Australian Dental Association Inc.

Submission to the Productivity Commission

Caring for Older Australians Issues Paper

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Authorised by

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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 12,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and
- to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

Thank you for the opportunity to respond to Productivity Commission's Issues Paper on Aged Care. Should you wish to discuss any of the matters raised in this response, please contact the Association.

Dentistry is Different

Dentistry is unique in the health sector and so requires special consideration. All too often the differences are not recognised and inappropriate models (such as those created for the medical service delivery model) are proposed to be applied to dentistry.

A common misperception is that dentistry is very similar to general healthcare delivery and so medical consultations may be regarded as similar to dental visits. Dental practice:

- is procedural in nature and routinely involves invasive and irreversible procedures;
- is labour-intensive, in that it requires the presence of specific dental staff to assist the dentist;
- requires a high capital investment; and
- has high overheads, as a dental practice is akin to a mini operating theatre.

Therefore, matters such as infection control, clinical waste disposal and staffing requirements make dentistry vastly different to other health services. Dentistry is also practised mainly in a small office-based setting within local communities. A dental visit usually involves procedures that one would expect in a mini hospital setting and thus requires very different consideration to the consultative-only procedures most often encountered in a medical consultation setting. This setting then needs to be duplicated to some extent wherever dental care is provided to patients as dental care delivery requires specialised equipment and materials. Dental health delivery is also very different to the many large institutionalised settings that exist in health elsewhere.

The challenge for health policy makers is to identify and embrace the fact that 'dentistry is different' while progressing health policy at the same time.

Introduction

The ADA commends the Productivity Commission for undertaking this review as it demonstrates the first stage of a concerted effort to improve the quality of life of the aged, who for too long have had to endure not only general health issues but also poor oral health and a poor quality of life due to dental pain and discomfort.

In past decades, many Australians with poor oral hygiene had to resort to dentures and the problems experienced with them as they progressively lost teeth to dental disease. Retention of teeth has improved the oral health and the general wellbeing of the elderly. But somewhat ironically the improvement has brought with it the need for managed and more complex ongoing care of those teeth – particularly when the elderly lose the ability to care for themselves. The prevalence of tooth decay, gum disease and oral cancer for people aged over 65 years is higher than for the general population.

This problem has been one that the ADA has been asking the Government to address for some time. To date, aged care facilities have been under-resourced to deal with the dental issues confronting their residents. Generally, aged care facility staff are not trained to improve the oral hygiene of residents or be alert to recognition of dental problems and for too long these problems were ignored. Maintaining good oral hygiene and dental screening of residents was, and still is, often non-existent.

This review is a significant step in the right direction for the Aged. When implemented, it should bring about a much improved dental health status for this group. To have staff better educated to attend to residents' oral hygiene and be educated to screen for problems will assist in allowing early intervention by dentists.

The inclusion of the measures in the Aged Care Assessment Team (ACAT) process requires facilities to comply on an ongoing basis. The Government's commitment to ongoing review in light of the Better Oral Health in Residential Care project currently being trialed in South Australia, NSW and Victoria through the Encouraging Best Practice in Residential Aged Care (EBPRAC) program is welcomed. This is an excellent program that has had the support of the ADA and will provide excellent advice to the Government for ongoing improvement.

This project was concluded and educational tools have been created to educate carers in facilities to screen for problems and assist with oral hygiene.

The ADA remains committed to ensure that facilities are implemented to undertake regular dental assessments of residents take place. The Association is willing to provide ongoing advice and support to Government in this area.

Australia's Ageing Population

As the proportion of older Australians increases the oral health needs for the elderly will continue to increase in the 21st century – this is demonstrated in the table below. Greater focus on prevention and care must be addressed as a matter of priority.

Table 1: Australia's ageing population

	2005	2021	2051
65+ years	2.67 million (13.1%)	4.54 million (18%)	6.3 million (26%)
85+ years	315,000 (1.5%)	440,000 (4.4%)	1.2 million (4.8%)

Given that many older Australians are retaining their natural teeth, dental health for older people is more complex today than ever before. Increasing evidence is emerging that supports the link between oral health and overall levels of general health. Research has demonstrated that the risk of cardiovascular disease, aspiration pneumonia, nutritional deficiencies and stroke are higher if one has poor oral health. Pain and social isolation are frequently linked to poor dental health. Ageing can mean that people are less able to manage many customary daily living tasks, such as cleaning teeth, that were once second nature.

Studies have shown that many residents being admitted to residential care facilities have compromised oral health and high levels of oral disease. In many cases it is going unchecked, it will deteriorate if oral hygiene and mouth care planning is not undertaken and implemented. According to a report released by the Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2006-2007: a statistical overview*, at 30 June 2007 – there were 170,071 operational residential aged care places, an increase of 3,780 compared with 30 June 2006.[1]

In an effort to improve the level of oral health amongst people in residential aged care facilities, the South Australian Dental Service initiated two innovative and significant projects, the Oral Health for Older People: Nursing Home Care Program, and, the Better Oral Health in Residential Care Project.

