

Australian Dental Association Inc.

**Submission to House of Representatives
Standing Committee on Health
Inquiry into
Chronic Disease Prevention and Management in Primary Health Care**

**Australian Dental Association Inc.
14–16 Chandos Street
St Leonards NSW 2065
PO Box 520
St Leonards NSW 1590
Tel: (02) 9906 4412
Fax: (02) 9906 4676
Email: adainc@ada.org.au
Website: www.ada.org.au**

Oral health “is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment”.¹

“Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity”.²

Introduction

The Australian Dental Association (ADA) is the peak national body representing Australian dentistry. The ADA seeks to encourage the improvement of the oral and general health of the public, advance and promote dentistry and support dentists to provide safe, high quality professional oral healthcare.

The ADA welcomes this Inquiry into Chronic Disease Prevention and Management in Primary Health Care. Dentists work at the coalface of dental care delivery and are well placed to provide advice and work with government on the prevention and management of chronic disease within the context of the primary healthcare setting. Oral diseases have been recognised as chronic disease and, as such, share risk factors common with other chronic diseases including heart disease, stroke, cancer, diabetes and obesity. Implementing initiatives which prevent and/or treat oral diseases will support efforts to address chronic disease more broadly.

Preventing and managing chronic oral disease - oral health issues

Good oral health is integral to good general health. In 2003, the *World Oral Health Report* confirmed the relationship between oral health and general health.³ Evidence continues to grow supporting the connection between oral health status and many major chronic diseases including cardiovascular disease (CVD), diabetes, respiratory disease and stroke.⁴

Oral diseases, including dental caries (tooth decay) and periodontal (gum) diseases and other less common conditions, are chronic diseases.⁵ Many factors including diet, health behaviours, lifestyle choices such as tobacco use and the social determinants of health contribute to oral diseases.⁶ Risk factors for oral diseases are also risk factors for other chronic diseases/conditions, with research

¹ National Advisory Committee on Oral Health: *Healthy mouths Healthy lives: Australia’s National Oral Health Plan 2004-2013* at p (v). Available at <http://oralhealthplan.com.au/sites/default/files/oralhealthplan-1.pdf> accessed 1 July 2015.

² World Health Organisation (2012), “Oral health” Fact Sheet no. 318 April 2012 available at <http://www.who.int/mediacentre/factsheets/fs318/en/> accessed 17 July 2015.

³ The World Oral Health Report (2003). *Continuous improvement of oral health in the 21st century – the approach of the WHO Global Oral Health Programme*. Available at <http://www.ncbi.nlm.nih.gov/pubmed/15015736> accessed 1 July 2015.

⁴ Dental Health Services Victoria (DHSV) (2011). *Links between oral health and general health – the case for action*. Available at https://www.dhsv.org.au/_data/assets/pdf_file/0013/2515/links-between-oral-health-and-general-health-the-case-for-action.pdf accessed 17 July 2015.

⁵ Australian Institute of Health and Welfare 2014. *Australia’s health 2014*. Australia’s health series no. 14. Cat. no. AUS 178. Canberra: AIHW

⁶ World Health Organisation (2012): *Social Determinants of Health*. Available at http://www.who.int/social_determinants/en/ accessed 1 July 2015.

finding that Australians living with chronic conditions are more likely to experience poor oral health.⁷ While having immediate implications for the individual, poor oral health affects society broadly through impacts upon wellbeing, the health system and economic productivity. Oral diseases, which in 2008-2009 were the second most costly disease group in Australia, are a serious social and economic challenge for policy makers.⁸

The ADA recommends that the prevention and management of oral diseases should focus upon three key areas:

1. Whole population approaches including a continued commitment to water fluoridation and an Australia wide emphasis on the importance of oral health hygiene and other lifestyle practices such as a healthy diet and smoking cessation over the life course.
2. Individual level education and prevention strategies directed to *at risk* groups in the community, including but not limited to Australians living with chronic conditions.
3. An improvement in access, within a primary healthcare setting, to timely, effective and affordable oral health treatments and services for all.

Measures within these key areas must be integrated and co-ordinated with other initiatives directed at the prevention and management of chronic diseases more broadly and the lifestyle factors which contribute to them.

Oral diseases are common but they are largely preventable.

