

Uniting *Care* Burnside Submission
to the
Legislative Council Standing Committee
on Social Issues

Inquiry into Dental Services in
NSW

June 2005

“Dental health is essential but [they] treat it like a luxury”

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Executive Summary

UnitingCare Burnside is an agency of the Uniting Church in Australia and a leading child and family agency in NSW. We currently provide a range of direct services to over 5000 vulnerable children, young people and families in both urban and non-urban areas of NSW each year.

All of Burnside's programs provide services in both metropolitan and rural/regional areas of NSW to people from low socio-economic groups who are primary users of public dental services. Through its programs, Burnside works with a range of groups that are priorities in terms of oral health. These include Aboriginal and Torres Strait Islanders, people with disabilities, people from culturally and linguistically diverse backgrounds, drug users, children, young people and people from rural and remote areas. Burnside's programs have a particular focus on working with disadvantaged children and young people.

Burnside's response is based on consultations with Burnside staff members and service users, as well as on some limited consultation with relevant staff from Area Health Services. The findings from the consultations have been augmented with relevant sections of the literature.

The greatest impediments to accessing the oral health care for disadvantaged groups are the waiting lists for public dental services, as well as the prohibitive cost of private dental treatment. Ever-worsening oral health is a consequence of delayed treatment and lack of preventative interventions. It results in an array of oral health problems such as abscesses, chronic toothaches, migraines related to dental problems, chipped and chalky teeth, severe decay resulting in extractions and face swelling.

The quality of treatment provided through public dental services is of major concern. Our consultation has highlighted a number of issues including: concerns about the qualifications and experience of oral health staff, experiences of negative attitudes of oral health staff towards service users, experiences of poor treatment, the lack of preventative focus and the emphasis on extractions rather than filling teeth.

Urgent reform is required in relation to the funding and delivery of oral health services in NSW, in order to improve oral health of disadvantaged groups. NSW has the lowest level of public funding of oral health compared to other states. State Government funding provided for oral health care per capita, should be increased to surpass the level of funding provided by Queensland, which has the highest per capita funding.

Recommendations

Urgent reform is required in relation to the funding and delivery of oral health services in NSW, in order to improve oral health of disadvantaged groups. The major issue relates to funding.

1. As recommended in *Australia's National Oral Health Plan 2004 – 2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004) oral health should be integral to general health in the development of health policy and the health reform agenda.

It is recognised that ideally Medicare should be expanded to include oral health treatment and care and that State Government funding should be matched by the Commonwealth. However given the dire situation in relation to oral health care, the State Government has an obligation to take immediate and substantial action to improve public dental service provision.

2. State Government funding provided for oral health care per capita should surpass the level of funding provided by Queensland, which has the highest per capita funding.
3. Substantial State funding should be provided to implement the recommendations of *Australia's National Oral Health Plan 2004 – 2013* in NSW.
4. Substantial State funding should be provided to implement the recommendations of the *NSW Oral Health Promotion: Framework for Action 2010* (NSW Oral Health Promotion Steering Committee, 2005a) and the companion plan about Aboriginal and Torres Strait Islander oral health promotion plan, currently nearing completion (NSW Oral Health Promotion Steering Committee, 2005b).

Funding increases must be provided to ensure that the publicly funded dental health system meets the following standards:

1. There must be timely access to services and interventions at all points along the continuum of care, from prevention and early intervention to treatment.

This includes:

- a. Prevention – there must be a focus on preventative dental services such as appropriate oral hygiene practices, access to and information on a healthy diet, regular check-ups, cleaning and scaling. Fluoridation should be expanded to include all towns with a population of over 1,000 people.
 - b. Early intervention- decayed teeth and other oral disease should be treated in time to prevent expensive, complicated oral health care and tooth loss.
 - c. Treatment – People experiencing pain should be able to access emergency dental care within twenty-four hours. Alternatives to extractions should be provided.
2. The quality of treatment and prevention provided through public dental services should be of a similar standard to that provided through the private sector.
 3. Oral health care should be provided in an accessible and culturally appropriate manner. This may mean developing new models of service delivery, such as outreach clinics located in methadone units or youth services.

1. Introduction

UnitingCare Burnside is an agency of the Uniting Church in Australia and a leading child and family agency in NSW. We currently provide a range of direct services to over 5000 vulnerable children, young people and families in both urban and non-urban areas of NSW each year.

Burnside's submission to the NSW Legislative Inquiry into Dental Services in NSW will focus on three aspects of the Terms of Reference of the Inquiry:

1. the demand for dental services, including issues relating to waiting times for treatment in public services;
2. access to public dental services, including issues relevant to people living in rural and regional areas of NSW;
3. the quality of care received in dental services.

These aspects of the Inquiry are relevant to the work of Burnside in a number of areas.

1. All of Burnside's programs provide services to people from low socio-economic groups who are identified as priorities in the *Australia's National Oral Health Plan 2004 -2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004) and who are primary users of public dental services. Burnside provides services in disadvantaged areas of Sydney, including Western Sydney and South Western Sydney. Burnside also has programs located in rural and regional NSW, including Dubbo, Coffs Harbour, Port Macquarie, Central Coast and Goulburn.
2. Burnside's programs have a particular focus on working with disadvantaged children and young people. Burnside has youth services located in North Parramatta, Dubbo and Campbelltown. The organisation also provides out-of-home-care, early intervention programs for children at risk of abuse and neglect, as well as support services for families with children.
3. Through its programs Burnside works with a range of groups that are identified as priorities in *Australia's National Oral Health Plan 2004-2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004). These include: Aboriginal and Torres Strait Islander people, people with disabilities, people from culturally and linguistically diverse backgrounds, drug users. Children, young people and people from rural and remote areas are also identified as priorities in *Australia's National Oral Health Plan*.

Burnside welcomes this Inquiry into dental services in NSW. It provides an opportunity to reform an oral health system that currently fails significantly in meeting the oral health needs of low-income earners and their dependents.

Burnside's response is based on consultations with Burnside staff members and service users. Six focus groups were held with staff and service users from Burnside's services. The focus group schedule consisted of about nine questions relating to the demand for dental services (including waiting times for public dental services), access to public services and the quality of treatment received.

About ten semi-structured interviews were conducted with both staff and service users from a variety of rural and metropolitan Burnside services. These interviews consisted of about six questions. Several unstructured interviews were held with relevant Area Health Service staff members.

The findings from the interviews and focus groups have been augmented with relevant sections of the literature. Burnside is providing a snapshot of the issues that were raised in the consultations that are relevant to Burnside and their service users. We hope that this provides a valuable contribution to the range of responses that the NSW Legislative Council on Standing Issues, Inquiry into Dental Health Services in NSW will receive.

2. Background

2.1 Definition of oral health

Oral health is not simply the absence of oral health problems but is a state of wellbeing in which an individual can eat, speak and socialise without discomfort or embarrassment. Oral health is about the ability of individuals, groups and populations to have opportunities to make healthy oral choices, promoting positive and sustainable wellbeing and contributing to general overall good health (NSW Oral Health Promotion Steering Committee, 2005c).

Oral health includes having healthy teeth and gums, but it also means that people's lives are not affected by a range of other conditions including diseases of the oral mucosa, cancers of the mouth and throat, malocclusion¹, birth defects (e.g. cleft palate), temporomandibular joint problems, or trauma to the jaw or middle of the face (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.50).

¹ Definitions for words underlined in this document appear in a glossary at the back of the document.

2.2 Economic implications

Oral health problems are widespread and have a significant economic impact. Dental caries is Australia's most prevalent health problem, edentulism the third most prevalent and periodontal disease the fifth most prevalent (Australian Institute of Health and Welfare 2000, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6).²

Dental caries and periodontal disease account for 90 percent of all tooth loss (Australian Health Ministers Advisory Council 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6). At the last national survey of oral health, over 38 percent of Australians had untreated dental decay (Barnard, 1993, Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6). More recent estimates suggest that 11 million people are suffering new decay each year (Brennan and Spencer, 2004, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6).

