

Issues in Oral Health for Low Income and Disadvantaged Groups in NSW

**An Advocacy Kit for Community & Welfare
Non-Government Organisations (NGOs)**



**NSW Oral Health Alliance (OHA)
July 2010**

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About this Advocacy Kit

The NSW Oral Health Alliance has designed this advocacy kit for community and welfare non-government organisations (NGOs). It aims to raise awareness of oral health issues for low income and disadvantaged groups in NSW and promote action in the lead up to the NSW State Election 2011.

The NSW Oral Health Alliance encourages organisations to consider unfair access to dental services and the major disparities in oral health outcomes for their clients. We hope that you will incorporate oral health into your election campaign priorities and take up this often-neglected issue in your advocacy with government, media, and the broader community.

About the NSW Oral Health Alliance (NSW OHA)

The NSW Oral Health Alliance is a group of non-government organisations convened by the Council of Social Service of NSW (NCOSS). It provides a forum for the discussion of oral health issues and undertakes coordinated activities to improve access to dental service for low income and disadvantaged people.

Members of the Alliance as at June 2010 include:

- AIDS Council of NSW (ACON)
- Association for the Promotion of Oral Health (APOH)
- Australian Dental Association - NSW Branch (ADA NSW)
- Brain Injury Association NSW (BIA)
- CJD Support Network
- Combined Pensioners and Superannuants Association (CPSA)
- Council of Social Service of NSW (NCOSS)
- Haymarket Foundation
- Hepatitis NSW
- Homelessness NSW
- Positive Life NSW
- Public Interest Advocacy Centre (PIAC)
- Rural Dental Action Group (RDAG)
- UnitingCare Burnside

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Introduction

Why healthy teeth and gums matter

Oral diseases are one of the most common health problems in Australia - yet the majority of oral health problems are preventable. In NSW, disadvantaged and low income people have significantly worse oral health than the general population and they have the greatest difficulty accessing dental services.

Poor oral health can have a significant impact on a person's health and well-being. A recent report by the Brotherhood of St Laurence that found of clients with oral health problems:

- 90% experienced pain or discomfort
- 80% had difficulty eating
- 86% were affected in their ability to go about daily activities
- 90% experienced embarrassment due to their teeth, contributing to poor self image, reducing their social interactions and limiting employment prospects.

As well as the individual impact, poor oral health also results in considerable social and economic costs to our community.

How this kit is structured

This kit aims to raise awareness of oral health issues for low income and disadvantaged groups in NSW and promote action in the lead up to the NSW State Election 2011.

It is structured in the following sections:

- **The Facts** – overview of low income and disadvantaged groups most at risk of poor oral health.
- **Key Issues** - outlines the main reasons why there is such an unfair disparity in oral health
- **Our Recommendations** – the NSW Oral Health Alliance's four priority recommendations to Government to improve equity in oral health.

- **Your Actions** - provides suggestions about how your organisation can take action to raise awareness of oral health issues and put pressure on Government to make teeth matter!
- **Case studies** – stories from clients of NGOs about their experiences with dental services and the impact of poor oral health
- **Resources and further information** – links to key policy and research documents, and information about how to access public dental services.

About the case studies

Each case study represents the experiences of an individual accessing dental services. In some instances, names have been changed to maintain privacy.

The case studies were collected by members of the NSW Oral Health Alliance via interviews with their clients, or the clients of their member agencies. Some case studies used in this Kit have been adapted from the 2009 Alliance report, Access to dental services amongst clients of non-government human service organisation.

The Alliance encourages you to talk with your clients' about their oral health experiences. If your client would like to share their story with us or is willing to be a media spokesperson, we would love to hear from you.

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The Facts

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A number of groups have significantly worse oral health outcomes than the rest of the NSW population. These include Aboriginal people, carers, children and young people, homeless people, low income people, older people, people with intellectual disability, people with mental health issues, people with special needs, refugees, and rural and remote people.

Aboriginal people*

- Aboriginal people have significantly worse health outcomes than the general population.¹ They are more likely to be at risk of poor oral health due to a range of factors, including:
 - poor water quality and the lack of fluoridation in some in rural and remote communities
 - poor diet and nutrition
 - poor general health
 - higher rates of chronic diseases, such as obesity, diabetes, and heart disease
 - higher rates of smoking and alcohol consumption
- Aboriginal Health Care Card Holders accessing public dental services have significantly higher levels of gum disease, tooth decay, and greater numbers of missing teeth than non-Indigenous patients.²
- Aboriginal adults have a higher prevalence of severe gum disease, have higher levels of untreated decay, and have more missing teeth than non- Aboriginal adults. They are also more likely to report avoiding certain foods because of dental problems, to rank their oral health as fair or poor, and report experience of toothache.³
- Compared to their non-Aboriginal counterparts, Aboriginal children experience:
 - Around twice as many decayed, missing, and filled teeth.⁴
 - More than twice the amount of untreated decay.⁵
 - Almost one-and-a-half times the rate of hospitalisation for tooth decay.⁶

- Less than 5% of remote Aboriginal pre-school children reported brushing their teeth on a regular basis.⁷
- Aboriginal people have greater difficulty accessing dental services due to:
 - High cost of dental treatment - around 40% of Aboriginal people delay or avoid dental care due to the cost,⁸ and more than twice as many Aboriginal people report that they would have a lot of difficulty in paying a \$100 dental bill (33.5%) compared with non- Aboriginal people (14.1%).
 - Lack of appropriate trained oral health workforce to meet the specific needs of Aboriginal people.
 - Lack of dental services, including both public and private oral health professionals and public dental infrastructure, in rural and remote communities.
 - Cost and availability of transport to attend dental services.

Carers **

- Carers play a central role in the delivery of oral hygiene and the maintenance of oral health of the people for whom they care.⁹
- There is a lack of data about the oral health of carers in NSW and Australia.
- As carers have higher rates of risk indicators such as poor general health, chronic disease and poverty, it is reasonable to assume that they have worse oral health than the general population.

