

# Promoting Oral Health 2000–2004

## Strategic Directions and Framework for Action

Public Health Division

Human  
**Services**



**Peoplefirst**

# Victorian Health Promotion Strategies

The Victorian Government has a strong commitment to the development and implementation of a collective set of health promotion strategies addressing priority health conditions, risk factors and health needs of particular population groups. These strategies are matched by a commitment to action to strengthen infrastructure support across the system for the planning and delivery of effective, quality local health promotion.

The Public Health Division of the Department of Human Services has responsibility for leading this work in partnership with the Victorian Health Promotion Foundation, major statewide non-government health advancement organisations and other key stakeholders.

The overarching goals for health promotion in Victoria are to develop healthy individuals and society by:

- Creating community settings and structures that promote and sustain good health.
- Enhancing the physical and social environments in which people live, work and play.
- Improving the skills and capacities of all Victorians to become and remain healthy.
- Reducing the risks of illness, injury and premature death in all sections of the population.
- Improving the health and quality of life of people who experience disease, injury or disability.

There is a shared commitment by all key stakeholders in health promotion to ensure that the benefits of improved conditions and better health outcomes are shared more equally across the community and that those who face specific barriers to good health receive particular attention.

Other major statewide health promotion strategies include:

- Injury Prevention
- Promoting Healthy Eating and Good Nutrition
- Physical Activity Promotion
- Strengthening Systems for Health Promotion

*Promoting Oral Health 2000–2004: Strategic Directions and Framework for Action*

Health Development Section, Public Health Division, Department of Human Services, December 1999, Melbourne, Victoria

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## FURTHER INFORMATION

Further information may be obtained by contacting:

Health Development Section,  
Public Health Division,  
Department of Human Services,  
Telephone: 061 (03) 9637 4023 Fax: 061 (03) 9637 5435

This publication is also available on the Internet:  
<http://www.dhs.vic.gov.au/phd/9909034/index.htm>

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# Contents

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Acknowledgments .....	2
Reference Group .....	2
Foreword .....	3
Glossary .....	4
THE CONTEXT .....	5
Introduction .....	6
Oral Disease .....	8
Overview .....	8
Dental Caries .....	9
Periodontal (Gum) Diseases .....	11
Oral Cancers .....	11
Oral Trauma .....	12
Special Needs Groups .....	13
Oral Health Promotion .....	14
Overview .....	14
Other Relevant Statewide Health Promotion Strategies .....	14
Other Relevant Statewide Health Promotion Initiatives .....	15
Evidence-Based Oral Health Promotion .....	16
Overview .....	16
Evidence-Based Recommendations for Oral Health Promotion Interventions for Victoria .....	17
Gaps in Oral Health Promotion, Research and Evaluation .....	17
Table 1: Evidence-Based Oral Health Promotion .....	18
FUTURE DIRECTIONS: THE ACTION PLANS .....	23
The Future Direction for Oral Health Promotion in Victoria .....	24
The Action Plans .....	24
1. Community Education and Skill Development .....	27
2. Developing Supportive Environments .....	29
3. Fluoride .....	31
4. Oral Health Research and Surveillance .....	33
5. Workforce Development .....	34
References .....	38
Appendix 1: Working Party Membership .....	40
Appendix 2: Goals for Oral Health in Australia .....	41

# Acknowledgements

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This Strategy has been developed in consultation with the reference group (members listed below). In addition, there has been a number of people and organisations represented in the development of the Strategy through membership of the different working parties (Appendix 1).

## *Reference Group*

<b>Mr Ray Judd (Chair)</b>	Department of Human Services (Public Health Division)
<b>Ms Kay Mills (Executive Officer)</b>	Department of Human Services (Public Health Division)
<b>Ms Jan Anderson</b>	Australian Dental Industry Association (Victorian Branch)
<b>Dr John Bergman</b>	Australian Dental Association (Victorian Branch)
<b>Ms Pam Clarke</b>	Australian Dental Industry Association (Victorian Branch)
<b>Dr Deborah Cole</b>	Dental Health Services Victoria
<b>Dr Neil Hewson</b>	Australian Dental Association (Victorian Branch)
<b>Ms Josephine Lang</b>	Department of Education (Curriculum Development Section)
<b>Dr Michael Morgan</b>	University of Melbourne (School of Dental Science)
<b>Mr Tony McBride</b>	Deakin University
<b>Dr John Rogers</b>	Department of Human Services (Aged, Community and Mental Health Division)
<b>Dr Mary Stephens</b>	Community Dental Advisory Group
<b>Professor Clive Wright</b>	Dental Health Services Victoria

Development of this Strategy was supported by the Health Development Section of the Public Health Division.

# Foreword

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*Promoting Oral Health 2000–2004: Strategic Directions and Framework for Action* represents an exciting new step for Victoria in working towards improving the oral health of the community. Oral health promotion has been identified as a priority for the Department of Human Services and this Strategy builds on the discussion paper, *Towards Better Oral Health, Background and Issues for Victoria's Oral Disease Prevention and Health Promotion Strategy* (1997).

Although not widely recognised, oral health is an essential component of good general health. Oral disease has a multifaceted impact on an individual's health and wellbeing with wide-ranging effects resulting in high health services and personal costs.

This Strategy complements other elements of oral health service delivery currently taking place in Victoria. In the public sector, Dental Health Services Victoria provides the preventive focused School Dental Service and manages the targeted Community Dental Program which is provided through 57 public dental clinics in community health centres and hospitals. In the private sector there are more than 800 dental practices in Victoria. Oral health promotion activities take place in many different settings and sectors. The contribution of public and private dental practitioners needs to be complemented by that of other health workers, teachers, parents and those responsible for healthy environments and products.

This Strategy has been developed as a result of the contributions of a wide range of people, including participants from the oral health sector as well as the broader, community-based sector, demonstrating a broad commitment to developing improved oral health outcomes in the community. I would like to thank the committed people, and the organisations they represent, who have been involved in the development of this Strategy.

I am confident that this Strategy will be a key step in developing improved oral health for the Victorian community. I look forward to the development of a number of partnerships and collaborations which will be forged as we move into the implementation stage.



HON JOHN THWAITESMP

Minister for Health

# Glossary

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<b>ACAS</b>	Aged Care Assessment Services
<b>ACHPER</b>	Australian Council for Health and Physical Education and Recreation
<b>ADA</b>	Australian Dental Association
<b>ADIA</b>	Australian Dental Industry Association
<b>AHPA</b>	Australian Health Promotion Association (formerly Australian Association of Health Promotion Professionals)
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AMA</b>	Australian Medical Association
<b>ANF</b>	Australian Nutrition Foundation
<b>ANZFA</b>	Australian and New Zealand Food Authority
<b>CEH</b>	Centre for Culture, Ethnicity and Health
<b>CHCs</b>	Community Health Centres
<b>COTA</b>	Council on the Ageing
<b>CHF</b>	Consumer Health Forum
<b>DGP</b>	Divisions of General Practice
<b>DHS</b>	Department of Human Services
<b>DHSV</b>	Dental Health Services Victoria
<b>DVA</b>	Department of Veteran Affairs
<b>DOE</b>	Department of Education
<b>GPDV</b>	General Practice Divisions Victoria
<b>GPs</b>	General Practitioners
<b>MAV</b>	Municipal Association of Victoria
<b>MCH</b>	Maternal and Child Health Nurses
<b>NGOs</b>	Non-government organisations
<b>NH&amp;MRC</b>	National Health and Medical Research Council
<b>NHF</b>	National Heart Foundation
<b>NPHP</b>	National Public Health Partnership
<b>PHA</b>	Public Health Association of Australia
<b>RDNS</b>	Royal District Nursing Service
<b>VACCHOI</b>	Victorian Aboriginal Community Controlled Health Organisation Incorporated
<b>VCOSS</b>	Victorian Council of Social Services
<b>VicHealth</b>	Victorian Health Promotion Foundation

# The Context

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# Introduction

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## Goal

The goal of this Strategy is to prevent and control oral disease and promote oral health amongst the Victorian population. Recognising that most oral diseases are preventable, this Strategy aims to facilitate better oral health for all, using a variety of health promotion interventions across a variety of sectors.

The Strategy addresses the following health outcomes:

- Reduced incidence of dental caries (decay).
- Reduced incidence of oral cancers.
- Reduced incidence of periodontal diseases.
- Reduced incidence of oral trauma.
- The realisation of social and emotional health and well-being associated with improved oral health.

See Appendix 2 for goals for oral health in Australia.

## Background

The need to develop a statewide oral health promotion strategy as a key action to prevent oral disease and promote oral health was identified in *Future Directions for Dental Health in Victoria* (1995). It was specified that this should be a strategy which targets all age groups, identifies roles for health, education and welfare providers and encompasses both the private and public sector.

To further progress this action, *Towards Better Oral Health, Background and Issues for Victoria's Oral Disease Prevention and Health Promotion Strategy* (1997), was developed as a discussion paper (in consultation with the reference group) which provided a framework to commence development of the Strategy. This document provided a comprehensive description of the key issues affecting the implementation of oral health promotion activities in Victoria to set the scene for consultation.

Following a consultation period which consisted of forums and the opportunity for written submissions to be provided, priorities were developed for the identification of specific interventions and these priorities were endorsed by the reference group.

Working parties were established in each of these priority areas to develop a set of key interventions (Appendix 1). These interventions have been formulated into action plans and also include the key agencies recommended to be involved with each of the interventions.

## The Strategy

This Strategy outlines a framework for oral health promotion activity across Victoria over the next five years.

