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RACP Submission to the Senate inquiry into the provision of and access to dental services in Australia

May 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 30,000 medical physicians and trainees, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) warmly welcomes the opportunity to provide feedback on the Senate inquiry into the provision of and access to dental services in Australia.

Our submission is informed by our paediatrician experts and focuses on the experiences of children and young people. Our recommendations relate to the inquiry's Terms of Reference areas that are of high relevance to our paediatricians' expertise and experience:

- Experience of children accessing and affording dental and related services.
- Adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas.
- Interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services.
- Provision of dental services under Medicare, including the Child Dental Benefits Schedule.
- Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services.
- Adequacy of data collection, including access to dental care and oral health outcomes.

As the Senate acknowledges, every child should have access to quality dental services. Oral health is an integral component of general health and wellbeing, which is the foundation for long-term health outcomes. However, too many families are unable to access or afford quality dental care, leaving children at risk of developing ongoing health issues that are often accompanied by further markers of social disadvantage. The RACP strongly supports the Senate's consideration of interventions that enhance the equity of the dental health sector.

Recommendations

The RACP provides the following recommendations to the Senate inquiry:

1. Reduce access barriers to dental care for children and young people, including measures to improve the availability of dental services in rural and remote areas and for First Nations children.
2. Address the financial cost as a barrier to dental care for children and young people in Australia.
3. Increase awareness among child health practitioners and families regarding the importance of dental health.
4. Mandate oral health training for all health practitioners who work with children.
5. Establish an oral health surveillance system to minimise health inequities and generate an ongoing evidence base.
6. Introduce mandatory regulations to restrict the marketing of unhealthy diets to children and young people.
7. Implement an effective tax on sugar-sweetened beverages to encourage reformulation and reduce consumption, and use the revenue generated to facilitate access to healthy diets.

Comments

The RACP provides the following comments to the Senate inquiry.

Why dental health among Australian children and young people needs to improve

In recent years the reduction in dental caries in children appears to have slowed or even reversed[1], with an overall increase in child dental caries and the mean number of teeth affected by dental disease. In addition, the inequalities for children seem to have increased. Dental caries are prevalent across all socioeconomic groups, however children from the lowest socioeconomic groups have more teeth with disease, are more likely to have some or all of their primary teeth missing, and have poorer paediatric oral health outcomes than other population groups[2]. Given oral health's importance to overall health and wellbeing, these inequities need to be addressed.

Dental decay remains the most common chronic childhood disease in Australia. The most recent nationwide findings reported that over 27 percent of children aged 5-9 years and 10.9 percent of children aged 10-14 years have dental cavities in their primary teeth[3]. Concerningly, over 80 percent of dental cavity burden among children is experienced by roughly one-fifth of the child population[4]. Specifically, children from remote areas, First Nations families, and/or low-income households are more than twice as likely to have dental cavities than their sub-group comparative peers[5]. The adverse effects of poor dental health can influence overall health and wellbeing. In children particularly, poor dental health has the potential to negatively impact a child's ability to eat, speak, sleep and socialise, which may adversely affect them later in life[6].

Access to fluoridated drinking water remains a significant contributor to oral health disparities in Australia. Community water fluoridation began in in 1953 after scientists discovered fluoride's strong protective effect against tooth decay[7]. Yet despite this initiative's success in reducing dental caries in children and adolescents by up to 44%, over 10 %of the Australian population do not have adequate access to fluoridated drinking water,[8] particularly those living in remote parts of the country, of which a disproportionate number are from First Nations families and/or low-income households. Equal access to fluoridated drinking water across the country in all towns and cities is a must for improving dental health amongst the Australian community.

The prevalence of oral disease in Australian children also has a significant impact on the healthcare system. Potentially preventable hospitalisations (PPHs) is an indicator that has been used to measure primary care performance. Dental conditions are responsible for the most PPHs for the 0-10 years age category in Australia[9]. Dental conditions also

[1] Armfield, J., & Spencer, A. (2008). Quarter of a century of change: caries experience in Australian children 1997-2002. Australian Dental Journal, 53(2): 151-159.
[2] COAG Health Council. Australia's National Oral Health Plan 2015-2024. COAG Health Council; 2014. Available at https://www.health.gov.au/sites/default/files/documents/2022/04/healthy-mouthshealthy-lives-australia-s-national-oral-health-plan-2015-2024-australia-s-national-oral-health-plan-2015-2024.pdf
[3] Do, L. & Spencer, A. (2016). The National Child Oral Health Study 2012-14. University of Adelaide Press, University of Adelaide.
[4] Ibid
[5] Ibid
[6] Sanders, A. (2007). Social Determinants of Oral Health: conditions linked to socioeconomic inequalities in oral health and in the Australian population. AIHW cat no. POH 7. Canberra: Australian Institute of Health and Welfare.
[7] Australian Dental Association (2023) Fluoride. May 30. Retrieved from Fluoride - Australian Dental Association (teeth.org.au)
[8] NHMRC (2017) NHMRC Public Statement 2017: Water Fluoridation and Human Health in Australia. Australian Government.
[9] Nguyen, T. (2017) Deeble Institute Issues Brief No. 20: Is the current model of public dental care promoting the oral health of young children in Australia? Australian Healthcare & Hospitals Association. Available at https://ahha.asn.au/publication/health-policy-issue-briefs/deeble-institute-issues-brief-no-20-current-model-public

account for the second highest number of population wide acute PPHs in Australia[10]. Most dental PPH interventions are costly too, as they often require general anaesthesia.

