

Senator Fatima Payman,

I would like to make the following submission to the senate regarding **Dentistry in Australia – the way forward.**

I am Dr Fatima Ashrafi, a Specialist Obstetrician Gynecologist with more than 30 years' experience in Obstetrics and Gynecology. This submission is on behalf of Australian Islamic Medical Association (AIMA) and our main aim is to take good care of our people's health – physician and mental including dental health.

Purpose of this submission is to review the Australian context for its dental care services and to discuss some of the nationally recognized issues in access to dental care and how to improve it.

Australia is the size of continental USA but with only around 21 million people, 85% of whom reside within 50 km of the coastline. Thus, access to health care has a strong urban-rural dimension. The universal healthcare coverage excludes dental care, 80-90% of which is delivered through traditional fee-for-service private dental care.

Oral health is crucial to our overall well-being. Keeping our mouths healthy helps us maintain our general health and physical wellbeing.

Oral health is the state of the mouth, teeth and orofacial structures that enables us to perform essential functions such as eating, breathing, and speaking, and encompasses psychosocial dimensions such as self-confidence, well-being, and the ability to socialize and work without pain, discomfort, and embarrassment. Oral diseases encompass a range of diseases and conditions that include dental caries, periodontal (gum) disease, tooth loss, oral cancer, oro-dental trauma, and birth defects such as cleft lip and palate. Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3.5 billion people. Poor oral health and dental decay are the cause of pain, poor nutrition, and embarrassment. When appearance and speech are impaired by dental disease, this may inhibit opportunities for education, employment, and social interactions.

Oral health is linked to whole-body health; problems with teeth and gums can lead to other health concerns like heart disease, stroke, weakened immune system, poor outcomes in pregnancy, aspiration pneumonia and more. Everyday lifestyle, general health status, and choices can positively or negatively impact our oral health standing. Daily medications such as antidepressants and blood pressure medications can cause dry mouth.

It's disturbing that Australians' dental health has not improved in recent years despite changes such as adding fluoride to drinking water which has reduced tooth decay in children and adults. The average number of children's baby teeth affected by decay has risen. Around 45% of children aged 12 have decay in their adult teeth. Over one-third of adults have untreated decay. And more than 20% of people aged 65 and over have lost all their teeth. Dental health statistics show that in Australia that 3 in 10 people delay or avoid seeing a dentist because of the cost.

This is worse for Indigenous Australians, especially in remote communities, where sugar-laden processed foods are now ubiquitous but dental services are scarce.

A public dental care system exists with varying eligibility criteria from state to state, mostly directed at children, low-income individuals, pensioners, and defined disadvantaged groups. Thus, access to dental care also has a strong socioeconomic dimension with disadvantaged people having serious access problems and extensive waiting times creating Dental divide. An **Aussie smile** is an instant indicator of socioeconomic status, employability, and self-esteem. It's also a predictor of physical health. Government and other reports have documented considerable polarization issues both in oral health and in access to dental care. Suggested change strategies have ranged from broad political changes in the dental care system to local oral health promotion initiatives, but overall, dental care remains a pawn in state-commonwealth political squabbles.

There are some publicly funded activities in dentistry such as Child Dental Benefits Schedule and rudimentary dental care in some public hospitals.

The Child Dental Benefits Schedule (CDBS), supports access to dental services for eligible children, aiming to help children develop and maintain good oral health early in life.

The CDBS is a legislative scheme defined under the *Dental Benefits Act 2008* and Dental Benefits Rules 2014.

The CDBS covers part, or all, of the costs (up to \$1026 over 2 calendar years) for basic dental services for children up to 17 years of age.

More needs to be done. Bad oral health can lead to clinical horrors,

The potential savings are huge.

Early data from non-interventional quality improvement project 'Oral Health Assessment of Hospitalised Patients' at Sydney's St Vincent's Hospital has yielded extremely fruitful data on over 660 hospitalised patients¹.

Countless patients had extended stays or delayed discharged specifically caused by the absence of timely oral and dental care.

