



AUSTRALIAN DENTAL
ASSOCIATION

Submission to the Royal Commission into aged care quality and safety

June 2019

About the Australian Dental Association

The Australian Dental Association (ADA) is the peak national professional body representing more than 16,000 registered dentists as well as dentist students. ADA members work in both the public and private sectors and across all areas of practice.

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.

The ADA maintains an active presence in every state and territory via its Branches. Branches provide education and face-to-face assistance to members, support the delivery of oral health messages and advocate on a range of issues impacting oral health at a state and territory level.

The ADA and its members also support the philanthropic and *pro-bono* work of the Australian Dental Health Foundation, which provides access to dental services for disadvantaged Australians. Recent initiatives include supporting mobile dental services for rural and remote communities, and the provision of free dental treatment for domestic violence victims under the Rebuilding Smiles program.

Through the Australian Dental Research Foundation, a joint initiative with the Australian Dental Industry Association, the ADA also plays a role in advancing oral health, dental knowledge and dental practice by funding dental research through the annual award of grants and scholarships.

Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

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List of Recommendations

Recommendation 1:

That as a matter of urgency, the Federal Government implement a Pensioner/Elderly Dental Benefits Schedule along the lines of the current Child Dental Benefits Schedule, as outlined in the ADA's Australian Dental Health Plan.

Recommendation 2:

That assessment of oral health and dentition be included as a specific, mandatory and reportable component of MBS-funded GP Health Assessments for Australians aged 75 and over and current/prospective residents of aged care facilities. GP's should refer patients who have potential oral/dental health problems or who have not visited a dentist within the last year to a dentist for a comprehensive oral examination.

Recommendation 3

That the National Assessment Screening Form's section on Oral Health include direct questions on oral health and recent dental visiting patterns that lead to timely referrals for older adults to receive oral health care.

Recommendation 4:

That a dentist examines aged care recipients on entry to Level 3 or 4 Home Care packages, and/or residential aged care, and participates in residents' oral care planning.

Recommendation: 5:

That as recommended by the Australian Nursing and Midwifery Federation, and the Australian Medical Association, the Federal Government require that each aged care provider adheres to minimum staff-to-resident and staffing mix ratios. These ratios should be calculated on the basis of an evidence-based, needs-based model of the time and skills required to provide safe, high quality care to clients assessed as having different levels of need, and the aggregate needs or "care complexity" profile of each aged care providers' client base.

Recommendation 6:

That all Personal/Home Care Workers employed by aged care providers be required to have Certificate III Aged Care qualifications, and that the curriculum of these courses be expanded to incorporate education and training in provision of routine preventive oral hygiene care to clients with more complex needs, including those with dementia, other cognitive or communication related disabilities, or other complex medical conditions.

Recommendation 7:

That the oral health content of entry level nursing qualifications and Certificate III aged care courses is strengthened, possibly by incorporating some of the excellent teaching and learning resources already developed in Australia, such as resource packages created for the Better Oral Health in Home Care and Residential Care programs.

Recommendation 8:

That all new permanent residents of aged care facilities and new clients of Level 3 or 4 home aged care packages have a referral pathway to a dentist or dental service placed on record for them by their aged care provider.

Recommendation 9:

Mechanisms should be put in place to encourage increased enrolment in courses that include specialist training in special needs or geriatric dentistry.

Recommendation 10:

That in line with the COAG Health Council's recommendations in Australia's National Oral Health Plan 2015-24, residential aged care facilities provide designated areas for dental treatment.

Recommendation 11:

That larger aged care facilities be required to provide dedicated dental surgeries onsite, and that where necessary, the Federal Government provides funding support to such facilities to help with associated establishment costs.

Recommendation 12:

That the Federal Government provide funding support to private dental practitioners to cover any significant travel costs that may be associated with the provision of dental treatment in RACFs or visiting services to under-served rural and remote communities.

Recommendation 13:

That eligibility for the Patient Assisted Travel Scheme (PATS) be extended to cover the costs of public transport to the nearest dental service for patients who urgently require basic dental treatment to prevent complications from untreated oral disease.

Introduction

The Australian Dental Association (ADA) welcomes the opportunity to provide a submission to the Royal Commission into Aged Care Quality and Safety, which is long overdue.

For many years, the ADA has advocated for better oral and dental health care provision for older Australians and aged care recipients, particularly those living in rural and remote areas. Along with the Australian Dental Health Foundation, the ADA, its state branches and individual ADA members have also been actively involved in a range of cooperative initiatives and philanthropic activities designed to address gaps in service provision. A short summary of some of the most recent of these initiatives is provided at **Appendix 1** to this submission.

However, as outlined in this submission there is compelling evidence that many older Australians are not receiving the oral and dental care they need, both before and after they access aged care services. Rates of oral disease including dental caries and periodontal disease are highest amongst the over 65 population and are increasing, as is the proportion of older people who are retaining their natural teeth, and the number of natural teeth retained. Ageing and heavily restored natural teeth require more complex and managed care than full dentures worn by edentulous patients. Unfortunately, that care is often not sought by or provided to older people at a time when their own capacities to manage oral hygiene self-care without assistance are often in decline

The oral and dental care needs amongst this population have been shown to seriously compromise both the general health and emotional and social well-being of older people, contributing to malnutrition, the onset or exacerbation of other health conditions, like cardiovascular disease and diabetes, premature deaths from choking and aspiration pneumonia, and the rising costs of preventable hospitalisations.

For some time, the ADA has been asking government to address two sets of systemic factors that are contributing to the lack of access to optimal oral and dental care experienced by many older Australians. One key issue is the lack of timely access to dental care, as a result of long waiting lists in the public dental system and increasingly unaffordable and low-value private health insurance cover for dental care. Prevention of major oral and dental health problems through regular check-ups and timely preventive and remedial care is the best means of minimising oral and dental health problems in older people. Current access to care barriers and paucity of government funding for a well detailed aged care dental scheme means that many older people enter the aged care system with poor dental health.

Secondly, the provision of daily oral care to those who need it most is almost non-existent, and this directly relates to the funding, staffing and practices of aged care services themselves – including:

- inadequate assessment of oral health needs,
- lack of involvement of dentists in oral health needs assessment, care planning and treatment,
- lack of staff training in the provision of daily oral hygiene care, and
- inadequate staffing levels which leave both nursing and personal care staff rushed, and likely to neglect.

Other key issues include practical barriers such as lack of affordable or suitable transport which prevent older people with mobility issues accessing private or public dental care services, particularly those living some distance from their nearest private practitioner or public dental clinic. Likewise, private dental practitioners face both practical and financial barriers and disincentives to providing domiciliary care, including lack of treatment rooms, equipment and staff support in aged care facilities, travel time and costs, and the complexity of providing safe domiciliary care to patients with multiple comorbidities often on complex polypharmacy regimes some of who may be unable to cooperate during treatment.

There are no simple solutions to these issues. However, the ADA hopes that the Royal Commission will give serious consideration to the range of evidence-based recommendations presented in this submission, adoption of which will go a long way towards improving both the quality and safety of oral and dental health care provision for older people accessing aged care services.

