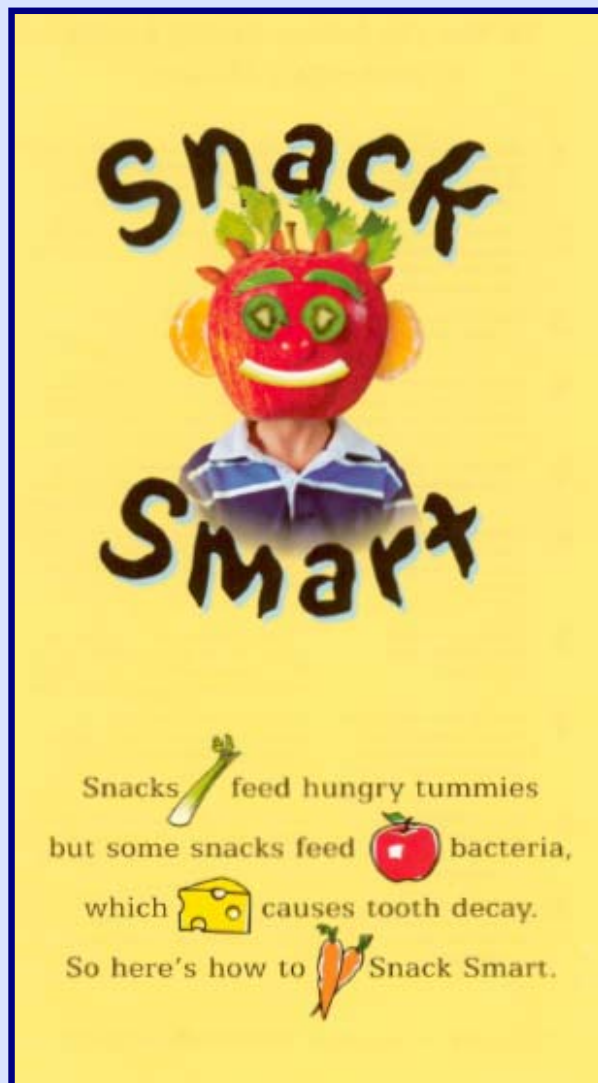




Submission in response to Health Promotion Priorities for Victoria



**Submission to Victorian Department of Human Services
by Australian Dental Association Victorian Branch Inc.**

April 2006



28 April 2006

Ms Sue Heward
Team Leader
Health Promotion Policy and Capacity Building Team
Department of Human Services
GPO Box 4057
MELBOURNE VIC 3001
Email: susan.heward@dhs.vic.gov.au

Dear Ms Heward

**SUBMISSION IN RESPONSE TO
'HEALTH PROMOTION PRIORITIES FOR VICTORIA'**

The Victorian Branch of the Australian Dental Association (ADAVB) welcomes the opportunity to provide this response to the discussion paper on Health Promotion Priorities for Victoria.

Your advice that many others have raised the importance of oral health during your consultations on proposed health promotion priorities was welcome news, although not especially surprising, as in our dealings with a wide range of health consumer and provider groups, we have noted a growing awareness of the significance of public dental problems, and the capacity of health promotion to help reduce demand for care which is difficult to access.

Taking our cue from the Discussion Paper, this submission addresses the suggested key questions, and focuses in particular on the need to incorporate oral health in some way in the new priorities. Our natural inclination is to argue for oral health to receive recognition in its own right, and yet we acknowledge that if it were genuinely integrated into health promotion on other priority areas, this could lead to very beneficial outcomes for the community's oral and general health.

The ADAVB is aware that some of the currently nominated priorities have oral health dimensions, most notably in relation to 'accessible nutritious food', 'reducing and minimising the harm from tobacco, alcohol and illicit drugs', and 'preventing injury'.

As we respond to the suggested questions and criteria, our strong case for oral health to become more visible in the health promotion priorities for Victoria, will become evident.



**Q1: What is your organisation's response to the proposed priorities?
Are they realistic? What in your view have we missed?
Using the selection criteria, what is the rationale for the inclusion of other issues?**

The current list of priorities is generally supported, however the dental profession joins with numerous other groups in seeking a higher profile for oral health promotion within the Department of Human Services' Health Promotion Program and VicHealth's Strategic Plan.

We note that the objectives of the consultation include:

"• to contribute to and support key government initiatives such as ... the Victorian Oral Health Promotion Strategy 2005–10." (emphasis added)

Given this objective, it is surprising that oral health does not feature more prominently in the final priority listing, and in discussion of the health promotion interventions associated with each.

In commenting on the extent to which health inequalities lead to economic costs, the Priority Setting Discussion Paper uses oral disease as a key example:

"For example, oral disease is a major indicator of inequality and is amongst the most costly diet related disease in Australia, representing \$4.4 billion spent in 2002–03 (Stewart 1999). Seventy-three per cent of sixty five year old persons who are health care cardholders suffer from complete tooth loss compared with forty-four per cent of sixty five year old persons who are not health care cardholders (Australian Institute of Health and Welfare 1998)." (P.14)

Despite this, the five priority issues identified in the present draft do not appear to specifically include oral health.

1. Physical activity and active communities
2. Accessible nutritious food
3. Promoting mental health and wellbeing
4. Reducing and minimising the harm from tobacco, alcohol and illicit drugs
5. Preventing injury

There is little point in having accessible nutritious food if one's oral health is so poor that one cannot eat properly. The strategic opportunities noted for this priority area include mention of a link to oral health promotion, but this is not explored with subsequent discussion.

