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Australian and New Zealand
Academy of Special Needs Dentistry

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The Australia and New Zealand Academy for Special Needs Dentistry (ANZASND) and Australian Society for Special Care in Dentistry (ASSCID) are the two lead organisations in Australia representing dental professionals and others interested in oral health of the special needs population. We are both Special Interest Groups which are run by volunteer committees, and have no paid staff to assist with preparation of this submission. We are jointly providing a submission to the House of Representatives Inquiry into Adult Dental Services in Australia.

Australia's National Oral Health Plan 2004–2013 (NACOH 2004) includes 'people with special needs" in **priority "Action Area Five"** and refers to people with physical and intellectual **disability**, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care. However, this is the only priority area which has no population based data collected for it, as yet (ARCPOH 2009).

The Australian Bureau of Statistics (ABS) 2003 Survey of Disability, Ageing and Carers defined **disability** as "any limitation, restriction or impairment which has lasted, or is likely to last, for at least six months and restricts everyday activities." Conditions include, but are not limited to, physical (loss of limb or motor function requiring the use of aids), intellectual, sensory (sight, hearing, speech), or psychiatric disability, and disorders of the nervous system to advanced dementia requiring constant help and supervision (ABS 2004). Disability may occur at any time in a person's lifetime or may be present from birth. Disability cuts across age, sex, race and socioeconomic background. Yet people with disabilities are rarely identified as a priority population group in public health policy and practice.

The National Survey of Adult Oral Health 2004–06 (Slade et al. 2007) covered most action areas for target populations like older people, people with low income and social disadvantage, Aboriginal and Torres Strait Islander people, but people with special needs were not included in the survey.

The most recent National Health Survey (AIHW 2010) included 'only severe or profound disability conditions like mental health, back problems, arthritis, cardiovascular diseases and asthma', but excluded 'people in institutions in Australia and those classified as having disability conditions in the Australian population such as Down syndrome, cerebral palsy and dementia'.

To summarise, there is **no national data**, but limited state-level data and information from local dental personnel (provided where appropriate in the terms of reference) on the growing special needs population managed by the few specialists in the much needed new specialty of Special Needs Dentistry.

Terms of Reference

Demand for dental services across Australia and issues associated with waiting lists

In a South Australian study of 485 adults with physical and intellectual disabilities, just over 50% communicated non-verbally or had little or no effective communication and the researchers depended on proxy reports from carers (Pradhan et al. 2009). Unlike the general population, the majority of the people in this population therefore are not able to **'demand for dental services'** and may not be aware of **'waiting lists'** and depend on their carers for their daily care and dental visits. In the same study, 43.6 % of carers reported one or more problems in obtaining dental care. The most frequent problem was lack of dentists with adequate skills in managing people with disabilities followed by cost of dental treatment, inconvenient location of dental clinics, lack of dentists willing to treat people with disabilities and transportation problems. Other problems included carers not being aware of services available for people with disabilities, not knowing where to take their care recipients, having the impression that there was a long waiting list to be seen at government clinics, and inadequate disabled parking outside dental clinics.

Similar barriers to recommended dental care were reported by carers in another study in which 286 Special Olympics (SO) athletes were screened at National SO Games in Adelaide in 2010. Additional barriers included anxiety and SO athletes not reporting pain and therefore parent/carer not being unaware of any dental problem (Pradhan 2012). This discrepancy was reflected in the large gap in the prevalence of treatment need identified by the screening dentists (39.5%) and reporting of pain by SO athletes (4.5%), who can communicate verbally and are higher functioning than other people with physical and intellectual disabilities. This is yet another reason to ensure this population receives regular dental care, so that that incipient disease, if any, is found and managed earlier with simpler procedures and less discomfort, thus reducing the need for more complex and costly dental treatment.

Due to reasons stated above, demand for dental services for the special needs population may not be reflected in waiting lists, or waiting times determined for the general population, as many in the special needs population may not be accessing dental services, or not on a regular basis. Barriers may be patient, carer, dentist and dental service related, and vary throughout the country. This is best answered by the public dental services in each state.

The Special Needs Unit at the Adelaide Dental Hospital in South Australia receives referrals from Community Dental Service (CDS) clinics, GP's and support agencies, which are prioritised according to need. Patients in pain are seen within 1 week following Relative Need Index (RNI) protocols. For others, the waiting period may be up to 6 months. This may appear not that long, however, patients from CDS clinics would have waited 12–18 months to see the CDS dentist. A few of these patients who can not be managed in the dental chair by non-pharmacological means due to behavioural issues or complexity of the dental treatment are placed on wait list for dental treatment under general anaesthetic (GA). GA waiting times are prioritised according to need and risk and may be up to 12 months.

