SOUTH AUSTRALIA's

Oral Health Plan

2019 - 2026

The South Australian Government's seven year plan for oral health care

Government of South Australia

SA Health

We offer sincere thanks to the many contributors to the development of the South Australian Oral Health Plan 2019 - 2026.

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1 FOREWORD

I am pleased to release the South Australian Oral Health Plan 2019-2026 which aims to improve the oral health of South Australians, particularly those groups who experience, or are at greater risk of, poor oral health.

This Plan builds on both the foundations and achievements of the inaugural Plan released in 2010 and provides the South Australian context for the goals and principles of Healthy Mouths – Healthy Lives, Australia's National Oral Plan 2015-2024.

A healthy mouth is fundamental to overall health, wellbeing and quality of life. It enables people to eat, speak and socialise without pain, discomfort or embarrassment. Poor oral health can interfere with daily function, impacts on social interactions and work productivity and is associated with a number of health problems and conditions.

Whilst oral health has improved in recent decades for many South Australians, the evidence shows there are still significant inequities in our community and areas of unmet need remain. The purpose of this Plan for the next seven years is to guide coordinated action that contributes to improved oral health.

In recognition of the wider impacts of oral health and the underlying causes of oral disease and conditions, this Plan necessarily involves not only the dental sector but the broader health and community sectors. The strengthening of existing partnerships and the development of new partnerships are a key feature of this Plan. It is these collaborative partnerships across the six foundation areas and eight priority population groups identified that will be a key enabler of the success of this Plan.

The development of this Plan has incorporated two consultation phases which included the public as well as the dental, wider health and community sectors. I would like to thank everyone who provided feedback and in doing so shaped and influenced the Plan. A monitoring group comprising representatives from key stakeholders, including community, will be established in the near future to advise on implementation of the Plan and track progress.

I look forward to seeing the achievements that can be made under this Plan.

Hon Stephen Wade MLC
Minister for Health and Wellbeing
12 September 2019

1.1 One page summary

FOUNDATION AREAS

	Oral Health Promotion and Prevention	Accessible Oral Health Services	Systems Alignment and Integration
GOALS	Provide evidence-based oral health information and programs	Provide South Australians with accessible oral health care	Work together to support healthy mouths and healthy lives
ACTION AREAS	> Optimise preventive effects of fluoride > Increase oral health literacy > Promote oral health and nutrition > Build capacity of health, education and community workers > Integrate oral health and general health policies	> Reduce the impact of transport barriers > Provide universal access for children > Improve access for priority populations	> Facilitate inter-sectoral collaboration > Develop integrated models of care > Optimise technology for integration

PRIORITY POPULATIONS

People who are socially disadvantaged or on low incomes	People living in regional and remote areas	Aboriginal and Torres Strait Islander people	Culturally and linguistically diverse people

Safety and Quality	Workforce Development	Research and Evaluation
Provide safe, quality oral health services	Ensure the oral health workforce meets the needs of the community	Use research and data to understand the oral health needs of the community
> Maintain dental service infrastructure > Facilitate consumer engagement > Implement oral health standards across sectors	> Build workforce capacity to meet the needs of priority populations > Increase cultural competency of oral health workforce > Optimise oral health workforce utilisation > Provide oral health competency training	> Contribute to oral health evidence > Utilise population oral health data

Frail older people	People living with mental illness	People with disabilities	People with complex medical conditions

2 INTRODUCTION [i]

The South Australian Oral Health Plan 2019 - 2026 is the South Australian Government framework for oral health action in South Australia for the next seven years. It provides an overview of the current oral health status of South Australians, including priority populations, and identifies key action areas to address the oral health needs of the population. The success of this Plan will depend on the strength of collaboration and engagement between all stakeholders in the South Australian community.

2.1 What is oral health?

Good oral health refers to the health of the mouth which includes the "oral and related tissues that enable an individual eat, speak and socialise without active disease, pain, discomfort or embarrassment".[1] It is a key indicator of overall health and is important for general wellbeing and quality of life.[2] Poor oral health interferes with daily function, impacts on social interactions and work productivity and is associated with health problems such as stroke, cardiovascular disease, aspiration pneumonia and adverse pregnancy outcomes.[3]

As described in the National Oral Health Plan 2015-2024 - Healthy Mouths Healthy Lives, the major oral diseases that cause poor oral health are dental caries (dental decay), periodontal disease (gum disease) and oral cancers. Oral diseases are amongst the most common and costly health problems experienced by Australians; oral disease is a highly prevalent chronic disease.

2.2 What determines oral health?

Oral health, as with general health, is determined by a complex interaction of social, economic, environmental, lifestyle and individual factors which influence early life opportunities, exposure to health hazards, and adoption of health behaviours.[4]

Evidence shows that disadvantaged groups experience poor oral health outcomes more frequently.[2] In addition, people often experience multiple factors of disadvantage, compounding their effect on health and wellbeing. For example, the link between poor education and low income is well known, while low income is, in turn, associated with poor health and inferior housing.[5]

Research has demonstrated the strong link between income and the risk of poor oral health, with low income affecting access to health care, utilisation of dental services, oral health literacy, knowledge and attitudes towards oral health.[6]

Socio-economic status is linked with levels of sugar, tobacco and alcohol consumption which in turn impacts oral health:

- Consumption of high levels of sugar increases the risk of dental decay
- Consumption of tobacco increases the risk of gum disease and oral cancer
- High levels of alcohol consumption increase the risk of oral cancers.[1]

The common risk factors for oral disease and several other chronic diseases such as obesity, heart disease, cancer and stroke, allow for shared prevention strategies across chronic disease.[7] However, social disadvantage may counter health promotion and prevention strategies and should be taken into consideration in the provision of oral health services.[8]

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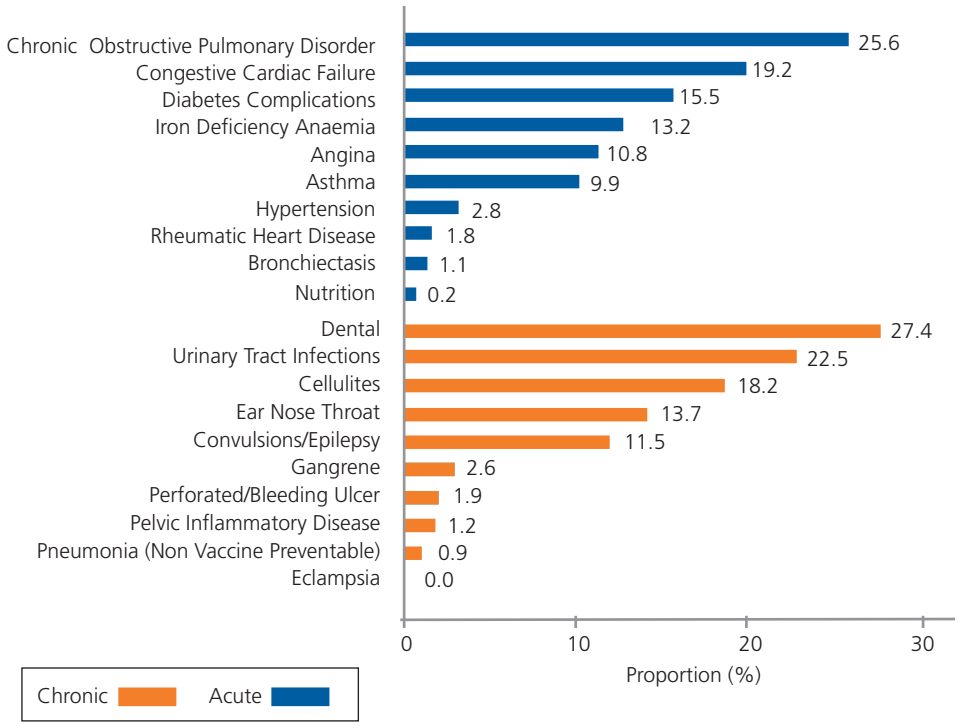
[i] *Where available, South Australian data is referenced, otherwise Australian data is used.*

3 OVERVIEW OF ORAL HEALTH STATUS IN SOUTH AUSTRALIA

3.1 Burden of disease

Dental problems are common in the Australian population with more than a quarter of children aged 5-10 years (27%) and adults (26%) having untreated dental decay.[9,6] Nationally, dental decay is the third highest cause of potentially preventable hospital admissions (PPHA) which could be avoided if timely and adequate primary care had been provided.[1] As reported in the Chief Public Health Officer's Report, dental problems are the most common acute condition causing PPHAs in South Australia.[4]

Proportion of chronic and acute potentially preventable hospitalisation in South Australia, Jul 2016 - Jun 2018



Source: Protect, Prevent, Improve - The Chief Public Health Officer's Report 2016 - 2018

Nationally and in South Australia, children in the 0-9 year age group experience the highest rate of PPHAs.[1] Dental decay is the main oral health problem that results in PPHA in this age group and often involves a general anaesthetic.[1]

Oral cancers, affecting lips, tongue, salivary glands, gums, mouth or throat, are the seventh most commonly diagnosed cancers in Australia.[10] Oral cancer is more common among older age groups, men (two thirds higher than women) and Aboriginal and Torres Strait Islander people (three times higher than the rest of the Australian population).[11] Risk of oral cancer is associated with tobacco and alcohol consumption and human papilloma virus infection.[12] In 2013, of the 124,000 new cases of cancer diagnosed across Australia, just over 3,000 were oral cancers.[13] Many oral cancers are not diagnosed until they are in the advanced stages with significantly higher mortality rates.[14] The National Oral Health Plan 2015-2024 recognises the important role that dental practitioners play in screening and early detection of oral cancers, which markedly improves five-year survival rates.[1]

Oral diseases are a major financial cost to the South Australian community with individual's out of pocket payments contributing the largest source of funds for total dental expenditure. The 2016/17 dollars spent on dental services in South Australia were provided through individual out-of-pocket payments ($169m), health insurance funds ($164m), the Commonwealth Government ($126m) and the State Government ($56m).[15]