** A carer is any individual who provides care and support to a family member or friend who has a disability, mental illness, drug and alcohol dependencies, chronic condition terminal illness or who is frail. Across NSW, there is estimated to be approximately 750, 000 carers.

* Aboriginal people' is used in the document to refer to Aboriginal and Torres Strait Islander people.

- Carers often overlook their own personal health care, including oral health, as their primary concern is the well-being of the person they care for.
- Financial cost of dental services is a significant barrier for carers to maintain their oral health. Carers have an average income 25% lower than non-carers, and around 44% of primary carers live in low-income households compared to 17% of non-carers.¹⁰ Carers will often allocate a significant proportion of their personal income towards the people that they care for, and have little resources remaining to meet their own healthcare needs.
- Accessing dental services can be difficult for carers, particularly for those with full-time caring responsibilities. There is a lack of adequate respite services for carers to attend to their own health needs, such as attending dental appointments.

Children and young people

- Good oral health in infancy and early childhood contributes to better general health in adulthood.
- The oral health of primary school children has deteriorated by 20% in the last decade.¹¹
- More than half of NSW children have evidence of tooth decay. Tooth decay is the single most common chronic childhood disease.¹²
- There is a four-fold increase in tooth decay between 12 and 21 years of age. Almost half of all teenagers have some signs of gum disease.¹³
- Children in low socioeconomic groups experience nearly twice the tooth decay as those in high socio-economic groups.¹⁴
- Aboriginal and Torres Strait Islander children experience on average twice as many decayed, missing and filled teeth than their non-Aboriginal counterparts, and have more than twice the amount of untreated decay.¹⁵
- Young children of mothers from non-English speaking countries have over two-thirds more decayed, missing and filled teeth, and more untreated decayed teeth, than those whose mother was born in an English speaking country.¹⁶
- Children in remote and very remote areas experience approximately 38% more decay than children living in major cities.¹⁷
- Children and young people in out-of-home care have difficulty accessing specialist dental services despite initial assessments that show evidence of gross decay.¹⁸
- More than one-third of children do not visit a dentist each year,¹⁹ and the majority of young adults have an unfavourable dental visiting pattern.²⁰

Children and young people

Catherine's story

Catherine is a young woman who lives in Campbelltown. In 2007, she began to feel pain in her jaw that was typical of un-surfaced wisdom teeth. Catherine attended a private dental assessment in October through a pro bono program. At this appointment the dentist told her that her wisdom teeth were impacted and needed to be extracted, along with extensive work on her molars. Catherine's dental treatment was not offered under the pro bono program, so she was referred to a public dentist for the work.

Catherine's local public dental clinic had a long waiting list. She got an appointment in August 2008, ten months after she initially sought help for the pain in her jaw. At the appointment the public dental clinic required Catherine to have another diagnostic assessment, despite the referral for surgery from the private dentist.

Following the assessment, Catherine was put on another waiting list for surgery. She is still waiting for to have her wisdom teeth extracted and has not been informed of how long she will have to wait.

Catherine is experiencing periodic pain from the wisdom teeth that are growing in her jaw. The advanced nature of her wisdom teeth growth, together with the health risks brought about by her untreated molars, means that she is at high risk of infection at the site of her impacted wisdom teeth.

Children and young people

Kylie's story

Kylie was sixteen years old when she started having trouble with her teeth. She presented at a public dental clinic with a swollen cheek and a painful mouth, and the dentist pulled the problem tooth out on the spot.

Gradually Kylie got more cavities but her public dental appointments were not timely enough to save her teeth. The waiting periods that she experienced from the time that she booked an appointment were so long that in the end she would present in severe pain and have them removed. One by one they were pulled out. She got so worried that when one of her front teeth got a tiny hole she rang to get an appointment at the public dental clinic as soon as she saw it. But by the time she got in to the dentist, the tooth had snapped and they had to pull it out.

At the public dental clinic, Kylie explained that "when I went in for treatment, it seemed like they didn't really have a plan. They should have given me a checkup and seen what needed to be done to save some teeth. Instead I would have pain in three places in my mouth and the dentist would ask: "Well which one gives you the worst pain?" It was often difficult to tell and I'd get one tooth out and have to wait for an appointment to get the other ones taken care of."

The length of waiting times for dental appointments and the dentists' lack of capacity to help Kylie keep some of her teeth resulted in complete deterioration of Kylie's teeth. Sometimes she waited for an appointment for two or three months in pain. When the pain became too strong to be helped by Panadeine Forte, she lost weight because she had difficulty eating around her sore teeth.

Kylie lost her self confidence as she lost more teeth and her remaining teeth became black and rotting. She started to cover her mouth when she talked and laughed, and she was no longer able to work in her customer service job.

Kylie was 25 years old when she had her last tooth removed and received dentures. This meant that she had to worry about the increase in oral health problems that are associated with dentures, up to fifty years before friends that were her age.

Homeless people

- Homeless people are much more likely to have tooth decay and much less likely to have visited a dentist in the last 12 months than the general population.²¹
- The Haymarket Foundation Clinic estimates that up to 80% of clients may have serious dental problems.
- Homeless people are at greater risk of poor oral health due to poverty, poor self care including lack of oral hygiene, substance abuse, mental illness, and co-occurring disorders.²²
- Homeless people find it difficult to afford and access mainstream dental services. Free dental services have long waiting lists, and their transient lifestyle can make it difficult for them to keep appointments.

Low income people

- There is a strong social gradient in oral health – the poorer you are, the worse your oral health:
 - Government concession card holders are more than twice as likely to report poor or fair oral health (30%), compared to non-card holders (13%).²³
 - Adult concession card holders have 1.4 times the tooth decay of non-cardholders.²⁴ Children in low socio-economic groups experience nearly twice the tooth decay as those in high socio-economic groups.²⁵
 - People living in the most disadvantaged areas are twice as likely to have complete tooth loss or inadequate natural dentition compared to people from high socio-economic areas.

Low income people

Peter's story

Peter lives in Malabar, Sydney and is retired. He has used the public dental system in NSW for years but recently has taken to going to a private dentist.

