

11. Improving oral health and access to dental care

Key messages

- Oral health – the condition of our mouth, our teeth and our gums – affects our overall health, wellbeing and quality of life:
 - Loss of teeth impairs eating, leading to reduced nutritional status and diet-related ill-health, particularly for children and older people.
 - Poor oral health is linked with other health conditions such as cardiovascular disease, preterm birth and low birth weight, hepatitis C, and otitis media.
 - Oral diseases create pain, suffering, disfigurement, disability and in some cases death.
- Common oral diseases such as tooth decay, gum disease and oral cancers are preventable with early detection and treatment. The absence of early intervention is costly and unproductive – estimates indicate there were 50,000 avoidable hospital admissions arising from preventable dental conditions in 2004–05.
- Many Australians suffer from poor oral health, sometimes waiting years to receive basic dental care through the public dental system as they cannot afford, or do not have access to, private dentists. Around 650,000 adults are on public dental waiting lists; the average waiting time is just over two years (27 months).
- Public dental services are under-resourced. Services provided through public dental services are predominantly for emergency care such as extractions. There is limited focus on prevention and restorative work.
- There are significant out-of-pocket costs associated with dental care. Low income households spend around 8.2 per cent of their household income on dental services.
- Good access to preventive and restorative dental care and, for those who need them, properly fitted dentures, is essential to good oral health, and is also important to maintaining good general health.

Our reform directions

- 11.1 We propose that Australia should have a scheme 'Denticare Australia' for universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay.
- 11.2 We propose that 'Denticare Australia' be based on a mixed approach of public and private cover. The additional costs would be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income, with people opting either to become a member of a dental health plan (with a private insurer), or to use public dental services.
- 11.3 We support an equitable approach to financing a universal dental scheme. Under the proposed approach, the funding of dental services will be linked to ability to pay through an increase in the Medicare Levy. We estimate that under this approach:
- Many people will pay no more than they currently pay for dental care – the increase in Medicare Levy of 0.75 per cent of taxable income will be smaller than existing out-of-pocket costs for dental services for many people.
 - People on low incomes will pay considerably less and have much better access to dental health services.
- 11.4 We support the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners.
- 11.5 We propose the national expansion of the pre-school and school dental programs.
- 11.6 We propose that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

Australians deserve a robust dental health system

■ Australians deserve a robust dental health system. Improving access to dental health services was frequently raised during our consultations and in our submissions.

*A comprehensive system is one which offers access to the full range of health services such as dentistry, allied health and community care.*¹

*I did mention around the table the state of dental health which is absolutely shocking. I have had many, many cases of a patient who has come to see me and their teeth are just rotting away and the fact is that that sort of problem tends to affect the whole health of the individual, and you find that sometimes services are being taxed simply looking after a problem that is initially actually about dental care.*²

*Dental health promotion needs to be built into the primary and secondary school curricula at strategic points in time with class outlines that are creative and fun but with clear health messages relevant at particular ages.*³

11.1 Defining and scoping dental health

The oral health of Australians is varied. Some enjoy good oral health, having timely access to high quality dental care. Many others in the community suffer from poor oral health, spending excessive periods, sometimes years, waiting to receive basic dental care in the public system.

1 Health Consumers Alliance of South Australia (2008), Submission 90 to the National Health and Hospitals Reform Commission.

2 Physiotherapist (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

3 L Pagonis (2008), Submission 526 to the National Health and Hospitals Reform Commission.

All too often it is the disadvantaged who suffer the largest share of oral disease and its consequent flow-on effects on quality of life. Despite the eradication of a number of life threatening and infectious diseases, Australia has not been able to deliver equitable access to dental care.

Australia's oral health standards have room for improvement. Despite the development of a national oral health plan there is yet to be a comprehensive national approach to oral health promotion and disease prevention.