The South Australian Dental Service is still funding care for residents of the facilities that were first seen under the project. This funding is quarantined and there is no waiting list. The residents are assessed by dentists and then the appropriate care is undertaken, including treatment under general anesthetic where appropriate. The funding is quite limited at this time and there are only about eight dentists involved – these are the dinists that participated in the original pilot.

Ageing population oral health issues also include:

- More retained teeth and more dental disease;
- Increasing treatment and management needs;
- Impact of dental disease on general health;
- Complications associated with polypharmacy;
- Poor access to dental care; and
- The need for funding of dental care.

The National Oral Health Plan 2004-2013

Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013 (the Plan) was prepared by the National Advisory Committee on Oral Health (NACOH), established by the Australian Health Ministers'

[1] Australian Institute of Health and Welfare 2008. *Residential aged care in Australia 2006-07: a statistical overview.* Aged care statistics series 26. Cat. no. AGE 56. Canberra: AIHW.

Conference in August 2001, comprising representatives from the Commonwealth, State and Territory governments, professional and consumer groups, and academic and educational bodies.

The purpose of the Plan is to improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of oral disease. The Plan aims to help all Australians to retain as many of their teeth as possible throughout their lives, have good oral health as part of their general good health, and have access to affordable and quality oral health services.

The National Oral Health Plan identified older Australians as one of seven key action items. The outcomes desired from the plan entail good oral health for older people, to help them maintain high levels of general health, quality of life, nutrition and social interaction. There are to be achieved through:

- Multidisciplinary approaches to oral health assessment and support for maintenance of oral hygiene; and
- Improved access to affordable, timely and preventively-focused oral healthcare.

Relevant patterns of disease are:

- The 1987–8 National Oral Health Survey found that, among 60–90 year olds with natural teeth, more than 90 per cent had periodontal disease (Barnard 1993):
- Diabetes predisposes to severe periodontal diseases and tooth loss (AHMAC 2001):
- With increasing retention of natural teeth, a range of chronic degenerative problems is expected to become more common, including tooth wear, tooth fracture, root caries, periodontal disease and pulpal necrosis: and
- Dry mouth – a common side-effect of medications taken by older people – dramatically increases the risk of severe dental caries (AHMAC 2001), as well as causing difficulties with eating, speaking and denture wearing (Guggenheimer & Moore 2003).

Access to care:
Most older people are living independently in the community and, if they are to maintain their oral health, they require access to affordable, preventively-focused dental care. Around 92% of older people continue to live independently, and therefore different types of dental strategies are needed to support these people as they age. More than four in every five Australians (83 per cent) aged 65+ years hold a concession card and are eligible for public dental care, but for many in these groups, long waiting lists mean that timely care is not available. As a result, their oral health deteriorates particularly rapidly (Chalmers *et al* 1999). Moreover, as they become frailer, their ability to get out of their homes unassisted diminishes which creates another problem in accessing care.

Oral healthcare planning:
As people move towards their retirement years, oral health management needs to focus on care that is sustainable throughout older age in the context of the person's general health and their financial circumstances. Particularly during the decade from age 50 to 60 years, people need to have access to preventively-focused oral healthcare and be actively involved in choices about the management of their oral health. This is required to achieve a level of oral health that can be maintained into older age and its potential for physical, cognitive and/or economic change.

Cognitive impairment:
People with cognitive impairment are at particular risk of oral disease. For those living in the community, the difficulties of maintaining adequate oral hygiene leads to high levels of caries and periodontal disease, and deterioration is rapid and ongoing once they are admitted to residential care (Chalmers et al 2000, 2001). This has a significant impact on quality of life and increases the cost and complexity of providing oral health services in community, hospital and residential aged care settings.

Comorbid conditions:
The extremely poor oral health of many older people also increases the cost and complexity of medical and aged care services. For example, tooth loss undermines the quality of nutrition and can cause loss of body weight (Chalmers et al 1998), while accumulation of dental plaque is linked to aspiration pneumonia (Loesche & Popatin 1998).

Access to care:
Almost eight per cent of people aged over 70 years are in residential aged care (unpublished data, Aged Care and Ageing Division, Commonwealth Department of Health and Ageing). Current programs to assist older people to remain in their own homes provide no support for maintaining oral hygiene, while the very small scale of public dental programs that provide visits to private homes and residential facilities means that they cannot address the need for preventively focused oral healthcare. However, where personal care and grooming services are provided to older people in their own homes, it would be expected that they would be assisted with cleaning their teeth or dentures as part of these services. Being stretched to provide timely care in practices, the cost and complexity of outreach oral healthcare, together with the limited experience and, for some, training in care for older people, means that few private dental providers offer this service. Lack of access to practical and affordable portable dental equipment is also a key barrier. At the same time, dental treatment in the normal dental surgery will always be less expensive than in a private home or residential aged care facility. Hence, mechanisms are needed to support the transporting of older people to dental appointments wherever this is reasonable. Lack of formal coordination between the dental and aged care sectors leaves confusion about who is responsible for residents' oral health and oral healthcare.