About six years ago Peter had a partial plate made up for his top teeth. He picked it up the day before Christmas and it broke the next day. He then had to pay \$90 to get it fixed by a private dental practice because the dental hospital was closed.

He explains that he'd rather have had his teeth capped than a partial plate but that's not an option in the public system. As his gums are shrinking (due to age) he has to get a new plate every couple of years.

About two years ago he had to have a tooth pulled out at the hospital. They left some of it behind, and he had to go back twice more before they got it all out.

In December 2007, he needed to get another tooth pulled out. The dental hospital couldn't see him that day, so they put him on the emergency list. He decided he'd borrow \$500 (Centrelink loan) to go to a private dentist and get it sorted out. He hasn't been called by the dental hospital yet, even though he's rung to check that he's still on the list.

Now he gets the \$500 (Centrelink) loan every year and goes to a private dentist. He also took \$1400 out of his superannuation to buy a plate rather than stay on the waiting list.

Peter believes that the problem with the public dental system is that you have to wait too long to see someone, and even when you do get in, they only look at the emergency reason you're there, not your whole mouth. So you have to go back again and again.

- People living in areas of greatest socio-economic disadvantage have difficulty accessing services due to economic restraints, reduced mobility, and a lack of services:

- Nearly half of people on low incomes* avoid or delay dental care due to cost.²⁶
- Almost half as many dental practitioners per head of population work in disadvantaged areas compared with the least disadvantaged areas.²⁷
- Around half of welfare participants cannot access dental treatment when needed or an annual check-up for children.²⁸

Older people

- Poor oral health can have a major impact on the health and social functioning of older people and can contribute to malnutrition.²⁹
- Older people are at increased risk of tooth decay and chronic degenerative problems as they are retaining their natural teeth for longer.
- Periodontal diseases and oral cancers are more prevalent among older people.³⁰

- Older people are more likely to be at risk of poor oral health due to multiple chronic disease; disabilities that make brushing and flossing their teeth difficult; using medications causing dry mouth; and barriers to accessing oral health care.
- Access to dental services is a critical issue for older adults because they require more clinical preventive supports than younger age groups.³¹
- Older people make up nearly 40% of all adults eligible for public dental care.³²
- Current programs to assist older people to remain in their own homes, such as Home and Community Care (HACC), do not provide assistance with oral hygiene.
- People in nursing homes and residential aged care facilities are more likely to have poor oral health due to a lack of support with daily oral hygiene, lack of regular assessment of their oral health needs, and lack of referral for treatment. They also have greater difficulty accessing dental care due to poor coordination between the dental and aged care sectors, transport barriers, and the small scale of public dental outreach programs.³³

* Incomes less than \$20,000 or holders of Government healthcare cards

Older people

Elizabeth's story

Elizabeth is a single Age Pensioner. Elizabeth would previously make an appointment every two years at a public dental clinic at a large Sydney hospital to receive dental care, or whenever the clinic would send a reminder. In late 2006 she sought an appointment for a routine check. She was advised that she would have to wait twelve months. In the meantime, Elizabeth tried to find other ways of getting a check-up. However, there are no other free services in her area and she cannot afford a private dentist.

When she was finally given an appointment one year later, the dentist cleaned Elizabeth's teeth but in the process the enamel of one tooth was cracked. As a result, she had to have this tooth removed, but had to wait about six months for an appointment. Meanwhile, Elizabeth was left in a lot of pain that did not subside. Without any further assistance being provided by the dental clinic, she began taking painkillers in an effort to suppress the pain and went to see her GP. Elizabeth's GP prescribed antibiotics which she took for a number of weeks because her whole mouth was now infected. "I just had to keep swallowing painkillers and antibiotics due to the infection," Elizabeth said.

When it was time for her tooth extraction in the middle of 2008, the dentist extracted the problem tooth but her mouth was left partially numb after the extraction. To this day part of her lip is still numb.

This procedure has left Elizabeth in pain and has dented her confidence, feeling anxious about going to the dentist.

"I was quite distressed, because nobody wants to be in constant pain," said Elizabeth. "Previously, I had pleasant experiences going to the dentist, but this has made me worried about who I am going to see and how long it would take for treatment."

Older people

Margaret's story

Margaret is an Age Pensioner who rents her home privately. About two years ago she experienced a throbbing sensation in her mouth that sent her in search of treatment at the local hospital's free dental clinic.

"I've always looked after my teeth and I knew something was wrong, I went to the public clinic and they gave me an appointment to come back in 3 months. At that time I had x-rays and a good check. I was told I had an infection around one of my molars and taught how to clean the area with Savacol and a dental pick. When I went back six months later and had another x-ray the molar had a large cavity. I was told that the home maintenance I was doing was good for another two years and I wasn't encouraged to come back."

"I've always been conscious of my teeth but when I hit pension age I realised I had to look after them. When I was working I could afford regular check up but not anymore. It took a lot for me to go to that hospital because of my pride. Now eighteen months later my tooth is disintegrating and not long ago I swallowed part of it while I was eating. I don't want to go back to the hospital, I'm frightened that I won't get the best treatment and I don't feel supported."

"Now I have to find the money to go to a private dentist. I'm renting and I get the pension, managing money is a continual battle and a struggle – it's wearying. But I'm a survivor and I'm now trying to work out how to get this done privately. I'll have to work it out with them and pay them off."

People in rural and remote areas

- People living in rural areas experience poorer oral health outcomes than urban residents:
 - In rural and regional areas people are more likely to have tooth decay, more likely to have no natural teeth, have less frequent dental check-ups, and have fewer preventative treatments.³⁴
 - Children in remote and very remote areas experience approximately 38% more decay than children in major cities.³⁵
 - Elderly rural concession card holders are three times more likely to have no teeth than city-dwelling non-card holders.³⁶
- There are a range of factors that contribute to the poorer oral health outcomes of people in rural and remote areas, including:³⁷
 - Greater socioeconomic disadvantage
 - Less exposure to fluoridated drinking water,
 - Greater exposure to injury risks
 - Geographic isolation
 - Poorer general health among Aboriginal people.
 - Lower levels of access to health services. People in rural and remote areas have longer average wait times to see a private dentist (3.9 versus 1.6 weeks), and receive significantly less hours of dentistry compared to the rest of the population.³⁸
- Access to dental services is a significant issue for people living in rural and regional areas due to:
 - Lack of private and public oral health care professionals.
 - Insufficient public dental infrastructure.
 - Transport to attend dental services.
 - Financial cost of services.

