AUSTRALIAN DENTAL ASSOCIATION

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Committee Secretariat
Standing Committee on Health, Aged Care and Sport
PO Box 6021
Parliament House
Canberra ACT 2600

By email:
Dear Committee

Re: Inquiry into Sleep Health Awareness in Australia.

Thank you for providing the Australian Dental Association (ADA) with the opportunity to submit input to the Inquiry into Sleep Health Awareness in Australia.

As the peak professional body for dentistry in Australia, our members, who work in both the public and private sector, in metropolitan and rural and remote areas and across all areas of practice see the effects of poor sleep on oral health regularly.

The dental profession has a proud history of helping to improve patients' oral health and general health by routinely talking about oral hygiene, diet, sugar consumption, smoking cessation, sports trauma prevention and adding sleep hygiene and sleep health to these discussions. In Australia, targeted screening around sleep health is becoming a routine part of our oral health assessment process.

The ADA is actively engaged in the policy direction of sleep health through its affiliation with the Australian Sleep Association (ASA). Furthermore, it contributes to and supports the policy statements addressing sleep and clinical dental practice developed by the FDI (World Dental Federation). The ADA has a specific policy on the use of dental appliances to treat sleep-disordered breathing which is attached for reference (Attachment A). These policies encourage dentists to screen patients for sleep-disordered breathing as part of a comprehensive dental and medical history. Patients that are at risk of sleep disorders are then referred to the appropriate physicians for a proper medical diagnosis.

Dentists have had an interest in sleep and its disorders for some time with the two most common ones being Bruxism and Obstructive Sleep Apnoea. The evidence base has grown significantly over the last decade but we continue to gain further insight into the dental and oral aspects around sleep and its disorders.

It is reported that up to 20% of children will brux (grind) their teeth while they sleep. Studies show this decreases as they get to teenage years with approximately 3% of the adult population still affected. Dentists are concerned about regularly seeing tooth wear, tooth loss and significant damage to teeth in bruxing patients. Rehabilitating and reconstructing bites is both costly and complex so having the opportunity to pick the destructive bruxism habit early is facilitated by regular dental care and continuity of care with the same dental practitioner.

There are no widely accessible sophisticated sleep diagnostics currently available to diagnose active or current sleep bruxism and clinicians rely only on self-reports, observation and evidence of historical tooth wear.

The only treatment modality available for Bruxism is a protective buffer or splint for patients to wear nightly, which helps minimise the damage caused by bruxism.

Over the last 20+ years, oral appliances and splints have evolved and been modified to the point where they are

now an effective tool for treating snoring and obstructive sleep apnoea. Unlike much of dentistry where concepts are created on clinical experience, these oral appliances have been created based on dentists working closely with sleep physicians and building a solid evidence-based through research to help guide best clinical practice.

The ADA is, however, concerned about the increasing commercialisation in the provision of such devices by non-dentists and believes that this is of significant concern that the Senate should consider the risks of this development in detail.

In responding to Term of Reference 2, we will expand further on this issue.

TOR 2. Access to, support and treatment available for individuals experiencing inadequate sleep and sleep disorders, including those who are: children and adolescents, from culturally and linguistically diverse backgrounds, living in rural, regional and remote areas, Aboriginal and Torres Strait Islander;

The treatment of Snoring and Obstructive Sleep Apnoea (OSA) has resulted in a relatively new field of Dental Sleep Medicine (DSM). DSM is a medical field where a dental device is used to provide a medical outcome. This is one of the few areas where an oral appliance is provided, not as a dental tool, but as a technique in the management of a medical condition.

OSA is increasingly recognised as an important public health concern. Large studies estimate that as many as 23% of women and 50% of men have OSA and up to 13% of men and 6% of women have moderate-severe OSA. It is thought that up to 75% of people are undiagnosed.

Dentists are in a perfect position to ask their patients about their sleep as 55.5% of the population has seen a dentist in the last 12 months. Dentists have the opportunity to screen patients with either validated questionaries or targeted questions that tease out who may have sleep disorders. To obtain a diagnosis it is necessary to involve the patient's medical practitioner and a qualified sleep medicine practitioner, who can interpret a sleep study.

