AUSTRALIAN DENTAL ASSOCIATION

2018-2019 Pre-budget Submission

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The Australian Dental Association (ADA) is the peak national professional body representing the majority of Australia's 16,000 plus registered dentists as well as dentist students. ADA members work in both the public and private sectors.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public; to advance and promote the ethics, art and science of dentistry; and to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare. Further information on the activities of the ADA and its Branches can be found at **www.ada.org.au**

Introduction

Whilst dental caries and periodontal disease is evidenced across all socio-economic groups, there are approximately 7 million, or 30%, of Australians whose oral health and access to oral and dental health care is less than optimal due to their socio-economic status. The incidence of untreated decay is far greater in certain sub-groups, whose access to timely preventative and remedial oral health care is constrained by their general health, inability to afford private dental services and long waiting times for public dental service.[1]

Therefore, the extremely limited access to private dental treatment currently provided through Medicare, and limited state and federal government funding for public sector dental services mean that many Australians who cannot afford private dental services face extended periods—in some cases, years—waiting in the public system until they qualify which may result in unsatisfactory patient outcomes.

The longer that oral and dental disease goes untreated, the greater its negative flow-on impact on general health and well-being, the greater the associated direct and indirect costs to the publicly funded health system, and the greater the economic cost to individuals and the nation through decreased human capital and productivity.[2]

In its 2016–17 and 2017–18 pre-budget submissions, the ADA has been vocal in its calls for the Federal Government to address the urgent need for additional, targeted and sustainable funding to meet the oral and dental health care needs of groups identified as "priority population" groups by the COAG Health Council in its first Australian National Oral Health Plan (2005–14), and again in the current ten-year plan for 2015–24.[3]

The ADA's Australian Dental Health Plan (ADHP), developed in 2016, addressed these needs. It called for the introduction of Federal dental funding schemes based on the Child Dental Benefits Schedule (CDBS) model for low-income Australian adults and aged persons. The ADHP suggested higher annual monetary claiming limits for low-income adults and elderly people with demonstrably poorer oral health and greater barriers to accessing appropriate dental care. Patients with disabilities or other special needs, those residing in remote and very remote locations, and those of Aboriginal and Torres Islander heritage require particular consideration with targeted outcomes, ensuring a better level of oral and dental healthcare.

[1] National Advisory Council on Dental Health (NACDH). (2012). *Final report of the National Advisory Council on Dental Health*, Department of Health and Ageing, Canberra, p. 19, 53; and COAG Health Council. (2015). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2015-20*24, pp. 33, 63-67. http://www.health.gov.au/internet/main/publishing.nsf/Content/C10065B9A8B6790FCA257BF0001BDB29/$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20(PUBLICATION).pdf

[2] NACDH, op. cit.; COAG Health Council. (2015). op. cit.

[3] COAG Health Council. (2004). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2005-2014*, and COAG Health Council. (2015), op. cit.

In this pre-budget submission, the ADA continues to advocate for additional 2018–19 Federal Budget funding to address the urgent unmet oral and dental health care needs of several of the population groups nominated by the COAG Health Council as priorities in two successive Australian National Oral Health Plans.

Specifically, this submission calls for increased Federal Budget funding to support improved access to timely, affordable, needs-appropriate and optimal oral and dental health care for two patient groups that are poorly served by current public funding arrangements:

- *The aged, and most particularly, residents of aged care facilities*, many of whom are not receiving the assistance they require from aged care facility staff to maintain oral health. Many in this group also face financial and other barriers to accessing the required remedial oral and dental health care they need to improve their oral and dental health

- *A significant number of children and adults with special needs for whom dental treatment can only be safely provided under general anaesthesia in dedicated operating facilities, and who are unable to access these facilities*. Government and private health insurance hospital funding arrangements are loaded against provision of such care, and as such access is virtually non-existent even when treatment required under GA is of an urgent nature. The inability to access GA services is an appalling outcome in a modern and wealthy nation that aspires to best practice health care.

Better access to oral and dental health care for the low-income aged population and aged care residents

In a demographic context where the proportion of the Australian community that can be classified as elderly/frail aged is increasing rapidly, and can be characterised by widespread unmet need for assistance to maintain oral hygiene, and/or affordable access to oral and dental health care, it makes political and economic sense to address these needs as a matter of priority in the 2018–19 Federal Budget.

