DENTIST

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Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600
AUSTRALIA

On 21 January 2011 the Minister for Mental Health and Ageing, the Hon Mark Butler, issued a media release on the Productivity Commission Draft Report on Aged Care. Minister Butler welcomed the release of the report 'Caring for Older Australians' which he hoped would provide the Federal Government with key advice on the direction of aged care in Australia and asked for additional submissions.

I accepted the challenge and made a submission to the Productivity Commission – number DR 496 and attended the public hearing with Professor Clive Wright, who was then the Chief Dental Officer for NSW before his retirement in late 2011.

http://www.pc.gov.au/__data/assets/pdf_file/0009/106110/subdr496.pdf

Under *'Scope of the Inquiry'* the Commission was asked to:

1. Systematically examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector.

2. Develop regulatory and funding options for residential and community aged care (including services currently delivered under the Home and Community Care program for older people) that: Older Australians might also increasingly require specialised care, such as for wound management, and other health (including dental) and nursing care, including dementia and challenging behaviour, incontinence, palliative and end-of-life care, and restorative care and rehabilitation, including transitional and sub-acute care.

I was extremely disappointed and disillusioned with the Final Report as there was no consideration given to dental or oral health issues even though the 'Scope' clearly asked for examination of 'clinical aspects'. The Report focused on the economics of Aged Care without addressing specific clinical issues.

In 1997 I submitted a lengthy submission to the Commonwealth Government Senate Community Affairs References Committee Inquiry into Public Dental Services. Much of what I submitted and was questioned on at the public hearings appeared in the final report and can be found in Hansard.

The following is a section of my submission on Aged Care. In 1997 I had concerns that I flagged. Now in 2013 these have become a reality.

> "There is a lifetime association between oral health, nutrition and disease. An interdisciplinary, coordinated approach between dentists, other health care providers and dieticians is essential for the elderly and disabled. Poor oral health is linked to weight loss and a greater dependence on more medications (including laxatives and antireflux agents) for a greater frequency of gastrointestinal disorders. The links between oral health and nutrition can be demonstrated. Infectious diseases of the mouth as well as oral manifestations of systemic diseases affect diet and nutrition but on the other hand good diet and nutrition may limit the progression of diseases of the oral cavity.
>
> Oral health care has not been seen as a priority nor has it been 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. As we near the year 2000 many of our 'baby boomers' will be approaching retirement age. Some will be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns and bridges, unlike the average 50-60 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the needs of the most disadvantaged members of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled."

Report
http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1996-99/dental/report/c02.htm

In 2005 the NSW Parliament Standing Committee on Social Issues held an inquiry into dental services in New South Wales.

The following is a section on Aged Care from my submission to that Inquiry. If anything the oral health of our elderly population is far worse.

> “The importance of oral health care needs to be acknowledged and seen as a priority by the medical profession and government. Many doctors have a limited knowledge of oral and dental anatomy and the close relationship between oral health and general health. We now see many of our ‘baby boomers’ retiring. Some will shortly be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns, bridges and implants, unlike the average 60-70 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the needs of the most dentally vulnerable members

of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled."

In December 2010 Poul Erik Petersen, Global Oral Health Programme, Chronic Disease and Health wrote to Chief Dental Officers through the world making the following comment on the oral health of older people.

> *Poor oral health of older people is a neglected public health problem worldwide. Oral health promotion and disease prevention is a priority action area of the World Health Organization (WHO) Global Oral Health Programme.*

Little of WHOs concern for oral health in the elderly seems to have struck a chord with State and Commonwealth Governments.

In April this year I have been invited as a Plenary Speaker to the 28th International Conference on Alzheimer's Disease in Taiwan and attach below the abstract for my presentation.

Hearing and vision impairment, cognitive decline and delirium, frailty, incontinence, falls, medication compliance and pharmacokinetics have long been regarded as geriatric giants; however, the implications of Poor Oral Health in the Elderly have for too long been ignored and are equally important. Mouth pain and discomfort associated with poor oral health 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 reasons for poor oral health such as rapid dental decay, acute and chronic periodontal infections, 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.

The implications of poor oral health in the elderly are being addressed globally; however, here we don't seem to have acted on the urgency of the situation.

The following summarize reports to Alzheimer's Australia by Access Economics (2009) and Deloittes (2011)

- By 30 June 2012, the first cohort of the Baby Boomer generation (those born in 1946-47) turned 65, with the number of people aged 65 increasing by 37,500 people from June 2011 (212,300) to June 2012 (249,800)
- By 2020 there will be around 75,000 baby boomers with dementia
- With a higher retirement age of 67, it will also be the case that more people will be unable to remain in the workforce due to dementia onset, or due to the need to care for someone with the condition
- There were 266,574 people with dementia in Australia in 2011
- Projected to increase to 553,285 by 2030, and 942,624 by 2050
- Dementia prevalence is greatest in the age bracket 85-89 years
- In the 12 months to 30 June 2012, the number of people aged 65 years and over in Australia increased by 134,700 people, representing a 4.4% increase

In the 50's and 60's the average age of new entrants into a Nursing Home was around 70 whilst the average age of new entrants today is around 83. In the 50's and 60s most Nursing Home residents had no natural teeth remaining, whereas today most 80 year olds have some natural teeth present. Greater tooth retention in older adults requires a different skill set by all dental health care workers to manage patients with age-related disorders.