Terms of reference - ADA recommendations

1. **Examples of best practice in chronic disease prevention and management, both in Australia and internationally.**

There is considerable research on the prevention and treatment of oral diseases. A detailed literature review is beyond the scope of this submission. However, having regard to the three key areas identified, the ADA suggests best practice in oral disease prevention and management is demonstrated by a commitment to the following:

(a) **Inclusion of fluoride in reticulated water supplies**

Both in Australia and internationally, the most effective whole population approach to prevention and management of oral diseases remains the inclusion of fluoride in reticulated water supplies. The safety and effectiveness of water fluoridation has been endorsed by all major Australian and international health organisations, along with Federal, State and Territory Departments of Health.⁹

⁷ Australian Institute of Health and Welfare (2012), *Chronic conditions and oral health* DSRU research report no.56. Cat.No.DEN 221 Canberra: AIHW. Available at <http://www.aihw.gov.au/publication-detail/?id=10737423228> accessed 1 July 2015. See also Dental Health Services Victoria (DHSV) (2011) op cit.

⁸ AIHW (2012) op cit.

⁹ Including the National and Medical Research Council, World Health Organisation and Centers for Disease Control and Prevention.

In Australia, dental health has improved since water fluoridation began in the 1950s. Australians born after 1970, on average, have half the level of tooth decay of their parents' generation.¹⁰ Most recently the *Queensland Child Oral Health Survey 2010-12* has reported variations in child oral health across parts of Queensland. The Survey found substantial differences between the levels of primary tooth decay in children living in long term fluoridated Townsville (39%) compared with children in the previously non-fluoridated rest of north Queensland (57%).¹¹

While fluoridation of public water supplies has been widely adopted in Australia, there remain parts of Australia which do not have access to fluoridated water. The ADA has consistently advocated for legislation that obligates all Australian local councils and water boards to introduce or maintain fluoride levels in reticulated water supplies in line with NHMRC guidelines. In addition, where inclusion of fluoride in the water supply is not possible, the ADA supports the use of fluoride supplements such as the fluoride tablets and drops.¹² The ADA also recommends that government work with the manufacturers of bottled water to encourage the inclusion of fluoride in bottled water.

(b) Reduce sugar consumption

In May 2015, the World Health Organisation (WHO) issued a guideline recommending the reduction in sugar intake for adults and children throughout the life course.¹³ The guideline was issued following a review by the WHO which confirmed the relationship between sugar intake and the development of tooth decay across age groups. Specifically, the WHO has recommended that daily sugar intake be reduced to 10% of total energy intake (with a further reduction of 5% recommended).

All Australian governments must ensure that the WHO guidelines, along with existing Australian dietary guidelines, are incorporated into public health interventions which seek to reduce sugar intake. These would include more stringent labelling of food products, educating the public about food acids and their effect of teeth and "hidden" sugars in "healthy" foods such as fruit juice drinks, yoghurts and other processed foods, reducing the marketing of sugary food and drinks, and working with manufacturers to reduce hidden sugar content in processed foods. In addition the ADA has consistently supported the imposition of a sugar tax on sugary drinks in an effort to curb consumption.¹⁴

¹⁰ Australian Institute of Health and Welfare (2012). *Australia's health 2012: in brief*. Cat. no. AUS 157. Canberra: AIHW.

¹¹ Spencer AJ, Roberts-Thomson K and Do LG, Executive Summary in Do LG and Spencer AJ (editors) (2014). "The beginning of change: Queensland Child Oral Health Survey 2010-12". Available at <http://fluoridealert.org/wp-content/uploads/queensland-2014.survey.pdf> accessed 1 July 2015.

¹² See ADA Policy Statement 2.2.1 *Community Oral health Promotion: Fluoride use (Including ADA Guidelines for the Use of Fluoride)*. Available at http://www.ada.org.au/app_cmslib/media/umlib/1214%20policy%20statement%202.2.1%20fluoride%20use.pdf

¹³ World Health Organisation (2015) *Guideline. Sugars intake for adult and children*. Geneva. Available at http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/ accessed 30 June 2015.

¹⁴ See ADA Policy Statement 2.2.2 *Community Oral health promotion: diet and nutrition*. Available at http://www.ada.org.au/app_cmslib/media/umlib/policy%20statement%202.2.2%20diet%20and%20nutrition2.pdf.