Increasing longevity and the increasing proportion of older people who have managed to retain their natural teeth are changing the oral health needs of this population compared to those of previous generations. Dentures are often easier for the frail aged and their carers to look after than natural teeth, however, an increasing proportion of aged care consumers who retain some or all their natural teeth may have had complex restorative treatment that requires a higher level of maintenance by experienced dental providers.[4] Older people with complex health conditions are often on equally complex medication ("polypharmacy") regimes. Some of these medications reduce the flow of saliva which this significantly increases the risk of dental caries, infective episodes and periodontal (gum) disease unless daily attention is given to oral hygiene.[5]

Australian Institute of Health and Welfare (AIHW) statistics suggest that more than half of all Australians aged over 65 have periodontal disease.[6] Compared to younger Australians, older people—and most particularly older low-income people—also have higher rates of tooth decay, which often goes untreated

[4] Lewis A, Wallace J, Deutsch A & King P. (2015). 'Improving the oral health of frail and functionally dependent elderly', *Australian Dental Journal*, 60 (1 – Supplement), p.97; Welsh S. (2014). 'Caring for smiles: improving the oral health of residents', *Dental Nursing*, 10 (4), pp.224-228.
[5] National Institute of Dental and Craniofacial Research. (n. d). 'Periodontal disease: causes, symptoms and treatments.' https://www.nidcr.nih.gov/OralHealth/Topics/GumDiseases/PeriodontalGumDisease.htm
[6] AIHW. (2017). *Older Australians at a glance 2017: Oral health and disease*. http://www.aihw.gov.au/ageing/older-australia-at-a-glance/health-and-functioning/oral-health-and-disease/

for significant lengths of time.[7] This often results in extractions that could otherwise have been avoided, and which carry the risk of life-threatening complications for the increasing number of older people on blood-thinning medications. Access to timely restorative and preventive care can significantly reduce such risks.

The 2010/11 National Dental Telephone Interview Survey, a nationally representative survey conducted for the AIHW, found that 9% of Australians aged 65 and had experienced toothache either "often" or "very often" during the previous twelve months. Despite this, many older people only visit a dentist when they have an urgent problem causing significant pain, or remain untreated in public systems.[8]

Long waiting lists for anything but emergency dental treatment through the public system reportedly leave many aged pensioners suffering "immense pain and diminished quality of life" for significant periods of time.[9]

Consumer organisations report that lack of access to affordable dental treatment is a rising source of distress and concern amongst Australia's elderly population, most particularly amongst pensioners and part-pensioners who cannot afford the care required. Even those with private health insurance can often not afford such care because the paltry rebates on offer do not significantly reduce out of pocket costs.[10]

The oral and dental health of aged care residents is of higher concern

As a corollary of increasing longevity, the proportion of aged care consumers with dementia, mild cognitive impairment and communication disorders is also increasing.[11] This population may not only require assistance to maintain their oral health but also have difficulties communicating that an oral health problem is causing them discomfort or distress. Taken together, these factors mean that provision of high-quality oral care is a more complex and challenging responsibility for residential and home/community aged care workers than in the past.[12]

There is considerable evidence that many aged care facilities in Australia, as elsewhere, are failing to rise to these challenges.[13]

It is common for residents of Australian aged care facilities to be found to have "poor oral hygiene with a high accumulation of plaque and calculus" that increases the risk (or severity) of periodontal disease and

[7] COAG Health Council. (2015). op. cit., p.66.
[8] Lewis et al., p. 97.
[9] Ibid, p. 9.
[10] see, for example, Submission No. 15 to the Senate Community Affairs Committee's recent Inquiry into Private Health insurance, from the Combined Pensioners and Superannuants Association, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Submissions
[11] Healthy Ageing Research Group, La Trobe University. (2016). *Submission to the Standing Committee on Community Affairs References Committee Inquiry into the future of Australia's aged care sector workforce*. Submission no. 237, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions
[12] Ibid.
[13] https://theconversation.com/the-shocking-state-of-oral-health-in-our-nursing-homes-and-how-family-members-can-help-77473 https://www.agedcarecomplaints.gov.au/wp-content/uploads/2015/12/Industry-Feedback-Alert-Oral-Health-and-Dental-Hygiene.pdf; Chalmers J M, Spencer A J, Carter K D, King P L and Wright C. (2009). 'Caring for oral health in Australian residential care', *Dental statistics and research series no. 48.* Cat. no. DEN 193. AIHW, Canberra; Hilton S, Sheppard JJ & Hemsley B. (2016). 'Feasibility of implementing oral health guidelines in residential care settings: views of nursing staff and residential care workers', *Applied Nursing Research*, 30, pp. 194-203; Slack-Smith L, Durey A and Scrine C. (2016). *Successful aging and oral health: incorporating dental professionals into aged care facilities*, Centre of Research Excellence in Primary Oral Health Care, School of Dentistry, University of Western Australia, available at http://rsph.anu.edu.au/files/Aged%20care%20Full%20report%20FINAL.pdf;

infections in or around their teeth and dentures.[14] Other studies suggest that the oral health of older people tends to decline significantly in the year or so before they enter residential care, and then "rapidly worsens following admission".[15]

Existing accreditation standards under the Aged Care Act 1997 set out in the Australian Aged Care Quality Agency's (AACQA) Quality of Care principles have long included an explicit expectation that the oral and dental health of residents is maintained (Standard 2, Expected Outcome 2.15).[16] Guidance material on the processes, practices and tools that facilities should use to achieve this standard is also provided to facilities by the AACQA.[17]