Caries is the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes (Australian Health Ministers Advisory Council 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6)

Approximately \$3.7 billion was spent on dental services in the year 2001-02, representing 5.5 percent of total health expenditure (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.8). Much of this is spent on repair and rehabilitation of tissue destroyed by dental caries and periodontal disease—diseases that are amenable to prevention through personal and public health measures that are safe and effective.

2.3 Consequences of poor oral health

Oral health problems have far-reaching consequences. Pain, infection and tooth loss are the most common consequences of oral disease, but it can lead to destruction of soft tissues in the mouth and, in rare cases, death. Oral disorders cause difficulties with chewing, swallowing and speech, and can disrupt sleep and productivity. They can affect the way a person looks and sounds, the face they present to the world. They can have a significant impact on self-esteem, psychological and social wellbeing, employment, interpersonal relations, and quality of life. Tooth loss is directly associated with deteriorating diet and compromised nutrition (Locker, 1992, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.5).

² Compared to hearing loss (second most prevalent, asthma (fourth), iron-deficient anaemia, alcohol dependence/harmful use, osteoarthritis, chronic back pain, and depression (sixth to tenth most prevalent)

Oral health and the health of the rest of the body should not be viewed in isolation. Dental health and systemic illness are mutually dependent (NCOSS, 2002, p.3). Poor oral health and untreated oral conditions can have a significant impact on general health. There is strong evidence suggesting causative relationships between major dental diseases such as caries and periodontal disease and specific medical conditions including arthritis and preterm birth.

Causative links have been found between oral bacteria and arthritis. Periodontal disease may contribute to preterm birth and low birth-weight (Australian Health Ministers Advisory Council, 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p. 6). Studies have found that expectant mothers with periodontal disease are seven times more likely to deliver premature, low birth-weight babies than women who do not have the disease (ADHA Surgeon General's Report, May 2000, cited by NCOSS, 2002, p.6).

In addition, many life-threatening diseases have oral complications that appear in the mouth before they show up in any part of the body (ADHA Surgeons report 26/7/02, cited by NCOSS, 2002, p.2). For example, patients with neurodegenerative conditions (such as Parkinson's disease) have problems with speaking, chewing, taste, smell and swallowing. People with AIDS have oral complications, such as pain, dry mouth, and mucosal infections (NSW Oral Health Promotion Steering Committee, 2005c, p.13). Diabetes directly affects the tissues of the gum that support the teeth. Approximately 95 percent of Americans who suffer from diabetes have periodontal disease (ADHA Surgeon's Report May 2000, cited by NCOSS, 2002, p.5).

Proper dental care increases the possibility of detecting potentially life-threatening diseases, as many symptoms appear in the mouth before anywhere else in the body. Providing oral health care can prevent, or detect early, the onset of medical diseases such as oral cancer. If detected early, oral cancer can be treated successfully 90 percent of the time (ADHA Surgeon General's Report, cited by NCOSS, 2002, p.6).

Oral diseases share common risk factors with all the diseases targeted as National Health Priorities. In particular, inappropriate diet, tobacco smoking, alcohol consumption, and exposure to ultraviolet radiation (i.e. the sun and/or sun beds) are leading causes of tooth decay, gum disease and oral cancer (Spencer, 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.6). An integrated, cross-sectoral approach to address common risk factors and promote protective factors could achieve significant improvements in oral and general health.

Oral health and general health are intrinsically inter-related. However, different systems of funding are used to provide general health care and oral health care.

2.4 Funding

The majority of oral health services in Australia are provided privately, with or without the assistance of private dental insurance. State and Territory government funded dental care for adults is limited to holders of concession cards issued by Centrelink. Children are eligible to access publicly funded dental services regardless of parental income. Since 1996, State and Territory governments have been the sole government funding bodies of public dental services.

The discontinuation of the Commonwealth Dental Health Program (CDHP) in 1996 has had a significant impact on public dental services across Australia. After the program was disbanded, the waiting lists grew by 20 percent in just over twelve months (National Dental Health Alliance, 2005; Pearkman and Ryle, 2005). According to the results of a survey conducted by the Australian Institute of Health and Welfare, the state of oral health has deteriorated significantly since the loss of the CDHP, particularly for low income-earners (NSW Health Department 2002a, cited by NSW Oral Health Promotion Steering Committee, 2005c).

NSW has the lowest level of public funding of oral health compared to other states (see Appendix One). The level of funding in NSW is about half that of Queensland, which has the highest level of funding per capita (The Association for the Promotion of Oral Health, 2005).

2.5 Policy and Planning

At the national level *Australia's National Oral Health Plan 2004 – 2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004) has recently been developed. The key action areas that the plan focuses on are: promoting oral health across the population, children and adolescents, older people, low income and social disadvantage, people with special needs, Aboriginal and Torres Strait Islanders and workforce development.

At a state level the *NSW Oral Health Promotion: a Framework for Action 2010* (NSW Oral Health Promotion Steering Committee, 2005a) and its companion document addressing the oral health of Aboriginal and Torres Strait Islanders (NSW Oral Health Promotion Steering Committee, 2005b) are nearing completion. These plans cover the whole of the community, prenatal, infants and preschool children, school aged children and adolescents, young adults aged 18-25 years, low-income earners and their dependents, older adults, rural and remote communities, people from diverse cultural and linguistically backgrounds, as well as health professionals and clinicians.

All of these plans include a focus on disadvantaged individuals and communities. A substantial funding commitment is required to fully implement these national and state plans.

2.6 Impact of disadvantage

Profound disparities exist across socio-economic groups in Australia in respect to oral and general health. People of lowest socio-economic status—the poor and disadvantaged—carry the highest burden of disease.

In particular, the incidence of caries and periodontal disease increases as socio-economic status decreases (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.27).

Various reports claim that people from disadvantaged backgrounds:

- receive nearly twice as many tooth extractions as the rest of the community (even though their underlying oral health problem is not significantly higher);
- have the highest level of perceived need;
- often use emergency departments and medical clinics to obtain pain relief or antibiotics for oral health problems;
- have lower rates of restorations;
- have longer intervals between their dental visits (including five years or more between dental visits);
- are eight times more likely to have no natural teeth (those aged between 45-64 years);
- report the major barrier to seeking dental care is its cost; and
- have an inferior standard of oral health when compared with the general population (Australian Institute of Health and Welfare 2002; Department of the Senate 1998, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.13).

Socio-economically disadvantaged groups may also include Indigenous Australians, a significant proportion of people living in rural and remote areas, the homeless, people in institutions or correctional facilities, low income earners and their families, some young adults and older people, as well as some people from culturally and linguistically diverse backgrounds.

These groups are highlighted as priorities in *Australia's National Oral Health Plan 2004-2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004). People with chronic illness or disability, also often socio-economically disadvantaged, are considered as a priority within this plan. The plan also notes that there are unmet oral health needs for a substantial number of low income or “middle” income Australians who are not eligible for public dental services. Twenty six percent of people not eligible for public dental care report that they delay or avoid dental treatment because of cost (Carter and Stewart 2003, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.28).

Burnside provides services to a range of disadvantaged groups. These are discussed in more detail below.

2.6.1 People from Culturally and Linguistically Diverse Backgrounds

The oral health of overseas-born persons who speak a language other than English is generally worse than Australian-born English speakers. When compared to Australian-born English speakers, overseas-born persons who spoke a language other than English report:

- a higher usage of emergency dental care;
- visiting the dentist with a problem (toothache) rather than for a check-up;
- a higher percentage of advanced periodontal attachment destruction;
- lower rates of preventative services;
- more extractions in the last twelve months (card holders received twice as many extractions as non-card holders);
- more experience of toothache (countries of Eastern Asia, South Eastern Asia and South Asia, specifically male and female people born in Lebanon and China, and males in Vietnam, Laos or Cambodia);
- fewer routine dental check-ups;
- lower rates of periodontal services;
- lower levels of dental insurance for card-holders;
- greater difficulty paying a \$100 dental bill.

