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Select Committee into the Provision of and Access to Dental Services in Australia
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Dear Honourable Senators

> *"Oral health has been a neglected dimension of global health for too long. Its siloed existence from general health care has led to oral health provision rarely being prioritised by policy makers."*[i1]

In 1997 I had the pleasure of making a submission to the Senate Community Affairs Reference Committee into Public Dental Services. I was interviewed by that Committee and part of my evidence can be found in section 2.45 of that report.[2] Although there was considerable goodwill generated at the time, we are now 25 years on from that Inquiry with little progress.

As a registered dentist in NSW for over 50 years and for the majority of my career based in a tertiary medical teaching hospital my submission to this Select Committee is guided by decades of clinical experience, research and teaching and endeavouring to impress upon medical students, doctors, nurses and hospital administrators that expediting access and providing dental services benefits favourable outcomes for medically compromised and hospitalised patients.

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[1] https://www.thelancet.com/action/showPdf?pii=S2666-7568%2821%2900142-2
[2] file:///C:/Users/pfoltyn/Downloads/report_pdf%20(6).pdf

Terms of Reference

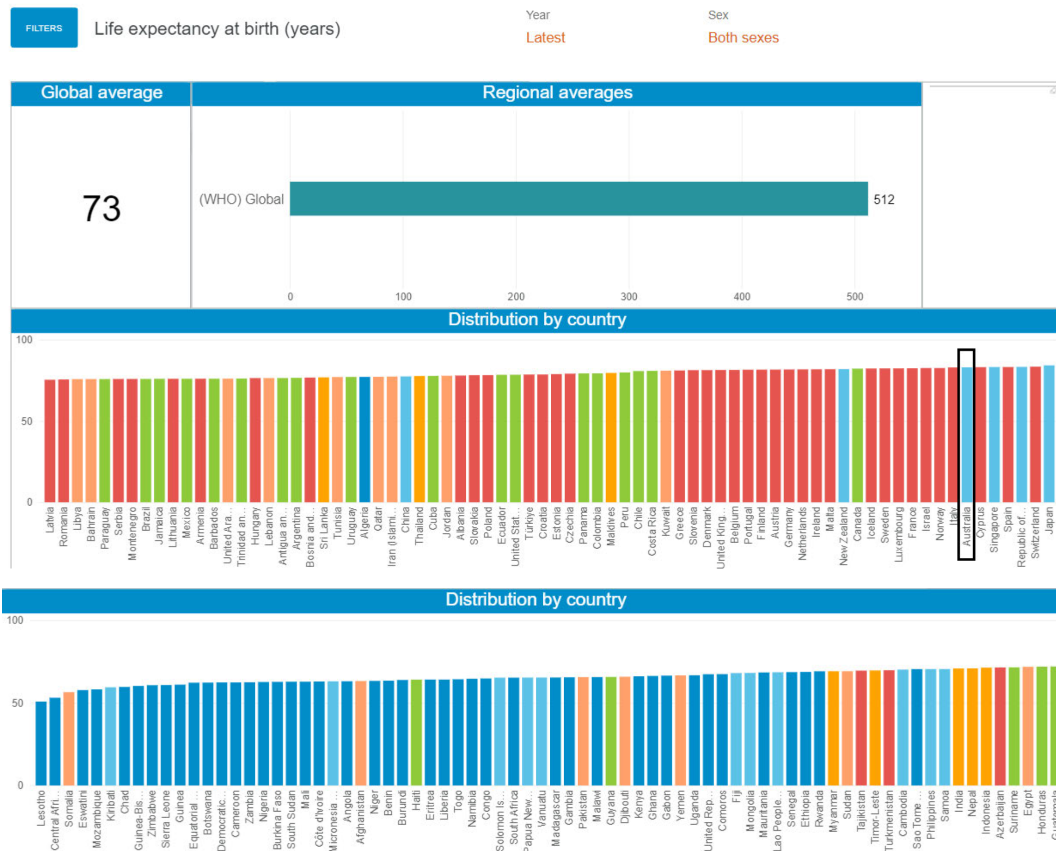
Although the Terms of Reference of this enquiry into the "Provision of and Access to Dental Services" are quite broad, a solid understanding of several underlying and overlapping significant health implications exacerbated by poor oral and dental health must be considered. Unrecognised consequences of dental disease can impact medical management, hospital admissions, length and cost of stay in hospital and for those in residential and home care, the most vulnerable Australians – our seniors.

