
The Menzies Centre for Health Policy

DENTAL AND ORAL HEALTH

Policy Issue Paper

Why dental and oral health is important

Tooth and gum diseases affect the lives of many Australians; their job opportunities may be restricted, productivity and self-esteem reduced, speech impeded, and the pain, discomfort and difficulties with eating affect their health and quality of life.

Dental care is a major health care cost that is primarily borne by individuals who directly contribute some 62% of dental expenditure, and indirectly fund a further 18.5% via private dental insurance.

Although dentistry is not perceived as an integral part of health care, ignoring dental health can have consequences elsewhere in the health care system. Heart disease and heart attacks, internal infections after surgery and premature birth can all be linked to dental and oral health. People with diabetes, HIV/AIDS and bulimia are predisposed to dental problems.

Dentists play a critical role in the early diagnosis of cancers of the throat and mouth, which make up 3% of all deaths from cancer. Oral health can also suffer as a result of taking antibiotics and treatments such as chemotherapy and radiotherapy. About 40% of people who have chemotherapy develop oral complications.

Many commonly prescribed medicines for conditions such as depression, anxiety, hypertension and acne cause dry mouth. Its effect can be devastating. In the absence of saliva, bacteria in the mouth run rampant and fungal infections can result. Dry mouth in older people can lead to malnutrition.

Australians' worsening dental health

Australia's oral health is characterised by very good but worsening child oral health, high levels of oral disease among adults, and major disparities in oral health and access to dental care between high and low income adults. People with household incomes less than \$80,000 and concession car holders have higher numbers of decayed teeth and are more likely to have lost teeth due to decay.

Over a quarter of Australian adults experienced pain due to problems with their teeth, mouth or dentures in 2002. A quarter reported avoiding foods and nearly a third reported that they found it uncomfortable to eat. Just under a quarter of Australian adults reported that they felt self-conscious or embarrassed because of oral health problems.

The dental health of Australia's school children has been in decline for a decade and one in every two teeth of 35-44 year olds has some decay. The percentage of people reporting a need for dental fillings or extractions was greater in 2004-06 than in 1987-88. Some 650,000 Australians - mostly poor and elderly - are on waiting lists for public dental care.



Dental care is unaffordable for many Australians

It has been estimated that some 40 percent of the adult population face barriers in accessing basic dental care due to unaffordable costs and a severe shortage of dentists. That means regular checkups and preventive treatment are simply out of the question.

Low income adults, people living in rural and remote areas, indigenous people, nursing home residents, people with disabilities, young adults on income support payments and single parent households are both more likely to have poor dental health and less likely to be able to afford treatment.

While the problems of access to dental services are most acute for low income and disadvantaged Australians, 2.3 million adults who are not eligible for public dental care report that they delay or avoid treatment because of the cost of dental care.

A recent national survey of adult oral health reports that of the people who visited a dentist during the preceding 12 months, the majority of people (83%) attended a private dentist and most (91%) paid out of pocket expenses for the visit.

The economic costs of poor dental health

Many people who cannot access dental care end up seeing a GP. Between seven and ten percent of GP visits are for dental problems, at an annual cost to Medicare of \$245-\$350 million. Most patients get the only solution a GP can offer – prescriptions for painkillers and antibiotics. The cost to the PBS of such prescriptions is unknown, but it is certainly several million dollars a year.

Other people end up in the Emergency Departments of public hospitals looking for relief, and each year more than 30,000 people are hospitalised because of a dental condition. The number of children requiring general anaesthesia for dental surgery, usually teeth extraction, has tripled in the past decade. Based on average costs for a hospital stay, these visits cost over \$100 million a year.

In just these three areas around \$500 million is spent every year on inappropriate, short-term fixes to dental problems.