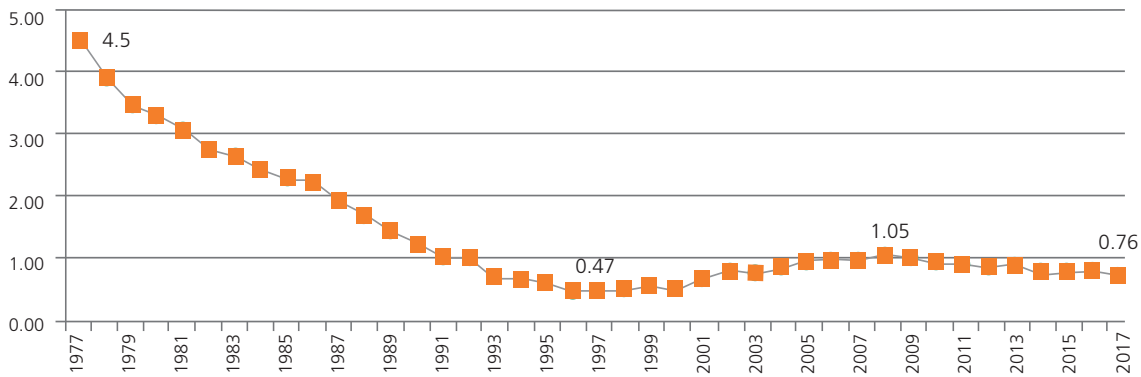
3.2 Children

According to the National Child Oral Health Study 2012-2014 (NCOHS), despite some improvement, child oral health remains a significant population health issue with a clear social gradient in oral health status.[9] Poor oral health early in life is the strongest predictor of poor oral health in adult life.

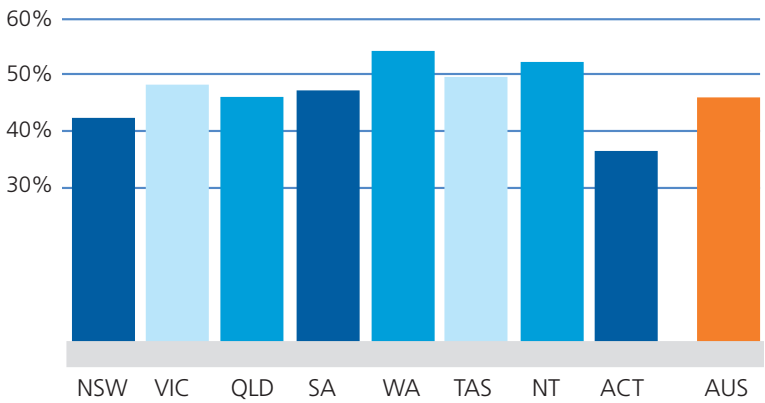
From the 1970's through to the 1990's there was a significant reduction in dental decay among South Australian children. This was largely due to water fluoridation, use of fluoride toothpaste and increased access to dental care focused on prevention and early intervention.

The 12 year old DMF(T)[ii] of South Australian children enrolled in the School Dental Service (SDS) decreased steadily from 4.5 in 1977 to 0.47 by 1996. However, over the next decade the 12 year old DMF(T) of children accessing SDS doubled to 1.05 by 2008.

SA School Dental Service - 12 year old Mean DMFT



Source: SA Dental Service Evaluation Unit: unpublished data (2018)



Proportion of children (2-17 years) accessingoral health care through a Government funded oral health program (Jul 2014 - Jun 2016)

Sources: State/territory public dental service data Australian Government Department of Human Services

Stemming the decline in child oral health was one of the 11 themes of the inaugural SAOHP. As a result of deliberate and sustained activities, good progress has been made and the DMF(T) of children enrolled in the School Dental Service has shown substantial improvement in recent years. South Australia and the Australian Capital Territory (ACT), have the lowest prevalence and severity of dental decay in the child population across the States and Territories.[9]

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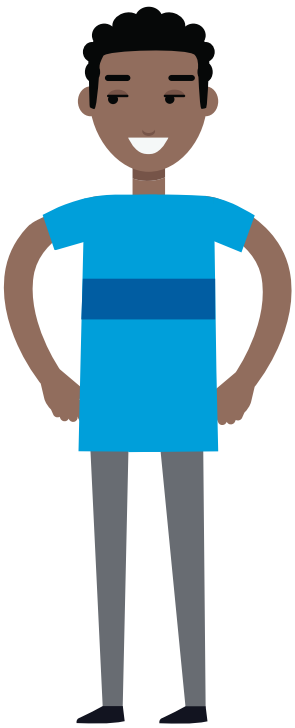
ii The DMF(T) index is the mean number of Decayed, Missing or Filled Permanent Teeth and is a measure used to quantify dental health. Twelve year old DMF(T) is recognised as an international measure for child oral health.

However, the NCOHS 2012-2014 demonstrated that the gains have not been consistent across all age groups and that there is a higher prevalence of dental decay in particular socio-economic, geographic and demographic groups.[16] Nationally and in South Australia, there is a higher prevalence and severity of untreated dental decay and total decay experience among children who are:

> Aboriginal and/or Torres Strait Islander
> from families where parents had school–level education
> in low income households
> living in remote or very remote areas, and/or
> whose last dental visit was for a problem, rather than a check-up.[9]



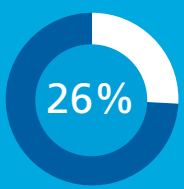
3.3 Adults

Current South Australian population data is not available for people aged 15 years and over. The most recent national population wide data is from the National Study of Adult Oral Health (NSAOH) 2004 - 2006; a new National study commenced in 2017.[6] The average decay experience in adults decreased between 1987 and 2006, due to a decline in the average number of teeth with untreated decay, attributed to improved access to dental care over this period. However, decay experience is still disproportionate across the social gradient and for specific populations.

Average DMFT scores are higher for Aboriginal and Torres Strait Islander people and older age groups, whilst adults from regional areas have the highest average number of teeth missing due to decay. Uninsured people have a higher level of untreated decay and teeth missing due to decay. Insured adults have more filled teeth with less untreated decay or missing teeth which is consistent with receiving timely dental care.[6]

One in five South Australian adults (19.8%) experience moderate to severe gum disease, with prevalence increasing with age.[6]

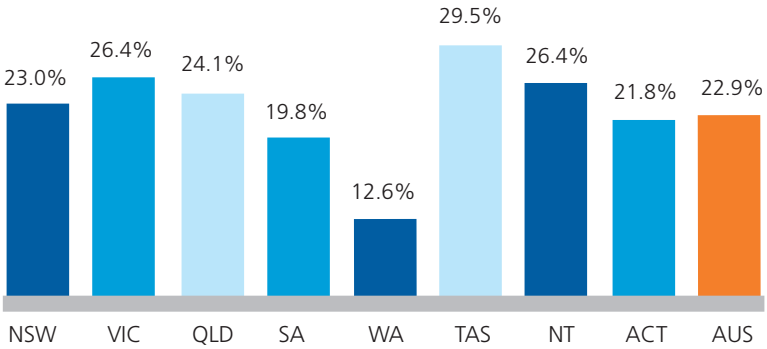
Proportion of dentate South Australian adults with untreated tooth decay



aged 15-64 years

aged 65+ years

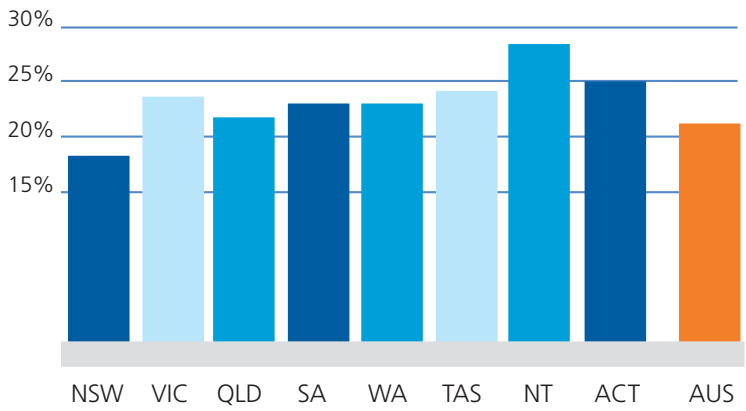
Proportion of dentate young people and adults (15+ years) with moderate or severe gum disease



Source: National Survey of Adult Oral Health 2004 - 2006

People on low incomes have less favourable dental visiting patterns than people from higher income households. The cost of dental care is frequently reported as a barrier to accessing care, even more so than the cost for general health care.[6] Concession card holders are more likely to avoid care or delay recommended treatment due to cost.[1]