Scope and organisation of this submission

The ADA's comments in relation to the Terms of Reference for this Inquiry are confined, for the most part, to the quality and safety of oral and dental care provided by aged care services.

This submission also discusses the wider question of access to affordable timely oral and dental health care for all older Australians, given that federal and state government policies in this area have a major impact on the oral health status of older people accessing aged care services, and their capacity to access required treatment whilst using aged care services. **Appendix 2** to this submission is the ADA's Australian Dental Health Plan, which makes recommendations to improve the access of disadvantaged Australians to affordable dental health care.

Given the overlapping nature of concerns relevant to many of the terms of reference for the Royal Commission, this submission is organised around specific issues and sub-issues, to avoid unnecessary repetition. Where major issues raised are relevant to more than one term of reference, this is indicated.

Trends in the oral health of older Australians (*Terms of Reference C, D & G*)

A range of factors mean that the provision of high-quality oral care is a more complex and challenging responsibility for residential and home/community aged care workers than it was in the past.¹

In the past few decades, there has been a rapid decline in the proportion of people over the age of 75 who are edentulous and wear full dentures, down to around 1 in 4, and a steady increase in the number of natural teeth that partial or non-denture wearers are retaining. Although these are positive trends, the retention of more natural teeth which may have had complex restorative care throughout increasingly long lifespans also increases the risks and incidence of degenerative problems such as tooth wear, tooth fracture and root decay.² This restorative work, that may be supplemented by partial dentures, fixed prostheses and/or implants designed to restore any missing teeth, requires a considerably higher level of maintenance compared to full dentures is met, which are often easier for the frail aged and their carers to look after.³ Regular review by a dentist is also imperative.

Many older people with complex health conditions take many medications which reduce the flow of saliva, and this significantly increases the risk of dental caries and periodontal (gum) disease.⁴ With increases in longevity, the proportion of aged care consumers with dementia, mild cognitive impairment and communication disorders is also increasing.⁵ Even mild cognitive impairment and the early stages of dementia can reduce the capacity for oral self-care and the capacity to seek and assent to dental treatment, so 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.

A whole range of factors may cause the oral health of older people to decline over time unless appropriate daily hygiene care and appropriate dental treatment is provided. Australian Institute of Health and Welfare (AIHW) statistics suggest that more than half of people aged over 65 have some level of periodontal (gum) disease,⁶ a chronic inflammatory disease caused by bacteria in dental plaque that may lead to recession of the gums, bone loss, and eventually tooth loss.

Dental caries continues to be the most prevalent oral health condition in older people, and like the incidence of periodontal disease, the incidence of untreated decayed teeth has increased over time predominantly as a result of increasing natural teeth retention and associated dental health maintenance issues.⁷

¹Lewis 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.

²Fricker, A and Lewis, A. (2009). *Better oral health in residential aged care – final report*, Central Northern Adelaide Health Service/South Australian Dental Service, Adelaide.

³Lewis et al, op. cit; Welsh S. (2014). 'Caring for smiles: improving the oral health of residents', *Dental Nursing*, 10 (4), pp.224-228.

⁴National Institute of Dental and Craniofacial Research. (n. d). *Periodontal disease: causes, symptoms and treatments*, <https://www.nidcr.nih.gov/OralHealth/Topics/GumDiseases/PeriodontalGumDisease.htm>

⁵Healthy 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).

⁶AIHW. (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/>

⁷Joshi, A. et al. (1996). 'Consequences of success: do more teeth translate into more disease and utilization?', *Journal of Public Health Dentistry*, Summer, 56(4), pp.190-7.

Population-based cohort studies that have measured the oral health trajectories of older community-dwelling people in several countries have shown that on average, they will develop caries affecting one additional tooth surface per year. Longitudinal South Australian research has found that this annual caries increment is doubled in nursing residents, and twice as high again amongst older people with dementia.⁸

The most common immediate consequences of poor oral health—pain, infection and tooth loss—have flow-on effects on nutrient intake, the capacity to communicate, and on mental, emotional and physical wellbeing. Tooth decay, oral cancer and periodontal disease are linked with other chronic health conditions like cardiovascular, cerebrovascular and respiratory diseases.⁹ Periodontal disease is now known to have a bi-directional 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.¹⁰ In 2007, one economic analysis estimated the indirect costs of periodontal disease to the Australian health system to be \$412 million per annum, and the total cost of poor oral health for older Australians to be more than \$750 million per annum.¹¹ Given the increase in the aged population and CPI movements over the past decade, today this cost is likely to be in the order of \$1 billion per annum.

Older people are over-represented amongst potentially avoidable hospital admissions,¹² and untreated oral health conditions are often the cause or causal factors in those admissions.¹³ A recent analysis of 10-year trends in preventable hospital admissions for oral health conditions in Western Australia found that the highest rate increases over time have been in the 60-74 and 75+ age groups.¹⁴ In older age groups substantial numbers were hospitalised for conditions such as caries, pulp and periapical conditions, stomatitis and other disorders of the teeth and supporting structures.

Furthermore, aged care residents with poor oral health have an increased risk of bacterial infections of the blood and aspiration pneumonia,¹⁵ which are also major causes of morbidity, hospital admissions and mortality amongst the frail elderly.¹⁶ Yet several systematic reviews of the literature have found that adequate oral health care in nursing homes significantly reduces the risk of developing aspiration pneumonia, and the risk of dying from it, along with preventable hospitalisations caused by this illness.¹⁷ For example, a 2015 systematic review and meta-analysis of randomised clinical trials concluded that daily brushing of the teeth/dentures of nursing

⁸ Thompson, W. M. (2014). 'Epidemiology of oral health conditions in older people', *Gerodontology*, 31 (Suppl. 1), pp. 9–16.

⁹ Dietrich, T. et al. (2017). 'Evidence summary: The relationship between oral and cardiovascular disease', *British Dental Journal*, 222, pp.381-5; Maarel-Wierink C. D. et al. (2011). 'Risk factors for aspiration pneumonia in frail older people: a systematic literature review', *Journal of the American Medical Directors Association*, 12, pp.344–354; Pillai, R. S. et al. (2018). 'Oral health and brain injury: causal or casual relation?' *Cerebrovascular diseases extra*, 8(1), pp. 1–15. doi:10.1159/000484989.

¹⁰ Ibid, p. 96.

¹¹ Econtech, cited in Lewis et al., op. cit., p. 96.

¹² Admissions that could have been prevented by preventive oral hygiene care and/or early detection and treatment of disease.

¹³ Lewis et al., op. cit., p.96; AIHW, op. cit. p.5.

¹⁴ Kruger & Tennant, op. cit; Thomson W. M, op. cit.

¹⁵ Hopcraft, op. cit., p.3.

¹⁶ Tada, A & Miura, H. (2012). 'Prevention of aspiration pneumonia with oral care', *Archives of Gerontology and Geriatrics*, 55 (1) 16-21.