Workforce skills:
There is an urgent need to develop the capacity of the oral health workforce to meet the needs (including oral health promotion) of older people. A multidisciplinary team approach is needed, involving a range of dental practitioners and other primary healthcare providers (medical and allied health) (Chalmers 2003).

Standards:
The National Oral and Dental Accreditation Standards for Residential Aged Care Facilities requires that residents have timely access to appropriate oral health assessment and dental treatment. The poor oral health status of people in residential aged care facilities is clear evidence that standards are generally not being met with current approaches and the very limited availability of geriatric dental services (Chalmers *et al* 1998). There is a need for an appropriate medical and oral health treatment area within residential facilities.

Profile of Residential Aged Care

The Melbourne Dental School has undertaken some research in Victoria which indicates that there are 830+ accredited residential aged care facilities in Victoria (3,000+ in Australia). Of these, 60% are based in Melbourne with 2–245 residents per home. That equates to 42,000 residents in Victoria (160,000+ in

Australia). This is projected to increase to 100,000+ by 2051. This makes approximately 50 per 1,000 people aged 65 or over are in residential care. Moreover, the length of stay has also increased from 131 weeks in 1999 to 143 weeks in 2005.

Accessing Dental Services

Time spent in aged care facilities are:

- 48% of residents are in aged care facilities for up to or equal to 2 years; and
- 31% of residents are in aged care facilities for over 3 years.

The time since their last dental visit is as follows:

- 11% – less than 12 months;
- 12% 1–2 years;
- 18% – over 4 years; and
- 58% – don't know.[2]

The location of their last dental visit was as follows:

- 39% – dental clinic;
- 6% – nursing home; and
- 55% – don't know.

Process Indicators	Outcome indicators
• The number of older people living independently in the community receiving timely dental care; • The proportion of "at-risk" older people living independently in the community receiving support in the maintenance of oral hygiene; • The proportion of older people living in residential aged care facilities who have an oral healthcare plan; and • The proportion of older people in residential aged care whose oral healthcare needs identified in their oral healthcare plans are being met.	• Improved oral health for older people living independently including reduced levels of periodontal diseases and untreated dental decay; • Improved oral health for older people in residential aged care facilities including reduced levels of periodontal diseases and untreated dental decay; and • Improved oral health related quality of life, as recorded by indicators such the oral health impact profile (OHIP).

Dental Service Utilisation

There are many barriers that impact upon ability to access dental care. Some of these include:

[2] Hopcraft 2010, Access to Dental Care in Residential Aged Care Facilities, The University of Melbourne.

- Cost;
- Mobility of residents;
- Carer's lack of dental knowledge;
- Low participation by private dentists;
- Lack of portable equipment with which to provide treatment at a residential aged care facility;
- 60% of Directors of Nursing report difficulty obtaining dental care; and
- Treatment provision is haphazard and symptom driven.[3]

Dental Service Provision

Private practitioners:

- 50% of Victorian and South Australian dentists provided care in the past 12 months.[4] The average time spent on treatment was one hour per month. Hopcraft *et al* found that rural dentists were more likely to provide care and that dentists preferred to treat patients at their own practice (only 53% provided care at a residential aged care facility). These statistics could stem from the fact that there is a lack of fixed or portable equipment and space at residential aged care facilities.

Public Practitioners: Royal Dental Hospital of Melbourne Domiciliary Service (an institutional home for aged and disabled veterans who cannot care for themselves)

- 1625 patients in a 12 month period (2.6 FTE dentists); and
- ~1,000 extractions, 400 restorations, 350 periodontal services.

These statistics indicate that that of 1625 patients, there are 1,000 extractions occurring. This number is extraordinarily high and indicates that more preventative education needs to occur to reduce such numbers.

Oral Health Trends

Currently, the following trends are being observed:

- a decrease in edentulism (being without teeth);
- increase in numbers teeth and restorations present;
- increase in the prevalence of periodontal disease;
- links between oral and general health; and
- high risk – physical and cognitive impairment.

[3] Hopcraft et al 2008; Chalmers et al 2001, cited in Hopcraft 2010, Access to Dental Care in Residential Aged Care Facilities, The University of Melbourne.

[4] Hopcraft et al 2008; Chalmers et al 2001, cited in Hopcraft 2010, Access to Dental Care in Residential Aged Care Facilities, The University of Melbourne.

Dentate status nursing home residents[5]

1970s	1996	1998	1999	2002	2006
10–20% dentate	35% dentate	34% dentate	37% dentate	47% dentate	54% dentate
	13.8 teeth	11.9 teeth	11.6 teeth	12.1 teeth	14.4 teeth

Caries status nursing home residents

1996	1998	1999	2002	2006
DMFT 24.9	DMFT 23.7	DMFT 24.4	DMFT 24.7	DMFT 25
1.0 decayed teeth	1.1 decayed teeth	1.0 decayed teeth	0.8 decayed teeth	2.7 decayed teeth
1.4 teeth root caries	1.5 surfaces root caries	1.3 teeth root caries	1.3 teeth root caries	N/A

Periodontal disease nursing home residents

1996	1998	2006
8% with no disease	Mild–moderate disease common	0% with no disease
89% bleeding or calculus	4% severe disease	26% 4–6mm pockets
4% 4–6 mm pockets		10% 6 mm+ pockets

Dentate resident treatment needs

- 70% had one or more untreated, decayed teeth;
- 50% required extractions;
- 46% required restorations;
- 88% require periodontal treatment; and
- 10% had oral pain/discomfort.

