Senate Select Committee

The Issue. Accessibility to Dental Services in Australia

This submission focuses on the needs of those without appropriate services in health care. I have read the Terms of Reference and will address them under 'any related matters'.

THE SUBMISSION

The Sponsor is the Oral Health Providers Association Inc (WA). Essentially it is a dedicated group of oral hygienists who want to work in health care under a medical umbrella as members of the medical allied health team to assist patients, doctors, nurses, and carers, achieve better health care outcomes.

My background

I come from three generations of medicos. My primary qualification is dentistry with a post graduate qualification in Public Health from the University of Sydney. I had five years NHS experience in the UK and 17 years in private practice in Perth. I left clinical dentistry for health reasons and went into public health (1982). I was directed to carry out research into the unmet dental treatment needs of the aged in WA. This involved comprehensive literature review and examining over 2000 WA elderly in nursing homes, hostels, and the community. I was appalled at what I saw. In 1986, the WA Government terminate the research. I resigned and subsequently operated the first ever Commonwealth funded nursing home program in WA for eight years. It was terminated by the Commonwealth when they changed the funding arrangements. Nothing replaced it. I was then appointed Oral Health Consultant with the largest aged care provider in WA for five years and was instrumental in initiating the Medicare Chronic Disease Dental Scheme with the support of the then Minister for Aged Care, Julie Bishop, Dr Mal Washer, the Federal Member for Moore, a former GP, and the Perth Coastal Division of General Practice. It was sound policy, but it did not achieve the objective. More on that later.

REASONS FOR THIS SUBMISSION

This Inquiry is about access to dental services in Australia. Australia's health system is ranked amongst the best in the world (4) with very little separating them. However, it is ranked near the bottom for dental health, 14th out of 16 OECD countries, by Forbes, the respected US publication. Why this disparity? Child dental health was declining, and adult dental health was poor. 50% of the population get regular dental care, the other 50% do not. Not just because they cannot afford it or think they don't need it, but because of health issues, health policy and legislation. Problems in the mouth are usually seen exclusively as dental problems because teeth are very visible and important for appearance and function. But what about health? The mouth has more than teeth in it. Blood vessels, nerves, salivary glands, tongue, soft tissues, and soft palate. Who looks after them? Not dentists. And then there are the bacteria and other species, protective and pathogenic. What happens to them?

AIHW reports on hospitalisations. 80% are for chronic disease complications. 50% are considered preventable. Most of these occur in the older age groups since the medical risk increases with age. Coincidentally they have the worst oral health. Pathogenic oral bacteria do not just cause dental problems. MEDICAL research is strongly connecting oral pathogens with strokes, heart attacks, arthritis, Alzheimer's, diabetes, peptic ulcers, pneumonia, kidney disease, and so on. We don't know how just yet. Research is continuing. But teeth are not the problem. A Japanese nursing home study found the risk of fatal broncho pneumonia was just as high in those WITHOUT teeth or dentures as those WITH them. Pathogenic bacteria were in mouths without teeth and were being aspirated into the lungs. GP's regularly see these patients, dentists do not. Dentists practice independently of medicine and outside health care. This is one of the reasons why we have problems in the health system. Preventing infection is a MEDICALLY NECESSARY service and therefore ESSENTIAL HEALTH CARE. Medicare is legislated to cover essential health care but has excluded oral and dental health from health care and allied health. It failed to make the distinction between essential health care and dentistry. Those most affected by this exclusion are the highest medical risk, most vulnerable, and most in need. These are the reasons for this submission. This is affecting everyone who is medically compromised, probably about ten million Australians with chronic medical conditions. (AIHW)

If you are treating a person medically the starting point should be the mouth. There is no point treating a person medically and ignoring a potential source of infection. Here we are treating the consequences but not the cause. Medical complications, as a consequence of an undiagnosed oral or dental condition, go untreated. This has been going on for years. So, what happens? These are actual situations I have had to deal with. There are hundreds more.

Case 1

Patient Aboriginal woman. Age mid 50's. Location regional nursing home. Facilities Hospital. Operating theatre. Anaesthetist. Doctors. Dentists. No public dental clinic. Private dentists provide subsidised services with gap payment. This woman was admitted six weeks prior to my visit. On morphine for pain. 24/7 nursing. On examination she had dental septicaemia and required immediate dental clearance and antibiotics. Problems. Dentists would not participate in Commonwealth CDHP program so no dentist. Went to DHS she would have to go to Perth. Hospital would not do dental (policy). Went to AMS. Not their brief. Go back to DHS. They sent a dentist. But she needed a GA. Can't be done. Took it to the Health Commissioner. Advised fix it. Put it through the hospital. Bill it as medical. That should have happened on admission HAD SOMEONE QUALIFIED EXAMINED HER.