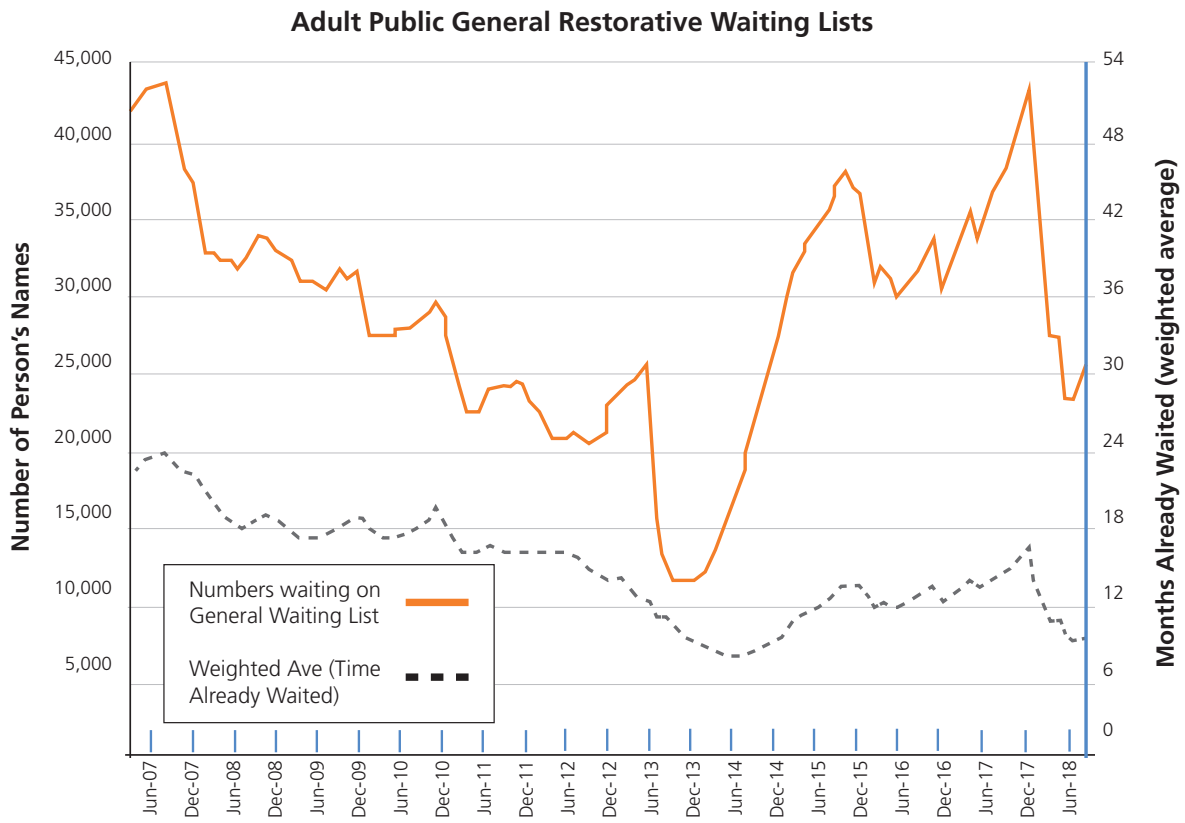
While public dental services ideally provide a comprehensive safety net for access to dental care, the reality is that only a small proportion of eligible adults access the public system and waiting times can be long.[1] For example, in a two year timeframe the South Australian Dental Service treated approximately 23% of the eligible adult population, which is similar to the National average of approximately 21%.



Proportion of adults (18+ years) eligible for state/territory provided public dental services who access care (Jul 2014 - Jun 2016)

Sources: State/territory public dental service data

In South Australia, public general adult restorative waiting lists have improved over the past decade with fewer people waiting for general restorative care, for less time.



Source: SA Dental Service Evaluation Unit: unpublished data (2018)

3.4 Priority Populations

People with self-assessed low health status are more likely to have experienced other factors of disadvantage.[5] People experiencing multiple disadvantages have poorer outcomes across a range of health and wellbeing indicators which can be perpetuated across generations.[6] Unfortunately, children and adults at highest risk of oral disease have the greatest difficulty in accessing care due to the compounding effect of multiple disadvantages. Evidence demonstrates that there are particular populations which experience the impacts of untreated dental decay more frequently and consistently and benefit from targeted oral health strategies.[3]

The South Australian Oral Health Plan identifies eight priority populations, including children and adults, for whom targeted action is required due to additional access barriers and higher oral disease burden:

- People who are socially disadvantaged or on low incomes
- People living in regional and remote areas
- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse people
- Frail older people
- People living with mental illness
- People with disabilities
- People with complex medical conditions

3.4.1 People who are socially disadvantaged or on low incomes

Adults who are socially disadvantaged or on a low income have more than double the rate of poor oral health than those on higher incomes, including higher rates of untreated dental decay and higher rates of tooth loss.[6] People living in low income houses are more likely to be uncomfortable with their dental appearance, experience toothache and avoid certain foods because of dental problems.[6]

Reasons for this are multi-dimensional, including affordability of care, communication and language barriers, transport challenges and appropriateness of service delivery.[3] In addition, people who seek dental care for a dental problem rather than a check-up are less likely to receive comprehensive treatment plans and preventive services, due to the extent of treatment required, resulting in less favourable outcomes.[6]

Research indicates that people who are socially disadvantaged, particularly women and children, are more likely to experience abuse.[17] Violence, abuse and trauma are associated with poorer health outcomes, including oral health, and victims require trauma-informed care to meet the unique treatment needs of these clients.[18]

3.4.2 People living in regional and remote areas

Across all measures surveyed in the 2013 National Dental Telephone Interview Survey, people living in regional and remote areas had poorer oral health compared with those living in major cities.[6]

Untreated tooth decay and tooth loss were higher and the frequency and recency of attendance at dental services were all lower in comparison to urban and metro populations.[6] Reliance on public dental services is higher for the regional and remote population, but there are fewer dental practitioners available in these areas resulting in access limitations. In addition, limited resources, affordable and accessible transport, fluoridated water supplies, affordable healthy food and oral hygiene products and higher service delivery costs contribute to poorer access and oral health outcomes.[20]

3.4.3 Aboriginal and Torres Strait Islander people

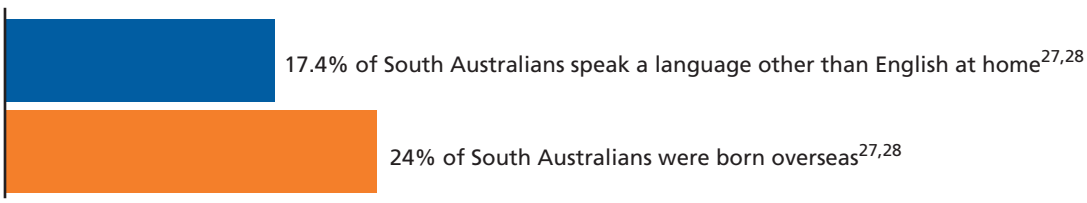
Differences in the social determinants, health risk factors and access to health care services contribute to the health gap between Aboriginal and Torres Strait Islander people and the rest of the population.[21] Many Aboriginal and Torres Strait Islander people experience multiple factors of disadvantage which compound their burden of disease.[22] For example, Aboriginal and Torres Strait Islander people experience a higher burden of chronic diseases, whilst a large proportion of Aboriginal and Torres Strait Islander people live in rural and remote areas with the associated limitations to health care access.[23,24]

Aboriginal and Torres Strait Islander people experience poorer oral health in comparison with the rest of the population.[25] Aboriginal and Torres Strait Islander children experience higher levels of decay in deciduous (baby) teeth, whilst dental decay, tooth loss and periodontal disease are higher for Aboriginal and Torres Strait Islander adults.[6,26]

Culturally appropriate, acceptable and safe dental services, integrated and co-located with primary health systems, are required to close the oral health gap.

3.4.4 Culturally and Linguistically Diverse people

The Australian Bureau of Statistics (ABS) defines cultural and linguistic diversity (CALD) using country of birth, language other than English spoken at home and English language proficiency.

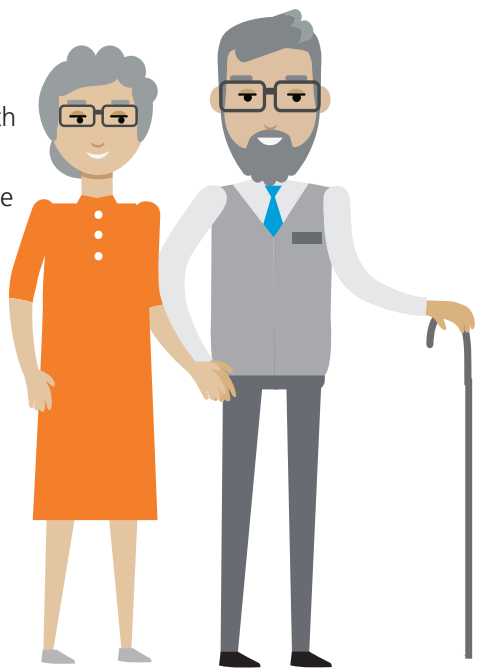


People with low English proficiency often experience high levels of disadvantage and multiple barriers to accessing services related to cultural translation and communication difficulties, challenges in navigating the health system and either unemployment or low-income employment. In particular there are substantial barriers for older people from CALD backgrounds to accessing health, aged care and community services.[29,30]

3.4.5 Frail older people

One in six people living in South Australia are over the age of 65 (18.3%) and South Australia has the highest proportion of people aged 85 years and over (2.7%).[31] In the 2016 Census, half of the people aged 85 years reported a need for assistance with a core activity such as mobility, communication or self-care.[31]

Accessibility to health care services is a particular issue for older Australians including challenges related to transport, physical access and the cost of care.[1]



Older people have higher rates of dental decay, moderate and severe gum disease and residents in care facilities have a higher prevalence of oral health problems.[6] Frail older people often require support in the maintenance of oral hygiene to avoid the adverse impacts of poor oral health on their overall health.[32]

The dental needs of frail older people are often complicated by multiple comorbidities and poly-pharmacy issues which increase the complexity of treatment and impact oral health (e.g. medications which cause dry mouth). The prevalence of dementia further contributes to the need for targeted oral health strategies for this population.[1]

3.4.6 People living with mental illness

In 2017-18, one in five Australians (20.1%) reported having a mental or behavioural condition and 3.6 million Australians (15.8%) reported co-existing long-term mental, behavioural and physical health conditions.[33]

Many people living with mental illness experience co-morbidities and multiple risk factors for poor oral health. Excessive alcohol and caffeine consumption, drug use and smoking, as well as dry mouth from the side effects of prescribed medications, negatively affect oral health.[34]

People living with mental illness have, on average, six more decayed, missing or filled teeth and are three times more likely to have lost all their teeth than people without mental illness.[1, 35]