Currently, we are ranked in the bottom third among OECD countries for rates of dental decay among adults.⁴ What is distressing about these statistics is that, with early detection, common oral diseases such as tooth decay, gum disease and oral cancers can be easily and cost effectively prevented. Prevention effort not only improves immediate oral health and wellbeing of an individual but also avoids further potential health complications.

■ We are ranked in the bottom third among OECD countries for rates of dental decay among adults

We need a national dental health approach to both oral health promotion and disease prevention that provides equitable access for all Australians to the essential dental care services.

11.2 Building on our strengths

Australia has made some great inroads in improving oral health.

- The Australian School Dental Scheme of the 1970s and 1980s provided a foundation for oral health education and improved dental care for a generation of school aged children.
- The introduction of fluoridation in a number of metropolitan cities and other locations has significantly improved the oral health of millions of Australians.

Our current oral health system is founded on a highly skilled dental workforce, and soon to be expanded with the introduction of four new university dental schools.

- New oral health professional roles have been developed, with extensions of the scopes of practice of a number of dental auxiliaries and the introduction of dental hygienists as part of the oral health care team.
- A significant share (around 45 per cent) of our population has government-subsidised private health cover supporting them to meet some of their dental costs.

11.3 Identifying the case for change

11.3.1 Recognising the impact of oral health on wellbeing

With a healthy set of teeth, people can eat, speak and socialise without pain and discomfort or embarrassment. Oral health affects our overall health, wellbeing and quality of life and contributes to a productive workforce and society.

Poor oral health, whether dental caries (tooth decay), or periodontal (gum disease), is often accompanied by infection, discomfort, pain, and social embarrassment. The prevalence of these impacts is a silent epidemic.

4 Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562__Fair%20dental%20care_%20final.pdf.

A quarter of Australians report that they avoid eating some foods as a consequence of the pain and discomfort caused by their poor dental health and nearly one-third found it uncomfortable to eat in general.⁵

Just under one-quarter of Australian adults report feeling self-conscious or embarrassed because of oral health problems.⁶ It is important to recognise that reduced self-esteem as a result of poor oral health can often impact an individual's social and community participation, and even their future employment opportunities.

11.3.2 Better oral health improves overall health

While oral disease is important in and of itself, if left untreated it can lead to further health complications, negatively impacting an individual's overall health.

A number of health conditions are associated with poor oral health. In particular, periodontal disease (gum disease) may contribute to cardiovascular disease, preterm birth and low birth weight, while diabetes directly affects the periodontium (the tissues of the gum that support the teeth). Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV infection, infective endocarditis, otitis media, and nutritional deficiencies in children and older adults.⁷

Estimates indicate that there were 50,000 avoidable hospital admissions in 2004–2005 arising from normally preventable dental conditions.⁸ A failure to provide access to essential dental care, such as preventive and restorative care, has the potential to place a large and unnecessary burden on our already busy hospital systems.

11.3.3 Investing in the future through prevention

Common oral diseases such as tooth decay, gum disease and oral cancers are largely preventable. Early detection and interception greatly improves the outcome. If individuals can be educated as to the importance of oral health and thus avoid the serious consequences of these conditions, it would represent a worthwhile investment and achieve significant savings in the future.⁹

The oral health of Australian children and young adults has been significantly improved over the last two to three decades through the introduction of fluoridation and the school-based dental services.¹⁰ Young adults have half the number of teeth with decay than their parents did at the same age. Compared to other OECD countries, Australian children aged 12 years old had the second lowest number of permanent teeth with tooth decay.¹¹

There is evidence ■ that children's oral health has peaked and is now declining

However, there is evidence that children's oral health has peaked and is now declining. There has been a 20 per cent increase in the number of primary school children with tooth decay¹², and the percentage of six year old children with no decay in their baby (deciduous) teeth decreased