The focus of my submission is therefore quite narrow and limited to hospitalised and medically compromised patients and the elderly. I will leave addressing the Commonwealth's role in the "Provision of and Access to Dental Services" in children and the funding and staffing of Local Health Districts dental clinics for others.

Dr Peter Foltyn – Mini CV

I have been a consultant dentist at St Vincent's Hospital, Darlinghurst since 1977 and am closely involved in the clinical care of patients with a broad range of systemic health issues and dental trauma through our busy Emergency Department. With the emergence of HIV in Australia in the 1980's I became heavily involved in HIV clinical management, research and education and conducted workshops for dentists, other healthcare workers and school children which helped demystify HIV/AIDS. In 2007 I was involved in setting up a fully functional dental clinic in a Sydney Residential Aged Care Facility which is still the only one in Australia to employ a full time oral health therapist. I have been an invited plenary session speaker at numerous dental and non-dental conferences both nationally and internationally presenting on a broad variety of dental subjects and more frequently over the past decade on the implications of poor oral and dental health in ageing. I am an active member of the Geriatric Dental Advisory Group based at Concord Hospital and a member of the NSW State Oral Health Executive and have authored papers on many aspects of oral and dental health. I was closely involved in the Royal Commission into Aged Care Quality and Safety and was a subpoenaed witness to those hearings. In 2022 I was awarded the ADA Valuable Service Award in recognition of my contribution to the dental profession.

Life expectancy in Australia[3]



Australia's moniker of "the lucky country" is not by accident. Successive governments of both persuasions have built on the ethos of hard work and fair play and rewarded Australians with easy access to medical and hospital care and often expensive pharmaceuticals which are the envy of many countries. This and our laid back and often stress-free lifestyle has contributed to Life Expectancy Tables regularly showing Australia as one of the leading countries for longevity.

18th and 19th century dentistry was primarily about the removal of painful teeth. The 20th century saw developments in saving teeth and improving appearance; however, it is now in the 21st century that we can unambiguously make a link between teeth, health and longevity. The average age of new entrants into Residential Aged Care in Australia is now around 84 and whereas in the 50's and 60's being 70 was considered old. "Provision of and Access to Dental Services" then was just about getting teeth extracted or repairing dentures. Today we have 90 and 100 year olds with teeth and for these geriatric Australians it can be a matter of life or death if they have active oral and dental infection which coincide with medical, surgical or pharmaceutical management for chronic health conditions such as renal disease, diabetes, heart disease, etc.

[3] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years)

Commonwealth funding for "Provision of and Access to Dental Services" in Australia is divorced from the rest of the body. Unlike sexual health, mental health, disability health, senior's health, which are all supported by the Commonwealth's Medicare Benefits Schedule anyone with an oral and dental health condition which is impacting their systemic health or requires assessment and/or treatment before having a surgery or a pharmaceutical procedures receives no benefit. "Provision of and Access to Dental Services" which are required prior to medical or pharmaceutical management or receipt of a Residential or Home Care package urgently requires Integration into the Commonwealth's Medicare Benefits Schedule.

The important relationship to systemic health is being ignored in medical undergraduate training leading to doctors not comprehending that "Provision of and Access to Dental Services" is critical and needs to be prioritised for many of their patients.

Because oral health care has not been seen as a priority nor fully appreciated by the medical profession and government, many doctors have a limited working knowledge of oral and dental anatomy and the close relationship between oral health and general health. Now in 2023 most of our "baby boomers" have, or will soon retire. Some will be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns, bridges and implants, unlike the average older person of decades earlier who was edentulous. Oral neglect by a nursing home or other facility can result in teeth deteriorating significantly within twelve months of entry to that facility impacting both quality of life and longevity. "Provision of and Access to Dental Services" for this cohort needs to be enabled by prioritising urgent access to public and private dental providers. A Seniors Dental Scheme, as recommended by the Royal Commission into Aged Care Quality and Safety and supported by the Australian Dental Association, must be implemented.

