Directions for improving oral health and dental services for Australians

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Australian children in the mid-1990s had among the best oral health in the world. Even with the deterioration seen across the last 15 years, the oral health of Australian children still ranks in the top tier of OECD countries. On a population basis, the need for treatment is manageable and costs for the coverage of five million children are considerable, but not as confronting as for adults. The cost for treatment per child is about one-third to one-quarter the cost for a concession card holder adult. Historically, Australia has invested in oral health and dental services for children through school dental services or community dental services. However, these services only reach a little less than 30 percent of primary and secondary school children. Services are somewhat loosely targeted toward lower and middle income families. While coverage has been declining rapidly since 2000, there is still a backbone of school or community dental services for children in Australia. What is desired is a system that captures those not visiting in any one year and which can re-orient dental services towards population and clinical prevention.

A number of issues favour the development of a universal approach to dental services for children. First, there is a desire for equality in opportunity to be dentally healthy as a child and for investment in future adult oral health. Second, the social pattern of both disease experience and untreated disease indicate that most children at risk will be excluded from a policy that targets only low income households, or less advantaged geographic areas. Only about half of children from low income households (<$40,001) have experience of dental decay and more than two-thirds of children with decay experience come from households with middle or higher incomes. An approach based on only school or community dental services will exclude many children at risk of dental disease. Third, there is already a strong base from which to develop a high quality parallel school or community and private dental services structure. What is really required is a ‘system’ that reaches out and retains all children in a desirable pattern of use of dental services. All children should have an entitlement for dental services on an annual basis. This entitlement could be exercised in the existing school or community dental services or in private dental practices. The subsequent increased revenue flow to school or community dental services would be sufficient to allow them to take on the task of outreach to vulnerable population sub-groups and the task of identification and then retention in care of ‘at risk’ children. This would also encourage those States lagging behind in coverage by school or community dental services to expand their infrastructure, possibly with shared Federal and State/Territory funding agreements. When the ‘system’ stabilised it might be expected that about 50 percent of children would be treated by the school or community dental services and 50 percent by private dental practitioners. The 50 percent involved in care from the school or community dental services would include ‘vulnerable’ children and marginalised population sub-groups as well as a ‘slice’ of the population who prefer their service or for whom they are the only service available in under-supplied areas. Implementation could be rolled out across three separate cohorts: pre-school, primary school, and secondary school children. The entitlement would be capped and for a benefit package of primary, preventively-oriented, dental services. This universal option would create an opportunity for planned data collection and evaluation and refinement of details like fee for service schedules versus capitation payment, frequency of courses of care, standards of care/disease management strategies for dental conditions, and access to higher level dental services in exceptional circumstances.

‘So this analysis is proposing the adoption of a universal entitlement program for children, phased in over a number of years by starting with pre-school children, then primary school followed by secondary school children.’

Adult dental services, particularly those for concession card holders, present quite a different situation. First, among concession card holders, about 50 percent have not made a visit in the last year. Second, even among those who have visited in the last 12 months, only one third visited a public dental service. Third, of those who visited a public dental service in the last year, most, about two-thirds to three-quarters, visited for an ‘emergency’ or same day dental care. This is a one-off, main problem, ‘palliative’ dental service. Hence, only about five percent of eligible concession card holder adults are receiving ‘primary’ dental care from the public dental services. The situation is one of acute resource scarcity and high level rationing of dental services.
The primary concerns for the report

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Two separate major issues are identified in the Report of the National Advisory Council on Dental Health: improving the oral health of children and teens, a concern in its own right and as the forerunner of the oral health of young and middle-aged adults in the future; and reaching a more equitable access to dental services among children and especially adults. Access is socially patterned with a suite of characteristics all associated with unfavourable patterns of use of dental services (infrequent visiting, visiting mainly for a dental problem) leading to differences in treatment and oral health outcomes among adults.

The Report considers addressing these two major problems within a set of long-term aspirations. It calls for movement toward a dental service that is highly integrated with the broader health system and also shares characteristics like equitable access to preventive and treatment services. However, the Council’s Terms of Reference requested consideration of how improvements could be phased over time. The background to this includes numerous concerns (cost, infrastructure and supply capacity) thought to be rate-limiting issues on growing dental services. As a result, the Report identifies two very short-term activities, and then presents a pair of broad policy options for both children and adults, supported by a block of enabling foundational or supplementary activities.

The policy options for children are put forward as ‘universal’ options, responding to the notion of equality of opportunity as well as the potential return to the population in an investment in future oral health. The policy options for adults are put forward as ‘targeted’ options, directed in the first instance to concession card holders. What the Report does not overtly do is lean one way or the other between alternative policy options for children and adults. This leaves decision-makers room to move, but also with somewhat less direction than they may wish. The purpose of this article is to focus some light on those directions through a description of the desired structure for dental services in the medium term. Therefore, the time horizon includes the 2012-13 Budget and forward estimates through to 2015-16.