**From:** Katy Theodore <Katy.Theodore@adavb.org>
**Sent:** Tuesday, 31 January 2023 6:12 PM
**To:** Measuring What Matters
**Subject:** Well-being indicators
**Attachments:** Differential Impacts of Caries Classification in Children and Adults 2016.pdf; Dental Health Services Statement of Priorities 2021-22.pdf; Developing a standard set of patient-centred outcomes for adult oral health an international cross-disciplinary consensus 2020.pdf; Report of the National Advisory Council on Dental Health 2012.pdf

"*A health indicator is a public health surveillance tool that defines a measure of health, for example, the occurrence of a disease or other related event. It allows the generation of evidence on the status and trends of the health situation of a population, including documentation of inequities, evidence that should serve as a basis for determining the most underprivileged groups in health, the stratification of epidemiological risk and the identification of critical areas as a basis for establishing policies and priorities in this area. Because of this, it is essential to choose an adequate index to assess the population reality*."
(From - Coelho, M. A. G. (2020). ICDAS and dmft/DMFT. Sensitivity and specificity, the importance of the index used: a systematic review. *Journal of Dentistry & Public Health*, *11*(2), 176-187.)

**Self-introduction:**

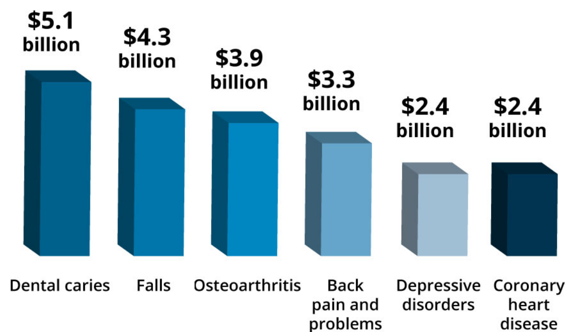
After graduating from dental school in 2009 I couldn't wait to enter private practice. I worked for four years in the private sector but became completely disillusioned with the financial incentives that played such a major role in the care that people chose to receive as well as care that clinicians recommend. After that, I joined the public sector with the hopes that I could avoid situations where money impacted on treatment choices as much as it had in my experience in the private sector. It was a rude shock to realise that the public sector funding models had *every bit* as much influence by perversely incentivising clinician behaviour which in turn negatively impacted on the health outcomes of the clients depending on the public service for their dental care. In large part perverse incentivisation is the consequence when we don't ***measure what matters***.

*Since* burning out after doing two solid years of public sector practice I've worked tirelessly to try and change the system from the inside and the outside. I've had non-clinical policy/advocacy/research/health promotion type roles developing value-based models of oral health care in the lead public oral health agency for the state and now at the Australian Dental Association's Victorian Branch (the ADAVB).

The ADAVB is the peak body and professional association for dentists in Victoria. We represent 75% of the state's registered dentists. I am lucky enough to be responsible for managing the policies, and advocacy, research and health promotion activities undertaken by the branch in my management role. I am still passionate about dentistry and oral health, especially preventive, public health and responsible use of public resources.

**Background**

- Oral Health Facts from the World Health Organisation 2022:
  - Untreated dental decay is the most common health condition in the world according to the Global Burden of Disease 2019.
  - Prevalence of the main oral diseases continues to increase globally.
- From the Australian National Advisory Council on Dental Health (NACDH) 2012 (see report attached):
  - Oral diseases destroy the tissues in the mouth, leading to lasting physical and psychological disability.
  - Tooth loss can reduce the functionality of the mouth, making chewing and swallowing more challenging, which in turn can compromise nutrition. Poor nutrition can impair general health and exacerbate existing health conditions.
- Poor oral health is also associated with a number of chronic diseases, including stroke and cardiovascular disease (DHSV 2011).
- In 2018/19 the AIHW reported that **more money was spent on treating dental decay in Australia than any other single disease condition**:




**The problem**

Typically (historically) we measure "oral health" with an index referred to as the **DMFT** (or "*dmft" in lower case* to make reference to *primary* - also known as "*baby*" - teeth) it stands for "**D**ecayed, **M**issing, **F**illed **T**eeth".

There are two issues with this measurement:

1. The variation in how dental practitioners record diagnostic information (unstandardised).
    - Supporting evidence attached in article "Melgar, Rosa Ana, et al. "Differential impacts of caries classification in children and adults: a comparison of ICDAS and DMF-T." *Brazilian dental journal* 27 (2016): 761-766."
2. It is a **unidirectional measure**. The numerical value of the indices can only every increase in an individual over time, and/or as a result of care. So, it doesn't capture "improvements" in oral health. For it to be valuable it must be compared across cohorts of the same age or age group. For example;
    - a sample of 6-year-olds in Canada with a comparable sample of 6-years-olds in New Zealand, or
    - the average DMFT of 12-year-olds in 1987 compared to the average DMFT of 12-year-olds in 2007.

DMFT and dmft indices do not reflect anyone's *current* oral health status, they can't demonstrate how oral health has improved because of access to care or be used to measure cost-effectiveness.

In Victoria, the agreements made between the government (who pay – in part – for public dental service delivery) and the agencies (who deliver the services) called The Statement of Priorities stipulate performance measures which reflect nothing about the quality of care provided, the value (or cost-effectiveness) of care provided, the impact of care provided, or the outcomes of care provided. See attachment "*Dental Health Services Statement of Priorities 2021-22*"

**Addressing the problem**

Oral health is defined by the World Dental Federation as "the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex".

Only by utilising measures that capture these aspects of oral health (that ***matter*** to people and impact on wellbeing) can we quantify the effectiveness of dental care and ensure appropriate (being cost-effective) utilisation of public resources. A significant amount of work to standardising just such measures has been undertaken in the last few years, having very much been driven by the lead public oral health agency here in Victoria.

**KEY POINTS:**

- Good oral health is fundamental to overall health and wellbeing (COAG 2015).
- It's not "universal healthcare" if it *doesn't* include **mental and dental** care.

- You can't improve what you don't measure.
- Measure what matters – and what matters for people's wellbeing is the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease in their teeth, mouth, jaws and face.
- We spend ***A LOT*** of money on dental care in Australia, and we don't really know how cost-effective any of it is, and we won't until we measure what matters.
- Oral health matters.

Prepared by KT

**Dr Katy Theodore** (she/her) B.D.S. (Ade,'09)
Policy, Advocacy, Research and Health Promotion

**katy.theodore@adavb.org**
**Australian Dental Association Inc.**
**c/o ADAVB**
**Level 3, 10 Yarra Street, South Yarra**
**PO Box 9015, South Yarra, VIC 3141**
**Phone: 03 8825 4600**
**www.adavb.org**

I acknowledge the Traditional Ownership of the unceded land on which I live and work, the Wurundjeri and Boon wurrung people of the Kulin nation, and their connection to land, sea and air. I give respect to Elders past, present and emerging.

I stand up against racial discrimination and am an **LGBTIQ+** ally.

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