"There are obvious partnerships with oral health promotion initiatives given they share common midstream risk factors and upstream determinants. This is timely given a recent increase in oral health funding in Victoria." (p.22)

Regrettably, the substantial increase in oral health funding since 2003/04 has not seen an across the board improvement in access to care or reduction in the need for care. Demand levels remain high and long waiting lists exist, especially in rural centres, but also in a number of metropolitan areas.

In Appendix 4 of the discussion paper, where indicative commitments to health promotion priorities are listed by Departmental Branch, the Primary Health Branch has two areas listed:



- *The health promotion priorities for 2007–12 will be used to inform primary and community health programs and PCP catchment planning and will be reflected in the upcoming Primary Health Funding Guidelines.*
- *Dental Health will review the evidence base for oral health promotion and review the implementation of the Victorian Oral Health Promotion Strategy 2000-04. These learnings and the broad health promotion priorities for 2007-12 will influence future initiatives, including policy direction for Dental Health Services Victoria.*

The first offers opportunity to better integrate oral health into general health care, and this has been highlighted in consultations on the ambulatory care framework. The second is at risk of isolating oral health issues so that they are dealt with as a lower priority.

ADAVB acknowledges that for oral health to be included in the priority list it needs to qualify against the decision making criteria (p.5):

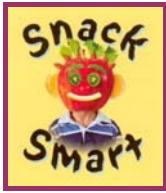
- *the significance of the impact and scale of the issue – using burden of disease data and other supporting evidence*
- *the degree of health inequalities – considering differential distribution of socioeconomic status and other factors, such as gender, ethnicity, being Indigenous, rurality*
- *evidence that indicates that these issues are amenable to change through health promotion and prevention action*
- *the strategic opportunities and capacity, for RRHACS, VicHealth and/or other key stakeholders, present now and over the next three years to address these issues.*

Our submission will address these criteria as it seeks a means by which to bring oral health promotion into a stronger relationship with other health promotion activities in Victoria. Recognising the need to use priority areas which can accommodate a broad range of concerns, we suggest that the current priority issues could be adjusted to more effectively achieve this objective.

Accordingly, we recommend that the priority issue of “accessible nutritious food” be amended so that the focus is on “**informed dietary choices**”. Obesity and poor oral health are high risk factors in a number of systemic diseases, and while the availability of nutritious food will help, ultimately it will be the decisions taken by individual members of the community about what they will eat and how they will maintain their oral health, which will make the biggest difference to their general health and welfare in the long term.

The health promotion approach needs to be based on the notion of self managed care, and establishing a partnership between individuals and their health care providers to stay healthy and minimize the need for treatment. If this can be achieved then some of Victoria’s workforce shortage problems will also be eased.

For optimal oral health, the promotional campaign would need to instruct the community in use of effective personal oral health maintenance behaviours, which should be undertaken at least twice daily.



Rationale for inclusion of Oral Health

a) Impact and scale of the issue

The introduction to the National Institute of Dental Craniofacial Research Strategic Plan states:

“Oral diseases affect the most basic human needs: the ability to eat and drink, swallow, maintain proper nutrition, smile, and communicate. Oral health and overall health and well-being are inextricably connected. Many systemic conditions such as human immunodeficiency virus (HIV)/AIDS, diabetes, Sjögren’s syndrome, and osteoporosis have important oral symptoms, manifestations or complications. The lips, tongue, gingivae (gums), oral mucosa and salivary glands can all signal clinical disease elsewhere in the body. Long considered to be localized infections only, periodontal or gum diseases are now being investigated as potential risk factors for the development of systemic disease. For instance, accumulating evidence now points to a possible link between periodontal diseases and the incidence of premature, low-birth weight babies, cardiovascular disease, and pulmonary disease. Oral diseases affect not only the health of the oral cavity and associated craniofacial structures, but can be detrimental to the overall health and well-being of individuals.”

(Source: <http://www.nidcr.nih.gov/AboutNIDCR/StrategicPlan/BurdenOralDiseases.htm>)

The World Health Organisation website highlights the importance of socio-behavioural factors in oral health for under-privileged groups in developed countries like Australia, as well as those in developing countries:

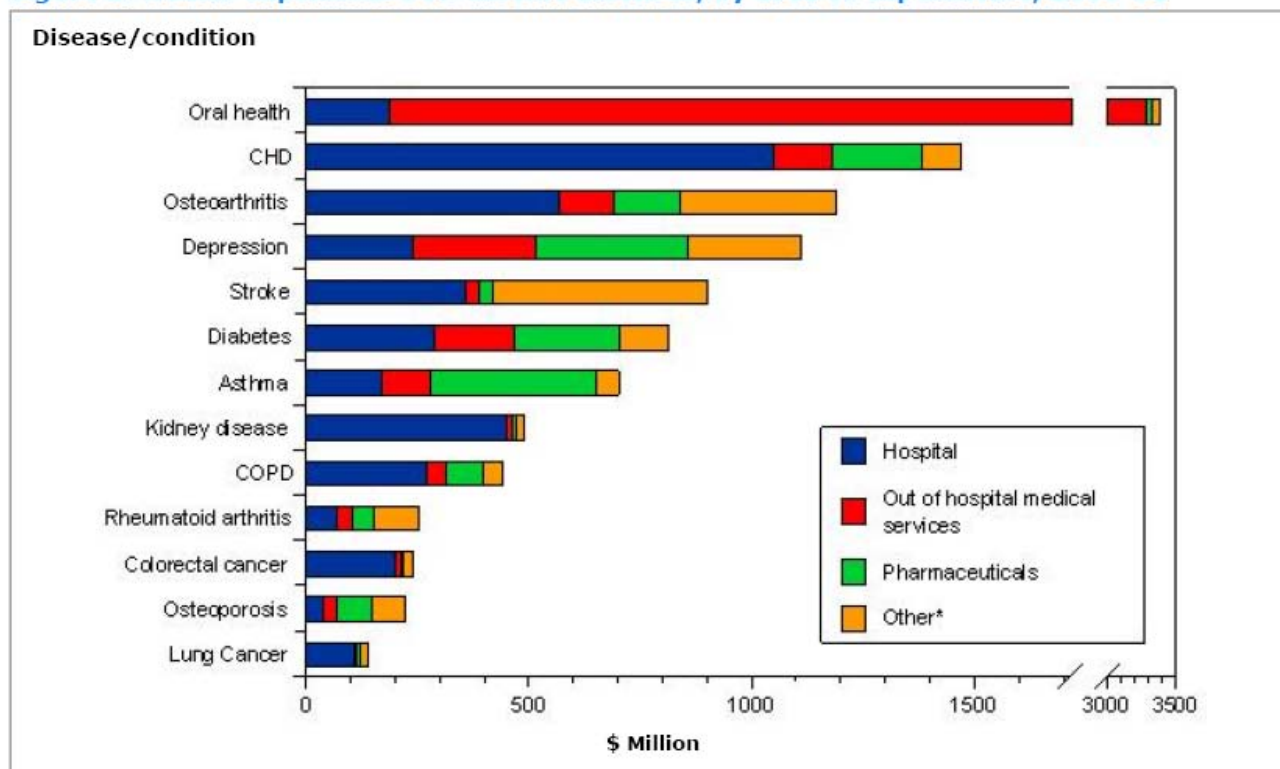
“Despite great achievements in oral health of populations globally, problems still remain in many communities all over the world - particularly among under-privileged groups in developed and developing countries. Dental caries and periodontal diseases have historically been considered the most important global oral health burdens. At present, the distribution and severity of oral diseases vary among different parts of the world and within the same country or region. The significant role of socio-behavioural and environmental factors in oral disease and health is evidenced in an extensive number of epidemiological surveys.”

(Source: http://www.who.int/oral_health/disease_burden/global/en/index.html - accessed on 23 April 2006)

The Australian Institute of Health and Welfare has reported that oral disease is one of the most expensive chronic diseases. This is graphically highlighted in the chart below.



Figure 1: Health expenditure on chronic diseases, by area of expenditure, 2000-01



Note:

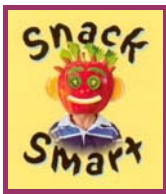
* Other includes areas of allied health services, aged care homes, research, and community mental health services for depression.
Source: The AIHW disease expenditure database.

(Source: http://www.aihw.gov.au/cdarf/data_pages/health_care_costs/index.cfm)

This graph does not do full visual justice to the cost differential between oral health and the next highest cost area of Coronary Heart Disease (CHD). At \$3.4 billion, oral health is well over double the cost of CHD and other chronic diseases. While these costs are borne mainly outside of hospital medical services, they are nonetheless a massive cost to the community, and with demand exceeding supply of dental services, the benefits of using preventive measures to reduce the burden and cost of oral diseases and conditions are self-evident.

The seven disease groups that account for the greatest health expenditure in Australia are (as at 2000/01):

- Cardiovascular diseases - \$5.5 billion (10.9% of total allocated health expenditure)
- Nervous system disorders - \$4.9 billion (9.9%)
- Musculoskeletal diseases - \$4.6 billion (9.2%)
- Injuries - \$4.0 billion (8.0%)
- Respiratory diseases - \$3.7 billion (7.5%)
- Mental disorders - \$3.7 billion (7.5%)
- Oral health - \$3.4 billion (6.9%)



(Source: Health system expenditure on disease and injury in Australia 2000-01, AIHW, Second edition, April 2005)

AIHW figures from 2003/04 indicate that with inflation, dental services are likely to cost over \$5 billion per annum in 2005/06.

“In 2003-04, expenditure on hospitals was \$26,413 million, made up of \$19,820 million on public non-psychiatric hospitals, \$6,059 million on private hospitals, and \$534 million on public psychiatric hospitals.

Expenditure on high-level residential care totaled \$4,985 million (6.3%), medical services \$12,961 million (16.5%), pharmaceuticals \$10,935 million (13.9%) and dental services \$4,694 million (6.0%). A further \$3,378 million (4.3%) was spent on other health professional services, such as physiotherapy, chiropractic and podiatry.”

<http://www.aihw.gov.au/expenditure/health.cfm>

The cost of dental decay can be measured in dollars, in lost work time, and in more subjective ways such as low self esteem. The Victorian Government currently spends around \$120m per annum on dental services for public patients, and a total of around \$1b each year is spent on dental services in Victoria when public and private dentistry are combined.

In an article in *Population Health Metrics* (2004), key AIHW dental researchers David S Brennan and A John Spencer, suggested that the community (and perhaps even policy makers), tend to underestimate the impact of oral diseases.

