AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Health Plan

Achieving Optimal Oral Health

2019

Introduction

A primary objective of the Australian Dental Association (ADA) is to increase the dental and general health of the Australian population.

The Australian Dental Health Plan (ADHP) seeks to provide a considered solution to this objective, whilst incorporating the considerable changes that have occurred in the dental healthcare environment over the past few decades. These changes have been driven by the following:

- *Increasing efficacy of dentistry,* through advances in dental knowledge and increased public interest, which have seen the means of dental-care provision advance enormously in the last 100 or so years from very basic and not very effective care. Dental technology and treatment modalities have advanced at an accelerating rate and transformed the range and sophistication of available dental services.
- *Increasing value placed on access to dental healthcare,* due to acceptance by patients and government that such access is part of the basic standard of living in a developed and modern country. In response to this there has been a widespread establishment of auxiliary dental service providers to attempt to secure access to dental care for all, regardless of capacity to pay, although the evidence indicates this has not been fully effective.
- *Rising real cost of state-of-the-art dental healthcare,* partly because of the inflationary (on balance) impact of technological progress, advanced treatments becoming available for previously untreatable conditions, and the complexities of bringing new healthcare modalities into Australia.

Funding for public dental care has been erratic over the years with various schemes introduced all with varying eligibility, often transient (apart from the DVA scheme), and often underutilised by the public and the profession.

In the national interest, the ADA feels there is a very real need for government-funded dental-care programs that are targeted, have clear eligibility criteria, cover a broad spectrum of dental services, can be introduced in phased stages, and have minimal, if any, capital costs.

On this basis the ADA presents the Australian Dental Health Plan.

Objectives

The Australian Dental Health Plan outlined in this paper is the ADA's vision for the Australian Government's involvement in the delivery and funding of dental care in Australia.

Background

Australia's Oral Health

Good oral health is a basic right enshrined in the World Health Organization's Liverpool Declaration and contributes to overall health, wellbeing and quality of life.

All Australians should be able to enjoy optimal oral health. However, despite improvements in the last 20–30 years, there is still evidence that too many Australians experience poor oral health.

The estimated avoidable costs of poor oral health to Australia exceeds $818 million per year.[1] According to recent Australian Institute of Health and Welfare (AIHW) reports:[2]

- Over 4 in 10 children aged 5–10 (42%) have experienced tooth decay in their primary ('baby') teeth; almost one-quarter of children aged 6–14 (24%) have had decay in their permanent teeth;
- Over 1 in 4 (26%) of young Australians and adults aged 15 and over have untreated dental decay; and
- Over 50% of Australians over the age of 65 years have gum disease or periodontitis; almost 1 in 5 (19%) of this age group have complete tooth loss.

Across all age groups, disadvantaged Australians experience relatively high rates of poor oral health, and many adults and older Australians in this group say they find it difficult to access timely dental treatment when they need it.[3]

The reality is that many Australians do not receive appropriate care or have the determinants of their oral diseases addressed. They are instead forced to incur expenses they can ill afford or remain on waiting lists for more invasive treatment of diseases that may have caused pain, discomfort or social and economic disadvantage for years.

As oral health deteriorates while people defer care or sit on waiting lists, costs to individuals, governments and the wider community—in the form of lost productivity, absences from work, presentations to GPs and emergency departments, PBS scripts for antibiotics and pain relief, the eventual dental treatment and avoidable hospitalisations—all increase significantly.

High sugar diets, poor oral hygiene, smoking and excessive alcohol intake all increase the risk of tooth decay, periodontal (gum) disease, oral infections, oral cancer and other oral conditions. They are also linked to increased risk of developing obesity and non-communicable diseases such as diabetes, cancer, cardiovascular and cerebrovascular disease, and chronic respiratory diseases.[4]

Evidence of the links between poor oral health and general health also continues to mount. For example, there is increasing evidence of a two-way relationship between diabetes mellitus and periodontitis,[5] and recent studies have found that the bacteria that causes periodontitis may raise the risk of Alzheimer's disease, or hasten its

1 Productivity Commission 2017, *Introducing competition and informed user choice into human services: reforms to human services (Chapter 12)*. Report No. 85, Canberra, and references therein. Available at https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf

2 AIHW. (2019). *Oral health and dental care in Australia,* web report edition updated 20 March 2019, Cat. no. DEN 231; AIHW (2018). *Older Australians at a glance*, web report edition updated 10 September 2018, Cat. no. AGE 87.