Education and prevention strategies in oral and dental health care must be put in place now for all medical undergraduate students, doctors and nurses in order to limit a disaster amongst our medically compromised, aged and disabled. Functionally dependent older Australians, including the homebound and institutionalised, are particularly disadvantaged. They have high requirements for extractions, scaling, oral hygiene instruction and dentures but most States have extremely limited domiciliary services. The Tasmanian Dental Service, for example, conceded that the current and future dental needs of the homebound, institutionalised and disabled is a significant problem that is beyond the scope of their dental workforce.

ACAT

As part of the management of Seniors Health we have Aged Care Assessment Teams (ACAT). These constitute teams of healthcare professionals who assess the health and care needs of older people who require support and services to help them live independently. ACATs are responsible for assessing the eligibility of older people for government-funded aged care services, including residential care, home care, and respite care.

The assessment process involves a comprehensive evaluation of an individual's physical, social, and psychological needs, as well as their support network and living environment. ACATs may include doctors, nurses, social workers, and other health professionals who have experience in aged care. Once an assessment has been completed, ACATs provide older people and their families with information and advice on the types of services that may be available to them. They may also provide referrals to other health professionals and services as needed.

Although ACAT assessments are generally free of charge for older people and are funded by the Australian Government in my decades of working in the Aged Care sector I have never received a referral to evaluate the oral and dental health of a prospective recipient. Unless seniors have good oral health before receiving a government funded package for Residential or Home care the logistical hurdles in negotiating "Provision of and Access to Dental Services**"** can be insurmountable**,** impacting the health and quality of life of the individual. Key to a successful aged care system in Australia is to ensure that older people receive the support they need to maintain their independence and quality of life as they age and MUST include expedited access to dental services.

Oral Health in Japan

In 1989, Japan introduced the 8020 campaign in order to promote oral health in seniors. Its objective was to encourage older people to retain 20 or more natural teeth at 80 years of age and was based on recommendations by Chief Dental Officers of Northern European countries. Having 20 teeth at 80 years was considered sufficient for people to eat and enjoy meals with a wide range of foods. The 80:20 oral and dental health concept is a duel philosophy that also emphasizes the importance of prevention and early intervention in maintaining good oral health based on the principle that 80% of oral health problems can be prevented through proper oral hygiene, a healthy diet, and regular dental checkups, while the remaining 20% require professional treatment.

There are 17.5 Million Japanese over the age of 85 years eligible for dental care. New dental hygienist programs are being promoted to meet both nursing home and community care oral health

needs. There has been an extensive focus on research in geriatric dentistry and innovative community education programs and oro-facial muscle training has been built into these programs. Private dentists still provide the bulk of the dental care and the use of portable equipment in some of the nursing homes.

All students of a dental discipline in Japan (ie dentists, oral health therapists, dental hygienists and dental prosthetists) regularly attend Residential Aged Care Facilities as part of their undergraduate training. They provide services for all residents as well as providing oral health education to staff and families and as a result develop a better understanding and commitment to managing oral health for the elderly. Japanese aged care research has shown that better oral and dental health in the elderly leads to better nutrition, increased confidence, better socialization, better communication, reduced risk for aspiration pneumonia and better overall health

The concept is widely promoted through public health campaigns and education programs, with a focus on encouraging individuals to take responsibility for their own oral health by adopting healthy habits and seeking preventative care. The 80:20 concept recognizes the connection between oral health and overall health and emphasizes the importance of maintaining good oral health throughout one's life to prevent the development of chronic conditions such as heart disease, stroke, and diabetes.

Overall, the 80:20 oral and dental health concept promotes a proactive and preventative approach to oral health, with the goal of maintaining healthy teeth and gums and preventing more serious dental and general health problems from developing. Supporting prompt “Provision of and Access to Dental Services” for Australian Seniors by this Senate Enquiry will place health care workers on notice that oral health matters.