Case 2

Elderly lady. Mentally competent. Supportive family. Pensioner. Wheelchair bound. Travelling well. Denture wearing. Advised she had a mouth ulcer. Ulcers are frequent. Last about 10-14 days with removal of denture and local analgesic application. This one didn't. When I saw her 2 months later the

ulcer was not an ulcer but an aggressive mouth cancer and needed IMMEDIATE treatment. She was now bed bound, lost a lot of weight, on morphine, and sleep deprived. A biopsy was needed, but no one would do it. I couldn't because I was a dentist (policy), it needed a specialist. DHS didn't have one. Private didn't do domiciliary. Eventually I contacted a colleague at the dental school in Oral Medicine. He did the biopsy gratis. It confirmed my diagnosis. She was referred to RPH and assessed for surgery. Being a public patient, she had to wait. If she was private, it could have been done next day. To facilitate treatment, I approached the Health Insurance Commission. Not possible (legislation 1973), the health funds not possible. They required 3 months waiting period(policy). She died in pain shortly afterwards. Her family was very upset. This is not a rare event.

Case 3.

Midland GP on a home visit. Husband with dementia looking after wife who has advanced dementia. She won't eat and can't swallow. It's been going on for a while. On examination her mouth is full of fungus and is blocking the oesophagus. GP requests a domiciliary dental service from DHS. She was not in any pain just starving to death. She was seen six weeks later!

GOVERNMENT LEGISLATION

Health policy is determined by the Commonwealth Government. If there is a policy deficiency it affects both the States, the Commonwealth, and EVERYONE else. The Commonwealth funds the States to deliver health services and shares the operating costs. Public dental services are a State responsibility. They are 'on demand' treatment services, NOT needs based, which poses a problem for those who are eligible but unable to physically access services. Access, equity, and choice are absent. HACC, NDIS, and Disability do not address this. The fundamental principles of WHO policy of which Australia and most other countries are signatories are 'every citizen is entitled to essential health care, that is, **medically necessary services.** This is MEDICALLY necessary NOT dentally necessary. Some countries include dental in their national health schemes, Australia does not because including them would have made Medicare unaffordable. Medicare was introduced almost fifty years ago. Things were different then. Life expectancy was about 70, and most elderly had full dentures. Now life expectancy is about 85 and most have some of their own teeth and increasingly dental implants. Unlike dentures, these must be frequently maintained and cannot be removed. I foresaw this problem in 1985. My Public Health thesis was titled 'Towards an Older Australia. The Implications for Dentistry'.

MICROBIOLOGY

Most diseases are preventable and caused by pathogenic bacteria. It is only over the past 30 years there has been a focus on the mouth and its microbiology (oral microbiome). Prior to that the focus was on particular bacteria and dental issues. Now it's the WHOLE BODY, the holobiome. The trigger was the Human Genome Project (1988-2001) an international multidisciplinary study of the healthy mouth. The mouth was selected because after the gut it was the most complex and easily accessible. Gene sequencing and new analytical techniques revealed 700 bacteria, viruses, and others of which only 400 have been identified. A healthy person's mouth has both protective and pathogenic bacteria. The immune system keeps this in check. A medically compromised person usually has a predominant

pathogenic profile which stresses the already compromised immune system. If it can't cope there is an inflammatory response. Medical research confirms this. I saw this in nursing home residents. Sick people just got sicker, needed more medications, more care, more nursing. There were obvious signs of infection in the mouth. You could see it if you looked but no one did. Anyway, what could you do? The services needed didn't exist.

Recently I had an aortic valve replacement. I require periodic periodontal treatment for several teeth. I have a healthy immune system but MUST now have antibiotic cover prior to treatment because instrumentation will release pathogenic bacteria into the blood stream that could infect the heart valve which is very serious and can be fatal. This is an ESTABLISHED medico-dental protocol to protect against a transient bacteraemia. Some preventive intervention would be justified in a high medical risk patient who may have an undiagnosed oral or dental condition. The role of the oral health provider would be to alert the medical practitioner of any such concern who would then determine an appropriate course of action.

SOCIAL AND ECONOMIC BENEFITS

I am confident of this because I have actually done this in the MCDDS in general practice and a mental health facility without funding. The estimated cost of the MCDDS was about $300 million. It ended up costing $1.2 billion. 80% of the cost was restorative dentistry which delivered a dental outcome but no significant health care outcome, there was no prevention or health behaviour modification. There was dislocation and lack of communication between the dentist and GP. The GP should have been in control not the dentist as the objective was health care NOT dentistry. The solution was to manage it in the health care setting. The patients were more comfortable with this than the dental setting. The social benefits were very evident. The recipients were healthier and socially transformed. Initially they were depressed and withdrawn dressed badly, low self-esteem, and lacked dignity. Afterwards they dressed and presented better, engaged confidently with others and were outgoing. They now had dignity and self-esteem and did not carry the badge of disadvantage. Most had never experienced good oral l health before, so their health behaviour changed too. This all disappeared with the removal of the MCDDS. It cost much more than it should, and this was very unfortunate. A lot of the treatment was inappropriate. Crown s and bridges are very expensive. Spending public monies on such items is not appropriate unless you are confident it will and can be maintained. Most dentists were very responsible and ethical but there were others who were not, and they were the ones who abused the program. It should have and would have cost the original estimate had it not been hijacked. The negative stereotype of a person with disability is reinforced by their inability to meet their self-care needs and the services needed are not provided.