An example of the potential cost savings is easy to appreciate in the following case of a patient who had a left ventricular assist device (LVAD) implanted.

The cost of this device and the associated costs is more than \$150,000. However, his oral health was not assessed by the referring outer suburban hospital and was not assessed at the time of his admission. He developed a life-threatening infection, most probably coming from his grossly carious and infected teeth and gums and will need to have all teeth extracted.

Antibiotics will limit the acute infection, but the additional days in ICU at around \$5000 per day will add to the cost of his overall admission. Due to the number of teeth involved, he will need to go to the operating theatres for the extractions, but only when deemed fit by his cardiac surgeon and anaesthetist to proceed with another general anaesthetic. There will be an increased anaesthetic risk and the likelihood of a delayed discharge, as he will need to recover from a complete dental clearance.

Had an oral health assessment been conducted pre-admission, the teeth could have been removed pre-emptively, as they were a source of infection. Even if the admission was urgent, the teeth could have been removed as a combined dental/cardiac procedure at the time of the LVAD placement, thereby negating a

second general anaesthetic and additional days in ICU, which impact on morbidity, delayed discharge, and increased risk of mortality.

Basic mathematics show that further \$ 100, 000 will be needed for this patient, if there are 200 patients like this this per year this incurs an additional cost of 20 million annually and this doesn't take the patients suffering, lost earnings etc into account.

Learning from others – how does it work in United Kingdom?

Who is eligible for free National Health Service NHS dental care?

NHS dental care is only cost-free for certain people. Most must contribute to the cost of the treatment they receive. However, the costs are capped to make them affordable for those who require considerable and lengthy treatment.

NHS dental care is free for all those under 18, students under 19 if they are in full-time education, pregnant women, and women who have had a baby in the last 12 months. Treatment is also free for those who claim **certain benefits**.

What does NHS dental care cover?

NHS dental care includes the following check-ups and treatments:

- regular check-ups (usually twice a year)
- dentures
- root canal treatment
- crowns and bridges
- fillings
- preventive treatment (such as fluoride varnish, fissure sealants, and a scale and polish, if deemed clinically necessary)
- orthodontic (teeth straightening) treatment for children under 18.

Personal anecdote: In 1996, I was in Scotland sitting for FRCS exams of the Royal College of Surgeons Edinburgh. The night before the exams the dental crown over the central incisor teeth fell off rendering me unable to attend the OSCE exams. A quick trip to the dentist sorted it all out. We were on a student visa. The dentist fixed the with competence and care and in the evening, I attended the OSCE, and I actually not only passed in first attempt, I was also the only one to pass the exam in that cohort. Passing the British exams improved my chances of becoming a Specialist in Australia.

NHS dental care does not cover cosmetic treatment, such as teeth whitening.

In Australia, public dental programs are unable to meet the demand for services. Private dental care is increasingly unaffordable, and millions of Australians go without the treatment they need.

Affordable and available dental care is crucial to addressing inequality in Australia. Teeth and gum problems can affect everything from your life expectancy and general health to your job prospects. The “dental divide” between rich and poor replicates disadvantage in Australian society. The establishment of

an entirely separate scheme (the Denticare model) will still require enormous amounts of evidence-based decision-making around who and what is covered, how this is paid for, and what subsequently happens to current federally- and state-funded dental programs.

Previous attempts to incorporate dental services into Medicare have failed.

The current Child Dental Benefits Schedule has a low uptake. Less than 40% of those eligible for the scheme actually use it.

There is plenty Australia could do to better integrate dental and medical care, including focusing on best-value investments such as fluoridation and preventive services. Many of the preventive actions needed to address obesity (for example, encouraging breast feeding and limiting sugary beverages) will also improve dental health.

We could also expand emergency dental services in hospital emergency departments and create a “Dental Health Service Corps” of dentists and other medical professionals to help in rural and remote areas.

In Australia, we are justifiably proud of our Universal health care but the dental divide exists. The only movement worth noticing is the increasingly bad numbers around waiting lists and costs to patients.

