

# NATIONAL POLICY FOR ORAL HEALTH IN SOUTH AFRICA

## 1. INTRODUCTION

The National Policy for Health Act, 1990 (Act 116 of 1990), necessitated the revision of the National Dental Health Policy as approved by the Cabinet in 1975. The formulation of policy is, however, a dynamic process and it must therefore be accepted that this policy will itself be subject to constant re-evaluation and adjustment as circumstances require.

## 2. BASIC PHILOSOPHY

The National Policy for Oral Health (NPOH) has as goal the promotion of the oral health of the population of South Africa by preventing and restricting oral diseases in order to ensure optimum oral health.

The underlying philosophy of this policy is based on the Primary Health Care Approach and includes the following elements:

- a) Manpower must be trained appropriately to meet the needs of the community. The relationship between high level and lower level manpower must be in accordance with the oral health needs of the community.
- b) Community involvement must be integral to this approach. In implementing this policy at regional level and lower, the community must be consulted and involved.
- c) The implementation of the policy must be scientifically justified and must take into account the circumstances obtaining in each individual community.
- d) Oral health services must be accessible, equitable and to the optimum benefit of the total community.

- e) Services must be affordable for both the users and providers.
- f) Appropriate facilities and equipment must be employed and local technology must be used as far as possible.
- g) The objective of primary health care is to create an awareness within the community that every person is primarily responsible for his/ her own health and ultimately empowering the community to a state of self-care.

Read with this the following premiss:

The Government accepts responsibility for the oral health education of the total community in order to prevent oral diseases with the co-operation of participants from the private sector. The Government further accepts the responsibility for providing for the oral health services needs of that part of the community which, according to the applicable criteria and specific means tests and/or statutory prescriptions, is state-dependent.

### 3. GOAL

To promote oral health.

### 4. AIM

To ensure optimum oral health.

### 5. SUBAIMS

To promote self-care.

To promote primary, secondary and tertiary care services.

To ensure the formulation of objectives and priorities.

To standardise services by creating norms and standards.

To ensure that the oral health status of the population is monitored.

To ensure that services are evaluated.

To ensure the optimum use of all resources.

To ensure national and international liaison in the field of oral health.

To ensure appropriate professional training.

To ensure appropriate research.

To ensure a partnership between the various governmental institutions, and between governmental institutions and the private sector in the provision of oral health services.

To ensure that advisory bodies/institutions on oral health matters are established.

## 6. NATIONAL OBJECTIVES

6.1 The following 5 output objectives with regard to oral health status have been set for the year 2000:

### Objective 1: 6-year age group

To ensure that 50% or more of the children in South Africa in this age group are free of caries. The weighted national mean was 33,7% in 1989.

**Objective 2: 12-year age group**

To ensure that the mean DMFT of children in South Africa in this age group will be 1,5 or less. The weighted national mean was 1,72 in 1989.

**Objective 3: 20-year age group**

- (a) To ensure that 60% or more of those in South Africa in this age group will retain all their teeth (excluding third molars). The weighted national mean was 52,2% in 1988.
- (b) To ensure with regard to periodontal diseases that 35% or more of those in South Africa in this age group will have at least three healthy sextants. The weighted national mean was 24,7% in 1988.

**Objective 4: 35 to 44 age group**

- (a) To reduce the level of the edentulous population to 6,22%. The weighted national mean was 10,36% in 1988. In addition to this at least 80% of those in South Africa in this age group should retain a minimum of 20 functional teeth.
- (b) To ensure with regard to periodontal diseases that 15% or more of those in South Africa in this age group will have at least three healthy sextants. The weighted national mean was 11,1% in 1988.

**Objective 5: 60 to 64 age group**

- (a) To reduce the level of the edentulous population to 21,41%. The weighted national mean was 26,76% in 1988. In addition to this at least 60% of those in South Africa in this age group should retain a minimum of 20 functional teeth.
- (b) To reduce the mean number of sextants with deep periodontal pockets of those in South Africa in this age group to 0,27. The weighted national mean was 0,34 sextants with deep periodontal pockets per person in 1988.