Medicare funded Over 75 Health Assessment

Australian medical practitioners are funded under Medicare to provide Health assessments for over 75’s. The following is a brief summary.[4]

> *“A health assessment of an older person is an in-depth assessment of a patient aged 75 years and over. It provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life. The purpose of this*

[4] https://www1.health.gov.au/internet/main/publishing.nsf/Content/7BF9D546722DA312CA257BF0001ED949/$File/Health%20Assessment%20for%20people%20aged%2075%20years%20and%20Older%20Fachsheet%20Final%20March%202014.pdf

health assessment is to help identify any risk factors exhibited by an elderly patient that may require further health management. In addition to assessing a person's health status, a health assessment is used to identify a broad range of factors that influence a person's physical, psychological and social functioning."

Australian Government
Services Australia

You are here: Statistics > Medicare Item Reports > Report processed

Requested Medicare items processed from July 2010 to June 2022

Click on the item hyperlinks below to get the patient age/gender breakdown of that particular item

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit
Item									
701	14,013,387	6,780,873	7,481,412	1,934,341	3,458,048	433,902	251,856	165,953	34,519,771
703	122,293,751	61,258,932	72,972,455	15,979,159	31,274,903	5,049,513	3,437,642	1,678,796	313,945,151
705	154,169,495	87,264,637	116,341,781	27,192,286	51,930,452	12,171,922	4,220,406	1,481,535	454,772,514
707	287,186,929	258,675,296	189,146,495	95,305,340	80,420,668	29,098,134	11,636,509	2,021,977	953,491,347
Total	577,663,562	413,979,737	385,942,142	140,411,126	167,084,072	46,753,470	19,546,412	5,348,262	1,756,728,783

The Medicare Item Codes used are 701, 703, 705 & 707 and since 2010 Medicare has paid Australian doctors nearly $1.8 Billion. I have never received a referral from a medical practitioner for an oral and dental health assessment as part of the Medicare funded Over 75 Health Assessment. Unless oral health professionals are involved in the Medicare funded Over 75 Health Assessment the purpose of this health assessment is not being met.

> *"The purpose of this health assessment is to help identify any risk factors exhibited by an elderly patient that may require further health management."*

By ignoring oral and dental health *"…risk factors exhibited by an elderly patient"* are being excluded in the Medicare funded Over 75 Health Assessment.

Prolonging life or a long death?

> "Two-thirds of all deaths followed a trajectory with extensive elder care utilization throughout the last year of life, and at least half additionally showed extensive medical care utilization," they found. Most deaths today do not comply with what is often referred to as a 'good' death."

A recent paper from Sweden by Marcus Ebeling, published in the American Journal of Public Health[5] highlights what living longer actually entails. In Australia our medical, pharmaceutical and hospital management keeps Australians alive for longer. But at what cost? I agree with Ebeling that we are,