¹⁷ Maarel-Wierink, C. D. et al. (2013). 'Oral health care and aspiration pneumonia in frail older people: a systematic literature review', *Gerontology*, 30 (1), pp. 3-9; Kaneoka, A. et al. (2015). 'Prevention of healthcare-associated pneumonia with oral care in individuals without mechanical ventilation: a systematic review and meta-analysis of randomized controlled trials', *Infection Control & Hospital Epidemiology*, 36(8), pp. 899-906; Sjögren, P. et al. (2008). 'Systematic review of the preventive effect of oral hygiene on pneumonia and respiratory tract infection in elderly people in hospitals and nursing homes: effect estimates and methodological quality of randomized controlled trials', *Journal of the American Geriatrics Society*, 56, pp. 2124 - 2130.

home residents could reduce the risk of pneumonia by close to 40% (RR, 0.61) and risk of *fatal* pneumonia by almost 60% (RR, 0.41).¹⁸

Substandard oral and dental health care provision by aged care services: extent and causes (*Terms of Reference. A, B, C, D & F*)

Residential aged care

Existing accreditation standards for residential aged care facilities (RACFs) under the *Aged Care Act 1997* as 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). Guidance material on the processes, practices and tools that aged care facilities and services should use to achieve this oral and dental health care standard has also long been provided to facilities by the AACQA and state health departments.

Despite this standard and the guidance materials provided, and reminder alerts issued to the sector by the AACQA in response to complaints about poor oral care in residential aged care facilities,¹⁹ the prevalence of generally inadequate oral health care provision in such facilities is acknowledged by many care staff who work or have worked within the sector and has been confirmed in a wide range of Australian studies in recent years.²⁰

The oral health of older people tends to decline significantly in the year or so prior to entering residential aged care as their functional capacities decline, but as many do not visit a dentist unless they are experiencing significant mouth pain, many are admitted to aged care facilities with pre-existing oral and dental disease.²¹ This often goes unnoticed because dentists and other dental practitioners are rarely engaged to conduct initial oral health assessments and care planning for new residents of aged care facilities. General medical practitioners are also uninvolved, seeing this as the role of nurses at the facility.²²

¹⁸ Kaneoka et al. op. cit.

¹⁹ <https://www.agedcarecomplaints.gov.au/wp-content/uploads/2015/12/Industry-Feedback-Alert-Oral-Health-and-Dental-Hygiene.pdf>

²⁰ <https://theconversation.com/the-shocking-state-of-oral-health-in-our-nursing-homes-and-how-family-members-can-help-77473>; 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; Chalmers J. M. et al. (2009). 'Caring for oral health in Australian residential care', *Dental statistics and research series no. 48*. Cat. no. DEN 193. AIHW, Canberra; Fallon, T. et al. (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 S, Sheppard J. J. & 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>; <https://theconversation.com/the-shocking-state-of-oral-health-in-our-nursing-homes-and-how-family-members-can-help-77473>

²¹ Lewis et al., op. cit.; Hopcraft et al., op. cit.

²² Slack-Smith et al., op. cit.

Without a recent dentist examination, care planning on admission and daily assistance with oral hygiene if they need it, the oral health of many RACF residents worsens rapidly following admission.²³

First-hand accounts of residential aged care nursing and care staff make it clear why these rapid declines in oral health occur in aged care. For example, staff of a large facility who participated in a recent research study part-funded by the National Health and Medical Research Council of Australia admitted that in their experience, many residents unable to brush their own teeth might only have their teeth brushed by staff “once a week”.²⁴ 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.²⁵ Other recent Australian studies of aged care residents find that residents without dentures who need help to clean their teeth are much less likely to receive that help than those with dentures, and commonly exhibit dental decay or periodontal disease that is more extensive or severe than that of other residents.²⁶

Many aged care staff are themselves deeply concerned at the poor quality of care (including oral and dental care) that the facilities or services they work for are providing to aged care consumers. The continuing trend in residential aged care towards an increasing proportion of residents who have dementia and other complex care needs, make care provision more time and skill intensive. However, the ratio of personal care staff to residents, and the education and training requirements of these carers have not kept up with these increasing demands. The ratio of registered nurses to less qualified staff, and to residents, has also fallen, with the result that personal care staff who may not have the time or training to provide quality care²⁷ are supervised by registered nurses who have no time to closely monitor and improve that care provision.

Many of the 1724 aged care nurses and personal care workers who responded to a survey conducted in 2016 by the Australian Nursing and Midwifery Federation (ANMF) suggested that their concerns on these issues are ignored by management.²⁸ Combined with relatively poor pay, and a tendency not to employ personal carer staff on a permanent full-time basis, this has led to a gradual exodus of registered nursing staff from the sector, incredibly high turnover rates of both nursing and personal care worker staff in many facilities, and the use of agency-sourced casual care staff who may not work with their older clients long enough to get to know them.

The ADA understands that the ANMF has already tendered a report of its recent project to determine the time and staffing it takes to provide high quality aged care²⁹ in evidence to the Commission. It is important to highlight the fact that the project confirmed that “mouth care” was amongst the top four types of care that is routinely neglected by aged care staff because they have insufficient time.

²³ 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; Lewis et al., op. cit., p.97.

²⁴ Hilton et al., op. cit., p. 9.

²⁵ Ibid.

²⁶ Webb et al. (2016). Oral and dental care in aged care facilities in New South Wales, Australia. Part 3 concordance between residents’ perceptions and a professional dental examination’, *Gerodontology*, 33, pp. 363-372; Hopcraft et al. (2012). ‘Oral hygiene and periodontal disease in Victorian nursing homes’, *Gerodontology*, 29, pp. 220-228.

²⁷ Adebayo, B. et al. (2017). ‘Culturally and linguistically diverse (CALD) carers’ perceptions of oral care in residential aged care settings in Perth, Western Australia’, *Gerodontology*; 34, pp.33–41.

²⁸ ANMF. (2016). op. cit.

²⁹ Willis, E. et al. (2016). *Meeting residents’ care needs: A study of the requirement for nursing and personal care staff*, Australian Nursing and Midwifery Federation, Melbourne.

Home Care

There is relatively little evidence available in relation to the quality of oral and dental health care provided by home care providers. However, available evidence suggests that substandard oral health care provision is likely to be common in aged home care, as a result of the same systemic factors found to operate in residential aged care.

For example, the ADA notes that in its recent submission to the Commission entitled *Aged Care in the Home*, the ANMF reports concerns expressed by care workers and nurses that the home care provider organisations they work for have unrealistic expectations about the time it takes to provide quality care to their clients, including hygiene assistance, so they are often too rushed to provide adequate care. The submission also notes that workers believe that care needs assessment, planning and service coordination with client's health care providers is often inadequate, particularly for clients with complex needs.

Lewis *et al.* 2016 study into oral care provided by South Australian Home Care package providers gives an insight into how these systemic factors operate to compromise the quality of oral and dental care available to aged home care recipients. The study considered the oral health of care recipients, and the culture and practices of home care providers before the implementation of the *Better Oral Health in Home Care* (BOHHC) project in 2012, and immediately after project implementation in 2014.