- (c) **Continue campaigns which promote healthy life practices, including the importance of good oral hygiene for all Australians over the life course, particularly those at risk of poor oral health.**

The *Australian National Oral Health Plan 2004-2013* noted the importance of oral health promotion in improving oral health.¹⁵ The ADA endorses that statement. Dietary and lifestyle campaigns, including the promotion of good oral hygiene habits namely brushing teeth with fluoridated toothpaste twice a day, daily flossing and regular visits to the dentist, should be directed to the whole community.

In addition individual-level education and prevention strategies should be directed to the following *at risk* groups in the community, including but not limited to Australians living with chronic conditions, namely:

- Children, adolescents and their parents (poor childhood oral health is a strong predictor of poor adult oral health);^{16 17}
- residents in remote areas;¹⁸
- people with special needs;¹⁹
- older people, particularly those resident in aged care facilities²⁰;
- socially disadvantaged people on low incomes;²¹ and
- Aboriginal and Torres Strait Islander Peoples.²²

Distribution of oral health promotional material in conjunction with providing families with details of eligibility for the Child Dental Benefits Schedule would be a simple, efficient and effective step.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

An expansion of the item numbers available under the Medicare Benefits Schedule is an ideal approach to reward and encourage best practice and quality improvement in chronic disease prevention and management. While there is a limited number of Medicare items connected with dentistry, there is scope to expand coverage for specific dental related items and extend

¹⁵ National Advisory Committee on Oral Health: *Healthy mouths Healthy lives: Australia's National Oral Health Plan 2004-2013*. Available at <http://oralhealthplan.com.au/sites/default/files/oralhealthplan-1.pdf> accessed 3 July 2015

¹⁶ National Advisory Council on Dental Health (2012) "Report of the National Advisory Council on Dental Health". Available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/final-report-of-national-advisory-council-on-dental-health.htm> accessed 1 July 2015.

¹⁷ Parental factors may have an important effect on their child's oral health see: AIHW (2012). Families and their oral health. DSRU research report no. 57. Cat. no. DEN 222. Canberra: AIHW.

¹⁸ The Oral Health Monitoring Group (2014) *Australia's National Oral Health Plan 2015-2024*, Consultation Draft, version 2.8

¹⁹ Ibid

²⁰ An extensive summary of the literature on the oral health of residents in aged care facilities is collated in the AIHW publication: Chalmers JM, Spencer AJ, Carter KD, King PL & Wright C (2009). "Caring for oral health in Australia residential care. Dental statistics and research" series no. 48. Cat. No. DEN 193. Canberra: AIHW. Available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455398> accessed 15 July 2015.

²¹ The Oral Health Monitoring Group (2014) op cit.

²² Ibid

coverage more broadly to support oral health promotion. The introduction of both specific and broader measures will also alleviate pressure on the public health system.

Specifically, existing Medicare dental items could be expanded to include:

- a. Items numbers utilised by anaesthetists in dental treatment. There is a need for these numbers to account for a wider variation in treatment modalities.
- b. Diagnostic radiography of teeth and associated tissues. The exclusion of dentists and dentist specialists from claiming a Medicare rebate for referral results in greater demand being placed on general medical practitioners and medical specialists. The referral process for a radiograph to a medical practitioner causes duplication and waste
- c. Item numbers which enable specialist Paediatric dentists to be included in surgical orthodontic extractions claimed through the Cleft Lip and Palate Scheme.
- d. Items numbers which enable dentists to refer patients directly to specialist physicians avoiding the need to be referred to a general medical practitioner and then to a specialist-e.g. patients who wear oral appliances long term to treat sleep disordered breathing including sleep apnoea. For patients with sleep apnoea, symptomatic relief is monitored by the sleep physician with the dentist monitoring the patient's dentition and also monitoring their compliance with the device. This is ongoing therapy but if the dentist advises the patient to consult the sleep specialist again, the patient must be referred by a general medical practitioner to be eligible for a rebate. The dentist should be in a position to refer the patient directly to the medical specialist.

Broadly, the *Child Dental Benefits Schedule* (CDBS) could be expanded to include specific item numbers for dietary advice, lifestyle education and mouth guard provision. Item numbers could also be allocated for the provision of toothbrushes and toothpaste (which should be free of the goods and services tax) to *at risk* Australians during these consultations, particularly those Australians who would benefit from high fluoride toothpaste.

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease and management in primary health care.