[5] Am J Public Health. 2023 Apr 13:e1-e9. doi: 10.2105/AJPH.2023.307281

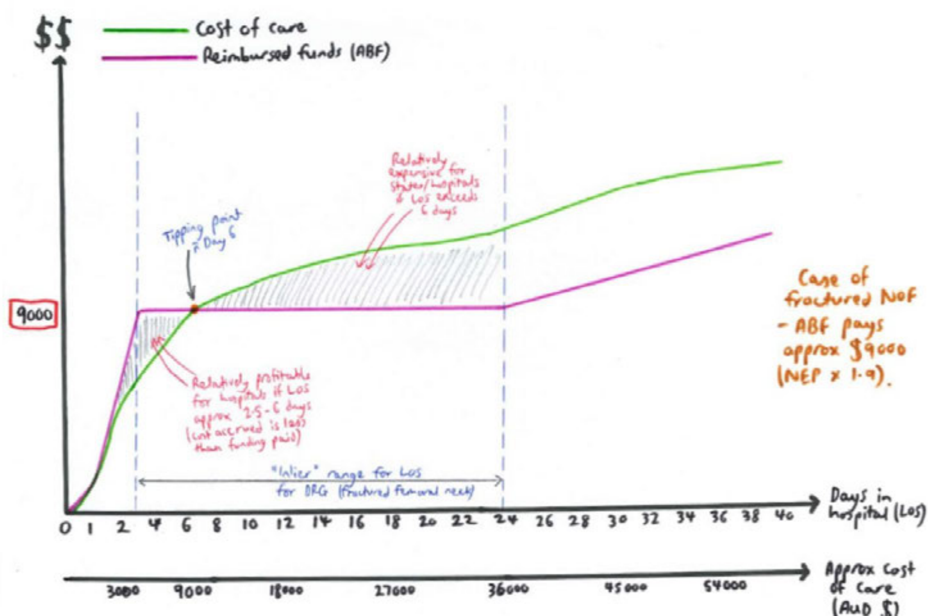
in the Australian vernacular, just moving the goal posts. Instead of a peaceful or "good' overnight death surrounded by family as often happened in the 50's today's technological and medical advances are keeping people alive for longer[6].

"Provision of and Access to Dental Services" in the end of life setting now becomes critical in avoiding painful, protracted and unnecessary deaths that originate from undetected or undiagnosed dental disease. The Australian Institute of Health and Welfare (AIHW) found that 8% of health service costs were spent by people in their last year of life, averaging $24,000 per person. If Australians are to live longer most will do so with underlying chronic conditions over a longer period of time. As poor oral and dental health is a condition that is generally ignored in the elderly failure to address it preventatively will add to health costs and the overall socio-economic and health burden due to illness, disability, and premature death.

One of Australia's leading Intensive Care specialists and researcher's, Dr Ken Hillman from Prince of Wales Hospital in Sydney was interviewed by the ABC and wrote in AusDoc[7] that his grandfather died peacefully in his own bed decades earlier but his mother died in hospital after 22 admissions in the last 6 months of her life.

I agree with Ebeling's statement and the interview with Dr Hillman that most deaths today do not comply with what is often referred to as a 'good' death.

Poor Oral and Dental Health and Length of Stay in Hospital



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[6] https://www.aihw.gov.au/reports/life-expectancy-deaths/the-last-year-of-life-health-service-use-patterns/contents/key-findings
[7] https://www.ausdoc.com.au/news/why-arent-they-screaming/

The graph above provides an example of a hospitalised patient having a surgical procedure and the amount of money that a hospital receives the procedure and the Average Length of Stay (LoS) expected. In this instance the patient was admitted for a fractured neck of femur (NoF), which is a common injury following a fall by an older person.

One X-axis represents the days the patient spends in hospital and the 2nd X-axis is the $ cost of that admission per day in hospital which decreases slightly over time. The Y Axis represents the $ amount that the hospital receives for a given procedure and in the example of a NoF it is $9000. A major heart operation could be $50-100K+ or a deep skin laceration requiring operating theatres and only a day in hospital $4000 but the chart or template is basically the same for all hospital admissions and in all States of Australia. In this example if the patient can be discharged before Day 7 the hospital actually makes a profit and if they can admit another patient for a procedure to the same bed and do this all over again they will make an additional profit. The reality is that many patients remain in hospital beyond the average determined length of stay. Again in the NoF example at 24 days the hospital gets some additional government money but are losing money by not discharging the patient sooner as they still have all the fixed costs such as nursing, cleaning, admin etc. It is the Independent Health and Aged Care Pricing Authority (IHACPA)[8] which sets the National Efficient Price.[9]

Through our recent research, which looked at the implications of poor oral and dental health, we found countless patients who have had extended stays in hospital caused by a failure to provide timely oral and dental care. One patient was in hospital for 25+ days before someone looked in his mouth and realised that his teeth were an absolute mess. He needed a general anaesthetic and all his teeth removed plus an extra couple of days for recovery. Several patient who were referred to us as part of their heart transplant workup and about to be discharged were found to have many teeth in need of extraction and poor oral health requiring several sessions with our dental hygienist to help rectify. In many instances patients spent several unnecessary days in hospital waiting for their poor oral and dental health to be attended to. During Covid restrictions the wait times were even longer. With the high cost of beds for complex procedures a reduction in 'Length of Stay' for all patients could potentially save all hospitals considerable sums of money.