Like the *Better Oral Health in Residential Aged Care* program that preceded it, the BOHHC project program was funded by the federal government under the *Encouraging Better Practice in Aged Care* (EBPAC) Program. It was designed to improve the oral health of older people receiving home care through a focus on structured oral health assessment and care planning on intake, development of staff training and oral self-care resources and delivery of staff training to better enable them to put best practice oral care into action. Dental treatment referral pathways were also built by funded project staff who developed a formal public dental service/home care provider partnership model.

Baseline measures of the oral health of the low-income aged consumers accessing all four "levels" of home care offered by the providers, taken before project implementation commenced, suggested that many had *entered* home care with significant unmet dental treatment needs.³⁰ However, this was missed by home care providers, who at that point generally made no attempt to assess the oral health of care recipients or develop oral health care plans.³¹

Close to one-quarter (23%) of the personal care workers interviewed at the start of the project admitted they disliked providing oral hygiene care. However, almost 62% said they were prevented from providing oral care by physical difficulties involved or client behaviour (e.g. client unable or unwilling to open the mouth), and over one-third (37%) said they were prevented from providing it because of lack of time.³² The workplace culture

³⁰ Lewis et al. (2016). 'Improving oral health for older people in the home care setting: An exploratory implementation study', *Australasian Journal on Ageing*, 35 (4), pp. 273–280, <https://www.sciencedirect.com/science/article/pii/S0020748918302773?via%3Dihub>

³¹ Lewis et al. (2016). pp. 276.

³² Ibid.

was framed by workers as one that saw care provision in terms of “a collection of tasks to be delivered as quickly as possible”, or as a “task and time” approach to care delivery.³³

Measures taken after immediate implementation of project processes in 2014 suggested that in the short-term, at least, the program had improved the self-assessed oral health and wellbeing of care recipients.³⁴ However, a three-year follow-up study of outcomes of the project published this year³⁵ found that the processes introduced to boost staff capability, care planning, care provision and access to dental treatment had not been sustained. Once funding for project staff who facilitated the implementation of the project and championed a focus on oral health care expired, the improved assessment, care-planning and staff training processes that had produced better outcomes gradually fell by the wayside.

The workplace culture of providers and care staff reverted to how it had been before the program was implemented. New home care workers were not provided with the training that the home care providers had themselves been trained to give during the life of the program, so in an environment of rapid staff turnover, the oral health care capabilities of the provider organisations declined. Further, care workers no longer watched for or alerted care coordinators to changes in client’s oral health status, so fewer referrals were made for dental treatment were made.

The fall-off of positive gains post-program implementation mirrors the disappointing longer-term outcomes of other attempts to improve oral health care practice in aged care, such the *Better Oral Health in Residential Aged Care Program*. The reality is that better-trained care staff can only keep providing better oral health care where workplace culture changes to accord oral health a high priority, where ongoing training is regularly provided to new staff, and where staffing levels are sufficient to give care workers the time they need to build relationships of trust with residents and follow best oral care practice.³⁶

Improving oral and dental health care for aged care recipients: what needs to change? *(Terms of Reference A, B, C, D, E, F & G)*

Improving the oral health of a rising aged care population who are living longer and have more complex oral health needs will require implementation of a range of **policy changes around aged care funding and workforce issues, that are necessary to enable and sustain better processes for oral and dental care assessment, care planning, daily oral hygiene provision by aged care providers.**

Furthermore, **to prevent the very poor oral and dental health seen in so many older Australians when they first access aged care services,** the ADA argues that **it is critical to take a prevention-focused approach, via**

³³ Ibid, p.278.

³⁴ Ibid.

³⁵ Lewis et al. (2019). ‘Can oral healthcare for older people be embedded into routine community aged care practice? A realist evaluation using normalisation process theory’, *International Journal of Nursing Studies*, 94, Une (forthcoming), pp. 32-41.

³⁶ Australian and New Zealand Academy of Special Needs Dentistry & Aust. Society for Special Care in Dentistry. (2013). *Submission to the House of Representatives Inquiry into Adult Dental Services in Australia*, Submission no. 021, dated 15/03/2013, p.6; Chalmers et al. op. cit.; Fallon et al., op. cit.

better funding for affordable access to dentist services for seniors and younger people with disabilities so they can access the professional care needed before and after they access aged care, to prevent deterioration of their oral and dental health as they age.

It is important that people approaching retirement age have affordable timely access to regular dental check-ups and treatment well into in their senior years, to prevent or reduce the severity of dental conditions like periodontal disease, and to ensure that restorations, dentures or other dental work are maintained, repaired or replaced if need be, prior to any significant age-related deterioration in mobility, physical health, or cognitive/communicative capacities.

Affordability of professional preventive care and treatment for older Australians

One of most important predictors of the state of oral health of older people when they first seek access to aged care services, and the extent of preventable hospitalisations of older Australians directly or indirectly related to poor oral health, is how regularly they have visited a dentist for check-ups and received any required dental treatment in preceding years.

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.³⁷

Consumer organisations report that lack of access to affordable dental treatment is a rising source of distress and concern amongst Australia’s elderly population, particularly those reliant on pension incomes. Even those with private health insurance may forgo treatment because all but the most expensive policies covering dental treatment exclude an increasing number of commonly required dental treatment items, and/or offer paltry rebates on included treatment items that do little to reduce out of pocket costs.³⁸

A recent poll³⁹ of over 225,000 older Australians aged 65+ found that many were no longer able to afford private health insurance. Almost half (48%) did not have private health insurance, and less than half (47%) with private health cover have “general treatment” (“extras”) cover that includes any cover for dental treatment. Furthermore, only 10% of those with private health insurance had the top level of dental cover provided by their fund as part of their policy.

Although over 60% of Australians become eligible for treatment through state-run public dental services once they access the aged or disability pension, the reality is that long waiting lists for anything but emergency dental

³⁷ Lewis et al., op. cit. p. 97.

³⁸ 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

³⁹ <https://www.yourlifechoices.com.au/news/poll-we-want-denticare>

treatment through the public system reportedly leave many aged pensioners suffering “immense pain and diminished quality of life” for significant periods of time.⁴⁰

Further, distance from public treatment clinics/hospitals, and/or “dissatisfaction with the standards or choice available” mean that many older Australians miss out on timely treatment.⁴¹ COTA SA⁴² points out that in South Australia, where publicly funded dental services are subsidised, but not free to adult concession card holders, many people (including older people) reliant on Newstart or very low incomes from paid work prior to aged pension age simply cannot afford to seek even public dental treatment. As a result, dental conditions are the highest cause of preventable hospitalisations in South Australia.

Financial concerns around the likely costs of treatment have also been identified as a significant barrier affecting the access of aged care residents to necessary dental treatment, once a need for it has been identified. Residential aged care staff report that residents and their guardians or families often refuse to seek treatment, on the grounds of cost alone, or a perception that the costs outweigh the benefits of dental treatment for older people in their last few years of life.⁴³ However, if some of the recommendations included in this submission can be put in place, then the need for extensive treatment at this age can be avoided.