*“Although dental problems are widespread in number and impose a large burden on society in terms of lost production, pain and suffering, and health expenditure there is a tendency to underestimate their importance due to the generally non-fatal nature of most oral diseases and complacency arising from acknowledged improvements in oral health, such as trends toward lower caries levels among children and decreased edentulism in adults. Australians spend \$2.6 billion on dental services, some 5.4% of recurrent health expenditure for 1998–99 [1]. While dental diseases are not usually life-threatening, the importance of delivering services needs to be considered in view of the repetitive and ubiquitous nature of dental problems which combine to create a large burden. For example, dental problems were ranked as the fourth most frequent illness condition, behind headache, hypertension and colds in a two week survey period [2], **dental caries (decay) has been ranked as the highest diet-related disease in Australia in terms of both total costs and health care costs [3], and periodontal (gum) disease has been reported to be the fifth most prevalent health condition in Australia [4].**”*
(emphasis added)

This study concluded that:

“Compared to the Australian Burden of Disease and Injury Study the adjusted disability weights for oral health conditions in this study were higher for comparable oral conditions of caries (0.044 versus 0.005 for caries involving a filling and 0.014 for caries involving an extraction), periodontal disease (0.023 versus 0.007) and denture problems (0.026 versus 0.004 for edentulism). In addition there were a range of common oral health problems such as pulpal infection, failed restorations and tooth



fracture that were not included in the Australian Burden of Disease and Injury Study which had relatively high disability weights. **The inclusion of a fuller range of oral health conditions along with revised disability weights would result in oral health accounting for a much larger amount of disability than originally estimated.**” (emphasis added)

(Source: David S Brennan and A John Spencer, Disability weights for the burden of oral disease in South Australia. *Population Health Metrics* 2004, **2**:7 doi:10.1186/1478-7954-2-7)

b) Degree of health inequality

All members of the Australian Health Ministers’ Council agreed to adopt a National Oral Health Plan (Healthy Mouths: Healthy Lives) in 2004, and each State committed to implement the recommendations in each of the seven priority areas identified for action. Whilst it was recognised that these seven areas are interdependent, Oral Health Promotion was recognised as an overarching action area.

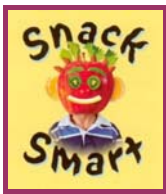
“Four broad themes underpin the Plan:

- **recognition that 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 – for all Australians; and**
- **education to achieve a sufficient and appropriately skilled workforce, and communities that effectively support and promote oral health.**” (p.iv) (emphasis added)

According to Healthy Mouths: Healthy Lives,

“Dental caries is Australia’s most prevalent health problem, edentulism the third most prevalent, and periodontal disease the fifth most prevalent (AIHW 2000). Caries and periodontal disease account for 90 percent of all tooth loss (AHMAC 2001). At the last national survey of oral health, over 38% of Australians had untreated dental decay (Barnard 1993). More recent estimates suggest that 11 million people are suffering new decay each year (AIHW DSRU personal communication 2003). Caries is the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes (AHMAC 2001).” (p.7)

In a paper called ‘Narrowing the inequality gap in oral health and dental care in Australia’, commissioned by the Australian Health Policy Institute at The University of Sydney, Prof A John Spencer, Professor of Social and Preventive Dentistry at The University of Adelaide and Director of the Australian Research Centre for Population Oral Health, outlined the key dimensions of inequality as follows:



“Abstract

The problems of oral disease and dental care are not diminishing. The oral health of two substantial groups of the Australian population, children using the school dental services and eligible adults using public dental services, has deteriorated at the end of the 1990s. As both of these groups are unrepresentative of the population, it is possible that this deterioration has occurred only among the more disadvantaged, polarising the burden of oral disease. Such a polarisation is supported by self-reported oral health and self-rated oral health, which both show marked social gradients and social impacts of oral disease that are also considerably more prevalent among those from lower income households. While dental care could modestly impact on this situation, access to dental care is also polarised. Eligible adults who use public dental care are at a marked disadvantage in many indicators of access to care. Further, their access to dental care has deteriorated during the period 1994 to 2002. Access to dental care is resistant to change. The continued existence of inequalities in access to the school dental services shows the magnitude of effort required to reduce social inequalities in access to care. Unfortunately, that level of effort is absent. The Commonwealth government has abandoned its leadership role in the financing of public dental services. While the State and Territory governments have increased their direct public subsidy of public dental services, predominantly among low income Australians, the Commonwealth government has led itself into a sizeable indirect public subsidy for private dental insurance that is received predominantly by those of middle or high income households. Dental services are the least subsidised of health services and the public subsidy is inequitably distributed. Such a situation reflects a failure in national policy, maintained by an inadequate response to the burden of oral disease and barriers to access to dental care among health bureaucrats and policy makers. The increased attention to the links between oral and systemic health is a challenge to this response. A recognition of common risk factors and the clustering of risks is also leading to an emphasis on integrated approaches to health, underpinned by shared psychosocial determinants of health and disease.

