a 'proportionate universal' approach. For instance, access to healthcare is directly proportional to a person's health needs and risk. 'Upstream' approaches that address the social and commercial determinants of health are required, as well as targeted population preventive interventions, including community-based health promotion and preventive-focused oral healthcare.
3. Access to affordable oral health care, as well as the uptake of the dental services is poor and inconsistent. Thus, accentuating the need for a proportionate universal, equitable oral healthcare system that is high-quality, person-centred, value-based, culturally appropriate, safe, affordable, timely, effective and cost-effective.
4. Priority populations – including Aboriginal and Torres Strait Islander Peoples, lower socioeconomic backgrounds, people with special needs, dependent older people and newly arrived migrants and refugees – should be given priority in public oral health programs.
5. Public oral health programs will be more effective if they enhance oral health literacy and self-efficacy, contributing to empowering with self-care. Regular and updated oral health resources with accessible professional support for oral conditions, educating about the risk of future oral disease burden and management options for care and promoting healthier lifestyles.

PHAA notes the following evidence:

6. Oral health is integral to overall health, well-being, and quality of life. A healthy mouth enables individuals to eat, speak and socialise without pain, discomfort, or embarrassment.[2] It is multidimensional and encompasses the physical, psychological, emotional, and social domains.[3]
7. Dental conditions rank as the third highest reason for acute potentially preventable hospitalisations.[4]
8. Oral diseases place a considerable burden on individuals, families, and the community. Dental caries (tooth decay) is one of the most prevalent health conditions in Australia.[2] One third of Australians aged >15 years have dental caries,[5] and one fourth of children aged 5-10 years have dental caries.[6]
9. One third of Australians aged >15 have moderate/severe periodontitis (advanced gum disease).[5]
10. Head and neck cancer ranks 7th among the top 20 most commonly diagnosed cancers.[7]
11. Poor oral health is a marker of socioeconomic disadvantage. Greater levels of oral diseases are experienced by Aboriginal and Torres Strait Islander Peoples, people from lower socioeconomic backgrounds, those living in rural and remote areas, some immigrant groups from culturally and

linguistically diverse backgrounds, people with specialised healthcare needs and ageing people.

12. A range of chronic health conditions are closely associated with oral diseases. Periodontitis and diabetes are closely interconnected[8] and are both associated with complications in pregnant women[9] and cardiovascular disease.[10] Poor oral health can also lead to difficulty in chewing, swallowing and tasting food thus leading people to adopt a poor diet,[11,12] and suffer other acute consequences like aspiration pneumonia and infective endocarditis.[13]

13. Barriers to accessing oral healthcare include the higher costs in the private sector, long waiting times for eligible adults (up to two to three years) in the public oral healthcare system,[14] low oral health literacy, transport problems and the maldistribution of the oral health workforce, particularly in rural and remote areas.[2]

14. Two fifths of Australians aged >15 years have unfavourable dental visiting patterns, at least once a year with a regular dental practitioner.[15]

15. Expenditure associated with dental care is one of the most significant areas of health expenditure, totalling $6.5 billion in 2020-21.[16] Per capita public dental funding varies markedly between federal, state and territory governments. Out-of-pocket expenses for oral health care ranks the second most costly expense annually, just after non-subsidised medications.[16]

16. The federal government private health insurance rebate supports those who can afford private health insurance. Almost half the amount contributed by the Commonwealth government to oral healthcare provides subsidy to private health insurance rebates,[17] and does not provide financial assistance to support the population with the greatest oral health needs.

17. Most oral diseases are amenable to prevention. They share common risk factors with other chronic diseases, for example excess sugar intake, tobacco use, and alcohol. Prevention interventions are necessary to target these risk factors,[1] ideally at a population level.

18. Community water fluoridation remains the most cost-effective and socially equitable means for preventing dental caries. However, the coverage of fluoridated water varies from 76% in Queensland and 100% in the Australian Capital Territory.[18]

19. The implementation of an appropriately designed health levy on sugar-sweetened beverages can improve oral health outcome, is cost-effective[19,20] and promotes health equity.[20,21]

20. The Child Dental Benefits Schedule has increased the utilisation of dental services by eligible children.[22] The proportion of children using the dental scheme is increasing from 29.5% in 2014 and 37.9% in 2018, and the take up varies markedly between states and territories – from less than 20% in Western Australia and the Northern Territory to over 40% in South Australia, Tasmania and Victoria.[23] In addition, there are insufficient evaluation frameworks to monitor the scheme's effectiveness and value of the investment.