(Carter et al. 1998; Department of the Senate 1998; NSW Department of Health 2002b, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.21). However, they do have lower rates of complete tooth loss.

Most newly-arrived refugee groups have significant oral health care needs (Finney Lamb and Smith 2002) and require urgent and extensive dental treatment. Reasons for this are dietary and nutritional issues, lack of fluoridated water, poor dental hygiene, poor access to dentists, dental education and preventative care as well as teeth (or the mouth) being a primary target for torture (NSW Refugee Health Service 2000 and 2002, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.22).

Several studies have identified many barriers to refugees accessing adequate health care. Finney Lamb and Smith (2002) report these are similar to those experienced by the broader migrant community and other marginalised groups. Barriers include:

- cultural and language barriers between a refugee and health care professional that can result in miscommunication, misdiagnosis and a lack of appropriate follow-up;
- financial constraints (Finney Lamb and Smith 2002);
- lack of trust of health service providers caused by experiences of human rights abuse from government authorities;
- fear - where refugees have experienced torture in which a health professional has participated;
- lack of understanding of available services;
- residing in a rural or regional area (Finney Lamb and Smith 2002);
- racism and discrimination have been shown to reduce access to care in some marginalised groups.

(NSW Oral Health Promotion Steering Committee, 2005c)

2.6.2 Rural and remote areas

People living in rural and remote areas are disadvantaged in terms of dental health. Research has found that people who lived in rural or remote communities report that they were more likely to:

- be edentulous
- wear a denture
- usually visit for a dental problem
- be uninsured

(Stewart, 1998, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.23).

The *NSW Rural Health Report* (Stewart, 1998 cited by NSW Oral Health Promotion Steering Committee, 2005c, p.23) suggests community members in rural and remote areas of NSW are disadvantaged because of:

- increased incidence of dental caries and gum disease relative to the general population;
- lack of accessible dental health services and suitable dental personnel compared with their urban counterparts;
- lack of access to affordable fresh produce;
- poor linkages between health services and specialist health sectors;
- low incomes;
- lack of water fluoridation in many communities.

Fluoridation of public water supplies is the single most effective public health measure for reducing dental caries across the population, with its most pronounced effects among those who are disadvantaged and most at risk (Acheson 1998; Department of Human Services 2000a, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.16). Even though fluoridated public drinking water is now available to most Sydney residents, only 60 percent of people outside Sydney receive fluoridated water (NSW Oral Health Promotion Steering Committee, 2005a, p.v).

2.6.3 Aboriginal and Torres Strait Islanders

A 1994-96 National Dental Telephone Interview Survey (NDTIS cited by NCOSS, 2002, p.13) of 17,691 adults, with 217 being Indigenous, revealed that:

- a higher percentage of Indigenous persons have no natural teeth (16.3%) compared to non-Indigenous persons (10.9%);
- a higher percentage of Indigenous persons (63.7%) visit for a dental problem rather than a check-up compared to non-Indigenous persons (49.7%);
- a higher percentage of Indigenous persons reported that they would have a lot of difficulty in paying a \$100 bill (33.5%) compared with non-Indigenous persons (14.1%) (AIHW Dental Statistics Research Unit, March 2000, cited by NCOSS, 2002, p.13).

Further, a 1995-96 Adult Dental Programs Survey of 5,926 health care card-holders who attended for public-funded dental care (with 278 being Indigenous), found that Indigenous people had higher numbers of decayed teeth compared to non-Indigenous people and experienced poorer periodontal health, especially in the 24 to 64 years age group. A higher percentage of Indigenous people had teeth extracted (50.6%) than non-Indigenous people (21.4%) (DSRU Report, March 2000, cited by NCOSS, 2002, p.13).

Diabetes mellitus is more prevalent in Aboriginal Australians (8-19% rural, 24% urban) than in Australians of Caucasian origin (2.3% rural, 3.4% urban). This high rate of diabetes significantly increases the risk of periodontal disease, thereby making the need for adequate public access to dental care crucial (Martin-Iverson, Phatouros and Tennant 1999, cited by NCOSS, 2002, p.13).

Oral health in Aboriginal and Torres Strait Islander communities, particularly in rural and remote locations, is affected by factors that operate from infancy through to old age, including water quality and fluoridation, diet, smoking, alcohol consumption, stress, infection, the cost and availability of oral hygiene items, the availability of dental services, and transport over distance to those services that exist (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.34).

2.6.4 People who use illicit drugs

Oral health problems amongst illicit drug users are often severe. Sheridan et al's (2001) study of 125 drug users and 129 non-drug users revealed that drug users self-report considerably more difficulty in accessing dental treatment, are less likely to have visited the dentist in the last twelve months and have a higher level of self-assessed oral health problems than non-drug users (Sheridan, Aggleton and Carson 2001, cited by NCOSS, 2002, p.8).

Illicit drug use is associated with a low expendable income, chaotic lifestyle and poor nutrition (especially the intake of foods high in calories and sugars). Consequently, illicit drug use is also associated with a higher rate of dental caries and periodontal disease compared with the general population (NCOSS, 2002, p.8). Problems with dental health are exacerbated by the use of methadone.

Barriers to accessing dental care encountered by illicit drug users arise from:

- affordability, dental health becomes a low priority;
- nature of lifestyle, difficulty with making or keeping appointments;
- perceived or real stigmatisation, or earlier experience of refusal of treatment by a dental professional;
- fear of pain - many drug users are unable to tolerate pain and fear that the pain they encounter in the dental visit will not be adequately managed;
- poor self esteem and self-consciousness about their appearance (NCOSS, 2002, p.9).

2.6.5 People with physical and intellectual disabilities

There is general agreement that the population with disabilities have higher rates of oral health problems than the general population, particularly problems of poor oral hygiene, gingivitis and periodontitis (Egan 2002, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.25). Disability-related factors such as medications, diet, inadequate oral hygiene as well as variable access to dental care are likely to account for much of the disparities (NCOSS, 2002, p.12). In addition, numerous developmental disorders affect the oral, dental, and craniofacial complex (NSW Oral Health Promotion Steering Committee, 2005c, p.25).

Level of function may be associated with dental health status. Desai et al's study (2001, cited in NSW Oral Health Promotion Steering Committee, 2005c, p.26) of 300 children (9 to 13 years) with disabilities (including learning disability, intellectual disability, speech problems, physical disability, motor incoordination, autism, epilepsy, cerebral palsy and/or visual problems) found a significant association between function level and dental health status. A decrease in function was associated with an increase in dental caries and periodontal disease.

Fiske and Shafik (2001, cited by NSW Oral Health Promotion Steering Committee, 2005c, p.26) report that use of dental services by people with disabilities is compromised by limited physical access to buildings, limited practitioner willingness to provide care, and financial difficulties.

2.6.6 Children and young adults

Children in low socio-economic groups experience almost twice as many caries as children in high socio-economic groups. Aboriginal and Torres Strait Islander children have around twice the caries rates seen in non-Indigenous children. Their oral health has continued to worsen over recent decades, in contrast to the improvements seen among non-Indigenous children (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.20).

Children aged less than 10 years, particularly those at socioeconomic disadvantage, are substantially more likely than other age groups to be hospitalised for dental conditions for which, given early access to appropriate services, hospitalisation could generally be avoided. Most of these admissions are for extraction of teeth due to gross dental caries. Admission for dental care is over three times more likely among rural children compared to their metropolitan counterparts (Department of Human Services 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.20).

