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INQUIRY INTO ADULT DENTAL SERVICES IN AUSTRALIA

Summary

Easy access to dental services should be a matter of priority for all adult Australians regardless of their social, economic or location circumstances.

To do this, Governments must introduce the same sets of conditions that exist for outpatient, general medical practice and legislate for the finances required for comprehensive dental services delivered by dentists.

Fragmentation of care is not patient friendly and has not been shown to be cost effective.

These services are best delivered via family based, patient centered general dental practices

1a. Demand for dental services across Australia and issues associated with waiting lists

The adult population of Australia has seen a dramatic change in the percentage of people with no natural teeth in the past 33 years (1). This has resulted in the retention of more natural teeth and that period of time has consolidated the retention of those teeth by the exposure of those teeth to reticulated water fluoridation, other tooth applied preparations containing fluoride e.g. fluoride tooth pastes, newer dental materials and clinical advances in technologies.
In addition the benefits of water fluoridation have spread through the generations who have been exposed to their natural teeth as a preventative measure; second to none that has reduced in prevalence of tooth decay in these generations compared to those previous, e.g. the elderly.

The current demand for dental services for dealing with decay in the whole adult population then is potentially broken down into two facets.

1. From early adulthood through to the oldest person with natural teeth there is an essential need for daily ongoing primary prevention to ensure that those teeth that are sound stay sound.
2. From early adulthood through to the oldest person with natural teeth there is a need for the earliest intervention with reliable diagnostic techniques and proven minimal intervention techniques and materials, where dental decay is evident, to ensure these procedures are available and cause the least destruction of tooth surfaces when repaired.

In relation to dental decay, is there any “light on the hill” with respect to the total prevention of dental caries as measured and reported as persons having no experience of dental decay? The answer is yes.

In the Australian Dental Generations AHIW publication (2) almost one in ten had no experience of dental decay, 10% (15 - > 75 year olds). It is 24.1% in those in 2004-2006 who were 15 – 34 years and 2.4% in those who were 35 to 54 years in 2004-2006.

Further analysis of the AHIW report provides data on those in the study that have dental decay which requires mechanical (restorative) care. The interesting feature of the examination for the prevalence of untreated dental decay is that it is overall 25% (1 in 4) for the adult population as a whole had untreated dental decay and this was consistently similar across the generations. (3) Also there was generally a 2 fold difference in dental decay between those who usually visited for a check up, 16.3% versus those who usually visits for a problem 37% across all adult age groups.(4)

As far as dental decay of the root surfaces of teeth is concerned this occurs because there is recession of the gums exposing the root surface to the oral environment. Thus, it is often seen in older generations.
The extent of the lesion is an issue in root decay where there is a need to restore the decayed surface, due to the approximation to the “nerve of the tooth” and the surfaces of the teeth that are decayed. Untreated root surface decay was highest in the oldest generation. (5) Not a surprise.

In adults there are two forms of periodontal diseases that are common. The first is gingivitis and this is an inflammatory response in the gums (gingiva) and is related to poor oral hygiene with the dental plaque, bacterial infection at the join of gum and teeth. With an improvement in oral hygiene methods and regular removal of dental plaque, the gingivitis is reversible.

In the 2007 AHIW which used the Gingival Index Scoring system it found that one in five adults had a score of two or more.(6) This is either bleeding on probing or spontaneous bleeding. Normal, healthy gingiva does not bleed in exactly the same way as normal healthy skin does not bleed and skin surfaces are the first line of defence against a microbial challenge.
For more destructive gum disease, known as periodontitis, the prevalence from the National Oral Health Survey for adults was 22%, most of this 20% was for moderate disease. Periodontitis involves irreversible bone support loss and over time with exposure associated with the age of individuals. The prevalence was 24% for 35 – 54 year olds in 2004-2006 and 43% in those 55 – 74 year olds. (7)

These diseases, dental caries and periodontal diseases, are true pathological processes related to a constant microbial challenge (infection), substrate utilization (fermentable carbohydrates-sugars) and the interaction with host responses. Also in the adult populations, tobacco usage plays a significant role in the severity of periodontal diseases. Systemic conditions such as type 2 diabetes influence micro vascular responses in various organ systems and the

healing capacity of the body. The current and potential epidemic of type 2 diabetes in the Australian population is a risk factor for oral diseases.