People living with mental illness are often disconnected from the general and oral health system, are disproportionately affected by unemployment or low income and are more likely to live in unstable accommodation or experience homelessness.[36] Poor mental health can contribute to higher rates of potentially preventable hospitalisation.[6]

3.4.7 People with disabilities

In the 2015 Survey of Disability, Ageing and Carers, almost one in five Australians (18.3%) reported living with disability. More than 50% of those with a disability reported having two or more intellectual, psychiatric, sensory/speech, acquired brain injury or physical/diverse disabilities.[37]

There is no national oral health data on people with disabilities; however dental service profiles indicate that people with disabilities suffer from poorer oral health when compared with the general population.[38]

The majority of people with disabilities are on a disability support pension or access other allowances and concessions, and cost is frequently reported as a barrier to accessing health services.[39]

Many people with a disability may not perceive or may be unable to express their need for oral health care. Carers may see oral health care as a lower priority or may lack time or resources to support daily oral hygiene or regular dental care visits.[38]

3.4.8 People with complex medical conditions

In 2015, 50% of Australians had at least 1 of 8 selected chronic conditions.[22] The likelihood of having one or more chronic disease increases with age and increasing numbers of Australians have several complex and often chronic medical conditions.[38]

There is strong evidence linking poor oral health and chronic conditions, in particular the association between periodontal disease and cardiovascular disease, diabetes, osteoporosis, obesity and malnutrition.[40]

Management of certain medical conditions, including infectious diseases and immune suppressing conditions, requires good oral health to prevent serious or potentially fatal complications.[41]

People with complex medical conditions may also experience oral health complications due to the treatment of their underlying condition. However, oral health care is not consistently included in general health care for people with complex medical conditions, resulting in sub-optimal care and less favourable outcomes.[1]

4 THE ORAL HEALTH WORKFORCE

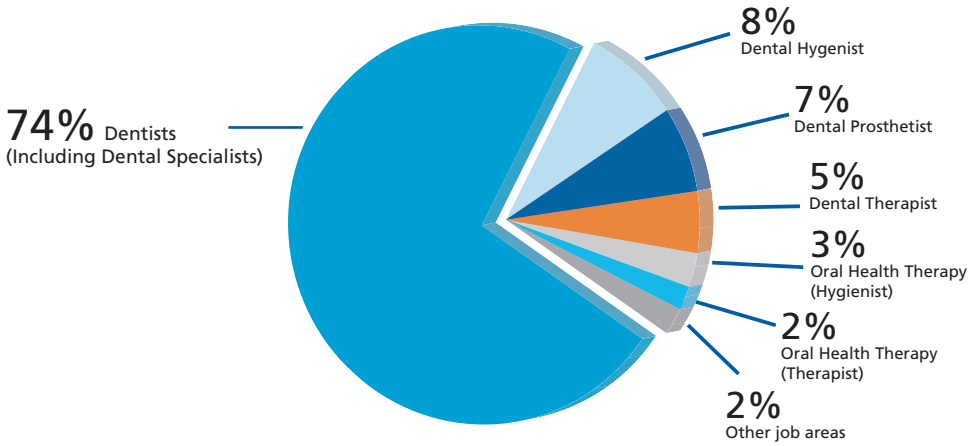
The oral health workforce comprises registered dental practitioners (dental hygienists, dental prosthetists, dental specialists, dental therapists, dentists, and oral health therapists), non-registered dental assistants and dental technicians.[1] South Australia compares favourably to other jurisdictions with a relatively higher number of dental practitioners per 100,000 population.

Distribution of dental practitoners in Australia by State/Territory, 2016

2016 State and Territory	Headcount	Total FTE	Avg. total hours	Rate per 100,000 population
NSW	6,025	5,724.3	36.1	77.8
VIC	4,589	4,230.4	35.0	74.3
QLD	4,067	3,885.6	36.3	83.9
SA	1,630	1,412.3	32.9	95.1
WA	2,331	2,062.5	33.6	91.1
TAS	345	339.5	37.4	66.7
ACT	357	342.1	36.4	88.5
NT	140	137.9	37.4	57.0
TOTAL	**19,490**	**18,139.6**	**35.4**	**80.5**

Source: NHWDS Data Tool and Resources, Australian Government, Department of Health 2016

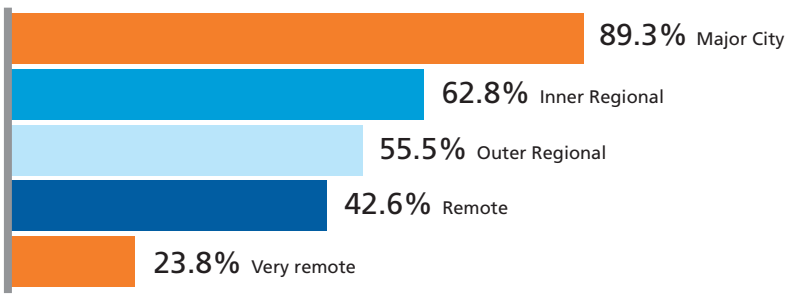
FTE rates of dental practitioners per 100,000 population 2016 by remoteness areas



Source: NHWDS Data Tool and Resources, Australian Government, Department of Health 2016

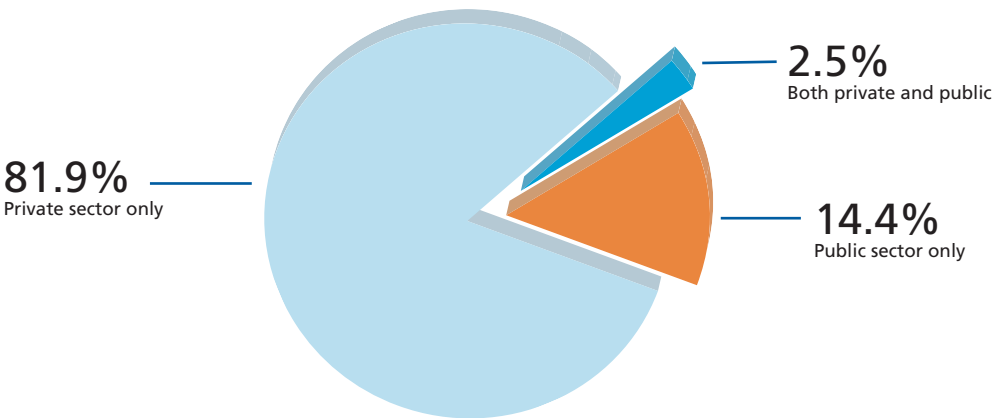
The national trend of fewer dental professionals practising in rural and remote areas holds true for South Australia, making access to care challenging in these areas.

Distribution of employed dental practitioners by remoteness area, 2016



Source: NHWDS Data Tool and Resources, Australian Government, Department of Health 2016

Percentage of dental practitioners per dental sector, 2016



Source: NHWDS Data Tool and Resources, Australian Government, Department of Health 2016

5 ORAL HEALTH SECTOR IN SOUTH AUSTRALIA

A number of stakeholders across government, non-government organisations and associations contribute to the oral health sector.

5.1 Private dental sector

The private dental sector offers oral health care to adults and children and is the only dental service option for non-concession card holder adults. Both nationally and in South Australia the private dental sector is the largest provider of oral health care.[42]

5.2 Public dental sector

SA Dental Service provides universal access to dental services for all South Australian children under 18 years through the School Dental Service (SDS). The Community Dental Service (CDS) and Adelaide Dental Hospital (ADH) provide dental services for South Australian adults with eligibility limited to current concession card holders. Specialist services are provided at the ADH. SA Dental Service works in partnership with the University of Adelaide and TAFE to educate and train many of the State's oral health workforce.

The Royal Flying Doctor Service operates a Commonwealth funded Dental Outreach Program which provides dental services for clients in specific rural and remote areas.

5.3 Public hospitals

Flinders Medical Centre operates a dental clinic for hospital inpatients. The Women's and Children's Hospital operates a tertiary specialist paediatric dental unit. The Royal Adelaide Hospital, The Queen Elizabeth Hospital and SA Dental Service operate a joint specialist Oral and Maxillofacial Surgery Unit in partnership with the University of Adelaide.

5.4 Academic, education and research sectors

5.4.1 University of Adelaide

The University of Adelaide provides undergraduate training for dentists and oral health therapists and a range of post graduate courses and specialist training. Student oral health practitioners gain most of their clinical experience in South Australian Dental Service clinics and contribute to public dental service delivery.

The University of Adelaide, via its Community Outreach Dental Program, provides dental and other health services for people experiencing homelessness or who have difficulty accessing conventional care. Services are provided on a voluntary basis by University of Adelaide staff, students, private dentists and allied health professionals.

5.4.2 Australian Research Centre for Population Oral Health

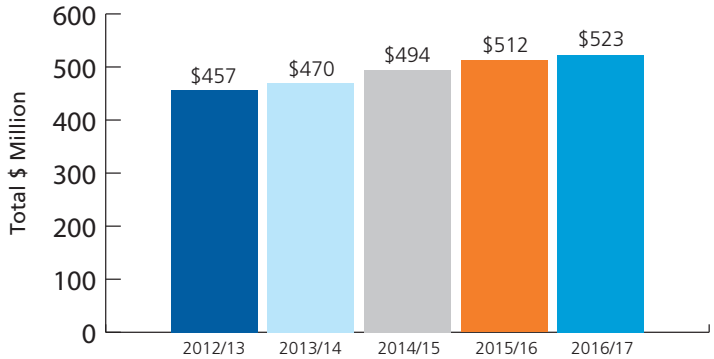
Established at the University of Adelaide, the Australian Research Centre for Population Oral Health (ARCPOH) undertakes research and training in population oral health. In partnership with the Commonwealth Departmentof Health and State/Territory Health Departments, ARCPOH is conducting the National Study of Adult Oral Health 2017-2018. Previous national child and adult studies have also been led by ARCPOH.[43]

5.4.3 TAFE

TAFE SA provides training for dental hygienists, dental technicians and dental assistants and delivers courses in radiography and dental practice management.

