AUSTRALIAN DENTAL ASSOCIATION

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The Hon Kevin Andrews MP
Chair
Joint Standing Committee on the National Disability Insurance Scheme
PO Box 6100
Parliament House
Canberra ACT 2600

Via email: ndis.sen@aph.gov.au

Dear Minister

Re: Inquiry into the Implementation Performance and governance of NDIS

Thank you for making the time to attend to the National Advisory Committee of the Australian Dental Association (ADA) and to provide further details in relation to the inquiry into the implementation, performance, and governance of the National Disability Insurance Scheme (NDIS). The Committee found it most useful.

As the peak body representing dentists across Australia, the ADA seeks to achieve two major goals:

- Encourage the improvement of the oral and general health of the public and promote the ethics, art and science of dentistry, and
- Support its members to provide safe high quality professional oral health care.

With branches in every state and territory, it has over 17,000 members working across both public and private sectors who include general and specialist dentists. In preparing this feedback, we have taken on board your advice to make a single submission from the profession by seeking input from individual members, our state and territory branches and our Affiliate organisations which include specialist dental societies and academies. You can find a full list of our Affiliates here.

The following information is provided as background to help contextualise our comments.

Dental Funding

As reported in the most recent Australian Institute of Health (AIHW) Health Expenditure report, spending on dental care was $10.6 billion in 2017-18.[1] Individuals contributed to most of this spending more than $6 billion toward their own dental care. The next largest contribution was from Commonwealth and State and Territory Governments at $2.4 billion ($1.5 b and $800 respectively) followed by health insurance rebates at just over $2 billion. What this data indicates is that at least 80% of dental services are delivered

[1] Australian Institute of Health and Welfare 2020. Health expenditure Australia 2018–19. Health and welfare expenditure series no.66. Cat. no. HWE 80. Canberra: AIHW.

to individuals in the private sector. That number is an underestimation as most of the services funded by the Commonwealth Government and even some state and territory services are outsourced to the private sector as that is where the workforce is located.

Dental Workforce

As of September 2021, the Dental Board of Australia reports that the dental workforce which includes dentists and dental specialists, allied dental practitioners such as dental prosthetists, dental hygienists and oral health therapists represent a total workforce of just over 25,000 individuals.[2] Dentists and dental specialists make up around 74% of that workforce. However, there are only 26 registered special needs dentists across the country with no representation of this speciality in ACT, Tasmania, or the Northern Territory.

While not reported in the Dental Board data, around 85% of the total dental workforce are employed and operating in the private sector.

It is important to understand both the expenditure of dental services and the workforce distribution when considering some of the challenges of access facing individuals with a disability.

Oral health of individuals with a disability

The ADA believes that individuals with a disability are entitled to the same level of access and range of care options as other members of the community and has actively advocated in a range of public consultations to increase awareness of the need for action on the delivery of oral health services for individuals with a disability.

For example, in 2018, the ADA provided input into the consultation on Specialist Dementia Care Units[3] highlighting the need for oral health assessment and treatment options to be considered during the process for admission and ongoing. For example, undiagnosed pain and discomfort due to unmet dental health care needs is often a significant cause of distress, agitation, and/or resistant or disruptive behaviour amongst the residential aged care population with dementia.

Amongst adults with intellectual disabilities, the incidence of tooth decay is three times higher than that of the wider Australian adult population, Due to the latent nature of dental disease onset, quality of life is often not impacted until the disease has reached an advanced and often untreatable state, 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

[2] Dental Board of Australia. Registration Data. September 2021, available at https://www.dentalboard.gov.au/About-the-Board/Statistics.aspx

[3] https://www.ada.org.au/News-Media/News-and-Release/Submissions/Specialist-Dementia-Care-Units-Consultation/ADA_Submission-to-DoH-SDCU-Consultation

than amongst the wider adult population.[4]

As has been well documented, poor oral health impacts on an individual's general health and wellbeing and can impact chronic conditions such as diabetes. Removal of teeth not only can impact on the ability of individuals to chew, but also impact on their quality of life, self-esteem, and self-image – the result impacting on their ability of individuals to attain the lifestyle they aspire for in terms of employment, social interactions, and quality of life.