Systemic Health

- Links have been demonstrated between poor periodontal health and cardiovascular disease, atherosclerosis, stroke (Genco *et al*, 2001; Mattila *et al*, 2005; Meurman, 2004); and
- Aspiration pneumonia is common (Muder, 1998; Marrie, 1990).

Function and Nutrition

- Poor nutrition and being underweight are significant problems in residential care (Kagansky *et al*, 2005; Bate et al, 1999)

- Correlation has been shown between number of teeth and BMI and number of occluding pairs and nutrition (Sheiham *et al*, 2002; Mojon *et al*, 1999)

[5] Saub, 1996; Chalmers et al 1998; Chalmers et al, 1999; Stubbs & Riordan, 2002, Hopcraft, 2010), cited in Hopcraft 2010, Access to Dental Care in Residential Aged Care Facilities, The University of Melbourne.

Measures to Improve the Oral Health of Older Australians

In an effort to improve the level of oral health amongst people in residential aged care facilities, the South Australian Dental Service initiated two innovative and significant projects, the *Oral Health for Older People: Nursing Home Care Program* and the *Better Oral Health in Residential Care Project* (Appendices 1 and 2).

The ADA recommends that such initiatives must be reviewed and, on the basis of the findings, plans to put in place more universally to address the oral health needs of people in residential aged care facilities.

To Achieve Improved Oral Health in Residential Care

Who needs to be involved?

- Older adults, their families/carers and guardians;
- General medical practitioners and Divisions of General Practice;
- Aged care assessment teams;
- All providers of aged care services to older people in the community;
- Residential aged care facility and hospital staff;
- Dentists and, under their prescription and supervision, other dental practitioners;
- The tertiary education sector;
- State/Territory and Commonwealth Governments; and
- Aged Care Standards and Accreditation Agency.

Where does it need to happen?

- Public and private dental clinics;
- Primary healthcare settings;
- Private homes;
- Hospitals;
- Residential aged care facilities; and
- Tertiary education settings.

What are other linked initiatives?

- National Strategy for an Ageing Australia;
- Health Senior Initiative;
- Aged Care Standards and Accreditation Agency; and
- Public Health Action Plan for an Ageing Australia.

The following should be considered:

- Evidence-based best practice model to promote better oral health in residential care;
- GPs and RNs (or other carers) to implement Oral Health Assessment Tool Kit;
- Linked to Nursing Home Oral and Dental Health Plan (DoHA);

- Public funding models to encourage greater participation by private dental care providers in aged care settings;
- Availability of portable dental equipment is a barrier to provision of treatment; and
- Dental policy in Australia that is responsive to the changing demography and treatment needs of the elderly population.

Dental Hygienists can be used in Nursing Homes

- Hygienists have been shown to be capable of detecting periodontal disease in nursing home residents;
- While hygienists are not trained to detect the full range of dental problems, they can be useful in screening residents who require treatment by dentists;
- Hygienists can provide cost-effective periodontal and preventive treatment and prevention and education critical to this population; and
- A model of care that utilises dental hygienists as part of the dental team has been shown to be a cost-effective and safe method of improving access to dental care for aged care residents. However, more research is required to further investigate dental hygienists working under the direction of a dentist.

Key Questions for Stakeholders

The Commission's Approach (page 5)

1. *Are there findings or recommendations from previous reviews of aged care in Australia that remain relevant? If so, of those that have not been acted on, which ones are most important? The Commission also invites advice on any international reviews and policy approaches that may be relevant to this inquiry.*

Healthy Mouths Healthy Lives: Australia's National Oral Health Plan was explained earlier. The short-medium term goals of the plan (two to five years) included:

1. Ensuring oral screening by dental professional on admission to RACF;
2. Development of a simple but practical oral healthcare plan for residents; and
3. Making available portable dental equipment to public and private oral health providers.

The first of these was not achieved. The second was achieved, but the third is questionable.

A report tabled in 29 June 2010 by the Parliament of South Australia entitled, 'Inquiry into Dental Services for Older South Australians', details 20 recommendations from their inquiry. These have been attached as Appendix 4 for further information. The focus of the inquiry was current and future dental care needs; factors that impact on oral health; the social, economic and health implications of poor oral health; the adequacy of current and proposed State and Commonwealth programs and funding; and possible measures to improve the oral health of older South Australians.

Flexible Care and Care for People with Special Needs (p 13)

2. *The Commission invites comment and evidence on the main strengths and weaknesses of aged care services — community, residential, flexible and respite care — as they are currently configured.*

During the 1970's, only 10 percent of people living in residential aged care facilities were dentate – that is, had all or most of their teeth. Today this percentage has risen to around 50 percent. The increasing rate of tooth retention, coupled with an ageing population means that there will be a strong demand for dental services in the future.[6]

Workforce is also an issue and staff of residential facilities need to be adequately trained to maintain good oral hygiene and perform dental screening of residents. Moreover, recruiting staff for rural and remote dental health services is a major problem, with the overwhelming bulk of dentists and allied health practitioners employed in urban areas.