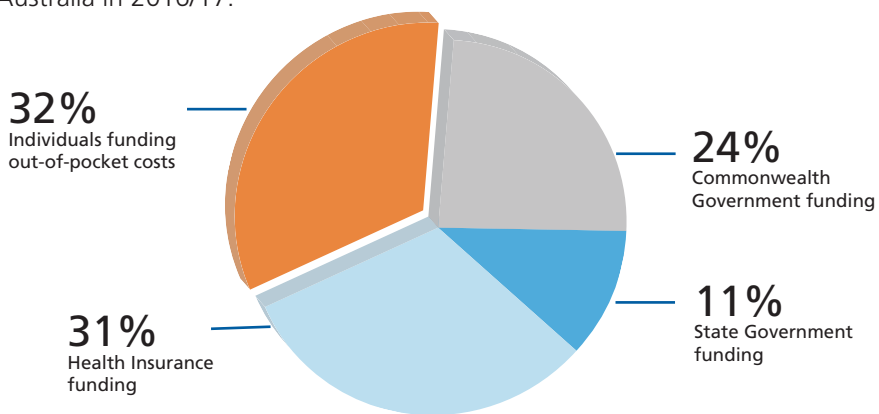
5.5 Funding arrangements for oral health in South Australia

Total expenditure on dental services in South Australia has increased slightly in recent years between 3% to 5% each year from $457m in 2012/13 to $523m by 2016/17.[15]



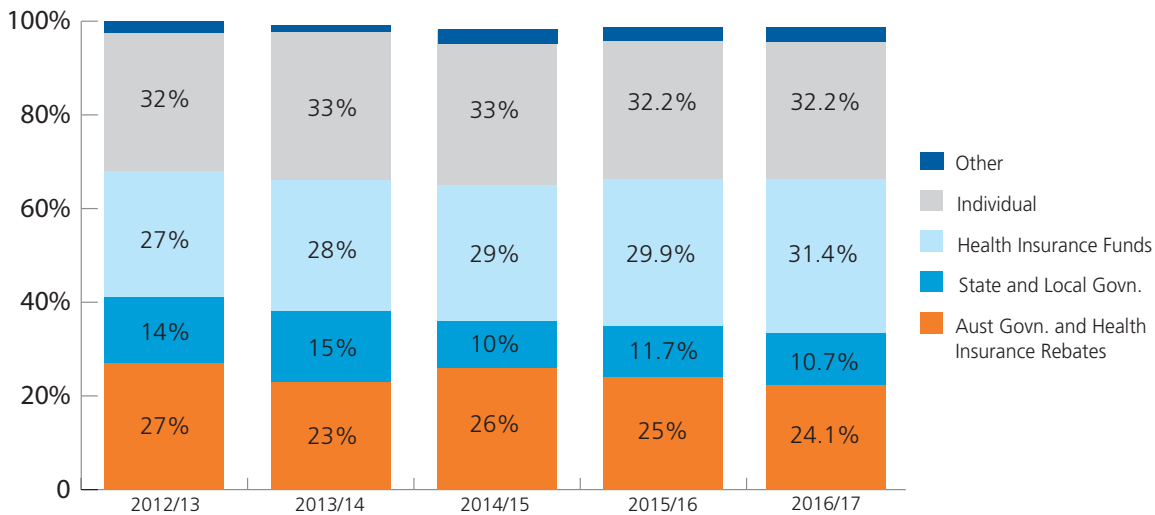
Source: Australian Institute of Health and Welfare 2018. Health expenditure Australia 2016-17.

Oral health funding arrangements have remained relatively stable over the past several years with the following breakdown for South Australia in 2016/17:[15]



The proportion of out-of-pocket costs for individuals for dental care is consistently higher than all other health services both nationally and in South Australia.

Percentage of Total Dental Expenditure SA 2012-2017

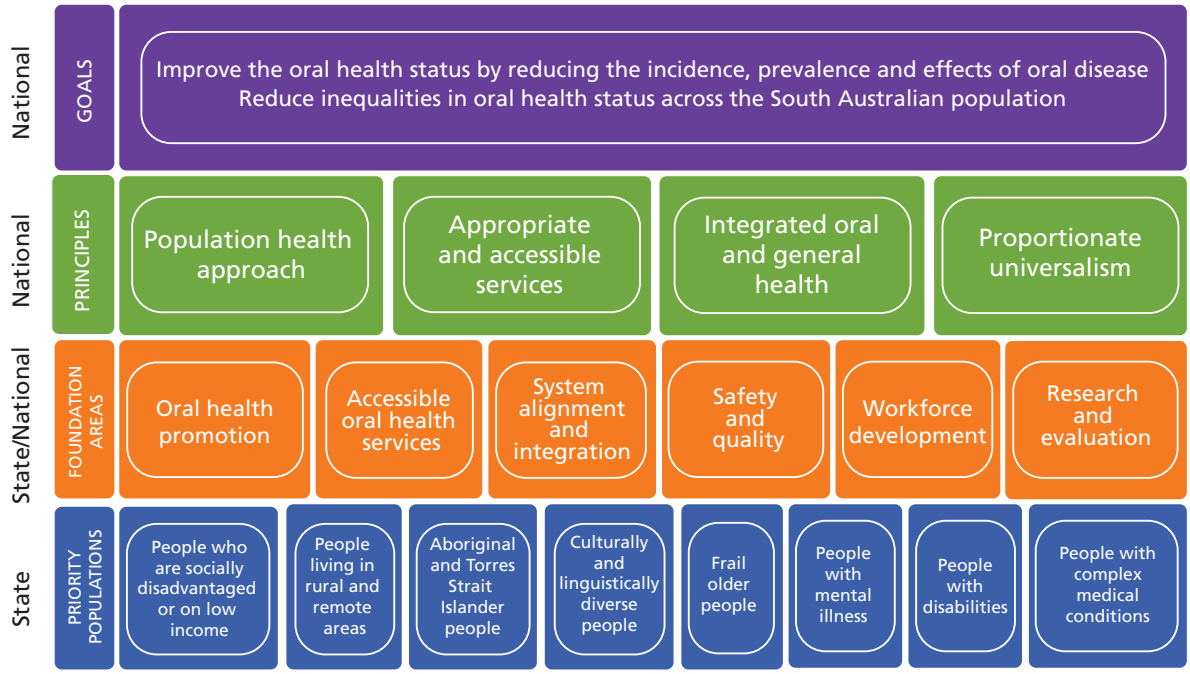


Source: Australian Institute of Health and Welfare 2018. Health expenditure Australia 2016-17

6 FRAMEWORK FOR THE SA ORAL HEALTH PLAN

6.1 Alignment with the National Oral Health Plan

The National Oral Health Plan 2015-2024 is based on two national goals, four guiding principles, six foundation areas and four priority population groups. The South Australian Oral Health Plan 2019-2026 aligns with this framework outlining action areas related to the six foundation areas of the National Plan. The thirty action areas are specific to the South Australian context and include eight specific priority populations.



6.2 Links with SA Health Plans

It is expected that the South Australian Oral Health Plan 2019-2026 strategies align with the SA Health Strategic Plan 2017-2020 and associated policies. The following South Australian plans, reports and frameworks identify oral health as an attribute of general health and wellbeing and support the South Australian Oral Health Plan:

- Health and Wellbeing Strategy 2019-2024
- South Australian Mental Health Strategic Plan 2017-2022
- South Australian Alcohol and Other Drugs Strategy 2017-2021
- South Australian Tobacco Control Strategy 2017-2020
- South Australian Public Health Plan 2019-2024
- Chief Public Health Officers report 2014-2016
- Aboriginal Health Care Plan 2010-2016
- SA Health Aboriginal Workforce Framework 2017-2022
- SA Aboriginal Health Needs and Gaps Report 2017
- SA Health and Local Health Network Reconciliation Action Plans

6.3 Implementation and Monitoring

A monitoring group of key stakeholder representatives, including community, will be established to advise on the implementation of the South Australian Oral Health Plan 2019-2026, identify the lead agencies and partners involved and report against National Oral Health Plan 2015-2024 indicators within the South Australian context.

7 SA ORAL HEALTH PLAN 2019-2026 ACTION AREAS

Collaboration with key stakeholders and partners across public and private sectors will be required to develop and implement strategies related to the following action areas. Where relevant, strategies should address the specific needs and impacts on children and adults of the eight priority populations.

1 ORAL HEALTH PROMOTION AND PREVENTION

GOAL: Provide evidence-based oral health information and programs

Oral health promotion aims to address the upstream causes of oral disease and promote preventative interventions. Multiple, evidence-based interventions are available at individual and population levels.

Collaboration across the dental and broader health and education sectors is important for:

- Creating supportive environments
- Improving oral health literacy
- Integrating oral health and general health
- Addressing the social determinants of health.

1.1 Optimise preventive effects of fluoride

Maintain current water fluoridation access and promote alternate forms of fluoride for people without access to fluoridated water supplies

The National Health and Medical Research Council has confirmed that Australian community water fluoridation programs are a safe, effective and ethical way to reduce dental decay across the population.[44]

Socially disadvantaged children and adults with high rates of dental decay and limited access to dental treatment and other forms of fluoride, benefit from water fluoridation.[20] Water fluoridation is a population level prevention strategy in line with the principle of proportionate universalism.[45] In South Australia, 92% of people have access to optimally fluoridated water. [20] This is slightly higher than the national average of 89% and is similar to other jurisdictions.

It is widely accepted and recommended that individuals brush their teeth twice daily with fluoridated toothpaste as an important oral health promotion practice. The National Child Oral Health Study 2012-2014 and the Australian Dental Association Oral Health Tracker Technical Paper indicate that the rate of twice daily brushing for Australian children (68.5%) and adults (51%) could be improved.[46] Regular, twice daily toothbrushing with an appropriate fluoride toothpaste should be promoted, especially in areas without water fluoridation.