Despite of this standard, the guidance provided, and reminder alerts issued to the sector by the AACQA in response to complaints about poor oral care in residential aged care facilities, the prevalence of "generally inadequate" oral health care provision in such facilities is acknowledged as a significant concern by many care staff who work or have worked within the sector.[18]

For example, residential aged care nursing and care staff who participated in a recent research study part-funded by the National Health and Medical Research Council of Australia noted that in the large facility in which they work, many residents unable to brush their own teeth might only have their teeth brushed by staff "once a week". Other residents less able or willing to participate in the process (e.g. to open their mouths, or help hold the brush) might "go weeks without having their oral care attended to," or just not have their teeth brushed at all.[19]

Given this evidence, the ADA reiterates the strong objections to the removal of explicit standards of oral care from the new Single Aged Care Quality Framework that we communicated to the Department of Health earlier in 2017 as part of a related consultation process.[20]

Workforce issues in residential aged care

Key factors consistently identified by aged care staff, academic researchers and independent reviews as impinging on the provision of adequate oral health care in residential aged care facilities include:

- inadequate staff knowledge and training in oral health assessment and provision of oral hygiene assistance to residents whose capacity to co-operate is reduced by medical conditions or intellectual impairments; and
- inadequate staff-to-resident ratios that leave care and nursing staff too overwhelmed with other tasks to spend sufficient time attending to residents' oral hygiene needs.[21]

It is understood that the Federal Government has recently appointed an Aged Care Workforce Strategy Taskforce to develop a strategy to address a range of workforce issues affecting the quality of care in

[14] Hopcraft, M S. (2015). 'Dental demographics and metrics of oral diseases in the ageing Australian population', *Australian Dental Journal*, 60 (1 – *Special Supplement on Dentistry for the Ageing Population*), p.3.
[15] Lewis et al., op. cit., p.97.
[16] See pp. 60-61 of https://www.aacqa.gov.au/publications/publications-providers-and-surveyors/Resultsandprocessesguide.pdf
[17] Ibid.
[18] Hilton et al., op. cit. p. 9; Australian Nursing & Midwifery Federation. (2016). *Submission to the Senate Community Affairs References Committee Inquiry into the Future of Australia's Aged Care Sector Workforce*, *Attachment 1: ANMF National Aged Care Survey Final Report*, July 2016, http://www.anmf.org.au/documents/ANMF_National_Aged_Care_Survey_Report.pdf; Slack-Smith et al., op. cit.
[19] Hilton et al., op. cit., p. 9.
[20] https://www.ada.org.au/News-Media/News-and-Release/Submissions/Response-to-Single-Aged-Care-Quality-Framework-D/ADA-submission-to-Department-of-Health-consultatio
[21] Australian Nursing and Midwifery Association, op. cit.; Chalmers et al., op. cit., Fallon T, Buikstra E, Cameron M, Hegney D, Mackenzie D, March J, Moloney C & Pitt J. (2006). 'Implementation of oral health recommendations into two residential aged care facilities in a regional Australian city', *International Journal of Evidence-Based Healthcare*, 4(3), pp. 162-179; Hilton et al. op. cit., and Slack-Smith et al., op. cit.

residential aged care facilities. The work of this Taskforce, which will include consideration of staffing mix, minimum education and training requirements, education and training curricula and quality, pay relativities, the debate around appropriate ratios of staff to resident numbers, and a range of other issues, is to be completed by June 2018.

The ADA looks forward to contributing its expertise to the work of this taskforce during its public consultation process in early 2018.

As a preface to more detailed input into this process, the ADA notes that it strongly supports the view that all residential aged care staff who deliver, or supervise the delivery of, clinical care should be required to undertake education and training that provides them with the requisite skills to provide high-quality oral care to aged residents with complex health issues and special care needs.

The ADA also broadly supports the recommendation of the Senate Community Affairs Committee's *Future of Australia's Aged Care Sector Workforce* report that government should develop scholarship and other support mechanisms to help nurses, doctors, dentists, and other allied health staff to undertake specific geriatric and dementia training, and to promote the supply of an adequately skilled workforce in regional and remote areas.

The need to involve dental practitioners in oral health assessments and Care planning on admission

A comprehensive study of factors affecting oral and dental care in residential aged care facilities recently conducted by the Centre for Oral Health Strategy in WA, has found that dentists and dental hygienists are rarely employed by aged care facilities to conduct initial oral health assessments and care planning for new residents. General medical practitioners are also uninvolved, seeing this as the role of nurses at the facility.

The study noted that this had profound implications, with oral and dental disease being overlooked on admission, and inadequate planning of individual oral care needs resulting in failure to provide an individually-appropriate level of assistance with oral hygiene, a failure to adequately monitor oral health needs, and the development or worsening of oral and dental disease.