The ADA's 2018-19 Federal Budget Submission drew particular attention to the need for access to general anaesthesia services for people with special needs. 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.

Access to general anaesthesia services for persons with special needs was also raised in our submission to the review of AR-DRGs to the Independent Hospital Pricing Authority (IHPA) as it related to pricing arrangement for dental treatment.[5] In its document Pricing Framework for Australian Public Hospital Services 2018-19, the IHPA states that the structuring of AR-DRG classifications is supposed to underpin pricing and funding decisions that support the following principles, amongst others:

- Timely Quality Care: Funding should support timely access to quality health services.
- Fostering clinical innovation: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- Minimising undesirable and inadvertent consequences: Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- Patient-based: Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.

Many dental patients are not being allocated the theatre time and hospital resources needed to deal with the complexity of their individual cases because the DRG's and National Efficient Price erroneously assume that all dental cases can be dealt with efficiently and provided with quality, up to date models of care in a short period of time.

Dental treatment under GA in a hospital facility is commonly more extensive, more resource intensive, and more complex than that performed in dental practice rooms. This is even more evident in difficult to treat paediatric and adult patients with a disability for a myriad or reasons. These cases are much more complex than patients needing their wisdom teeth out, or emergency dental extractions. The current national efficient price for dental services under Activity Based Funding does not recognise the complexity

[4] 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.

[5] https://www.ada.org.au/News-Media/News-and-Release/Submissions/Australian-Refined-Diagnosis-Related-Groups-Classi/ADA-submission-to-IHPA-AR-DRG-Consultation-22-06-1.aspx

of treating such patients and therefore is not an attractive option for hospitals who are trying to maximise the use of their operating facilities.

The ADA submits that the current "catch-all" structure of DRG D40Z is not achieving these objectives for a growing number of special needs patients who urgently need dental treatment under GA and that a complexity split should be introduced for DRG D40Z Dental extractions and restorations

The ADA has also actively participated in a series of roundtables conducted by the Commonwealth Department of Health on the Health of People with Intellectual Disability where we promoted the need for consideration of oral health care in government policy development.

The ADA is also committed to educating the dental workforce so that they are better able to provide treatment to individuals with a disability. Through our education portal, we have over 17 hours of material for CPD (50+ hours covering the wider special needs topics). Over the last three ADA National Congresses, (run every two years), the topic of special needs has been part of the main scientific program presented to the delegates.

Access Challenges

The NDIS specifically excludes health services, education, and justice services as this is provided elsewhere and is mostly limited to people ranging from 7-65 years, with early childhood and aged care residents missing out. These are two of the most vulnerable groups for oral disease – even in the wider population without disability.

Coordinating adequate support to assist those living with a disability is complex for consumers and their families. Disability services and supporting organisations are poorly linked with primary dental care and assessment services therefore, dental, and oral health is overlooked as part of the primary health care model. So while some allied health services such as speech pathology, physiotherapy, exercise physiology, audiometry and occupational therapy can be accessed via Medicare plans, dental and oral health care is excluded. This siloed approach to services does a dis-service to a patient-centred approach to care required for overall health and wellbeing.

It is a significant oversight that dental assessment and access to treatment has been missed for one of the most vulnerable groups in the community. Without a family member or carer strongly advocating for those living with a disability to access supports for daily activities, respite care, personal care, or aids to assist with living, accessing health care services (primary, secondary and tertiary) becomes less of a priority for an already overburdened family.

Public Dental Care

Public services are unable to provide comprehensive care, including effective prevention of dental diseases to all who are eligible. Access to public dental services is very limited particularly in regional and rural locations and most have long patient waiting lists, particularly for specialty services such as special

needs dentistry, that result in periods of suffering in pain and infection, exacerbating mental and general wellbeing

As mentioned earlier, often because of their more complex needs, individuals with disabilities may require specialist treatment, such as sedation or general anaesthesia in order to receive treatment. There are likely to be additional costs borne by these individuals for this care yet there are no avenues within NDIS for any funding in this area – this is despite these measures often being essential to meeting their basic dental needs and ensuring this treatment is provided safely such as extra staff/support workers for patients with challenging behaviour, or extra staff to stay with patients requiring overnight admission.