3. *Are the aged care services that older Australians require available and accessible? Are there gaps that result in a loss of continuity of care? Is there sufficient emphasis within the current system on maintaining a person's independence and on health promotion and rehabilitation? How might any inadequacies in the system be addressed?*

As previously stated, poor access to dental care is an issue for the elderly. The lack of access to practical and affordable portable dental equipment is also a barrier. Mechanisms are needed to support the transportation of older people to dental appointments.

Funding is required to increase the availability of portable dental units and in the longer term, an investigation needs to be undertaken into the feasibility of ensuring all new-build designs for aged care facilities, or those undergoing a major upgrade, integrate a multi-purpose health room for use by health professionals, including dentists, if not a clinic of their own.

4. *Is the current system equipped, or can it adapt, to meet future challenges?*

No, the current system is not equipped to meet future challenges in relation to dental health for the aged. This could change if nursing homes had dental surgeries located on the premises and had the appropriate infrastructure to accommodate wheelchairs.

Issues remain in relation to disability, special needs and access. If the infrastructure isn't there, then transport is needed to move patients to and from the dental surgery.

5. *Should there be greater emphasis on consumer-directed care in the delivery of services, and would this enable more older Australians to exercise their preference to live independently in their own homes for longer with appropriate care and support?*

[6] Parliament of South Australia 2010, Inquiry into Dental Services for Older South Australians, p 2.

There needs to be a greater emphasis on education, preventive dentistry and maintenance of good oral condition (for example, existing denture care). However, such measures will only help with oral hygiene.

Again, one can't simply pick up an entire dental surgery and make it portable. Adequate transport services are required to and from the facilities for broken teeth, etc. Perhaps a taxi or an ambulance service could be expanded to address the current need.

6. *Comments are also invited on the current system (and possible alternative arrangements) for providing services to people with special needs, including those living in rural and remote locations, those with culturally and linguistically diverse backgrounds, Indigenous Australians, veterans, the older homeless, older people with a mental illness, those with a disability, and other special needs groups, such as gays and lesbians.*

The requirement for transport services is reiterated.

Objectives of the Aged Care System (p 15)

7. *How effective has the aged care system been in addressing these objectives? What changes, if any, should be made to the objectives? What are the implications of such objectives for any redesign of the current system?*

An adequate clinical setting needs to be incorporated into residential aged care homes to take into consideration residents in wheelchairs and those with back problems etc.

8. *Should the objectives have equal weighting or should some have higher weighting, and if so why? Where conflicts might arise, which objectives should be given priority?*

Quality of life requires the highest rating. The aged deserve access to services that allow them comfortable, pain-free living – this should also be a priority.

9. *Should Australia have an 'aged care system' as currently conceived, or could a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?*

Health cannot be compartmentalised into age groups, as ageing is a continuous process. Problems are progressive and treatment should be continuous. For example, one's health does not change at 37 or 73 years of age. However, there are people with special needs, for example: once in nursing home there is increasing frailness and this impacts on oral and general health. So any system should recognise special needs rather than be based on age.

Who Should Pay and What Should They Pay For? (p 16)

10. *Who should pay for aged care services? Are the current government subsidies and user charges for aged care appropriate? Are there components of aged care costs – accommodation, living expenses, personal and healthcare — that warrant government subsidies and/or should they be the personal responsibility of older Australians? To what extent should means testing be applied?*

The above question can be answered with reference to the Australian Dental Association's *Federal Budget Submission 2010–11*.[7] The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	TOTAL
Oral health examination by dentists for residents in aged care accommodation (assuming 60,000 examinations annually)	$100 per examination	$6,000,000
Development of an oral health plan for each person in residential accommodation	$2,000,000	$2,000,000
Oral health training manual	$250,000	$250,000
Portable dental equipment	$2,000,000 plus $300,000 per year to support	$2,300,000
TOTAL		**$10,550,000**

Recommended Initiatives

The ADA encourages Government to consider the recommendations in their entirety. Further detail on the initiatives listed in 4.3.1 appears below.

- Leadership needed

  The Commonwealth Government should provide informed leadership to implement the range of initiatives outlined in Australia's National Oral Health Plan.

- Health Assessments, oral hygiene programs and transportation to be provided. In so doing provide:

[7] Australian Dental Association 2010, Federal Budget Submission 2010-11, www.ada.org.au.

  - Improved oral health assessments through the Home and Community Care program and the Aged Care Assessment Service;
  - Improved oral hygiene programs to assist older people to live independently in the community;
  - Ensure that oral health is taken into account when developing a care plan for people in residential accommodation; and
  - More affordable transport to enable older people to attend dental appointments.

- Greater funding for public dental care.