3 Ibid; ABS. (2018). *Microdata: patient Experiences in Australia* 2016–17, Cat. no. 4840.0, Canberra.

4 World Health Organisation. (2018). *Oral health: key facts*, September 24, https://www.who.int/news-room/fact-sheets/detail/oral-health; Dietrich, T et al. (2017). 'Evidence summary: The relationship between oral and cardiovascular disease', *British Dental Journal,* 222, pp. 381–5; Pillai, R S et al. (2018). 'Oral health and brain injury: causal or casual relation?' *Cerebrovascular diseases extra*, 8(1), pp. 1–15.

5 Mealey, B & Rethman, M (2003). 'Periodontal disease and diabetes mellitus: bi-directional relationship', *Dentistry Today*, 22, pp. 107–13; Preshaw, PM et al. (2011). 'Periodontitis and diabetes: a two-way relationship', *Diabetologia*, 55, pp. 21–3.

progression.[6] It has also been found that frail older people with poor oral hygiene also have an increased risk of bacterial infections of the blood and aspiration pneumonia.[7]

Australia needs a dental healthcare system that ensures all Australians can access timely treatment of oral disease as well as preventive oral healthcare. This will have positive flow-on effects on general health and well-being and reduce the direct and indirect costs of poor oral health to individuals and taxpayers in general.

The ADA understands the oral health needs of the population and what is required to meet existing gaps in service delivery.

Current Australian Government involvement

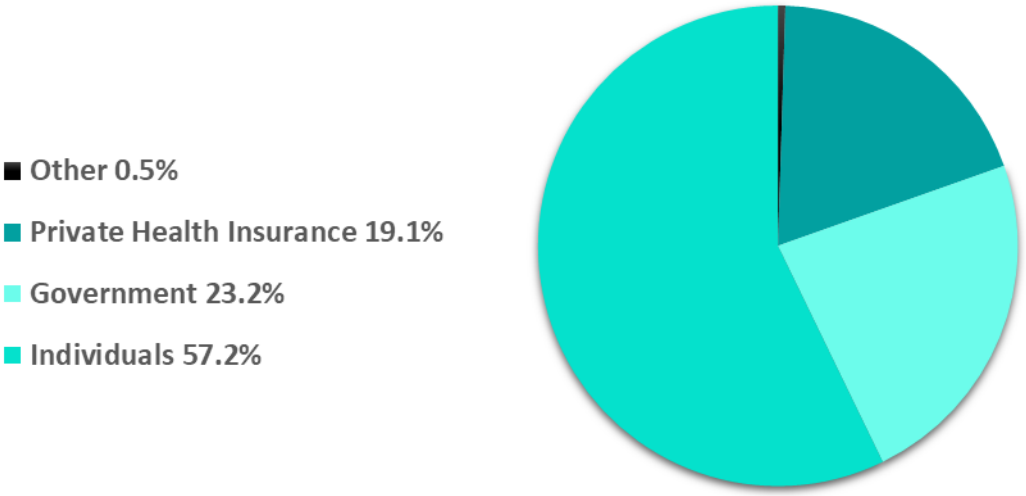
A number of Australian Government dental schemes are in operation. These are the Child Dental Benefits Schedule (CDBS), the Cleft Lip and Palate Scheme, and the Department of Veterans' Affairs (DVA) Scheme.

This paper proposes a modified version of the CDBS as a model for additional targeted dental schemes to make quality care, with a greater focus on prevention, more accessible to other population groups with significant unmet oral healthcare needs.

Current national dental expenditure

According to the latest AIHW report, *Health Expenditure in Australia 2017–18*, total expenditure on dental healthcare in 2017–18 was estimated at $10.5 billion. Governments at all levels contributed $2.4 billion of this amount. After medication expenses, dental-care costs are an individual's next largest health expense.

Dental Expenditure in Australia 2017–18



[6] Dominy, S et al. (2019). 'Porphyromonas gingivalis in Alzheimer's disease brains: evidence for disease causation and treatment with small-molecule inhibitors', *Science Advances*, 5(1), eaau3333.

[7] Maarel-Wierink CD et al. (2011). 'Risk factors for aspiration pneumonia in frail older people: a systematic literature review', *Journal of the American Medical Directors Association*, 12, pp. 344–354.