Multi-case studies of long-term residential aged care facilities that have a high proportion of residents with severe disabilities and cognitive impairments have found that participation of dental professional in resident care planning is fundamental to maintaining or improving their oral health.[22]

Affordability and accessibility of dental treatment for residents

With respect to access to dental treatment once a need for it has been identified by residents or facility staff, the affordability and accessibility of dental care are also significant barriers to care. In residential aged care, both issues account in part for low rates of dental referral, and the refusal of residents and their guardians or families to seek treatment.[23]

The ADA believes that where possible, dental care is best provided by dentists in dedicated dental surgeries. However, it recognises that this is not always possible for aged care residents with significant mobility constraints or concerns about leaving a familiar environment for treatment.

In line with recommendations of the COAG Health Council,[24] the ADA has already recommended that revised Single Aged Care Quality Standards, currently under development by the Federal Department of Health, include a requirement that residential aged care facilities provide designated areas and

[22] Thorne et al. cited in Chalmers et al., op. cit., p.2.
[23] Chalmers et al., op. cit.; Hilton et al., op. cit.
[24] 2015, op. cit.

equipment for dental treatment. Larger residential aged care facilities should be required to establish fully equipped and dedicated dental surgeries.

The indirect costs of poor oral health amongst older Australians

The most common immediate consequences of poor oral health—pain, infection and tooth loss—have flow-on effects that significantly add to costs in the broader health system. Tooth decay, oral cancer and periodontal disease are linked with the onset or worsening of other chronic health conditions like cardiovascular, cerebrovascular and respiratory diseases.

Older people are over-represented amongst potentially avoidable hospital admissions, and untreated oral health conditions are often the cause or causal factors in those admissions.[25]

Periodontal disease is now known to have a causal relationship with diabetes, another high-prevalence chronic disease experienced by 17% of elderly Australians, with another 17% of this population at high risk of developing the disease.[26]

Aged care residents with poor oral health are also more at risk of bacterial infections of the blood and aspiration pneumonia,[27] which is a major cause of morbidity and mortality amongst the frail elderly.[28]

For these reasons, budget measures focussed on the prevention of poor oral health and dental disease amongst the aged population are important to reduce the wider economic impact of poor oral health amongst older Australians.

In 2007, one economic analysis estimated the indirect costs of periodontal disease to the Australian health system to be $412m per annum, and the total cost of poor oral health amongst older Australians to be more than $750 million per annum.[29]

A decade later, this total cost figure is likely to be closer to $1 billion, given ongoing increases in the aged population and the real costs of medical services over the past decade.

Addressing affordability barriers: Aged Pensioner Dental Benefits Schedule (APDBS)

To address the affordability barriers to comprehensive dental care compromising the oral and general health and wellbeing of the most financially disadvantaged elderly Australians, the ADA recommends that the 2018–19 Federal Budget introduce an Aged Pensioner Dental Benefits Schedule, designed along the same lines as the CDBS.

It is envisaged that key features of the scheme would include:

- An entitlement to claim all services listed in the current ADA Schedule and Glossary, up to a monetary cap of $1000 per two-year period;
- Eligibility confined to a specific age and concession card status. e.g. 65+ years, and in receipt of a Pensioner Concession Card;

[25] Lewis et al., op. cit., p.96; AIHW, op. cit. p.5.
[26] Ibid, p. 96.
[27] Hopcraft, M S. op. cit., p.3.
[28] Tada, A & Miura, H. (2012). 'Prevention of aspiration pneumonia with oral care', *Archives of Gerontology and Geriatrics*, 55 (1) 16-21.
[29] Econtech, cited in Lewis et al., op cit., p. 96.

- Access to all services based upon the current edition of the ADA Schedule, with prior approval required for certain identified Schedule items;
- Utilisation of both private dentists through their clinics, and public dentists through public sector clinics;
- Utilisation of dental hygienists and therapists working in structured professional relationships with participating dentists, within their scope of practice;
- Utilisation of participating dentists willing to provide dental services in hospitals, or on-site at suitably equipped residential aged care facilities;
- Private dentists participating in the scheme to have the same options to either charge their customary fees, or to bulk-bill, as per the principal that operates for GP services under Medicare;
- Co-payments should be covered by private health insurance rebates where patients have applicable private health cover'
- Care under general anaesthetic permitted with prior approval;
- A 50% higher bi-annual monetary cap for Pensioner Concession Card holders with the following characteristics, in recognition of their poorer oral health and greater barriers to accessing required oral and dental health care:
    - Aboriginal and Torres Strait Islander descent;
    - living in Remote and Very Remote regions as per ABS Remote Area Classification RA4 & RA5;
    - disabled or with other special needs; and
    - registered residents of aged care facilities.

The APDBS would significantly ease the affordability barriers to private dental care experienced by financially disadvantaged residents of aged care facilities.