- 5 Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562_Fair%20dental%20care_%20final.pdf
- 6 Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562_Fair%20dental%20care_%20final.pdf
- 7 Australian Health Ministers' Advisory Council Steering Committee for National Planning for Oral health (2001), Oral health of Australians: National planning for oral health improvement: Final Report (South Australian Department of Human Services).
- 8 Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: <http://www.ada.org.au/newsroom/articles>
- 9 Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.
- 10 J Armfield, K Roberts-Thomson and A Spencer (2003), The Child Dental Health Survey Australia 1999: Trends across the 1990s, Australian Institute of Health and Welfare Dental Statistics and Research Series No. 27 (University of Adelaide).
- 11 J Spencer (2001), What options do we have for organising, providing and funding better public dental care?, Australian Health Policy Institute Commissioned Paper Series 2001–02.
- 12 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

from 61 per cent to 56.6 per cent between 1996 and 2000.¹³ A decline in access to school dental programs, and changing dietary patterns which increase the risk of tooth decay, have been associated with these changes. Another cause for concern is that the good oral health of children does not appear to carry through to adulthood.

Why should we do something about this? Poor oral health in childhood will precede a higher incidence of oral diseases, and poor general health in adulthood.

Continued investment in the promotion of good oral health for children and young adults is needed to sustain the early achievements of fluoridation and school dental services.

Australia currently lacks a universal approach to promoting oral health. Poor oral health is associated with a number of risk factors such as smoking, alcohol consumption and poor nutrition which could be addressed through oral health promotion campaigns. In considering such an approach, the Australian Dental Association emphasises that oral health promotion could be integrated into general health promotion:

Rather than focusing on single diseases, contemporary oral health promotion recognises that many diseases – such as heart disease, stroke, cancer, diabetes, periodontitis and tooth decay – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma and common health factors such as improved diet and exercise.¹⁴

There are great opportunities for oral health promotion to be integrated into general health promotion, taking an approach that is not just focused on the young but has oral health promotion built in across the life course. Suggestions received through submissions were to include oral disease screening questions into medical health checks, or that childhood obesity programs, as well as focusing on physical activity levels, should also consider dietary patterns and nutrition. Dental decay is a diet-related disease and therefore these programs could also incorporate a focus on the reduction of drinks and foods with extrinsic sugars and high acids.

One example where oral health has been linked to other campaigns is the National Health Warnings Campaign for smoking. One of the graphic warnings is that mouth and throat cancer is caused by smoking. 'The concept for the "Mouth Cancer" media campaign was tested with smokers of all ages and from different backgrounds. They found the proposed scene with a woman with mouth cancer talking to have a strong impact.'¹⁵

11.3.4 Providing access to dental services for all

Access to dental care is through private dentists or the public dental system. The public dental service has two main programs: school dental services; and public dental services for adults which are means tested. Approximately 30 per cent of all Australian adults are eligible for public dental care.

One in four Australian adults has 'unfavourable' access to dental services. That is, they visit a dentist less than once a year, usually for a dental problem rather than prevention, and usually do not see the same dentist. Those with unfavourable access to dental services are:

- almost four times as likely to have a tooth extracted than those that have favourable access to dental care; and
- half as likely to receive preventive care relative to those that have favourable access.¹⁶

■ One in four Australian adults has 'unfavourable' access to dental services

13 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

14 Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.

15 National Health Warnings Campaign, Questions & Answers, at: <http://www.quit.org.au/downloads/Health-Warnings-Mouth-Cancer-Background.pdf>

16 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

The significant out-of-pocket cost associated with dental care has created access issues for many of the most disadvantaged in our community, leaving them to bear a disproportionate share of oral disease. Avoiding and delaying dental care due to cost is worst among:

- low income people – 46.6 per cent of people on incomes less than \$20,000 avoid or delay dental care;
- health Care and Concession card holders – 44.0 per cent of cardholders avoid or delay dental care;
- people without private health insurance – 42.7 per cent of non-insured people delay/avoid dental care; and
- Aboriginal and Torres Strait Islander peoples – 37.9 per cent delay/avoid care.¹⁷

Compared to their expected use of dental services based on their population share, the lowest income group in the population use dental services at only 49 per cent of the recommended level. In contrast, the highest income group uses dental services at 172 per cent of the levels recommended by dental experts.¹⁸