People with mental health issues

- The National Oral Health Plan identified mental health clients as one of the major disadvantaged groups facing significant issues around declining oral health and poor access to dental services.
- Studies have suggested that mental health clients have poor oral hygiene practices.³⁹ This is due to low levels of self-care, a lack of understanding of oral health care, and mistrust of dental professionals.
- People with mental health issues have higher rates of co-morbid risk factors, such as poor diet, alcohol and drug use, and smoking that mean they are at increased risk of oral disease.⁴⁰
- Common medications for mental illness cause dry mouth, which increases the risk of developing dental caries (cavities), gum disease, and oral

infection. Long-term anti-psychotic medication use can cause excessive teeth grinding or clenching that can lead to severe dental damage.

- People with mental health issues face significant barriers to accessing appropriate oral health services, including:
 - Fear, anxiety and dental phobia that influence the acceptance of dental care^{41,42}
 - Inadequate knowledge and skills of dental teams for managing patients with mental health problems⁴³
 - Stigma and the attitude of some oral health professionals has been identified as a barrier to dental care⁴⁴
 - Cost of dental services
 - Professional carers lack oral health knowledge and skills. This includes knowing how to assist clients with oral hygiene, identifying potential oral health issues, and awareness of available services.⁴⁵

People with intellectual disability

- People with intellectual disability, "...face stark health inequalities"⁴⁶ which are also reflected in their oral health outcomes.
- Dental disease is the most common health problem faced by people with intellectual disability. It is estimated to be experienced by around 86% of people with intellectual disability.⁴⁷
- People with intellectual disability have a rate of dental disease up to seven times higher than the general population.⁴⁸
- People with an intellectual disability often need assistance with oral hygiene. Carers (both informal carers and formal carers in residential settings) often lack the understanding, time, and/or resources to assist the person maintain good oral health.
- Access to appropriate dental treatment is a significant issue for people with an intellectual disability. This is due to a range of factors including:
 - Insufficient oral health professionals trained and skilled in working with people with intellectual disability.
 - Communication difficulties between the oral health professional and the person with an intellectual disability.
 - Insufficient time scheduled in routine appointments to adequately address the needs of people with intellectual disability.
 - Carers' low level of awareness of oral health problems and how to access dental services for people with intellectual disability.

- Access to affordable transport to attend dental appointments
 - High cost of private dental services that is prohibitive for most people with intellectual disabilities who are dependent on disability support pensions
 - Long waiting times for public dental services
 - Without access to timely appropriate dental treatment, people with an intellectual disability and oral health problems may experience chronic pain and distress. This may manifest in behaviours that people find challenging.
- People with special needs**
(chronic physical conditions, substance use issues, blood borne disease)
- People with special needs experience substantially higher levels of oral disease, with considerably less access to treatment.⁴⁹
 - A disabling condition may place people at increased risk both of oral disease itself, and/or during treatment for that disease
 - Smoking and use of methadone and other opioids can also lead to a worsening of gum conditions.
 - Some medications for chronic conditions can cause a dry mouth and contribute to dental problems. Some people, including those on Interferon, have a lower resistance to gum infection than others.
 - People with Hepatitis C may experience additional teeth and mouth problems. These can include dry mouth, tooth sensitivity and decay, gum infections and mouth ulcerations.
 - Residential settings, such as supported accommodation, can act as a barrier to accessing either private or public dental care.
 - The oral health workforce lacks the skills and capacity to provide appropriate care to meet the needs of people with special needs.

People with Special Needs

Adam's story

Adam is a seven year old boy at risk of Creutzfeld-Jakob Disease (CJD) due to a family genetic history of the disease. CJD is a disease that is both genetic and transmissible.

Adam was scheduled to have two molars removed at a public dental hospital. In the six months leading up to the surgery, Adam's mother Sally, made significant efforts to provide Adam's dentist and dental team with all the relevant information about CJD, including risks of infection.

When Adam and Sally arrived at the Dental Hospital on the day of the surgery, Sally was frustrated to find that the hospital staff appeared to be unaware of the infection control guidelines for CJD.

Adam and Sally experienced considerable distress as a result of the staff's lack of knowledge of infectious disease protocols. Sally believed that there was a real sense of fear from the nursing staff right through to the anaesthetist, despite the fact that molar extraction does not expose surgeons to tissue that would be infectious.

A nurse approached Sally and asked her about, "this CJD problem your son has", in front of Adam. This was particularly upsetting for Adam. While he is at risk of CJD, he has not been diagnosed with it. He asked Sally if he had CJD, "...like Grandpa had?" as Adam had watched his grandfather die from the disease a few years earlier.

Although the dental hospital had informed Sally that Adam would be the first scheduled appointment on the day, there was a five-hour delay in his surgery. This was very distressing for Adam as he had been fasting since dinner-time the night before in preparation for the surgery.

Adam's surgery only went ahead after Sally telephoned a NSW Health contact provided by her support group who was extremely knowledgeable regarding CJD.

People with Special Needs

Steven's story

Steven is 49 years old and lives in Sydney. He was diagnosed with HIV in 1984.

When Steven was able to afford private dental care his HIV doctor had difficulty finding a private dentist who would treat him because of his HIV infection. Combined with Steven's increasing immune suppression, this lack of access to dental services resulted in significant tooth decay and gum infection.

When Steven's health deteriorated in 1995, he was severely immune compromised and was unable to work. Steven was placed on a Disability Support Pension and became eligible for treatment at Sydney Dental Hospital (SDH).