By supporting access to private dentists for the purposes of oral health assessments and care planning on admission to residential aged care, the APDBS will also support the individually-tailored planning and delivery of daily oral health care that has been found to be so important to the oral and general health trajectories of residents.

Furthermore, the ADPBS will also support affordable access to dental care for Pensioner Concession Card holders living independently in the community, or with the support of government-funded Community/Home Care services.

Funding the APDBS

The funding of affordable access to timely early diagnosis and treatment of disease and decay along with regular preventive oral health care can be expected to generate budget savings through significant and progressive reductions in the massive direct and indirect fiscal and economic costs of poor oral health for older Australians. As indicated earlier in this submission, these costs are likely to be in the order of $1b per annum.

Given that it is poor oral health amongst the most disadvantaged aged persons that generates the vast bulk of these public costs, the indirect savings that would flow from implementation of a PDBS would more than cover the direct costs of the program within a few years, and potentially generate significant ongoing net budget savings in the medium to long-term.

Additional budget measures to support better oral and dental health care in residential aged care facilities

The ADA also recommends that the Federal Budget includes:

- Capital funding to support provision of on-site dental treatment facilities and equipment in larger residential aged care facilities; and
- Scholarship funding to support the upskilling of nurses, doctors, and dental practitioners through education and training courses focussed on the oral and dental care needs of geriatric and dementia patients.

Funding to improve affordable access to dental treatment under general anaesthesia for children and special needs adults

Provision of dental treatment under general anaesthetic (GA) in hospitals and dental day procedure facilities, rather than in the normal dental clinic, is in some circumstances necessary to ensure that required dental care can be delivered as safely, efficiently and with as little distress to the patient as possible.

Treatment under GA is only used in circumstances that preclude treatment under local anaesthetic or lighter sedation in the normal dental practice setting. It is used to reduce cognitive, sensory, and skeletal motor activity to ensure the successful completion of dental treatment which the patient is unlikely to be able to "receive, tolerate or cooperate with" if provided under local anaesthesia or conscious sedation. [30]

Oral and maxillofacial surgeons already have the facility to use GA to surgically treat patients with cleft lip or cleft palate or cancer, and patients who have experienced extensive orofacial or dental trauma requiring significant surgery. In these circumstances, dental treatment under GA is recognised with specific item numbers in the Medicare Benefits Schedule.

However, dentists who treat paediatric or special needs patients also frequently need access to general anaesthetic facilities to treat uncooperative children who often require long procedures, and adult patients with disabilities or other special needs. Both generalist and specialist dentists need access to GA facilities for individual patients whose circumstances require it. Advances in anaesthesia have increased the safety of this treatment modality, but access to appropriate operating facilities is essential to minimise the risk of adverse outcomes.

Young children, patients with dementia or Alzheimer's disease, psychiatric or intellectual disabilities, behavioural or personality disorders, morbid fear of the dentist, or Post Traumatic Stress Disorder, may also need to undergo longer procedures under GA to minimise psychological distress, or because they have difficulties comprehending, communicating or co-operating with the dentist. Treatment under GA may also be indicated for other patients whose physical particularities or impairments, or medically compromising conditions (e.g. epilepsy, Motor Neurone disease, and many others) render treatment in the chair impractical or unsafe.

[30] American Academic of Paediatric Dentistry (2012), cited in ADA Victoria. (n. d.) *Fact sheet for hospitals and day procedure centres: General anaesthesia (GA) and dentistry*, http://www.adavb.net/LinkClick.aspx?fileticket=KvpIGFUNWGc%3d&tabid=1224&mid=3468&language=en-AU

In 2015–16, a combined total of 67, 266 episodes of this kind of comprehensive dental treatment under GA[31] were delivered in Australian public and private hospitals and day facilities. Almost three-quarters (73%) of these services were provided in privately owned hospitals and day care facilities, and the remainder through publicly funded dental or general hospitals.[32]

The number of Australians who need dental treatment under GA is growing

The population of patients who are likely to require general dental treatment under GA in Australia is growing. This is the result of several factors. One factor is that medical advances are resulting in longer life spans for patients with disabilities and/or multiple chronic diseases or medical conditions that may preclude dental treatment without general anaesthesia. Longer life spans and an ageing population profile are also increasing the absolute numbers of Australians with neuro-degenerative diseases such as dementia and Alzheimer's.

The oral health of patients in these groups is often compromised both by side-effects of their medical conditions or medications (e.g. dysphagia or xerostomia) and by reduced capacities for adequate oral hygiene self-care.[33] For example, amongst adults with intellectual disabilities, the incidence of tooth decay is three times higher than that of the wider Australian adult population, and this is thought to be a product both of sub-optimal attention to self-care, and the side-effects of medications used to manage behaviour. These adults may also find it difficult to articulate that oral pain or discomfort is causing distress. The net result is that rates of *untreated* decay that eventually requires extraction, and of early onset, extensive periodontal diseases are much higher amongst Australian adults with intellectual disabilities than amongst the wider adult population.[34]

Further, the incidence of autism spectrum disorder (ASD) diagnoses is rising for both male and females in Australia.[35] Around 150,000 Australians, or some three-quarters of those diagnosed with ASD, are identified as having a disability. Most of this group are also identified as having *profoundly* or *severely* limited capacities in relation to self-care, and/ or understanding and communicating with other people.[36] Over one-third of those identified as having an autism-related disability are also affected by other disabilities (most commonly intellectual and/or psychiatric) that may compromise their capacity to tolerate dental treatment without GA.