The framework has been informed by an overview of the evidence base of oral health promotion and extensive consultation with individuals both from the oral health sector and beyond. There are a variety of oral health promotion activities currently being undertaken in Victoria. These include the training of maternal and child health nurses, the Oral Health Promotion Unit at Dental Health Services Victoria (DHSV) and the Waverley Preschool Dental Program. The Australian Dental Association (ADA) conducts national public awareness campaigns on dental health issues and the professional dental associations incorporate preventive oral health information into their activities. Action on issues such as school canteens and water fluoridation has also been drawn upon in framing future action plans.

## The Action Plans

The action plans which form the basis of the Strategy have been designed to identify key interventions, organisations and partnerships which will enhance the development of effective oral health promotion interventions. The action plans encompass a variety of sectors and all age groups and represent the formation of collaborations and the development of partnerships between key agencies. They have been developed across the following key areas:

- Community education and skill development in oral health promotion to develop improved oral health knowledge, attitudes and behaviours of all Victorians.



- 
- Development of environments which are supportive of good oral health.
  - Facilitation of adequate and appropriate access to fluoride.
  - Facilitation of, and support for, the continued development of oral health research and surveillance.
  - Development of the oral health promotion capacity of the oral health and community workforce, to enhance oral health promotion practice in the mainstream primary health care and community support system.

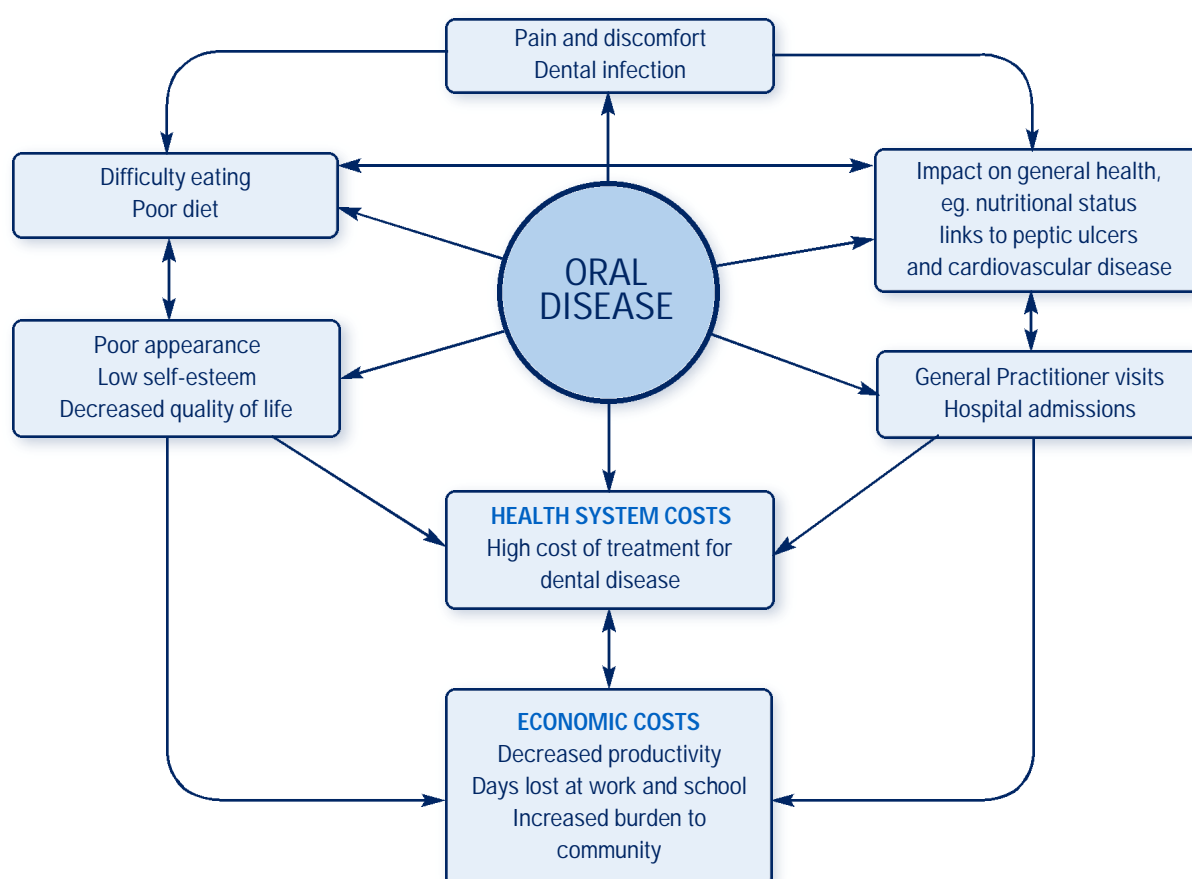
Each of these key areas has goals and sub-goals under which a range of interventions and key organisations for implementation are identified.

## Overview

### The significant personal burden of oral disease

Oral disease, much of which is preventable, is o

The following data builds on the extensive



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## Dental Caries

### Children

The dental caries experience of primary school children has decreased significantly since the 1970s. This is the result of several factors including water fluoridation, fluoride toothpaste and the increased availability of dental services (Dooland 1992). Figure 2 shows the caries experience in the deciduous teeth of six-year-olds and in the permanent teeth of 12-year-olds seen by the School Dental Service (DHSV 1999). The caries experience is represented by the dmft score in deciduous teeth (mean number of decayed, missing and filled teeth), and by the DMFT score in permanent teeth. The graph shows a plateau in the reduction rate of caries for six-year-olds in the mid-1980s and for 12-year-olds in the mid-1990s (Figure 2).

About half (53%) of all primary school children seen by the School Dental Service have signs of caries (DHSV 1999).

Preschool children, in particular, have high levels of untreated caries. Almost 80% of the caries experienced by five-year-old children is untreated (DHSV 1999).

Children living in fluoridated communities have far better oral health than their counterparts living in non-fluoridated areas. For example, six-year-olds living in fluoridated areas have 42% less caries experience compared to the same aged children living in non-fluoridated areas (DHSV 1999).

### Adolescents

Adolescents' dental health has improved, but most adolescents still have dental caries (Department of Human Services 1997). About 25% of adolescents have untreated caries (Soo and Morgan 1995) and the proportion of adolescents at high risk of oral disease (30%) are not receiving regular preventive care and are more likely to attend only for emergency care (Dooland 1992). However, up to 80% of the caries in teenagers is in those grooves and fissures of teeth which may be sealed as a preventive measure (Soo and Morgan 1995).

The level of untreated caries is linked to disadvantage. Adolescent dependants of concession card holders have 43% more untreated caries than dependants of non-card holders (Soo and Morgan 1995).

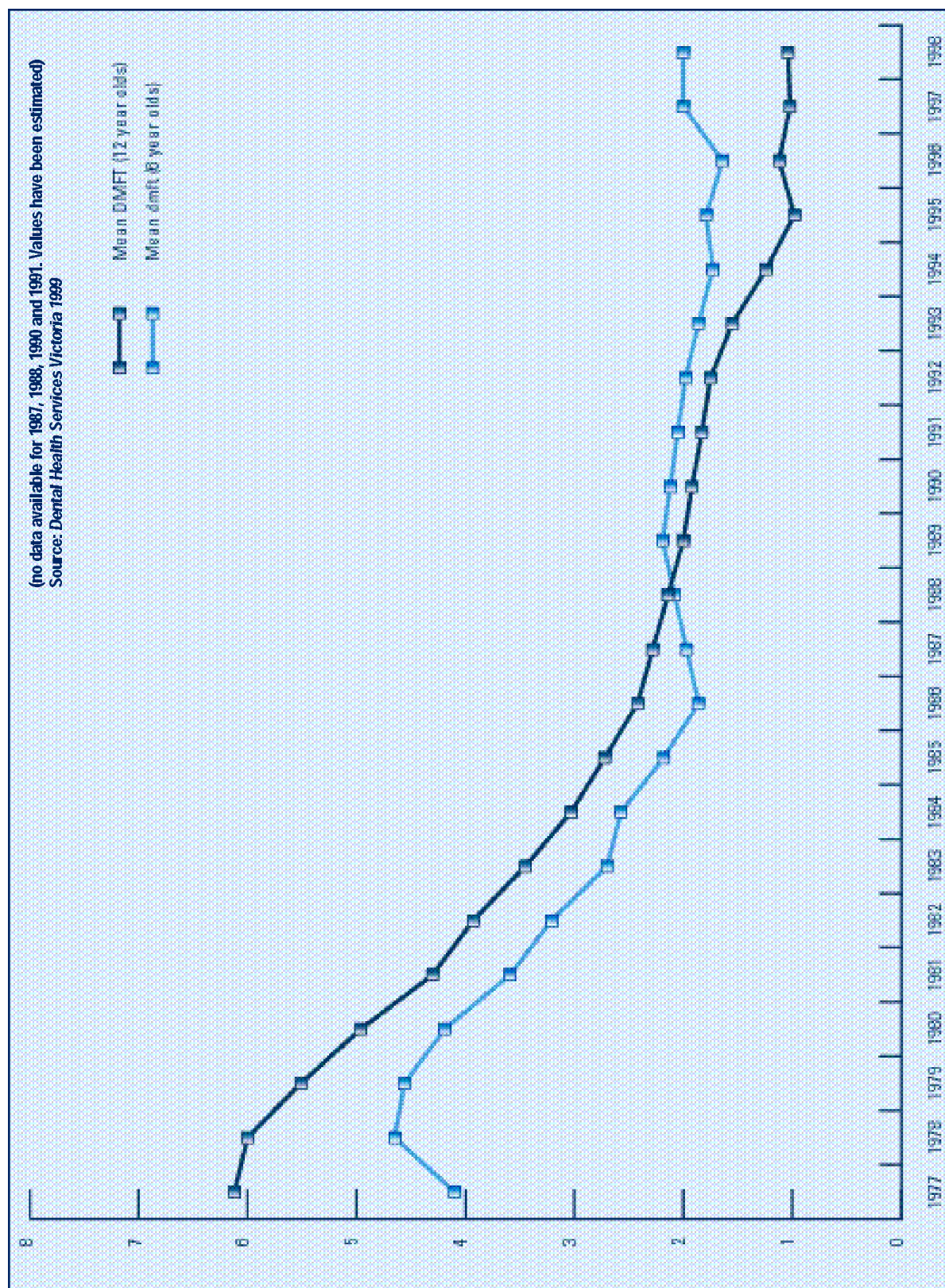
### Adults

The extent of untreated caries in adults is also linked to disadvantage. Concession card holders are 35% more likely than non-card holders to report having toothache and 49% more likely than non-card holders to avoid foods due to some form of pain (Australian Institute of Health and Welfare 1993). They are about twice as likely to have had their teeth extracted (Dooland 1992). Concession card holders are also nearly 30% less likely to visit the dentist each year than non-card holders (AIHW 1993).