WORKFORCE AND EXPENDITURE

In Australia, there are 17,000 dentists. 90% of dentistry is private. The Commonwealth encourages private health through subsidy. If it didn't public dental services would be swamped. There are only about ten special needs dentists for probably 2 million who need care, and obviously that workforce is inadequate to meet the need. Countries with nationalised dental schemes have found universal cover is

not affordable creating a gap. The governments cannot afford to pay what the dentists want so the gap increases. Inevitably the patients can't pay the gap nor can health funds. This is what happens. In the UK 90% of dentists in regional areas have withdrawn from NHS. People cannot find a NHS dentist. The US has had a Medicare Chronic Disease Dental Scheme since 1988. Dentists won't participate because the fees are too low, it excludes restorative dentistry, and the medical conditions covered too restricted.

In 2019-2020, the DIRECT costs of dental services were $11.1 billion for 50% of the population. The INDIRECT costs are unknown as there is no data available. It could be anything from $1-3 billion recurrent annually. If you had universal Medicare coverage adding the other 50% with all their problems and accumulated need it would probably be 1.5-2 times more. It is just not affordable. The way forward is to address the health care issue. It is the best option, most affordable, and will markedly improve everything for everyone, and in time things would improve.

PATHWAYS TO IMPROVING ORAL HEALTH AND HEALTH CARE OUTCOMES

1. Start with legislation. Include oral health in health care but treat it as essential health care not dentistry. That legislation is already in place.

2. Include oral health in the allied health team. Use oral hygienists instead of dentists as a health care resource and integrate oral health within medical management. Unlike dentists they are prevention, education, and maintenance. The priority is to reduce the medical risk in high risk groups through infection control not restorative dentistry. They have the right to practice independently now. This is a different dental patient, in a different setting, with different needs, different outcomes, different practices, and different abilities. The cost of this is minimal against what is presently spent. It will save more than it costs.

3. Instead of the conventional toothpastes and mouthwashes which are ineffective against pathogenic bacteria use antibacterials and treat them as clinical items and covered as such. The annual cost per person may be $200. In a 40-bed nursing home the annual cost would be $8000. One avoided case of pneumonia costing $25,000 saves $17,000. It is estimated prevention costs 5 times LESS than treatment.

4. Prioritise medically necessary dental care. Delaying it adds significant costs.

5. Manage priority groups in health care not dentistry so you can evaluate health care outcomes.

6. Do NOT spend millions on comprehensive dentistry unless you can maintain it afterwards. Clean up mouths so they can be maintained. Use intermediate not permanent restorations. It is much more affordable, and the hygienists are registered to do this. They are NOT registered to act as dentists. This would not affect dentistry as it does not participate in health care, and it does not intrude on it.

DATA COLLECTION

At present there is disconnection with medicine and oral health. Dentistry will continue practicing as it always has. I can't see this changing. Doctors and patients MUST have a resource in health care that supports them. The data related to health care should be available to medical practitioner not supplied by dentistry because it is outside health care. The inclusion of an integrated oral health resource within medicine is what is missing in the multidisciplinary team. It should be available, accessible, and appropriate. By adopting this approach, you would achieve far better outcomes for everyone. Health policy should not be dictated by dentistry, but by health care, and what works best. Under these arrangements the GP would have all the necessary information to identify 'medically necessary oral and dental care' and do something with the emphasis on infection control and quality of health care, and adopt a proactive, community focused, outreach approach.

CONCLUSION

If this was adopted, Australia would have the best health system in the world. This has never been done before. It is logical, affordable, and consistent with WHO policy. As it is essential health care it does not intrude on dentistry. I would suggest a pilot in Midland WA to develop an evidence based (microbiology and radiography) operational model.

Dr Patrick Shanahan BDSc (WA) DipPH (Syd) Centenary Medal Recipient 2001

Past Appointments

Member of ADA Expert Working Party advising Commonwealth.

NSW Review of Dental Services

National Lecturer, National Nursing Homes Association

Visiting Lecturer UWA Dental School

Visiting Lecturer Curtin University School of Nursing, Edith Cowan School of Nursing, WA School of Nursing.

National Dental Congress Perth

Speaker - University of Melbourne Medical School (Student Congress)

ABC Radio Interviews -

Ockham's Razor (Robin Williams Science Program)

Dr. Norman Swan - Health Report

SUCCESSFUL LEGISLATION

National Oral Care Standard - 1988

Dental an Approved service - 1995

Medicare Chronic Disease Dental Scheme - 2004