11. *How important is the provision of choice for older people requiring care? Are there components of aged care which older people value choice more highly than others? Is there any evidence which suggests that the provision of greater choice may have resource implications? Should subsidies that 'follow' approved clients be paid to providers directly or should care consumers be given the choice of receiving such payments first to promote a greater capacity to exercise choice?*

Consumers should be given choice and the ability to exercise that choice. This is very important for their quality of life. Choice is regarded by most people as very important and particularly when involved in something as personal as healthcare. Where a person is unable to exercise the option of choice, they must be accorded some dignity and not just be made to feel like a number in the system.

12. *What are the possible medium and long-term fiscal impacts of such administrative reforms?*

Having basic care provisions as part of the care process will help with long-term health maintenance because if disease is prevented, there will be a reduced financial burden in the long-term.

A Workforce to Care for the Elderly (p 24)

13. *What are the key issues concerning the current formal aged care workforce, including remuneration and retention, and the attractiveness of the aged care environment relative to the broader health and community care sector?*

This issue has been discussed previously. However, it is reinforced that current workforce numbers in this area are inadequate, but the workforce make up does not need to be modified.

These numbers need to be increased with incentives for retention once trained.

ADA Recommendations to Improve Older People's Oral Health

The ADA believes that the Commonwealth Government should provide informed leadership to implement the initiatives outlined in Australia's National Oral Health Plan to improve older people's oral health. They should also involve the State and Territory Governments. Amongst a number of key points, the Plan calls for:

- Mandatory and uniform oral health assessments through the Home and Community Care program and the Aged Care Assessment Service;
- Improved oral hygiene programs to assist older people to live independently in the community;

- Secure sufficient resources to ensure that oral health is taken into account when developing a care plan for people in residential accommodation;
- More affordable transport to enable older people to attend dental appointments;
- Greater funding for appropriate public dental care;
- Development of additional professional education for dental practitioners in special needs dentistry and in the training of carers and nursing home staff; and
- Also, initiatives such as the Oral Health for Older People: Nursing Home Care Program and the Better Oral Health in Residential Care Project must be examined and plans put in place more universally to address the oral health needs of people in residential aged care facilities.

Conclusion

Changes are required for dental services for older Australians. Dental services need to be reconfigured in a way that ensures the focus is on early detection and intervention. Doing so will help alleviate some of the burden placed on the overall health system by reducing, among other things, the need for surgical intervention and hospital admissions.

Thank you for the opportunity to participate in this inquiry.

Dr Neil Hewson
Federal President
30 July 2010

Appendix 1

Oral Health for Older People: Nursing Home Care Program

The main points of this program are summarised below:

- Funded by the SA Dental Service and developed as a collaborative partnership with the Australian Dental Association (SA Branch) and private dental practitioners, the programme commenced as a two-year demonstration project in 2003.
- A small number of private dentists experienced in delivering dental treatment services to older people living in Residential Aged Care Facilities (RACFs) were recruited by the SA Dental Service.
- For residents to be eligible for publicly-funded dental care they required either a Pensioner Concession Card or Healthcare Card (however, those who were ineligible were still able to receive a dental examination under the scheme and then have treatment services as private patients).
- A fee for service payment structure, (the 'Aged Care Dental Scheme'), was developed based on the Department of Veterans Affairs Licensed Dental Officer schedule. Via the scheme, all initial assessments were fully covered but RACF residents were required to contribute towards the cost of their dental care by paying a small co-payment. An additional feature of the scheme was that any RACF resident could receive an initial assessment which was fully covered, regardless of concession status. Subsequent dental treatment could then be arranged via their private dentist or the visiting dentist.
- The project aim was to improve the level of oral health amongst people in residential aged care facilities, thus improving their general health and quality of life.
- Central to the clinical service delivery model was the provision of clinical services on site using appropriate portable dental equipment.
- The uptake and acceptance of the project by RACF residents and staff and the participating private providers was evaluated after two years. The evaluation demonstrated continued commitment and involvement of the private providers and RACFs, and positive outcomes in terms of oral and overall general health and quality of life for project participants. As a result of these outcomes, the project developed into an ongoing limited programme which continues to be funded and supported by the SA Dental Service.
- Currently, residents of 48 RACFs are receiving dental treatment services from eight participating private dentists and one dental hygienist on a sessional basis. The frequency of treatment sessions at 25% of these facilities is from 1–4 times per month. The session frequency at the remaining RACFs is on average once every 2– 3 months. Since the commencement of the programme in 2004, 2,000
- individual RACF residents have received 3,600 dental courses of care incorporating 11,000 service items.

Ongoing achievements of the programme include:

- Provider meetings, partnership forums, and regular information updates - development of a network of private practitioners who have considerable experience in the field of aged care dentistry.
- Awareness of the importance of oral health amongst the RACF sector.
- The development of *The Oral Health Protocols for Residential Aged Care Facilities* – a nationally recognized publication. Specific information for RACF staff relates to the provision of oral hygiene assistance to residents, treatment guidelines for oral health conditions, provision of support and assistance for visiting dental teams, and documentation templates.