Australians' oral health status deteriorates rapidly in later adolescence and early adulthood (Spencer 2001, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p. 7). There is a four-fold increase in dental caries between 12 and 21 years of age, and almost

half of all teenagers have some signs of periodontal disease (Sanders and Spencer 2003, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.7).

Recent figures from public dental clinics showed that young people aged 18-24 years had, on average, about five teeth with untreated decay. In Queensland, nearly 20 percent of dentate young adults (18-29 years) reported that they had experienced toothache at some time during the previous four weeks (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.7).

3. Results of consultations

3.1 Barriers to accessing services

3.1.1 Waiting lists

Currently public dental services accept only concession card holders, and they face long waiting lists. According to the Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health (2004) demand from concession card holders for dental care far outstrips State and Territory dental services' capacity to supply treatment and waiting lists are five years and more in some areas, despite significant increases in expenditure. There are about 500,000 people on waiting lists around Australia for public dental treatment and only about 11 percent of those eligible for treatment receive it each year (The Senate, Community Affairs References Committee, 2004).

From consultations and interviews it has been found that waiting times for dental services vary across different parts of the state. Rural services have extremely long waiting lists. Respondents indicated that the public dental clinic at Coffs Harbour on average has a seven year waiting list for services. According to respondents the service does not usually undertake fillings or procedures that take time. Emergencies are treated more promptly. However they only treat the cause of the pain, not other dental problems.

In consultations conducted with a Burnside service in another regional centre, it was highlighted that in emergencies young people will receive brokerage for a private dentist to treat the current pain or emergency, but not for ongoing treatment to assist with long term dental issues. This still incurs a long wait because private dental practices only allow one appointment a day for brokerage and only allow one off brokerage rather than follow up treatment. From our consultations conducted in Sydney, respondents have identified waiting periods for services ranging from four weeks to two years.

A staff member indicated that a service user waited for three years without teeth to receive dentures from the Coffs Harbour dental clinic because they are seen to be "cosmetic." One respondent from Coffs Harbour noted that teeth are often removed with people waiting years for dentures. Respondents from other services in Sydney have also reported similar waiting times, with one person in her twenties waiting for two years for dentures to replace her

top teeth. This long wait has caused further dental problems and she now needs all her teeth extracted. She was told by a private dentist that

"[She] has a small bridge [and she] will look like a horse with dentures especially with them on the bottom and the top."

She has also been advised that there will be at least a three month wait between her full tooth extraction and the receiving of her dentures. The respondent described the effect on herself and life:

"How embarrassing, I can't turn up to work with no teeth."

"I'm supposed to be working with kids, that would freak them out, a lady with no teeth."

"It's shattering, you know, it's gross."

It appears that the current public system is being used primarily for emergency treatment or for those in severe pain. According to respondents, if the person is in pain they are likely to be seen within a couple of months. Otherwise they go on to the bottom of the waiting list. Several respondents indicated that they have resorted to exaggerating their condition as they are in pain and are scared of not being categorised as an emergency and having to live with worsening pain until there is an available appointment. One respondent noted that

"Waiting a month when you have a massive headache or sore teeth, [is] really bad."

Several respondents commented that when an appointment is missed due to illness or in some cases, when people have been running late, they go back to the bottom of the list and start the waiting process again.

The absence of preventative care or treatment results in a constant influx of dental emergencies. Dental problems and diseases are not being treated until people are in pain and as one respondent commented:

"You have to be allocated as a crisis or emergency before being seen and then they just pull the tooth."

One staff member that we interviewed commented about a particular service user with a disability who was experiencing holes in his teeth, swollen gums with "gunk" coming out of the wound and ongoing pain. A worker advocated on his behalf to the local service, due to the urgency of this situation. The closest dental service could not fit him in for four weeks. After further advocacy he was able to access a service two days later. It meant travelling by train from South West Sydney to Bowral.

Generally the waiting times for children to access public dental health services differ from that of adults. Many respondents indicated that children are seen quite promptly. One dental service in South West Sydney Area Health Service has a waiting list for children in pain of about ten days, much shorter than for adults. There are long waiting lists for dental prevention check ups.

The primary school dental checks provide some form of ongoing dental care for children but these check-ups have been reduced in frequency. One respondent from a rural centre noted that only children with serious dental problems are referred on for further treatment. A respondent from another rural area indicated that the primary school dental checks referral process provide the only way into the public system. However, these only occur every two years.

A worker from a rural centre described the current primary school dental system in their area:

“There is a dental system through the school and children will receive a referral if necessary, but parents have to ring up within three days of the child receiving it, otherwise the referral is disregarded. It takes approximately six weeks for the child to be seen and appointments are not made in consideration of family needs or work commitments but rather at a time the dental service tells you to come. If you miss the appointment you have to go through the cycle again.”

The centralised booking call centre used for making public dental service appointments was identified to be a source of frustration, as respondents can be on hold for thirty minutes. A worker identified that for young people this process is frustrating, as they are put on hold and then are told they are unable to see a dentist for a month or so, so they just think, “*Oh stuff it!*” and do not receive treatment. A respondent noted that people with children find it difficult to sit on hold for thirty minutes while supervising their children.

Respondents commented that they are unable to make follow up appointments at the service where they are receiving treatment and are told to use the centralised system. Patients are not guaranteed a follow up appointment in a timeframe recommended by the dentist, but rather when the next appointment is available.

3.1.2 Cost

The majority of oral health services in Australia are provided through the private sector. This raises a significant access issue. For those who are eligible for public dental services there are lengthy waiting lists. Disadvantaged groups who are not eligible for public dental services (including some migrants who are not eligible for a healthcare card), as well as those who are eligible, have difficulty accessing regular private oral health services due to the cost. Currently private dental treatment costs an average of \$295

per hour (ranging from \$200 to \$450) (Australian Dental Association 2003b, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.11).

Dental insurance can assist in covering some of the costs for private dental care. Approximately 20 percent of people earning under \$20,000 per annum have dental insurance while only 3.7 percent of concession card holders who attend public dental clinics have private dental insurance (Carter and Stewart 2002, cited by Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p. 16). Whilst the Commonwealth tax rebate may be moderating the pressure on state dental programs, the majority of the tax rebate is received by higher income earners, who would not normally access public dental clinics (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.16).

Dental insurance assists with some of the private dental care costs incurred by individuals. However there is a limit on treatment covered by insurance policies. This acts as another barrier for disadvantaged people, particularly as they may require extensive dental work, as a result of years of not being able to access services for check-ups.

“Even the health funds, even when you join, you’re only up for maybe two fillings a year.”

“You join up and think you’re going to get fifteen fillings and you can’t.”

In all the consultations respondents identified the cost of dental care as one of the main barriers to accessing private dental services. Many respondents commented that the cost of dental care was so expensive and waiting lists for public dental services are so long, that they have avoided treatment until it was an emergency or the pain has become intolerable. Some respondents had resorted to home dental treatment by trying to extract the painful teeth and relieve the pain of abscesses by creating holes in their gums.

Respondents who needed more extensive treatment such as root canal therapy, removal of wisdom teeth, dentures and orthodontic work highlighted that these necessary treatments are difficult to obtain. This is due to the cost of treatment by private dentists and the long waiting lists for treatment available in public dental services. Respondents indicated that some types of treatment such as braces and removal of wisdom teeth are not available through the public dental system.

“If there is like braces, there is none of that. You know that’s just a non-...wait until you grow up and you get a job and buy them...but you will need them.”

“She’s got a problem with her wisdom teeth. It’s thousands of dollars. She just can’t do it. She’s got four kids, five kids or something. She can’t do it. The kids come first.”

Several overseas born respondents noted that it is much cheaper to go back to their country of origin to receive dental treatment. A respondent commented that people go back to Serbia to receive dental treatment due to the costs in Australia. Several respondents commented that it is cheaper to obtain dentures in Thailand, rather than going to the dentist here.