The economic costs of poor dental health go well beyond the health budget, in terms of lost productivity and absenteeism from school and work. Oral disease causes an estimated loss of one million days of work per year and costs the economy around \$2 billion in direct costs and lost productivity. Tooth decay and its related health consequences account for up to 70 per cent of this. Even the military suffers, with 8.4-14.6% of soldiers having their work performance impacted by dental problems at some point in a six-month deployment.

Case studies

Example 1

Cost of private dental treatment for patient presenting with a tooth abscess:¹

Emergency holiday dentist – radiograph and emergency drilling treatment	\$80.00
Radiograph and removing old filling	\$175.00
Root canal therapy	\$227.50
Post, temporary filling	\$320.00
Cast, crown, etc	\$1345.00
Total	\$2147

¹ Dental Services, Report of Standing Committee on Social Services, NSW Legislative Council, March 2006.

Example 2

Figures released in March 2007 showed that the median wait for public dental attention in the Victorian town of Moe was 66 months.

Example 3

A three-year-old Sydney boy son battled raging fevers and headaches from a decaying tooth. His mother was told to give him children's painkillers and be prepared to wait at least a year for treatment. It would cost about \$4000 to have the procedure done by a private dentist in a private hospital.

Example 4

Every one of the major hospitals in NSW will have about five people wheeled in a month with a life-threatening dental infection that will put them into intensive care.

Current programs

The States and Territories have historically funded school-based dental programs for children and public health programs for adults.. Both these types of programs vary considerably from State to State in their scope, in the population covered, and in the co-payments required.

Eligibility criteria for public dental services, by State

State	Eligibility (holders of the following)
NSW	PCC, HCC, Commonwealth Seniors Card, & dependents of cardholders
TAS	PCC,HCC
SA	PCC, HCC
VIC	PCC, HCC
WA	HCC/PCC/ DVA
NT	HCC, PCC, Sickness benefits recipients
QLD	HCC, PCC, Commonwealth Seniors Card and Qld seniors

PCC - Pensioner Concession Card

HCC - Health Care Card

DVA - Department of Veterans' Affairs

However in effect eligibility for dental services is controlled by the Federal Government which determines who is eligible for the cards which control access to State-funded services.

Dental spending by States and Territories

The latest expenditure figures on dental health are from the AIHW *Health Expenditure 2004-05* which was published in September 2006. Total spending for 2004-05 was \$503 million. It is known that most, if not all States and Territories have increased their dental budgets since 2004-05. It is not possible to break out the spending for school-based programs, although is around 20% of the total budget.

Table 1: Expenditure on dental services, States and Territories, 2004-05

NSW	VIC	QLD	SA	WA	TAS	NT	ACT	TOTAL
\$143m	\$107m	\$128m	\$49m	\$50m	\$11m	\$8m	\$8m	\$503m

The amount each State and Territory spends per eligible person is also quite variable, and care should be taken in comparisons as eligibility also varies.

Table 2: Total spending on dental services, 2004-05

SOURCE	AMOUNT	PERCENTAGE (Dental health spending)
Commonwealth - direct	\$368m	7.3%
Commonwealth – indirect	\$82m	1.6%
States and Territories	\$503m	10%
Individuals	\$3,399m	67%
PHI	\$701m	14%
Other	\$10m	-
TOTAL	\$5,064m	100%

The majority (82% of Commonwealth expenditure is spent on the PHI rebate. The remainder covers the DVA Dental Scheme, and Medicare inpatient, oral surgical and radiology services.

Two-thirds of all dental costs are borne by the patient or their family.

Dental workforce shortages

By 2010, Australia will be short of 1500 dental workers, mostly dentists. That equates to 3.8 million dental visits that won't happen. The shortage of dentists is already acute in rural and remote areas. A survey by the Rural Dentist Action Group in 2006 found 18-month delays for dentures after teeth were removed and 400 kilometre trips to the nearest school dental program.

There are currently six dental schools (1 each in WA, SA, Vic, NSW and 2 in Qld) with a seventh school planned for rural NSW. These schools currently produce 240 domestic dentists a year. This will rise to around 450 graduates a year by 2013.