Universal health coverage (UHC) has been identified as a key strategic priority of the World Health Organization (WHO), aiming to have 1 billion more global citizens benefitting from UHC in 2025 than there were in 2019[11]: "*UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship".* While acknowledging the varying needs across countries, the WHO stresses that reorienting national health systems towards primary health care would be an effective means of achieving its UHC target. To fulfil its commitment to the WHO, Australia needs to improve access to primary dental care for children and young people.

Improving affordability of dental services for children and young people

The Child Dental Benefits Schedule (CBDS) was introduced in 2014 to remove financial barriers to child and teenage dental healthcare in Australia. Although there is evidence that the schedule has generated a marginal increase in dental attendance among low-income groups, a significant percentage of disadvantaged Australians are still not receiving adequate dental health care[12].

The most recent audit of the schedule revealed that the $1.4 billion worth of benefits paid from 2014 to 2018 was 41 percent lower than the expected expenditure[13]. This is consistent with the finding that 30 percent of the eligible child population were utilising the schedule's funding in its first year and that utilisation had dropped by a further 16.3 percent over the following three years[14].

There is consensus among our RACP paediatricians that financial cost remains a barrier to dental care for children and young people in Australia. The CDBS provision of $1052 of dental treatment over two calendar years for eligible families would appear sufficient for at least one free annual appointment. However, our RACP members have consistently observed that standard appointments are not enough for the average disadvantaged child who has often developed serious oral conditions by the time they present at a dental clinic for the first time. Our RACP members believe that the low uptake of the CDBS can be at least partly explained by the fact that its benefits fail to render non-standard dental appointments affordable for many disadvantaged families.

Improving access to dental care for children and young people

Healthcare access comprises several components and not simply financial access. Our RACP members noted that some of these other components also impact the dental health of children and young people in Australia.

A comprehensive synthesis of the literature exploring the conceptualisation of health care access identified five components of service accessibility: approachability; acceptability;

[10] Australian Institute of Health and Welfare. (2020). Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18.
[11] The World Health Organisation. (2021). Universal Health Coverage. Retrieved from https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
[12] Stormon, N., Loc, D., & Sexton, C. (2022) Has the Child Dental Benefits Schedule improved access to dental care for Australian children? *Health and Social Care in the Community,* 30(6):4095-4102
[13] Commonwealth of Australia (2019). *Report on the Fourth Review of the Dental Benefits Act 2008.* Retrieved for Canberra ACT.
[14] Putri, D., Kruger, E., & Tennant, M. (2019). Retrospective analysis of utilisation of the Child Dental Benefit Scheme. *Australian Health Review,* 44(2): 304-309.

availability and accommodation; affordability; and appropriateness[15]. A description of each of these components can be found in the study by Levesque et al (2013)[16]. Affordability was discussed in the previous section and our RACP members haven't found service quality to be a common issue. This section will thus explain how the remaining three components are problematic in the context of dental care access for Australian children and young people. Most of the supporting evidence stresses the disproportionate impact on two groups: regional Australians and First Nations people.

Children living in rural and remote communities face higher rates of dental disease compared to those who live in metropolitan regions, and disease rates tend to go up with level of remoteness[17]. Moreover, hospital separation rates for children with dental caries are significantly worse in rural Australia than in metropolitan areas[18] and these figures can be attributed to the relatively low uptake of the CDBS in regional Australia[19].

Similarly, First Nations people have significantly higher levels of tooth decay than the general population. Indigenous children have twice the rate of caries compared to non-Indigenous children and higher incidence of invasive dental treatment[20]. A recent analysis of the CDBS revealed that attendance rates among Indigenous children were 31 percent lower than they were for their non-indigenous counterparts[21].

A disproportionate percentage of regional and First Nations children and young Australians who are eligible for CDBS provisions are not utilising them for the following reasons:

- **Geographical access barriers** to dental services in regional Australia, where a high proportion of indigenous families happen to live. 2021 ABS data revealed that in comparison to metro areas, which had 56.7 dentists per 100,000 people; outer regional areas had 34.6; remote areas had 26.6; and very remote areas had 18.8[22].
- Multiple studies have indicated that very few dental services cater to the cultural needs of Indigenous Australians[23] [24] [25] representing a **cultural appropriateness barrier**.
- Evidence suggests knowledge and awareness deficits (**informational access barrier**) also play a significant role in CDBS underutilisation. A recent CDBS population study concluded that poor promotion of the CDBS was a key factor in its low uptake[26]. Researchers found that not only was there limited awareness of the scheme itself among vulnerable populations, but that policymakers and stakeholders had failed to sufficiently promote oral health importance in general.