Many respondents recommended that dental care and treatment should be included under Medicare. Through Medicare, many are able to keep up their general health as they can go to the doctor. However, they are unable to maintain their dental health as they have no means to pay for private dental treatment. One respondent commented

“Medicare should not only be for doctor’s visits, but is also needed to cover dental work for people on lower incomes, pensions and especially children.”

3.1.3 Transport/Travel

Transport was identified as a barrier to accessing dental services for those living in and around rural centres. A major issue for those living outside rural town centres is that there is no public transport available. One respondent indicated that some people may need to drive for two hours. If they don’t have their own car they have to rely on others for a lift, making it difficult to plan and attend dental appointments.

For those living within rural centres there is limited public transport which many find difficult to afford. In some rural centres the dental service is not located in the town centre, making it very difficult to access by bus.

Respondents from Sydney had varied comments and experiences of accessing dental services. For many of the respondents the ability to access a dental service largely depended on its location, knowledge about the purpose of the service and availability of public transport in the area. One respondent noted that young people are able to access dental services in that area via public transport, but have still found it difficult to attend due to costs, long waiting periods and their lack of understanding and knowledge about treatment they may receive.

Some respondents commented on the inaccessibility of specialist services. Many have travelled for long periods of time within Sydney or to major cities from rural areas to access specialist services. Several respondents commented that some children have had to travel alone to either Westmead Hospital or Sydney Dental Hospital for specialist treatment.

A worker from one rural youth service highlighted that transporting young people to dental services is putting pressure on their limited resources. Some

respondents identified that it is appropriate for youth services to assist with transporting young people to dental services. However many centres do not have the adequate resources or funding to provide assistance.

3.1.4 Lack of knowledge of dentists, dental treatment and dental education

The importance of knowledge of dental care is highlighted in the draft *NSW Oral Health Promotion Plan: Framework for Action 2010* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004).

“Although it is well established that knowledge alone will not necessarily lead to appropriate practices, lack of knowledge can affect care. If parents are unfamiliar with the importance and care of their child’s primary teeth, or if they do not know that dental sealants exist, they are unlikely to take appropriate action or seek professional services. If the public is unaware of the benefits of community water fluoridation, public referenda and funding for such interventions are not likely to be supported.” (NSW Oral Health Promotion Steering Committee, 2005a, p.vi).

Knowledge of dental care includes knowledge about the location of services, the types of treatments available, good nutrition and oral self-care.

Several respondents indicated that there is a need for more education about the location of public dental clinics and the types of treatments available. One respondent highlighted that

“Low socio-economic families don’t know how to access free dental services. Kids don’t have experience of going to the dentist.”

This was particularly highlighted in relation to young people. It was recommended that information should be widely available in the community about what to expect, the services available and people’s entitlements. One respondent identified that information should be provided in an appropriate format such as community forums or letter-box drops.

Some children, young people and adults have minimal or no experience of the dentist.

Due to the long waiting lists in the public dental system, people are only accessing services when they are in pain. Dental services are accessed infrequently as check-ups are not occurring. This contributes to a lack of knowledge about dentists and dental care.

Question: *“Do clients have fears of going to the dentist due to previous negative experiences?”*

Response: *“They don’t go often, it’s almost non-existent for check-up.”*

In addition, consultations with staff and services users from culturally and linguistically diverse backgrounds indicate that some cultural groups have had little access to dental care in their country of origin. For example, in Laos

“There is no regular check-up, only for an emergency.”

Subsequently there are few opportunities for education about oral health in a clinical setting.

3.1.5 Dental education

Many respondents, both rural and urban, highlighted the need for dental education. Dental education was described in one consultation as being “...*poor or non-existent.*” Staff members from a Burnside service identified that many young people accessing their service don’t understand the importance of keeping their teeth clean.

“It’s not being picked up from their family.”

Knowledge of appropriate dental treatment for very young children may not be widespread. One respondent with a daughter under school age commented:

“I don’t even know if she’s s’posed to see a dentist.”

In a consultation conducted with staff members who work with people from culturally and linguistically diverse backgrounds, the need for education and information about dental health and nutrition was highlighted. It was identified in this consultation that there is very poor dental hygiene and a lack of information about dental care and nutrition for many of the culturally and linguistically diverse communities that they service. While dental checks are offered in public primary schools and referrals are made to public dental clinics, “...*nothing is done to educate the family about dental hygiene or nutrition.*”

It was noted that there are problems with nutrition, with families feeding their children sweets and fast food. In another consultation with a staff member it was identified that the diets of non-Western overseas-born Australians are often better when they are living in their country of origin. When they come to Australia, their dental health declines rapidly with the change of diet.

Work conducted with students of Intensive English Centres has revealed that some students lack knowledge of dental products such as floss, toothpastes as well as the types of foods that they should have in their lunchboxes.

An issue that was highlighted in one consultation involving staff members that work with people from culturally and linguistically diverse backgrounds, was the lack of awareness of parents of the negative impact on quality and positioning of teeth from the long-term bottle feeding of children. While the local Community Health Service has launched an information and education

package about this issue, respondents considered this still to be a prominent problem. It was noted that in some Asian communities even the primary school age children are still using bottles.

"I find that very general, in every family, in every people who come to the group, it is a very poor hygiene either from bottle-feeding up until six years old and people have not enough information about how to use different bottles, not just the rubber ones but the other ones, and the food to eat. The whole lot of feeding and nutrition and dental... I find it across the board."

Respondents identified the need for information sessions for parents in their first language so that they may understand the importance of oral health care and nutrition.

3.1.6 Language

Respondents identified that a lack of English-language skills can be a substantial barrier to accessing dental services. According to one respondent, low self-esteem combined with language barriers leads to people not accessing dental services.

One staff member commented that access is quite frustrating for clients as they have to ring up and the voice on the answering machine is in English. In an emergency, clients have had to ring dental services or hospitals and have not been able to communicate in any other language but English and have only been able to receive advice if they have the suitable papers ready from which to give information.

Another respondent gave an example of a client who experienced difficulties due to language barriers. The staff member made an appointment for the client. The client couldn't be seen for two to three months for dental care. As it got closer to the appointment a dental health worker/nurse called the client to confirm the appointment, because the client couldn't speak or understand English, she didn't know what to answer and she was then removed from the list. The worker eventually worked out what had happened after the client spent long periods of time waiting and had to re-book the client who couldn't be seen for another two to three months.

Even when there are interpreters available, contacting dental services can be difficult, particularly for newly arrived migrants who may not even know how to make a telephone call.

3.1.7 Competing with other issues

A staff member consulted from a Burnside service identified that dental health may not be a priority for some young people accessing their service because of the more pressing issues facing homeless young people or young people at risk of homelessness. Other priority issues may include funding immediate accommodation, obtaining food, legal matters or other more pressing health issues, such as a fractured arm. Mental health issues may be more pressing.

“Dental hygiene and being more proactive goes way down the ladder.”

This does not mean that young people are unconcerned about their dental health. When about half a dozen young people from the service were interviewed many of them were concerned about their dental health, as quite a few of them had significant dental problems and were unable to regularly access services and maintain good dental health.

3.1.8 Poor reputation of dental services

Concerns about the quality of care provided by community dental services also act as a barrier to accessing services.

Staff members from a regional centre identified that people are fearful of dental hospitals and “*dodgy*” procedures in community dental services. They identified that the “*...word out there is that you wouldn't want to go there.*”

Respondents in one focus group expressed concern about accessing local public dental services after hearing other respondents discuss very negative experiences of treatment received in public dental clinics.

3.1.9 Access to childcare

One respondent noted that access to childcare was a barrier for her accessing dental services. She identified having children at the dentist during her own dental treatment as problematic, because the dentist could not complete all the work as the children were not supervised and could not sit still.

