

Not just house-keeping: oral health and the Federal policy vacuum

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Tessa has held policy, research, advocacy and management roles in the areas of human rights and criminal justice. In previous positions she has researched the legal, social and political implications of the UK's *Human Rights Act 1998*; developed policy and engagement strategies on corporate social responsibility; coordinated the biennial human rights report to the Commonwealth Heads of Government Meeting (Uganda, 2007); managed a forensic mental health jurisdiction in NSW; and administered a public education and publications program in criminology.

Tessa's PhD from the London School of Economics examined executive discretion and the public protection agenda in decisions about the release of mentally disordered offenders. Her book, *Protecting the public? Detention and release of mentally disordered offenders* was published by Routledge in 2010.

Outline of presentation

This presentation will continue the session's policy analysis on oral health, focusing on the prospects of meeting the dental needs of people on low incomes and in disadvantaged communities. ACOSS' focus is the needs of people on low incomes and, particularly in relation to health, the needs of people living in rural and remote parts of the country who are disadvantaged in terms of access to mainstream health services. Today I want to examine the current and possible directions for oral health nationally, particularly in the context of several processes being driven by the Federal Government. These are the National Oral Health Plan; the National Preventive Health Strategy; and the national health reform. My aim is to consider both the barriers and opportunities for policy development to redress the ongoing gaps access to oral health services and the consequential challenge to improving oral health outcomes.

The problem

One in three or 7 million Australians report that they have delayed or avoided dental treatment because of cost issues. These are not just health care card holders; for example in South Australia 40% of the population are eligible for public dental care.

Waiting times are also a significant barrier to good oral health. Even where waiting times are dropping in some states and territories, people are still waiting up to two years for necessary dental treatment.

How does Australia compare internationally?

Poorly! In 2001, Australia was positioned third to last in the rank order of oral health among 35-44 year olds in 21 of the 29 OECD Countries with comparable data and by 2009, the National Advisory Committee on Oral Health was ranking Australia as second-worst in the OECD.

What does ACOSS advocate?

ACOSS prioritises access to dental services and improving oral health outcomes for people on low incomes and disadvantaged in relation to good health care, as a key objective to addressing health inequalities in this country.

There is a marked and growing gap in the oral health outcomes of Australians including children and teenagers, Indigenous Australians, and those isolated from services in rural and remote communities. Our priority is to improve access to services and oral health outcomes for low income Australians, starting with health care card holders. Having said that, and as demonstrated in the SA example above, we must recognise that there are many people who are not eligible for health care cards but still miss out on dental care due to cost (eg working poor, underemployed by part-time or casual hours, struggling families, people with disabilities and people with aged care needs both of which are examples of where oral health often gets overlooked).

So what does the national policy landscape look like in relation to these objectives?

The national policy landscape—three key elements with respect to oral health

- National Oral Health Plan
- National Preventive Health Strategy
- National Health Reforms

National oral health plan

The national oral health plan is the clearest statement of oral health policy at a national level. Launched in 2004 it is an eight-year plan For our purposes today, it’s interesting to note the action areas in relation to redressing disadvantage in terms of oral health:

National Oral Health Plan(NOHP) Action Areas

1. Promoting Oral Health across 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 Workforce development
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For this audience, it should be immediately apparent that rural health is missing from this list.

Comparing these actions areas with commitments or activity by the Commonwealth Government, this is the picture we get:

National Oral Health Plan(NOHP) Action Areas	CW Activities/ Commitments by NOHP Action Area
1. Promoting Oral Health across Population	Medicare Teen Dental
2. Children and Adolescents	Medicare Teen Dental; NTER
3. Older People	Better Oral Health in Res. Care; Chronic Diseases Dental Scheme
4. Low income and social disadvantage	CDDS; aim to address more broadly through Cwth Dental Health Program (not introduced)
5. People with Special Needs	CDDS/CDHP
6. Aboriginal and Torres Strait Islander Workforce development	Post-NTER interventions; Indigenous Dental Mobile Pilot Training initiatives; Oversight Committee; national registration

The problem is that many of these programs are poorly targeted, inefficient and are not achieving outcomes at anything like the rate we need to be to improve oral health in those missing out the most. If we take Aboriginal and Torres Strait Islander people for example, the monitoring data for the NOHP reveal significantly higher levels of children having general anaesthetics for oral health problems amongst ATSI compared with non-ATSI communities at all ages, but particularly in the 5-9 age group, meaning when children are most commonly getting their second teeth. Additionally, ATSI children experienced much higher rates of caries (dental disease) than non-ATSI children (data was up to the age of 12). But even here, the lack of data makes it very difficult to get an accurate population-based picture. There’s significant disparity in the availability of data across states and territories; and very poor data for ATSI adults. So even in the context of the NOHP, the capacity to monitor and evaluate outcomes against that Plan is severely limited.

National Preventive Health Strategy

Oral health is a particularly good example of poor access to services and poor oral health outcomes being made worse because so much of the condition that results, the poor oral health of people without access to timely services, is preventable. So where better to acknowledge this than in the NPHS?