If we care about health and well-being, tackling preventable disease, reducing hospital admissions, addressing workforce absenteeism and productivity, and closing the gaps in health disparities, then we must bridge the dental-medical divide.

It’s increasingly hard to rationalise the current approach, which excises the mouth from the rest of the body.

Medicine and dentistry remain distinct practices that have always been treated differently by the health care system, health insurance funds, public health professionals, policymakers, and the public leads.

Those Australians who can afford regular and routine dental care report low levels of extractions and relatively low levels of fillings. But for too many Australians, a visit to the dentist is an unaffordable luxury. In such circumstances, many people are forced to seek pain relief from general practitioners and emergency departments, adding to the pressure on these services.

The consequences are also costly: there are potentially preventable hospital admissions for dental conditions and cases of general anaesthesia for dental procedures, mostly for children having teeth pulled.

The previous Labor government made real efforts to address preventive services for children and tackle the long waiting lists for public dental services for adults.

Better collaboration between dentists and other health professionals will help bridge the divide.

The potentially avoidable costs to the health-care system and to people’s quality of life has led to increased pressure for a Medicare-style universal insurance scheme for dental care (Denticare) or the inclusion of dental care into Medicare. Dental services urgently require integration into the Medicare Benefits Schedule (MBS).

Advocates for better oral and dental health struggle to be heard and to attract funding because the topic is not as appealing as research into cancer, heart disease and many other specialised medical services or procedures.

Quantitative analysis can demonstrate both the clinical need and projected savings to hospitals and federal health expenditure with Medicare funding.

I have spoken to several dental professionals about this dire situation with the nation's oral health. I am enclosing views of a dentist and a dentistry student:

Dr Zaheer Kadwa

BDS Sc (UQ), Master Clinician - Implants (LLU), FICOI, MCOI

I am writing to express my strong support for the implementation of a new dental care initiative called "Denticare." With my 11 years of experience in the private dental sector, I have witnessed firsthand the challenges faced by many individuals who are unable to access essential dental services due to various reasons. Denticare could bridge this gap and provide much-needed support to a significant portion of the population.

Denticare aims to address the following key issues:

Limited Financial Resources

Work Commitments: Denticare could offer extended hours of operation, allowing working individuals to receive dental care at times that suit their schedules.

Long Waiting Lists: The existing government dental services often have waiting lists that stretch for years, leaving eligible patients without timely access to necessary treatments. Denticare could significantly reduce these waiting times.

Navigational Barriers: The process of accessing government dental services can be confusing and unfamiliar to some eligible patients. Denticare would streamline the process.

I firmly believe that Denticare could operate effectively by adopting a structure like successful government schemes such as the Department of Veterans Affairs (DVA) and the Child Dental Benefit Scheme (CDBS).

The Denticare scheme has the potential to significantly improve the oral health and overall well-being of countless individuals.

I kindly request the government's consideration and support for the funding of Denticare. I would be more than willing to provide further information, participate in discussions, or contribute in any way possible to make this vision a reality.

Mustafa Hamimi - third-year dentistry student studying at Griffith University, Gold Coast Campus.

This year I have had the opportunity to treat patients under qualified supervision, through the Queensland Dental Public Health System at the Griffith University Dental Clinic. As students we offer free comprehensive dental check-ups to eligible Queensland Health patients, the majority being of low socio-economic standing. I have gained insights into the crisis in Australian Dental Public Health system. While there are services such as the Griffith University Dental Clinic that provide care to patients that need it most, these services are placed under stress, and contain never-ending supply of patients that require urgent advanced dental care but have nowhere else to turn to.