“I can't get my teeth fixed as I can't stay for long enough.”

3.2 Implications and Consequences

Respondents identified that the inability to access quality dental services in a reasonable timeframe resulted in ever-worsening dental health.

“I was telling them for two years that I needed something done and it wasn't until they were coming out that they would do something and now I need dentures...I'm 25 and I need dentures.”

Lack of treatment and prevention leads to an array of dental problems, including chronic pain, cavities, ulcers, abscesses and other complications.

Ongoing pain is a significant issue for many people eligible for public dental care. One respondent reported that she was currently taking ten Nurofen a day on top of the methadone program to relieve her current level of pain.

Most young people interviewed as part of this consultation had significant dental problems. When asked a question about their current dental health one young person answered that he was experiencing chronic pain, face swelling and a continuous bleeding mouth which was affecting his food intake. Overall the young people interviewed experienced chronic toothaches, cavities,

plaque build up, tooth decay, chipped teeth, face swelling, bleeding from the gums, ulcers, bad breath and migraines related to dental problems.

Respondents who had previously used illicit drugs reported particularly high levels of dental problems. This included being in constant pain, only being able to eat soft foods because of pain, using pain killers on a regular basis to try and get rid of pain, having teeth removed because of decay to the point of requiring dentures, as well as chipping and chalky teeth. The effect of illicit drugs and methadone has caused a variety of problems.

From the consultations it was apparent that some young people and people who had used illicit drugs do not access the dentist until pain is unbearable. One young person emphasised:

“Dentists are usually the last place we go.”

Respondents commented on their current options in relation to pain relief.

“We don’t have much choice, we’re gonna be in pain and pull it out or put up with the pain.”

A number of respondents explained that it is common for many people to go and get antibiotics from the medical centre to relieve pain rather than go to the dentist.

Several respondents commented that home dental surgery was becoming a common treatment for those experiencing extreme pain. A staff member from a rural service stated that people were pulling their rotten teeth out and creating holes in their gums to help relieve the pain of abscesses. One young person reported that they had tried to fix their teeth by pulling out the damaged tooth with pliers, but found this more painful so continued to experience the pain of the damaged tooth.

3.2.1 Diet

In the consultations it was emphasised that dental problems contributed to poor diet and food intake, as well as reduced level of health. Many respondents commented on their inability to eat a variety of foods with one stating:

“I don’t really eat, just nibble off the baby’s plate.”

“I would love to eat an apple but I can’t.”

Another respondent highlighted that she can’t eat food properly due to her dental problems and has to eat food with her front teeth *“...like a rabbit.”*

Several respondents complained of unnecessary weight loss as they are unable to maintain a normal diet.

“You can be up three and four nights and can’t sleep and toothache is the worst pain I have ever felt, you can’t eat and I lost that much weight.”

3.2.3 Appearances

Many respondents indicated that poor dental health can adversely affect appearances.

“I’ve got Aboriginal friends who are missing rows of teeth.”

“A lot of young people who come in shouldn’t have teeth looking like that, at that age...brown, missing teeth.”

This can impact on people’s self esteem, contributes to stigmatisation and may limit people’s employment opportunities. One respondent spoke about people in their early twenties with no front teeth and continued to comment that,

“Generally for self-esteem [that] isn’t a good thing, let alone anything else.”

A respondent accessing a methadone program commented about the negative impact of her appearance:

“No matter what I have done with my life to make it better and what I have achieved, I feel like that’s always there.”

“I used to smile heaps, but now I can’t.”

Several respondents indicated that the state of people’s teeth will always be a barrier as they are stigmatised by their appearance. One staff member noted that

“Many people will stigmatise them...means that they are a certain type of person, judging them because of that. It is sad we live in a society like that, but that is the reality.”

A number of respondents perceived that employment opportunities would be reduced due to their appearance. Some respondents indicated that because of their visual dental health problems their confidence to attain a job was reduced.

3.3 Quality of Care

A number of issues were raised in the focus group in relation to the quality of care provided through the public dental system. These included concerns about the qualifications and experience of staff, poor treatment outcomes due to language and communication difficulties, the need for staff to explain treatment options and treatment processes, negative attitudes towards service users, experiences of poor treatment, need for increased awareness of and

sensitivity to people's backgrounds and life circumstances, the lack of preventative focus and the emphasis on extractions rather than filling teeth.

3.3.1 Qualifications and experience of staff

Several respondents had concerns about the qualifications and level of experience of dental staff at dental hospitals.

Some respondents identified Westmead Hospital Dental Clinic as having a high number of dental students, who on occasions have not been properly supervised. One respondent explained her own experience of Westmead Hospital Dental Clinic which involved her daughter. At the time the respondent was a new migrant and had limited English. Her daughter had a visible infection in her mouth and it was obvious that there was something wrong. The respondent knew this, but the student at the dental clinic who performed the assessment tried to send them home. The respondent disagreed with the assessment and complained as she knew there was something wrong with her daughter. The staff member then brought a specialist to see her daughter and the daughter was diagnosed with a serious infection. The student was called and told to "*never do this again*". The respondent commented that if this was someone else they may have gone home and the child would have remained ill and the infection would have become more severe.

Another respondent commented about her experience of being treated by a dentistry student at Sydney Dental Hospital,

"I had one guy that was shaking so much that his ring was hitting my tooth."

According to another respondent, the qualifications of the dental health workers at community dental health services appeared to be just dental nurses or dentistry students undertaking their practical training. Other respondents commented that the public dental clinics require more staff members who are appropriately qualified and experienced.

3.3.2 Language

Being able to communicate well with dental staff was identified as a problem for those who have limited English. Respondents identified that people may be unable to properly communicate their concerns or problems they are experiencing with their dental health. One staff member explained how a service user from South East Asia who could not speak English went to a dental hospital for treatment. He was spoken to only in English although it was obvious that this person could only speak a few English words. The South East Asian service user kept answering "yes" to the questions asked of him by staff but he did not know to what he was agreeing. This resulted in the extraction of many teeth, as he continued to answer "yes" when they asked if he wanted more teeth pulled out.

One respondent highlighted that the person's spoken language is specified on the public dental services intake forms and that the indication of a specific

language should enable the use of an interpreter. It appears that interpreters are not always provided. A respondent commented that

“The dental hospital should be using interpreters. Family members/friends need to go with people to the dentist and interpret for them as interpreter services are not being provided.”

One staff member noted that people tried to go to dentists who spoke their “own language” similar to the way people access doctors who speak the same language. A difficulty with this situation is that many can not afford private dental services, which may have bilingual staff.

Most private dental services do not arrange interpreters. They require that it is arranged for the patient externally. This involves another cost on top of the private dental consultation making it unattainable for many seeking dental treatment.

3.3.3 Explaining treatment

Respondents in a number of consultations identified the importance of dental staff explaining treatment options, the treatment that will be undertaken, as well as steps involved in the treatment.

Young people that were interviewed suggested that procedures and treatment should be explained to them in a way that they can understand, so as to reduce confusion and bad experiences. A staff member identified that she knows of several young people who have left the public dental services in fear, without having any treatment done. This was because they were told that they were going to have teeth pulled out, but this was not explained to them properly.

One young person who was interviewed found it difficult to understand dentists who had English as their second language.

A staff member commented that having someone at the dental clinic who was trained in community and social issues and who had an appropriate “bedside manner” would be useful. They could explain treatment options, the procedures involved and processes which the patient would need to go through. This would allow for more patients to feel comfortable at the dentist as they would have a sense of ownership and understanding of their situation.

3.3.4 Negative attitudes to service users

Many respondents commented about the negative attitudes of staff at public dental services. People from some disadvantaged groups mentioned that they are “*spoken to*” about their dental problems rather than being consulted. Many respondents gave negative feedback about the attitudes of staff towards services users. A respondent commented that they felt “*judged*” by the dental health staff.