During this time, Steven recalls lining up in the SDH waiting room and was often not seen by a dentist until late in the afternoon. He only received basic dental services with a focus on pain prevention. He also received a number of extractions.

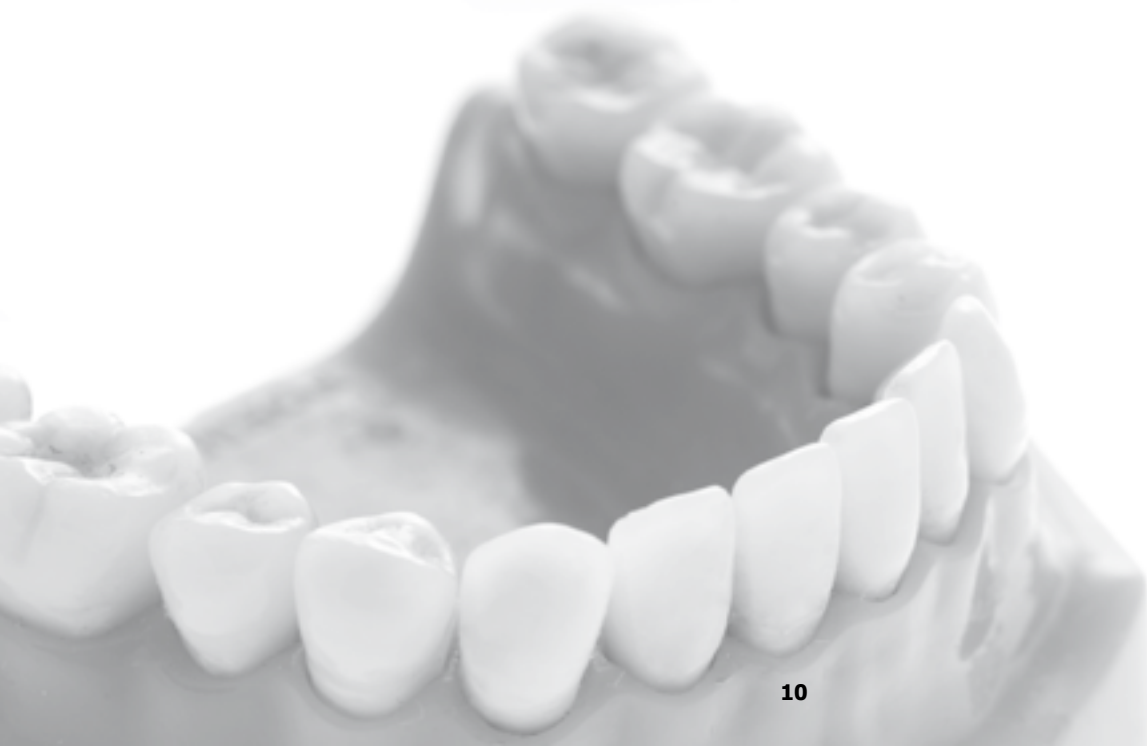
Steven was later informed that he was eligible for the '2.3' dental program, which expedites assessment and treatment for people with HIV. This reduced his waiting time for appointments, although he still did not receive more comprehensive dental treatment.

In 2002, Steven sustained oral health trauma in an assault. His recovery was slowed by complications from post-surgery infection, and his oral health subsequently deteriorated. He experienced severe tooth decay and required multiple extractions. Steven could feel holes in his teeth with his tongue and regularly attended a public dental hospital for check-ups. He was told that no work was needed.

When the Medicare Dental Scheme was introduced for people with chronic health conditions, Steven was referred by his doctor to a private dentist for assessment and treatment. Over the last three years, most of his teeth have been repaired and he now believes that the condition of his oral health is better than ever before.

"Private dentists are light years ahead in technology, quality and treatment" Steven says.

"For the first time in 20 years, I have begun to go out again. I smile without covering my mouth or feeling self-conscious. It's made such a difference".



Refugees

- The National Oral Health Plan identified that the oral health needs of recently arrived refugees are among the highest in the country.⁵⁰
- A study by the Sydney Dental Hospital found that almost double the number of refugees surveyed had 5 or more untreated decayed teeth (29%), compared to Australian-born emergency dental care recipients (14%).⁵¹
- Generally, people from non-English speaking countries have poorer oral health outcomes than Australian-born residents, including more tooth decay, higher usage of emergency dental care; more extractions, lower rates of preventative services, and greater difficulty paying dental bills.⁵²
- Refugees have a high risk of poor oral health due to factors including: torture related injuries, a lack of access to health care in periods of conflict, a lack of water fluoridation in their countries of origin, and poor diet or nutrition while in exile.
- Once in Australia, the availability of low cost, high sugar foods can exacerbate existing oral health problems.
- Barriers to effective oral health care for refugees include: language and cultural factors, financial pressures, transport difficulties, and the ongoing effects of torture and psychological trauma.⁵³

Refugees

Ibrahim's story

Ibrahim came to Australia hoping to be recognised as a refugee. He fled his country out of fears for his safety from religious persecution.

Living in Sydney as an asylum seeker was very tough for Ibrahim. He spoke limited English and found adjusting to life in a big city very challenging. Although he was legally entitled to work, recurring flashbacks and nightmares about the torture he endured in his old country made it difficult for Ibrahim to hold down a job. Under the Asylum Seeker Assistance (ASA) Scheme, Ibrahim received a small amount to cover basic living expenses, such as food and rent.

In late 2009, Ibrahim began to experience severe tooth ache. Despite being in constant pain, he did not go to a dentist because he could not afford the cost of private treatment and was ineligible for public dental services.

Ibrahim's Red Cross caseworker was able to find a place for him in a dental clinic run for asylum seekers and staffed by volunteer dentists. On the day of the clinic, Ibrahim was very nervous as it was the first time he'd been to the dentist in more than 20 years. However, at his appointment the dentist explained the procedure using an interpreter so that Ibrahim could understand what he was doing.