The number of Australian children who are requiring extensive dental treatment under GA also continues to grow, albeit at a somewhat lower rate than the astonishing *threefold* increase seen between 1993-94 and 2003–04.[37]

In South Australia, for example, there was a 55% increase in the number of children who needed dental treatment under GA over the decade to 2014–15. In the year to June 2017, 2500 children under the age

[31] as opposed to treatment funded under Cleft Lip/Palate or Oral and Maxillofacial Surgery MBS Item numbers.
[32] AIHW. (2017). *Admitted Patient Care 2015-16*, pp. 148-9.
[33] https://bitemagazine.com.au/special-needs-dentistry/
[34] Taylor, M. (2010). *Holes in the system: oral health for Australians with intellectual disability,* 45the Annual Conference of the Australian Society for Intellectual Disability, Brisbane.
https://www.asid.asn.au/Portals/0/Conferences/45thBrisbane/Conference%20Papers/Taylor_Fri_1.15_Health28.pdf
[35]
https://www.asscid.org.au/ASSCID/Events_Education/Conference_2017/ASSCID/Past_Conference/2017/Home___6th_Walkabout_Conference___ASSCID.aspx?hkey=3483c646-5718-4d71-a961-30d7dc2c8839
[36] AIHW. (2017). *Autism in Australia*, https://www.aihw.gov.au/reports/disability/autism-in-australia/contents/autism
[37] Jamieson, L & Roberts-Thomson, K. (2006). 'Dental general anaesthetic trends among Australian children', *Biomed Central Oral Health,* 6, p.16.

of 8, twenty-four of them under twelve months of age, had to undergo dental treatment under GA. Some of these children need most of their deciduous teeth extracted due to extensive decay.[38]

Likewise, in NSW, rates of children aged 5 -14 undergoing extractions and restorations in hospital almost doubled from 2094 (2001) to 4088 (2014–15).[39] On average, four NSW children per month need to undergo "full clearances" (i.e. removal of all teeth) in NSW hospitals, meaning that every tooth in their mouths is so badly damaged that it is beyond restorative care and must be extracted.[40]

Although the statistics suggest that children requiring dental treatment under anaesthetic span all household income quintiles, it remains that the highest rates amongst children who are not 'special needs' are those from low-income families, most of whom do not hold private health insurance, and children living in rural and regional areas (who are also often living in low-income families).

These figures point to the critical importance of the Child Dental Benefits Schedule (CDBS) as a means of reducing the need for dental treatment under GA as far as possible over the long-term, through increasing affordable access to timely preventive dental care for a greater proportion of those low-income children who can tolerate treatment in the usual dental clinic setting, if any developing oral health problems are caught early enough.

However, the low awareness and utilisation of the CDBS noted by the South Australian Health Minister when the SA statistics cited above were released also reinforces the need—recognised in two recent government reviews—for greater Federal government funding to promote public awareness of the Scheme. The ADA has actively promoted the scheme to patients and the wider public, but the Federal Government is most able to reach eligible families through targeted communications, which need to be more frequent and effective.[41]

However, without discounting the importance of long-term strategies to boost oral health awareness and access to preventive dental treatment in routine care settings, there is also an immediate need for the Federal government to address the access barriers that are preventing many CDBS-eligible children from receiving the dental treatment under GA they urgently need *now*.

Funding and affordability-related barriers to dental treatment under GA are growing too

At the same time as the need for dental treatment under GA is rising, affordable and timely access to such services is increasingly *compromised* by legislative and policy settings that are severely constraining the availability of both public and private operating facilities, and making treatment in private facilities unaffordable, even for patients who have private health insurance.

Key factors that are reducing access and affordability and increasing waiting times are:

- lack of public funding through Medicare;
- inadequate funding of public dental services resulting in long waiting times for concession card holders;

[38] http://www.abc.net.au/news/2017-07-18/dental-issues-in-sa-babies-on-the-rise/8720430
[39] http://www.smh.com.au/news/Health/Something-is-rotten-with-our-state-of-inequality/2005/02/14/1108229934431.html
[40] Ibid.
[41] http://www.smh.com.au/federal-politics/political-news/child-dental-scheme-a-success-despite-governments-failure-to-promote-it-20160329-gnswhh.html

- activity-based public hospital funding formulas that make it relatively uneconomic for public hospitals to schedule these services;
- the inadequacy of the minimum payments that private health insurers are required by law[42] to make to private hospitals and day procedure facilities with respect to associated admission/theatre costs, which is also making it financially unviable for many such facilities to schedule these services;
- poor private health insurance rebates for the medical costs of dental treatment done under GA in day care facilities; and
- poor private health insurance rebates for dental treatment provided under GA, restrictions on the number of items that can be claimed, restrictive annual monetary limits, and limitations on rebateable theatre time.