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[8] https://www.ihacpa.gov.au/

[9] https://www.ihacpa.gov.au/resources/national-efficient-price-determination-2023-24

Mouth cancer

In Australia, there are over 5200+ new cases of head and neck cancer diagnosed annually with the vast majority of these being in the mouth. The average age at diagnosis is around 64 and it is therefore very appropriate to provide regular mouth screening for oral cancer in older patients. Additionally, there is an established association between dental trauma from sharp edges or broken natural or denture teeth and early cancers of the tongue and cheek, which can be present as a result of dental neglect. Early diagnosis may limit treatment to surgery alone with 80-90 per cent survival at five years; however, a later diagnosis may reduce survival to 20 per cent at five years. Advanced presentations are also associated with additional, often toxic and debilitating treatments such as radiotherapy and chemotherapy which, for an older person or one with dementia, may be problematic and may be denied to them if they are unable to completely cooperate.

Delirium

- In Australia between, 2016-2017 900 deaths were attributed to delirium
- Delirium is responsible for 10.6% of cases of dementia
- The cost of delirium in Australia in 2016-2017 was estimated to be $8.8 billion[10]

Delirium is a serious condition and closely linked with elevating the risk of falls, affecting cognition, prolonging length of stay in hospitals, a factor in dementia, responsible for multiple hospital readmissions, influence patient flow and hinder timely delivery of healthcare and discharge planning. As infection is a common contributing reason for delirium, infections caused by poor oral and dental health take on greater significance. As the mouth and teeth are rarely routinely assessed for older people a potential trigger for delirium is regularly being overlooked.

Poor oral health in an older person can lead to infection, which is a well-established risk factor for delirium. Delirium is in turn an established risk factor for falls, a leading cause of death for the elderly. All geriatric admissions to hospital must have oral health assessments integrated into the admission process and equally oral health assessments must be provided before entering a residential aged care facility. The Commonwealth Department of Health and Ageing publication 'Delirium Care Pathways'[11] was developed as a guide and resource for clinicians; however, there is

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6756419

[11] https://www1.health.gov.au/internet/main/publishing.nsf/Content/FA0452A24AED6A91CA257BF0001C976C/$File/D0537(100 9)%20Delirium_combined%20SCREEN.pdf

no mention of teeth let alone considering oral and dental infections being a possible cause of delirium.

As a 402 bed Public Hospital close to the centre of the Sydney CBD, St Vincent's Hospital Darlinghurst we have the largest and closest Emergency Department to several older and wealthier harbour side suburbs as well as having some of Sydney's poorest inner-city areas within its catchment. Due to its location, the hospital services a higher percentage of older patients compared to outer Sydney suburban hospitals with young families and on any given day acute delirium accounts for 5-10 hospital admissions through the Emergency Department. The over 100 geriatric patients in our study, which to date has assessed over 650 patients, has provided us with an opportunity to review current and past records. It has become very clear that had oral health been assessed at a previous admission it would have revealed that many patients have active oral and dental infections which could help explain their presentation with acute delirium, increased falls risk and in many instances multiple readmissions.

… is poor oral health the smoking gun?

Aspiration pneumonia

Aspiration pneumonia is a serious complication of inhalation of food, stomach acid, saliva or microorganisms into the lungs. In one study, a large US hospital provided oral care for patients in their Intensive Care Unit to decrease risk factors for aspiration pneumonia from inhaled microorganisms. By simply brushing and swabbing the teeth of unconscious patients, this act saved lives and reduced mortality, morbidity and hospital costs.