The clinic also showed Ibrahim how to brush and floss his teeth properly to reduce the risk of developing future oral health problems. Ibrahim later told his caseworker that he was very grateful to the volunteers at the clinic. His tooth felt better and he was no longer in any pain.

Ibrahim knows that attending the dentist for a regular check up is just as important to help prevent further dental problems. However, he still cannot afford to see a private dentist and remains ineligible for general public dental services.



Key Issues

Why is the oral health of low income and disadvantaged groups so bad?

Systemic barriers to accessing dental services are the main cause of continuing inequities in oral health for low income and disadvantaged people in NSW.

The majority of oral health care is provided by private dentists. However, fees for private dental services can be expensive, and there is a lack of private dentists in some areas, particularly in rural and remote areas.

Public dental services are provided by the NSW Government, with some Commonwealth funding for specific programs, such as the Teen Dental Program. However, unlike universal access to GP services under Medicare, only people with Government concession cards are eligible for public dental services.

The National Health and Hospital Reform Commission recommended the introduction of a scheme to provide universal access to basic oral health care (Denticare) as a key priority. However, there was no reform to oral health in the recent COAG National Health and Hospital Network Agreement and the States will continue to have funding responsibility for public dental services.

What is wrong with the public dental system in NSW?

For those people who are eligible for public services, they may have to wait months, or in some cases years, to receive treatment due to big waiting lists and the long wait times for treatment.

While the quality of public dental treatment in the NSW is generally high, the system is unable to cope with the high demand for services due to a lack of investment, inadequate public dental infrastructure, and workforce shortages.

The desperate state of the public system is highlighted by:

- Around 132,800 people are currently on waiting lists for general dental services in NSW, of which more than half are likely to have been waiting at least six months.⁵⁵
- Only 13% of all dentists in NSW work in the public sector,⁵⁶ and yet 57% of the population are eligible for public oral health services.⁵⁷
- NSW has the lowest per capita funding for public dental services of any State or Territory, at \$23.20 per person.⁵⁸ There was no real funding growth for oral health in the 2010-11 State Budget.

Other contributing factors

Multiple disadvantage experienced by many low income and disadvantaged people may also compound their lack of access to dental treatment in both private or public settings. This can include:

- financial hardship which limits the type of treatment that can be afforded and the frequency of dental visits
- a lack of transport that can restrict the persons ability to physically get to and from dental services
- mental health issues that can impact on the persons ability to remember or attend appointments
- housing instability or transience which can impede treatment continuity or limit follow-up or reminder services.



Our Recommendations

The NSW Government must accept its responsibility for public dental services in the absence of national reform, and commit to reducing oral health inequalities in NSW.

Immediate priority must be given to reform of the public oral health workforce and investment in public dental infrastructure, particularly in rural and remote areas.

The NSW Oral Health Alliance is calling for the NSW Government to:

1. Increase funding for public dental services

Bring per capita funding for public dental services in NSW into line with Queensland. This will require approx. \$102.5m in additional funding.

2. Expand the dental workforce

Invest in comprehensive public oral health workforce development initiatives, including the development of a workforce strategy.

3. Enhance public dental infrastructure

Invest in public dental infrastructure and develop flexible service delivery models

4. Address the oral health inequities

Fund targeted initiatives for those most in need, including older people, people with intellectual disability, refugees, Aboriginal people, and people in rural and remote communities.



Your Actions

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By raising awareness of oral health issues in the community and in the media we can put pressure on the government to take teeth seriously!

Your organisation can take action by informing your clients, your members, other agencies, and your local community about oral health issues and encouraging them to take action too.

You can also lobby politicians to develop fairer oral health policies.

What you can do

1. Contact your local MP

Send a letter, email, or request a meeting with your local MP to express your concerns about oral health.

- **State MP:** www.parliament.nsw.gov.au/prod/parliament/members.nsf/V3ListCurrentMembers
- **Federal MP:** apps.aec.gov.au/esearch/

2. Write to the NSW Health Minister and Shadow Health Minister

Tell the Minister and Shadow Minister why oral health is an issue for your client group and demand action to reduce the inequities in oral health.

- NSW Health Minister Carmel Tebbutt
email: dp.office@tebbutt.minister.nsw.gov.au
- NSW Shadow Health Minister Jillian Skinner
email: northshore@parliament.nsw.gov.au

3. Send a media release

Write a media release for your local newspaper or radio station. You could highlight your clients' experiences of the public dental system or promote your organisation's advocacy work around oral health.

What you can do (continued)

4. Write a letter to the Editor

Send an opinion piece or write a letter to the Editor of the major newspapers.

- The Sydney Morning Herald
email: letters@smh.com.au
post: GPO Box 3771, Sydney NSW 2001
- The Daily Telegraph
email: news@dailylegaph.com.au
post: 2 Holt St, Surry Hills NSW 2010

5. Educate your staff and clients

Hold a workshop with your staff about oral health risks for your clients and how to incorporate oral health into regular care and support.

Run an information session for your clients about the importance of good oral health.

Distribute information about eligibility and access to public dental services to your staff and clients (see **Resources and Further Information** at the end of this Kit).

6. Encourage client self-advocacy

Encourage your clients to tell their oral health stories. They could share their experiences through creative writing, giving media interviews, or discussion in peer circles.

7. Gather evidence

Carry out a survey or undertake research on oral health issues for your client group. Document case studies about your clients' experiences.

8. Spread the word

Feature an article in your organisations newsletter or on your website about oral health issues for your clients or access to public dental services.

Hold a meeting or forum with your members.

Use your existing networks or form new partnerships with other organisations in your field to advocate for better oral health policy.

If you need some additional information or resources or would like some assistance with organising an activity, please contact the NSW OHA:

email: solange@ncoss.org.au

Resources & Further Information

How to access public dental services

Free dental care is available at NSW Public Dental Clinics for:

- All children under 18 years of age.
- Adult Centrelink concession card holders (Health Care Card, Seniors Health Card, Pensioner Concession Card)

For further information about public dental services or to make an appointment, ring the Public Dental Call Centre in your local area.