When the data is reviewed for Australia's older population it is well recognized that there is a great need for dental care (8).
In a study(9) that examined older persons in Residential Aged Care Facilities, while there are challenges and questions about the material and methods of this study, it showed that 75% of the residents examined required dental care within the scope of practice of an independent practitioner – a dentist- as defined by the Dental Board of Australia.

In summary: Across Australia there is a significant need for traditional dental services provided by dentists to adults ,in hopefully a reducing pattern, as the life long benefits of exposure to fluorides, improving socioeconomic status and educational achievements of the population are attained.

The issue of the workforce will be addressed later.

1b. Waiting lists comments

Waiting lists provide government with an idea of demand and in the acute care health sector it is possible by the use of severity and disability criteria to allocate people to sub lists.

In dentistry, especially within the "so called" public sector of dentistry, the general way patients are allocated to waiting lists relates to their first experience and reason for that attendance.

- A person attends or makes contact with an acute dental problem
- A triage process occurs via the contact and a decision is made, by reception staff utilizing various questions (pain/bleeding) to allocate an urgent appointment within 48 hours.
- If this occurs then at the actual appointment the acute issue is addressed

- If other pathology is present then the person is placed on a waiting list for general dental care
- If the replacement of missing teeth is considered justified the patient will be allocated to a denture (prosthetic) waiting list.

These two waiting lists may be different in length. In some States the person is not placed on a waiting list, they are encouraged to contact the service, after the acute episode, and it is up to them to do so.
Where all persons are placed on a waiting list, after the acute episode, their desires and determination for care are not seriously considered and the waiting list can be used by management to inflate the demand.

Because of these issues this committee also needs to understand the relevance of "failure to attend" (FTA) figures and demand these of the various State instrumentaties to really understand true waiting list issues.

1. The mix and coverage of dental services by State and Territory Governments and the Australia Government

The Australian Government provides for a comprehensive range of dental services via the Gold Card eligibility for Veterans (DVA). While the fees provided may be debatable, the DVA has not limited the extent of the services available to this group. This is best exemplified by the scope of treatments or options available to the dental practitioner when considering the replacement of a front upper tooth, in an eligible Iraq war naval veteran, who lost the front tooth on active duty. The options are many from a temporary acrylic partial denture (so his wife recognizes him) to a single tooth, osseo integrated implant.
By correspondence with DVA approval can be obtained for the "best fit care" based upon evidence, clinical skills and patient's best interests.
This process and the use of the dental schedule is exactly the same as that which applies for adults who seek medical services (outpatients) via their general medical practitioner under the current Medicare scheme arrangements. Some

treatments require prior approval (e.g., prescriptions of certain drugs, use of HbA1c tests for diabetics) and this ensures that extended care plans are updated and in place particularly for those with chronic diseases (Consider the diabetic epidemic).

However, the States, all of them, fall down in the mix and coverage of dental services. Each state has restrictions placed upon the range of services provided to adults. Also different States have additional financial barriers that they place upon the people eligible for these services (e.g. co payments). Since eligibility criteria relate to social and economic disadvantage, that is the need for a Commonwealth Health Care Card; these people are being classified by the States as second class citizens when it comes to the scope of services they can obtain.

This is “morally bankrupt” for the State to discriminate in this way in relation to a true pathological condition that produces pain, discomfort, social isolation and reductions in productivity.

However, as a previous public sector employee and educator, I have to express great reservations about the State Dental Services which provide the people and clinical environments for the education of dentists. Yes, they limit the scope of services available to these people for whom they claim responsibility and also restrict the educational experience for students and trainees.

In February 2010 at a meeting in Sydney, the Director of the South Australian Dental Services said, and I was there and have a copy of his presentation, that their service does not treat chronic periodontal diseases and has no recall programs for its patients. This is in sharp contrast to World Wide evidenced based best practice (10).

Periodontal diseases are actively treated successfully and one in 5 Australian adults has the moderate level of the conditions.

For undergraduate students and now voluntary internship candidates to be exposed to such nonsense that is not evidence based, is a disgrace.