Dental places are very expensive (in band 1 at \$18,000-\$23,000 pa) and HECS fees are over \$8000.

There is a major problem with getting enough dental therapists and these will be essential for many aspects of a public dental program.

Currently graduates with a Bachelor of Oral health can work either as a dental hygienist (well paid in private practice) or a dental therapist (poorly paid in the public sector).

There is currently no national accreditation system for dentists, dental hygienists and dental therapists, although this is part of the National Oral Health Plan.

Governance issues

The Constitution, since a referendum in 1946, clearly gives the Commonwealth responsibility to make laws for the provision of *"hospital benefits, medical and dental services"* – section 51(xxiiiA).

Despite the fact that the Constitution clearly recognises the role of the Commonwealth in the delivery of dental services, the Howard Government says that these are solely a State responsibility. Indeed Prime Minister has claimed that a federal takeover of dental services would undermine the existence of the States.

The Federal Minister for Health, Tony Abbott recently remarked, *"I know people are very unhappy about the state of [public] dental schemes. Every time dentistry is in the public arena people demand that the Federal Government take it over. Those people ... should direct their concerns to the state governments. They need to take responsibility and I think that public dental care is appropriately in their domains."*

This peculiar rationalization of responsibilities, and an approach to healthcare that excises the mouth from that of the rest of the body, means that the inevitable costs of dental disease are borne elsewhere and with higher impact in the healthcare system and on patients.

National recognition of the importance of oral health

A comprehensive national oral health plan, *Healthy Mouths, Healthy Lives, Australia's National Oral Health Plan 2004-2013* was endorsed by Australian Health Ministers on 29 July 2004. The plan acknowledges that "profound disparities exist across socio-economic groups in Australia with respect to oral and general health. In particular, the incidence of caries and periodontal disease increases as socio-economic status decreases."

The Plan covers seven action areas:

1. Promoting oral health across the population
2. Children and adolescents
3. Older people
4. Low income and social disadvantage
5. People with special needs
6. Aboriginal and Torres Strait Islander peoples
7. Workforce

The action areas have short, medium and long term timeframes.

Three years on there is little to show and the implementation of this plan is well behind schedule. The main reason for this is that there is no leadership to drive the implementation and the states and territories have shied away from outcome indicators. There is a monitoring group but it is powerless to do anything.

Howard Government's position on dental care

Abolition of the Commonwealth Dental Health Program

The Howard Government abolished the Commonwealth Dental Health Program (CDHP) in 1996, claiming that the program was never meant to be ongoing and that it had served its purpose. In May 1998, the Senate Community Affairs Reference Committee Report on Public Dental Services found that when the CDHP was abolished, there were approximately 380,000 Australians waiting an average of 6 months for public dental care. By May 2000, that figure had blown out to 500,000 Australians waiting between 8 months and 5 years for public dental care. The collection of national figures was stopped by the Howard Government, but it is now estimated that 650,000 elderly and low-income Australians are on waiting lists for public dental care.

Private Health Insurance Rebate

The Federal Government's major commitment to dental health is expressed through the Private Health Insurance (PHI) rebate, about \$400 million of which goes to those able to afford ancillary dental cover.

It's not a particularly generous handout, with PHI fund members receiving an average dental benefit of just \$46 each year. That's less than half what the States spend on dental services (an average of \$96.60 for each eligible person), and dramatically less than any dentist's bill, with average charges for a checkup, X-ray, scale and clean of around \$280.

Medicare funding for dental services in 2007-08 Budget

The Government has committed the very reasonable sum of \$377.6million for dental services over the next four years, but done this in such a way that very few people will get what they need. That's because the funding will go through the chronic disease management program, the dental component of which is so poorly designed that since its inception in July 2004, only 5000 Medicare services a year are being provided. The original estimates were that 60,000 dental consults would take place each year. The Government has spent less than \$2 million on the program, although many patients have been out-of-pocket, some by as much as \$500.