## 6.2 Objective 6

In addition to the above five objectives, to strive to obtain useful national data in respect of the following oral conditions before 1995:

- (a) Premalignant lesions and squamous cell carcinoma of the oral cavity;
- (b) trauma of the face and oral structures;
- (c) malocclusion at the age of 12 years.

## 6.3 Objective 7

To establish before the end of 1993 and to maintain a national database on oral health at the Department of National Health and Population Development, as the overall co-ordinating department.

# 7. PRIORITIES REGARDING THE PROVISION OF PUBLIC ORAL HEALTH SERVICES

## 7.1 Priorities with regard to the users of oral health services

In this regard, a distinction is drawn between the following two main categories of services, namely organised and non-organised services:

### 7.1.1 Organised services

According to priorities, organised services involve the following:

#### (a) Oral health services for children

The main target group is the pre-school and primary school child. As far as schoolchildren are concerned, the highest priority is afforded children starting school and thereafter, if possible, the higher standards inclu-

ding even the high school pupil.

(b) Institutional and hospital oral health services

- the disabled
- the aged
- in-patients
- prisoners serving sentences, and prisoners in detention awaiting trial.

7.1.2 Non-organised services

These include all out-patient services. Out-patients receive services on demand only. These services are not of a high priority in attaining the objectives of the public oral health service, but where such patients request services for the relief of pain, sepsis and trauma, and owing to the ethical obligation to assist such patients, this category nevertheless necessitates a special priority.

7.2 Priorities with regard to the providers of services

Oral health manpower is utilised/deployed in accordance with the unique demands for oral health services in the various communities.

For the oral health instructional/educational task oral hygienists, oral health educators, nursing and teaching staff and others are primarily employed. Where a need exists for community oral health workers, they are recruited from the community and trained, after which they provide services within the community.

Dentists are primarily employed to meet the demand for comprehensive curative services (preferably advanced), while dental therapists are primarily employed to meet the demand for basic curative oral health services. Under certain circumstances where the ideal first-level staff are not available, dentists/part-time district dentists/fee-per-item dentists may also be employed.

Dental specialists provide specialised services to patients on referral from dentists. The specialist in community dentistry is used primarily in a non-clinical capacity.

### 7.3 Priorities with regard to the provision of services

#### 7.3.1 Educational and preventive services

- (a) Oral health education/instruction is the highest priority.
- (b) The next priority is the provision of preventive programmes for schoolchildren and pre-school children on an organised basis at schools and pre-school institutions.

Further specific protection measures under these priorities are -

- (i) individual preventive treatment of state-dependent patients at oral health clinics, state hospitals and institutions.
- (ii) optimum fluoridation of drinking water is regarded as the most effective preventive measure against tooth decay and should be considered a priority preventive measure within communities.

#### 7.3.2 Curative services

- (a) For the early diagnosis and treatment of oral diseases it is necessary that screening, epidemiological and individual physical examinations be conducted periodically.
- (b) The substantial backlog in the provision of services to some state-dependent communities, with the resultant great need and demand for curative services, means that the provision of basic curative services, remains of necessity a high priority in such cases.

Here, the first priority is obviously the relief of pain and sepsis and the treatment of trauma cases.

The second priority is basic restorative dentistry, followed by more advanced treatment, for example endodontics.

The third priority is services focussed on rehabilitation. These include services such as the provision of dentures.

The fourth priority under curative services is the provision of advanced and highly specialised dental treatment, excluding those specialised services necessary for the relief of pain and the treatment of trauma and certain pathological conditions, which are obviously first priority services.

## 8. PERSONNEL NORMS

Within the Public Oral Health Services the following personnel norms are accepted as guide-lines:

Dentist/Dental Therapist to population number	1:15 000 (As calculated from results of the National Oral Health Survey 1988/89)
Oral Hygienist to population number	1:50 000 (WHO, 1980)
Dentist/Dental Therapist to dental assistant	1:1,5 (As accepted in principle by the CFA)



The nature of the demand for oral health services within a particular community will largely determine the ratio of dentist to dental therapist. It will similarly determine the ideal ratio of dentist, dental therapist and oral hygienist to population number for that community. Since the oral health status and the demand may change in the course of time, it is accepted that the personnel norms for a particular community may therefore also change.