Medicare and private health insurance funding of dental treatment under GA

The Medicare Benefits Schedule does not fund dentists to provide routine dental procedures under GA in private and public facilities, and access to such treatment for children in low-income families is also excluded under the CDBS.

If the patient holds an extras insurance policy that covers dental treatment provided in a hospital setting (and most of the more affordable policies do not) they may be covered for some of the dental component of the cost, but not all.

There are two Medicare Item numbers that provide very limited benefits for anaesthetist fees for dental treatment under GA – one for extractions, and one for restorative treatment. Both these item numbers assume that the anaesthetist will be required for no more than 1.5 hours, and that a single type of treatment will be required.

In practice, because it is often difficult to conduct a thorough prior examination in the chair, the nature and extent of required treatment under GA is often difficult to predict in advance. It may include an examination, radiographs, a scale and clean, multiple restorations, extractions (both simple or surgical) or any combination of the above services. Available statistics suggest that cases requiring nothing more than one restoration or extraction are the exception rather than the rule.[43] For this reason, it often takes longer than services provided under anaesthetic by other medical specialties such as ophthalmology, ENT or orthopaedics that are also assumed to take 1.5 hours or less and attract similar rebates (75% of MBS Fee of $118.80 i.e. $89.10).

Anaesthetist charges are considerably higher than the MBS fee, even if the dental treatment under GA can be completed within 1.5 hours. If the patient holds a hospital insurance policy with an appropriate level of cover, the insurer will rebate the other 25% of the MBS fee—but not the gap between the MBS fee and the actual fee charged by the anaesthetist.

Access to affordable dental treatment under GA in private hospitals or licenced private day care facilities with dental service capabilities is also increasingly limited because many private health insurers pay such low amounts for such services under “hospital cover” policies that it is not economically viable for such facilities to make their operating theatres available to generalist and specialist dentists who need them.

[42] under the *Private Health Insurance Act 2007*

[43] Data presented in AIHW (2017*). Admitted Patient Care 2015-16,* p.94, and p.148 suggests that on average dental services conducted under GA in private or public operating facilities include an average of 5.5 treatment item numbers.

Many private health insurers are unwilling to negotiate reasonable benefit contracts with private hospitals for dental services provided under GA. In part, this because the DRG (Diagnosis Related Group) classification system that underpins minimum benefits they are required by legislation[44] to pay for same-day or overnight services of this kind does not factor in the variations in operating theatre time that may be required in individual cases, and underestimates the reasonable costs of these procedures.

Dental services under GA are classified as Band 1, Type B procedures for the purposes of the *Private Health Insurance (Benefit Requirement) Rules 2011*. There are four Type B bands, and of these, Band 1 requires the lowest minimum benefit payment, on the assumption that procedures included in Band 1 are relatively simple, relatively short, and vary little in time and cost. For example, medical procedures included within the Band 1 classification include the provision of an ultrasound, or cauterisation of a cherry birthmark—procedures usually of short duration, that vary relatively little in complexity, and that do not require additional staff with dental training.

The Australian Academy of Paediatric Dentistry recently provided the Senate Community Affairs Committee with evidence of the widening gap between the amounts private health insurers are willing to pay hospitals for dental treatment under GA, and to the rates they are willing to pay for general, plastic, ear nose and throat, podiatry or ophthalmic surgery procedures that are classified under higher 'bands' in relevant legislation.[45]

As dental patients often need multiple procedures that require a longer per-patient time in the theatre than say, ophthalmology patients, ophthalmologists can schedule more patients in a morning or afternoon's operating theatre list than a dentist, thus producing more income for the hospital.[46]

As private facilities can make two to three times the amount of income from medical operating lists as they make from dental operating lists, some facilities are dropping their dental lists, and many smaller day facilities have closed. The result is that dentists and dentist specialists who have been accredited by these facilities to provide these services for years, and those newly seeking accreditation, are finding it increasingly difficult to get access to private operating theatre time.[47]

Other dentists report some private facilities placing per patient time limits on their access to an operating theatre, meaning that there may be insufficient time available to deliver the comprehensive dental treatment needed by the patient under the one anaesthetic.[48]

The upshot of this is that many privately insured patients are unable to access or afford required dental treatment under anaesthetic in private facilities, and are forced to join very long waiting list queues in the public health system.