As people enter late middle age the need for dental care increases. This is associated with the breakdown of existing restorations and with caries of the exposed root surfaces.

Older adults are retaining their teeth to a far greater degree than in the past. In 1979, 66% of those over 65 years had no natural teeth remaining compared with an estimated 27% in 2009 (Spencer 1999). It is predicted that the number of teeth in older adults requiring restoration or extraction due to dental caries in Victoria will be over 1 million in 2009 (based on Spencer 1999).

**Figure 2** Caries Experience of Six-Year-Olds (Deciduous Teeth) and 12-Year-Olds (Permanent Teeth)



**Figure 2** Caries Experience of Six-Year-Olds (Deciduous Teeth) and 12-Year-Olds (Permanent Teeth)

## Periodontal (Gum) Diseases

Periodontal diseases are also common and their prevalence and severity increase with age. The extent of the diseases range from gingivitis (swollen gums) to more severe periodontitis (loss of the supporting structures around the teeth).

While almost half of teenagers have some signs of periodontal diseases, over 90% of 60–69 year olds are affected (Barnard 1993). In disadvantaged groups, 25% of 45–54 year olds have moderate periodontitis whilst 10% have severe periodontitis (AIHW 1996).

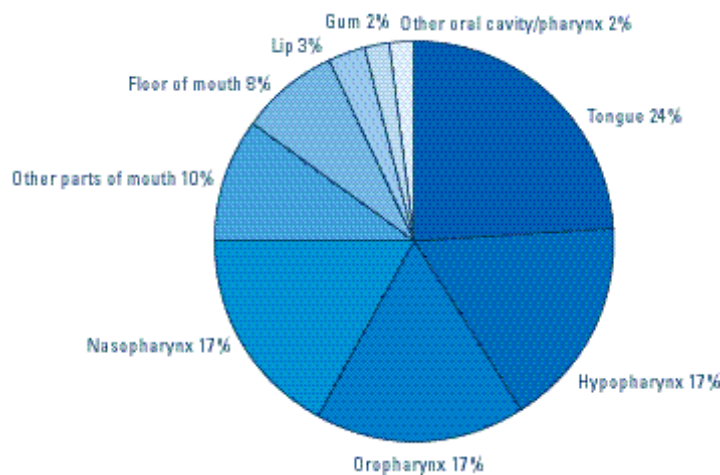
One-third of Australians who experience bleeding gums are not aware that it is a symptom of gum disease and similarly are unaware that bleeding gums while brushing is caused by germs in the mouth (Rowland Healthcare 1997).

## Oral Cancers

The number of new cases of oral cancer is increasing slightly and oral cancer is more common in men than women (Anti-Cancer Council of Victoria 1999). While the cause of oral cancers is not completely understood, smoking is an important risk factor and cancer of the lip can be caused by the ultraviolet radiation in sunlight (Anti-Cancer Council of Victoria 1997). Excessive consumption of alcohol raises the risk of developing oral cancer and all types of alcohol are implicated (Blot 1992). Alcohol and tobacco may act together to increase their individual effects, referred to as tobacco-alcohol synergism (Brugene et al 1986). Oral cancers encompass cancers of the lip, tongue, gum, floor of the mouth, oropharynx, nasopharynx, hypopharynx and other parts of the oral cavity, mouth or pharynx. In 1995, there were 650 new cases of oral cancer and 167 deaths due to oral cancers in residents of Victoria (Anti-Cancer Council of Victoria 1998). The highest number of deaths due to cancer in this grouping was due to cancer of the tongue (24%) followed by cancers of the oropharynx, nasopharynx and hypopharynx which were all 17% (Figure 3). The highest number of new cases of cancer in this grouping was cancers of the lip (40%) followed by cancers of the tongue (16%, Figure 4). Oral cancers represented 5.6% of new cases of cancer in 1995 and deaths due to oral cancer comprised 2.9% of cancer deaths recorded.

From 1979 to 1996, there has been a significant downwards trend in mouth cancer mortality rates in Victorian males aged 45–64 years (1.8% per year) and males 75 years and older (3.2%). For females, however, no such trend is obvious. A significant association between socioeconomic status and the development of mouth cancers is apparent in males aged 15–74 years, with higher mortality rates associated with lower socioeconomic status regardless of area of residence (metropolitan areas, rural centres, other rural and remote areas). For females the picture is slightly different, with women aged 45–64 years living in rural centres having higher mortality rates of mouth cancers than those living in metropolitan areas after socioeconomic status is taken into account (Department of Human Services 1999).

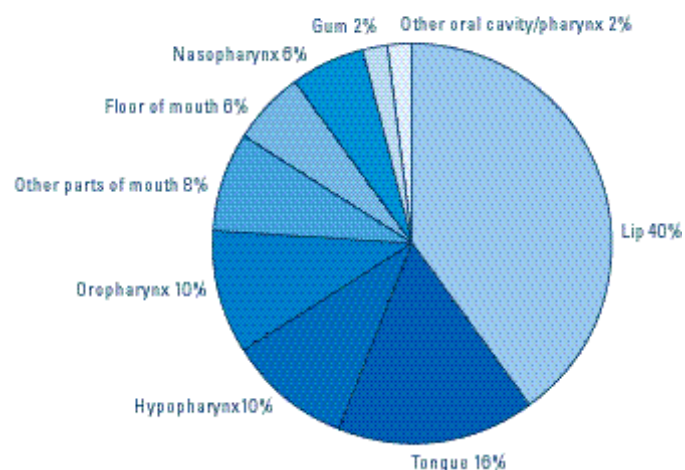
**Figure 3**  
**Deaths Due to Oral Cancer in 1995**



Source: Anti-Cancer Council of Victoria, Cancer Epidemiology Centre *Canstat: Cancer in Victoria 1995, 1998*.



**Figure 4**  
**New Cases of Oral Cancer in 1995**



Source: Anti-Cancer Council of Victoria, Cancer Epidemiology Centre *Canstat: Cancer in Victoria 1995, 1998*.

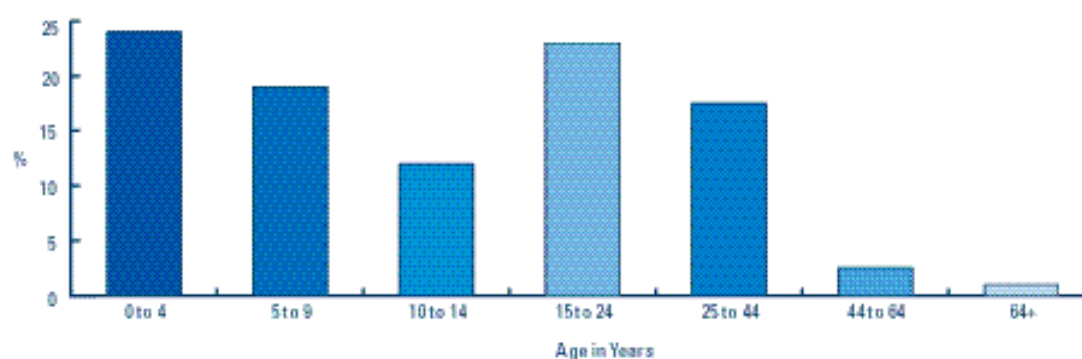
## Oral Trauma

There were 661 cases of dental injury recorded as emergency presentations at 25 Victorian public hospitals for the 1995–96 and 1996–97 financial years (Victorian Emergency Inpatient Data Set, Victorian Injury Surveillance System, Monash University Accident Research Centre, unpublished data). Figure 5 represents these data according to age group at presentation. Almost two-thirds (62%) of presentations were male and 47% of presentations occurred on weekend days.

Depending on a variety of factors, including the time and location of the injury and the existence of other injuries sustained at the same time,

presentation may occur at a range of locations including: a private dentist, a community dental service, a private or public hospital or the Royal Dental Hospital of Melbourne. As there is currently no common data collection system across agencies, it is not possible to capture a comprehensive picture of the true extent of dental injuries. Consequently, these data may be an under-representation due to the limitations of this data set, however, they provide a snapshot of people with dental injury who present at Victorian public hospitals.

**Figure 5 Dental Injury by Age Group**



Source: Victorian Injury Surveillance System, Monash University Accident Research Centre

# Special Needs Groups

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Facilitating access to dental services for the most vulnerable and disadvantaged groups in the community is a government priority. These include concession card holders\* in the following groups:

- People with a mental illness.
- People living in Supported Residential Services.
- Homeless people.
- People using Drug and Alcohol Treatment Services and those on methodone programs.
- People with disabilities.
- Aboriginal and Torres Strait Islanders.
- People who are homebound, including those in Residential Aged Care Facilities.
- People with HIV/AIDS.
- New arrivals to Victoria under refugee/special humanitarian programs who have been exposed to trauma or torture.
- Young people.