Water fluoridation is the primary source of fluoride exposure and helps reduce dental decay for all, at all stages of life.

Alternate forms of fluoride, such as fluoride varnish programs can be used for communities with limited or no access to water fluoridation. Legislation changes are required to enable non-registered practitioners, such as dental assistants and Aboriginal Health Care Workers, to apply fluoride varnish.

1.2 Increase oral health literacy

Promote national key oral health messages across health, education and community settings, using a wide range of promotion channels

According to the AIHW's 16th biennial report on the health of Australians, only 41% of Australians aged 15–74 were assessed as having adequate or more than adequate health literacy skills.[47]

The Australian Commission on Safety and Quality in Health Care identifies individual health literacy and the health literacy environment as the core components contributing to overall health literacy levels. Strategies aimed at increasing health literacy should focus on building the capacity of individuals as well as the capacity of the health system to support individuals in making healthy choices.[47]

Low health literacy is a risk factor for poor health and has been shown to impact the safety and quality of healthcare, and contribute to higher healthcare costs.[48]

It is important that evidence-based recommendations for personal preventive behaviours are consistent, simple and widely available to health professionals and the public. Eleven evidence-based oral health promotion messages were developed in 2009 for the Australian public and are aligned with recommended general health messages regarding breastfeeding, tap water, nutrition and smoking cessation.[1]

These messages should be promoted by the oral health sector and the wider health and education sectors in traditional and non-traditional environments.

Improve the oral health literacy of priority populations and build their capacity to make healthy choices

An individual's health literacy refers to their ability to access, understand and apply information to make effective decisions about their health and healthcare. Improved health literacy can affect a person's ability to navigate the health system, seek support from health professionals and understand treatment and prevention instructions.[46]

Health literacy is influenced by individual factors such as level of education, cultural background, and the health care environment. Low health literacy amongst socially disadvantaged and low income earners compounds the health disparities experienced by these groups.[46]

Strategies to improve oral health literacy of priority populations should include the provision of specific, culturally sensitive oral health information, using plain language and simple diagrams and pictures.[1]

1.3 Promote oral health and nutrition

Strengthen and embed oral health and nutrition policies in early childhood, education and community settings

Poor nutrition, especially high sugar consumption, is a risk factor for dental decay. Embedding oral health and nutrition standards and policies focused on reducing sugar consumption across non-dental settings is an important strategy for reducing the prevalence and severity of dental decay, particularly in the early childhood years.

The Council of Australian Governments (COAG) Health Council endorsed five actions in 2016 to limit the impact of unhealthy food and drinks on children, which includes collaboration across health, education and the sports and recreation sectors.[49]

It is important that these sectors facilitate health promoting partnerships to provide expertise and evidence-based resources focused on healthy eating and drinking messages, standards and policies. Child Care, pre-school, school and sports/recreation settings are key environments for developing healthy habits for life-long impacts.

Promote the benefits of and advocate for affordable nutritious foods and oral hygiene products in regional and remote communities

Whilst the dental sector cannot directly affect the pricing of nutritious foods and oral hygiene products, it can play an advocacy role in raising awareness of the direct links between these enablers and positive oral health outcomes. Oral health promotion programs for regional and remote areas should take into account the specific barriers experienced outside major population centres, including the higher cost of nutritious foods and oral hygiene products.

1.4 Build capacity of health, education and community workers

Work with health professionals who interact with pregnant women, parents, carers, and children to ensure that they have the information they need to maintain good oral health at the key stages of childhood development

The importance of optimal childhood development and its impact on adult health and wellbeing warrants specific attention during key developmental stages. Despite being preventable, dental decay is one of the most common childhood infections, causing adverse impacts on individual quality of life and a high cost burden for families, communities and the health care system.[50]

Non-dental professionals can provide information and support for pregnant women, parents, carers and children regarding key preventive dental behaviours such as toothbrushing, the use of fluoride toothpaste and initiation of the first dental visit.

Non-dental professionals can also play a critical role in the detection of early childhood caries and referral for treatment.[4]

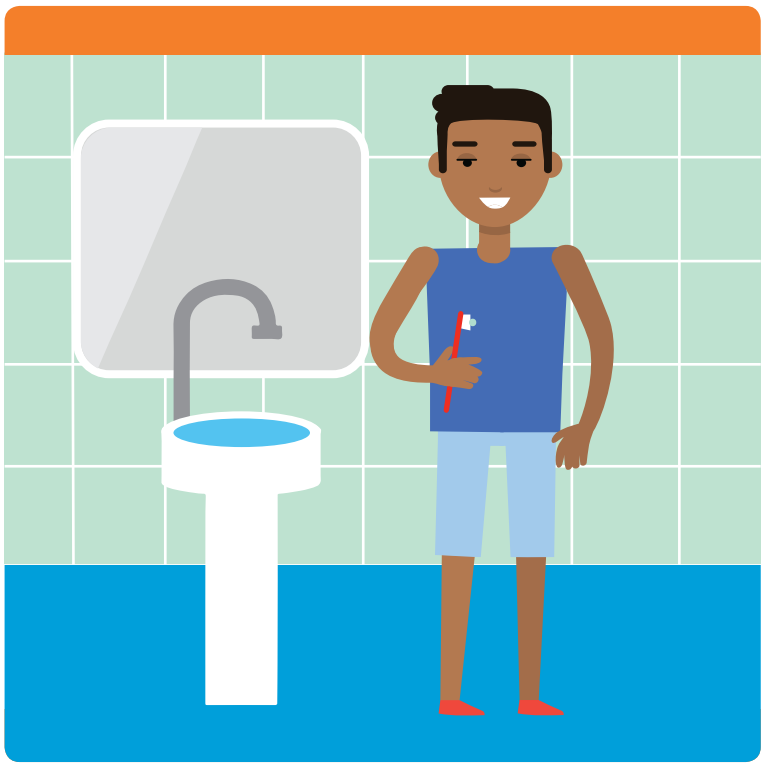
1.5 Integrate oral health and general health policy

Advocate for the integration of oral health in general health and education policies and plans at the local, state and national level

Integration across settings is an effective system-level strategy for improving access and health outcomes and reducing costs.

Early intervention and prevention to address common risk factors, such as high sugar consumption, alcohol and tobacco use and dry mouth, will impact the burden of preventable chronic diseases, including oral disease.

In South Australia, the Health in All Policies (HiAP) initiative and Public Health Partner Authorities (PHPAs) provide a framework for working across government agencies in developing public policies aimed at integrating oral health into population health and wellbeing strategies.[51]



2 ACCESSIBLE ORAL HEALTH SERVICES

GOAL: Provide South Australians with accessible oral health care

Service uptake is impacted by health literacy, the ability to perceive the need for services and by barriers which limit access. Clients should "have access" through service availability and should be able to "gain access", where services are approachable, acceptable, affordable and appropriate.[52]

2.1 Reduce transport barriers

Identify opportunities to reduce the impact of transport as a barrier to access

In most cases transportation is required for accessing health services. Whilst the dental sector is not able to provide transportation services to improve access, transportation opportunities should be considered when planning and reviewing dental services, policies and funding arrangements.

Identifying public transport routes, existing transport programs or funding schemes is especially important for priority populations.

2.2 Provide universal access for children

Maintain and promote universal access to publically funded dental services for all children until their 18th birthday

Regular check-ups, prevention focused dental care and specific programs targeting high risk children are the foundation for good oral health. The public sector School Dental Service was established based on principles of prevention and population health and is a universal service providing comprehensive dental care for all South Australian children until their 18th birthday.

The National Child Oral Health Survey highlights the lower disease rates of those jurisdictions with established school dental services. For example, whilst more South Australian children live in low income households than the national average, South Australian children have lower dental caries experience and untreated decay.

In addition, South Australian children have higher than national average initiation, frequency and recency of dental check-up visits and fissure sealants.[9]

The Commonwealth funded Child Dental Benefit Schedule (CDBS), implemented in January 2014, has increased access across both public and private sectors for children in families eligible for Family Tax Benefit A.[53] However, as noted in the fourth review of the Child Dental Benefits Act, utilisation rates have been lower than expected with only 38% of eligible children accessing the benefit in 2018.[54] Recommendations from the review included improved communication and promotion of the benefit and eligibility criteria.

2.3 Improve access for priority populations

Continue to work with the Commonwealth Government to ensure sustainable federal funding to support access for priority populations

The social gradient in health outcomes is especially pronounced for oral health with many people grappling multiple factors of disadvantage. Only one in five Australians can access the oral health care they need and almost 6 million Australians live with at least one untreated oral health issue.[55]

Whilst the public dental sector runs programs for priority populations, it can only accommodate about one fifth of the eligible population every two years, resulting in long public dental waiting lists.[6] The Commonwealth funded National Partnership Agreement (NPA) on Adult Public Dental Services is focused on reducing public dental waiting lists.[56] However, funding cycles and activity targets limit opportunity for long-term workforce and infrastructure investment. The bulk of this federal funding is expended through private sector dental schemes.

Work with the Australian Government to ensure that low income earners are able to receive regular dental check-ups and timely treatment

The overall out of pocket costs for dental care are much higher than any other healthcare costs, with 32% of annual dental care spend in South Australia contributed by individual out of pocket payments.[6]

Research has shown that despite being eligible for public dental services, concession card holders are more likely to avoid or delay care due to cost and report cost as a barrier to accessing recommended treatment.[1] In addition, the number of low income households is increasing, including low income earners not eligible for public dental care who are unable to afford dental care in the private sector.[57]

Financial burden is often cited as a reason why people do not seek regular dental care or comply with treatment recommendations.[6]

Maintain programs which increase access to dental services for Aboriginal and Torres Strait Islander people

Since the mid 2000's, SA Dental Service has implemented strategies to increase the number of Aboriginal and Torres Strait Islander people accessing publicly funded dental care in South Australia. The Aboriginal Oral Health Program uses multiple strategies to address a broad range of issues that might prevent Aboriginal and Torres Strait Islander people from accessing dental care and achieving good oral health.