The mix and coverage of dental services supported by state and territory governments, and the Australian Government

Dental services are provided at:

- Community Dental Services
- Special Needs Services (centralized in some capital cities)
- Restricted hospital based services available to eligible hospital registered patients
  Many hospital-based services were closed in 1990s and there is a certain amount of luck whether a patient with complex medical problems attends a hospital which can provide them with a dental service appropriate to their needs or not. Many of these services have limited resources to provide ongoing care.
- Private Practice
  Some patients are seen with 'voucher' funding. This is particularly the case with denture work and emergency dental care.

Some patients require home-based (Domiciliary) services. These are patchy. Melbourne Metro, Adelaide Metro and Shepparton (Victoria) have publically funded services. Adelaide Metro and Hunter Health hire out portable dental equipment, and provide public funding to private dentists to see patients in residential aged care facilities. These services are unable to provide services to homebound patients not in residential care facilities.

A small percentage of special needs patients need access to intravenous (IV) sedation or general anaesthetic (GA) facilities. In the South Australian study, 18.8 % of care recipients required a GA for routine dental examination and treatment, and 13.1 % were usually treated in the chair under oral sedation (Pradhan et al. 2009). The availability and accessibility of IV and GA services vary from state to state. It is more problematic when patients are medically complex, and not suitable for Day Surgery. Medicare does not provide item numbers for dental treatment provided under GA (only for Oral and Maxillofacial Surgeons). Private Health Funds do not fund private hospitals at rates which support dental GAs. Other surgeons operate with considerably better financial arrangements.

In the South Australian study (Pradhan et al. 2009), the most frequently reported dental services provided to care recipients included check-up, followed by scaling, fillings, extractions and other treatments including dentures and radiographs. It is likely that services provided in other states would be similar as most patients with special needs do not cope with complex dental treatment like fixed orthodontics, crown and bridge and implants.

Availability and affordability of dental services for people with special dental health needs

Funding streams include:

- Public (state funded) dentistry
- DVA Gold Card
- Transport Accident Compensation, but with limitations to care provided, full comprehensive care is rarely funded.
- Private Funding through a mix of health insurance and private funding

(At specialist level, no specialists are 'preferred providers' for health funds, as the rebate levels fall far below the cost of providing services)

Medicare Funding through Chronic Disease Dental Scheme (CDDS) closed on 1 December 2012. We acknowledge the serious problems that this scheme had, and that CDDS could not have continued as it was. However, it has left a group of patients with far more limited access to oral health care as a result. This will send many special needs patients back into the public system, increasing demand. The public system in many places will not be able to provide ongoing maintenance care in the same way as CDDS did, meaning that there may be a breakdown in the regular recall visits established resulting in a decline in oral health and some of the health benefits that CDDS enabled and funded. This scheme was accessible throughout the country, and not just in major cities.

Employment levels of people with disabilities and their carers are very low and so many people with disabilities rely on welfare benefits. They therefore face financial barriers to the receipt of dental care services. Some are not eligible for public dental services, due to means tests, and other family members working. This group will be particularly hard hit, as they are funding their high dental care costs without assistance. Typically this group is comprised of medically complex patients with expensive health care costs, in addition to the cost of oral health care.

Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

Patients that can't be managed at local community level need to travel to their capital city in their state to access services. GA sessions are often neither available nor affordable. Long distance travel is even more difficult for patients with disabilities confined to wheelchairs. To overcome these significant barriers, specialists from Adelaide occasionally visit South Australian country towns to provide the much needed dental treatment to special needs patients.

In the Hunter New England Local Health District, Resi-DENTAL Care Program has been initiated based on primary care principles that provide support with the implementation of the Commonwealth endorsed education and training package Better Oral Health in Residential Aged Care for carers and residents. It also involves working collaboratively with private dental practitioners to coordinate and support the provision of dental care in the residential care setting using portable dental equipment, thus bringing regular dental services to the resident, overcoming access to services and transportation issues and reducing the need for residents seeking dental care within the public sector. Given the success to date with this program, this model of care could be adapted in other states.

The coordination of dental services between the two tiers of government and with privately funded dental services

New commonwealth funding to be provided through state services, hopefully will lead to more coordination. Eligible concession card holders can obtain dental treatment with private dentists under the General Dental, Emergency Dental and Denture Schemes. However, special needs patients don't always cope well with new clinics and providers each visit. Therefore, care should be taken to ensure continuity of care with the same provider in a familiar environment for better outcomes.