The Sleep Health Foundation lists the two most commonly used treatments for moderate to severe OSA as Continuous Positive Airway Pressure (CPAP) and oral appliances. Oral appliances are widely considered the best therapy for snoring. Snoring concerns much of the population and has spurned an industry that sells unproven and unscientific rings, sprays, pillows and alternate therapies that cost the consumer millions of dollars each year.

Oral Appliances that are prescribed by medical practitioners then planned, fitted and adjusted by dentists have been shown in multiple studies to be beneficial in treating snoring and OSA. A custom fabricated oral appliance used to advance the lower jaw during sleep may be as effective as CPAP in the health outcomes of patients with mild to moderate OSA. Adherence to therapy is also an important consideration as oral appliances are generally well tolerated but long-term unmonitored use can lead to significant side effects including changes to patients bites.

Not all patients respond well to oral appliance therapy. By holding the jaw forward when one sleeps, oral appliances basically act to modify the patient's anatomy. Anatomy is just one of the many factors that influence the presence and severity of OSA. So treatment may include many options. We know that if we were to fit all OSA suffers with an oral appliance that up to half the patients may be inadequately treated and 37% may discontinue treatment within the first year.

When appropriate, these devices are generally considered long-term therapy and not a simple 'buy it and your set' device. Patients who are prescribed these devices are monitored by a multidisciplinary team that can include a sleep physician, their GP, ENT surgeons, dentists and other allied health professionals. There is a need to report and refer to each other and it is a concern that the current Medicare system has limitations in rebates and ultimately who patients will be referred to. The ADA believes that the lack of Medicare rebates for patients in such circumstance is restricting clinical pathways.

As an example, a dentist can refer a patient to an ENT surgeon to have surgical intervention that may or may not help and a rebate is paid, yet if they refer a patients to a sleep physician for a proper diagnosis, there is no rebate paid and it is commonplace for these referrals to be knocked back and patients to look at no treatment or for self-prescribed and self-fitted devices.

The ADA would argue that it is not good medicine to place patients in such positions and indeed it is common to

see patients who have failed one therapy, show up with a prescription for another when it may have been better to do it the other way around. Savings can be made and better treatment outcomes will result in a truly multidisciplinary approach.

The issues around Medicare funding and rebates is a large one, and ideally, we would like to see patients access rebates that allow them to be supported within and across the multidisciplinary system. There are many patients who are long-term wearers of oral appliances that avoid follow up medical reviews and further sleep studies because of the Medicare rebate barriers. Ideally, the prescribing medical physician should have a clear referral pathway back to them for as long as the therapy lasts. We know that OSA can change with age and patients need to have access to their full team.

In light of the above, the ADA recommends:

1. **That referral by dentists to sleep physicians attract a Medicare rebate for patients.**

Anti-snoring devices that are sold online or over the counter are available and the dental and medical professions are concerned that self-prescribed self-fitted devices may mask the symptoms of OSA. The patient may be quiet and the snoring stopped but the OSA may remain untreated with significant medical morbidity and risk remaining. A quiet patient who still has some underlying OSA can still be a risk when they are driving home and have residual sleepiness. All oral appliances regardless of who sells them should be provided following a proper medical diagnosis and a prescription for the therapy.

In the past, the state dental boards had very tight policies on Dental Sleep Medicine but once the national registration and accreditation scheme was introduced, the Dental Board of Australia (DBA) has been silent on this even after numerous submissions from the ADA and ASA.

The ADA and the ASA both have policies and guidelines in regard to the clinical pathways and referrals that need to be in place for best patient outcomes. The ADA's policy on DIY/Mail Order Dentistry is also included for information at Attachment B. Yet the manufacturers and industry supplying over the counter or online anti-snoring oral appliances are not held to the same account as dental professionals.

In light of the above, the ADA recommends:

2. **That over the counter self-prescribed and self-fitted devices be subject to the same regulations as medically prescribed and dentist fitted oral appliances for snoring and obstructive sleep apnoea**

The ADA would be very happy to expand on any of the comments provided above. Please do not hesitate to contact Ms Eithne Irving, Deputy Chief Executive Officer on 02 8815 3332 or eithne.irving@ada.org.au should you wish to discuss further.

Yours sincerely,

Dr Hugo Sachs
Federal President