These groups have been identified following research and consultation as:

- Likely to have poorer oral health than average  
and/or
- Less likely to access available dental care  
unless they have a problem  
and/or
- Likely to be more difficult to provide with  
appropriate and acceptable care.

These groups have also been identified in the action plans as a priority for oral health promotion interventions. A variety of actions including workforce initiatives have been identified to ensure that oral health promotion interventions targeting the special needs groups are developed and implemented in a comprehensive manner.

\* Concession card holders refers to the Commonwealth concession cards which entitle the holders and their dependants to state concessions including transport and public dental services, namely the Health Care Card and the Pensioner Concession Card, referred to subsequently as concession card holder.

# Oral Health Promotion

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## Overview

Health promotion is defined as ‘a process of enabling people to increase control over and improve their health’ (Nutbeam 1998).

In Australia, the goals of health promotion are to develop a healthy society, healthy communities and healthy individuals through:

- Developing settings and structures that promote and sustain health.
- Improving the physical environments where people live, work and play.
- Improving people’s capacity to become and stay healthy.
- Reducing risk of illness, injury or premature mortality in the population.
- Improving the health and quality of life of people who experience disease, injury or disability (NH&MRC 1996a).

The World Health Organisation has guided health promotion internationally through the Alma Ata Declaration which was followed in 1986 by the Ottawa Charter for Health Promotion (World Health Organisation 1986). The Ottawa Charter defines five action areas for health promotion:

- Building healthy public policy.
- Creating supportive environments.
- Strengthening community action.
- Developing personal skills.
- Reorienting health services.

Oral health promotion is defined as the use of these actions to pursue oral health goals (Sprod et al 1996).

Future health promotion challenges were articulated in the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (1997) which confirmed the relevance of the strategies identified in the *Ottawa Charter for Health Promotion* (1986). These are to:

- Promote social responsibility for health.
- Increase investment for health development.

- Consolidate and expand partnerships for health.
- Increase community capacity and empower the individual.
- Secure an infrastructure for health promotion.

## Other Relevant Statewide Health Promotion Strategies

When considering oral health promotion, it is important to make links with relevant broader health promotion strategies. Important health promotion links with relevance to this Strategy include:

### *Taking Injury Prevention Forward, Strategic Directions for Victoria*

This strategy includes the aim: to reduce the rate of dental injuries in sport and recreation. This includes the use and promotion of mouthguards, developing standards for their use, and promoting their appropriate storage, wear and care. The use of other protective equipment is also endorsed, such as helmets when playing cricket. These issues are identified in the action plans providing an important link between the two strategies.

### *Healthy Eating, Healthy Victoria: A Lasting Investment: A Strategic Framework for the Implementation of the Victorian Food and Nutrition Policy*

Victoria’s food and nutrition policy also has important links with effective oral health promotion. *Healthy Eating Healthy Victoria* identifies key areas for action. Collaborative work is already underway between the Department of Human Services and the Department of Education to explore links and areas of implementation for oral health promotion and food and nutrition initiatives utilising interventions from the oral health promotion action plans.



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### *Other Relevant Statewide Health Promotion Initiatives*

Initiatives which will be developed as part of the Victorian Government's strategy against drug abuse will focus on education, legislative change, treatment and rehabilitation to address the illicit drug issue. It will be important to develop links between this Strategy and oral health promotion.

In addition, the National and State Tobacco Strategies, and the Victorian Smoking and Health Program (Quit) and Sunsmart statewide health promotion initiatives should be supported as there are important links between the development of oral cancer, smoking behaviours and exposure to ultra violet radiation in sunlight. There are also well-established links between smoking and gum disease.

# Evidence-Based Oral Health Promotion

## Overview

The Department of Human Services seeks to support health interventions that are effective and efficient. It is, therefore, imperative that service planners and providers have access to advice on the best evidence for health gain and are able to define performance indicators that will aid accountability and evaluation.

DHSV was commissioned by the Department of Human Services to conduct a review of the evidence base for oral health promotion\*. Two key pieces of work, which comprise well-researched critical summaries of evidence-based oral health promotion interventions and techniques, were used as the basis for this interpretation (Sprod et al 1996 and Kay and Locker 1997). Further research following the publication of these reports, was also reviewed. Local and national oral health promotion activities and health promotion programs such as the Victorian Smoking and Health Program (Quit) and SunSmart were also reviewed and, where applicable, incorporated into the analysis.

The interventions identified have been placed in what is believed the 'best fit' domain using the framework of the *Ottawa Charter for Health Promotion* (World Health Organisation 1986).

The evidence has been classified according to the type of evidence and the potential benefit to health as described below, using adopted definitions (Wales Office of Research and Development for Health and Social Care 1998), an adaptation of two systems (Bandolier 1999, Enkin 1995):

\* A copy of the full report is available from the Health Development Section, Department of Human Services.

The presentation of these data recognises that the boundaries of the evidence-based approach may unduly restrict the interpretation of emerging forms of socially based health promotion achievement, and the contribution newer methodological approaches may be providing to our understanding of effective outcomes.

As new information on effectiveness and the benefits of different interventions is constantly entering the scientific literature, the conclusions derived in the following section represent only that literature available as of May 1999.

Table 1 summarises an analysis of the evidence to date on the effectiveness of oral health promotion interventions in areas relevant to implementation of this Strategy. The table is organised according to the five strategies of the Ottawa Charter. Each section is examined according to specific oral health promotion interventions, the health impact, and the type of evidence and potential health gain, according to the definitions outlined above. The health impacts identified are:

- Community awareness raising leading to the development of healthy public policies.
- Influential in health behaviour change.
- Prevention and control of dental caries.
- Prevention and control of oral cancers.
- Prevention and control of periodontal diseases.
- Prevention of oral trauma.

TYPE OF EVIDENCE	HEALTH GAINS NOTATION
<b>Type I evidence</b> —at least one good systematic review, including at least one randomised controlled trial (RCT)	(1) <b>beneficial</b> —effectiveness clearly demonstrated
<b>Type II evidence</b> —at least one good RCT	(2) <b>likely to be beneficial</b> —effectiveness not so firmly established
<b>Type III evidence</b> —well designed intervention studies without randomisation	(3) <b>trade-off between beneficial and adverse effects</b> —effects weighed according to individual circumstances
<b>Type IV evidence</b> —well designed observational studies	(4) <b>unknown</b> —insufficient/inadequate for recommendation
<b>Type V evidence</b> —expert opinion; influential reports and studies	(5) <b>unlikely to be beneficial</b> —ineffectiveness is not as clearly demonstrated as for 6
	(6) <b>likely to be ineffective or harmful</b> —ineffectiveness or harm clearly demonstrated

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### *Evidence-Based Recommendations for Oral Health Promotion Interventions for Victoria*

- Community access to fluorides (either water and/or toothpaste).
- Topical fluoride therapies for high risk groups.
- Improving general and dental health practitioner knowledge of oral cancer incidence, risk factors and detection methods.
- Improving access to dental sealants, especially for high caries risk individuals.
- Reducing intake and frequency of sugar consumption.
- Developing oral hygiene skills in children.
- Increasing education levels of parents, particularly regarding dental caries in infants.
- Improving access to timely dental examinations.
- Generally improving access to dental care.
- Improving access to custom-made mouthguards for risk groups.
- Improving parental capacity to support child and adolescent oral health (that is, supports for parenting skills, encouragement as well as preventive knowledge).
- Enhancing environmental supports within community settings (such as canteens and food services, tooth brushing in child care centres, role model behaviours, nursing homes, residential care services, materials produced in languages other than English).
- Supporting primary health care interagency collaboration and networking.
- Actively promoting dental health service provider policy direction toward minimum treatment interventions and effective preventive interventions and health promotion, and not just treating the aftermath of dental disease.
- Developing dental health knowledge among health professionals who access at risk groups, such as maternal and child care nurses, nursing home staff, district nurses, meals on wheels managers, child care workers, youth workers, residential care workers, pharmacists, general practitioners and Aboriginal health workers.

### *Gaps in Oral Health Promotion, Research and Evaluation*

There is also the need to pursue rigorous and appropriate research efforts in oral health promotion in the following areas:

- Interventions which target people who do not get access to services.
- Interventions that target people with highest levels of oral disease.
- Interventions that target early socialisation of behaviours of at risk groups within specific settings (for example, low income, specific culturally and linguistically diverse groups, teenage mothers).
- Qualitative assessments of intervention effectiveness/ineffectiveness, and process evaluations, especially where effectiveness was expected but not achieved, and vice versa.
- Evaluation of programs which provide resources to health care workers and dental professionals (Horowitz 1995).
- Development of participatory methods of education based on public health models.
- Interventions that respond to needs identified by community representatives and primary care workers.
- Measures of the value of collaboration across health professions and delivery networks.
- The development of policies requiring the reorientation of public sector delivery to incorporate health promotion as well as clinical preventive interventions.
- Incorporation of oral health promotion into mainstream health promotion where common risk factors exist.

Some of these areas have been worked through more thoroughly as a result of being identified as key priorities by the working parties and appear as specific interventions in the action plans. A number of the proposed interventions extend beyond the realm of the action plans and are consequently documented for future action.