Workforce issues relevant to the provision of dental services

In Australia, we have only 15 Special Needs Dentistry specialists.
7 are in Victoria (one semi retired)
2 are in NSW
2 are in Queensland
4 are in SA (one semiretired). None of them are full-time clinicians.
None are in WA, Tasmania, NT or ACT.

All work in major metropolitan areas. Thus the few specialists need to take on leadership and mentoring roles, to enable general dentists to provide much of the care required by special needs patients. They also provide direction in relation to setting up and supporting new services to better meet the needs of special needs patients.
Tasmania has a relationship with Special Needs Dentists in SA, in the management of patients with medical issues via teleconferencing.
NT has a relationship with a Special Needs Dentist in Queensland, but only has limited availability.
WA is struggling to set up services without any specialists to lead the process.

Therefore, there is an urgent need for:

1. Appropriate training at undergraduate and post-graduate levels
   There are international guidelines being developed through International Association for Disability and Oral Health (IADH), with Australian input through Dr Mina Borromeo at the University of Melbourne, on training programs. These need to be implemented throughout all training programs in Australia.

   Post-graduate training can be encouraged with incentives like scholarships to local students. All students currently in training (six at University of Melbourne and one at The University of Adelaide) are on overseas scholarships, and will return to their home country at the completion of their course.

2. Appropriate training and continued support for both paid and unpaid carers via associated organisations
   Oral care training modules should be incorporated into Certificate courses at TAFE.

There have been some initiatives in this area, particularly in relation to making educational oral health DVD/CDs. The Commonwealth funded 'Better Oral Health in Residential Care' in 2010. However, feedback from dental professionals working with patients who should have benefited from the scheme, and talking to their carers is that it has had little impact. The quality of the educational information provided was excellent, but the educational model (train the trainer with limited training and support), and lack of support to implement the changes in practice at workplace level, and change organisational culture have limited its effectiveness. Evaluation needs to look at changes in work practices, organisational and work place culture changes, and improvement (if any) in oral health status of residents. Evaluations immediately after training do not identify long term benefits, or problems with the training program.

3. Utilisation of dental hygienists and oral health therapists for routine maintenance of oral hygiene and on-going educational and hands-on training for carers
   Although Chalmers et al. (2001) identified the under-utilisation of dental hygienists in the aged care sector more than a decade ago, there has been no increase in the utilisation of dental hygienists in the aged care or disability sectors.
   Under current scope of practice, oral health therapists could provide far more care to special needs patients, and yet they have limited employment opportunities presently in the public sector.

4. Continuing professional development (CPD) in various topics in Special Needs Dentistry to general dentists and carers to maintain knowledge and skills

In summary, more training and continued support for workforce in this area is needed to provide dental care to special needs patients in all settings, including community dental clinics, special needs clinics and domiciliary care, both in residential care facilities and for those being cared for in their own homes.

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SUMMARY of key points we are calling for in this submission

* Consultation with ANZASND and ASSCID during planning, funding, implementing and evaluating projects which impact on Special Needs Patients. An ongoing dialogue of ideas and feedback is required long term.

* Ongoing consultation between the Federal Government and Public Service and the Dental Profession. Federal Funding for Dental Services is relatively new and has been problematic recently. There is a need for the Dental Profession to have people to talk to in Medicare and other agencies who have a knowledge of dentistry. It has not been possible to provide feedback, to get anomalies addressed, or rulings on regulatory requirements which are unclear. A purely bureaucratic response to legislation is not going to mend and build bridges with the Dental Profession, and develop Oral Health Programs of high quality and effectiveness.

* Improved Training and Education across a broad number of areas both within the dental profession and beyond to enable dental health care providers and organisations and other stakeholders with the necessary skills to provide high quality oral health care to the Special Needs Population.

* Scholarships to encourage post-graduate training in Special Needs Dentistry.

* Better regulation of Agencies providing care to those with Special Needs. This involves attitudinal and organizational change, and changes in work practices. Documentation of Oral Health Care Plans, although necessary, is inadequate without the additional changes above.

* Improved Statistics and appropriate statistics about the Australian Special Needs Population, as presently we lack population-based data to assist with planning.

* Targeted Funding and program Initiatives which will help to reduce the oral (and general) health care disparities between the Special Needs Population and general population in both metropolitan, rural and remote areas.

* Improving oral health services includes not just services in clinics, but also home based (Domiciliary) services, and access to services which can provide at clinic (Nitrous Oxide)

Access to IV Sedation and General Anaesthetic, at both day surgery and inpatient level for more complex cases is needed. This will require funding changes and require Health Funds to improve remuneration to hospitals with dental lists in the private sector.

This needs to occur alongside improved access and levels of service in Community Dental Services, for patients with Special Needs.