Closing the dental divide

Ending the dental–medical divide is essential for efficient health care expenditure and improved health outcomes

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A smile from any Australian, young or old, tells an instant story of a dental divide that is painful, costly and harmful to health and wellbeing. Their oral health and dentition are measures of their socioeconomic status, employability and self-esteem and predictors of their physical health.

Oral diseases can ravage the rest of the body and physical illnesses and trauma affect oral health.[1] Moreover, the risk factors for oral disease and dental decay — high sugar diets, poor hygiene, smoking and excessive alcohol consumption — are also risk factors for heart disease and cancers.[1] Yet medicine and dentistry remain distinct practices that have never been treated the same way by the health care system, health insurance funds, public health professionals, policymakers and the public.

Medicare was established to ensure all Australians have affordable access to health care, but from the beginning routine dental care was excluded.[2] It is a separation that is increasingly hard to rationalise on health grounds.

The burden of disease associated with oral health problems is huge. Tooth decay is Australia's most prevalent health problem, and edentulism (loss of all natural teeth) is also very prevalent.[3] In terms of quality of life, the impact of oral conditions is estimated to be greater over a 12-month period than the effect of all infectious diseases combined or of either breast cancer or lung cancer.[4] But it is telling that the data supporting these statements have not been updated in over a decade.

The Australian dental black hole

A recent report from the Australian Institute of Health and Welfare highlights that Australians' dental health has not improved in recent years.[5] There has been a rise in the average number of children's baby teeth affected by decay and an increase in the number of adults reporting adverse oral impacts. Nearly half of all children aged 12 years had decay in their permanent teeth, over one-third of adults had untreated decay, over 50% of people aged 65 years and over had gum disease and over 20% of this age group had complete tooth loss.[5]

There are consequences for the people involved, the health care system and the economy as a whole. The pain, infection and tooth loss that result from untreated dental caries and oral disease cause eating and speaking difficulties and disrupt sleep and productivity. Poor oral health has been linked to infective carditis, coronary heart disease, stroke, adverse pregnancy outcomes and aspiration pneumonia. Destruction of the soft tissues in the mouth can cause lasting disability and even death.[6] Impairment of appearance and speech by dental disease may inhibit opportunities for education, employment and social interaction.[6]

> "dental disease may inhibit opportunities for education, employment and social interaction"

In terms of overall numbers, Australia has an adequate dental workforce, but there is a gross distortion in its distribution; 80% of dentists, 84% of dental hygienists and 63% of dental therapists work in metropolitan areas, most of these in the private sector.[7] There is an adequate supply of dentists only in the major cities for those who can afford private dental care.

In the absence of regular dental checks, and when access to dental services is limited by geography, affordability and long waiting times for public services, dental problems quickly become medical problems. Many patients seek pain relief from general practitioners and emergency departments. In the 2011–12 financial year there were 63 327 potentially preventable hospitalisations for dental conditions and 128 712 separations for dental procedures requiring a general anaesthetic.[5]

Who pays for better teeth?

The costs are substantial: $7.857 billion was spent on dental treatment in 2010–11 and additional care costs exceeded $1 billion.[1] Dental care constitutes around 6.4% of national health spending — to which individuals contributed 58% in 2010–11. The federal government, via direct outlays and premium rebates, contributed $1.437 billion.[8]

While people who can afford regular and routine care report low levels of extractions and relatively low levels of fillings,[9] for too many Australians a visit to the dentist — for any reason — is an unaffordable luxury. People who have private health insurance are more likely to access dental care, but insurance cover is clearly inadequate, with 78.7% of people with ancillary cover reporting that they paid some of the cost of care, and 9.4% of people reporting they paid all of their expenses.[5]

If we are serious about a focus on effective and efficient health care expenditure, equitable access and closing the gaps in health disparities, then it is time to end the dental–medical divide. I am putting forward the following initiatives for consideration in the current political and economic environment in which integrating dental care into Medicare is seen as a step too far. Implementing my proposals will require

concerted action from all stakeholders, but depends more on changes in cultures and focus than increased resources.

Intergrating medical and dental care

First, it is time to make dental and medical professionals partners in delivering health care services and to include the mouth as part of the body. At the very least this should entail some shared training, recognition that dental services are an integral part of primary care, inclusion of dental information on personally controlled electronic health records, and professional courtesies around patient referrals. Primary care doctors, nurses and allied health professionals need training and skills in oral health screening, providing oral hygiene advice and emergency pain management. Specialists need to consider the dental implications of their patients' diagnoses and treatments. And dental professionals need to advise patients' doctors about infections and other oral health problems. In particular, they have a key role in screening for cancerous and precancerous lesions.

Second, health promotion activities related to eating well, smoking and substance misuse, breastfeeding and better management of chronic conditions and polypharmacy need to include oral health information. It is not just health professionals who need to bridge the dental–medical divide, it is the public too. They need to be educated that bad teeth and poor oral hygiene are not simply cosmetic problems but the cause of sickness, disability and even death.

Third, oral hygiene is a critical aspect of care for the frail aged, people with mental illness, people with disabilities and those on certain medication regimens. Children with spasticity and people with developmental disabilities will need special services, and there is little point to investing in dental care if, at the end of life, there is no one to help nursing home residents brush their teeth.

Fourth, if private health insurance funds are keen to play a role in primary care to ensure that their customers are less likely to need acute care services, then it is time for them to consider their role in providing better dental care with reduced costs. The caps on current services mean that even an annual check-up can leave the patient out of pocket.

Where best to invest

In the absence of universal dental care, the best-value investments for governments are in three broad areas: fluoridation, preventive services for children, and preventive and treatment services for the poor and those with special needs. This will require dental services that are more accessible, especially to those living outside metropolitan areas, and more affordable.

So my final recommendation is for an investment in a "Dental Health Service Corps" made up of dentists and dental staff, doctors, nurses, community and Aboriginal health workers and public health professionals to take oral health services and education where they are needed. This could be modelled on the Commissioned Corps of the US Public Health Service (but without the military affiliation), where professionals enlist for a defined period and are rewarded by having their tertiary education debts paid off.[10] To be really effective it needs a public health focus, because dental caries and associated problems are largely diseases of social deprivation and their control is as much about improving the social environment as about intervening to improve the oral environment.[5] It might also prove cost-effective to set up emergency dental services within hospital emergency departments, at least on weekends.

It is time for governments, health professionals, policymakers and community groups to put their money where their mouths are and act together to improve the oral health of all Australians, so that in the future the only gap-toothed Australian smiles are those indicating a visit from the tooth fairy.

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