The ADA’s Australian Dental Health Plan and Aged Pensioners Dental Benefit Scheme

In the ADA’s 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 2015–24.⁴⁴

The ADA’s Australian Dental Health Plan (ADHP) developed in 2016, attached at Appendix B to this submission, addresses these needs. It calls 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 suggests 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.

For example, it is envisaged that the key features of a Pensioner/Elderly Dental Benefits Schedule (PEDBS) would include:

⁴⁰ Ibid, p. 9.

⁴¹ Smith, W. and Hetherington, D. (2016). *The adequacy of the aged pension in Australia*, The Benevolent Society, The Longevity Innovation Hub & Per Capital Australia Ltd.

⁴² https://www.cotasa.org.au/lib/pdf/submissions/COTA_SA_submission_to_SAOHP.pdf

⁴³ Chalmers et al., op. cit.; Fallon et al., op. cit.; Hilton et al., op. cit.

⁴⁴ COAG Health Council. (2004). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2005-2014*, and COAG Health Council. (2015), op. cit.

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

National Seniors,⁴⁵ COTA⁴⁶ and other peak organisations representing older Australians have all recently reaffirmed their view that a scheme along of the lines of that advocated by the ADA in the ADHP is critical to help older Australians on lower incomes afford the basic dental care they need to avoid pain and infection, difficulty eating, social embarrassment, and the deterioration in general health or exacerbation of chronic health conditions associated with untreated oral and dental disease.

The PEDBS would significantly ease affordability barriers to private dental care experienced by older people early in their senior years, by financially disadvantaged residents of aged care facilities and by older people accessing home care packages. By supporting access to private dentists for the purposes of oral health assessments and care planning on admission to residential aged care or a home care package, the PEDBS 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 aged consumers. Furthermore, it will help to ensure

⁴⁵ <https://nationalseniors.com.au/advocacy/current/federal-election-2019>

⁴⁶ <https://www.agedcareguide.com.au/talking-aged-care/aged-care-peak-bodies-respond-to-stop-gap-federal-budget>

that older people can maintain reasonable levels of oral health before they are admitted to aged care facilities or approved for high-needs home care packages.

Rural general medical practitioners, who practice in small rural and remote towns with no resident full-time dentist, that are unaffordable distances from public treatment clinics and do not receive regular visits from public dental services, have also suggested the need for regular visits from a dentist who could treat both public and private patients. Under a scheme like the ADA's proposed PEDBS, attending a visiting private dental service would be more affordable for low-income residents in these communities, and would make it more economically viable for private dentists to provide regular services to these areas.

Funding affordable access to timely early diagnosis and treatment of disease and decay along with regular preventive oral health care will 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 \$1 billion per annum.

Given that it is poor oral health amongst the most disadvantaged older people that generates the vast bulk of these public costs, the indirect savings that would flow from implementation of a dental benefits schedule for older people 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.

Recommendation 1:

That as a matter of urgency, the Federal Government implement a Pensioner/Elderly Dental Benefits Schedule along the lines of the current Child Dental Benefits Schedule, as outlined in the ADA's Australian Dental Health Plan.

Assessment and care planning

The ADA believes that early detection of potential oral health problems by GP's through Medicare-funded health assessments and by ACAT/RAS teams, who are required to ask applicants for residential/home care about any oral health or swallowing problems they are having, is critically important. These assessment events can then trigger referrals that prompt older people to seek dental check-ups and to consent to any dental treatment they need, particularly if affordability and accessibility barriers are removed by the implementation of the Pensioner/Elderly Dental Benefits Schedule recommended by the ADA.

The ADA also believes that residential aged care applicants and applicants for higher need (Level 3 and 4) Home Care Packages should be examined by a dentist (preferably their regular dentist, if they have one) on admission to these programs, unless they have had such an examination within the previous six months and been deemed dentally fit. To support continuity of care, the dentist who provides, or has recently provided this examination, should also be invited to assist the aged care service in developing an oral and dental care plan for the older person.

For aged care recipients who do not have a regular dentist who will continue their care, aged care providers should take steps to build referral pathways with local public dental services and private practitioners who can contribute to care planning for the aged care recipient, and provide ongoing professional dental care and treatment as required.

Medicare-funded health assessments by GPs

General medical practitioner (GPs) are often the first point of contact for individuals who have a health problem. Therefore, GPs are in an ideal position to be early identifiers of oral health problems which could, if not addressed, lead to patients needing complex and costly dental treatment down the track or worse, admission to hospital for a condition that if caught and managed early might have been preventable.

Several Medical Benefits Schedule (MBS) items are designed to reimburse a medical practitioner to undertake a health assessment of target groups within the Australian community. These Item numbers include MBS 701, 703, 705 and 707 (time-based Health Assessments that can be provided to a range of patient categories including people with intellectual disabilities, people aged 75 years and older; and permanent residents of residential aged care facilities) and MBS Item 715, a Health assessment for Aboriginal and Torres Strait Islander peoples of various ages.

Notably, MBS Schedule guidance lists examination of oral and dental health as a mandatory component of health assessments for patients with intellectual disabilities, and Aboriginal and Torres Strait Islanders under (but not over) the age of 55 – the age at which this group become eligible for aged care services. However, there is no mention of any mandatory (or even optional) requirement to assess the oral or dental health of patients aged 75 and older, or residential aged care applicants/residents.

In other words, the MBS essentially tells GP's that assessment of the oral and dental health of anyone (other than people with intellectual disabilities) who may be in receipt of age care, or at an age where they may be eligible and interested in applying for it, is not their responsibility.

The ADA believes that where possible, a dentist should undertake a comprehensive dental examination to complement a GP's comprehensive medical assessment on entry to residential aged care. Nevertheless, some residential aged care facilities and rural/remote home care providers are located in areas that have access to a GP, but no local dental services, and infrequent access, if any, to visiting dental services. These communities, in particular, may benefit from a change to the MBS to include oral and dental health as reportable parts of GP health assessments for Aboriginal and Torres Strait Islander patients over 55, other patients 75 and over, and patients entering or residing in residential aged care facilities.

GPs working in such towns – those where there may be a pharmacy but no local dental clinics and limited access to visiting dental services – often serve communities with significant oral health problems, and patients who present with acute or chronic dental infections resulting from unmet needs for dental treatment. Many such

GPs express interest in accessing training to give them practical skills to deal with dental emergencies and provide oral health screening and education during regular interactions with their patients.⁴⁷

In recognition of this need, and its experience in producing high quality online audio-visual training resources, the ADA's current Strategic Plan includes plans to develop educational and training resources to support GPs who undertake oral and dental health assessments or serve aged care recipients who have no regular local access to dentists.

Recommendation 2:

That assessment of oral health and dentition be included as a specific, mandatory and reportable component of MBS-funded GP Health Assessments for Australians aged 75 and over and current/prospective residents of aged care facilities, and that GP's refer patients who have potential oral/dental health problems or who have not visited a dentist within the last year to a dentist for a comprehensive oral examination.