[15] Levesque, J., Harris, M., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 18.
[16] Ibid
[17] Gardiner, F., Richardson, A., Gale, L., et al. (2020). Rural and remote dental care: patient characteristics and health care provision. *Aust J Rural Health, 28:292-300.*
[18] Nguyen, T. (2017) Is the current model of public dental care promoting the oral health of young children in Australia. Deeble Institute issues brief, No.20.
[19] Nguyen, H., Thu Le, H., & Connelly, L. (2020). Who's declining the "free lunch"? New evidence from the uptake of public child dental benefits. Health Economics, 30(2): 270-288
[20] Orr, N., Gwynne, K., Sohn, W., et al. (2021). Inequalities in the utilisation of the Child Dental Benefits Schedule between Aboriginal and non-Aboriginal children. *Australian Health Review, 45(3)*
[21] Stormon, N. (2022). Has the Child Dental Benefits Schedule improved access to dental care for Australian children? Health & Social Care in the Community, Vol. 30(6):4095-4102
[22] ABS (2021). Employed health professionals, clinical full-time equivalent rate, by remoteness area.
[23] Slack-Smith, L., Durey, A., & Scrine, C. (2016) Oral health in Indigenous adults: Perceptions and beliefs around oral health and dental care, Centre of Research Excellence in Primary Oral Health Care
[24] Shrivastava, R., Couturier, Y., Girard, F. (2020) Two-eyed seeing of the integration of oral health in primary health care in Indigenous populations: a scoping review, International Journal for Equity in Health, 19(107)
[25] Stormon, N. (2022). Has the Child Dental Benefits Schedule improved access to dental care for Australian children?
[26] Bastani, P., Izadi, R., Manchery, N., et al. (2022) How does the dental benefits act encourage Australian families to seek and utilise oral health services? *PLoS One, 17(11): e0277152*

Disadvantaged families may not have to pay for an annual dental appointment for their children, but if they do not have timely access to a culturally appropriate service or are not aware of the CDBS or the necessity of dental care, then the opportunity costs of travelling to and waiting for a service outweigh the perceived benefits.

It is for these reasons that the RACP recommend the following interventions:

- Reduce access barriers to dental care for children and young people, including measures to improve the availability of dental services in rural and remote areas and for First Nations children.
- Increase awareness among child health practitioners and families of the importance of dental health.
- Mandate oral health training for all health practitioners who work with children.

Creating a national oral health registry

Historically, the most effective means of addressing multi-faceted public health issues has been through the implementation of a rigorous and cohesive nationwide strategy. Our RACP members believe a compulsory national oral health registry should be the centrepiece of a broader strategy to tackle the inequities in oral health among children and young people in Australia.

As stressed above, oral health inequities are a major concern among Australian children and young people that significantly impact overall health outcomes. The establishment of a compulsory national oral health registry would mitigate these inequities by improving the quality of serious dental interventions and facilitating the surveillance of access barriers. It is for this reason that the RACP makes the following recommendation:

- Establish an oral health surveillance system to minimise health inequities and generate an ongoing evidence base.

Other initiatives to improve oral health among children and young people

The RACP believes in a holistic approach to combatting oral health inequities among Australian children and young people. Over the past few years, the RACP has been advocating for policy changes aimed at improved children's diets. Whilst the focus of this advocacy work has been on lowering obesity levels, two of our most important recommendations are directly linked to oral health.

Since our 2018 position statement on obesity[27], the RACP has been advocating for regulations to restrict the marketing of healthy diets to children and young people and for an effective tax on sugar-sweetened beverages. The former was also a central tenet of our Kids Catch-Up campaign[28]. Since the release of our Child Health Advocacy Strategy in 2022[29], we have been increased our efforts to promote oral health in children and young people by supporting the Obesity Policy Coalition's sugar tax and 'Brands off our Kids' campaigns[30].

The RACP therefore makes two final recommendations:

- Introduce mandatory regulations to restrict the marketing of unhealthy diets to children and young people.

[27] racp-obesity-position-statement.pdf
[28] https://kidscatchup.org.au
[29] child-health-advocacy-strategy-2022-25.pdf (racp.edu.au)
[30] Brands off our kids! - Food For Health Alliance

- Implement an effective tax on sugar-sweetened beverages to encourage reformulation and reduce consumption, and use the revenue generated to facilitate access to healthy diets.

Thank you for the opportunity to provide feedback on the inquiry. If you would like to discuss any of the matters raised in this document, please contact the RACP Policy and Advocacy via policy@racp.edu.au.