In summary, the mix and coverage of dental services for all people in Australia should be broad and comprehensive and guidelines and standards for care for each procedure outlined in the Schedule of Dental Services must be developed. The limitations applied by current States must be removed and careful allocation of Commonwealth funds be made uniform and tied to specific measures with taxation increases in the Medicare levy to fund the adult dental needs.

3. The availability and affordability of dental services for people with special dental needs (Aboriginals)

This area of special dental needs has not been well defined. Is it that the inquiry is talking about people with special needs, for example, those with acute or chronic mental illnesses? Could it be those with congenital and/or acquired developmental disorders (cleft lip and palate, Downs syndrome), those adult Australians living in Residential Aged Care Facilities with high care needs or, for that matter, at home with high care needs? If Aboriginals are considered as those with special needs is it that location/remoteness that which defines their special need?

The issue here is not that the dentistry is “special” rather it is that the circumstances that allow the dentist to provide care are different and that the frequency of the care may need to be significantly altered.

In Tasmania, for example, much of the care is provided on an outpatient basis via private clinics. Inpatients care at acute care hospitals usually relates to the period in the Facility, for example, during ambulatory chemotherapy care or as an inpatient after trauma.

Complex restorative dentistry after road trauma is usually covered via trauma insurance schemes and private dental care. Each State may have data on the costs to their budgets on this care, but is it not readily available. The costs of and finances available for the complex care offered via the Cleft Palate Lip

Scheme could act as a guide as this is managed and financed via the Commonwealth and Medicare.
Any scheme that advances the dental care to those with special needs must include funding for inpatient general anesthesia and short bed stay services utilizing the private sector and day stay facilities.

In summary, there is a need to determine those conditions and circumstances that are considered “special needs patients” and then apply dental services to these people, accepting that the special need may in some circumstances be more expensive due to time and difficulty in providing the care.

4. The availability and affordability of dental services living in metropolitan, regional, rural and remote locations

In the past dental services for those living in different geographical locations in Australia has been inequitable. State services cannot recruit dental professionals to rural and remote locations and private facilities are not financially viable. However, recent data suggests that these zones are now showing increases in dental practitioner numbers. For adult Australians to receive recommended dental care there is a need to look at a range of ways to deliver these services utilizing all modes of delivery. E.g. fly in fly out.

5. The coordination of dental services between the two tier of government and with privately funded dental services

This whole area of the physical provision of adult dental services via different tiers of government is stupid. If the study of Medicare is undertaken for the provision of general medical services on an outpatient basis, it is obvious that the family medical practice model has suited Australians since the early 1970’s.

That is to say a person with an illness that is not life threatening attends a general medical practice and he/she receives a service. This service is semi financed from the public purse with the scheduled fee and some of this is raised via the Medicare levy. The practitioner can charge that fee (bulk bill) or request a higher fee for which the patient is responsible for the additional cost. While the Commonwealth (Super clinics) and to some degree the States (e.g. Sexual Health Clinics) may provide outpatient, general family practice services, the vast majority of services are provided by private, medical practitioners in accredited practices.

For all, unfortunately limited, general dental services provided by “so called” public dental services there is a waste of monies in attempting to delivery of these services in the public sector. Why “so called public dental services”, because they are grossly underfunded, they offer mostly emergency dental care and they ignore the prevention of disease. In addition, the location of these facilities are more often driven by political interference and they limited the care to “the public” they service, inferring by that process, these people are less deserving citizens. We do not do that with medical services, what a lousy nation.

The answer to ensuring better access to all adult Australians to better dental health is to transfer the provision of general dental services to the private sector insisting upon quality guidelines, standards and practice accreditation. The financing of these services would be via taxation arrangements and an increase in the Medicare levy by a realistic percentage, with built-in 3 year reviews.

The remaining State dental services should

- Be stripped of the general dental services
- Be involved in managing water fluoridation to all populations of 1000 persons or greater.
- Provide only consistent, evidence based and tested oral health promotion messages.

- Provide where sensible, domiciliary dental services, special needs patients with dental services
- Provide visiting dental services or contract out these services to rural and remote areas. Contracting could be as per the current arrangements for Defense personnel in non-frontline bases)
- Provide the clinical infrastructure services required by educational institutions to ensure clinical competence and experiences to ensure the graduates are equipped to deliver quality care. These should always be closely collocated with major teaching medical hospitals and research facilities (Westmead Hospital).