The Australian Dental Health Plan (ADHP)

Australia needs a dental healthcare system that is cost-effective, administratively efficient, reduces dental disease in the community, and ensures that Australians of all ages can access timely, affordable and clinically optimal oral healthcare in their local area.

The ADA proposes a model that would retain the CDBS (with some modifications) and use it as the template for additional schemes of targeted dental benefits assistance for other population groups demonstrated to have relatively poor oral health and significant unmet dental treatment needs.

The ADA has designed an Australian Dental Health Plan (ADHP) that will deliver on the goals of *Australia's National Oral Health Plan 2015–2024*[8] by:

- providing a system based on targeted schemes governed by a uniform and simple set of administrative rules and regulations;
- allowing for the staged introduction of each targeted scheme over time;
- providing quality care to these eligible target populations on an equitable, efficient and sustainable basis; and
- addressing the risk factors that lead to poor oral and general health.

Current and former Australian Government dental schemes have varied in terms of the types of services funded, eligibility requirements and administrative arrangements. By contrast, the ADA proposes an ADHP with the following uniform features:

- a common schedule and set of treatment descriptors for eligible dental services;
- a specified and manageable budget with the imposition of Annual Monetary Limits (AML) on the potential treatment subsidy available to each eligible patient over a specified period;
- consistent eligibility criteria and terminology;
- a common fee schedule; and
- measurable outcomes.

This uniform model will minimise administrative complexity and costs, both for government and dental practitioners, and improve the efficiency of all schemes that operate under the model.

As with the existing CDBS program, patients (or their parents/guardians/carers) could check their eligibility and the balance of their remaining monetary entitlement under the scheme through their Medicare online account or myGov. Practice staff can check the same details through HPOS, the Australian Government's Health Professionals Online Service portal.

Australian Dental Health Plan Principles

The ADHP will adopt the following principles for each scheme that is created under the model:

- eligibility criteria determined by the Australian Government;
- administration through the Department of Health/Department of Human Services with funding provided by an amendment to the *Dental Benefits Act 2008* to suit each scheme;
- utilisation of both private and public sector clinics;

[8] COAG [Council of Australian Governments] Health Council. (2015). *Healthy mouths, healthy lives: Australia's National Oral Health Plan 2015–24,* http://www.coaghealthcouncil.gov.au/Portals/0/Australia%27s%20National%20Oral%20Health%20Plan%202015-2024_uploaded%20170216.pdf

- utilisation of a common schedule and glossary of dental terms – the ADA's *The Australian Schedule of Dental Services and Glossary*;[9]
- access to all services based upon the current edition of the ADA Schedule;
- benefit levels to be set at the DVA Schedule for Dentists and Dental Specialties[10] and indexed annually;
- opportunity for participating private dentists to be able to bulk bill or charge usual and customary fees with a co-payment through a rebate system that parallels Medicare;
- public clinics must bulk bill;
- prior approval to be obtained by the treating dentist for complex treatments;
- AML to be applied;
- differential Fees for GP and Specialist Dentists; and
- coverage of dental services delivered in private and public clinics as well as under general anaesthetic/sedation in day procedure and hospital facilities.

Eligibility for the ADHP

The ADHP proposes three aged-based dental schemes that will cover Australians of *all* ages who need better access to timely, quality oral and dental health care. The three schedules proposed include a modified version of the existing CDBS scheme, and two new income-tested schemes – one for adults aged 18–64, and another for seniors aged 65 and over.

It is proposed that the eligible population for the Adult scheme would be those aged 18–64 who hold any type of Health Care Card or Pensioner Concession Card issued by the Australian Government, plus their eligible dependents.

For the Seniors scheme, the eligible group would be those aged 65 and over who hold a Pensioner Concession Card, a Commonwealth Seniors Health Card, or a Health Care Card issued by the Australian Government (and, in a small number of cases, any eligible dependents).

By extending eligibility to those who hold one of these Commonwealth concession cards, these two new schedules would cover all adults and seniors in receipt of Commonwealth income support payments, and some on similarly low incomes who just miss out on eligibility for payment of Commonwealth pensions/allowances.

