07 February 2011

Inquiry into Caring for Older Australians
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Sir/Madam

On 21 January 2011 the Minister for Mental Health and Ageing, the Hon Mark Butler, issued a media release from the Productivity Commission Draft Report on Aged Care. Minister Butler welcomed the release of the Productivity Commission's draft report 'Caring for Older Australians' which he hopes will provide the Federal Government with key advice on the direction of aged care in Australia. I wish to accept Minister Butler's invitation "... to all those interested in aged care reform to make submissions to the Productivity Commission".

I have been involved in Public Health dentistry since being appointed to Sydney's St Vincent's Hospital in 1977 as a Visiting Dental Officer. Back then we still had tobacco advertising, HIV infection had not raised its head, compliance costs for infection control and occupational health and safety were negligible and health costs were not causing the significant angst amongst politicians as they are now. The average age of entry into a residential aged care facility (RACF) was at least 10 years less than it is now. 80 was very old and those who got to this venerable age often just needed their false teeth adjusted or fixed as their only need for accessing dental care.

What a difference we now have in Australia within a relatively short period of time. The average age of admission to a RACF is now closer to 83 with many of today's new residents having several natural teeth present. Whether this is as a result of fluoridated water, better nutrition or a greater understanding of the benefits of looking after our teeth and gums or just better dentistry doesn't seem to matter much when you enter a RACF. By this stage there are numerous health issues, countless medications being taken, cognitive and fine motor deficits, all of which contribute to the inability of many residents to properly look after their teeth and gums.

Our public health system offers Australians some of the most advanced medical procedures, drug treatments and preventative strategies in the Western World. Unfortunately for the new generation of older Australians, having teeth when you are over 80 can leave you in the invidious position of not being able to access dental care either due to financial constraints, lengthy waiting times in the public sector, cognitive impairment, limited mobility or logistical difficulties in getting to appointments. Dentists can find elderly patients challenging to manage as they often have complex medical histories, are difficult to communicate with and can be poor medical historians. They will often take considerable time getting in and out of the dental chair and surgery and are often late as they wait for public transport or are reliant on others to get them

to their appointments. Time consuming consultations with the family, carers and the family doctor can be needed before commencing even minor treatment. As the elderly often tolerate short appointments only optimum treatment may be relegated to patching up or repairing teeth. Health, age and cost tend to dictate treatment decisions.

To many residents themselves, their family, carers and RACF personnel, dental issues are often not a priority. Toileting, getting the resident out of bed, caring for the feet, getting to meals on time, preventing falls, adequate hydration – these are the pressing and time consuming activities that nursing staff feel they need to attend to first. Oral and dental health too many is not a priority. You might rightly ask does it really matter. “My mother is 91. She has lived a good life, why burden her with dental treatment?”

The answer to this is an unequivocal, "You’re right you shouldn’t have to.''
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The problem we have is that the current older members of our community have placed a much higher value on good health than in previous generations, including oral and dental health. Many nursing home residents will have had good regular dental care and in many instances complex dental procedures carried out. Unfortunately salivary glands either cease to function properly or are greatly affected by medications, health issues and ageing itself. Saliva lubricates the mouth, assists with the swallowing of food and produces enzymes which protect the teeth against tooth decay. Without saliva, teeth which have hitherto been looked after may now start to decay rapidly. When you then add the uncontrolled consumption of sweets, biscuits and sugar that occurs even in the better nursing homes coupled with the resident’s reduced motivation to look after themselves and the progressive cognitive and fine motor deficits many elderly develop in later life, it's not hard to understand why the teeth and gums can deteriorate rapidly.

Oral pain and discomfort can be devastating, compounding psychosocial problems, disrupting family dynamics and frustrate nursing home staff. As appearance, function and comfort suffers so may the person's self esteem and confidence.

