AUSTRALIAN DENTAL ASSOCIATION

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31 July 2020

Royal Commission into Aged Care Quality and Safety
GPO Box 1151
ADELAIDE SA 5001

Via email: ACRCSolicitor@royalcommission.gov.au

Dear Commissioners,

## Re: Post Melbourne 4 Hearing submission

Thank you for providing the Australian Dental Association (ADA) with the opportunity to provide a post-hearing submission on issues raised in relation to the provision and funding of oral health care for aged care recipients at Melbourne Hearing 4.

As the ADA has already made two lengthy submissions to the Commission summarising our position on relevant issues,[1] this submission will be brief. Its focus is limited to addressing several points of evidence raised during the hearing, and alerting Counsel Assisting to additional matters of fact pertinent to the refinement of Propositions D1 and D4.

### *Funding mechanisms (Propositions D1 and D4 from Adelaide Hearing 5)*

***D1 - Fund public dental to provide outreach services to Australians accessing aged care services in their place of residence via a new NPA***

***D4 - Fund services delivered by hygienists and dental/oral health therapists to carry out regular oral health assessments and personal care worker education in oral hygiene. (At para 53, Proposition D4 also envisaged the potential funding of provision of "ongoing and basic dental services" by oral hygienists and/or dental and oral health therapists including oral examinations, scale clean and polish, extractions and restorations (not endodontic or prosthodontic)."***

In relation to these propositions, the ADA has already made it clear that for a variety of reasons, it believes that Australian Government funding of a Senior Dental Benefits Schedule (SDBS) as proposed under its Australian Dental Health Plan[2] would be a far superior mechanism to a new National Partnership Agreement (NPA) for funding dental outreach services for the frail aged.

The ADA has also suggested that while it would see merit in the Australian Government funding aged care providers to engage dental practitioners to provide ongoing education to aged care staff in oral hygiene care and routine oral health screening, and to promote oral health to families and clients/residents, funding for regular preventative oral health services (e.g. dental examinations and scale and clean services) would be better provided under an SDBS scheme, which could also fund the dental treatment needs of most aged care recipients.

The ADA notes that the representative of the NSW Department of Health strongly supported the ADA's proposed SDBS funding mechanism over an NPA mechanism is his oral evidence to the Melbourne 4

[1] Exhibit 17-1 Tab 10 [RCD.9999.0306.0001.0] and Tab 35 [RCD.9999.0368.0001.0]
[2] https://www.ada.org.au/Dental-Professionals/Australian-Dental-Health-Plan/Download-your-copy-of-the-Dental-Health-Plan/Australian-Dental-Health-Plan-2019.aspx

hearing, and for many of the same reasons. These include the importance of giving older people a choice of public or private provider (e.g. who may be the dentist they have been seeing for years), the private dental profession's familiarity with and acceptance of such schemes, and the importance to aged care providers (many of which are national chains) of knowing that there is a scheme based on nationally consistent eligibility criteria and treatment rules which can fund dental care for a high proportion of their residents/clients.[3]

It is also important to correct erroneous assertions about the likely impacts of an SDBS model of funding on access to care made in evidence provided by Nicole Stormon, the Australian Dental and Oral Health Therapists' Association (ADOHTA) representative. In her witness statement, Ms Stormon states that the CDBS has been underutilised, and that an SDBS model would be too, because it "would put the onus of accessing dental services on the individual"[4]. As a result, she suggests that "the most vulnerable people would miss out because there is no insurance (sic) that all these people actually access the scheme".[5]

In response, the ADA would suggest that there is "no insurance" that the vulnerable frail aged will wish to utilise preventive oral care or minimally invasive treatment services *however* they are funded – whether via block funding for a part-time dental practitioner, or via a capped individual entitlement scheme like the SDBS. Even if such care is fully-funded, some aged care residents/clients will decline or withdraw consent to professional preventative oral health care or minimally invasive dental treatment if they find it distressing or uncomfortable, and their right to do so must be respected.

This is another reason why the ADA believes that funding dental care via an SDBS mechanism, rather than a mechanism limited to clients of aged care providers is so important: it ensures that all those aged over 65 with Commonwealth concession cards can access timely, affordable dental care *before* they require high-needs home care or residential care, so they are in sound oral health before their capacity to tolerate preventative oral hygiene care and dental treatment declines.

Secondly, while an SDBS model would provide for individual *choice*, it would not put the onus of *accessing* services on individuals using residential aged care or high needs home care packages. As the Commission is aware, under the current Quality of Care principles that apply to all residential and home aged care providers, RACFs are required to assist residents to obtain necessary health practitioner (including dental) services, either by arranging for those services to visit the resident or vice versa.

Likewise, if a recipient of a home care package wants assistance to access health services to be included in their package, then the home aged care provider will be required to provide that assistance, through referrals to practitioners, scheduling of appointments, and, where necessary, provision of transport to and from those appointments if the health care service is provided outside the home.

Thirdly, utilisation of an SDBS is likely to be high, in part because a range of highly active seniors advocacy organisations have been calling for such a scheme for some time and will promote it widely to their constituency through a range of member-based and non-member-based informal channels. Aged care providers and their staff will also be happy to inform residents/clients and their families about such a scheme, given evidence from the sector that referrals to dentists for much-needed treatment are currently often refused by residents/families given concerns about potential out-of-pocket costs.