Specifically, these concession card holders include adult/senior Australians who:

- receive a part or full disability support pension, aged pension, or double orphan pension;
- receive a part or full income support allowance payment (e.g. Newstart, Carers Payment, Youth Allowance, Austudy, Parenting Payment, Sickness Benefit), because they are:
  - a full-time carer for a person or persons who are frail aged, seriously ill or disabled;
  - a person with a partial disability who does not meet eligibility requirements for the Disability Pension and receives Newstart (the unemployment payment) instead;
  - unemployed or underemployed, including parents of young children and all other single/partnered Australians in this situation aged up to 65;

[9] The Australian Dental Association (ADA) has developed this publication in conjunction with all sectors of the profession, private health insurers and all levels of government. Currently in its 12th edition, it was first created in 1986 and serves as the definitive and universally accepted coding system of dental treatment and is endorsed by the National Centre for Classification in Health (NCCH). Like the Medicare Benefits Schedule, it lists dental treatments and allocates a number for each service.

[10] Department of Veteran's Affairs. (2019). *Fee schedule of dental services for dentists and dental specialists*, https://www.dva.gov.au/providers/fees-schedules/dental-and-allied-health-fee-schedules

- sole parents/principal carers of children in receipt of Parenting Payment (single) or Parenting Payment (couple);
- in receipt of Sickness Allowance as they are unable to work at their job or attend enrolled full-time study commitments for an extended period due to illness or accident, or
- in receipt of Youth Allowance or Austudy as they are full-time post-secondary students or apprentices aged 16 or over;

- are a working parent(s) with children under 8 whose income is low enough to make them eligible for the full rate of Family Tax Benefit Part A;
- are a farmer/farming couple in financial hardship receiving Farm Household Allowance;
- are working singles or couples on very low incomes who have a Low-Income Health Care Card; or
- are self-funded retirees who meet the aged pension income test but are ineligible for it as they just exceed the assets test. (This group gets a Commonwealth Seniors Card that provides access to PBS medicines and bulk-billing by GP's).

Targeted Schedules

What follows are some recommendations for modifying the CDBS and creating similarly targeted schemes for other sectors of the community.

1. Child Dental Benefits Schedule (CDBS)

The existing CBDS is the foundation model upon which the ADHP is based. The scheme covers children between the ages of 2 and 17 from both low and middle-income households.

Directing a focus to this age group was, and will continue to be, a sound investment in Australia's long-term dental health, as it will reduce the incidence of oral disease and costs of dental care into the future.

The CDBS has been embraced by participating dentists, who promote the scheme in their practices. Utilisation of the scheme has gradually increased since it was introduced in 2013, up to almost 38% of eligible children in 2018.[11] However, a poll conducted in 2018 found that some 25% of eligible families are not yet aware of the scheme.[12]

To improve the effectiveness of the CDBS, several additional program features and conditions should be introduced to the scheme and applied consistently across other schemes that may be developed for other population groups (e.g. adults and seniors).

The recommended improvements to the existing CDBS are as follows:

- eligibility should be from 0–17 years of age, to ensure that parents of babies and pre-toddlers can access professional advice on how to care for their oral health, as primary (baby) teeth can be present at birth;
- AML should reflect the current costs of dental services and the needs of the sector being targeted;
- AML and fees should be increased on an annual basis;

[11] Murphy, B et al. (2019). *Report on the Fourth Review of the Dental Benefits Act 2008*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/5AE86FB9D21A8277CA257BF0001F952F/$File/Report%20on%20the%20Fourth%20Review%20of%20the%20Dental%20Benefits%20Act%202008.pdf

[12] https://www.rchpoll.org.au/wp-content/uploads/2018/03/NCHP10_Poll-report_Child-oral-health.pdf

- access to a full range of services;
- dental treatment in hospital and day procedure facilities under general anaesthetic to be funded under the scheme;
- as poor oral health levels are more pronounced amongst disadvantaged groups and in rural/remote areas, a 50% increase in the AML should be introduced to meet the exceptional needs of some sectors of the population such as:
    - children of Aboriginal and Torres Strait Islander descent;
    - children residing in remote and very remote regions as per Modified Monash Model (MMM2019) categories MM6 and MM7;
    - children with disability and special needs.
- no AML for children eligible under Cleft Lip and Palate Scheme.

2. Seniors Dental Benefits Schedule (SDBS)

It is expected that by 2056 there will be one in four people living in Australia over the age of 65 years and 1.8 million people will be over the age of 85 years. Increasing numbers of older people are retaining their natural teeth and by 2021 only 3% of the population will have complete tooth loss.