MBS

Under the Medicare Benefits Scheme, a medical practitioner may undertake and claim for providing a health assessment for a person with an intellectual disability to comprehensively assess their physical, psychological, and social function and to identify any medical intervention and preventive health care required.[6] The health assessment includes a requirement to check the individual's dental health. Including dentition.[7] While it is within the scope of a medical practitioner to practice dentistry, they are not as familiar with examining and detecting oral disease or providing oral health advice to the same level as a dentist especially in people who have limited cooperation. For this reason, most often the dental health check would be missed or cursory in nature and only conducted if there are overt signs of disease or if a family member or carer has concerns. Even when the medical practitioner does detect something of concern there is no mechanism for referral under the NDIS for the individual to receive treatment.

Specialised education and equipment

A lack of access to dental education, including basic oral hygiene techniques is all but non-existent for carers [formal and informal] of people requiring assisted living across all age groups. Yet there is clear evidence that when teeth are cleaned twice daily with a toothbrush and fluoride toothpaste, individuals eat a diet low in sugar, that the risk of dental decay is reduced, and maintenance of oral health and function is achieved.

There are often increased costs associated with oral hygiene products for individuals with a disability including items such as suction toothbrushes for individuals with swallowing deficits, specialised toothbrushes and aids for assisting brushing, such as hand grips, foam blocks or wedges for those with motor and sensory deficits, high strength fluoride tooth paste and other hygiene products, yet there is no funding to cover these additional costs. The financial costs are above and beyond those expected for individuals in the community without a disability. Consideration should be given to providing access to these products under the scheme in the same way individuals who have diabetes can access reduced cost needles and syringes.

It would be helpful as a minimum, to ensure eligible NDIS recipients and their families and carers, have

[6] MBS Fact Sheet, Health assessment for people with an intellectual disability. 2014. Commonwealth Department of Health: https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_intellectual_disability

[7] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=701

access to oral health information, as increased oral health literacy will assist in reducing oral health inequalities among people living with a disability. The ADA has worked with bodies such as Inclusion Melbourne to develop appropriate information for individuals with a disability regarding the importance of maintaining their oral health. This initiative was supported by a 16-page guide for dental practitioners which outlines treatment pathways, information about communication and consent and strategies for achieving better long-term oral health outcomes for people with intellectual disability. [8]

Opportunities

The current scope of the NDIS does not address the oral health of people with disabilities because it does not facilitate the involvement of health care. To address this disparity, the application process for NDIS should ensure all health professionals from a variety of backgrounds, including dental practitioners, contribute to decisions about funding allocations for individuals with disabilities to ensure the funding represents a holistic approach to support services.

Secondly, government funding must be made available so that individuals with disabilities have improved access to oral health care. The link between oral health and general health and wellbeing is acknowledged broadly yet dental and oral health care continues to be excluded in many government programs. Greater attention to its importance and co-dependency and explicit reference in inquiries such as this would be welcome. The ADA has developed the Australian Dental Health Plan which provides a model for funding such care.[9]

By making these small but important changes, it would at least acknowledge that oral health is a vital component of overall health for all people but especially the vulnerable members of our community, such as those living with disabilities.

If the Committee would like any further information in relation to this submission, please do not hesitate to reach out to Mr Damian Mitsch, Chief Executive Officer on 02 8815 3333 or ceo@ada.org.au. The ADA would be more than happy to expand on any matter raised in this submission.

Yours sincerely,

Dr R Mark Hutton
President

[8] https://inclusionmelbourne.org.au/projects/your-dental-health/
[9] https://www.ada.org.au/Dental-Professionals/Australian-Dental-Health-Plan