



SA Dental Service

# South Australia's Oral Health Plan 2010-2017

The South Australian Government's plan for  
oral health care over the next seven years



Government  
of South Australia

SA Health

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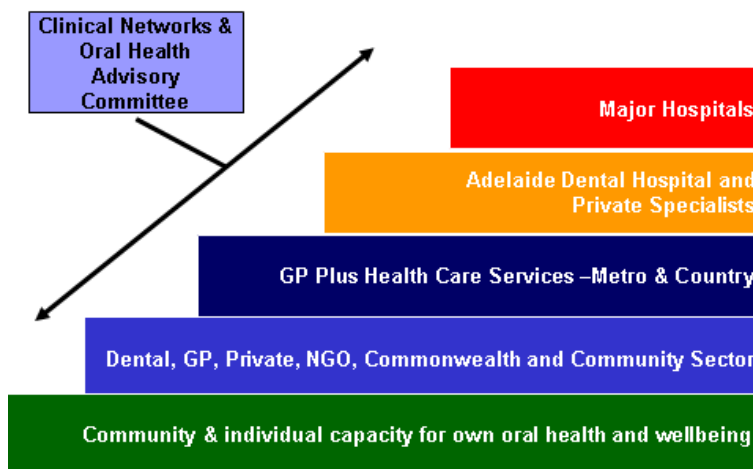
## Foreword

Australia's first *National Oral Health Plan 2004-2013* (National Plan) was endorsed by the Australian Health Ministers' Conference in August 2004, and is underpinned by the following themes:

- > oral health is an integral part of general health
- > a population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease
- > access to appropriate and affordable services – health promotion, prevention, early intervention and treatment
- > education to achieve a sufficient and appropriately skilled workforce, and communities that effectively support and promote oral health
- > research and evaluation to ensure that oral health outcomes are maximised as an essential component of general health with the funding available.

*South Australia's Oral Health Plan 2010-2017* (Oral Health Plan) has been developed within the framework of this National Plan, as well as *South Australia's Health Care Plan 2007-2016* (Health Care Plan). *South Australia's Oral Health Plan* outlines a stepped approach to resources that are intended to promote oral health and treat oral diseases for the whole population.

**Figure 1: The Stepped Model of Oral Health Services in South Australia**



The stepped model above is based on descriptions of stepped health care services provided in *South Australia's Health Care Plan*. The Health Care Plan outlines a reform agenda to ensure that all South Australians have access to quality, safe, complete and affordable health care.

The aim of *South Australia's Oral Health Plan* is to improve the oral health of all South Australians, but particularly those groups of people who are most at risk of poor oral health.

The strategies aim to enable people to have:

- > good oral health as part of their general health and wellbeing
- > access to appropriate private or public oral health care provided by the right provider at the right time in the right place at a cost they can afford.

In conjunction with the Oral Health Plan, an action plan will be released that further explains the strategies and timeframes associated with the implementation of the strategies outlined on pages 18 to 26.

## Burden of disease for oral health

Dental problems are very common in the Australian population: 26% of adults have untreated dental decay, 23% have moderate to severe gum disease, 15% experience toothache often or very often<sup>1</sup>.

Diseases of the oral cavity have significant impacts on people's lives and wellbeing. For example, poor oral health:

- > interferes with daily functions and work productivity<sup>2</sup>
- > impacts on social interactions<sup>2</sup>
- > can lead to considerable morbidity and even death<sup>2</sup>.

Disadvantaged groups in the population are known to experience these impacts more frequently<sup>3</sup>.

Oral diseases cause hospitalisation, which could be avoided, particularly in young children with early childhood caries. In 2003-04, the most common reason for children under 15 years of age to undergo general anaesthesia in hospital in Australia was for dental extractions and restorations<sup>4</sup>.

Poor oral health has an adverse impact on other health conditions. For example, periodontal disease may contribute to cardiovascular disease, pre-term birth and low birth weight babies, aspiration pneumonia, infective endocarditis and nutritional deficiencies in children and older adults<sup>2</sup>.

Oral diseases are also a major financial cost to the South Australian community. Even when the hospital component of the cost is largely excluded, oral health service expenditure represents 4.9% of total health expenditure in the state in 2001-02<sup>5</sup>. Private expenditure formed 71% of the total \$243 million dollars spent on dental care in South Australia in 2001-02<sup>5</sup>. These costs relate primarily to repair and maintenance of teeth and gums due to dental caries and periodontal disease.

Poor general health also has an adverse impact on oral health. For example, diabetes directly affects the tissues of the gum that support teeth. Similarly, hepatitis C and HIV infection have significant impacts on oral health<sup>2</sup>.

## Social determinants of oral health

Dental decay is primarily a disease of poor diet while poor oral hygiene is a primary contributing factor in periodontal disease.

While most dental treatments repair disease, thereby alleviating symptoms and limiting dysfunction and disability, most dental services do not alter the upstream causes of disease, which instead are influenced more broadly by social determinants. Social determinants of health have been described as 'the material and social conditions of a society that decisively influence opportunities and life chances of population groups, their quality of life and ultimately their life expectancy'<sup>6</sup>. The underlying causes of oral health can be attributed to many of those same social determinants, primarily income and income distribution, education, employment status, housing and social integration. It is these social determinants that influence early life opportunities, exposure to health hazards, and adoption of health behaviours. Social disadvantage counteracts programs that seek to promote health and prevent disease.

Evidence from a study of South Australian adults demonstrate that these social determinants are attributes not only of individuals, but also of the places in which they live. For example, residency in poor neighbourhoods has an impact on tooth loss that is independent of the effect on tooth loss of individuals' low income<sup>7</sup>.