**Table 1 EVIDENCE-BASED ORAL HEALTH PROMOTION**

Domain or Strategy	Health Impacts	Type of Evidence	Potential Health Gain	Comments on Implementation
<b>BUILDING HEALTHY PUBLIC POLICY</b>				
<b>Advocacy</b>	Community awareness raising leading to the development of healthy public policies	VI—expert opinion <sup>12</sup>	2—likely to be beneficial	Advocacy operates at a variety of levels to raise the profile of oral disease by demonstrating the impact of oral conditions on the individual and society
<b>CREATION OF SUPPORTIVE ENVIRONMENTS</b>				
<b>Water Fluoridation</b>	Prevention and control of dental caries	I—good systematic review <sup>13</sup>	1—beneficial	A long established and effective method of reducing dental caries. Supportive environments create the background through which known effective agents transcend social, economic and cultural barriers. Accurate community knowledge and support are necessary to accompany implementation of community water fluoridation.
<b>Fluoride Toothpastes</b>	Prevention and control of dental caries	I—good systematic review <sup>14</sup>	1—beneficial	The majority of fluoride toothpaste trials demonstrate a clinically relevant anticaries effect. In general terms, the caries reductions have been in the order of 30%.
<b>Access to Timely Clinical Examination</b> Opportunity to access a diagnostic service prior to frank manifestation of disease.	Influential in health behaviour change, the prevention and control of dental caries, periodontal diseases and oral cancers	IV—well designed observational studies <sup>15</sup>	2—likely to be beneficial. Some evidence that early detection and preventive interventions are potentially beneficial.	Early diagnosis and preventive interventions are likely to be beneficial for specific groups such as school aged children. Early detection and the use of x-ray provide opportunity for less invasive therapies. Problems arise when practitioners are not up-to-date on minimal intervention strategies. The strategy also provides opportunity for health education intervention.
<b>Sucrose Substitutes</b>	Prevention and control of dental caries	II—at least one good randomised controlled trial <sup>16</sup>	3—trade off between beneficial and adverse effects. Clinical trials have established effectiveness, but side effects limit usefulness.	There are two main groups of sucrose substitutes: caloric and non-caloric sweeteners. Both groups have some disadvantages. There is a need to work closely with food manufacturers to facilitate benefits. Opportunity for Australia to pursue Toothfriendly® confectionery.
<b>Settings Approaches</b> The use of places and social contexts to promote and sustain good health, e.g. workplaces, schools.	Influential in health behaviour change	II—at least one good randomised controlled trial <sup>17</sup>	2—likely to be beneficial	General health promotion and specific studies show potential. Early studies demonstrated a relationship between diet and dental caries. Tailored messages can be used in specific settings.
<b>School-Based</b>	Influential in health behaviour change	IV—well-designed observational studies <sup>18</sup>	2—likely to be beneficial	There are good general health promotion and oral health promotion reviews and studies but not RCTs. Oral health education in schools as part as primary socialisation must be viewed in the context of family and other environmental supports and reinforcement.

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Domain or Strategy	Health Impacts	Type of Evidence	Potential Health Gain	Comments on Implementation
<b>CREATION OF SUPPORTIVE ENVIRONMENTS (cont)</b>				
Work-Based	Influential in health behaviour change	IV—well designed observational studies <sup>20</sup>	4—unknown benefits	An emerging area with both general and oral health promotion reviews and studies. Programs involving screening and prevention improve worker oral hygiene and reduce time lost from work. Long term changes are unknown, however there appears to be potential in this area.
<b>STRENGTHENING COMMUNITY ACTION</b>				
Community Development	Influential in health behaviour change	V—expert advice <sup>20</sup>	2—likely to be beneficial	This area has potential use in addressing specific oral health issues at the community level, for example, water fluoridation.
Group Health Education Interventions				
Primary Health Workers For example, pharmacists, maternal and child nurses, etc.	Influential in health behaviour change	V—expert opinion <sup>20</sup>	4—unknown benefits	Limited work done in this area of oral health promotion evaluation. There appears to be potential for future development.
Preschool Children and Parents	Influential in health behaviour change, and also the prevention and control of dental caries	III—well-designed intervention studies <sup>20</sup>	1—beneficial	There are a variety of interventions involving new parents/careers and risk groups which show important health benefits. Most evidence focuses on studies of nursing caries. 46% of five-year-old children enrolling in the Victorian School Dental Service in 1998 had dental caries experience, 78% of which was untreated.
Adolescents	Influential in health behaviour change	IV—well-designed observational studies <sup>20</sup>	2—likely to be beneficial	Studies largely of association between knowledge and behaviour. Adolescents demonstrate a need for greater autonomy in oral health decision-making, and more information about oral health care.
Older Persons	Influential in health behaviour change	V—expert opinion <sup>20</sup>	4—unknown benefits	Observational studies and analysis. Some reports demonstrate positive outcomes in behaviour change and in others the evidence is equivocal.
<b>DEVELOPMENT OF PERSONAL SKILLS</b>				
Oral Hygiene Instruction				
Plaque Control (including flossing)	Influential in health behaviour change, and the prevention and control of periodontal diseases	I—at least one good systematic review <sup>20</sup>	1—beneficial	Dependent on individual learning styles and techniques. In motivated patients, and those with existing periodontal disease, benefits have been demonstrated.

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Domain or Strategy	Health Impacts	Type of Evidence	Potential Health Gain	Comments on Implementation
<b>DEVELOPMENT OF PERSONAL SKILLS (cont)</b>				
Dental Floss	Prevention and control of periodontal diseases	II—at least one good systematic review <sup>28</sup>	1—beneficial	Good evidence to recommend flossing as an adjunct to toothbrushing for control of gingivitis in adults.
Toothbrushing. Using a fluoride toothpaste	Prevention and control of dental caries	I—at least one good systematic review <sup>28</sup>	1—beneficial	Demonstrated benefits of toothbrushing with a fluoride toothpaste. See Fluoride Toothpaste above.
<b>Access to Regular Dental Care</b> (See also 'Access to Timely Examination') <b>Smoking Cessation Advice</b>	Influential in health behaviour change Prevention and control of oral cancers	IV—well-designed observational studies <sup>29</sup> I—at least one good systematic review <sup>28</sup>	2—likely to be beneficial 1—beneficial	Facilitates personal skill development through reinforcement and contact with preventive therapies. Depends on behavioural interventions and motivation. Dentists are a complementary source of smoking cessation advice.
<b>Dietary Advice</b>	Influential in health behaviour change	V—expert opinion <sup>30</sup>	2—likely to be beneficial	Depends on learning styles, settings and a variety of behavioural determinants. Some studies show effectiveness especially where carers have control over dietary factors. See 'Preschool Children and Parents'.
<b>Mouthguards</b> (For use in organised contact sports)	Prevention of oral trauma	IV—well-designed observational studies <sup>29</sup>	2—likely to be beneficial	Some evidence to suggest that custom (fitted) mouthguards are superior in preventing trauma to teeth.
<b>Fluorides</b> (self-applied, for example, in mouthwashes, tablets, drops)	Prevention and control of dental caries	I—at least one good systematic review <sup>28</sup>	1—beneficial	Effectiveness depends on motivation, agent and continuity. Use of fluoride drops and tablets should be restricted to children at higher risk of developing dental caries and living in a non-fluoridated area.
<b>REORIENTATION OF HEALTH SERVICES</b>				
<b>Fluorides</b> (professionally applied, for example, gels, varnishes, etc.)	Prevention and control of dental caries	I—at least one good systematic review <sup>28</sup>	1—beneficial	Effectiveness depends on access, agent and continuity. Targeted approaches to high risk individuals/groups show better cost-effectiveness.
<b>Dental Sealants</b> Application of acid-resin or anti-adhesive coating to susceptible tooth surfaces	Prevention and control of dental caries	I—at least one good systematic review <sup>28</sup>	1—beneficial	PdZs show effectiveness. Greater cost-effectiveness can be gained by appropriate targeting of at-risk individuals and tooth sites.
<b>Sealing and Prophylaxis</b>	Prevention and control of periodontal diseases	I—at least one good systematic review <sup>28</sup>	2—likely to be beneficial	Questionable in general prevention. Evidence of benefit relates to individuals with specific periodontal conditions. Benefit in preventing progression in these circumstances.

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# Future Directions: The Action Plans

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# The Future Direction for Oral Health

## Promotion in Victoria

Following a consultation period around key issues identified in *Towards Better Oral Health* (1997), key priorities were established. More focused consultation was conducted with key stakeholders around these priorities which resulted in the development of interventions which have been consequently formatted into action plans.

The development of the action plans has been the result of a collaborative effort from a broad cross-section of key stakeholders, both from the oral health field and the wider community sector. The final action plans recognise that effective, sustainable, oral health promotion activities will be the product of collaboration across a range of relevant sectors and community groups. While governments have a key role to play in both policy making and purchasing, the action plans also recognise the opportunities which can be derived in strategy implementation through collaboration with key agencies.

This Strategy aims to identify areas where oral health promotion can be integrated comprehensively to reach the entire population, recognising that the responsibility for effective and comprehensive oral health promotion extends beyond the oral health workforce.

The provision of public dental services is an important issue both in Victoria and across Australia, particularly in relation to access to services and equity. These issues are also central to the delivery of effective oral health promotion interventions. As it is beyond the scope of this Strategy to address fundamental issues in the funding and delivery of oral health services, the action plans have been developed to be implemented within the current service delivery context.

key stakeholders, both from within the Department of Human Services and external organisations.

The action plans provide an opportunity for organisations to identify a course of action which could be undertaken to address oral health promotion in a systematic manner. They also set the scene for a more coordinated statewide approach to oral health promotion activities in Victoria. It will be important that these actions are measured so that progress towards the key indicators is evaluated. In addition, it is anticipated that any duplication can be avoided and knowledge and information about best practice in the area of oral health promotion is shared to achieve an improvement in the oral health status of all Victorians.

Action plans have been developed in the following areas:

- Community education and skill development.
- Development of supportive environments.
- Facilitation of adequate and appropriate access to fluoride.
- Oral health research and surveillance.
- Workforce development.

There are defined goals in each action area, objectives under each of these goals and a sequence of strategies or interventions. In addition, the target group and key organisations have been identified.