## 9. TARIFFS FOR PUBLIC ORAL HEALTH SERVICES AND ORAL AND DENTAL TRAINING HOSPITALS

9.1 The following services are provided free of charge:

(a) Organised services at -

(i) schools and pre-school institutions

- screening of schoolchildren and pre-school children
- education of teachers, schoolchildren and pre-school children
- preventive programmes for schoolchildren and pre-school children.

(ii) Clinics and other facilities

- services to state-dependent schoolchildren and pre-school children.

(iii) State institutions and hospitals

- services to state-dependent in-patients (since these patients would already have paid admission fees).

## (iv) Prisons

- emergency services and basic restorative dental services to state-dependent prisoners serving sentences
- emergency services to state-dependent prisoners in detention awaiting trial.

## (b) Oral health education services.

9.2 Out-patient services are provided on demand to state-dependent patients at specific approved tariffs.

9.3 Patients who are not state-dependent (private) may receive comprehensive treatment at oral and dental training hospitals at approved tariffs.

In the remainder of the public oral health services private patients will receive emergency treatment only, and then only under circumstances where the services of a private dentist are not readily available.

## 10. LEVELS OF ORAL HEALTH CARE

## 10.1 Self-care

The ultimate aim of oral health services is to make the community, as far as possible, self-reliant in the maintenance of good oral health.

## 10.2 Primary oral health care (POHC)

POHC services are basic oral health services that are deployed within communities utilising facilities that are directly accessible to patients from the communities concerned.

POHC services entail specific non-clinical activities such as:

- a) Oral health education of the total community;
- b) Oral health instruction as well as preventive programmes at schools and other institutions;
- c) Screenings at schools and other institutions for the early detection of oral diseases in order to provide for the timeous treatment thereof;

as well as the following clinical activities:

- d) Preventive services to individual patients;
- e) Dental emergency service: relief of pain and sepsis;
- f) The restoration of teeth by using direct conservative procedures.
- g) Preliminary diagnosis of oral anomalies and diseases and the referral of patients for further treatment

### 10.3 Secondary oral health care (SOHC)

SOHC services are more advanced oral health services that are provided to patients only on referral from the POHC level.

### 10.4 Tertiary oral health care (TOHC)

TOHC services are highly specialised services that are provided mainly in medical and in dental academic hospitals to patients on referral from the SOHC level.

Oral health personnel are utilised/deployed on the various levels of oral health care as described in paragraph 7.2.

## 11. IMPLEMENTATION OF THE NATIONAL POLICY FOR ORAL HEALTH (NPOH)

This policy (NPOH) will be implemented by those authorities that have been entrusted with the responsibility for providing public oral health services.

The institutions concerned with the training of oral health manpower will determine their own internal policy. The categories and numbers of manpower to be trained will be determined in consultation with the Committee of Dental Deans, the Subcommittee on Oral Health Matters and the Department of National Health and Population Development.

All institutions concerned with oral health research will determine their own internal research policy. Research at national level with regard to services and epidemiology will be dealt with by the Department of National Health and Population Development and the Subcommittee on Oral Health Matters in consultation with other interested parties.

The South African Medical Services will determine its own oral health policy.

The private sector (including medical aid schemes) will accept responsibility for the oral health of private patients (that is, those who are not state-dependent).

## 12. PHYSICAL FACILITIES

All accommodation needs and planning for the public oral health services as well as the oral and dental training hospitals, will be dealt with in accordance with the applicable policy and norms.

## 13. EQUIPMENT, INSTRUMENTS AND CONSUMABLE SUPPLIES

All requirements for the inviting of and recommendations concerning tenders for the purchase of dental equipment for public oral health services and oral and dental training hospitals will be arranged annually by the Department of National Health and Population Development in consultation with all interested parties.

All requirements for the inviting of and recommendations on tenders for term contracts for the purchase of dental instruments and consumable supplies will be arranged by the South African Medical Services in co-operation with the Department of National Health and Population Development.

Contributions from experts and expert advice should be sought in respect of the above.

#### 14. INFORMATION TO THE DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT (NHPD)

The Department of National Health and Population Development is responsible for collecting national oral health data/information and will be assisted in this regard by the participants concerned and the relevant institutions.