Appendix 2

Better Oral Health in Residential Care Project

The main points of this project are summarised below:

- A collaborative project between the SA Dental Service, the aged care sector, the Australian Dental Association, medical practitioners, the nursing profession and the Commonwealth Government that funded it.
- The SA Dental Service led the $1.3 million project. Funding was given by way of a grant provided by the Department of Health and Ageing's Encouraging Best Practice in Residential Aged Care (EBPRAC) Program.
- The two-year project was aimed at enabling medical general practitioners (GPs) and registered nurses (RNs) to assess the oral health status of residents in an aged care facility. Oral hygiene was implemented by care workers trained in best oral health practice and timely dental treatment was provided as required by dental professionals, following the development of oral health plans by RNs.
- The project complemented *Australia's National Oral Health Plan 2004-2013* and had as its goal the development of an evidence-based, best practice model to promote better oral health within the Australian residential aged care sector.
- The project was undertaken by a consortium led by the SA Dental Service, the Department of Human Services (Vic), the Centre for Oral Health Strategy (NSW) and six residential aged care facilities. The Australian Research Centre for Population Oral Health evaluated the project.
- The project built on an earlier project to develop and trial an Oral Health Assessment Tool Kit, conducted in 2005.
- Participating GPs and RNs were provided with the tool kit, incorporating multimedia educational materials to enable them to undertake an oral health assessment. RNs developed care plans for residents' oral health needs in the context of overall general health. Their efforts were supported by a training programme for care workers and an oral health educational portfolio.
- Participating residential aged care facilities included Helping Hand Parafield Gardens and Resthaven Craigmore in metropolitan Adelaide, Tanunda Lutheran Home in South Australia's Barossa Valley, Umoona Aged Care Service in Coober Pedy, Kara Aged Care Facility in Newcastle, New South Wales and Kyabram & District Health Service in Victoria.

Appendix 3

ADA's 'DentalAccess' is the Best Solution to Improve Australia's Oral Health

The ADA has long argued for more resources to be applied to the oral healthcare of aged and disadvantaged Australians and it has been pleasing to see the National Health and Hospitals Reform Commission [NHHRC] give the matter of oral health serious consideration. The ADA believes equitable access to dental care is an essential requirement of the Australian health system. This document sets out how such access can be most effectively achieved without the collateral damage likely to occur to the delivery of high quality effective dental care by going down the uncharted path of "Denticare Australia".

DentalAccess is a targeted model to provide for the 30-plus per cent of Australians who cannot access dental care. It is a targeted, equitable, cost-effective fair go for Australians who suffer a double disadvantage when it comes to oral health. On one hand disadvantaged Australians cannot afford or otherwise access quality dental services, largely because the public system is underfunded and lacking in infrastructure. On the other hand, financial and social disadvantage is a recognised precondition to a complex array of health problems, among them poorer oral health and wellbeing.

The ADA calls for the abolition of the Enhanced Primary Care [EPC] - Medicare chronic disease dental scheme presently funded by the Commonwealth Government. The EPC program utilises medical practitioners as the gate-keepers, is not means-tested and has high annual monetary limits (AMLs) which have led to high usage of expensive dental treatments. It is incongruous that the Government is funding crowns for people under this scheme yet it is not able to provide even basic treatment such as fillings for many aged and disadvantaged people.

The ADA wishes to play a constructive role in delivering a successful dental scheme or system for aged and disadvantaged Australians and suggests that their Submission entitled 'Dental Access Proposal: Proposal To The Australian Government For A Scheme To Assist Disadvantaged Australians Obtain Improved Access To Dental Care' (copy attached) be used as a basis for that process. While increased funding is required, significant dental care for the aged and disadvantaged should be able to be implemented relatively quickly as part of a staged process at the same time as public dental infrastructure and workforce are augmented.

More importantly, as the frail elderly in aged care facilities cannot physically come to these centres and there is considerable expense in putting dental facilities in aged care settings some extra funding should be considered to overcome this additional barrier. One of the problems is that many aged care residents are chair-bound and cannot move into a standard dental chair, so there is a need for extra portable equipment or for a method to facilitate treating them in their wheelchairs or mobile chairs.

The public infrastructure would include dental hospitals, university clinical teaching facilities and community health centres. By introduction of these measures all Australians will have improved access to a high standard of dental care without the need to introduce a scheme which will enhance 'middle class welfare' whilst doing little to assist the disadvantaged.

RECOMMENDATIONS

1. The Committee recommends that the Minister for Health, in conjunction with other relevant agencies, develop and implement a comprehensive public awareness strategy aimed at increasing community understanding of oral health and its relationship to overall health and wellbeing. This strategy should take into account particular needs in different regions and, wherever possible, incorporate oral health messages into existing health promotion campaigns.

2. The Committee recommends that the Minister for Health, in conjunction with the South Australian Dental Service and other relevant stakeholders, expand the Oral Health for Older People: Nursing Home Care program and ensure it is properly resourced and provided with sustainable long-term funding, Federal and State, to enable the program to be rolled-out across South Australia.

3. The Committee recommends that the Minister for Health, in conjunction with relevant stakeholders, develop and implement a range of programs to ensure frail elderly people living in the community have better access to oral health care so as to minimise oral health decline. As part of this, the Committee further recommends that consideration should be given to targeting existing community services and providing them with appropriate resources to better support the oral health of older people living in the community.

