Celebrating successes in oral health and looking to an innovative future.

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This article is adapted from an editorial published in the most recent edition of the Australasian Medical Journal. Thanks to the Editor for his approval.

Marc Tennant and Estie Kruger, International Research Collaborative – Oral Health and Equity, The University of Western Australia, write:

If this was the 1960’s we would be talking about how every child is suffering dental pain and abscesses. We would be talking of massive drives of tooth extraction and how it is better to get false teeth when you are 20 years old than to continue to suffer the scourge of dental pain. But, we are not in the 1960s and this is nothing like the current situation.

Today, dental decay is nothing of the problem it was previously. Why?

The principal driver has been the population level fluoride exposure. In children this has reduced dental decay from an average of 10 decayed teeth per 12 year old, to a current level where statistical averages can no longer be reasonably used.

In fact, prevalence of 12-year-olds free of decay runs at more than 60 per cent and growing. This effect is not limited to children, with the rates of full denture wearing in adults turning around from 75 per cent wearing, to 75 per cent not needing in 50 years, and are predicted to continue to fall to near zero levels over the next 20 years.

However, this demolition of decay through public health has exposed a tyranny of our society—socioeconomic divide (1).

The remaining decay is not even or randomly distributed. Those at the margins of society, or in poverty, have in many cases not seen any real improvement in dental health (2).

Against this relatively rapid swing from universal chronic disease to a very skewed distribution associated with poverty and marginalised groups, we have not seen the concomitant shift in targeted health care.

Dental care in Australia is fundamentally a private model, with small practices, setting prices and locating themselves based on business decisions. This makes up some 80 or more per cent of the total care provided (3). A relatively small state and territory government safety net for the poor
provides the remaining 20 per cent. And school dental services in some states remain universal coverage.

Obviously, under a small business model dental practices are at their highest densities in the cores of our cities where people are able to pay the fees for care (or have private health insurance). But this is opposite to where new disease is at its most intense, and a classic example of the “inverse care law”.

Surely the Australian government is aware and has been acting? Yes, however, with a near wholly privatised sector, these levers are limited and at times have consequences that policy makers were unprepared for.

The first lever government has, is workforce numbers. In the late 1990s Australia was training some of the lowest numbers of dentists since World War II (in absolute numbers). The government in collaboration with universities moved to support a change in educational models to provide more opportunity for dental education. This has been a national iconic success. A relatively small input in dollar terms, with a substantial long-term benefit—every policy maker’s dream outcome.

The second lever the government experimented with, was to outsource care for those in need to the private sector. This billion-dollar expenditure was brought to a close (running some half a billion dollars over budget) after it became evident that a number of “interesting pathways” and models of use were occurring (4). Policy makers were burnt. All would agree the principle was good, but the implementation framework left a lot to be desired.

The third lever the government has continued to use, is a small funding program to attract dentists to move from the city to the country. This relatively small, and formal, open-detailed reporting of the outcomes is yet to be available. However, from a policy perspective the principles are correct, but again, it is vitally important that in the economic reality of small-business-led care, its implementation framework be robust.

At the State level (those responsible for the safety net) the level of adaptation to the new disease distribution has been varied. This is especially evident in the operation of school dental services. Casting our eye back to the 1960s we can imagine that a universal—see every child every six months—was a perfectly logical model when extraction and pus drainage was the primary need. More recently, cutting edge school dental services have now moved to being targeted at those child groups of poverty and marginalised children. The days of universal service are behind us.

The vast majority of service and practitioners are private small business models driven by normal economic drivers. With the development of new dental schools (and a parallel increase in International dental graduates receiving registration in Australia) there have been murmurs of workforce “over supply”. Not unsurprising as the economic cooling of Australia in the last couple of years has been coincident with the growing output of new-graduate dentists. Demand for care has dropped, especially for non-essential care (e.g., cosmetic), at the same time as supply has increased. Also, we are at a juncture where the baby boomer practitioners are looking to sell their practices as retirement nest eggs, and values are at risk of falling.
As harsh as it sounds, an argument can be made that a downturn leading to price pressures, and expanding service options, may actually be a reasonable outcome at a population level. The main population-level defence that needs to occur under these conditions is to protect against over servicing. This will be a challenge of the next decade; maybe a challenge that needs to be integrated into accreditation systems?

The next substantive national-level challenge in dental health that needs urgent and appropriate attention is the changing demographic in Australia. We are a rapidly ageing population. Ageing and dental health are complex issues, including the co-morbidity of multiple systemic conditions, the use of many medications which may have side effects that are hazardous to oral health, the diminishing ability to sustain good oral hygiene practices, and lack of access to appropriate care for the elderly, or those in residential aged care (5).

No elderly person should be without access to good oral health.

The need to target other high-risk groups will remain at the forefront of Australian dental public health for decades to come. The days of universal “one-size-fits-all” approaches are gone. Disease and suffering are not evenly distributed any more. Australia’s complex geographic and demographic spread is going to require novel systems of addressing the oral health needs of people at socioeconomic disadvantage and those distant from the cores of our cities because these are the people who do, and will continue, to suffer (6).

State systems have to adapt to address these needs, and the successes of the last decade are exemplars of tailored solutions that can, under all sorts of economic conditions, sustainably address complex issues for marginalised (geographically, socially, and economically) groups (7). The solutions are achievable within the constraints of Australia’s dental healthcare system, we just need to innovate rapidly. Visionary leadership that has a strong connection to evidence-based public health research is essential.

Australia has come a long way in addressing dental ill-health; however, many problems and risks remain. We are not at the end, but achievements of the last 30 years should be celebrated. Strategic, expert-led reflection on these past efforts in order to drive the next wave of evidenced-based innovation must be focused on an inclusive, all-of-society agenda, particularly with the shifting pattern of disease burden.