### *The Action Plans*

The action plans are targeted towards improving oral health outcomes and are framed around identified key priority areas. The emphasis of their development has been on identifying interventions which are both effective and can be readily implemented

The action plans draw upon a comprehensive suite of methodologies which reflect the broad range of content areas, target groups and settings for implementation. A variety of interventions has been identified across each priority action area, reflecting the diversity of these areas. The framework will guide action across a five-year period, a fundamental component of which will be to engage

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## 1. Community Education and Skill Development

### Goal

1. Develop improved oral health knowledge, attitudes, and behaviours of all Victorians.

### Sub-Goal

1.1 Improve access to oral health promotion information and education.

The education of individuals requires a multifaceted approach. Both individual and population focused interventions have been identified which target a variety of population groups in the development of sustainable interventions. The importance of a consistent suite of agreed messages to be adapted and used across a variety of settings and target groups has been recognised. The need to work with the consumers and their stakeholders (including the relevant peak bodies) has been identified when working with special needs groups in the community with significant levels of oral disease. The action plans also identify the need to develop an improved focus for oral health at the policy making level across a variety of sectors.

## 2. Developing Supportive Environments

### Goal

2. Develop environments which are supportive of good oral health.

### Sub-Goals

2.1 To develop a school environment that is supportive of good oral health through its policies, curriculum and activities.

2.2 Promote the replacement of cariogenic (dental decay causing) products with low cariogenic products (less likely to cause decay) where available.

In developing environments that are health promoting, it is important that the environment is structured to ensure that alternative healthy food choices are readily available. As there are a number of areas that could be covered under such a broad heading, this section has identified two key areas for action which arose during the consultation and strategy development phase:

- The school environment and
- The replacement of cariogenic products with low cariogenic products where available.

While specific environments have been targeted as detailed in action plans, these are not in any way reflective of the entire realm of oral health promotion interventions which could be introduced in this section, but are identified as a starting point for key activities in this area. There are other important settings for oral health promotion which have been referred to in the action plans including child care centres and aged care settings.

## 3. Fluoride

### Goal

3. Facilitate adequate and appropriate access to fluoride.

### Sub-Goals

3.1 Ensure that Victorians have adequate and appropriate access to appropriate levels of fluoride in tap water, as specified in the Australian Drinking Water Guidelines (NH&MRC et al 1996b).

3.2 Improve community information and education about non-water supplies of fluoride.

Fluoride acts directly on the tooth surface and is of benefit in preventing dental caries in people of all ages. Fluoride may be ingested through the water supply in fluoridated areas, or through the use of tablets, drops and topical application. The latter may be via fluoride toothpastes or professional application.

Approximately 75% of Victorians drink water containing fluoride at the optimal level which prevents decay. Most water supplies naturally contain fluoride and some have levels which confer dental benefit. Fluoride toothpastes have an additional preventive effect. Fluoride supplements may be needed for children at high risk of dental caries who live in an area where the community water supply is not optimally fluoridated.

Any extension of water fluoridation should be accompanied by readily available accurate information and appropriate community support.

The fluoride action plans emphasise interventions concerning:

- Water fluoridation and
- The appropriate use of other sources of fluoride.

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## 4. Oral Health Research and Surveillance

### Goal

4. Facilitate and support the continued development of oral health research and surveillance.

### Sub-Goals

4.1 Obtain clear data regularly on the oral health status of the Victorian population.

4.2 Encourage sound research in oral health promotion.

There is a need for improved data on the oral health status of Victorians. The last statewide oral health survey was conducted in 1987–88. The need to facilitate further research in oral health promotion has also been identified, including the development and testing of different oral health promotion models. Additionally, improved coordination in research efforts across the State is required.

## 5. Workforce Development

### Goal

5. Develop the oral health promotion capacity of the oral health and community workforce to enhance oral health promotion practice in the mainstream primary health care and community support system.

### Sub-Goals

5.1 Increase the capacity of the community-based workforce to integrate oral health concerns into their practice.

5.2 Facilitate the development of links and improved understanding of primary health and community services by the oral health workforce.

5.3 Increase the skill levels in health promotion among the oral health and primary health and community support systems workforce.

It is recognised that oral health promotion activity is not solely the responsibility of the oral health workforce. Consequently, the workforce development action plans encompass a variety of oral health promotion interventions. These include mechanisms to develop both the health promotion skills of the oral health workforce and to develop the capacity of the community workforce to integrate oral health promotion issues into their practice. The specific issues addressed by each of these groups will vary. Education targeting the oral health practitioner

will address core oral health issues including dental caries, periodontal diseases and oral cancer in addition to more general health and health promotion information. Education which targets the community-based workforce should include more general oral health information as well as specific health promotion information. An important additional component is the development of improved links and understanding between the oral health workforce and the primary health and community support services workforce.

In educating the community-based workforce, oral health promotion education should be targeted at the community level, encouraging the integration of oral health promotion interventions into the policies and activities in a range of community settings. In addition, any strategy to increase skills in the workforce to deal with oral health issues should include skills to ensure early detection of disease and appropriate responses, especially referral.

## Goal 1 Develop improved oral health knowledge, attitudes, and behaviours of all Victorians.

1.1 Improve access to oral health promotion information and education			
OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
1.1.1 Define a suite of agreed oral health promotion messages which can be used widely in the community <sup>**</sup>	Victorian community and special needs population groups	<ul style="list-style-type: none"> <li>+ Collate and analyse currently used key messages (locally and internationally)</li> <li>+ Consult with stakeholders including representatives from key dental health promotion agencies and dental industry to develop consensus on priority topics and key messages to be used in Victorian context</li> <li>+ Identify (in collaboration with health promotion agencies) methodologies for dissemination of key messages</li> <li>+ Pilot key messages</li> <li>+ Identify organisations and sectors where these messages can be consistently applied using industry dental providers, existing health agencies and health promotion organisations</li> </ul>	<p>ADHA, ADA, DHS, DHSV State/Territory oral health units</p> <p>Relevant health promotion organisations (e.g. QUIT) Major oral care companies, education sector</p>
1.1.2 Develop dissemination strategy for key messages defined (see Action Plan 1.1)	As above	<ul style="list-style-type: none"> <li>+ Target ways in which key oral health promotion messages can be embedded, e.g. relevant health promotion campaigns, key policies and calendar health Weeks</li> <li>+ Work with relevant organisations to embed key messages in defined mechanisms/vehicles to ensure maximum exposure of messages in most efficient and effective manner</li> </ul>	As above
1.1.3 Target oral health promotion education and information to identified special needs populations	Identified special needs populations, including the aged, the homebound, those in residential or supported care, Aboriginal and Torres Strait Islanders, people of culturally and linguistically diverse backgrounds, the homeless, people who are HIV+ or have AIDS, people with a mental illness, people with a disability	<ul style="list-style-type: none"> <li>+ Consult with the agencies and community networks associated with the specified population to identify mechanisms to embed the relevant oral health promotion messages at the policy and service delivery level e.g. client assessment, intake systems, recall systems, accreditation and workforce development (see Action Plan 5)</li> <li>+ Develop agency specific oral health promotion strategies</li> <li>+ Provide appropriate oral health promotion information to organisations (See Action Plan 5)</li> <li>+ Adapt key messages, linking these to relevant health issues for target population identified (Action Plan 1.1)</li> </ul>	<p>DHS, DHSV, hospitals, GPs, PDNS, ACOs, NGOs, DHA, peak bodies, support groups and cultural networks, consumer groups</p> <p>Health and Welfare Organisations Local government</p>

<sup>\*\*</sup>Topics may include: the need for regular dental clinic visits; the use of fluoride; oral hygiene issues; dietary issues.

## Goal 1 Develop improved oral health knowledge, attitudes, and behaviours of all Victorians.

### 1.1 Improve access to oral health promotion information and education

OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
<b>1.1.1</b> Develop mechanisms to enhance access to oral health promotion information and the exchange of ideas, knowledge and information	Victorian population	<ul style="list-style-type: none"> <li>Investigate options for dissemination of information eg. information technology (online resource centre, DHS Better Health Channel), regular bulletin using existing channels through the primary health and community support system and oral health network</li> <li>Publicise these mechanisms and link to action plans 1.5 and 5</li> </ul>	DHS, DHSV, University of Melbourne, ADIA, DGP, GPDV, CHC, local government, ADA
<b>1.1.2</b> Develop and maintain an improved focus on oral health at the policy making level	Politicians, consumers Public health organisations Dental health organisations Dental professional organisations Peak bodies Relevant NGOs Private sector organisations	<ul style="list-style-type: none"> <li>Develop a network of key stakeholders with the capacity to influence key decision and policy makers</li> <li>Establish and maintain communication between this network and key oral health promotion professionals to advise of relevant oral health promotion initiatives</li> <li>Establish mechanism to resource key decision makers eg. information forums, bulletins, internet</li> </ul>	DHS, DHSV, NH&MRC, AIHW, ADA, ADIA, NHPH, CHC, ACOSS, VODSS
<b>1.1.3</b> Develop an improved awareness of importance of wearing appropriate protective equipment during sporting activities e.g. use of mouthguards, helmets etc	Victorian population, particularly sporting clubs	<ul style="list-style-type: none"> <li>Provide appropriate and relevant information to key organisations</li> <li>Link with Action Plan 1.1</li> </ul>	DHS, ADA, DHSV, NGOs