In summary, by the development of guidelines, standards and accredited family based, patient centered practices, the delivery of adult dental care can be comprehensive, finances via a Medicare outpatient model, monitored and where required, expanded and/or regulated as advances in knowledge occur.

6. Work force issues relevant to the provision of dental services

This is currently a contentious issue for the recent expansion of dental schools in Australia and the immigration of dentists from overseas has seen a substantial increase in dentist graduates.
As well, Health Workforce Australia and the Dental Board of Australia have been lobbied by State Government Dental Services (DHSV/ SADS), other dental clinical providers (Dental Therapists, Dental Hygienists and Oral Health Therapists) to allow for expanded duties and the relaxation of supervision provisions that existed previously in legislation.

Two recent papers in their discussion sections, attempted to provide support for a change in supervision and expansion of duties of dental hygienists and dental therapists. The first paper, by Hopcraft *et al (9)* showed that dental hygienists and dentists can examine residential agent care persons in their facilities, and the exam results were comparable. However when it came to needs for care,

75% of those persons examined required a dentist to provide all the care those aged individuals needed.
The aim of the paper was to show the compatible of the result of the examination undertaken by a dentist and a dental hygienist. However, as 75% of the residents needed a referral to a dentist all their care.

What it really showed was

- The poor level of oral health of those in Residential Aged care facilities
- Their dental needs required a dentist.
- That sending teams of dental hygienists to carryout examinations under less than ideal conditions to find 75% of the residents required more than they can offer, due to limited competency/ scope of practice skills and knowledge, would be a waste of resources.
- And an examination by the dental hygienist to find that 75% of residents needed a dentist was not costed.
- The majority of people required a dentist to deliver the care.

Yes, there is a need for care and our Society should see this is funded and delivered but in the most cost effective and efficient way – by dentists to meet the needs.

The second paper by Calache, H *et al* (11) is of even greater concern for its outcome if acted upon is counter intuitive at a time when the Commonwealth is about to embark upon a more comprehensive dental care plan for children and adolescents 2 – 17 years of age from January 2014.

The States have over the years destroyed the School Dental Services which was originally introduced in the early 1970s to address dental decay levels in children via the utilization of dentists and dental therapists. Calache (13) states that 47% of children aged under six in Victoria have dental decay yet he uses his paper's findings to support the change in the direction for limited restorative dental

treatments towards adults by dental therapists at the risk of diluting the potential and essential preventive services for our children. The materials and methods of this paper had significant limitations

- A dentist had to examine the patient.
- Because of the limitation and restriction placed on the tooth and person who was to receive the care, a dentist then had to select the cavity for restoration by the therapist. No definition of the carious lesion, its rate of progress and history of the lesion was outlined.
- The dentist had to be available while the dental therapist carried out the restoration.
- Six months later the dentist had to review the restored tooth.

No information was provided on the cost effectiveness of this process.
With increasing numbers of dentist graduates from Australian Universities and from migration levels the need to alter the scope of practice of dental therapists to provide adult limited restorative care is not justified and will ensure confusion in the population on who does what. As the Australian adult population ages more people will need team based patient centered care and so fragmentation of the patient and their needs is stupid when all models encourage a team approach to dental care with ease of access for the consumer.

In summary, The dramatic changes that are now in train with respect to dentist numbers being graduated by Australian Dental Schools and the current recruitment of overseas dentists is the ideal time to address the financing and access needs of the Australian adult population as a whole. Health care is a constant factor in the minds of the Australian population and they expect the best range of services, delivered by the best available clinicians, close to home without extended waiting times. They do not want to know who pays so long as they do not. However, the role of Government is to have a serious conversation with the population on Health Care – its financing and delivery. Health must be depoliticized and all governments must utilize the available resources in a team approach to adult dental care. Narrow focused special interest groups, such as

dental therapists, cannot provide comprehensive dental care required by the adult population. Only the dentist whose numbers are at an all-time high can do so and if Government see oral health as part of the overall health needs of the people of Australia then it needs to address the issue for all.

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