NSW Public Dental Call Centres

| Area | Phone number |
|---|--|
| Greater Southern Area Health Service: | 1800 450 046 |
| Greater Western Area Health Service: | 1300 552 626 (Far West & Macquarie) 1300 552 208 (Mid West) |
| Hunter New England Area Health Service | 1300 651 625 |
| North Coast Area Health Service | 1300 651 625 |
| Northern Sydney Central Coast Area Health Service | 1300 789 404 |
| Southern Eastern Sydney Illawarra Area Health Service | 1300 369 651 (Illawarra) 1300 134 226 (South East Sydney) |
| Sydney South West Area Health Service | 02 9293 3333 (Eastern region) 1300 559 393 (Western region) |
| Sydney West Area Health Service | 1300 739 949 02 9845 6766 |

Key policy and research documents

- Healthy mouths healthy lives: Australia's National Oral Health Plan 2004-2013
- National Advisory Committee on Oral Health, South Australian Department of Health on behalf of the Australian Health Ministers Conference, Adelaide, 2004
[www.sadental.sa.gov.au/Portals/57ad7180-c5e7-49f5-b282-c6475cdb7ee7/Oral Health Care.pdf](http://www.sadental.sa.gov.au/Portals/57ad7180-c5e7-49f5-b282-c6475cdb7ee7/Oral%20Health%20Care.pdf)
- NSW Oral Health Strategic Directions 2005-2010
- NSW Department of Health, Sydney, 2008
www.health.nsw.gov.au/pubs/2008/pdf/oh_direction.pdf
- NSW Oral Health Promotion: Framework for Action 2010
- NSW Department of Health, Sydney, 2006
www.health.nsw.gov.au/pubs/subs/sub_oral.html

- Access to dental services amongst clients of non-government human service organisations
- NSW Oral Health Alliance, Sydney, 2009
www.ncoss.org.au/component/option,com_docman/task,doc_download/gid,480/Itemid,78/
- Public dental care and the Teeth First trial - A history of decay
- Brotherhood of St Laurence, Melbourne, 2010
www.bsl.org.au/pdfs/Bond_Public_dental_care_and_the_Teeth_First_trial_2010.pdf
- NCOSS Vote 1 Fairness in NSW: Oral Health, Council of Social Service of NSW (NCOSS), Sydney, 2010
www.ncoss.org.au/content/view/3207/195/
- Dental Services in NSW, Report 37, March 2006
- NSW Legislative Council Standing Committee on Social Issues, Sydney, 2006
[www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/4fa2d0149b588095ca25714200077d20/\\$FILE/FINAL-%20COMPILED%2030%20MARCH.pdf](http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/4fa2d0149b588095ca25714200077d20/$FILE/FINAL-%20COMPILED%2030%20MARCH.pdf)



Endnotes

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- ¹ Australian Bureau of Statistics (ABS): The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 Australian Institute of Health and Welfare, Commonwealth of Australia 2008 [www.abs.gov.au/ausstats/abs@.nsf/mf/4704.0/ (Accessed 13/3/2009)]
- ² Brennan DS, Roberts-Thomson KF, Spencer AJ: Oral health of Indigenous adult public dental patients in Australia. *Aust Dent J* 2007, 52:322-328
- ³ Kaye F Roberts-Thomson, A John Spencer and Lisa M Jamieson, Oral health of Aboriginal and Torres Strait Islander Australians, *MJA* 2008; 188 (10): 592-593
- ⁴ Jamieson L, Armfield JM & Roberts-Thomson KF, Oral health of Aboriginal and Torres Strait Islander children, Dental statistics and research series no. 35, Australian Institute of Health and Welfare, 2007.
- ⁵ Centre for Oral Health Strategy NSW, The New South Wales Child Dental Health Survey 2007, NSW Health, Sydney, 2009.
- ⁶ Jamieson L, Armfield JM & Roberts-Thomson KF, Oral health of Aboriginal and Torres Strait Islander children, Dental statistics and research series no. 35, Australian Institute of Health and Welfare, 2007.
- ⁷ *ibid.*
- ⁸ National Health and Hospitals Reform Commission, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, Commonwealth of Australia, Canberra, June 2009
- ⁹ Chalmers JM, Spencer AJ, Carter KD, King PL & Wright C, Caring for oral health in Australian residential care. Dental statistics and research series no. 48. Cat. no. DEN 193, AIHW, Canberra, 2009.
- ¹⁰ A Profile of Carers in Australia, Cat No 4448.0, Australian Bureau of Statistics. Canberra: 2008.
- ¹¹ Spenser J & Harford J, Improving oral health and dental care for Australians, ARCPOH, University of Adelaide, Adelaide, 2008
- ¹² Centre for Oral Health Strategy NSW Oral Health Promotion: Framework for Action 2010, NSW Department of Health, Sydney, 2006.
- ¹³ National Advisory Committee on Oral Health, Healthy Mouths Healthy Lives – Australia's National Oral Health Plan 2004-2013, South Australian Department of Health on behalf of the Australian Health Ministers Conference, 2004
- ¹⁴ Centre for Oral Health Strategy NSW, The New South Wales Child Dental Health Survey 2007, Department of Health, Sydney, 2009
- ¹⁵ Centre for Oral Health Strategy NSW, The New South Wales Child Dental Health Survey 2007, Department of Health, Sydney, 2009.
- ¹⁶ *ibid.*
- ¹⁷ *ibid.*
- ¹⁸ Nathanson, D and Tzioumi, D (2007), "Health needs of Australian children living in out-of-home care", *Journal of Paediatrics and Child Health*, Issue 43, 2007. Royal Australasian College of Physicians [RACP], Health of children in "out-of-home care", *RACP: Sydney*, 2006.
- ¹⁹ Population Health Division. The health of the people of New South Wales - Report of the Chief Health Officer. Sydney: NSW Department of Health. Available at: www.health.nsw.gov.au/publichealth/chorep/ (Accessed 10/5/2010)
- ²⁰ Spenser J & Harford J, Improving oral health and dental care for Australians, ARCPOH, University of Adelaide, Adelaide, 2008
- ²¹ www.sesiahs.health.nsw.gov.au/Publications/Homelessness_Health/HSreport.pdf
- ²² apha.confex.com/apha/135am/techprogram/paper_145467.htm
- ²³ AIHW, Dental Statistics and Research Unit, The National Survey of Adult Oral Health 2004-06: NSW, Cat no. DEN 176, Dental Statistics and Research Series no. 40, Australian Institute of Health and Welfare, Canberra, 2008.
- ²⁴ *ibid.*
- ²⁵ Centre for Oral Health Strategy NSW, The New South Wales Child Dental Health Survey 2007, Department of Health, Sydney, 2009.