Such results come as no surprise, given that one in every twelve dollars of all household spending by low income households is spent on paying for dental care. This accounts for approximately 8.2 per cent of household spending among the lowest income households.¹⁹

The high cost burden, coupled with the much lower use of dental services by low income households, highlights the significant cost and access barriers to dental care.²⁰

There are about 650,000 adults on waiting lists for public dental services across all Australian states and territories

■ Eligibility for public dental services is patchy. The fortunate few who are eligible for public dental services are left in line to wait. Current estimates indicate that there are about 650,000 adults²¹ on waiting lists for public dental services across all Australian states and territories. While the average waiting time for adults to access public dental services across Australia is 27 months²², it has been reported that some people can wait as long as five, six or seven years.

11.3.5 Making oral health part of the broader health system

*Dentistry is currently perceived as an ancillary health service rather than a core health service. The lack of integration of dental services with general health services at all levels, including education, service, insurance, administration and government, has resulted in an overall decrease in the health status of the population.*²³

The 'separateness' of oral health from general health is embedded in the current organisational and funding arrangements for health. It has rightfully been said that 'public dental care, as a means-tested residual program, is a torn and tattered safety net, characterised by institutionalised scarcity and harsh rationing of personal dental treatment'.²⁴

17 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

18 National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households, Discussion paper commissioned by National Health and Hospitals Reform Commission.

19 National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households, Discussion paper commissioned by National Health and Hospitals Reform Commission.

20 National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households, Discussion paper commissioned by National Health and Hospitals Reform Commission.

21 Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: <http://www.ada.org.au/newsroom/articles>

22 Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: <http://www.ada.org.au/newsroom/articles>

23 Association for the Promotion of Oral Health (2008), Submission 421 to the National Health and Hospitals Reform Commission.

24 J Spencer (2001), What options do we have for organising, providing and funding better public dental care?, Australian Health Policy Institute Commissioned Paper Series 2001–02.

One consumer pithily phrased this as:

*If you've got a boil on your bum, it's covered by Medicare; if you've got a boil on your gum, it's not!*²⁵

While 'general health' services have been subsidised to ensure universal access with shared responsibilities across Commonwealth and state governments for medical and public hospital services, 'oral health' services have been means-tested and inadequately funded.

11.3.6 Sharing the burden of dental costs

The landscape of who pays for dental services is very different to our universal health programs (see Figure 11.1).

Figure 11.1: Individuals pay much higher shares of the cost for dental services than for public hospitals, doctors and medicines

	Service	Commonwealth	State governments	Private health insurance	Individuals	Other	Total
Universal	Public hospitals	39.9%	53.2%	1.7%	0.5%	4.7%	100%
	Medical services	78.3%	0%	4.2%	12.0%	5.6%	100%
	Pharmaceuticals	83.0%	0%	0%	17.0%	0%	100%
Dental	Dental services	9.2%	9.0%	14.3%	67.3%	0.2%	100%

Source: Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006–07, Table A3, current prices 2006–07 expenditure.

Governments contribute less than 20 per cent of all spending on dental services; health insurers contribute about 14 per cent; and individuals bear two-thirds of the total cost directly as out-of-pocket payments.

In fact, existing Commonwealth Government spending on dental health services is largely directed to those in our community who have relatively good access to dental services – privately insured individuals. In 2006–07, 79 per cent of the Commonwealth's spending on dental health occurred through the private health insurance rebate, accounting for \$414 million of the Commonwealth's \$528 million expenditure on dental health services.²⁶

■ Governments contribute less than 20 per cent of all spending on dental services

11.4 Creating a better future

One of our most important challenges is improving access to dental health services. There are major inequities in who is able to access dental care, who has reasonable oral health status, and who pays, and how much, for dental services.

The separation of oral health from general health is not compatible with our principle of comprehensiveness. We have indicated in this principle that the health and aged care system should be able to meet the entire range of people's health needs over their lifetime. Of course, this must include what is happening in their mouths.