These findings demonstrate that the underlying causes of poor oral health are likely to be similar to the underlying causes of other health disorders. They emphasise the need for broad based policies that extend beyond health services to address the adverse effects of social and economic disadvantage. Such policies are consistent with South Australia's Social Inclusion Initiative promoting a society where all people's basic needs are met, people feel valued and differences among people are respected.

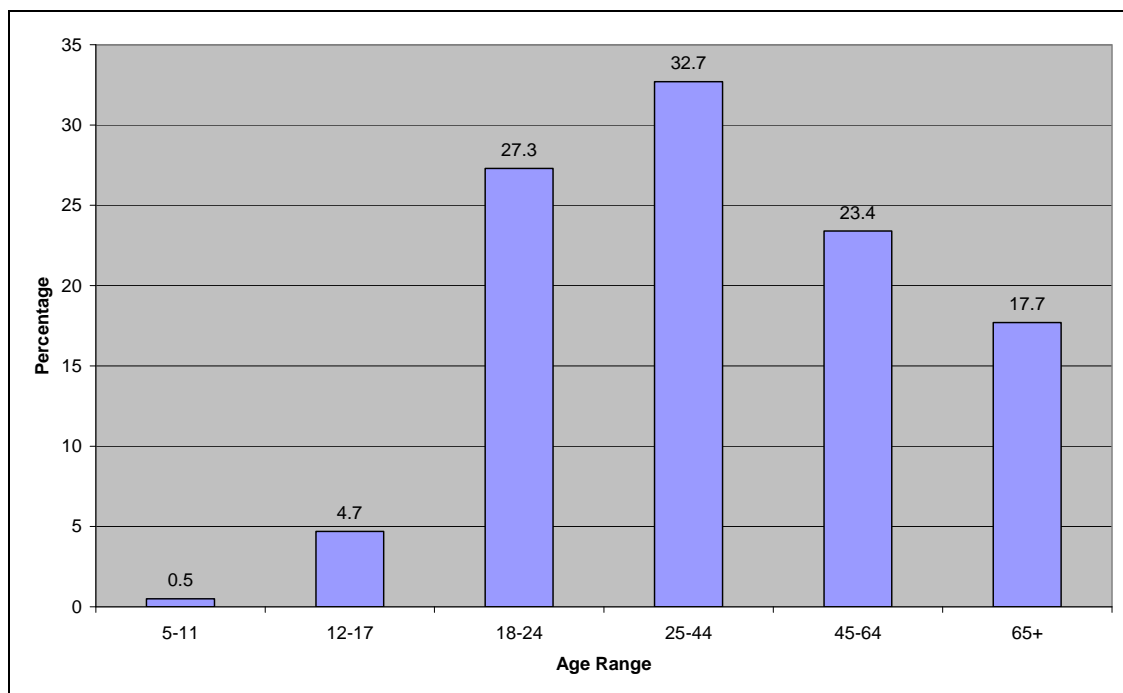
## South Australia's oral health challenges

### Access to services

#### Dental care

With the exception of children, who are eligible for the School Dental Service, three quarters of South Australians receive dental care through private dental practice, with or without the assistance of dental insurance<sup>1</sup>. Nationally, many adults, and particularly middle and low income earners, report that cost is a barrier to accessing oral health services<sup>8</sup>.

Figure 1: People who avoided/delayed dental care because of cost



Source: Adapted from Carter KD & Stewart JF (2003). *National Dental Telephone Interview Survey 2002*. AIHW cat. No. DEN 128 Adelaide: AIHW Dental Statistics and Research Unit.

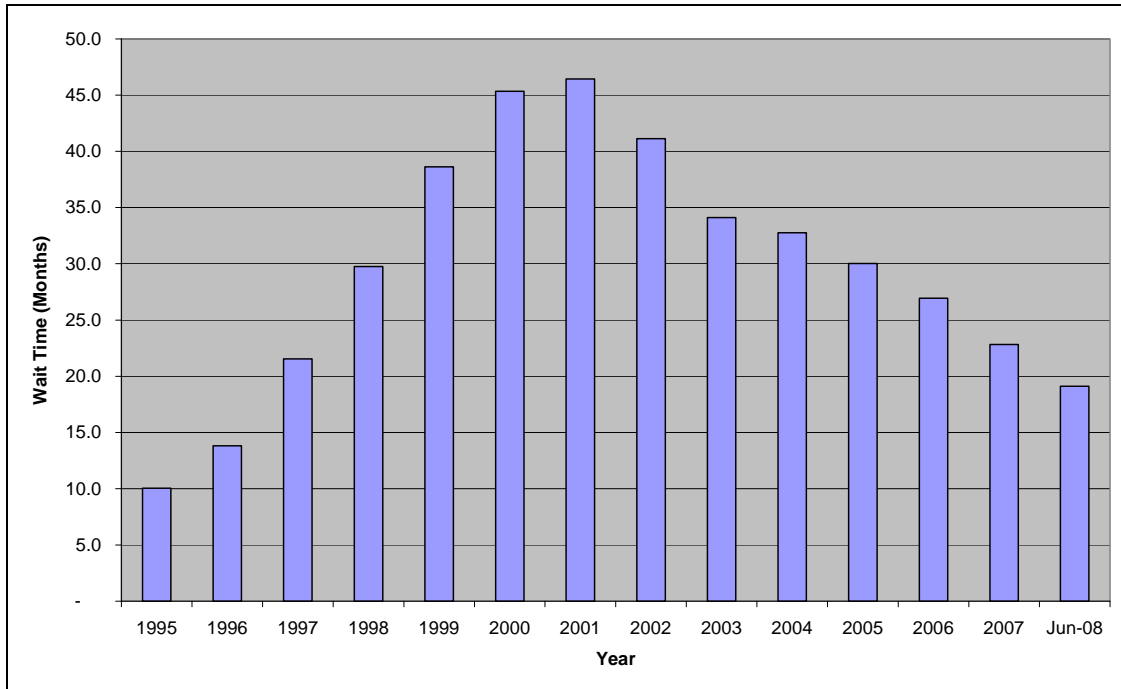
Adults who hold a Health Care Card or Pensioner Concession Card issued by Centrelink, or a Pensioner Concession Card issued by the Department of Veterans' Affairs, or are the dependent of a card holder, are eligible for public dental care. However, over one half of concession card holders who attend the dentist do so at private dental practices<sup>1</sup> probably reflecting barriers to accessing public dental services including waiting lists.