Closing the Gap funding is used to employ Aboriginal and Torres Strait Islander project staff to raise awareness of oral health and community engagement with dental services. As a result the number of Aboriginal and Torres Strait Islander adults and children seen by SA Dental Service has increased significantly over the past ten years.[58]

The Aboriginal Health Council provides funding to SA Dental Service which contributes to clinical care for Aboriginal and Torres Strait Islander people in rural and remote areas. SA Dental Service works in partnership with the following organisations, providing funding for dental programs operated by:

- Tullawon Health Service based in the Yalata community,
- Umoona Health Service in Coober Pedy, and
- Nunkuwarrin Yunti in Adelaide.

Maintain priority access to public dental care for concession card holders who have complex medical conditions

Oral health care should be included in the coordination of health care for people with complex medical conditions as poor oral health can adversely affect the management of a number of medical conditions.[39]

Delays in the provision of dental care can have serious consequences; priority access to public dental services, via appropriate referral pathways from hospitals units and medical practitioners, is required.[1]

3 SYSTEM ALIGNMENT AND INTEGRATION

GOAL: Work together to support healthy mouths and healthy lives

Coordinated responses to reduce oral health service gaps and improve access are a challenge due to the complexity of the oral health system with multiple service providers, diverse funding sources and unregulated pricing.

Strategies focused on integrating oral health within the general health system require system alignment, collaboration and cooperation across the dental sector and broader health system.[59]

The limited capacity of regional and remote areas to sustain multiple health care service providers requires innovative strategies to maximise the use of available resources. Exploring opportunities for collaboration and partnership between private, public and non-government service providers is essential for the sustainability of service delivery.

Integrated and flexible service delivery models have the potential to maximise workforce capacity and capability.

3.1 Establish inter-sectoral collaboration

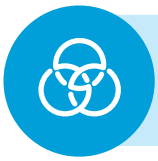
Facilitate inter-sectoral collaboration between the oral health and general health sectors at policy, program and service delivery level to improve integration and increase access for priority populations

Inter-sectoral collaboration between dental and general health care sectors is a cost-effective approach for improving access and providing efficient services, especially for priority populations. Successful collaboration facilitates active engagement from stakeholders and is more likely to result in sustainable policy, program and service delivery outcomes.

Targeting common risk factors, service mapping and raising awareness of available services with the local community are important strategies to improve system alignnment and integration.

Collaborative partnerships have been shown to improve service quality through innovation, information sharing and co-ordination. Collaborative health care providers tend to be more responsive and patient centred, leading to increased patient involvement in decision-making and engagement in healthy behaviours.[60]

3.2 Develop integrated models of care



Develop evidence-based models of care that incorporate oral health education, prevention and screening in the general health sector

Recent publications indicate that primary health care providers don't often consider oral health care in their care planning due to a lack of knowledge and awareness of the impact of oral health on general health and wellbeing.[61]

The lack of healthcare policies and strategies which include oral health, as well as inadequate interdisciplinary training and workload increase, are all listed as common barriers to integrated general and oral health care. The perception of oral healthcare needs, by both the patient and primary healthcare provider, is also a major contributing factor as oral health conditions are rarely life threatening and therefore not often prioritised.[57]

Preventive oral health care and effective self-care strategies should be integrated into primary health care settings, with training provided for screening and referral for dental treatment.

Incorporate oral health into existing screening, care planning and care processes for carers and care workers of frail older people

Oral health is a significant factor affecting older people's quality of life and overall health and wellbeing. Tooth decay, tooth loss and use of dentures, gum disease and dry mouth are commonly experienced by older people.[6]

Carers and care workers are well placed to support maintenance of oral hygiene, recognise oral health problems and incorporate oral health into care planning and dental referral processes.[32]

Ongoing educational and support programs are required to sustain oral health literacy in a workforce with high staff turn-over, as well as building the capacity of the emerging aged care workforce. Effective strategies for integrating oral health into daily hygiene, general health assessment and care planning processes are available through Better Oral Health Care resource packages.[62]

The ability of carers and care workers to maintain and improve the oral health of older people has been effectively demonstrated [32]

Support non-dental professionals to undertake a simple, evidence-based oral health screen and referral for children from birth to 5 years

Integrating oral health best practise into models of care for general health optimises patient outcomes and strengthens health professionals understanding of the relationship between oral health and general health. The SA Dental Service Children's Population Oral Health Program is a primary prevention approach for 0-5 year olds, particularly those children at risk of developing early childhood caries. The program provides training for non-dental professionals to promote oral health messages and screen young children for early childhood caries. A simple referral pathway for priority dental treatment in the public or private dental sector is available for young children with early childhood caries.[63]

Evaluation of the Children's Population Oral Health Program showed the evidence-based Lift the Lip screening and referral tool was accurate and effective for use by non-dental professionals.[57] The Program has been successfully integrated into the child health assessments conducted by the Child and Family Health Service nurses across South Australia.[60]

3.3 Optimise technology for integration

Optimise the use of technology to enhance oral health service delivery and increase health system integration in South Australia

E-health technologies such as online education, electronic health records and web-patient portals could be used to facilitate information sharing, system alignment and integrated care. Technologies such as telehealth, especially for specialist care, may deliver long term cost efficiencies allowing resources to be redirected to other service delivery costs.

Technology in dentistry can provide opportunities for communication and the exchange of clinical information and images for dental consultation, diagnosis and treatment planning. This has the potential to improve access and engagement with clients and ultimately minimise the disparities between rural and urban service delivery, ultimately reducing costs in the long term.[65]

4 SAFETY AND QUALITY

GOAL: Provide safe, quality oral health services

In August 2012, the Australian Health Ministers endorsed the first Australian Safety and Quality Goals for Health Care, which include:

Safety of care
That people receive health care without experiencing preventable harm

Appropriateness of care
That people receive appropriate, evidence-based care

Partnering with consumers
That there are effective partnerships between consumers healthcare providers and organisations at levels of healthcare provision, planning and evaluation.[66]

Accreditation against the National Safety and Quality Health Service (NSQHS) Standards is required for all public dental clinics and services and is voluntary for private dental practices. Ensuring continuous improvement in the safety and quality of oral health services should be a priority for all stakeholders of the oral health system.

4.1 Maintain dental service infrastructure

Ensure oral health service infrastructure is maintained at a standard which supports the delivery of high quality, safe services

In order to provide high quality, safe services, dental service infrastructure needs to be maintained and upgraded to meet contemporary standards.[65] This not only impacts the quality of dental services provided, but is also important for supporting clinical training for dental students and attracting and retaining a high calibre dental workforce.

It is important that where possible, dental services are located in health precincts to improve access and enhance collaboration and co-ordination of health services.

4.2 Facilitate consumer engagement

Involve consumer representatives and stakeholders in the planning, design, delivery and evaluation of oral health services in South Australia

The National Safety and Quality Health Service (NSQHS) identifies consumer-centred care as one of three dimensions required for a safe and high-quality health system in Australia, emphasising the importance of placing consumers at the centre of the healthcare system.[65]

Consumer participation should occur across the three levels of service delivery, namely individual care, program planning and design, as well as organisational governance. There is clear evidence that consumer engagement improves consumer experience, the quality of health care and delivers a range of service benefits, including:

> Increased compliance with prescribed treatments
> Reduced anxiety and greater confidence in the treatments received
> Improved consumer management, safety and service delivery
> More responsive and innovative programs, and
> Cost savings through decreased use.[1]

NSQHS Standard 2 - Partnering with Consumers provides a framework for health services to create an environment that is responsive to patient and carer input, needs and priorities.[65]

Involve Aboriginal and Torres Strait Islander community and stakeholders in the planning and delivery of oral health services in South Australia

The second edition of the NSQHS Standards defines six actions to specifically meet the health care needs of Aboriginal and Torres Strait Islander people, including improved consumer engagement and cultural safety of health services.[68]

Community and consumer engagement from a strengths-based approach recognises the critical importance of culture as a health protective factor for Aboriginal and Torres Strait Islander people and is underpinned by cultural respect, meaningful engagement and genuine partnerships with families and communities.

Development of strategies to improve the physical health and wellbeing of Aboriginal and Torres Strait Islander people requires a holistic approach that incorporates the social and cultural context of the community.

Community engagement requires a relationship built on trust and integrity between groups of people working towards shared goals and should occur through partnerships with Indigenous organisations such as community-controlled health organisations.[68] Active community participation, local decision-making, locally controlled resources, and respectful support by non-Aboriginal partners are critical for effective engagement and service delivery.

4.3 Implement oral health standards across sectors

Collaborate with peak bodies to develop and implement oral health standards and tools across sectors

Oral health components are included in the accreditation standards of a few health services and industries (e.g. Mental Health, Child Care, Aged Care). Developing oral health tools and standards across various sectors is an important policy-level strategy to raise awareness of the impact of oral health on general health and wellbeing and include the non-dental sector in responding to poor oral health outcomes.

5 WORKFORCE DEVELOPMENT

GOAL: Ensure the oral health workforce meets the needs of the community

Access to care is dependent on the availability of an oral health workforce with the appropriate composition, size and capacity to meet the community's needs for prevention and treatment of oral health conditions.

Sustainable education programs developed in partnership between the tertiary education sector and dental service sector are required to ensure sufficient supply of qualified South Australian based oral health providers. Dental and oral health students gain much of their clinical training by treating public patients in public dental clinics. This is enhanced by the support of clinical leadership from dental specialists, including those in the tertiary education sector.

Ongoing training, support and professional development is critical for building a workforce with high-level skills and capacity to provide safe, high quality oral health services.