This will result in high demand for ongoing dental care by the elderly, many of whom may have complex and chronic medical conditions.

The SDBS will have:

- AML set at specific limits;
- eligibility confined to a specific age group, e.g. people who are 65+ years and who are in receipt of a Pensioner Concession or Commonwealth Seniors Health Card;
- access to all services based upon the current edition of the ADA Schedule and Glossary;
- dental treatment in hospital and day procedure facilities for general anaesthetic funded under the scheme;
- given specific issues that impact on the dental health of this cohort, an AML limit increased by 50% for seniors:
    - of Aboriginal or Torres Strait Islander background;
    - living in Remote and Very Remote communities as per Modified Monash Model (MMM 2019) Categories MM6 and MM7;
    - with disabilities and special needs;
    - living in residential aged care; or
    - receiving Level 4 Home Care Packages.

3. Adult Dental Benefits Schedule (ADBS)

There are many adults who suffer from disadvantage as a result of low income, unemployment or poor health. Poor oral health is strongly correlated with low socioeconomic status. People in this group rarely visit a dentist for preventive care and when they do attend, it is often only when a serious problem has developed.

On average, Aboriginal and Torres Strait Islander people experience poor oral health earlier in their lifespan and in greater severity and prevalence than the rest of the population. Adults living in regional or remote areas have higher levels of tooth loss and more untreated decay.

All states and territories offer some form of public dental care to eligible adults; however, infrastructure and the size of the dedicated dental workforce in these facilities vary considerably, resulting in discrepancies in services provided and long waiting times for treatment. In a majority of the states and territories, adults who may be living on poverty-level incomes still have to pay co-payments to access public health services, even though they are eligible, which further reduces access to care.

Considerable impact was made on waiting lists when additional funds were available for dental care under the National Partnership Agreements (NPAs) between the Australian Government and the states and territories. Most jurisdictions used the additional monies provided under the NPAs to purchase services from private sector dentists who were in oversupply and will continue to be in oversupply for many years, as confirmed by Health Workforce Australia. This is a long-term sustainable model for dental service provision.

Committing federal or state funding to build new public dental infrastructure in areas that are well serviced by existing private (or public) infrastructure is an inefficient use of resources better spent on treatment provision.

NPA funding should be made available for use under the ADBS, which would adopt the key elements of the CDBS.

The ADBS scheme would have:

- eligibility limited to 18–64 years of age;
- means testing or targeting criteria applied;
- access to all services based upon the current edition of the ADA Schedule and Glossary;
- dental treatment in hospital and day procedure facilities under general anaesthetic funded under the scheme;
- AML imposed as determined appropriate;
- AML increased by 50% for adults:
  - of Aboriginal and Torres Island background;
  - living in Remote and Very Remote communities as per MMM 2019 MM6 and MM7 classifications; or
  - with significant disability and special needs.

Funding the ADHP

Proposed funding options for the introduction of the ADHP components could include one or more of the following:

- Phasing out the Private Health Insurance Rebate for general treatment policies. The total projected cost of the premium rebate for hospital and general treatment policies in 2019–20 is $6.3 billion, and around $800 million of this amount will subsidise benefits for dental costs paid out by health funds.[13] A component of this subsidy could be allocated towards funding the ADHP;
- Introduction of a tax on the consumption of sugary drinks;
- Increased taxation of tobacco products; and/or
- An increase of 0.5% to the Compulsory Medicare Levy. The current 2% levy raised $15.8 billion in 2017–18, so a 0.5% increase would initially raise an additional $3.9 billion per annum.

[13] 2019–20 Health Portfolio Budget Statements, *Budget Related Paper 1.9*, Section 2, Outcome 4: Individual health benefits, p. 85. Estimate of dental costs that will be funded by the PHI premium rebate were derived using the AIHW's methodology, and data on private health insurer expenditure in the year to March 2019 contained in APRA (2019). *Quarterly Private health Insurance Statistics March 2019*.

Adjunct Initiatives

The Australian Government must acknowledge that to be fully effective, funding of dental care treatment must be supported by immediate action to strengthen the foundations of good oral health.

Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024 includes a range of preventive initiatives that have the ADA's full support. These initiatives are critical to improving the oral health of the nation and should be funded and implemented by the Australian Government in cooperation with the states.