Furthermore, a substantial proportion of the community report that a dental visit is stressful and this is an undoubted barrier to dental care<sup>9</sup>.

Loss of the Commonwealth Dental Health Program in 1996 halved the funding available for the treatment of the 400 000 South Australian adult concession card holders who were eligible for publicly funded dental care.

This dramatically reduced their access to timely and affordable dental care and public dental waiting lists increased from well under 10 months in 1996 to 49 months in 2002. Additional funding by the State Government has reduced this waiting time to 18 months in 2008<sup>10</sup>. The Australian Government has indicated its intention to introduce a new version of the Commonwealth Dental Health Program.

**Figure 2: Average Wait for Restorative Dental Care**



Source: SA Dental Service: Evaluation and Research Unit Unpublished Data 2008

### Ageing population

The number of people aged 65 years or older in Australia will rise from 2.2 million in 1997 to about 4 million in 2021<sup>11</sup>. South Australia's population is older than the national average and this trend will be even more evident in our state.

Conversely, in the last two decades of the twentieth century, the percentage of adults with no natural teeth more than halved, from 20% in 1979 to 8% in 2002<sup>12</sup>. Almost all of the reduction occurred, because of the passing of older generations that had experienced an 'epidemic' of dental extractions during the first half of the twentieth century<sup>13</sup>. During the next four decades, the trend is expected to continue, and the prevalence of complete tooth loss is projected to fall to 1% or less by the 2040s<sup>1</sup>. Older people are now retaining their natural teeth to a far greater degree than in the past, with benefits to their ability to eat, speak and socialise.

Many oral conditions can be exacerbated by the presence of a range of general medical conditions and physical or cognitive disability. For example, some medications prescribed for older people may reduce the amount of saliva, predisposing users to higher levels of dental decay and periodontal disease and making denture wearing difficult<sup>2</sup>.

While retention of natural teeth has many advantages, it also brings with it an increased need for dental maintenance including regular check-ups, preventive care, restorative and periodontal treatment. If oral health has been maintained during middle age, it often can be

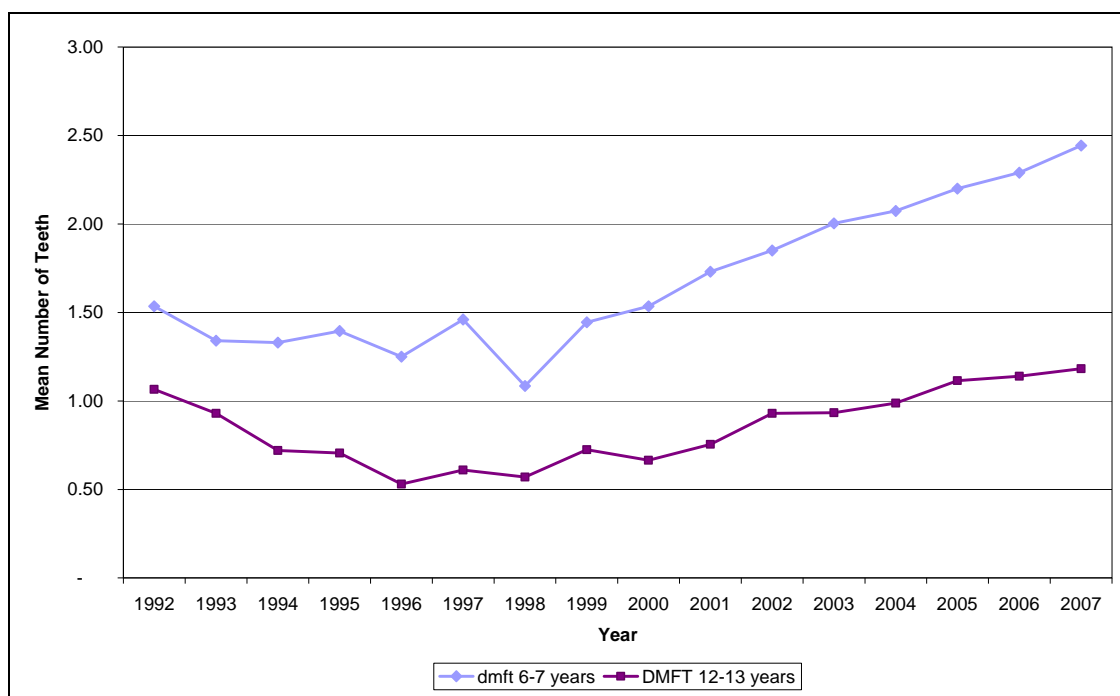
managed with uncomplicated dental care in older age. However, people who go without dental care over many years are likely to develop a backlog of dental disease as they age, requiring more complex dental care such as crowns, repeated treatments for periodontal (gum) disease, and replacement of badly diseased teeth that require extraction. These difficulties are magnified when the treatment has to be provided in residential settings.

All the above factors combine to present challenges for the provision of dental services for older people in South Australia.

### Dental decay among children

There were major improvements in the oral health of children from the 1960s. By 2001, South Australian children had the lowest level of dental decay in their permanent teeth when compared to other Australian states and territories<sup>14</sup>. In the deciduous (baby) teeth, South Australian children ranked second lowest in their level of dental decay. However, in recent years some of these gains have been lost and children in all socio-economic groups are now experiencing more decay<sup>10</sup>.