*The inter-relatedness of oral and general health is undeniable. This is being recognised across different health settings more than ever. There is a need to improve Australian’s oral health and diminish inequalities in oral health and access to dental care. Six key areas of policy are vital: extend the coverage of water fluoridation; **engage in health promotion**; revitalise the school dental services; reform the public dental services; reshape funding arrangements for public dental care; and, expand the dental labour force. Only a commitment to such policies across all jurisdictions will reverse the deepening inequalities in oral health and access to dental care in Australia.” (emphasis added)*

In acknowledging the link between oral and general health, the recent NSW Parliamentary Inquiry into Dental Services in NSW noted:

“The causes of the two major dental diseases (caries and periodontal disease) are inadequate diet, stress, poor hygiene, smoking, alcohol/substance misuse and injury. These risk factors are common to a number of chronic diseases and health impacts. Links with general health conditions were identified by witnesses and include diabetes, pre-term delivery and low birth weight as well as in extreme cases death. ... Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV infection, infective endocarditis, otitis media, and nutritional deficiencies in children and older adults.”



Given the rightful significance attached to childhood obesity in the Discussion Paper, the work done by researchers from University at Buffalo is of interest as it found that obesity is a significant predictor for periodontal disease, independent of age, gender, race, ethnicity, and smoking. This study was documented in a recent supplement to the Journal of Periodontology (JOP). Furthermore, analysis of this national sample suggests that insulin resistance mediates the relationship between obesity and periodontal disease. It was found that the severity of periodontal attachment loss increased proportionally with increasing insulin resistance. In addition, the number of teeth lost increased significantly with increasing levels of insulin resistance. Individuals in the highest insulin resistance category lost 1.1 more teeth compared to individuals in the lowest category.

“People who have a higher body mass index produce cytokines (hormone-like proteins), that lead to systemic inflammation and insulin resistance,” said Robert J. Genco, vice provost at the University at Buffalo and editor of the JOP. *“We propose that chronic stimulation and secretion of proinflammatory cytokines associated with periodontal infection also occurs, contributing to insulin resistance, which may further predispose to diabetes mellitus.”*

Genco and his research team recently showed that diabetics with periodontal disease may have greater mortality from diabetic complications such as cardiovascular disease and kidney complications than diabetics with little or no periodontal disease.

“The presence of periodontal infection combined with obesity may contribute to type 2 diabetes and its complications, such as coronary heart disease,” said Kenneth A. Krebs, DMD and AAP president. *“Although further studies are needed, people should remember that living a healthy lifestyle along with daily brushing and flossing and visiting your oral health care provider is always in fashion.”*
(Source: American Academy of Periodontology - <http://www.perio.org/consumer/obesity06.htm>)

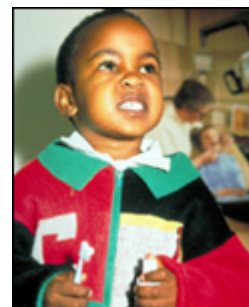
It makes sense that if oral health problems share common risk factors with general health conditions, then health promotion activities need to incorporate or integrate both oral and general health messages.

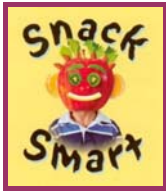
The World Health Organisation (WHO) has established a Global Oral Health Programme in recognition of the importance of oral health as a key component of general health. While the objectives of the WHO programme are targeted at poorer developing countries, it is arguable that with waiting lists of up to five and a half years for public dental treatment in a number of Victorian centres, a substantial portion of our community has much in common with citizens of developing countries.

In discussing the objectives of the WHO Global Oral Health Programme (ORH), the WHO website notes:

“Noncommunicable chronic diseases, which continue to dominate in lower-middle and upper income countries, are becoming increasingly prevalent in many of the poorest developing countries. They create a double burden on top of the infectious diseases that continue to afflict these countries.”

The objectives of the WHO Global Oral Health Programme (ORH), one of the technical programmes within the Department of Chronic Diseases and Health Promotion (CHP), have been reoriented according to the new strategy of disease prevention and promotion of health. Greater emphasis is put on developing





global policies in oral health promotion and oral disease prevention, coordinated more effectively with other priority programmes of CHP and other clusters and with external partners.” (emphasis added)

(Source: http://www.who.int/oral_health/objectives/en/index.html)

Reinforcing the link between oral and general health, this same website continues:

*“Oral health is part of total health and essential to quality of life and WHO projects intend to translate the evidence into action programmes. **The Oral Health Programme therefore gives priority to integration of oral health with general health programmes at community or national levels.** The WHO Oral Health Programme works from the life-course perspective, currently community programmes for improved oral health of the elderly and of children is given high priority. The implementation of school oral health programmes within the framework of the WHO Health Promoting Schools Initiative is supported and guidelines are developed. Oral health systems reorientation towards prevention and health promotion is recommended in light of the Ottawa Charter, the primary health care concept and the Jakarta Declaration on leading Health Promotion into the 21st Century. In addition, global goals for oral health by the year 2020 are specified for development of quality of oral health systems. The Programme works for application of evidence-based strategies in oral health promotion, prevention and treatment of oral diseases worldwide, health systems research and development. Emphasis is also given on prevention and care of oral mucosal lesions, including oral cancer and oral manifestations of HIV/AIDS, cranio-facial disorders, trauma and injuries.”* (Emphasis added)

In the lead up to the 2004 Federal Election, the Oral Health Alliance, comprising representatives of the Brotherhood of St Laurence, Catholic Social Services Victoria, Council on the Ageing, Health Issues Centre, Public Health Association of Australia, Victorian Healthcare Association, the Victorian Council of Social Service Australian Dental Therapists Association, and the Australian Dental Association Victorian Branch, outlined the case for further Government action to address oral health promotion as a key action area in public dental policy.