In the short-term, the ADA considers that the Australian Government should prioritise urgent action on the following fronts to build better foundations for improved oral health in Australia:

Foundation Area 1: Promote awareness of the importance of good oral health

Although perceived cost is a reason that many Australians avoid seeking dental treatment, or getting recommended treatment they need, the evidence suggests that it is often not the only reason.

Many people give lack of time as a reason for avoiding dental care, and for people who are frail, disabled, or living a long way from the nearest dental clinic, transport or transport costs can be a problem.

Importantly, though, there is also evidence that low-income Australians, Australians living in rural and remote locations, and frail older Australians are less likely than higher income Australians to report that they *need* dental care, even though statistics suggest they suffer more oral health problems.[14] Amongst other living expenses, dental care is often accorded a low priority unless there is a serious problem causing pain.

Oral diseases are often viewed almost as an inevitable part of ageing and not worth treating unless they are causing considerable pain. Across the community, there also appears to be little understanding of the negative impacts poor oral health can have on *general* health.

Education of the population as to the importance of oral health, its impact on general health, and the cost-benefits of dental care (most particularly attending the dentist regularly for check-ups and preventive treatment) is a sound investment for a federal government. If the overall population recognised the importance of good oral health and preventive oral health care, and made positive changes, overall health levels would improve, individual and government health expenditure would decline, and other economic costs associated with poor oral health (such as lost productivity) would decline too.

The ADA, its branches, and its members already expend considerable resources producing oral health promotion materials, conducting media campaigns, and spreading the message through direct communication with patients and the public. However, much more needs to be done. Australian Government action on this front is also needed to raise awareness, and the ADA would be happy to provide expert advice on the content of any national oral health promotion campaign.

The ADA calls on the Australian Government to:

- **Fund a major national oral health promotion campaign in order to educate Australians about the importance of oral health, and what they can do to support their own oral health and that of their families.**

[14] ABS. (2018). *Microdata: patient experiences in Australia, 2016–17* (Cat. No. 4840.0); Barnett, T et al. (2016). 'Sorry, I'm not a dentist': perspectives of rural GPs on oral health in the bush', *Medical Journal of Australia*, 204(1), https://www.mja.com.au/journal/2016/204/1/sorry-im-not-dentist-perspectives-rural-gps-oral-health-bush; Lewis A, Wallace J, Deutsch A & King P (2015). 'Improving the oral health of frail and functionally dependent elderly', *Australian Dental Journal*, 60 (1 – Supplement), p. 97; Webb, BC et al. (2016). 'Oral and dental care in aged care facilities in New South Wales, Australia. Part 3 concordance between residents' perceptions and a professional dental examination', *Gerodontology*, 33, pp. 363–372.

Foundation Area 2: Fluoridation

The therapeutic benefits of water fluoridation are clear. An extensive review undertaken by the National Health and Medical Research Council (NHMRC) has recently affirmed that water fluoridation reduces dental decay by 25–44%, and that there is no evidence that the concentration of fluoride used in public water supplies in Australia causes any health-related harm.[15]

The ADA believes that all localities with 1,000 or more residents that have mains supplied (reticulated) water should have water that is accessible and fluoridated. Non-mains supplied localities should have subsidised alternative forms of dental prevention made available to them. Under the ADHP, there should also be an incentivised payment for topical fluoride application in non-fluoridated areas.

The ADA calls on the Australian Government to:

- **Promote the benefits of water fluoridation to the Australian public; and**
- **Support state and local governments to extend access to fluoridated water to all Australian communities with reticulated water supplies.**

Foundation Area 3: Dietary and sugar control

It is well established that dietary carbohydrates and especially 'free sugars' (monosaccharides and disaccharides) play a major role in the causation of dental decay. Causes of non-carious tooth structure loss (dental erosion) include the exposure to acid from the consumption of soft drinks, sport drinks, fruit and fruit juices, wine, vinegar, and chewable vitamin tablets. Pre-existing conditions such as Sjogren's disease, gastric reflux or multiple medications exacerbate these effects. Consumption of foods that combine simple carbohydrates and food acid can be particularly destructive to teeth.