One young person said that they “...look down on you” and tell you “...that there is no excuse not to see a dentist” to which she replied, “I don’t have money to see one.”

Some respondents who are on the methadone treatment program commented that they are treated differently when staff members find out they are using the methadone program. One respondent said that staff at the service view service users as “methadonians”. Another commented

“When you tell them you’re on methadone it seems like they judge you.”

“If they find out that you’re on methadone they rip them out because they don’t care.”

Some of the respondents who had previously used illicit drugs made comments about the type of attitudes they encountered.

“They rip them out because they think you don’t look after them- why should we? They make you feel real dirty and bad about yourself because you didn’t look after your teeth.”

“She was teaching me to brush my teeth like I didn’t know or something.”

3.3.5 Quality of treatment

Respondents’ experiences of public dental treatment differed, depending on the services they had accessed. Some services had better reputations than others. For example, in one consultation, respondents indicated that some pensioners will not go to Liverpool Public Dental Service as the quality is not as good as others and that the service has a bad reputation. Another person at this consultation had quite good experiences at that service. In another consultation a respondent said that the Rosemeadow Clinic had a good reputation, particularly in relation to children.

In general, young people who were interviewed described the treatment that they had received at public dental services as “average”. One respondent commented that dental treatment was better when they explained the procedures in “everyday terms.” Other young people had experienced being rushed through treatment whilst others had found it useful and had received adequate services.

There were numerous stories about poor treatment undertaken at public dental services. One respondent spoke about the root still being in the gum after a tooth extraction. She said that

“It was like gristle coming out of my gum.” The respondent then went to a private dentist who said it was “...the worst job.”

A young person said that he had fillings done that weren't filed back properly. The fillings caught on food and his toothbrush which "...*made it feel like they were being ripped out.*"

A worker described how a boy who was preschool age was taken to Westmead Hospital dental clinic. The hospital removed all his teeth in one day and his parents didn't understand why and did not know how to look after him when they went home. This resulted in the boy getting abscesses and becoming unwell.

Another respondent described open holes in gums after tooth removal as an example of poor treatment.

Respondents commented that they aren't able to see the same dentist when returning to the public dental services. This lack of continuity, coupled with reports of high turnover of dentists, is problematic for those needing follow up and ongoing treatment. One respondent said that the Hoxton Park Dental Service had provide a great service and made an effort to save her teeth, but that the particular dentist who was treating her has left. Now she is treated by a different dentist every time she needs follow-up treatment. She said that she was getting different recommendations for treatment every time she went in, as she could never see the same dentist twice.

3.3.6 Sensitivity to peoples' backgrounds and circumstances

Throughout the consultations it was apparent that many services are not sensitive to peoples' backgrounds and circumstances. Some respondents identified that there needs to be more understanding about the ongoing needs and difficulties that young people face in seeing a dentist. This includes such things as completing forms, which some young people with learning difficulties find challenging and a deterrent to accessing services.

It was also suggested that public dental health services and professionals should discuss with their patients their dental health needs or concerns. This is opposed to making an assessment by only looking at the patients' mouths.

Some dental services were identified as having inappropriate access points which were not sensitive to young people and their backgrounds.

A respondent identified the need for specialised care for refugees because many of them have had traumatic experiences. Dental treatment could also be experienced as traumatic. Therefore services need to be culturally appropriate and sensitive.

3.3.7 Preventative oral health care

Many respondents have noted that preventative dental health care is greatly needed. Many of the young people consulted considered that they should be able to go in for check-ups so as to prevent long term dental problems.

One worker explained how some of their service users have lined up from eight in the morning at the dental clinics for emergency care, but that no regular treatment or follow-up is available.

"It is only for an emergency, they don't get regular dental care and that's why it becomes an emergency."

3.3.8 Extractions

Many respondents indicated that public dental services do not usually undertake fillings or other procedures that may take time. Some respondents highlighted that you need to be allocated an emergency or crisis before being seen and "...then they just pull the tooth". As one respondent explains:

"It was my experience a couple of years ago that rather than fill a tooth they would just pull it out. Then you've got no more tooth, what are you going to do?"

One respondent commented about what she was told by a dental health professional at a public dental clinic.

"If it's a big hole we're just going to take it out, we're not going to bother to fix it."

One respondent was refused preventative dental treatment to prolong the life of a tooth. She was told

"We are going to have to pull the tooth out anyway, what's the point in putting a filling in?"

Another respondent commented:

"There's no reason now to have a tooth pulled out these days. They can save a tooth when you've got near nothing. You know it's just a shame that they're pulling out good healthy teeth, just because it's got a hole in it and it's hurting."

Staff members from one Burnside service indicated that people accessing dental services have been given the choice of a Panadol or the removal of a tooth to stop the tooth aching.

"I had a lot of pain in one tooth and I went there (referring to dental clinic) and the only option was to remove it, but I don't want to remove it as it is right at the front. So they put a filling in it, but now I am having trouble with it again and I don't know what I am going to do because I don't want it removed because I will have to wait a long time to get another tooth."

As mentioned previously, respondents commented on the lack of availability of certain treatments through the public dental system, including braces and removal of wisdom teeth.

4. Conclusions and Recommendations

People from low socio-economic backgrounds and rural/regional NSW are substantially disadvantaged in terms of oral health. Other groups, such as people who currently use /have used illicit drugs, Aboriginal people, people with disabilities, people from culturally and linguistically diverse backgrounds and homeless young people are also often greatly disadvantaged.

Early intervention and prevention is not being provided to adults using the public dental system. One of the most effective preventative measures in relation to oral health (particularly for disadvantaged groups), fluoridation, is not available to forty percent of people living outside of Sydney (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004, p.v).

The greatest impediments to accessing oral health care for disadvantaged groups are the waiting lists for public dental services, as well as the prohibitive cost of private dental treatment. Other barriers include inadequate public transport, language, lack of affordable childcare, lack of knowledge of oral health services and treatment as well as lack of education about oral health care and nutrition.

Ever-worsening oral health is a consequence of delayed treatment and lack of preventative interventions. It results in an array of oral health problems such as abscesses, chronic toothaches, migraines related to dental problems, chipped and chalky teeth, severe decay resulting in extractions, and face swelling. It significantly impacts on quality of life, with people enduring months of acute pain before treatment and with some resorting to home dental surgery to alleviate pain. For many people, poor oral health affects their appearance, impacts on their self-esteem, contributes to stigmatisation and impacts on employment opportunities, perpetuating the cycle of disadvantage.

The quality of treatment provided through public dental services is of major concern. Our consultation has highlighted issues in relation to the qualifications and experience of staff, poor treatment outcomes due to language and communication difficulties, the need for staff to explain treatment options and treatment processes, negative attitudes towards service users, experiences of poor treatment, the need for increased awareness of and sensitivity to people's backgrounds and life circumstances, the lack of preventative focus and the emphasis on extractions rather than filling teeth.

From our consultations it is apparent that there is a need for significantly enhanced service provision at all points along the continuum of care. This includes prevention, early intervention and treatment. Funding must be provided to public oral health services to enable concession card holders living in the community to have timely access to preventatively focused dental care that meets minimum standard benchmarks for oral health service provision.

The failures of the public dental system primarily affect those who are already disadvantaged through poverty. Those in poverty face multiple disadvantage in terms of housing, access to education and employment. People of low-socio-economic status are significantly more likely to suffer disability, recent illness and serious illness than people from high socio-economic status (National Health Strategy, 1992).

Poverty, unemployment and social isolation are important determinants of health. The primary determinants of disease are mainly economic and social, so there is a need for economic and social remedies (Rose, 1992).

However, in addressing oral health, there is a need not only to address the underlying socio-economic determinants of health such as employment and poverty, but to improve the provision of oral health prevention and treatment for disadvantaged groups. Public dental health services have been chronically under funded, particularly since the abolition of the Commonwealth Dental Health Program in 1996. Since the program was disbanded the state of oral health has deteriorated significantly in NSW, particularly for low-income earners.