ACAT/RAS Assessments

Aged Care Assessment Team (ACAT) assessments for entry into residential aged care, and Regional Assessment Service assessments for entry aged home care programs both use a National Assessment Screening Form that includes mandatory sections on potential problems with oral health and swallowing. These assessments provide additional opportunities to screen for oral health issues and ensure that clients with oral health problems, or those who have not had a dental check-up in the previous year, are referred to a dentist.

However, the oral health questions on the form should be couched in more direct language to better detect any potential oral health problems, and whether the client has had a comprehensive dental examination within the last six months. If not, or if any oral health or swallowing problems are disclosed, the clients should be referred to a dentist.

Recommendation 3

That the National Assessment Screening Form's section on Oral Health include direct questions on oral health and recent dental visiting patterns that lead to timely referrals for older adults to receive oral health care.

Examination and care planning by a dentist on entry to residential aged care or Level 3/4 home care packages

Given evidence that the oral and dental health of older people tends to decline rapidly in the year prior to entering residential aged care,⁴⁸ the ADA is also of the view that on admission, new residents of residential care

⁴⁷ Barnett et al. (2016). "Sorry, I'm not a dentist" Perspectives of rural GPs on oral health in the bush', Medical Journal of Australia, 204(1), <https://www.mja.com.au/journal/2016/204/1/sorry-im-not-dentist-perspectives-rural-gps-oral-health-bush>

⁴⁸ Lewis et al, op. cit.

facilities should be examined by a dentist before admission, and regularly thereafter, in order that the development and ongoing revision of care and services plans for each resident [or their guardian] is informed by the expertise of registered dental practitioners.

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 professionals in resident care planning is central to improving and maintaining the oral health of such residents.⁴⁹

Many frail older people with diminished capacity to clean their teeth who once would have gone straight into residential care are now requesting and receiving care in the form of Level 3 or 4 home care packages instead. Given this, the ADA believes that a dentist examination and input from a dentist should also inform care planning when clients first access Level 3 or 4 home care funding, i.e. should be part of the ACAT assessment

In a “consumer-directed” care system, it is important that the choices and preferences of aged care consumers (and their families) once admitted to residential aged care, or when deciding on the services they want to be delivered via their home care funding package, are informed by expert clinical advice and information. Examining dentists can inform patients, and their families, guardians or carers who attend with them about daily oral hygiene routines and toothbrushes, other preventive treatments that can prevent or reduce the need for expensive remedial treatment interventions, and about the adverse impacts that failure to detect and treat dental and oral health problems can have on general health or specific health conditions already experienced by the individual consumer.

Recommendation 4:

That a dentist examines aged care recipients on entry to Level 3 or 4 Home Care packages, and/or residential aged care, and participates in residents’ oral care planning.

Workforce issues: An adequate number and mix of appropriately qualified and trained staff

The ADA notes the widespread concern articulated by the National Aged Care Alliance (NACA), the *Senate Committee Aged Care Workforce Report*, and the *Tune Report* that unless pay, contract terms, working conditions, workloads, skills development opportunities, and day-to-day training and support offered by residential aged care providers and management are improved to match those offered in other health care settings (e.g. acute care), or by other employers (e.g. public sector positions, or disability services providers) the aged care sector will have great difficulty attracting and retaining workers in these categories.

Education and training

Numerous studies have shown that where aged care staff are given education, explicit expected standards of care, practical training, assessment tools and tips to guide practice, along with management buy-in to support

⁴⁹ Thorne et al. cited in Chalmers et al., op. cit., p.2.

cultural change and embed good practice, the quality of oral and dental care they provide to aged people can be significantly improved.⁵⁰

With respect to education and training, the ADA believes that all aged care staff who supervise or provide personal care should receive education and skills training in the provision of oral hygiene maintenance, and simple dental screening to monitor oral health status and trigger dental referrals when needed.

In particular, the aged care workforce involved in direct care, need greater knowledge and skills in how to manage the provision of routine preventive oral hygiene care to aged consumers with more complex needs, including those with *dementia, other cognitive or communication-related disabilities, or other complex medical conditions*. Such patients may be unable to open their mouths easily; exhibit care-resistant or aggressive behaviour; may be unable to communicate any pain or discomfort they feel or where it is located or to articulate what they need to feel less agitated or upset.

Currently, there is no requirement for direct care staff to have any qualifications; many do have Certificate III qualifications, but this is not mandatory, and these programs do not fully equip their graduates to provide oral hygiene care in aged care environments. Furthermore, given the high turnover of care staff, training courses that may be run intermittently by aged care providers are not adequate to meet the training needs of direct care staff.

The ADA believes that it should be mandatory for personal/home care workers employed by RACFs or home care providers to have, as a minimum, a Certificate III in Aged Care qualification and that courses leading to this qualification include education the provision of oral hygiene care for patients with dementia, disabilities and other complex health conditions, as mentioned above. Likewise, the ADA suggests that the oral health content of entry-level nursing courses, which is far from comprehensive, should be boosted to include education in relation to assessing and providing for the oral health care needs of aged care consumers.

The ADA also notes that learning and teaching resources developed under the government-funded *Better Oral Health in Residential Care and Home Care* projects⁵¹ have been validated as effective teaching and learning resources, and that recent research suggests that they could be easily incorporated into existing entry-level nursing and relevant Certificate III courses.⁵²

Alternatively, a wide range of other oral health education and training resources designed for aged care staff, informal carers and families, and older people themselves have been developed over the years, and these should be better utilised, both in formal education programs, and by aged care providers, in the context of ongoing training for staff and oral health promotion to clients.⁵³

⁵⁰ Chalmers et. al., op. cit.; Fallon, T. et al. (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.

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<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/oral+health+care+for+older+people/better+oral+health+for+education+providers>

⁵² Lewis, A. et al. (2018). "Evaluating students learning outcomes in oral health knowledge and skills", *Journal of Clinical Nursing*, 27 (11-12), pp. 2438-2449.

⁵³ see a consolidated list at Appendix A of Health NSW's *Oral health for older people toolkit*, at <https://www.health.nsw.gov.au/oralhealth/Publications/oral-health-older-people-toolkit.pdf>

Staffing numbers and staffing mix

It has been argued that the Australian Government's investment in the *Better Oral Health in Residential Care Program* in 2010 had relatively little long-term impact on the oral health status of residents, despite the high quality of the educational material provided. In particular, feedback from aged care staff was that lack of support from management to implement the changes in practice at workplace level and to "change workplace culture" were key factors that limited the effectiveness of the program.⁵⁴

Rostering adequate care staff was a crucial aspect of the cultural change required. Staff/resident ratios did not allow building relationships of trust and to follow best-practice techniques. More time per resident was needed to overcome barriers and provide a better oral hygiene care service for the residents.⁵⁵

In this regard, the ADA shares the view of the Australian Medical Association (AMA), the Australian Nursing and Midwifery Federation (ANMF) and many other peak organisations that it is particularly important to require that aged care services provide the right number and mix of staffing to ensure that the care needs of aged care recipients with varying levels of functional dependency can be catered for. The ANMF's recent work to develop an evidence-based, needs-based model for calculating how many and what kind of staff are needed by providers has the twin virtues that it builds in appropriate adjustments for the fact that different aged care providers cater to clients with different levels of assessed need ("care complexity"), and puts quality and safety of care front and centre, is a major step in the right direction. The ADA believes that the Commission should recommend a similar approach.