- ²⁶ National Health and Hospitals Reform Commission, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, Commonwealth of Australia, Canberra, June 2009
- ²⁷ ABS Health and Socio-economic disadvantage, Australian Social Trends 41022.0 March 2010
- ²⁸ Saunders P and Wong M, Still doing it tough: an update on deprivation and social exclusion among welfare service clients, Social Policy Research Centre UNSW, Sydney, 2009
- ²⁹ National Health and Hospitals Reform Commission, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, Commonwealth of Australia, Canberra, June 2009
- ³⁰ National Advisory Committee on Oral Health, Healthy Mouths Healthy Lives – Australia’s National Oral Health Plan 2004-2013, South Australian Department of Health on behalf of the Australian Health Ministers Conference, 2004
- ³¹ Centre for Oral Health Strategy NSW Oral Health Promotion: Framework for Action 2010, NSW Department of Health, NSW, 2006.
- ³² Spenser J & Harford J, Improving oral health and dental care for Australians, ARCPOH, University of Adelaide, Adelaide, 2008
- ³³ National Advisory Committee on Oral Health, Healthy Mouths Healthy Lives – Australia’s National Oral Health Plan 2004-2013, South Australian Department of Health on behalf of the Australian Health Ministers Conference, 2004
- ³⁴ The Health of the People of NSW – Report of the Chief Health Officer 2004, NSW Health, Sydney, 2004.
- ³⁵ Centre for Oral Health Strategy NSW, The New South Wales Child Dental Health Survey 2007, Department of Health, Sydney, 2009.
- ³⁶ National Advisory Committee on Oral Health, Healthy Mouths Healthy Lives – Australia’s National Oral Health Plan 2004-2013, South Australian Department of Health on behalf of the Australian Health Ministers Conference, 2004
- ³⁷ NSW Population Health Division 2008, AIHW 2008
- ³⁸ AIHW Dental Statistics and Research Unit, Geographic variation in oral health and use of dental services in the Australian population 2004–06, AIHW Dental Statistics and Research Unit, Canberra 2009, No. 41, Cat. no. DEN 188, Australian Research Centre for Population Oral Health. Available at: www.aihw.gov.au/publications/den/den-188-10713/den-188-10713.pdf p 1
- ³⁹ Tang WK, Sun F, Ungvari G, O’Donnell D. Oral Health of Psychiatric In-Patients in Hong Kong. *International Journal of Social Psychiatry*. 50:186, 2004.;
- ⁴⁰ Harris CK, Warnakulasuriya KAAS, Johnson NW. Oral and dental health in alcohol misusers. *Community Dent Health* 1996; 13 : 199-203
- ⁴¹ Lutch HA. Dental phobia. *Br J Psychiatry* 1971; 119 : 151-58
- ⁴² Davies R, Bedi R, Scully C. Oral health care for patients with special needs. *British Medical Journal*. 2000;321:495-8.
- ⁴³ Fiske J, Lloyd H. Dental needs of residents and carers in elderly peoples home and carers attitudes to oral health. *Eur J Prosthodont Restor Dent* 1992; 1 (2) : 91-95
- ⁴⁴ Kenny A, Translating evidence to practice: improving oral health outcomes for rural mental health clients, 10th National Rural Health Conference, La Trobe University
- ⁴⁵ Fiske J, Lloyd H. Dental needs of residents and carers in elderly peoples home and carers attitudes to oral health. *Eur J Prosthodont Restor Dent* 1992; 1 (2) : 91-95
- ⁴⁶ National Health and Hospitals Reform Commission, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, Commonwealth of Australia, Canberra, June 2009
- ⁴⁷ Beange H, McElduff A, Baker W (1995) “Medical disorders of adults with mental retardation: a population study” *AJMR* 99: 595-604
- ⁴⁸ Scott A, Marsh L, Stokes ML (1989) “A survey of oral health in a population of adults with developmental disability: comparison with a national oral health survey of the general population” *ADJ* 43; 257-261
- ⁴⁹ National Advisory Committee on Oral Health, Healthy Mouths Healthy Lives – Australia’s National Oral Health Plan 2004-2013, South Australian Department of Health on behalf of the Australian Health Ministers Conference, 2004
- ⁵⁰ *ibid.*
- ⁵¹ Kingsford Smith et al 2000
- ⁵² Centre for Oral Health Strategy NSW Oral Health Promotion: Framework for Action 2010, NSW Department of Health, NSW, 2006.
- ⁵³ *ibid.*
- ⁵⁴ NSW Oral Health Service Waiting List for Ambulatory Care - January 2010, NSW Health, accessed at: www.health.nsw.gov.au/cohs/list_flow.asp#para_1, on 01/03/10.
- ⁵⁵ NSW Oral Health Alliance, Access to dental services amongst clients of non-government human service organisations, Council of Social Service of NSW (NCOSS), Sydney, 2009
- ⁵⁶ Dental Therapist Labour Force in Australia 2005, Research Report no 35, Cat no. DEN 173, AIHW Dental Statistics and Research Unit, ARCPOH, Adelaide, 2008.
- ⁵⁷ NSW Health, Public Oral Health Services accessed from www.health.nsw.gov.au/cohs/health_services.asp
- ⁵⁸ ADA NSW July 2009