25 Audience member (20 May 2008), Pulling teeth, SBS Insight episode, at: <http://news.sbs.com.au/insight/episode/index/id/21>

26 Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

Reform direction 11.1

We propose that Australia should have a scheme 'Denticare Australia' for universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay.

In developing 'Denticare Australia', we have been conscious of several critical situational factors in deciding how best to shape, organise and finance such a scheme.²⁷

First, most current spending on dental services goes toward restorative and preventive care. The costing that we have commissioned indicates that a new dental scheme covering restorative, preventive and diagnostic dental services, together with extractions and dentures, would equate to almost 80 per cent of total current spending on dental services. The remaining 20 per cent of current spending is directed towards what might be considered 'elective' dental care, including crowns, bridges, implants and services such as cosmetic and laser dentistry.²⁸

We believe that, given the huge gaps in access for many people to any dental health services, the priority focus of 'Denticare Australia' should be on prevention, early diagnosis and management, and restoration of function (including through the supply of dentures). We further note that the approach we have taken elsewhere in this report, of requiring health services to be evidence-based and provided as cost effectively as possible, should apply equally to the proposed scheme for dental services.

Second, we have been strongly influenced in our design of 'Denticare Australia' by the dominant role of private dentists in providing most dental services and by the relatively high uptake of private health insurance for dental care. About 45 per cent of the population currently have private health insurance for dental services; a further 35 per cent of the population do not have private health insurance but use the services of private dentists. Only 20 per cent of the population neither have private health insurance nor use private dental services, and instead rely solely on public dental services (see Figure 11.2).

Private dental services and the continued use of private health insurance for dental care must remain as significant components of a new dental scheme

■ This is not a 'greenfields' situation – in other words, we are not starting from scratch. Accordingly, we believe that private dental services and the continued use of private health insurance for dental care must remain as significant components of a new dental scheme.

27 The NHHRC has commissioned two interrelated papers that helped shape the formulation of our reform directions for dental health services. These two papers, available on our website, are: Improving oral health and dental care for Australians (J Spencer and J Harford); and Costing a social insurance scheme for dental care (PriceWaterhouseCoopers).

28 We note that additional work will be required to reach agreement on the scope of services that would be eligible for coverage under the proposed universal scheme. Preliminary estimates are included in the PriceWaterhouseCoopers paper.

Figure 11.2: There is currently strong use of private dental insurance and private dentists

		Services Accessed	
		Private practitioner	Public scheme
With dental health insurance (Current = 45%)	Non School Age 81% of insured	35%	1%
	School Age 19% of insured	5%	3%
Total with dental insurance		40%	5%
No dental insurance (Current = 55%)		35%	20%
Total dental services in sector		75%	25%

Source: PriceWaterhouseCoopers (2008), Costing a social insurance scheme for dental care, Supplementary report, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Reform direction 11.2

We propose that 'Dentcare Australia' be based on a mixed approach of public and private cover. The additional costs would be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income, with people opting either to become a member of a dental health plan (with a private insurer), or to use public dental services.

The principle is to use an increase in the Medicare Levy as the most equitable approach to raising the additional funds required to achieve universal coverage. The extra Medicare Levy funding would be combined with all existing funding by governments (Commonwealth and states) to create the funding pool used as the basis for the scheme.

How this would operate at the level of individuals and families is that:

- Everyone eligible to pay the Medicare Levy would pay an extra 0.75 per cent of taxable income towards a universal dental scheme 'Dentcare Australia'.
- This levy would replace existing premiums paid for private dental health insurance covering preventive, diagnostic and restorative services and most out-of-pocket costs for these dental services.
- Everyone, regardless of whether they have private health insurance for other health services, could choose either a dental health plan from a private health insurer or to rely on expanded public dental services funded by 'Dentcare Australia'.
- For people choosing a private dental health plan, 'Dentcare Australia' would pay the premium for that plan for them from the new funding pool. At the outset, the premium payment would be set at a level so that individuals and families were covered for about 85 per cent of the current costs of private dental services covered under the package.
- 'Dentcare Australia' would also provide additional funding for public dental services to expand their availability for people choosing to rely on them. There would be no out-of-pocket costs for people using public dental services; however, there might still be some waiting times to access care.