In Residential Aged Care Facilities, aspiration pneumonia is the silent killer of the frail elderly. Regular tooth cleaning, denture care and preventative strategies for maintaining reasonable oral health reduces the risk of aspiration pneumonia and hence death. Facilitating prompt "Provision of and Access to Dental Services"

As manpower may be an issue in providing the level of care required in RACFs, it would not be unreasonable to obligate overseas trained oral health professionals seeking to practice in Australia to provide up to six months of part-time service in an RACF as a requirement to obtain registration under AHPRA. New Australian graduates in a dental discipline could also be seconded to the public health system and RACFs as a registration AHPRA requirement.

State run public dental services must be obligated to expedite and prioritise both oral health assessments and provision of services for prospective RACF residents. Patients of record at state run

public dental services should be flagged when turning 75 and pro forma oral health assessments completed and provided to the patient with copies sent to medical GPs. The vast majority of dentists in private dental practice use dental practice software which could very easily have incorporated pro forma Australian Government templates for an over 75 oral health assessment.

In 2015, Australia's then treasurer The Hon Joe Hockey tabled in Parliament the 'Intergenerational Report' which in summary told us that Australians will live longer, we will continue to have one of the longest life expectancies in the world and that, by 2054/55, life expectancy at birth is projected to be 95.1 years for men and 96.6 years for women. If we exclude death from childhood diseases, reduce motor vehicle accidents and smoking and alcohol related deaths and find cures for common cancers, Australians reaching the age of 100 will be unexceptional.

Carmen Lawrence, the Hon Minister for Human Services and Health in the Keating Government of the early 1990s, is on record as saying that Australia has one of the highest level of prescribing psychotropic medications to the elderly in the Western world. This practice remains relatively unabated today and in combination with poor diet, poor oral health and a dry mouth exacerbates the harm.

Neurocognitive decline and delirium, frailty, incontinence, falls, hearing and vision impairment, medication compliance and pharmacokinetics, skin breakdown, impaired sleep and rest are regarded as geriatric giants by gerontologists, geriatricians and nursing home staff. As these are all interrelated in the elderly, failure to act on one can impact on the others. However, the implications of poor oral health have for too long been ignored and deserve equal status. Mouth pain can be devastating for the elderly, compound psychosocial problems, frustrate carers and nursing home staff and disrupt family dynamics. As appearance, function and comfort suffer, so may a person's self- esteem and confidence. The contributing factors for poor oral health such as rapid dental decay, acute and chronic periodontal infections and compromised systemic health on a background of a dry mouth, coupled with xerostomia-inducing medications, reduced fine motor function, declining cognition and motivation will not only lead to an increase in both morbidity and mortality but also impact on quality of life.

Revised Aged Care Quality Standards

The **Aged Care Quality and Safety Commission** defines the Standards that apply to Aged Care in Australia as *"…a framework of core requirements for quality and safety. Some Standards will apply differently to organisations, depending on the types of care and services they provide."*

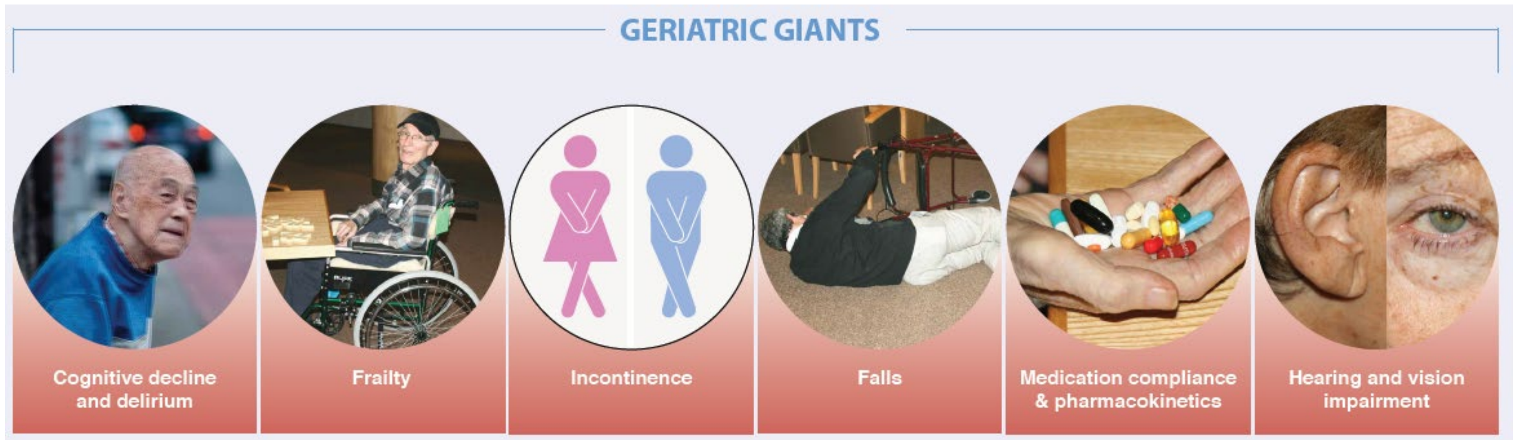
Aged Care Standards exist to foster and protect good health, avert ill health and improve the quality and delivery of health care services for older Australians who are entering Residential Aged Care; however, the changes to section 5.4.13 of the Revised Aged Care Standards pertaining to oral and dental health have to date been quite inexplicit in only stating that:

a) timely clinical oral health assessments are conducted

The term *"timely"* is clearly too vague. Residential and Home Care providers will only pay lip service to implementation leading to no beneficial improvement in the management of a critical aspect of the health and well-being of the most vulnerable Australians in the community. There needs to be a prescriptive element built in.

- If an oral health assessment is not provided prior to receiving a Residential or Home Care package or entering a Residential Aged Care Facility it must be provided within 21 days of receipt of the package
- An approved fillable oral health assessment form must be completed to comply with these Standards
- When a fillable assessment form is completed before receiving a Residential or Home Care Package it should contain key clinical elements such as identifying active and suspicious dental caries, periodontal health, quality of dentures, relevant medical and pharmaceutical information, relevant histopathological information and any dental prosthetics etc and be prepared by an AHPRA registered dental professional.
- An OPG x-ray together with any other clinically relevant imaging should be able to be uploaded onto the individual's MyAgedCare or link.
- When a fillable assessment form is completed after receiving a Home Care Package or entering a Residential Aged Care Facility a fillable Oral Health Assessment Tool (OHAT) should also be completed. The person completing the form must be an AHPRA registered dental practitioner. It is envisaged that in this setting an AHPRA registered oral health therapist or dental hygienist rather than a dentist may need to complete the form.
- All Residential Aged Care Facilities and approved aged care providers who deliver Home Care Packages must establish a relationship with an oral health professional who can provide an oral health assessment and/or treatment within 48 hours of a request being made.

Ageing, cognitive decline, immobility, poor hand eye coordination and arthritic changes impact the most important Activity of Daily Living – the ability to provide comprehensive and consequential Self Care.



The established Geriatric Giants need a new addition – Poor Oral Heath

Medical, surgical, pharmaceutical, technological and lifestyle interventions have become more common and predictable in recent decades with significant increases in life expectancy. Regrettably our seniors are developing accelerated tooth decay because of polypharmacy induced xerostomia, hyposalivation, deteriorating cognition, poor fine motor skills, diminished motivation and oral dysfunction. Dental abscesses and chronic periodontal infections as a result of poor oral health can have a direct impact on an older person's morbidity and mortality and as many years of good oral care counts for nought when teeth are neglected or self-care in later life is not possible the harmful consequences of poor oral health can be significantly elevated.

Poor oral health can surreptitiously impact systemic health through persistent bacteraemia impacting all parts of the body at risk of a blood borne infection, causing sepsis in the vulnerable elderly. "Provision of and Access to Dental Services" has moved beyond the provision of dental

services to relieve pain, replace missing teeth and improve cosmetics. "Provision of and Access to Dental Services" must accommodate and consider those medically compromised and older Australians who need a clean and healthy mouth as part of their overall health care.

Dr Peter Foltyn
There is a close interrelationship between poor oral health, systemic health and quality of life.

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[i] https://www.thelancet.com/action/showPdf?pii=S2666-7568%2821%2900142-2