5.1 Build workforce capacity to meet the needs of priority populations

Build capacity in the oral health sector to effectively address the needs of priority populations

Training and professional development for the oral health workforce should reflect the competencies required to address the needs of priority populations. The existing and future oral health workforce need to work as part of multidisciplinary teams to address the needs of Priority Populations.

For people with additional or specialised needs, the combination of multiple disadvantages and health challenges results in complex oral health needs. These additional and specialised needs often require specialised dental services which often have long waiting lists due to resource constraints.[1] Increased competency amongst the broader workforce is required to address the needs of people with additional and/or specialised health care needs.

Education and training for general dental practitioners through the South Australian Special Needs Dentistry Network is an effective method for building capacity and expanding access. Expandedrural scholarships and rural placements for students are important incentives to addressing mal-distribution of oral health workforce across regional and remote service sites.

5.2 Cultural competency of the oral health sector

Promote incorporation of cultural competency and safety across training, education and assessment, clinical management protocols and guidelines for the South Australian oral health workforce

Lack of cultural competency within the health workforce is a barrier to the provision of health services for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. Increasing the cultural competency of the oral health workforce will improve equity, access and the oral health outcomes of people from culturally diverse backgrounds.

The revised 2017 Australian Commission on Safety and Quality in Health Care accreditation standards require health services to implement strategies to improve cultural competency and cultural awareness of the health workforce to meet the needs of Aboriginal and Torres Strait Islander consumers.[66]

The SA Health Aboriginal Cultural Learning Framework has been developed to provide a consistent approach to building cultural competency and safety, enabling health care staff to deliver quality, culturally safe, responsive health care for Aboriginal and Torres Strait Islander people.[69]

Increase representation and engagement of Aboriginal and Torres Islander in the South Australian oral health workforce

Cultural and clinical safety are essential for delivery of high quality care. Increased representation of Aboriginal and Torres Strait Islander people amongst the oral health workforce and in the planning of services will enable more culturally appropriate and effective oral health services.

The SA Health Aboriginal Workforce Framework 2017-2022 aims to attract, retain and develop Aboriginal and Torres Strait Islander staff, and increase the cultural competence of the SA Health workforce.[70]

5.3 Optimise oral health workforce utilisation

Optimise oral health workforce utilisation to maximise flexible and efficient service delivery across South Australia

Optimising the full range of skills within the oral health workforce, aligned with relevant legislation and regulation, is essential to enable flexible service delivery.

The strategic utilisation of an appropriate skills-mix across the oral health and non-oral health workforce has the potential to improve access and oral health outcomes for South Australians.

Enhance programs to recruit and retain dental practitioners students and professionals in South Australian regional and remote areas, including rural scholarships and graduate placements

The challenges of attracting and retaining oral health workforce in regional and remote areas have a significant impact on the cost of establishing and maintaining services. Targeted workforce development strategies are required to make regional and remote placements attractive and professionally worthwhile for dental practitioners.

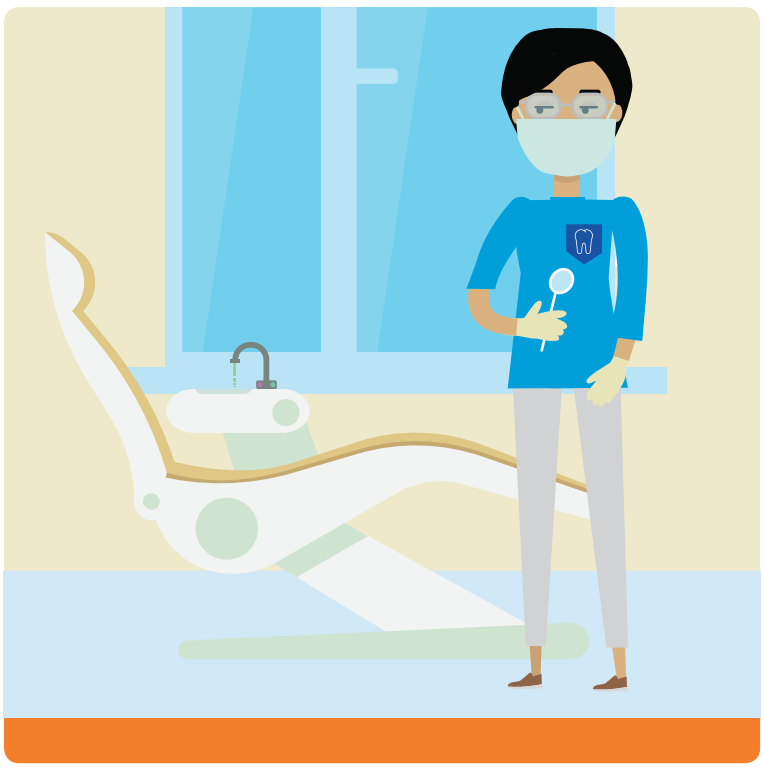
Regional and remote scholarships, tertiary education fee assistance, graduate placements and remote vocational training programs can assist in incentivising placements and reducing inequitable distribution of the oral health workforce.

5.4 Provide oral health competency training

Work with the South Australian tertiary education and vocational sector to include oral health units of competency in health and community service qualifications

The education and training of other health and human service professionals should include oral health units aimed at increasing knowledge and understanding of the relationship between oral health and general health and the importance of integrating care for improved health outcomes.

Training packages and competency units are available to support skill development for non-dental professionals, care providers and educators, for integrating oral health literacy, screening and referral into their practice.[71]



6 RESEARCH AND EVALUATION

GOAL: Use research and data to understand the oral health needs of the community

An evidence-based approach for the design, implementation and review of oral health programs and services requires access to both population and service level data. This information assists decision making regarding the required service level and mix, and informs planning when services gaps are identified and changes are required.

6.1 Contribute to oral health evidence

Support research and evaluation that contributes to the development of evidence-based programs and models of care for priority populations

It is important to use a robust and contemporary evidence-base for oral health promotion and service delivery. Research should support the development and evaluation of models of care, interventions and programs for priority populations. Collecting data and building evidence regarding the oral health status, management of dental conditions, service gaps and barriers impacting priority population will ensure tailored programs are effective and efficient.

6.2 Population oral health data

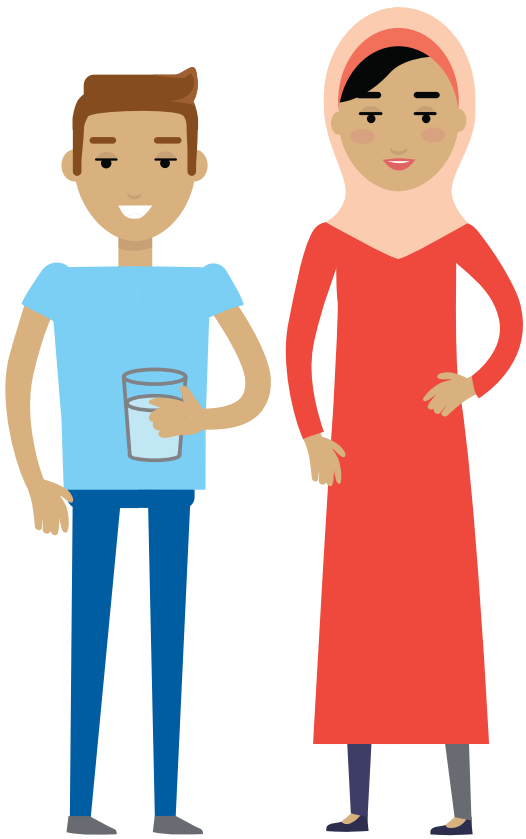
Support the routine collection, reporting and sharing of population oral health data to facilitate continuous improvements and innovation

As outlined in the National Oral Health Plan 2015-2024, population-level evaluation across public and private dental sectors is challenging due to limited data availability. This also includes limited representation of priority populations in existing data-sets, due to challenges associated with population size, identification and standard data collection practices.

An increased focus on ensuring nationally representative data on Priority Populations is required to support evaluation of access and outcomes for prioritygroups.[1]

8 GLOSSARY

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ADH	Adelaide Dental Hospital
AIHW	Australian Institute of Health and Welfare
ARCPOH	Australian Research Centre for Population Oral Health
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CDS	Community Dental Service
COPD	Chronic Obstructive Pulmonary Disease
CPHO	Chief Public Health Officer
DA	Dental Assistant
DMFT	DMFT: Decayed Missing and Filled Permanent Teeth
DT	Dental Therapist
NCOHS	National Child Oral Health Survey
NOHP	National Oral Health Plan 2015-2024
NSAOH	National Study of Adult Oral Health
OHT	Oral Health Therapist
PHC	Primary Health Care
PPHA	Potentially Preventable Hospital Admissions
SA	South Australia
SADS	South Australian Dental Service
SAOHP	South Australian Oral Health Plan 2019-2026
SDS	School Dental Service



9 APPENDICES

9.1 Development of the South Australian Oral Health Plan

The South Australian Oral Health Plan provides the strategic context for the operation of SA Dental Service, the wider oral health sector as well as SA Health with respect to oral health in South Australia.

The SA Oral Health Plan incorporates the vision and priorities of the South Australian Government for oral health for South Australia from 2019 – 2026. Much effort in developing the SA Oral Health Plan has been devoted to consultation with stakeholders. This approach recognises that the fundamental areas identified for action in the inaugural plan remain relevant, supplemented by emerging trends and new issues.

Several stakeholder workshops were conducted and a consultation paper was sent to a wide range of government and non- government agencies and associations for comment. The Consultation paper was placed on the SA Government 'YourSAy' website. Feedback was used to develop the Draft South Australian Oral Health Plan which was redistributed for further feedback.

Development of the plan was overseen by the South Australian Oral Health Plan Working Group and endorsed by the Hon Stephen Wade MLC, Minister for Health and Wellbeing.

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