4. The Committee recommends that the Minister for Health, in conjunction with training providers and other relevant stakeholders, work towards improving oral health care training for general practitioners and registered nurses to ensure oral health screening becomes a routine part of patients' general health assessments and check-ups. As part of this work, the possibility of making greater use of the General Practitioner Oral Health Assessment Tool Kit should be examined.

5. The Committee recommends that the Minister for Health lobby the Commonwealth Government to ensure that general practitioners and nurses are provided with educational support and access to resources to more effectively manage the oral health of elderly patients.

6. The Committee recommends that the Minister for Health, in collaboration with the Commonwealth Government, address the financial and administrative disincentives which presently impede medical and dental practitioners' involvement in the Medicare Chronic Disease Dental Program to ensure better knowledge of and improved access to this program. The Committee further recommends that the Minister explore opportunities to integrate the Medicare Chronic Disease Dental Program with State-funded programs to maximise the impact and sustainability of State and Federal programs.

7. The Committee recommends that the Minister for Health encourage the Commonwealth Government to further develop the proposed Denticare Australia scheme, or similar universal dental health scheme. This recommendation is made on the understanding that any national dental scheme must, among other things:

    - appropriately address and sustainably fund the predicted future increase in demand for dental services by older people;
    - ensure waiting times are kept to a minimum and in line with best practice;
    - focus on preventive care and maintenance; and
    - ensure more complex dental treatment is covered.

8. The Committee recommends that the Minister for Ageing, in conjunction with the Minister for Health, lobby the Commonwealth Government and the aged care industry to ensure residential aged care facilities are properly resourced to implement and maintain the staff training requirements associated with the Commonwealth's *Nursing Home Oral and Dental Health Plan*.

9. The Committee recommends that the Minister for Ageing, in conjunction with the Minister for Health, lobby the Commonwealth Government to ensure that the *Nursing Home Oral and Dental Health Plan* includes the provision of clinical dental care following oral health assessment so that an effective referral pathway leading to timely, affordable and appropriate clinical dental care is in place for those residents indentified as needing dental treatment.

10. The Committee recommends that the Minister for Health continue to provide more resources, as a matter of urgency, to further reduce waiting times and enable older South Australians to achieve and maintain good oral health.

11. The Committee recommends that the Minster for Health ensure oral health is better integrated into the development, funding and delivery of general health services, including all relevant State health plans, policies and promotions.

12. The Committee recommends that the Minister for Health – in conjunction with the Australian Dental Association (SA), the South Australian Dental School and other relevant stakeholders – consider ways to improve the capacity of the oral health workforce to meet the current and predicted future needs of older South Australians. The Committee further recommends that the Minister for Health should develop and implement strategies aimed at:

    - encouraging more dentists to work in aged care facilities and in rural and remote areas;
    - helping to attract and retain dentists and allied health care professionals in both the public and private sectors;
    - ensuring geriatric oral health is afforded the appropriate level of focus in South Australian dental education institutions; and
    - ensuring that any measures implemented are matched with appropriate funding allocation.

13. The Committee recommends that the Minister for Health, in conjunction with the Australian Dental Association (SA) and other relevant stakeholders, review the current scope of practice and supervisory requirements of dental hygienists with a view to enabling them to take a greater role in providing oral health care to the aged community. Any measures put in place to expand the current scope of practice should not replace the important diagnostic and treatment role provided by dentists.

14. The Committee recommends that the Minister for Health work with the University of Adelaide to establish a dedicated research position in Geriatric Oral Health to ensure South Australia remains at the forefront of oral health research.

15. The Committee recommends that the Minister for Health take immediate steps to provide funding for more mobile portable dental units to provide restorative and preventive dental services to older South Australians living in the community and in aged care facilities.

16. The Committee recommends that the Minister for Health investigate the feasibility of ensuring all new build designs for aged care facilities, or those facing major upgrade, integrate a multipurpose health room for use by health professionals, including dentists.

17. The Committee recommends that the Minister for Health consider co-locating dental health services with other general health services wherever possible.

18. The Committee recommends that the Minister for Health review current community-based transport options to ensure older South Australians living in the community have access to a range of properly resourced transport services to enable them to attend dental health services.

19. The Committee recommends that the Minister for Health urge the Commonwealth Government to review the Aged Care Accreditation Standards and their implementation to ensure that the standards are sufficient to mandate effective oral health care and that processes are in place to ensure that all aged care residents undergo an oral health assessment upon admission to an aged care facility. The Committee further recommends that these assessments:

    - are followed up with the development of an individual oral health plan which includes oral health screening at regular intervals (at least every 12 months) and appropriate referral as needed;
    - are regularly monitored and evaluated to meet the needs of residents; and
    - form part of the ongoing accreditation assessments of the facility.

20. The Committee recommends that the Minister for Health, in conjunction with the Commonwealth and other key stakeholders, ensure that all aged care facilities have a designated senior staff position responsible to oversee oral health services in the facility, including the provision of appropriate and ongoing staff training in oral health care.