A Fact Sheet published by the Alliance stated:

“Almost all oral diseases are preventable. Yet millions of Australians require dental treatment for oral diseases each year. Both individuals and governments have a part to play in prevention of this unnecessary oral disease. Individuals need to accept more personal responsibility for their own dental health through ensuring good oral hygiene and diet. The role of governments is to increase investment in prevention and early intervention measures, including fluoridation and ensuring dental health treatment is accessible and affordable.”

The most visible measure of inequality is the time public dental patients must wait for access to restorative dental treatment and dentures. The graph below illustrates the 13 rural clinics which have waiting times of more than three years as at December 2005. It is generally true that rural clinics have longer waiting times than metropolitan clinics, however this is not always the case. Indeed there are five metropolitan clinics which also have waiting times of over three years, namely Frankston, Eltham, Fitzroy, Plenty Valley and Footscray.

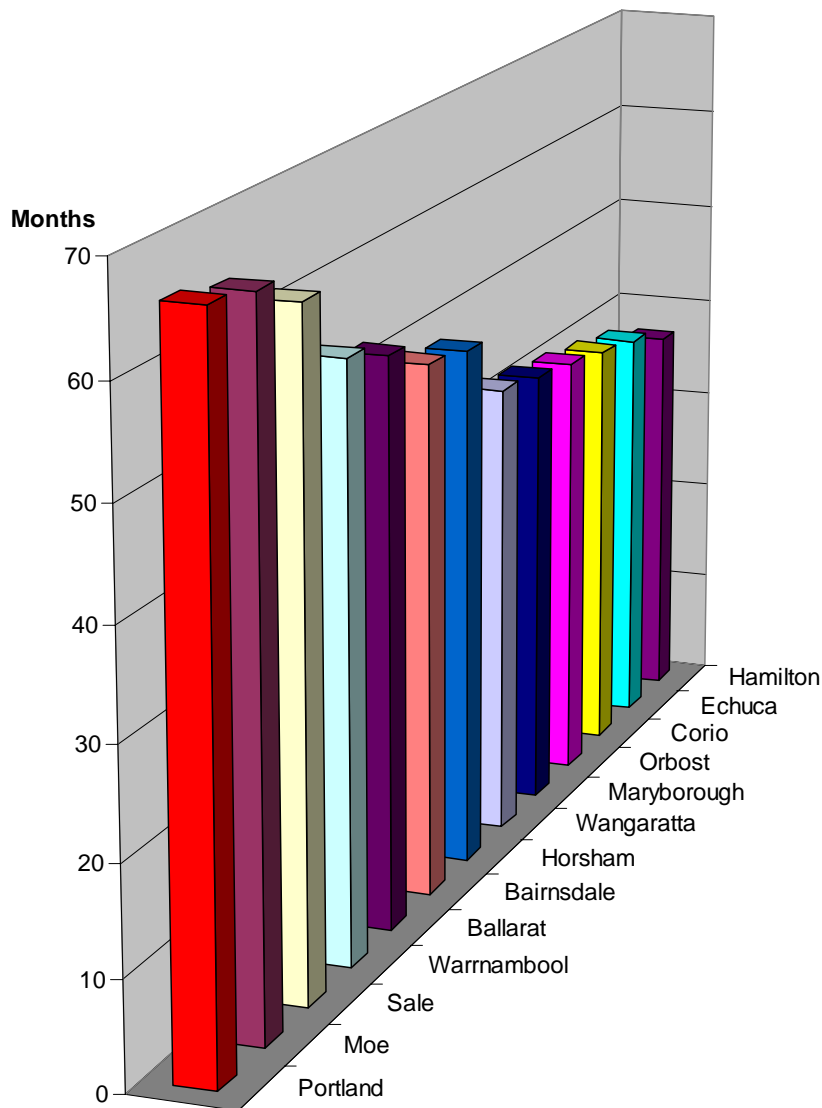


It is interesting to compare the targets set for medical elective surgery treatment times with dental data, and to note the significant gaps. Urgent medical treatment requires admission within 30 days, semi-urgent within 90 days and non-urgent at some time in the future but 365 days is used as a national guide.

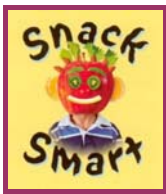
(Source: <http://www.health.vic.gov.au/yourhospitals/elective/index.htm#targets>)

This means that tens of thousands of Victorians eligible for public dental treatment are expected to wait three, four or five times as long as other non-urgent elective surgery candidates. Surely this is a strong basis for establishing the higher priority which should be attached to oral health in the health promotion program.

**Unlucky 13 - Rural Dental Waiting Times >3 years
Dec. 2005**



Source: <http://svc023.wic022p.server-web.com/yourhospitals/dental.asp>



Australia's Health 2004 includes a section on dental services, which states:

“There were differences in the visiting rate and services received by card holders who received publicly-funded care and those card holders and non-card holders who received private care at their own expense (Table 6.14). The frequency of check-up visits in the last 12 months ranged from 14% of public-funded card holders to 34% of noncard holders, indicating differences in use of services and the likelihood of receiving ongoing preventive care.

Dental extractions and fillings were more frequent among card holders who received publicly-funded care than other groups. For every 100 card holders receiving publicly funded dental care within the previous year, 42 had one or more teeth extracted and 53 had one or more fillings. In comparison, of card holders who received private care, 17% had extraction(s) and 46% received filling(s) (Table 6.15).