Figure 3: Mean number of teeth with caries experience for children



Source: SA Dental Service: Evaluation and Research Unit Unpublished Data 2008

Reasons for the deterioration are not clear but are thought to include:

- > increased consumption of sugary foods and drinks<sup>15</sup>
- > reduced exposure to fluoride in toothpaste following the introduction in the 1990s of low concentration fluoride toothpastes for young children<sup>16</sup>
- > increased drinking of rain water and bottled water that have low fluoride levels<sup>17</sup>.

The increases in dental disease among children are placing additional stresses on the School Dental Service.

### **People with special needs**

Special needs refers to people with intellectual or physical disability, medical or psychiatric conditions or substance abuse problems, which increase their risk of oral health problems or increases the complexity of the oral health care required<sup>18</sup>. There are compelling reasons to give priority to the oral health care of people with additional needs.

### **People with chronic medical conditions**

People with a range of chronic medical conditions are also frequently more vulnerable to oral disease and may face additional problems with dental care<sup>18</sup>. Examples include diabetes, cancer and blood-borne diseases such as HIV-AIDS and hepatitis C. There are compelling reasons to give priority to the oral health care of people with chronic medical conditions.

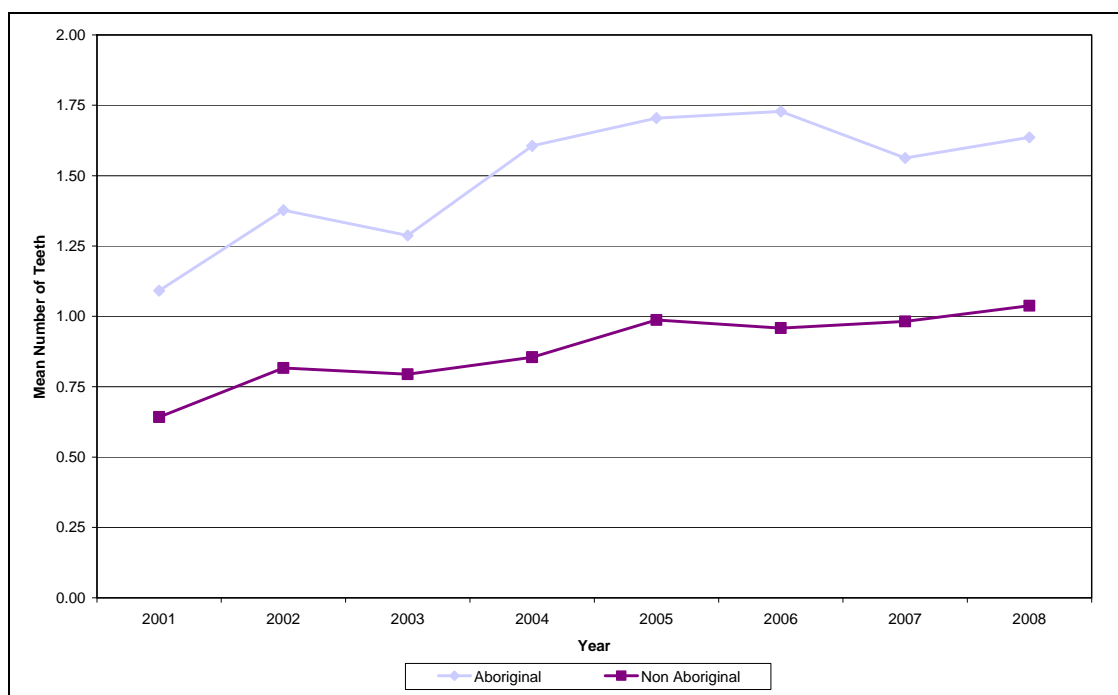
### **Aboriginal people\***

Aboriginal children are at risk of developing further caries through to adulthood, with increasing numbers of teeth affected and eventually extracted. At the age of six years, 72% of Aboriginal children had some tooth decay compared with 38% of other Australian children<sup>19</sup>. This figure holds true for South Australia, with Aboriginal children experiencing approximately 70% more dental caries than non-Aboriginal people and they have more teeth with untreated dental decay<sup>5</sup>. While decay experience among Aboriginal children in Adelaide increased in the 1990s in line with the rest of the community, it more than doubled in Aboriginal children in remote areas<sup>20</sup>. This deterioration among Aboriginal children is the result of poor diet and poor oral health practices together with lack of access to fluoridated tap water.

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\* SA Health respects the different and diverse cultures that make up Aboriginal and Torres Strait Islander peoples and their communities. The term "Aboriginal" will be used to describe this population group.

**Figure 4: Mean number of teeth with caries experience for Aboriginal and non-Aboriginal 12-year-olds**



Source: SA Dental Service: Evaluation and Research Unit Unpublished Data 2008

The teeth that are retained will also suffer from much higher levels of periodontal disease, which is likely to be earlier in onset and of greater severity than periodontal disease in other Australian adults. Aboriginal adults have a higher prevalence of severe periodontal disease than non-adults and are more than twice as likely to have advanced periodontal disease<sup>19</sup>. Periodontal disease accounts for 30% of tooth loss<sup>21</sup>, contributing to the higher number of missing teeth in Aboriginal people. This may be the result of complications arising from other non-dental chronic diseases, such as diabetes. The higher prevalence and severity of periodontal disease may subsequently place these adults at risk of further chronic degenerative diseases, such as diabetes and cardiovascular disease.

Data from the Australian Bureau of Statistics in 2008 indicates that in 2004-05 the burden of disease was two-and-a-half times higher in Aboriginal Australians than in other Australians. Cardiovascular disease, mental disorders, chronic respiratory disorders and diabetes were the major causes of the disease burden in the Aboriginal population.