As noted by Dr McGowan of the South Australian Department of Health and Wellbeing in his evidence, 'access to dental care is greatly enhanced if it's triggered by…ongoing assessment of the need rather than leaving it to people just to be a demand-led initiative.' [6] Such ongoing assessment of need, and a greater volume of referrals to dental practitioners will occur if the ADA's recommendations for making aged care providers more accountable for maintaining oral care, for better oral health screening as part

[3] Dr Lyons, Melbourne Transcript, Friday 17 July 2020, pp. 8317-8319.
[4] Exhibit 17-10, Statement of Nicole Stormon, [RCD.9999.0299.0007]
[5] Nicole Stormon, Melbourne Transcript. Thursday 16 July 2020, p. 8190.
[6] Melbourne Transcript, Friday 17 July 2020, pp. 8319.

of ACAT assessments, for mandatory inclusion of oral health screening as part of Medicare-funded GP assessments, and for mandatory dental examinations on (or within six months prior to) entry to an RACF or Level 3 or 4 home care packages and regularly thereafter are implemented.

Further, because dental practitioners would have to register with the Australian Government to participate in a scheme such as the SDBS (as they must do if they wish to participate in the CDBS), then the www.myagedcare.gov.au website could provide a complete list of participating practitioners by location for the information of aged care providers, healthcare practitioners, older persons, and/or their carers and families. Of course, the ADA would also promote the scheme on its website, through traditional and social media, and by providing flyers and posters for participating dentists to display in their practices, just as it has done to help promote the CDBS.

### *Proposition D4: Scope of practice issues*

In its earlier response to Proposition D4, the ADA has already stressed that it does not agree with the proposition that dental hygienists, dental therapists and oral health therapists should be engaged to provide other dental services such as extractions and restorations in residential aged care facilities without the involvement of a dentist.

It is important to reiterate this point, with specific reference to the competencies expected of dental practitioners registered within different practitioner divisions under the category of general registration as defined by the National Law.

The Commission should be aware that dental hygienists, dental therapists, and oral health therapists are not a homogenous group, and that their qualifications range from Certificate IV through to bachelor's degrees (AQF 8).

For example, as shown in the Australian Dental Council's 2016 publication *Professional Competencies of the Newly Qualified Dental Hygienist, Dental Therapist and Oral Health Therapist,* **the competencies that dental hygienists are expected to have on graduation do *not* include providing restorative care, or performing tooth extractions on patients of any age.**

**Further, although the expected competencies of dental therapists and oral health therapists do include provision of simple direct restorations, they do *not* include performing extractions of permanent adult teeth, let alone the teeth of frail aged patients with complex health conditions who may be on multiple medications that significantly raise the risks associated with invasive treatment.**

**It is also important to note that not all dental therapists graduated under the three year university level degrees that are supposed to provide these competencies – some have not upgraded from their original 2 year diploma qualifications, and thus do not have the education and training required to treat adult patients older than 25 years of age.**

With respect to oral health therapists, while the curriculum they study includes some overlaps and shared content with the education a dentist receives in first year, the depth of understanding required of a dentist is much higher. Student dentists cover topics in their third year that are not in the curriculum for oral health therapists, such as

- Advanced biosciences including immunology, microbiology, physiology, and pharmacology
- Surgical anatomy of the head and neck
- Oral medicine

- Advanced radiology
- Endodontics and dental trauma
- Removable prosthodontics
- Oral and maxillofacial surgery; and
- Prescribing drugs and medicines.

Then, during their fourth year, student dentists study complex periodontal therapy, dental implantology, surgical periodontics, maxillofacial surgery, oral medicine, paediatric dentistry, special needs dentistry, molar endodontics, fixed prosthodontics, occlusion, and orofacial pain. Lastly and most importantly, across their fourth and fifth years, student dentists develop their skills in comprehensive treatment planning, learning how it all inter-relates.

**Ms Stormon stated during the Melbourne hearing that 'no dental practitioner can do all aspects of dental care." [7] The ADA respectively disagrees. A dentist has the full scope of practice required to provide all aspects of dental care.**

**Only dentists have the deeper and broader knowledge of pharmacology, complex multiple health conditions, how to manage medical emergencies and to make optimal treatment decisions that is necessary when assessing the need for, or providing, anything more than preventive oral care to frail aged care residents.**

**It is for this reason that the ADA supports a team-focussed approach to provision of dental care in aged care facilities, whereby dental hygienists, dental therapists and oral health therapists work with a dentist so that different aspects of dental care are referred to the practitioner most appropriate to perform them.**

### *Question put by Commissioner Briggs about ADA engagement with aged care providers and Australian Government Health Portfolio Departments*

Finally, the ADA would like to correct a response provided by Dr Matthews to a question put by Commissioner Briggs with respect to the engagement of the ADA at a national level with aged care providers and relevant departments in Canberra.[8] At the national level, the ADA is an active member of the National Aged Care Alliance (NACA), a representative body of 54 peak national organisations in aged care, comprising consumer groups, aged care providers, unions and health professionals, working together to determine a more positive future for aged care in Australia.

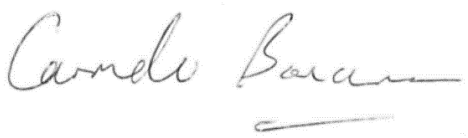
As a member of NACA, ADA representatives attend quarterly NACA meetings which include briefings and discussions with the Minister for Aged Care and senior departmental representatives, in addition to formal and informal discussions with NACA members representing aged care providers, health professionals, consumers, and aged care workers regarding the many pressing reforms required in aged care.

The Federal Executive of the ADA and its CEO and Deputy CEO also meet regularly with relevant health portfolio Ministers in Canberra to discuss a wide range of relevant matters.

[7] Transcript, Melbourne Hearing, 16 July 2020, p. 8197.
[8] Transcript, Melbourne Hearing, 16 July 2020, pp. 8193-4.

Should you have any further questions concerning these matters, please do not hesitate to contact Dr Fiona Taylor, Senior Policy Officer, on 02 8815 3334 or at fiona.taylor@ada.org.au

Yours sincerely,



Dr Carmelo Bonanno
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