However, it is also important to note that both the Senate Community Affairs Committee's *Future of Australia's Aged Care Sector Workforce* report and the *Tune Report* identify a need for aged care providers to better utilise and integrate existing medical, dental, and allied health expertise and resources into the aged care workforce, though not necessarily through direct employment relationships.

The ADA supports the view that to boost the quality of clinical and oral health care, aged care providers should see their clinical care workforce as clinical care teams including both employed staff, and flexible collaborative partnerships with independent private dental practices and public practitioners working within their own clinics, in the aged person's home, or on-site at RACFs in suitably equipped examination and treatment facilities.

The ADA also believes that all providers of residential aged care and/or Level 3 or 4 home care packages should ensure that every client has a referral pathway for dental care identified for them when they first access the service. For those who do not have a regular dentist who will continue to treat them while they are accessing aged care services, this should be the name of another registered private dentist or local public dental service willing to treat clients of the provider/facility.

Two recent NSW examples of innovative, dental team-based approaches to provision of better oral and dental care for aged care recipients that have received support from the ADA, individual ADA members and the ADHF

⁵⁴Australian and New Zealand Academy of Special Needs Dentistry & Aust. Society for Special Care in Dentistry. (2013). *Submission to the House of Representatives Inquiry into Adult Dental Services in Australia*, submission no. 021, dated 15/03/2013, p.6.

⁵⁵ Chalmers et al., op. cit.; Fallon et al., op. cit.

are Concord Repatriation General Hospital's *Reach-OHT* program,⁵⁶ and the Senior Smiles program,⁵⁷ information on which has already been provided to the Commission.⁵⁸ These programs help to ensure that aged care clients have access to professional assessment, diagnostic and treatment services, as well as regular preventive care from professionally trained oral health practitioners who also function as champions for oral health, through on-site provision of oral health care education to aged care clients and their families, and aged care staff.

Additional education for health professionals in geriatric, dementia and disability care

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, 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.

With respect to the capabilities of the registered dental practitioner workforce, the ADA notes there is currently no requirement to include gerodontology as a stand-alone subject in undergraduate courses, and although coverage of issues in geriatric dentistry varies between dental schools, it is mostly very limited. Clinical exposure to older patients and residential aged care facilities through undergraduate dentistry courses also varies between dental schools.⁵⁹

Further, there is no accredited program for specialisation in geriatric dentistry in Australia. The subject is incorporated into programs leading to qualifications as a Doctor of Clinical Dentistry in Special Care Dentistry or Special Needs Dentistry, a specialisation which also includes care of patients with disabilities and complex comorbidities. There are very few dentists registered as specialists in Special Needs dentistry in Australia. Mechanisms should be put in place to encourage an increase in enrolment in specialist training in this area.

The ADA has long advocated for dental schools to provide more education on the oral and dental care of older Australians through undergraduate and postgraduate programs, and in the meantime, is doing its part to meet future skills demands by offering an expanding suite of continuing professional development courses in geriatric dentistry, covering the full spectrum of relevant issues.

⁵⁶ Wright C, Law G, & Chu S et al. (2017). 'Residential age care and domiciliary oral health services: Reach-OHT- The development of a metropolitan oral health programme in Sydney, Australia', *Gerodontology*, 34(4), pp.420-426.

<http://onlinelibrary.wiley.com/doi/10.1111/ger.12282/full>

⁵⁷ Wallace J.P. et al. (2016). 'Senior smiles: preliminary results for a new model of health care utilizing the dental hygienist in residential aged care facilities', *International Journal of Dental Hygiene* 14(4), pp. 284–288.

<http://onlinelibrary.wiley.com/doi/10.1111/idh.12187/abstract>

⁵⁸[http://www.adansw.com.au/getattachment/e618bbcd-16f4-44ff-b99e-0d93adf76289/Model-Scopes-of-Clinical-Practice-Discussion-P-\(2\).aspx](http://www.adansw.com.au/getattachment/e618bbcd-16f4-44ff-b99e-0d93adf76289/Model-Scopes-of-Clinical-Practice-Discussion-P-(2).aspx)

⁵⁹ Nilsson et al. (2019). 'A call to greater inclusion of gerodontology in the dental curriculum: A narrative review', *Australian Dental Journal*, 64(1), pp. 82-89.

Recommendation 5:

That as recommended by the Australian Nursing and Midwifery Federation, and the Australian Medical Association, the Federal Government require that each aged care provider adheres to minimum staff-to-resident and staffing mix ratios. These ratios should be calculated on the basis of an evidence-based, needs-based model of the time and skills required to provide safe, high quality care to clients assessed as having different levels of need, and the aggregate needs or “care complexity” profile of each aged care providers’ client base.

Recommendation 6:

That all Personal/Home Care Workers employed by aged care providers be required to have Certificate III Aged Care qualifications, and that the curriculum of these courses be expanded to incorporate education and training in provision of routine preventive oral hygiene care to clients with more complex needs, including those with dementia, other cognitive or communication related disabilities, or other complex medical conditions.

Recommendation 7:

That the oral health content of entry-level nursing qualifications and Certificate III aged care courses is strengthened, possibly by incorporating some of the excellent teaching and learning resources already developed in Australia, such as resource packages created for the Better Oral Health in Home Care and Residential Care programs.

Recommendation 8:

That all new permanent residents of aged care facilities and new clients of Level 3 or 4 home aged care packages have a referral pathway to a dentist or dental service placed on record for them by their aged care provider.

Recommendation 9:

Mechanisms should be put in place to encourage increased enrolment in courses that include specialist training in special needs or geriatric dentistry.

Better access to professional dental care in domiciliary, rural/remote and hospital settings

The ADA recognises that rapid expansion of an increasingly dentate aged population receiving care in residential facilities, in their home, and in rural and remote communities where it is not sustainable to have a

dental clinic, will increase the need for dental practitioners to provide treatment in locations outside a dental clinic.

As the Commission has already heard in evidence provided by representatives of the Australian Medical Association and Royal Australian College of Practitioners,⁶⁰ lack of full facilities available when providing treatment outside a dental clinic, along with a range of other issues worsened by inadequate qualified staffing in residential aged care facilities can compromise the provision of care, so dental practitioners strongly prefer to provide treatment in their clinics where possible.

For many older people accessing lower level home care packages whose health and mobility are relatively good, attending dental appointments presents less of an issue, as funding available under those packages can be used to pay home care staff to transport them to attend such appointments.