The ability of Aboriginal people to achieve good oral health outcomes is affected by environmental conditions. These include:

- > the availability of cool fluoridated drinking water, affordable fresh fruit and vegetables and cold storage of food
- > access to toothbrushes and fluoride toothpaste
- > the impact of overcrowding and lack of hygienic conditions.

The *National Survey of Adult Oral Health 2004–2006* found that Aboriginal adults have a higher perceived need for dental treatment than other Australians, particularly for dentures, fillings and extractions.

### **Rural and remote people**

Children living in rural and remote areas experience between 25% and 30% more dental caries than metropolitan children aged 11 to 12 years, and 25% to 30% more extreme disease experience in deciduous teeth<sup>22</sup>.

Adults resident in non-capital cities have 10% more dental caries experience and twice the rate of untreated coronal tooth decay than capital city dwellers<sup>1</sup>.

The rate of complete tooth loss (edentulousness) in country areas is one-third higher in the over 55 year age group when compared with metropolitan Adelaide residents of similar age and 62% higher across all ages for rural residents<sup>1</sup>.

### **Migrant people**

Children born in non-English speaking backgrounds experience 80% more decay in their deciduous teeth and 30% more decay in their adult teeth than other children<sup>10</sup>. No equivalent information of the oral health adults is available, but it is likely that the oral health inequality among adults is even wider than for children.

### **Disadvantaged people**

About one quarter (28%) of South Australian adults have a health care card and, therefore, are eligible for dental care in the public sector<sup>1</sup>. Consistently, they have poorer oral health than those without a health concession card, as indicated by the most prevalent oral disorders: tooth loss, dental decay and gum disease<sup>1</sup>. Additionally, concession card holders are much less likely to attend the dentist for a check-up, and they are more likely to report that they avoided dental visits or had to forgo recommended dental treatment because of costs.

The cost of dental care is also cited as a barrier to dental care by people who are not eligible for public dental services<sup>8</sup>. Between 2001 and 2006 dental fees in South Australia increased by 30.4% compared with a 16.7% increase in the Consumer Price Index<sup>23, 24</sup>.

Nationally, private dental fees increased at a rate of 50.5% in the past decade while the increase in general health fees was 29.7%. By way of comparison, costs in the general economy increased by 18%<sup>5</sup>.

### **People with dental insurance**

Nearly half (46%) of South Australian adults have dental insurance<sup>1</sup>. Compared to the uninsured, South Australian adults with dental insurance fare better on virtually all measures of oral health (tooth loss, untreated dental decay, and gum disease) and consistently they report better access to dental care<sup>1</sup>.

## **Where we are now**

Water fluoridation, the widespread use of fluoride toothpaste and the universal availability of timely, preventively focused dental care has given South Australian children the opportunity to enter adulthood with excellent oral health.

However, there are a number of groups within the South Australian community with limited access to these foundations for good oral health. As a result their oral health outcomes are poor with consequent impacts on their general health and wellbeing.

This Oral Health Plan identifies barriers to improved oral health outcomes for these groups and strategies to overcome them including workforce, infrastructure, health promotion and improved access to services.

## **Infrastructure**

### **Public Dental Services**

The South Australian Dental Service operates the majority of public dental services in South Australia including:

- > the School Dental Service for children to their 18<sup>th</sup> birthday
- > the Community Dental Service providing emergency and general dental care for adult concession card holders
- > the Adelaide Dental Hospital, incorporating general dental services (including teaching clinics for undergraduate and postgraduate students) and specialist dental services.

In addition, the Flinders Medical Centre and The Queen Elizabeth Hospital operate small dental clinics, predominantly treating hospital patients, and the Women's and Children's Hospital maintains a specialist paediatric dentistry unit.

Dental programs, primarily for Aboriginal people, are also operated by:

- > Tullawon Health Service at Yalata
- > Nunkuwarrin Yunti in Adelaide
- > Pika Wiya in Port Augusta
- > Nganampa Health Service in the Pitjantjatjara Home Lands
- > Umoona Tjutagku in Coober Pedy

In addition, the Aboriginal Health Council funds the Aboriginal Dental Program under which Aboriginal people in country areas with a concession card are able to receive dental care from participating private dentists.

### **The Oral Health Workforce**

To secure a sustainable long-term solution to the national dental workforce shortage, the School of Dentistry has significantly increased undergraduate students studying Dental Surgery and Oral Health programs in recent years. With these increased student numbers there are additional challenges ensuring that they are able to gain the clinical experience they need as part of their course.

In addition to managing more complex cases, dental specialists provide leadership in undergraduate dental education and the professional development of the general dental workforce. However, the dental specialist workforce is ageing and it is not clear that postgraduate courses are training sufficient new specialists in all areas of specialisation.

In the vocational education sector, student numbers have also increased in response to the demand for trained dental staff. Dental Assisting trainee numbers have increased fourfold over the past 10 years to 180 students, graduating in 2010. There has been a similar growth in the number of students graduating with the Certificate IV in Dental Assisting, which includes the mandated units for dental radiography in addition to other areas of skill demand, such as oral health promotion and practice management at the Certificate IV level.

The number of Dental Hygienists that have graduated has increased over the same period and has been accommodated by the recent redevelopment and expansion of the dental clinic at TAFE SA Gilles Plains campus. The redevelopment of this facility also provides more opportunity for dental students from the School of Dentistry at Adelaide University to treat SA Dental Service patients, while being assisted by Dental Assisting students studying at TAFE SA. This encourages a team approach to oral health care, highlighting the effectiveness of the collaboration between government agencies and the higher education sector, and ensuring the efficient use of public resources. It also highlights the progressive nature of the vocational education sector in South Australia.