While more than 95% of dental care in Australia is provided in the primary healthcare setting, there remains a disconnect between the medical and allied health services and the dental surgery. The absence of a specific role for dentists was a problematic feature of the previous Medicare Local network. However the establishment of Primary Health Networks (PHNs), with the *key objective of increasing efficacy and effectiveness of medical services for patients, particularly those at risk of poor health outcomes and improving coordination of care*, provides an opportunity for this disconnect to be a thing of the past.²³

It is vital to include dental practitioners within the suite of providers available to treat patients within the PHNs. Whether employed on site, or alternatively operating on a referral basis,

²³ Australian Government Department of Health (2015) Primary health Networks (PHNs) http://www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks accessed 21 July 2015.

these dentists will be available to treat patients quickly and effectively in close consultation with general medical practitioners and other health care providers. Doctors and dentists should be encouraged to work together as team leaders to ensure the delivery of optimal oral and general health care.

The proposed governing bodies of the PHNs, including the PHN Boards, the Clinical Councils and Community Advisory Committees, also provide an opportunity for the coordination and integration of oral health care within healthcare more broadly. Representation from dentists should be included on these bodies. The ADA seeks to work with government on the inclusion of dentists in these governing bodies.

In addition, PHNs provide an ideal environment for the integration of oral health prevention during general health consultations, particularly with *at risk* individuals. Studies support the efficacy of oral health promotion, particularly among expectant mothers and parents of infants.²⁴ Accordingly, PHNs should be encouraged to engage in oral health education and adopt a policy of referring parents of infants and young children to the dentist. The ADA recommends that the first dental visit should occur when a baby's first tooth becomes visible or they reach 12 months of age.²⁵ It is essential that the community is well informed about the importance of early intervention and primary care from a dentist in maintaining good oral health.

The importance of dentists in primary healthcare is demonstrated by research which records what happens when Australians can't access dental care. Usually dental care is sought from other parts of the health sector, including general practitioners.²⁶ The cost of seeking such care from a medical general practitioner has been estimated to be anywhere between \$10 million and \$300 million per annum.²⁷ In addition, potentially preventable hospitalisations (PPH) related to dental conditions were reported in 2010–11 to be in excess of 60,000 or 2.8 separations per 1,000 population.²⁸

Recently an analysis undertaken in Western Australia has concluded that PPH remain a considerable and increasing financial burden on health budgets. Aboriginal people and children under 14 years were the most likely to be admitted for dental conditions (predominantly dental caries) with the highest rates of hospitalisation among those from the

²⁴ Plutzer, Kamila and Spencer, A. John. (2008) "Efficacy of an oral health promotion intervention in the prevention of early childhood caries" *Community Dentistry and Oral Epidemiology* Vol 36 (4) (August 2008) p 335-346

²⁵ Australian Dental Association Babies and Toddlers *When should my child first see the dentist?* Available at http://www.dentalhealthweek.com.au/downloads/DHW_factsheet_BabiesandToddlers_Seeingthedentist.pdf

²⁶ National Advisory Council on Dental Health (2012) *Report of the National Advisory Council on Dental Health* 23 February 2012. Available at [http://www.health.gov.au/internet/main/publishing.nsf/Content/C10065B9A8B6790FCA257BF0001BDB29/\\$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20\(PUBLICATION\).pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C10065B9A8B6790FCA257BF0001BDB29/$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20(PUBLICATION).pdf) accessed 1 July 2015.

²⁷ Ibid at p 19

²⁸ Chrisopoulos S & Harford JE (2013) *Oral health and dental care in Australia: key facts and figures 2012*. Cat.no. DEN 224. Canberra: AIHW available at <http://www.aihw.gov.au/publication-detail/?id=60129543390> accessed 1 July 2015.

most socio-economically disadvantaged areas.²⁹ Over the 10 year period analysed, overall direct costs amounted to in excess of \$157 million.³⁰

4. The role of private health insurers in chronic disease prevention and management in primary health care.

Access to affordable oral health care is essential to the improvement and maintenance of Australian's oral health and, more broadly, the prevention and management of chronic disease. Figures released by the *Australian Institute of Health and Welfare* show that individuals are by far the biggest contributors to the cost of dental care.³¹ A significant portion of these individuals also hold private health insurance (PHI).