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[44] *Private Health Insurance (Benefit Requirement) Rules 2011,* Part 2, cl.5, and Schedule 3

[45] see Tabled Document No. 3, at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Additional_Documents

[46] Senate Community Affairs Committee (2017). Transcript of Public Hearing held in Sydney on October 31, 2007, p. 26. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Public_Hearings

[47] Australasian Academy of Paediatric Dentistry. (2017). *Submission to the Senate Community Affairs Committee Inquiry into Private Health Insurance,* https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Submissions

[48] Ibid.

Access to dental services under GA through public dental services or public hospitals

Generally, it is only patients with low enough incomes to hold Centrelink Health Care or Pensioner Concession Cards who can obtain treatment through Federal/State funded public dental services.

Although waiting times vary from state and are not published in sufficient detail to make accurate Australia-wide estimates or comparisons, it is evident that patients who meet the income thresholds and require comprehensive dental treatment under GA can be left waiting in queues for many months.

At Westmead Hospital, which does most of the dental work under GA funded by the NSW public dental system, the average waiting time for an extraction or filling is nine months and often exceeds one year. Although children are prioritised for attention, it remains that they may also wait many months for treatment, unless decay develops into a serious dental abscess, at which time they will be prioritised for urgent treatment.[49]

The Senate Community Affairs Committee also heard recent evidence that in Victoria and Queensland, children and young people with chronic health conditions or other special needs who seek access to comprehensive dental treatment in public hospitals will face a wait of nine months to a year.[50]

In the *Australian National Oral Health Plan 2015-24*, the COAG Health Council argued that DRG classifications and associated National Efficient Price estimates which determine "activity-based" public hospital funding were disadvantaging patients who had a legitimate need for admission to public hospitals for dental treatment under GA.[51]

Essentially, COAG validated the observations of many specialists and generalist dentists that DRG classifications are giving hospitals an economic incentive to prioritise admission of patients with other medical or surgical needs over the admission of dental patients whose clinical need might be greater.

Noting that "timely access to operating theatres for dental treatment under general anaesthesia is critical", COAG called for a review of DRGs and funding models for dental services to rectify the fact that DRGs relevant to hospital-based dental procedures are too narrow in scope, and underestimate the time and costs involved.[52]

That call was made in 2015. However, subsequent versions of the DRG classifications and NEP Determinations released by the Independent Hospital Pricing Authority during 2016 and 2017 have not addressed these issues. The ADA calls on the Federal Government to recognise that for the vulnerable patients who need it most, access to dental treatment under GA is as essential to health and wellbeing as is access to medical procedures under GA, and to ensure that the 2018–19 Federal Budget embeds this reality in the wider public and private health funding system.

Recommendations: improving affordable access to dental treatment under GA

The ADA recommends:

- That Federal activity-based hospital and day procedure facility funding models for dental services under GA be urgently revised to ensure that 2018–19 NPAH budget allocations accurately reflect the range, complexity, costs and relative clinical need for such services;

[49] Ibid.
[50] Senate Community Affairs Committee. (2017), op. cit. p. 25
[51] (2015). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan (2015-2024)*. pp. 33–34.
[52] Ibid.

- That *Private Health Insurance (Benefit Requirement) Rules* be amended to require that the minimum rates private health insurers must pay for the provision of comprehensive dental treatment under GA are time-based and commensurate with rates paid for other medical procedures of similar length and complexity provided under GA;

- That claiming eligibility under the CDBS be expanded to allow claims for all treatment items currently listed on the Schedule when it is necessary to provide them under GA in hospitals and day surgeries, subject to prior approval;

- That additional funding is allocated to promoting awareness of the CDBS to eligible families; and

- That Medicare funding is expanded to include the provision of comprehensive dental treatment services under GA in DGAPFs to children and adults whose special needs (which may include intellectual, physical, psychiatric disabilities or medical conditions) preclude other forms of treatment delivery.

Conclusion

The Australian Charter of Healthcare Rights endorsed by Australian Health Ministers in 2008 states that Australians have a fundamental right to adequate and timely healthcare that addresses their healthcare needs.[53]

Federal Government funding for dental care, with the exception of DVA and Cleft Palate Schemes, has shown no consistency or durability over the last decade.

The recommendations contained in this submission represent long-overdue steps towards the full realisation of these rights, and towards full implementation of the *Australian National Oral Health Plan 2015–24*. They also represent sound fiscal policy, geared towards realisation of significant savings through reductions in the massive direct and indirect cost burden of oral and dental disease to the Australian taxpayer, and the Australian economy.

The ADA would be happy to provide clarification on any of the points made in this submission or further comments if required. Please do not hesitate to contact the ADA Chief Executive Officer, Mr Damian Mitsch at ceo@ada.org.au or 02 9906 4412 should you have any questions.

Dr Hugo Sachs
Federal President
Australian Dental Association

[53] https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Charter-PDf.pdf; https://www.safetyandquality.gov.au/wp-content/uploads/2009/01/A-guide-for-patients-consumers-carers-and-families-v3.pdf