In 2010, TAFE SA is also offering the first Dental Prosthetist course delivered in South Australia. An agreement is in place between TAFE SA and SA Dental Service to allow students of the Advanced Diploma in Dental Prosthetics to provide dentures for people on public dental waiting lists.

In metropolitan and CBD Adelaide there are 64.6 dentists per 100 000 people. However, outside the capital city there are only 28.1 dentists for 100 000 people in South Australia<sup>25</sup> and only Tasmania and the Northern Territory had lower ratios. The SA Dental Service has been successful, at least in the short- to medium-term, in attracting dentists to country areas through the Public Dental Sector Workforce Scheme, the use of overseas trained dentists, and through programs of enhanced remuneration. For example, six of the 26 dentists employed in the public sector outside of Adelaide are overseas trained dentists employed through the Public Dental Sector Workforce Scheme. A further 10 Adelaide-based dentists receive enhanced remuneration to visit country areas on a weekly basis to provide dental care to public patients and these arrangements have recently been extended to dental therapists. However, the shortages of private dentists in country areas are having a significant impact on the accessibility of private dental services in many areas. There are also problems attracting and retaining other members of the oral health team (dental therapists, dental hygienists and dental assistants) to rural areas.

### **Capital works/ageing public infrastructure**

Most community-based public dental clinics across the state are two to three surgery facilities that were located in the grounds of selected primary schools in the 1970s for the treatment of children. Since the 1970s there have been major changes in the demographics of oral health, infection control standards and the use of information technology. As a result, many of these older, small clinics are no longer adequate for the provision of modern dental care.

The Adelaide Dental Hospital is SA Dental Service's largest public dental facility. It is also the major centre for dental education in the state in collaboration with the University of Adelaide and TAFE SA. The building fabric requires updating and it does not have sufficient dental surgeries to support the increased number of undergraduate and post-graduate students that are educated on site.

### **Dental education and research**

The Centre for Dental Studies (at TAFE SA Gilles Plains Campus) operates educational programs for dentists, dental hygienists/dental therapists, dental prosthetists and dental specialists. The centre has leading under and post graduate research programs.

The School of Para Dental Studies of TAFE SA trains and educates dental hygienists, dental assistants and laboratory dental technicians in cooperation with the School of Dentistry and SA Dental Service.

### **Planning and coordination**

Historically, oral health services have tended to plan, implement and evaluate their programs somewhat separately from other health services. In recent years, with a growing awareness of the interactions between oral and general health, dental services have been included in wider health planning and program development to a greater degree.

Greater integration of oral health service policy development and program planning into the wider health sector systems has the potential to increase the awareness of oral health even further. This integration needs to be achieved while recognising the rather specialised nature of dental care.

### **Research**

The National Plan identifies a need to foster research relevant to the seven key population oral health areas including:

- > promoting oral health across the population
- > children and adolescents
- > older people
- > low income and social disadvantage
- > people with additional needs
- > Aboriginal and Torres Strait Islander people
- > workforce development.

The University of Adelaide is a leading dental research institution with a number of nationally and internationally recognised research centres. These include the Colgate Australian Clinical Dental Research Centre, the Centre for Orofacial Research and Learning, and the Australian Research Centre for Population Oral Health. SA Dental Service has developed formal links with the University of Adelaide and collaborative oral health research undertaken through this relationship has led to significant enhancements to public dental services in South Australia.

The further development of oral health research capacity linked with the dental service sector is central to guiding policy development, the design of new programs and their evaluation.

## **Models of Care**

The guiding principles of *South Australia's Oral Health Plan* are:

- > structure the system to deliver person-centred care
- > improve the coordination and integration of services to present a complete system of oral health care to the consumer
- > improve the level of early intervention and illness prevention services
- > reduce access inequalities for the disadvantaged
- > focus on the needs of Aboriginal people using the Aboriginal Cultural Respect Framework for SA Health<sup>26</sup>
- > optimise opportunities across Government, with the private sector and the Australian Government
- > recognise that *South Australia's Oral Health Plan* is a part of a system with appropriate links
- > use suitable datasets, key performance indicators and reporting mechanisms to enable the monitoring of key outcomes to inform oral health planning.

## Meeting the challenges

### **Water fluoridation**

Water fluoridation is the most cost-effective population health measure for the prevention of dental decay, with its most pronounced effects among those who are most disadvantaged<sup>27</sup>.

Work has begun to fluoridate the water in Mount Gambier, as it is the only remaining major South Australian community that does not have access to reticulated water with appropriate levels of fluoride.

*We will explore the potential to fluoridate the water supplies of the few remaining smaller centers without access to this important public health measure, including Roxby Downs and Coober Pedy.*

### **Oral health messages for the whole population**

As dental science progresses it is inevitable that recommendations will change with time. However, it is important that recommendations for personal preventive behaviours are consistent and simple. Greater consistency and clarity of recommendations is needed for the full range of personal preventive behaviours including:

- > the use and type of fluoride toothpaste
- > drinking fluoridated tap water
- > dietary choices
- > the frequency of dental check-ups
- > smoking cessation
- > oral hygiene and plaque removal
- > links to general health.

*We will work with the Australian Government, other state/territory governments, dental professions and the tertiary and vocational sectors to ensure a nationally consistent set of oral health messages is developed and promoted.*

### **Making timely dental care more affordable and accessible**

Dental insurance reduces the out-of-pocket cost of private dental care and is associated with higher rates and better patterns of dental attendance.

We will work with the Australian Government and the private health insurance sector to explore ways of reducing the out-of-pocket cost of dental care.

The wider use of all oral health providers in addition to dentists (such as dental therapists, dental hygienists and prosthetists) has the potential to improve access and oral health outcomes for South Australians. In July 2009, the Regulations under the *Dental Practice Act 2001* were amended to remove the restriction on dental therapists to the treatment of people under the age of 18 years.