(Source: <http://www.aihw.gov.au/publications/aus/ah04/ah04-c11-040804.pdf>)

While dental decay is one of the most prevalent and expensive diseases, much of it is preventable. It should therefore be a key area for attention in any comprehensive health promotion or disease prevention strategy for Victoria.

c) Action areas that are amenable to change through health promotion and prevention action

The population health approach was recommended in the *National Oral Health Plan 2004-2013* as the most appropriate and effective approach for improving oral health and aims to systematically:

- promote health and prevent and intervene early in the pathway to disease through strategies that involve individuals, communities and whole societies
- build individual and community capacity and provide enabling cultures and environments
- provide a comprehensive range of high quality, integrated health care services
- reduce disparities in health status through equitable allocation of health resources and access to health services.

As recently recommended by the NSW Parliamentary Review of NSW Dental Services, the four pillars of prevention in oral health promotion, consistent with a population health approach, are:

- education and awareness programs
- application of appropriate behaviour types of programs, such as oral hygiene instruction
- contact with provider programs, which are access issues related to constant reinforcement
- water fluoridation.

In this context, the preventive initiatives that were recommended by the NSW Parliamentary Committee were:

- fluoridation,
- oral health promotion, such as education and awareness programs
- oral health promotion teams, including oral hygiene instruction
- collaboration of health workers
- nutrition programs.

(p.132)



Targeted oral health promotion would clearly address the second and fourth aims of the population health approach as outlined in paragraph 7.25, namely, to build individual and community capacity and reduce disparities in health status through equitable allocation of health resources and access to health services.

In November 2005, the UK Department of Health published *Choosing Better Oral Health: An Oral Health Plan for England*. They noted that:

"... many of the key factors that lead to poor oral health are risk factors for other diseases. People living in areas of material and social deprivation and other vulnerable groups in society have poorer oral health and they often access dental services less frequently. Poor oral health has a major financial impact on both the individual and society at large." (p.5)



That plan set six key areas for action, all of which have a preventive focus, namely

1. Fluoride
2. Improving diet and sugar intake
3. Encouraging preventive dental care
4. Reducing smoking
5. Increasing early detection of mouth cancer
6. Reducing dental injuries

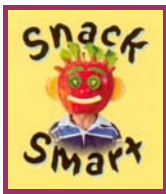
The Dental Unit within the Department of Human Services has commissioned an update to the Oral Health Promotion Plan for Victoria, and this report is imminent. Without access to this new plan for the coming period, we can but recommend that similar measures are adopted for the Victorian community, and that oral health promotion be integrated into general health promotion priorities wherever possible.

AIHW has identified six modifiable risk factors for dental caries and gum disease (see Appendix 1), including:

- lack of water fluoridation
- infrequent dental visits
- excess of sweet or sticky foods
- medication that alters saliva flow
- tobacco smoking
- inadequate tooth-brushing or flossing of gums and teeth.

(Source: http://www.aihw.gov.au/cdarf/diseases_pages/index.cfm)

The food and tobacco factors are already addressed within the Department's proposed priorities, while fluoridation is being effectively addressed by the Department's Environmental Health Unit. Of the remaining three, the one which would be most amenable to health promotion through the priority setting process is the last – **improving oral hygiene behaviours**.



While regular advertising of toothpaste and other oral hygiene products is evident through electronic and print media, little information is forwarded to support the most effective means of achieving oral hygiene. If television and movie presentations are representative, no one in Australia, the United Kingdom or the United States knows how to floss.

d) Strategic opportunities for RRHACS, VicHealth and other key players, present now and over the next years, to reduce and minimize oral diseases and conditions

Some excellent oral health promotion initiatives are already receiving Government attention, notably the commitment to fluoridate regional water supplies, and the use of graphic warnings on tobacco packaging. A similar level of commitment is required in a number of other areas affecting the oral health of most members of the community. These areas are notably:

- Nutrition e.g. soft drinks, sports drinks, sweets,
- Oral hygiene
- Sports safety

DHSV has an Oral Health Promotion Unit, which has done some very effective work in development of resources and pilot projects with various target audiences.



If the Department were to change from the current focus of 'accessible nutritious food' to 'informed dietary choices', we feel there would then be greater capacity to deal with such vital oral health issues as consumption of high calorie and high sugar beverages, especially soft drinks. The recent announcement by the Minister for Education that these drinks are to be banned from school canteens and vending machines is a welcome start in dealing with this problem, but consumers themselves need to be encouraged to understand the threat these drinks pose to children's health, and then to make the responsible choice not to allow children to consume large quantities of such drinks on a daily basis. Indeed this area is of such concern that we feel it warrants legislative response similar to that involved in the introduction of graphic warnings on tobacco packaging, which would see dietary ratings and/or warning labels printed on all beverages.

Q2: The paper has focused on midstream risk and protective factors and uses an upstream determinants of health lens to discuss these factors. Do you have any comments or suggestions on this approach? Do you have any other suggestions on how to achieve this balance in finalising the health promotion priorities for 2007-12?

The ADAVB agrees that behavioural and psychosocial factors that contribute to disease rates and which are amenable to change are the most appropriate focus for the setting of health promotion priorities, especially where inequality, socioeconomic or environmental factors contributed to those unhealthy behaviours and attitudes. Given the extent to which poor oral health is a product of disadvantage, as for obesity and other conditions which pre-dispose people to more serious diseases such as coronary conditions and diabetes, the ADAVB is surprised that it did not rate some more specific mention in the proposed priorities for health promotion.