The ADA acknowledges that PHI plays a role in funding the provision of oral health care. Health expenditure figures reveal that in 2012-13 total spending on dental services was \$8.3 billion. Of this amount PHI funds contributed \$1.396 billion (approx. 16% of total expenditure) and individuals contributed in excess of \$5 billion.³² An increasing number of insured Australians face challenges in meeting the cost of their oral health care due to the failure of many PHI funds to adequately rebate Australians for the cost of their dental care. This is particularly the case in relation to the provision of oral health instruction and advice.

Research undertaken by the ADA reveals an increasing discrepancy between customary fees charged for dental services and the rebate levels paid to policy holders by the PHI industry. This increasing gap has an adverse impact upon insured patients accessing dental care and, where those patients suffer other chronic conditions, general health further deteriorates.

Given the Australian government's financial incentives and other policy measures which encourage Australians to take out PHI, it is important to the sustainability of Australia's healthcare system that Australians with PHI continue to receive the best dental coverage and value for the cost of their PHI. The ADA maintains that PHI, as a part funder of dental care, has a role to play in the prevention and management of chronic oral diseases. In particular PHI funds should be encouraged to rebate patients for oral health prevention items including the lifting of restrictions upon treatment such as extra application of fluoride or more regular consultations from dentists where clinically necessary. Government must ensure, through regulation if necessary, that PHI funds meet this obligation.

²⁹ Kruger, E. and Tennant, M. (2015) "Potentially preventable hospital separations related to oral health: a 10 year analysis" *Australian Dental Journal* 2015; 60:205-211.

³⁰ Ibid at p 210.

³¹ Australian Institute of Health and Welfare (2014) *Health expenditure Australia 2012-13* Table A3 available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544656> accessed 1 July 2015.

³² Ibid

5. The role of State and Territory Governments in chronic disease prevention and management.

As the providers of public dental services, State and Territory governments play a vital role in the management and prevention of chronic disease. This is particularly so given that public dental services are mostly directed at and utilised by Australians who fall within *at risk* groups.

The Federal government must assume a leadership role in this area. It is the responsibility of the Federal government to ensure that any funding is utilised to provide timely and quality dental care to *at risk* groups either through public dental facilities or in private dental practice. When access to dental care is delayed or restricted due to lack of funding, opportunities for prevention and early intervention are lost. The health and wellbeing of individuals and the community overall can suffer in many ways including an increase in:

- Public waiting times for basic dental care;
- The need for more costly restorative care or tooth loss;
- The need for emergency dental care;
- The number of acute potentially preventable hospitalisations due to dental conditions; and
- The negative impact on the management of other chronic diseases.

6. Innovative models which incentivise access, quality and efficacy in chronic disease prevention and management.

and

7. Best practice of multidisciplinary teams chronic disease management in primary health care and Hospitals

Innovative models:

(a) A focus on children through the Child Dental Benefits Scheme

Since January 2014, the ***Child Dental Benefits Schedule (CDBS)*** has provided families in receipt of government payments including Family Tax Benefit A, a \$1000 allowance every two years for basic dental services for children aged two to 17 years. Available to public and private patients, families receive financial assistance to enable their children to undergo examinations, x-rays and some dental prevention (cleaning, fissure sealants and fluoride treatment). Where needed, they are also able to have their children's teeth undergo restorative treatment (fillings or root canal) and in some cases oral surgery (extractions).

While there is room for improvement with the CDBS, long term it is the ADA's view that the CDBS will make a real difference to the future oral health of Australian children as they grow into adulthood.

(b) Voucher scheme - referring dental patients from public hospitals to primary health care settings.

The *voucher scheme* initiated by NSW and Queensland governments enables public dental patients to access dental treatment from private dentists in a primary health care setting. The utilisation of private dentists and private infrastructure makes economic sense and has proven very successful in reducing the number of patients on public dental waiting lists as well as freeing up the public system to treat more patients.

Outsourcing dental care and utilising private infrastructure has reduced the public dental waiting lists in both New South Wales and Queensland. In NSW,³³ the scheme has made a real impact upon the number of NSW residents, particularly adults, waiting for public dental treatment.³⁴ In Queensland, the effect on public dental waiting lists has also been significant. The number of Queenslanders on general public dental waiting lists was cut in half and the long wait list slashed from 62,513 to 8,494.³⁵

(c) Better Oral Health in residential care

In 2007, a two year oral health project called *Better Health in Residential care* commenced in South Australia which resulted in the development of a model which encourages the integration of oral care processes into existing care frameworks in residential aged care facilities (RACF). The model supported the sharing of roles among doctors and health care professionals (including oral health professionals) by the development of an Oral Health Assessment Tool (OHAT) utilised on admission to a RACF.