Link Between Teeth and Morbidity

There are several published reports which concluded that the fewer teeth one has at the age of 70 the higher the morbidity associated with a range of systemic medical conditions and the likelihood of earlier death than for someone with most of their teeth. In 2011 these conclusions may now no longer be valid. For many elderly having teeth may in fact cause greater harm than being edentulous as accessing and maintaining good oral and dental care is beyond their ability and that of the RACF to access.

Ventilator Associated Pneumonia (VAP)

In Washington DC a 337-bed regional medical centre has been performing oral care on patients to decrease risk factors for ventilator-associated pneumonia (VAP), a common hospital acquired infection. The initiative aimed to save

100,000 patient lives by introducing six changes in hospital procedures. Each change addressed a problem, such as preventing the incidence of VAP. The hospital sought to lower VAP and central-line infection rates because of their impact on mortality, morbidity and hospital costs.

As there is a close correlation between VAP and aspirational pneumonia in the elderly understanding VAP is important in this discussion.

VAP Summary

- Pneumonia is the leading cause of death from nosocomial infections
- Aspiration of pathogenic oral microorganisms is a risk factor for the ventilator assisted patient in Intensive Care
- VAP is the most common infectious complication among ICU patients, accounting for up to 47% of all infections
- Several studies support the provision of oral care for the ventilator assisted patient as a means of improving nursing care, well-being, morbidity, mortality, and reducing health care costs
- A 9,080 US patient study found that the average VAP patient spends 9.6 additional days on mechanical ventilation, 6.1 extra days in ICU and 11.5 more days in hospital
- VAP patients incurred an average of US$48,948 of additional hospital costs compared to uninfected patients
- In 17 months, one US hospital reduced VAP by over 75% and saved US$1.6million
- Studies have shown that improving cleanliness of the oral cavity by tooth brushing and oral lavage in ICU can reduce the incidence of VAP

Relationship Between VAP and Oral Health in the Elderly

- Pneumonia is the leading cause of death amongst the elderly and people who are chronically and terminally ill
- Aspiration of pathogenic oral microorganisms is a risk factor for the elderly
- Several studies support the provision of oral health for the elderly as a strategy for reducing the incidence of pneumonia
- Removal of dental plaque and general debridement of oral microorganisms, together with regular dental reviews, maintenance and oral health education of nursing home staff, family members and carers will lessen the incidence and provide other health benefits

1997 Senate Community Inquiry into Public Dental Services

In 1997 I submitted a lengthy submission to the Commonwealth Government Senate Community Affairs References Committee Inquiry into Public Dental Services. Much of what I submitted and was questioned on at the public hearings appeared in the final report and can be found in Hansard.

The following is a section of my submission on Aged Care.

> "There is a lifetime association between oral health, nutrition and disease. An interdisciplinary, co-ordinated approach between dentists, other health care providers and dieticians is essential for the elderly and disabled. Poor oral health is linked to weight loss and a greater dependence on more medications (including laxatives and antireflux agents) for a greater frequency of gastrointestinal disorders. The links between oral health and nutrition can be demonstrated. Infectious diseases of the mouth as well as oral manifestations of systemic diseases affect diet and nutrition but on the other hand good diet and nutrition may limit the progression of diseases of the oral cavity.
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> Oral health care has not been seen as a priority nor has it been fully appreciated by the medical profession and government. Many doctors have a limited working knowledge of oral and dental anatomy and the close relationship between oral health and general health. As we near the year 2000 many of our 'baby boomers' will be approaching retirement age. Some will be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns and bridges, unlike the average 50-60 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the needs of the most disadvantaged members of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled."

Report

http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1996-99/dental/report/c02.htm

Inquiry into Dental Services in NSW

In 2005 the NSW Parliament Standing Committee on Social Issues held an inquiry into dental services in New South Wales. The terms of reference included:

(a) the quality of care received in dental services,

(b) the demand for dental services including issues relating to waiting times for treatment in public services,

(c) the funding and availability of dental services, including the impact of private health insurance,

(d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,

(e) the dental services workforce including issues relating to the training of dental clinicians and specialists,

(f) preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and

(g) any other relevant matter.