The premium paid by 'Dentcare Australia' to a private health insurer for each person choosing their dental plan would be 'risk adjusted' – that is, it would be higher for people likely to require more dental services and lower for people likely to require fewer. Private health insurers could still offer coverage for 'elective' dental services such as orthodontics, cosmetic and laser dentistry that are not covered by 'Dentcare Australia'.

Reform direction 11.3

We support an equitable approach to financing a universal dental scheme. Under the proposed approach, the funding of dental services will be linked to ability to pay through an increase in the Medicare Levy. We estimate that under this approach:

- Many people will pay no more than they currently pay for dental care; the increase in Medicare Levy of 0.75 per cent of taxable income will be smaller than existing out-of-pocket costs for dental services for many people.
- People on low incomes will pay considerably less and have much better access to dental health services.

In addition to our proposals relating to the financing of 'Dentcare Australia' to provide universal access, we believe that there is a range of other issues that needs to be tackled to improve oral health status.

■ It has been estimated that a full residency program would increase the public dental workforce by over 50 per cent

Our fourth reform direction recognises the need to expand the clinical experience and training of the dental sector workforce. We support the concept of a change to the current education of the dental workforce through the introduction of a dental education and residency program, an idea that was advanced in several submissions.^{29,30,31} This program would provide a solid grounding for new graduates prior to their registration in the care of complex public dental patients. In addition to routine dental care, the residency program could include the development of competencies in geriatric dentistry, special needs dentistry and dentistry for the intellectually disabled. It has been estimated that a full residency program would increase the public dental workforce by over 50 per cent.³²

Reform direction 11.4

We support the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners.

Good oral health should begin at an early age. Our fifth reform direction is aimed at continuing to improve young people's oral health through school dental programs with a focus on both the provision of dental services and oral health education programs.

As outlined earlier, there has been a significant improvement in the oral health of young people over the last 30 years, with young adults having better oral health than their parents, reflecting their exposure to fluoride in drinking water and toothpaste, and a period of high coverage by school dental services.³³ However, this improvement appears to have levelled out and is now declining.

29 School of Dentistry, University of Adelaide (2008), Submission 175 to the National Health and Hospitals Reform Commission.

30 The Association for the Promotion of Oral Health (2008), Submission 421 to the National Health and Hospitals Reform Commission.

31 Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.

32 J Spencer and J Harford (2008), Improving Oral Health and Dental Care for Australians, Discussion Paper commissioned by the National Health and Hospitals Reform Commission

33 School of Dentistry, University of Adelaide (2008), Submission 175 to the National Health and Hospitals Reform Commission.

Nationally there has been a 20 per cent increase over the last 10 years in the number of primary school children with tooth decay.³⁴

We were told in the submissions received about the limited access in many states to dental care under school dental programs. We believe that school dental programs are well placed to diagnose, treat and promote good oral health, and that these efforts must be sustained to reduce the level of oral diseases in adulthood.

■ We believe that school dental programs are well placed to diagnose, treat and promote good oral health

Reform direction 11.5

We propose the national expansion of the pre-school and school dental programs.

Our final reform direction supports increased funding for oral health promotion. We believe that oral health promotion is an essential first step in maintaining and improving oral health, and in improving overall health and wellbeing immediately and in the future – prevention is better than cure.

As outlined earlier, oral diseases such as tooth decay, gum disease and oral cancers are largely preventable, sharing a range of risk factors such as smoking, poor diet and alcohol consumptions with many diseases. These factors underpin the need for an improved oral health promotion program. We believe the positive effects of an oral health promotion campaign would be compounded if oral health messages were also integrated into other health promotion campaigns, as has been done for smoking.

Reform direction 11.6

We propose that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

34 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.