The OHAT does not replace a comprehensive dental examination undertaken by a dentist but is utilised as an oral health screening tool to monitor an older person's oral health, inform oral health planning, evaluate oral hygiene and trigger a dental referral.³⁶

(d) Victoria's Aged Care Pilot Project

Victoria's Aged Care Pilot Project seeks to improve access to dental care for residents of aged care facilities. The project is funded by the Victorian government and led by Dental Health Services Victoria, in partnership with the Victorian Department of Health and

³³ The NSW *Oral Health Fee for Service Scheme*. See: <http://www.health.nsw.gov.au/oralhealth/Pages/nsw-oral-health-fee-for-service-scheme.aspx> accessed 22 July 2015.

³⁴ NSW Government. *Number of residents waiting for dental Treatment – 30 June 2012 to 31 March 2015*. Available at <http://www.health.nsw.gov.au/oralhealth/Pages/waiting.aspx> accessed 22 July 2015.

³⁵ Queensland Government (2014). Media Statement Minister for Health, the Honourable Lawrence Springborg, Monday February 10 2014, *Health Sinks its teeth into dental wait lists*. Available at <http://statements.qld.gov.au/Statement/2014/2/10/health-sinks-its-teeth-into-dental-wait-lists> accessed 22 July 2015.

³⁶ A summary of the operation of the OHAT is available at: Lewis, A. Wallace, J. Deutsch, A. and King, P. (2015) "Improving the oral health of frail and functionally dependent elderly" *Australian Dental Journal* 2015; 60(1 Suppl):95-105.

Human Services and the Australian Dental Association Victorian Branch. The project is delivering basic public dental care to eligible residents in pilot residential aged care facilities (RACFs). Where possible, the dental services are provided at the RACF site, which removes a significant dental care access barrier for residents. The effectiveness and efficiency of this model of care is currently being tested. While this project targets treatment of RACF residents, it also promotes improved oral hygiene by residents, with assistance from RACF staff and others (e.g. family members).

(e) Nepean Centre for Oral Health, Nepean Hospital, New South Wales.

The Nepean Centre for Oral Health, a joint Federal and NSW government initiative opened in April 2013. The centre's location near Nepean Hospital enables a close working relationship between the dentists at the Centre and the medical staff at the Hospital which is more conducive to a *whole person* approach to oral health care. The dentists treating patients at the Nepean Centre, regularly consult with specialist dentists and treating doctors in caring for their patients many of whom live with chronic conditions for which they are patients at the Nepean Hospital.

(f) Brisbane Dental Hospital, Queensland.

The Brisbane Dental Hospital is funded by the Queensland government. Primarily a referral centre for patients requiring specialist dental care, the Hospital treats many patients with head and neck cancer. After surgery and radiation, these patients need help with rehabilitation and preventative measures to ensure their oral health is maintained. Dentists at the Hospital work closely with the head and neck oncology team from the Royal Brisbane Hospital to ensure an integrated approach to their treatment.

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end users of medical and health services.

(a) Age Pension Dental Benefits Schedule (APDBS) – a model proposed by the ADA

In its pre-budget submission, the ADA proposed to government that an Age Pension Dental Benefits Schedule (APDBS) be introduced to specifically target the oral health needs of the aged in receipt of the full age pension.³⁷ The ADA suggested using the existing Child Dental Benefits Schedule as a model to develop the APDBS. The ADA maintains that the APDBS represents a good model for chronic disease prevention and management.

³⁷ Australian Dental Association Federal Pre-Budget Submission 2015-2016. Available at http://www.ada.org.au/App_CmsLib/Media/Lib/1502/M850700_v1_635590808920306487.pdf.

The increasing health care needs of Australia's ageing population are widely acknowledged. Oral diseases including dental decay, gum disease and oral cancer are chronic diseases, and older people are particularly susceptible and affected.³⁸ An investment by the government is necessary to support preventive treatment and early intervention in this population.

The prevalence of oral diseases among people over the age of 65 years is significantly higher than for the general population. Over 50% of Australians over the age of 65 years have gum disease (periodontitis).³⁹ While many more of the aged are retaining their natural teeth, over 20% of Australians over the age of 65 years have complete tooth loss.⁴⁰ Those who have retained their teeth often have complex restorations such as crown and bridge work and/or implants which need particular maintenance and care; care that is often not maintained when motor skills are decreased or cognitive impairment exists.