*We will continue to explore more flexible service delivery opportunities for all oral health providers aimed at enhancing oral health outcomes for all population groups.*

Many low income earners are not able to afford private dental care and must rely on publicly funded dental services.

*We will work with the Australian Government to ensure that low income earners are able to receive regular dental check-ups and timely treatment.*

Higher disease levels in country areas and the higher cost of service delivery when distributing public dental resources across the state is reflected in the provision of services by SA Dental Service. As a result, waiting times for emergency and general public dental care in most country areas are about the same as for people in Adelaide.

However, when more complex treatment is required, there are frequently no local visiting dental specialists and patients have to travel to Adelaide for this more complex care. SA Dental Service has operated a limited visiting public dental specialist program in some major country centres for people who are eligible for public dental care.

*We will progressively extend the visiting public dental specialist program to all major country centres across the state in line with the Country Health Care Plan.*

### **Meeting the needs of older people**

The overwhelming majority of older people are living in the community with or without the support of a range of programs assisting them to maintain their independence. SA Dental Service has successfully involved general medical practitioners in the Oral Health for Older People program in the inner southern suburbs of Adelaide.

*We will work with general practitioners and the range of health professionals who interact with older people in their homes, to include a simple oral health screening tool in their assessment of their clients' needs. This assessment will provide assistance to maintain oral hygiene and act as a referral pathway for dental treatment where needed. When these clients are eligible for public dental care, this treatment will be provided on a priority basis in collaboration with the private dental sector.*

While the oral health of many older people in the community is already poor, there is a further rapid deterioration once they are admitted to residential aged care<sup>28</sup>. The Australian Government has announced that it will be implementing the national *Nursing Home Oral and Dental Health Plan* based on a program developed in South Australia.

*We will work with the Australian Government in the implementation of the Nursing Home Oral and Dental Health Plan to ensure people in residential aged care:*

- > have an oral health assessment as part of their health check and care plan*
- > receive the support they need to maintain oral hygiene*
- > receive the dental treatment they need in a timely way.*

### **Stemming the increase in dental decay among children**

Many pre-school children develop very severe and extensive dental decay<sup>10</sup> frequently requiring hospitalisation for treatment under general anaesthetic (SA Health data)<sup>29</sup>.

Diets rich in carbohydrates contribute to both obesity and dental decay. Hence, many of the programs aimed at supporting healthy weight among children will assist in reducing the prevalence and severity of dental decay.

*We will support the implementation of the healthy eating guidelines created by the Department of Education and Children's Services for pre-school centres and schools, and the Right Bite Strategy for school canteens, Crunch and Sip and OPAL to increase the use of tap water as the drink of choice and to encourage the consumption of nutritious foods.*

*We will work with the range of health professionals who interact with pregnant women and parents of young children to ensure that they have the information they need at key stages in their child's development to maintain their oral health.*

The Children, Youth and Women's Health Service is already including a simple oral health assessment, as part of their universal and targeted home visiting programs. In this way, young children can be referred to the School Dental Service, or their private dental provider, to treat the decay early before hospitalisation is required.

Initial work has commenced with the appropriate health professionals to discuss the potential for a broader health policy through the Commonwealth Government's new Healthy Kids Check for four-year-old children, which includes an oral health component. However, dental screening at four years of age is too late to prevent much of the early childhood caries that leads to hospitalisation.

*We will encourage the Australian Government to support medical practitioners and other health professionals to undertake a simple oral health assessment for young children from 12 months of age, as part of Medicare, including referral for treatment by an oral health professional where necessary.*

Access to regular check-ups and preventively focused dental care is a foundation for good oral health.

*We will maintain universal access to the School Dental Service for all South Australians until their 18<sup>th</sup> birthday. This will be supported by the new Australian Government's Medicare Teen Dental Program that will fund an annual check-up and preventive care.*

### **Dental Care for people with special needs**

Special needs refers to people with intellectual or physical disability, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care.

The provision of dental care for people with special needs is complex and requires special skills. Much of the dental care can be provided in community-based dental clinics, both in the private and public dental sectors. However, many special needs patients must be treated by registered dental specialists, frequently in collaboration with medical specialists.

*We will form a special needs dentistry network led by the Special Needs Unit at the Adelaide Dental Hospital to expand the capacity of both the public and private dental sector in the management of special needs patients.*

Poor oral health can adversely affect the management of a number of medical conditions and delays in the provision of dental care can have serious consequences.

*We will develop a program of enhanced access to public dental care for adult concession card holders who have a complex chronic medical condition, on referral from appropriate hospital units or medical practitioners.*

### **Improving oral health for Aboriginal people**

Decay rates among Aboriginal children, particularly in rural areas, are higher than those of the rest of the community and the gap is widening<sup>10</sup>. Poor diet is central to this and also contributes to a range of other health conditions among Aboriginal adults, such as diabetes. Diabetes itself then leads to an accelerated progression of periodontal (gum) disease and tooth loss.

*We will work with rural Aboriginal communities to ensure that healthy foods, cold tap water with adequate fluoride levels where feasible and toothbrushes and toothpaste are available at an affordable price. We will also include oral health messages in wider health promotion programs for Aboriginal people.*

A trial liaison program to make mainstream public dental services more accessible and affordable to Aboriginal people has shown some success in Adelaide's northern, western and southern suburbs. Under this program, Aboriginal adults taking part in a range of health programs are also screened for oral health problems and referred for priority dental treatment at the local public dental clinic.

*We will progressively extend the Aboriginal Liaison Dental Program to the whole of South Australia in collaboration with Aboriginal communities.*

The complexity of providing regular dental care for Aboriginal people in small rural communities has been magnified by the current shortage of dental providers.