The 'strategic direction' of the Strategy was to: 'Refocus primary healthcare towards prevention' (DOHA Official, NOHP Monitoring Workshop, 17-18 November 2009).

Yet there is no mention of dental or oral health in the National Preventive Health Strategy, launched in 2009 by the Health Minister. The only times the words oral health even feature in the Strategy is in the list of formal consultations conducted by the Preventative Health Taskforce, noting two participation by the National Oral Health Promotion Steering Group and University of Melbourne, Cooperative Research Centre for Oral Health Science

While the NPHS outlines some general principles and core objectives in terms of population health, it focuses on specific chronic conditions rather than the health impacts across the population of chronic conditions generally. Had it taken that broader approach, there might have been ways that we could define a policy framework for oral health accordingly. As it is, we have to work very hard to read into Australia's NPHS any interest in improving oral health.

National Health Reforms

Overview of National Health Reform—COAG 14 February 2011 (here I acknowledge the work of Solange Frost and NCOSS, March 2011)

What's changing?

- New funding arrangements for public hospital. Hospitals funded for the services they provide (activity-based funding). An independent body to set the "efficient" price of services. Commonwealth to fund half of efficient growth costs.
- Local Health Networks (LHNs)—new administrative structures for public hospital and some health services. In NSW, 15 Local Health Networks supported by 3 Clinical Support Divisions have replaced the former 8 Area Health Services.
- Medicare Locals (MLs)—new independent regional organisations to coordinate access to local primary health care services. They will have similar geographic boundaries to LHNs.
- Aged Care becomes the full responsibility of the Australian Government, including Home and Community Care (HACC) aged care, except in Victoria and Western Australia.
- New performance and monitoring framework for hospitals and health care services.

When will it happen?

- Reforms are being progressively implemented from 2009/10.
- The first 15 Medicare Locals will commence in July 2011. A further 15 will commence in January 2012, with the remainder starting in July 2012.
- Activity-based funding for hospitals from 1 July 2012.

What does it mean for community-based services?

- Relationship and engagement opportunities with Medicare Locals
- Funding and policy for some primary health care services transferred to Commonwealth
- All aged care services funded by the Commonwealth, and basic community care services funded by the State. No substantive changes to service delivery until 2015.

Question: What does is mean for oral health?

Answer: good question!

The absence of oral health from the reform agenda is stark. Canvassed in terms of 4 NHHRC recs; but no action from the Cwth. We know Cabinet has rejected Denticare. But what about oral health promotion? Workforce development? Tackling the vested interested that prevent allied health professionals—including but not limited to allied oral health—to pick up some of the unmet need?

The failure to include oral health within a Federal policy framework is a major driver of the ongoing failure to improve oral health in Australia. Without a policy framework there is no impetus to assess funding levels: their existence, adequacy and need. Without funding, there is no capacity to address the severe lack of access to timely, adequate services that impacts upon the 40% (approximately) of people who report that they go without oral health care because of cost.

And this is where I drew my title from: the absence of oral health from the structures that are being embedded for Australia's future health policy framework means that the challenge before us is not simply to write oral health in to those existing and developing frameworks. Unfortunately, it's not just a matter of house-keeping. There is a real and drastic gap in Australia's health policy framework as it relates to oral health. Bruce talked about the policy vacuum for rural Australia and this is perhaps the starkest example of Australia's failure to develop oral health policy. But from ACOSS' perspective, this is a population-wide problem and it needs a very significant coalition of interests to make any impact or improvement in this regard.

ACOSS policy for improved oral health—access to timely services, improved oral health

- Starting point: Australia's claims a universal health system. Universality means access for all, not access to everything, to improve primary health care. The most realistic and feasible option for universal oral health care would be a limited scope of dental services based on those that are cost-effective in producing oral health or quality of life gains.
- Adequate and sustainable resourcing of the community sector, including health and allied health services.
- Primary health care model with funding from the Commonwealth directed towards regional organisations that can allocate funding as per the needs of their population (funding allocation on a capitation basis)
- A single funder model whereby Commonwealth funding ensures that access to basic oral health care is not determined on the basis of ability to pay.
- ACOSS does not support the two-tiered funding model that relies upon contributions from private health insurers, as recommended by the NHHRC. Government should be the single funder for universal access to oral health care.
- Given ACOSS' priority to address the growing gaps in oral health outcomes amongst low income groups and communities, we would accept a policy that targeted oral health care to meet the needs of people on low income and living in communities that are isolated from access to services (for whatever reason). However oral health must be included in broader health policy and services to attain the objective of better health for all.

What changes can we anticipate?

Some room for optimism—we think there is a recognition by government that oral health needs attention. But there is a weary recognition of this fact, with little indication that government has the will or knows how to make the sorts of changes necessary to really make a difference.

The Cwth government committed to considering an allocation for dental in the coming Federal Budget (May 2011) as part of its deal with the Greens following the last Federal election. We know that there are negotiations under way but all very tight-lipped about what that allocation might look like.

So we must keep up the pressure. We must continue to advocate. And we must make sure that oral health is not left as house-keeping—something to get to when we have the time or can be bothered—but is a site of serious, structural reform.

Thank you.