As a group, the aged comprise one of the largest groups of Australians being admitted to hospital due to dental issues.⁴¹ Common risks factors for oral diseases, particularly periodontal disease and other systemic diseases, are increasingly being recognised in health literature.⁴²

Diabetic patients are more likely to develop periodontal disease and conversely, development of periodontal problems impacts on the ability to maintain a healthy diet, and can increase blood sugar and diabetic complications.

An association between periodontal disease and heart disease, including its exacerbation, has also been established.⁴³ Linkages have been suggested between periodontitis and other systemic diseases including osteoporosis, respiratory disease, aspiration pneumonia and some cancers. A recent study published in the *American Journal of Preventative Medicine* has considered specifically the impact of frequent periodontal treatment on general health in patients living with certain medical conditions. The study found that patients with existing medical conditions, who had received at least one periodontal disease treatment, subsequently had lower medical costs and fewer hospitalisations compared with patients who had not received any treatment for periodontal disease.⁴⁴

Residents in aged care facilities are particularly at risk of poor oral health. The ADA is concerned about worsening oral health in residential aged care. Studies have shown

³⁸ AIHW 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW. Available at <http://www.aihw.gov.au/publication-detail/?id=60129547205> accessed 1 July 2015.

³⁹ AIHW 2014. *Oral health and dental care in Australia: key facts and figures trends 2014*. Cat. no. DEN 228. Canberra: AIHW. Available at <http://www.aihw.gov.au/publication-detail/?id=60129548265> accessed 1 July 2015 at page 5.

⁴⁰ Ibid at p 6.

⁴¹ Ibid at p17.

⁴² Cullinan MP, Ford PJ, Seymour GJ.(2009) "Periodontal disease and systemic health: current status" *Australian Dental Journal* 2009; 54: (1 Suppl): S62-S69.

⁴³ American Academy of Periodontology see <http://www.perio.org/consumer/other-diseases> accessed 1 July 2015.

⁴⁴ Jeffcoat MK, Jeffcoat RL, Gladowski RN, Bramson JB, Blum DDS. (2014) "Impact of Periodontal Therapy on General Health. Evidence from Insurance data for Five Systemic Conditions" *American Journal of Preventative Medicine* 2014; 47(2):166-174.

that high levels of plaque accumulate on resident's natural teeth and dentures, which in turn place them at high risk for developing aspiration pneumonia, a commonly occurring event necessitating transfer to an acute care facility.⁴⁵ Dislodgement of teeth, fillings and calculus as well as ill-fitting dentures contributes to this problem. A recent study has found that nursing home residents have high levels of untreated decay, particularly those with high pre-existing medical conditions requiring intensive care.⁴⁶

It makes good sense from a health and economic perspective for government to address the aged as a priority. Good oral health is integral to general health. As such the APDBS represents a good model for chronic disease prevention and management which could be utilised easily in primary health care.

(b) Medicare Chronic Disease Dental Scheme

Despite its closure in 2012, the Medicare Chronic Disease Dental Scheme (CDDS) remains an innovative model in the primary health care setting. The introduction of the CDDS represented an acknowledgement at the highest levels of government of the connection between chronic conditions and oral health. While the CDDS did present administrative challenges and result in duplication of services, particularly the necessity for referrals from GPs to dentists, the ADA suggests that a proper evaluation of the CDDS scheme will reveal efficient and effective outcomes in chronic disease prevention and management. The ADA urges Government to refer to the CDDS in this Inquiry.

Conclusion

The ADA is happy to expand on any matters raised in this submission. In the event the Committee conduct hearings, we would welcome the opportunity to present oral evidence. Please do not hesitate to contact Mr Robert Boyd Boland at ceo@ada.org.au should you have any queries.

Yours faithfully,



Dr Rick Olive AM RFD
Federal President
31 July 2015

⁴⁵ Chalmers JM, Carter KD, Fuss JM, Spencer AJ & Hodge CP. (2002) "Caries experience in existing and new nursing home residents in Adelaide" *Gerodontology* (2002) 19:30-40.

⁴⁶ Silva M, Hopcraft M & Morgan M. (2014) "Dental caries in Victorian nursing homes" *Australian Dental Journal* 2014; 59 321-328.