*To achieve sustainable ongoing dental services for small rural and remote communities, we will develop targeted programs that take account of the unique circumstances of individual communities with a focus on meeting the oral health needs of Aboriginal people. The Aboriginal Cultural Respect Framework for SA Health will be a foundation for these programs and will be developed and managed in close collaboration with the Aboriginal Community Controlled health sector.*

As part of South Australia's Strategic Plan target T2.5, we will contribute to improving Aboriginal healthy life expectancy by increasing coverage of public dental services for Aboriginal people in rural and remote communities in South Australia. A successful pilot remote Aboriginal dental program has been established in the Umoona Tjutagku Health Service at Coober Pedy, as a model for communities that are too small to support a full-time dental program. Under this model a dental clinic is provided and regular visits arranged by visiting dental staff. A key feature of the program is the absence of fixed appointments with assessment and treatment provided at the same visit.

*We will work with the Australian Government to progressively expand dental programs to other small remote Aboriginal health service centres across South Australia based on the experiences of the Coober Pedy model.*

The presence of Aboriginal people in the oral health workforce will assist in making culturally responsive dental services available to Aboriginal people.

*We will increase the number of Aboriginal people working in all areas of the oral health workforce in collaboration with the tertiary and vocational education sectors.*

### **Ensuring a sustainable oral health workforce**

Learning is the key to providing a first-class oral health service and a workforce with high-level skills and capacity. We want to ensure that all oral health providers have access to ongoing training, support and professional development.

The availability of dental care across South Australia is underpinned by the graduation of sufficient South Australian-based dentists and allied oral health providers through educationally sustainable programs in the tertiary education sector. These dental and oral health students gain much of the clinical experience they need as part of their course in public dental clinics treating public patients.

*We will collaborate with the tertiary and vocational education sectors to support the clinical education of the increased number of dental and oral health students through the full range of public dental programs, including making public patients, clinical space and staff available. Where necessary for their educational program, students will be able to treat fee paying patients in public and private dental facilities.*

The oral health workforce working in South Australian country areas is well below the national average making it difficult for many communities to receive the dental care they need. While correcting the overall shortage of dentists will contribute to increasing the number of dental providers willing to work in country areas, more active measures are needed in the shorter term. Enhanced remuneration and conditions for dentists has been implemented as one measure to address the shortage with significant success.

*We will work with the Australian Government and the dental education sector to develop and implement a range of measures to attract and retain dentists and other professions within the oral health workforce to country South Australia. These measures will include expanded rural scholarships and placements for students.*

The ability of the general dental workforce to provide high-quality dental care into the future is enhanced by the availability of clinical leadership from the dental specialists, including those in the tertiary education sector. However, South Australia has an ageing specialist dental workforce with the possible threat of shortages emerging in coming years.

*We will undertake workforce planning for all areas of dental specialisation to ensure that high-quality and sustainable specialist training programs are in place in South Australia.*

There is very limited oral health content in the education programs for many other health and human service professionals including medical practitioners, nurses, Aboriginal Health Workers, consumers and carers. This limits their awareness of oral health and the degree to which they can contribute to oral health improvements for their clients.

*We will work with the tertiary education, vocational sector and the Community Services and Health Industry Skills Council to ensure that an oral health component is included in curricula of education programs for all health and community professionals.*

### **Establishing modern public dental infrastructure**

A network of high-quality public dental clinics is central to the provision of affordable high-quality dental care for eligible children and adults. It is also central to attracting and retaining a high quality public dental workforce. Ideally, these dental clinics should be located with other primary health services to enhance collaboration between these services to achieve better coordinated health care for patients.

*We will include dental surgeries for both the School Dental Service and the Community Dental Service (for eligible adults) in the Elizabeth, Marion, Noarlunga and Modbury GP Plus/GP Super Clinics and in the planning for major GP Plus Health Care Centres across the state.*

Furthermore, where appropriate, these new public dental clinics will also include clinical space for dental students to gain their clinical experience. These new state-of-the-art dental facilities will replace many of the older, small School Dental clinics built in school grounds in the 1960s and 1970s.

The inclusion of new dental facilities in GP Plus Centres will be a major step forward for the School Dental Service. However, in order to ensure that School Dental care continues to be accessible for all children, a number of smaller school-based dental clinics will need to be retained.

*Over the next seven years we will progressively upgrade the remaining School Dental Service clinics to bring them to the standard needed for modern high quality dental care.*

The current Adelaide Dental Hospital provides the combined functions of primary dental care for eligible adults and a specialist referral hub. It also provides facilities for the undergraduate and postgraduate programs of the School of Dentistry of The University of Adelaide.

*In partnership with The University of Adelaide, we will develop a program to progressively upgrade clinical facilities at the Adelaide Dental Hospital to better meet the dental service and dental education needs of the state.*

### **Planning and coordination**

As the importance of oral health to general health and wellbeing has been more widely recognised it has become essential that oral health issues be factored into planning and coordination of all areas of health. This requires mechanisms to engage all elements of the dental sector.

The Oral Health Advisory Committee has been reconstituted with its wide membership from the full dental sector to provide policy and program advice on oral health direct to senior health executives in the Department of Health.

*We will ensure that the dental sector and consumer representation has appropriate high-level input into planning of the health system including GP Plus Clinics, and membership of the Clinical Senate.*

### **Improving information technology**

New information management systems are fundamental to improving the delivery of oral health care services in the future. Over the coming years, we will develop information technology to allow service providers to have appropriate access to patient information – with the consent of the patient.

*We will investigate the development of public dental ICT and electronic patient record systems to enhance patient access, improve connectivity between public and private clinical and business systems in line with the current e-health environment.*

Where can I find out more?

Visit [www.sadental.sa.gov.au](http://www.sadental.sa.gov.au)

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