## 2. Developing Supportive Environments

### Goal 2 Develop environments which are supportive of good oral health

2.1 Develop a school environment that is supportive of good oral health through its policies, curriculum and activities			
OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
2.1.1 Develop oral health promotion strategies for use in the school class room	All members of the school community	<ul style="list-style-type: none"> <li>Ensure Oral health promotion activities are incorporated in the school environment (providing information to facilitate skill development of preventive Oral health behaviours and linkages with the home environment)</li> <li>Identify relevant sections of Curriculum Standards Framework for primary and secondary school students</li> <li>Ensure adequate resourcing for teachers using appropriate channels, including professional development for teachers and support by School Dental Program staff</li> <li>Identify current relevant resource materials e.g. curriculum resources, professional development, Internet options, organisations already working with schools</li> </ul>	<p>Curriculum Development Unit (DOE) Victorian Home Economics and Textiles Association Australian Council for Health and Physical Education and Recreation Health Education Association of Victoria Catholic Education Commission Association of Independent Schools of Victoria Board of Studies, Curriculum Information Services Branch (DOE) Non-government organisations Health Promoting Schools Project (DOE)</p>
2.1.2 Develop school policies and activities which are Oral health promoting	Link with key messages (Action Plan 1.1 and 3)	<ul style="list-style-type: none"> <li>Incorporate general Oral health promotion activities into school, target school centres specifically prevent dental injuries e.g. use of mouthguards, liaise with DOE to ensure Schools of the Future Reference Guide includes information on dealing with Oral trauma</li> <li>Promote Oral health promotion activities incorporating use of key messages (Action Plan 1.1) and using relevant calendar health weeks e.g. <ul style="list-style-type: none"> <li>Nutrition Awareness Week</li> <li>Dental Health Week</li> </ul> </li> <li>Consider development of incentives e.g. award relevant to teachers using Oral health strategies</li> </ul>	<p>Association for School Councils in Victoria Health Promoting Schools Project Victorian Primary Principals Association Nutrition Advisory Committee regarding schools as an arena for action NHF, Sport &amp; Recreation Victoria DHS-School nursing service, DOE DHS, DHSV, ADA, ADIA, ANF VicHealth and other relevant health promotion organisations All key stakeholders</p>

## Goal 2 Develop environments which are supportive of good oral health

2.2 Promote the replacement of cariogenic products with low cariogenic products where available			
OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
2.2.1 Enable the public to make informed choices through clearer labelling of food which is identified as being less cariogenic	Victorian population	<ul style="list-style-type: none"> <li>Investigate methods used locally and internationally regarding the use of a logo to identify dentally friendly products</li> <li>Contact companies which have attained this endorsement and use it on their products outside Australia</li> <li>Investigate use of this existing logo on some products within Australia</li> <li>Investigate use of existing logo with other products within Australia</li> </ul>	DHS, DHSV, ADA, ADIA, University of Melbourne, Australian Nutrition Foundation, Australian Sugar Industry, Australian Food and Groceries Council, the Tooth Friendly Institute, VicHealth, ANZFA
2.2.2 Increase the provision of non-cariogenic medication and other products in GP and pharmacy settings	GPs, Pharmacists Pharmaceutical companies Parents Professional associations and organisations	<ul style="list-style-type: none"> <li>Develop education and information strategy for dissemination to relevant individuals, organisations and professional groups</li> <li>Work with relevant organisations to ensure that non-cariogenic medication is acceptable and available from pharmacies and GPs</li> <li>Ensure non-cariogenic products are readily available in dental and GP surgeries</li> </ul>	DHS, ADIA, relevant professional groups eg. Australian Council of Professionals, GPs, pharmacists, pharmaceutical companies, professional associations and organisations
2.2.3 Maximise access to low cariogenic products across a variety of settings eg. Workplace, school, community retail settings	Victorian population	<ul style="list-style-type: none"> <li>Aim to ensure that a greater range of non-cariogenic products is available at an affordable price</li> <li>Discuss with relevant organisations and oral health promoting agencies</li> <li>Investigate feasibility of placing low cariogenic items at the supermarket check areas</li> </ul>	Australian Food and Groceries Council Australian Nutrition Foundation DHS, DHSV, ADA, ADIA Victorian Retail Traders Association

### Goal 3 Facilitate adequate and appropriate access to fluoride.

#### 3.1 Ensure that all Victorians have adequate and appropriate access to appropriate levels of fluoride in tap water, as specified in the Australian Drinking Water Guidelines

OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
3.1.1 Enhance Victorians' knowledge of the beneficial effects of water fluoridation through the development and dissemination of accurate information	Victorian population, particularly non-fluoridated communities	<ul style="list-style-type: none"> <li>+ Develop a strategy for use at the local level for communities considering water fluoridation</li> <li>+ Develop resources to support communities considering water fluoridation, eg. fluoride fact sheet, press kit, resources for use in schools (Action Plan 2.1)</li> <li>+ Document case studies of local community activity around community water fluoridation</li> <li>+ Obtain support of health and Welfare Organisations including key decision makers, health professionals and relevant professional groups</li> <li>+ Determine water authorities knowledge of and support for community water fluoridation</li> <li>+ Actively encourage all Victorian water authorities to consider water fluoridation</li> <li>+ Update existing booklet, Fluoride Levels in Victorian Towns and Cities</li> <li>+ Regularly issue information on current activity in this area, including dental caries comparative data and relevant publications</li> </ul>	<p>DHS, ADL, DHSV, University of Melbourne</p> <p>Local ADL members, politicians, DGP, CHF, AMA, VCOSS, GPOA, local government</p> <p>DHS Water Authorities</p> <p>DHS</p> <p>DHS, ADL, DHSV</p>



### Goal 3 Facilitate adequate and appropriate access to fluoride.

3.2 Improve community information and education about non-water supplies of fluoride			
OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
3.2.1 Promote the appropriate use of fluoride	Oral health professionals, pharmacists, GPs, MCH, ADA	<ul style="list-style-type: none"> <li>Identify and document current patterns of toothpaste usage and tooth brushing for the adult and child population</li> <li>Contribute to the NH&amp;MRC current development of consensus guidelines and information on appropriate use of fluoride toothpaste, the use of fluoride supplements and the application of topical fluorides</li> <li>Target appropriate members of the workforce for training and information (Action Plans 5)</li> <li>Include fluoride information in oral health promotion messages (Action Plan 1.1)</li> <li>Publish and disseminate Oral health promotion guide for Children's Services following consultation with key stakeholders</li> <li>Encourage children's services (preschools and childcare centres) to adopt toothbrushing programs, particularly where children are at high risk of developing dental caries</li> </ul>	<p>DHS</p> <p>DHS, DH&amp;V, ADA, NH&amp;MRC, University of Melbourne</p> <p>DHS, DH&amp;V, ADA, MAV, MCH, relevant peak bodies</p> <p>DHS, DH&amp;V, ADA, ADA, ADA</p> <p>DHS, DH&amp;V, local government, oral care companies, ADA</p>

## Goal 4 Facilitate and support the continued development of oral health research and surveillance.

4.1 Obtain clear data regularly on the oral health status of the Victorian population		
OBJECTIVES	INTERVENTIONS	KEY ORGANISATIONS
4.1.1 Advocate for regular data collection and analysis, locally state-wide and nationally	+ Identify government mechanisms to support conducting a regular National Oral Health Survey	Network of Dental Advisers Oral Health Professionals Associations DHS, University of Melbourne, AIHW, PHA and other health related organisations
	+ Establish partnerships for collection of oral health data using variety of methodologies eg. Computer Assisted Telephone Interview	DHS
	+ Advocate for and facilitate the inclusion of oral health data collection in general and targeted population research to gather surveillance information	DHS, University sector Health and research institutions eg. Anti-Cancer Council, VicHealth, QUIT, DHS, DHSV, AIHW, Health Insurance Commission
4.2 Encourage sound research in oral health promotion		
4.2.1 Develop and test oral health promotion models which build on and use approaches based on the current evidence using Organisational, economic and other types of supports to promote oral health and improve oral health status	+ Conduct a review of the published oral health promotion research and identify current oral health promotion practice	DHS DHSV
	+ Establish research priorities in oral health promotion and advocate for continued research liaising with funding bodies directly	Research institutions, Funding agencies Health promotion agencies DHS, DHSV, VicHealth
	+ Identify previously funded oral health promotion research projects	As above
	+ Advocate for and make specific recommendations to relevant health promotion agencies and funding bodies for further oral health research	eg. QUIT Anti-Cancer Council VicHealth
	+ Develop evaluation strategy of key messages and their dissemination (Action Plan 1)	As above
4.2.2 Develop support for oral health promotion research through the health service system and education sector	+ Link oral health promotion research with existing health promotion strategies	University and health sectors DHS, VicHealth Health Promoting Schools Project (DHE) VACCHOI
	+ Support demonstration projects which use appropriate oral health promotion strategies or pilot proposed models	Oral Health Professionals Associations Research institutions Funding agencies Health promotion agencies

**Goal 5** Develop the oral health promotion capacity of the oral health and community workforce to enhance oral health promotion practice in the mainstream primary health care and community support system.

**5.1** Increase the capacity of the community-based workforce to integrate oral health concerns into their practice to facilitate the identification and implementation of oral health promotion practices and/or referral to appropriate oral health services.

OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
<b>5.1.1</b> Increase knowledge of oral health issues and services, and improve skills in oral health promotion among the community-based workforce	Community-based and institutional workers, i.e. general practitioners, nurses, allied health workers, children services staff, teachers, youth workers, home-based workers (including home help staff and carers), drug and alcohol staff, pharmacists, workers working with people of cultural and linguistic diversity, Koori health workers, institutional staff in range of sectors (e.g. nursing homes, prisons, community residential units, hospitals), volunteer workers, health bureaucrats, policy makers	<ul style="list-style-type: none"> <li>Identify existing relevant training programs or organisations conducting training for health professionals into which oral health promotion information could be incorporated</li> <li>Identify the key components of a generic training package and consult with relevant individuals, professionals, training bodies and professional associations</li> <li>Develop a generic short-course training package to suit the needs of the relevant workforce, tailored to different workplaces and populations and drawing from information from other similar training packages (e.g. University of New England, Queensland University of Technology)</li> <li>Consult with relevant specific population groups and organisations, and develop additional modules targeting special needs populations</li> <li>Develop mechanism for delivering such training to varied groups of practitioners in consultation with the relevant professional and training bodies</li> <li>Identify and support oral health champions in a range of settings and different professional areas</li> <li>Identify appropriate vehicles for the development and dissemination of oral health promotion information to the relevant workforce, including linkages with relevant existing health promotion programs and strategies (Action Plan 1)</li> </ul>	<p>DHS, DHSV, NGOs, community-based agencies, education sector, DGP, GPDV</p> <p>DHS, DHSV</p> <p>As above and relevant community-based agencies, e.g. COTA, WOODS, CBH, MUOCHO</p> <p>Relevant professional groups, DHS, relevant community and peak organisations</p>
<b>5.1.2</b> Build oral health into the assessment procedures, protocols and policies of primary health and community support services	Primary health workforce, DHS, consumers	<ul style="list-style-type: none"> <li>Identify appropriate protocols and policies, and consult with relevant stakeholders</li> <li>Develop training package targeting health workers (link with Action Plan 3.1)</li> <li>Develop mechanism to facilitate integration of oral health factors into appropriate identified vehicles</li> <li>Identify any relevant accreditation standards into which oral health issues could be incorporated</li> </ul>	DHS and other organisations as listed above

**Goal 5** Develop the oral health promotion capacity of the oral health and community workforce to enhance oral health promotion practice in the mainstream primary health care and community support system.

5.2 Facilitate the development of links and improved understanding of primary health and community services by the oral health workforce			
OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
5.2.1 Develop the oral health workforce's knowledge of the community based public health care system	Oral health professionals	<ul style="list-style-type: none"> <li>Identify relevant existing communication mechanisms with the oral health profession and community-based organisations</li> <li>Develop training courses covering community-based service systems including referral processes</li> </ul>	ADHA, DHS, DHSN, AMU, VUOSHOL, education sector, non-government organisations
5.2.2 Increase understanding of links between oral and general health (and referral systems), including between public and private sectors	Oral health professionals and primary health workforce	<ul style="list-style-type: none"> <li>Develop appropriate mechanisms to incorporate training into existing oral health continuing education programs, identifying links between oral health, general health and health promotion</li> <li>Identify relevant health issues and train oral health professionals to provide appropriate advice/information on related health issues to their clients, referring on when appropriate and necessary</li> </ul>	As above

**Goal 5** Develop the oral health promotion capacity of the oral health and community workforce to enhance oral health promotion practice in the mainstream primary health care and community support system.

### 5.3 Increase the understanding and skills levels in health promotion among oral health and primary health and community support systems workforce

OBJECTIVES	TARGET GROUP	INTERVENTIONS	KEY ORGANISATIONS
5.3.1 Increase understanding and skills in health promotion	Oral health and primary health workforce	<ul style="list-style-type: none"> <li>Develop generic training packages, drawing from information from other similar training packages, which encompasses:               <ul style="list-style-type: none"> <li>General Overview of health promotion principles</li> <li>Models and strategies</li> <li>Health education skills</li> <li>Health promotion planning skills</li> <li>Advocacy and policy skills</li> <li>Cultural sensitivity</li> <li>Information on existing relevant health promotion campaigns</li> <li>Key Oral health promotion information</li> </ul> </li> <li>Investigate feasibility of developing Oral health promotion unit or module able to be taken as 'stand-alone' or as part of other post-graduate degrees or professional upgrade, tailored specifically for Oral health professionals and the community workforce</li> <li>Identify specific Oral health promotion needs for Oral health professionals at undergraduate, postgraduate and continuing education level, through investigating current Oral health promotion training mechanisms</li> <li>Develop specific training packages for Oral health professionals to increase health promotion skills addressing key Oral health issues and identified needs</li> <li>Develop mechanisms for implementation of training package in line with the DHS workforce development framework</li> <li>Build drivers, recognition and incentives into system for training in Oral health promotion</li> </ul>	Primary health workforce, DHS, DHS, university sector, AHFA PHU, GPOH, DOH, AOH, nongovernment organisations

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# Appendix 1

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## *Working Party Membership*

### Community Education and Skill Development

<b>Dr Deborah Cole*</b>	Dental Health Services Victoria
<b>Jan Anderson</b>	Australian Dental Industry Association
<b>Andrea Campbell</b>	Department of Human Services
<b>Dr Pam Dalglish</b>	Dental Health Services Victoria
<b>Dr Mark Evans</b>	Australian Dental Association
<b>Mirta Gonzales</b>	Centre for Culture, Ethnicity and Health
<b>Dr Joanne Hood</b>	Victorian Aboriginal Health Service
<b>Dr Anne-Marie Laslett</b>	Public Health Association of Australia (shared position)
<b>Mandy Leveratt</b>	Brotherhood of St Laurence
<b>Dr Rachel Martin</b>	Public Health Association of Australia (shared position)
<b>Jill Thompson</b>	Council on the Ageing

### Facilitating Adequate and Appropriate Access to Fluoride

<b>Dr John Rogers*</b>	Department of Human Services
<b>Diane Barbis</b>	Department of Human Services (Loddon Mallee Regional Office)
<b>Dr Martin Dooland</b>	Dental Health Services Victoria
<b>Martyn Kirk</b>	Department of Human Services
<b>Dr Shane McGuire</b>	Dental Health Services Victoria
<b>Dr Jo Molloy</b>	City of Greater Geelong
<b>Lenore Tuckerman</b>	Colgate Oral Care
<b>Dr Anne-Marie Vincent</b>	Australian Dental Association

### Oral Health Research and Surveillance

<b>Dr Michael Morgan*</b>	University of Melbourne (School of Dental Science)
<b>Stephen Begg</b>	Department of Human Services
<b>Dr Hanny Calache</b>	University of Melbourne (School of Dental Science)
<b>Dr Martin Whelan</b>	Dental Health Services Victoria

### Workforce Development

<b>Tony McBride*</b>	Deakin University
<b>Dr Helen Best</b>	Australian Dental Association
<b>Rayleen Formosa</b>	Dental Health Services Victoria
<b>Diana Herd</b>	Department of Human Services
<b>Karen Hickman</b>	Hume City Council
<b>Anne Kimber</b>	Department of Education
<b>Julie Satur</b>	Dental Therapists Association
<b>Dr Mary Stephens</b>	Banyule Community Health Service
<b>Dr Rhyl Wade</b>	Department of Human Services

\*Convenor of working party



# Appendix 2

## *Goals for Oral Health in Australia (Department of Human Services 1997)*

Two documents describe goals for oral health in Australia. The Health Targets and Implementation Committee in 1988 proposed four specific targets:

1. To reduce the prevalence of dental caries to 35% or less for children aged 5–6 years (Note: most authorities interpret this to mean dental caries of deciduous teeth, since the 1987–88 National Oral Health Survey Australia (NOHSA) found only 2% of five-year-olds and 7% of six-year-olds had caries experience in permanent teeth).
2. To reduce the mean index of decayed, missing or filled permanent teeth to 1 or less in children aged 12 years.
3. To reduce the proportion of people having no natural teeth to 7% in adults aged 35–44 years.
4. To reduce the proportion of people having no natural teeth to 40% or less in adults aged 65 years (Note: most authorities interpret this to mean people aged 65 years or more).

All of these targets are readily quantifiable; and baseline rates can be established from the 1987–88 NOHSA.

A revised set of targets and proposed targets were formulated by Nutbeam et al (1993).

- i. Priority population: all children six years—to reduce by 50% the proportion who have permanent teeth with caries experience as measured by the DMFT index. Baseline=0.9 DMFT, cited from Australia's Health, 1992. (Note: this target is inappropriate for six-year-olds: in the 1987–88 NOHSA, only 7% of them had one or more DMF teeth. A 50% reduction would be relevant for mean 12 year-old DMFT which in the 1987–88 NOHSA was 1.77, thereby creating a target of around 0.9. Neither is the target relevant for the deciduous dentition—in 1987–88 the proportion of six-year-olds with 1 + DMFT was 44%, and mean DMFT was 1.62).
- ii. Priority population: all people 65 years or more—to reduce to 38% the prevalence of edentulism among people 65 years and older.

Five proposed targets relate specifically to people from low socioeconomic status (SES) groups (although the criteria for designating low SES are not stated). In addition, four of the proposed targets specify additional subgroups of Aborigines/Torres Strait Islanders and people from non-English-Speaking Backgrounds (NESB). There are no baseline data for any of these groups.

- iii. For low SES group children in rural communities—to increase 12-year-old DMFT to 1.5 or less. Additional priority groups: Aborigines/Torres Strait Islanders and people from NESB. (Note: 'increase' should be replaced with 'attain'.)
- iv. For 18-year-olds—to increase the proportion who have retained all their natural teeth. Additional priority groups: Aborigines/Torres Islanders and people from NESB. (Note: for effective quantification, 'retained all their natural teeth' should be replaced with 'no teeth that are missing due to caries'.)
- v. For young people and adults 15–64 from low SES groups—to reduce the proportion who have untreated dental caries. (Note: the age category for 'young people' is not specified.)
- vi. For young people and adults 15–24 from low SES groups—to reduce the prevalence of missing teeth. Additional priority group: Aborigines/Torres Islanders and people from NESB. (Note: the age category for 'young people' is not specified. Prevalence should be interpreted as 'mean number of missing teeth', since the alternative 'proportion of people with missing teeth' is 98% for people in the upper end of this age range.
- vii. For adults 35–64 from low SES groups—to reduce the prevalence of edentulism. Additional priority groups: Aboriginal/Torres Strait Islanders and people from NESB.