Sugar-sweetened beverages are a large contributor of added sugar to Australian diets. Australia is one of the biggest consumers of sugary drinks in the world, and consumption is particularly high amongst children and young people, and in socio-economically disadvantaged households.[16] Sugary drinks are a leading contributor to tooth decay, given that they contain acid that weakens tooth enamel, and produce more acid when the sugar combines with bacteria in the mouth.

A single can of sugar-sweetened soft drink contains on average around 10 teaspoons, or 40 grams of free sugars. The World Health Organisation (WHO) recommends that children and adults limit their daily intake of free sugars to around 10% of their daily energy intake and notes scientific evidence that this lower intake is associated with lower rates of dental caries.[17]

For a healthy adult, this means limiting free sugar intake to around 50 grams or 12 level teaspoons a day. WHO adds that further reducing intake to below 5% of daily energy intake (or roughly 6 teaspoons a day) appears to provide even greater health benefits particularly related to dental health.[18]

However, this is difficult to do, given the mass marketing and availability of sugary drinks and Australia's current inadequate food-labelling laws, which do not provide enough clear information about the sugar content in drinks and other foods to allow consumers to make informed choices in line with dietary guidelines and WHO recommendations.

[15] NHMRC Public Statement 2017. *Water Fluoridation and Human Health in Australia.* https://www.nhmrc.gov.au/about-us/publications/2017-public-statement-water-fluoridation-and-human-health

[16] http://www.rethinksugarydrink.org.au/facts*; Roy Morgan Young Australians Survey, July 2015–June 2016,* http://www.roymorgan.com/findings/7101-sweet-drinks-much-more-popular-with-kids-than-older-aussies-201701031624; ABS. (2014). *Australian Health Survey: Nutrition First Results – Foods and Nutrients, 2011–12*, Cat. No. 4364.0.55.007.

[17] World Health Organisation. (2015). 'WHO calls on countries to reduce sugars intake among adults and children', Media release, 4 March, https://www.who.int/mediacentre/news/releases/2015/sugar-guideline/en/

[18] Ibid.

The ADA calls on the Australian Government to:

- **introduce a health levy on sugary drinks to increase the price by 20%;**
- **support a social marketing campaign to highlight the impact of sugary drinks on oral and general health and encourage people to reduce their consumption; and**
- **change food-labelling laws to require that added sugars be clearly listed on all packaged food and drink products through front-of-pack labelling.**

Foundation Area 4: Tobacco control

The detrimental effects of tobacco on general and oral health are well documented.[19] Tobacco use harms nearly every organ of the body and is the single most preventable cause of premature mortality and morbidity.

From the dental perspective, tobacco:

- is an aetiological factor in the development of oral cancer, leukoplakia, erythroplakia and keratosis;
- is an important risk factor in the development of periodontal disease;
- contributes to greater levels of tooth loss;
- contributes to development of acute ulcerative gingivitis;
- contributes to xerostomia, abrasion and erosion;
- causes increased staining of teeth;
- delays wound healing; and
- causes increased risk of failure in osseointegrated implants.

All these consequences add substantially to the costs of dental care borne either by individuals or government. Timely cessation of smoking will usually result in improvements to general and oral health and will achieve substantial savings for both individuals and government.

Government initiatives to date in the areas of public education on the risks of smoking, tobacco product labelling, advertising and taxation have helped to achieve considerable reductions in the initiation of smoking and rates of smoking cessation in Australia, but they have not yet eradicated it.

Although e-cigarette products have been touted as potential smoking cessation aids, there is now growing evidence implicating e-cigarettes in a range of harms to individual and population health.[20] Given this, the ADA supports the decision of the Therapeutic Goods Administration (TGA) not to approve e-cigarette products as therapeutic smoking cessation products, and will continue to do its part to raise awareness of the potential dangers of vaping and e-cigarettes.

The ADA calls on the Australian Government to:

- **continue restrictions on the marketing of tobacco products**
- **increase taxation on their sale;**
- **continue subsidisation of TGA-approved smoking cessation products; and**
- **continue raising awareness of the dangers of vaping/e-cigarettes and water pipes.**

[19] Reibel, J. (2005). 'Tobacco and oral health', *Bulletin of the World Health Organisation*, 83(9), pp. 641-720.

[20] Joint Statement of the Chief Medical Officer and State and Territory Chief Health Officers. (2019). 'E-cigarettes linked to severe lung illness', https://canceraustralia.gov.au/sites/default/files/statement_on_e-cigarettes_in_australia.pdf