The politicisation and lack of support regarding the integration of dental care into Medicare overlooks the fact that dental care is medical care. Dentists are trained to not only focus on the teeth, but to look holistically at how the oral health and mouth affect the rest of the body. We are trained to look at the gums, tongue, throat, and lips for early signs of cancer. We advise and treat patients on how their teeth affect how they function in speaking and chewing. Dental decay is one of the most prevalent non-communicable diseases in society but lacks adequate public funding. Without early diagnosis and intervention, a simple shallow cavity can progress into a large unrestorable lesion requiring root canal and a crown. This treatment option can cost many thousands of dollars in the private system. Outside the public system, patients simply prefer to have the tooth extracted and replaced with dentures and even that is hard to afford. It is common to see patients with mouths riddled with cavities and gum disease. By the time patients are willing to seek help, it's too late for minimal intervention, so advanced care is needed. These advanced cases can require complex specialist treatment by a periodontist, endodontist and oral surgeon.

As a student, I have seen firsthand how important dental care is to an individual's overall wellbeing and quality of life. I believe more action is required in expanding and integrating the scope of government funded dentistry into Medicare. By doing this, financial barriers to treatment would be removed, and dental care would be more accessible to all members of the public.

I propose the following initiatives as first steps towards the better integration of dental and medical care to improve health outcomes and contain overall health care spending:

1. Government investment should focus on the best-value investments, which span three broad areas: fluoridation, preventive services for children, and preventive and treatment services for the poor and those with special needs eg pregnancy, people with disability.
2. Dental and medical professionals must become partners in delivering health care services. This should entail some shared training, recognition that dental services are an integral part of primary care, inclusion of dental information on Personally Controlled Electronic Health Records and professional courtesies around patient referrals.
3. A "Dental Health Service Corps" made up of dentists and dental staff, doctors, nurses, community/Aboriginal health workers and public health professionals could ameliorate the maldistribution of the dental workforce and take oral health services and education where they are needed.
4. Health promotion activities around tackling obesity, smoking and substance abuse, breast feeding, and better management of chronic conditions and the use of multiple medications need to include oral health information. Help with oral hygiene is also a critical aspect of care for the frail aged, people with mental illness, people with disabilities and those on certain medication regimes.

5. Governments should consider establishing emergency dental services within hospital emergency departments, at least on weekends.
6. Access to dental services for refugees across Australia remains fragmented and limited, particularly in rural and regional areas. Refugees are not using services because of several barriers, including long waiting times, variation in assessment criteria, different eligibility criteria and limited interpreter services. Consequently, their pattern of service use does not accurately reflect their needs.

Australia needs better co-ordinated, more extensive dental services that are easily accessible for this very high-risk group. Identification of refugees as a special needs group and provision of targeted interventions addressing barriers to care are needed.

7. Oral health should be part of prenatal care, and tips on how pregnant women and new moms can protect their oral health and the oral health of their infants. Pregnancy makes women more prone to periodontal (gum) disease and cavities. Oral health may be considered an important part of prenatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby. **Protect Tiny teeth.** Oral health should be part of prenatal care and tips on how to protect the oral health of their infants. 1 in 4 women of childbearing age have untreated cavities.
Children with poor oral health status are nearly 3 times more likely to miss school because of dental pain. All health care providers, including primary care, pediatric and maternity care providers, may consider paying more careful attention to oral health.
8. More opportunities for studying dentistry and dental nursing.
9. Better integration of immigrant dentist.
10. Accountability.
11. Better coverage by Private insurance with reduced out-of-pocket costs by Medical Insurance companies.
12. Good Pay package for Dentists and dental staff.
13. And most important incorporating Oral and Dental health into **Medicare**.

Implementing these proposals will require concerted action from all stakeholders. Bad teeth and poor oral hygiene are not simply cosmetic problems but the cause of sickness, disability and even death. A Senate Select Committee is currently conducting yet another inquiry into dental services in Australia

Hopefully, this Senate Enquiry inquiry will (finally) drive politicians to see dental care as essential to health, wellbeing, and a fair society – and to act. Only through universal and inclusive healthcare will we be able to pave an economically sustainable path towards true public health which includes oral and dental health.

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References:

1.Bad oral health can lead to clinical horrors — so why has Medicare gone AWOL?

Dr Peter Follyn, Medical Observer AusDoc 30 Aug 2023.