Q3: Of these priorities, which ones are current priorities for your organisation?

The ADAVB regularly encourages members to provide smoking cessation advice and assistance to their patients, working in partnership with Quit Victoria to raise awareness and provide resources and protocols to facilitate this role for dentists and their staff.

Nutrition is one of the key focal areas for our oral health promotion activities and this applies across all age groups, but especially children and aged persons. This year's Dental Health Week, scheduled for August 2006, will provide advice to parents and children about diet and oral health, amongst other dental health issues affecting children. Support for Nutritional and Dietary advice will make further inroads into reducing the risk of decay. It is however important to note that some strategies of healthy eating of fruits and vegetables – such as grazing every couple of hours – may be counter productive in terms of dental disease.

Targeted oral health promotion. While ADAVB and ADA Inc. have long supported annual dental awareness campaigns, these are starting to become more fragmented in their approach, particularly due to the competition of different oral hygiene product manufacturers to attain product differentiation in the market. The profession therefore now favours activities targeted at high risk groups, such as Diabetes sufferers, aiming to reduce their risk habits.

Fluoridation remains a safe, cheap and effective preventative measure which is slowly increasing in access to the Victorian community. It is important to note that one in five Victorians are still missing out on this benefit.

Q4: What would it take for your organisation to shift to new priorities?

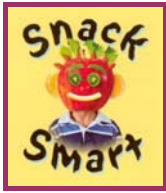
No comment.

Q5: What steps will your organisation need to take to shift its focus and its practice?

Training of non-dental health workers in awareness of dental disease and appropriate preventative measures is an area which demands further development. ADAVB is willing to support targeted Oral Health education of both health sector workforce and risk groups in the community.

Q6: What support (information, workforce development, policy environment) would your organisation benefit from RRHACS/VicHealth to assist in addressing these priorities?

Opportunity to develop health education packages in coordination with continuing education in the relevant workforces.



Branch representatives would be pleased to amplify the points briefly outlined in this submission in order to assist the Department in its further consideration of the draft regulations.

Yours sincerely

Garry Pearson
Chief Executive Officer

Note re Snack Smart image

The Snack Smart image which appears on the cover and in page headers throughout, was used by the ADA in a national dental health awareness campaign in 2004



Appendix 1 – Chronic Diseases (AIHW)

http://www.aihw.gov.au/cdarf/diseases_pages/index.cfm

Oral diseases

Oral diseases continue to be among the most costly yet preventable health problems, resulting in high direct and indirect costs to individuals and governments. They commonly cause pain, discomfort, and problems with eating, speech, communication and socialising. While most oral diseases are not associated with mortality, there are some deaths related to oral cancers.

There are two main forms of oral diseases:

- Dental caries (tooth decay), caused by acid-producing bacteria that live in the mouth. Tooth decay progresses from demineralisation of the tooth or its root to infection of the tooth pulp, abscess formation, fracture of the tooth, and tooth loss.
- Periodontal (gum) diseases, a group of inflammatory diseases that affect the gums, deeper connective tissues and the jaw bone, all of which support and protect the teeth. These cause swelling of the periodontal tissue which can be associated with the recession of the gums or formation of periodontal pockets in the gums. A common outcome is lack of support for the tooth resulting in tooth mobility, formation of gum abscesses and tooth loss.

Other oral diseases include mouth ulcers, dental and gum problems, oral cancer, tooth impactions, misaligned teeth and jaws, and trauma to teeth and mouth.

Oral diseases are considered 'chronic' in that the underlying causes involve long-term processes that can result in irreversible tissue destruction and which can re-occur over the course of a lifetime.

Modifiable risk factors for dental caries and gum disease include:

- lack of water fluoridation
- infrequent dental visits
- excess of sweet or sticky foods
- medication that alters saliva flow
- tobacco smoking
- inadequate tooth-brushing or flossing of gums and teeth.

Dental caries and periodontal diseases are preventable and treatment is available via interventions to limit progress, alleviate pain and suffering and restore function. Public health programs such as water fluoridation and school dental services are also essential for primary prevention, education and awareness raising.

PURPOSES

The objectives of the ADAVB are to promote the:

- improvement of the dental health of the public;
- art and science of dentistry; and
- highest standards of professional dental care

MEMBERSHIP

- Approximately 2300 Dentists in private and public practice, and also 4th & 5th year students and ADC candidates
- 95% of registered private practitioners
- 9 suburban and 7 country groups

MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education programs (eg. Dental Awareness Month)
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent Graduate support
- Dental Assistant Training update seminars
- Member Service Plans (eg Professional Insurances; preferred suppliers)
- Industrial relations advice and representation
- Defence and legal support
- Advice on Practice Management
- Quality Assurance (including Doctors Health Advisory Service)
- Benevolent Fund
- Library and resource collection
- Political representation
- Representation to Government bodies
- Superannuation (Professional Provident Fund)
- Sports and social functions
- Publications – Newsletter, Journal, Award details, Manuals etc.
- Home Page (find us at <http://www.adavb.com.au>)

INFORMATION & DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with member dentists. Information on treatments, facilities, dental issues and careers is available.



PRESIDENT

Dr Chris Callahan
BA, BDSc
FRACDS

Phone: 9822 1836

CHIEF EXECUTIVE OFFICER

Mr Garry Pearson
MEdSt, HDT (SAC)
AFAIM, MAICD

Phone: 9826 8318