- Dental health care workers will need to understand the nature of dementia, and work closely within an expanded team of allied health, family and residential care providers.
- The increasing maintenance of natural teeth throughout life, combined with growth in technologically complex dental procedures, places the frail aged at high risk and likelihood of rapid oral health deterioration when cognitive and physical disability and diet changes impact on their lives.
- We need to establish strong oral health regulations for residents of an Aged Care Facility (RACF)
- We need to establish a specialised workforce in oral health care for older people
- We need to establish increase Aged Care funding
- We need increased access to dentists and auxiliaries for the aged care sector
- We need improved coordination of services and information sharing
- We need better communication and clinical attitude towards elderly

Proposed Changes

- A dental assessment must become part of an ACAT assessment
- Similar to the Commonwealth's 'Teen Dental Scheme' every person who turns 75 should be able to access a free OPG (panoramic dental x-ray) and dental examination
- The Commonwealth must produce brochures or pamphlets on the interrelationship between oral health and ageing
- The scope of practice for dental hygienists and dental therapists must be widened to allow them to treat the aged without direct supervision of a dentist
- Periodic placement at aged care facilities for all students in dental related courses
- Residency requirements for all graduates in dental related courses
- Public sector placement requirement for all foreign graduates seeking Australian practice registration

I draw your attention the following attachments to assist you in understanding my concerns. Please read in the following order

1. Interview with Linda Mottram – ABC Radio

2. Editorial March 2011
   Letter to the Editor Australian Dental Journal

3. Reply to Editorial March 2011

4. Implications of Poor Oral Health
   Article in Australian ADA News Bulletin

Comments

In February about 5 weeks ago on a Friday a 79yr old male who was formerly a high functioning professional person in reasonable systemic health was admitted to the St Vincent's Hospital Emergency Department with a significant left sided facial swelling. At the end of 2012 he had been diagnosed with Dementia but was cognitively and physically reasonable only the week before his presentation to St Vincent's. He had a near full complement of teeth, although heavily restored. It was not possible to immediately examine him due to muscle spasm associated with his oral infection and his disorientation and lack of compliance precluded obtaining an OPG or small dental x-ray. We couldn't even be sure whether it was an upper or lower jaw problem. It was assumed his infection was dental in origin and IV antibiotics were commenced. A CT of facial bones was eventually taken and an OPG x-ray reconstructed from the CT data set. He clearly had a dental abscess on a lower wisdom tooth which needed extraction. His wife, who was quite understanding accepted that a general anaesthetic (GA) was going to be needed and that there could be an impact on his cognition.

Over the ensuing days I saw him 3 times, made several phone calls, visited the radiologist to review the CT slices, needed to communicate with his geriatrician, neurologist, an anaesthetist for a pre anaesthetic consultation and arrange theatre time for a single tooth extraction under GA, follow up appointment and further communication with his wife. As a private patient my account should run into thousands of dollars to reflect the real amount of time spent managing this case; however, as a single tooth extraction the patient and health funds would be up in arms. In the Public Hospital system a lengthy stay is not uncommon but not all hospitals have dentists on staff that can devote this much time to one tooth. Dentistry is traditionally meant to be provided to the ambulant patient. I can see a time when there will be regular hospital admissions of dental origin that will take days if not weeks to resolve. If this becomes a common occurrence the workload in the public hospital alone will be unsustainable within current budget constraints. I eventually took him to the operating theatres and successfully extracted his lower left wisdom tooth on about Day 8. In total he spent 24 days in hospital and was discharged to a nursing home.

When I mentioned this to an anaesthetist who was assisting for me with two other cases she was adamant that this patient's protracted hospitalisation plus all the other resources expended on this patient could not be warranted and that the family should have been asked to exercise their enduring power of attorney and not have him treated. Wow life and death dental issues. My second patient that day was for removal of all remaining teeth (22) in a person with a floor of mouth cancer who declined to have his teeth removed prior to his radiotherapy and subsequently developed accelerated dental decay in all his teeth primarily due to radiotherapy induced xerostomia. Again considerable resources expended including a course of pre and post hyperbaric treatment at Prince of Wales Hospital. And the guy still smokes.

As a dentist I certainly can't make the suggestion to any family that we shouldn't treat their loved one because they might die within 12 months or that the resources to be spent by the state can't be justified. Dentists today who intend to be in practice for another 10 years or more will find dental practice a very different landscape to what we have been used to.

With an ever ageing population, now with teeth, poor oral and dental health will impact on both morbidity and mortality. Better Oral Health education and increased availability of services is essential to avoid Australians dying prematurely of dental related issues.

Peter Foltyn