21. There is an inadequate and inefficient skill-mix of dental practitioners in Australia.[24] The scope of practice of dental therapists, oral health therapists, dental hygienists, dental prosthetists, and dental assistants are underutilised. Other non-dental professional primary healthcare practitioners should be trained and utilised in delivering oral health preventive interventions.

22. Oral health curricula have limited focus on population health needs, person-centred, value-based healthcare, and evidence-based practice. Non-dental postgraduate degrees, such as the Master of Public Health, largely do not integrate oral health issues.

23. Oral health indicators being used to monitor the implementation of the National Oral Health Plan 2015- 2024 is a good foundation to develop a sustainable and effective national oral health surveillance system.[25] However, further development is needed to incorporate indicators proposed by the World Health Organization's Oral Health Action Plan 2023-30.[26]
24. Less than 1% of the National Health and Medical Research Council grant funding are allocated to oral health research.[27]
25. There needs to be strengthened and continued focus on high quality oral health research to address oral health inequities and integration of oral health into primary healthcare. Value-based healthcare has shown growing potential to improve oral health outcomes efficiently and achieve universal healthcare coverage that includes oral health.[28]
26. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goals 3 – Good Health and Wellbeing and Goal 10 – Reduce Inequality Within and Among Countries.[29]

PHAA seeks the following actions:

27. The federal government to develop a health workforce strategy to support, train and develop an appropriate multi-skilled, multi-disciplinary, flexible health workforce to provide affordable, safe, high-quality oral health care for all Australians. This will require strengthening training on population needs, person-centred, value-based healthcare and evidence-based practice for effective clinical and community care decisions to be made.
28. Integrate oral health promotion and disease prevention in general health promotion policies following a common risk factor approach and the development of supportive health environments in key settings.
29. Strengthen oral health competencies and clinical practice within general health and wellbeing checks conducted by primary health care workers such as Aboriginal and Torres Strait Islander health practitioners, general practitioners, nurse practitioners and midwives, maternal child health nurses, pharmacists, speech pathologists and occupational therapists.
30. Integrate oral health within Medicare using a phased in approach and initially targeted towards priority populations. Australia's goal should be to implement universal access to affordable oral healthcare for all Australians. It should promote proportionate universalism and an equitable healthcare system that includes oral health.
31. Abolish the rebate for private health insurance on dental services and redirect the funding towards public oral healthcare programs and oral health prevention interventions.
32. Advocate for the integration of oral health into all relevant policies and public health programs, including policies related to Non-Communicable Diseases (NCDs) and Sustainable Development Goals (SDGs).
33. Prioritise the development, implementation, evaluation, and translation of inter-disciplinary models of care that integrate a holistic model of health and wellbeing.
34. Promote community water fluoridation to all communities with populations of 1,000 or more and targeted topical fluoride programs where it may not be feasible.
35. Introduce an appropriately designed health levy on sugar sweetened beverages and restrict the

advertising of discretionary foods.

36. Advocate for a national oral health surveillance system based on the suite of indicators and the implementation of Australia's National Oral Health Plan. The monitoring reports should be conducted and publicly released regularly.
37. Advocate for increased priority for oral health research and bring together researchers, policy decision- makers and health practitioners to enhance oral health research translation into policy and practice.
38. Embed oral health issues in public health and primary health care courses to strengthen the capacity of public health practitioners to promote oral health.
39. Enhance the effectiveness, efficiency, and uptake of the Child Dental Benefits Schedule by introducing evidence-based guidelines, risk based preventive dental care pathways, and by monitoring treatment services and access by population groups with higher oral health needs.
40. Advocate to introduce blended payment systems for government funding that incentivise optimum health outcomes and use risk adjusted premiums, which are aligned with value-based healthcare agenda.[28]
41. Oral health should be a recognised and accepted as a National Public Health Priority in Australia. There should be increased funding of oral health research, focused on prevention and population health, by the National Health and Medical Research Council and other government research funded organisations.

PHAA resolves to:

1. Advocate for the above steps to be taken based on the principles in this position statement.
2. Advocate for universal equitable access to affordable oral healthcare within Medicare.

ADOPTED September 2023

(First adopted 1994, revised and re-endorsed 1995, 2003, 2006, 2007, 2008, 2010, 2012, 2014, 2017 and 2020)

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