However, aged care staff often report that a lack of suitable and affordable transport services pose significant barriers to aged care residents who would otherwise be willing to seek treatment within private dental clinics. Governments should provide funding support for travel to ensure that such services are readily available to aged care consumers who are able and willing to travel to receive treatment in the normal dental clinic setting.

This is important because even if RACFS had onsite dental clinics, the time lost in travelling to and from satellite facilities and the logistical barriers that arise because the onsite facilities for dental care tend not to have well-equipped dental surgeries on the premises create an additional burden to the provision of this care.

In line with the COAG Health Council's recommendations in *Australia's National Oral Health Plan 2015-24*, residential aged care facilities should plan for an increased demand for dental care from residents unable or unwilling to travel, by providing designated treatment rooms for provision of medical and dental care that meet minimum requirements for safe delivery of care and infection control (e.g. sink with running water, no carpets, meet infection control requirements and so on). Larger aged care facilities should ideally establish dedicated dental surgeries, and government should provide any necessary funding assistance to meet establishment costs.

Government should also provide funding support to private dental practitioners to cover any significant travel costs that may be associated with the provision of dental treatment in RACFs.

The ADA is aware that the number of private domiciliary dental services, which in some cases are supported by mobile anaesthetist teams, has steadily expanded in recent years to meet burgeoning demand. Some public dental services are also providing domiciliary care.

In recognition of the need to support the oral health needs of older and Indigenous Australians in regional, rural and remote areas who have no local dentist service, the Australian Dental Health Foundation has also provided grants to support a number of mobile dental services and mobile denture clinic projects servicing older people, aged care residents and Indigenous communities in regional, rural and remote areas.

It remains, however, that GP's living in rural and remote areas with no local dental service report either that their area receives no visiting dental service, or receives such a service only infrequently, which leaves patients who cannot afford transport to larger towns or dental hospitals at risk of chronic infection and the more serious complications of untreated oral disease. Eligibility for the Patient Assisted Travel Scheme (PATS) should be

⁶⁰ Royal Commission into Aged Care Quality and Safety. (2019). *Public Hearing Transcripts*, 18 February and 20 February 2019.

extended to help such patients meet any necessary costs of travel to obtain urgently required basic dental treatment.

To meet the needs of aged care consumers in rural and remote areas who are unable to travel, government funding support with establishment or travel costs may be required to increase the supply of mobile dental clinic services.

Government action to ensure affordable and timely access to dental treatment under general anaesthesia in hospitals or accredited day facilities is also urgently required to meet the dental treatment needs of aged care consumers who can only be safely treated in these settings. This issue, and the range of government action required to ensure adequate and affordable access to this treatment modality, is discussed in detail in the ADA's 2018–19 Pre-Budget Submission and its 2018 Submission to the *Independent Hospital Pricing Authority*.⁶¹

Recommendation 10:

That in line with the COAG Health Council's recommendations in Australia's National Oral Health Plan 2015-24, residential aged care facilities provide designated areas for dental treatment.

Recommendation 11:

That larger aged care facilities be required to provide dedicated dental surgeries on-site, and that where necessary, the Federal Government provides funding support to such facilities help with associated establishment costs.

Recommendation 12:

That the Federal Government provide funding support to private dental practitioners to cover any significant travel costs that may be associated with the provision of dental treatment in RACFs or visiting services to under-served rural and remote communities.

Recommendation 13:

That eligibility for the Patient Assisted Travel Scheme (PATS) be extended to cover the costs of public transport to the nearest dental service for patients who urgently require basic dental treatment to prevent complications from untreated oral disease.

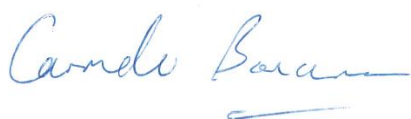
⁶¹<https://www.ada.org.au/News-Media/News-and-Release/Submissions/2018-19-Federal-Pre-Budget-Submission>;<https://www.ada.org.au/News-Media/News-and-Release/Submissions/Australian-Refined-Diagnosis-Related-Groups-Classi>

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.⁶² The recommendations contained in this submission represent long-overdue steps towards the full realisation of these rights for older Australians, 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 appear at a public hearing of the Royal Commission in order to provide further evidence or clarification on any of the points made in this submission. Please do not hesitate to contact the ADA Chief Executive Officer, Mr Damian Mitsch at ceo@ada.org.au on 02 8815 3333 should you have any questions.



Dr Carmelo Bonanno
Federal President
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⁶² <https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Charter-PDF.pdf>;

Appendix 1: Older Australians' oral health: recent ADA activities

Recent examples of the ADA's advocacy, member education, and philanthropic activities supporting better access to affordable, high-quality oral and dental health care for older Australians, particularly those with dementia, those on low-incomes and those living in rural and remote areas include the following:

- **Submissions to Federal Department of Health consultations during 2017-2019 on aged care reform**, including consultations on the *Single Aged Care Quality Standard Framework*, a proposal to establish *Specialist Dementia Care Units*, and the deliberations of the *Aged Care Workforce Strategy Taskforce*;
- **Submissions to consultations** by the *Independent Hospital Pricing Authority*, *Federal Treasury*, the *ACCC*, various *Parliamentary Committees* and a range of **other regulatory bodies on policy matters that directly affect the affordability and accessibility of oral and dental health care for disadvantaged groups, including older Australians** for example:
 - unacceptably high waiting lists for public dental care,
 - the rising cost and diminishing value of private health insurance,
 - the case for Medicare funding of a scheme like the Child Dental Benefits Scheme for Aged Pensioners and other priority groups identified in *Australia's National Oral Health Plan 2015-24*; and
 - declining access to timely and affordable access to dental treatment under General Anaesthesia in hospitals/day surgeries for patients with special needs, disabilities, or complex medical conditions to whom the required treatment cannot be safely delivered under lighter sedation in normal dental practice settings.
- **Development of a wide range of online continuing professional education resources** and videos for dentists that provide information, tips, tools, and practical demonstration of best practice approaches and techniques **for provision of minimally invasive, patient-centred oral and dental care for older patients, including a 10-part series on care of patients with dementia, funded by Alzheimer's Australia**;
- **Establishment of an ADA Rural Dentist Network**, which has membership on the National Rural Oral Health Alliance (NRHA), and active engagement with the National Aged Care Alliance (NACA);
- **Philanthropic support for better access to oral health care for disadvantaged older Australians, particularly Indigenous communities in regional, rural and remote areas** through the Australian Dental Health Foundation (ADHF). The ADHF supports community service grants, scholarship funding for Indigenous dental students and other students from rural/remote areas, and provision of pro bono dental services by ADA members to disadvantaged individuals and communities. Recent community service grants have funded several mobile/outreach services designed to provide accessible oral and dental health care services to aged care recipients and Indigenous communities in regional, rural and remote areas. These have included the *Denture Technology Project*, a mobile denture service, and the *Senior Smiles Dental Outreach Program*, a mobile dental clinic serving aged care facility residents in rural and remote areas of South Australia