Some small steps have been made towards improving services. A comprehensive national oral health plan (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004) has recently been developed. As part of the NSW Oral Health Strategy, an oral health promotion framework for NSW and companion Aboriginal and Torres Strait Islander oral health promotion framework (NSW Oral Health Promotion Steering Committee, 2005a; NSW Oral Health Promotion Steering Committee, 2005b) is nearing completion. However substantial funding is required to implement the recommendations of these documents.

Urgent reform is required in relation to the funding and delivery of oral health services in NSW, in order to improve oral health of disadvantaged groups. The major issue relates to funding.

1. As recommended in *Australia's National Oral Health Plan 2004 – 2013* (Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health, 2004) oral health should be integral to general health in the development of health policy and the health reform agenda.

It is recognised that ideally Medicare should be expanded to include oral health treatment and care and that State Government funding should be matched by the Commonwealth. However given the dire situation in relation to oral health care, the State Government has an obligation to take immediate and substantial action to improve public dental service provision.

2. State Government funding provided for oral health care per capita should surpass the level of funding provided by Queensland, which has the highest per capita funding.

3. Substantial State funding should be provided to implement the recommendations of *Australia's National Oral Health Plan 2004 – 2013* in NSW.
4. Substantial State funding should be provided to implement the recommendations of the *NSW Oral Health Promotion: Framework for Action 2010* (NSW Oral Health Promotion Steering Committee, 2005a) and the companion plan about Aboriginal and Torres Strait Islander oral health promotion plan, currently nearing completion (NSW Oral Health Promotion Steering Committee, 2005b).

Funding increases must be provided to ensure that the publicly funded dental health system meets the following standards:

1. There must be timely access to services and interventions at all points along the continuum of care, from prevention and early intervention to treatment.

This includes:
 - a. Prevention – there must be a focus on preventative dental services such as appropriate oral hygiene practices, access to and information on a healthy diet, regular check-ups, cleaning and scaling. Fluoridation should be expanded to include all towns with a population of over 1,000 people.
 - b. Early intervention- decayed teeth and other oral disease should be treated in time to prevent expensive, complicated oral health care and tooth loss.
 - c. Treatment – People experiencing pain should be able to access emergency dental care within twenty-four hours. Alternatives to extractions should be provided.
2. The quality of treatment and prevention provided through public dental services should be of a similar standard to that provided through the private sector.
3. Oral health care should be provided in an accessible and culturally appropriate manner. This may mean developing new models of service delivery, such as outreach clinics located in methadone units or youth services.

Glossary

Craniofacial: Pertaining to the head and face.

Dental caries: An infectious disease that results in demineralisation and ultimately cavitation of the tooth surface if not controlled or remineralised. Dental cavities may be either treated (filled) or untreated (unfilled).

Determinants: Factors that act together in complex ways

Diabetes Mellitus: a variable disorder of carbohydrate metabolism caused by a combination of hereditary and environmental factors and usually characterised by inadequate secretion or utilisation of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.

Edentulism/edentulous: Complete loss of all natural teeth. A condition characterised by not having any natural teeth.

Gingivitis: Inflammation of the gums, characterized by redness and swelling.

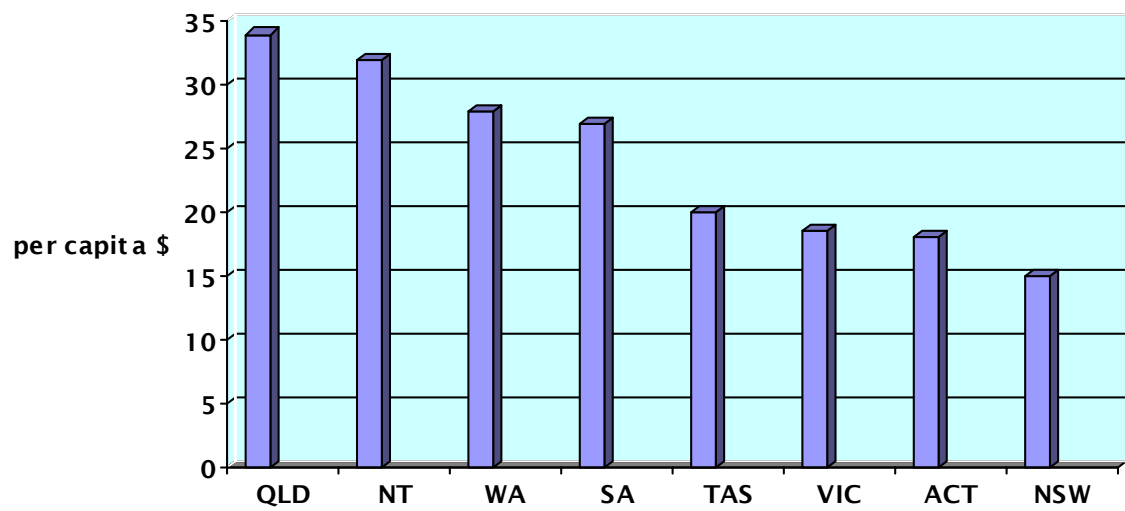
Malocclusion: Poor positioning or inappropriate contact between the teeth on closure

Periodontal disease: A cluster of diseases caused by bacterial infections and resulting in inflammatory responses and chronic destruction of the soft tissues and bone that support the teeth. Periodontal disease is a broad term encompassing several diseases of the gums and tissues supporting the teeth.

Temporomandibular joint: The joint that connects the lower jaw to the skull.

Appendix One

State Dental Expenditure



Source : The Association for the Promotion of Oral Health, 2005. *The national oral health plan: proposals for implementation*- Sydney: Unpublished Paper, June 1, 2005.

References

- The Association for the Promotion of Oral Health, 2005. *The national oral health plan: proposals for implementation*- Sydney: unpublished Paper, June 1, 2005.
- Australian Health Ministers Advisory Council, National Advisory Committee on Oral Health. 2004. *Health mouths healthy lives: Australia's national oral health plan 2004 – 2013* – Adelaide: South Australian Department of Health.
- Finney Lamb, C. and Smith, M. 2002. 'Problems refugees face when accessing health services', *NSW Department of Health Bulletin*, vol. 13, no. 7, pp. 161-2.
- National Dental Health Alliance (NDHA). 2001. *Improving the dental health of people on low incomes*. Retrieved April 26, 2005 from <http://teeth.8m.com/natall/info.htm>.
- National Health Strategy. 1992. *Enough to make you sick: how income and environment affect health*.- Melbourne: National Research Paper No 1, Sept 1992.
- NCOSS. 2002. *Review of oral health in Australia for the Oral Health Alliance*- Surry Hills: NCOSS. [www/teeth.8m.com/ncoss2.htm](http://www.teeth.8m.com/ncoss2.htm).
- NSW Oral Health Promotion Steering Committee. 2005a. *NSW oral health promotion: framework for action 2010 (draft)* – North Sydney: NSW Health.
- NSW Oral Health Promotion Steering Committee. 2005b. *NSW oral health promotion: framework for action 2010: Aboriginal and Torres Strait Islander Peoples (Draft)* – North Sydney: NSW Health.
- NSW Oral Health Promotion Steering Committee. 2005c. *NSW oral health promotion: a report on the literature (draft)* – North Sydney: NSW Health.
- Pearlman, J., Ryle. G. 2005. "Something is rotten with our state of inequality." *Sydney Morning Herald*, February 15, 2005.
- Rose, G. 1992. *The strategy of preventative medicine*-Oxford: Oxford University Press.
- The Senate, Community Affairs References Committee, 2004. *A hand up not a hand out: report on poverty and financial hardship* – Canberra: Commonwealth of Australia.