Under the current requirements of the program, in order to receive a Medicare benefit for dental treatment, patients must meet three criteria. They must have a chronic condition with complex care needs, have a dental problem that significantly adds to the seriousness of their chronic condition and be receiving care from a general practitioner under a written management plan.

If these conditions are met the GP can refer the patient on to a dentist. Under the system, patients are limited to three dental services in a 12-month period and the Medicare rebate for each service is \$77.95. Many in the dental profession have turned their back on the Medicare items because the rebate of \$77.95 is for one hour's work.

The proposed changes will lift the cap on the number of dental services that can be provided in any given year, but limits the overall cost to Medicare to \$2000 a year, including contributions from the Medicare safety net.

There is nothing in the Government's package that can claim to address the crisis in dental health. Access is limited to a small number of very sick people, although for some patients with cancer, advanced diabetes or HIV/AIDS, it will help. But few of the people on the waiting lists fall into this category.

The legislation to enact these changes was passed by the Senate on 20 September, 2007.

More dentists and dental workers

The 2007-08 Budget contained some provisions to educate and train more dentists and dental workers in rural areas.

There is \$65 million for a new dental school at Charles Sturt University. When it is up and running this school will provide about 50 new dentists and oral health workers a year. This dental school will be the only dental school in Australia that does not operate in conjunction with a medical school.

There is also \$12.5 million provided to expand the number of rural placements for dental trainees, but a scrutiny of the budget numbers shows that this is a short-term commitment as only minimal funds are allocated beyond July 2009.

Labor Party position on dental care

The Labor Party has pledged to fund up to 1 million additional dental consultations over the next three years by re-establishing a Commonwealth-funded public dental health program that will be means-tested and funded up to \$290 million to clear the backlog of people waiting for treatment at public dental hospitals. This policy commitment was released on 18 September 2007.

The funding for this program comes from the \$378 million committed by the Howard Government to provide Medicare funded dental services. A Rudd Labor Government will not continue this program.

Labor has said that there will be further announcements on dental policy in the lead up to the election.

Suggested areas for policy action

1. Extend the coverage of water fluoridation.

Fluoridation is a safe, effective and equitable measure that can prevent dental decay across all age groups and in all geographical settings. No other single action can be taken that would achieve the cost effectiveness of water fluoridation.

The recent AIHW report shows that members of the fluoride generation (born since 1970) had about half the level of decay that their parents' generation had developed by the time they were young adults. This is evidence that exposure to fluoride in water and in toothpaste during childhood produced substantial benefits for oral health among Australian

adults. There is still much to do to achieve full coverage. Large parts of Queensland are unfluoridated and in NSW there are nearly 700,000 people living in areas that are supplied with unfluoridated water.

2. Engage in dental health promotion.

This can be integrated into other general health promotion campaigns such as those for obesity and healthy ageing, given oral diseases share a number of risk factors with the national health priority areas.

Children of preschool age and pregnant women should be the target of oral health campaigns. Evidence indicates that there is a high prevalence of early childhood cavities, with 84 per cent of children under five years never before visiting a dental care provider.

3. Reform public dental services.

There is an urgent need to evaluate what works well, what doesn't and why. We need to examine the interaction between public and private sectors in the provision of dental services, determine equitable means to prioritise people seeking public dental care and target vulnerable groups waiting for dental care with proactive intervention programs.

4. Reshape funding arrangements for public dental care.

In 2002 - 03, 68 per cent of medical health services expenditure was funded by government sources while only 20 per cent was sourced from individual out-of-pocket spending. This is almost the reverse of dental services expenditure, where the majority (68%) was privately funded by individuals and only 17 per cent was government funded.

5. Expand the dental workforce.

There is a shortage of the dental labour force and a national dental labour force plan is required.

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