The following is a section on Aged Care from my submission to that Inquiry. Sadly little had changed since my submission to the 1997 Senate Inquiry, if anything the oral health of our elderly population is far worse.

> The importance of oral health care needs to be acknowledged and seen as a priority by the medical profession and government. Many doctors have a limited knowledge of oral and dental anatomy and the close relationship between oral health and general health. We now see many of our 'baby boomers' retiring. Some will shortly be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns, bridges and implants, unlike the average 60-70 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the needs of the most dentally vulnerable members of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled.

Australia's First Dental Plan for Nursing Homes

In early December 2008 a senior dentistry lecturer at the University of Western Australia, Dr Clive Rogers, stated that "..neglect of dental care in nursing homes amounts to abuse". Dr Rogers when interviewed by the ABC's Lateline programme stated that "…nursing homes are passing accreditation tests even when their residents' mouths and teeth are so ravaged they risk serious illness or premature death." Dr Rogers put together a library of photos to show the extent of the problem and has also conducted his own national survey of 18

visiting dentists, who all have experienced working in nursing homes across all states and territories.

I would strongly encourage the Commission to view Dr Roger's interview

http://www.abc.net.au/lateline/content/2008/s2438332.htm

On December 5 2008 Julia Gillard, then Deputy Prime Minister, stated that "…the Government will make sure that reports of dental health neglect in nursing homes are investigated."

On March 1 2009 the then Minister for Ageing, the Honourable Justine Elliott MP, in response to the revelations exposed on the ABC in December 2008 trumpeted '**Australia's First Dental Plan for Nursing Homes'.** The Federal Government had allocated $3M to improved dental health in Nursing Homes. In Minister Elliott's words "…under the plan a staff member from all 2830 aged care homes will be trained in dental hygiene by next year (2010)." Simple math shows that this "plan" entailed no more than $1060 of education and training resources being made available for each nursing home. This generally allowed one designated person from a RACF to attending a training programme. With the high turnover of aged care staff some nursing homes have now lost those who received the limited training that was on offer.

At least the link between aged care and oral health was acknowledged; however, this plan offered no meaningful way forward.

Oral Health Assessment Tool (OHAT)

OHAT assessments are supposed to be carried out for all residents of RACFs in Australia following the Commonwealth Government funded 'Better Oral Health in Residential Care' roll out early in 2010. We have reviewed OHAT assessments carried out by non dental personal at various nursing homes and found that the results are appalling. Residents marked off as having sound teeth only to find that they are edentulous or have gross caries/periodontal infection.

Even when OHAT assessments are carried out reasonably well there is often no follow through. OHAT is generally insufficient for a dentist to ascertain the specific treatment needs of an individual resident. And that's assuming that the nursing home is even able to find someone for the resident to see and that the family is prepared to pay for the treatment or can arrange a Medicare EPC referral in advance.

Medicare EPC Scheme

In about 2005 the Medicare EPC Scheme emerged. The first version covered little more than dental consultations. Towards the end of 2007 and before the Federal elections that year the Medicare EPC Scheme was radically overhauled providing for $4250 towards dental care for people who are medically compromised or have dental problems which exacerbate their medical condition. The elderly and nursing home residents by default qualified for treatment under this scheme; however, the vast majority of the more than $500m per year

spent on Dental Services under the Medicare EPC Scheme has funded crowns, bridges, dentures etc for many who are generally well and even working. The Medicare EPC Scheme provides limited benefits for the elderly as access to dentists in private practice or in hospital settings prevents many from receiving desperately needed treatment.

Aged Care Conferences

Sadly Oral Health is often neglected as a topic for Plenary Sessions of major meetings/conferences on Aged Care in Australia. This has to change. Oral Health just can't continue to be ignored. Prospective residents of RACFs, their families and carers and the medical community need better education on oral and dental health and its impact on aged care. In October this year Melbourne will be hosting an International Conference on Gerontology and Geriatrics. An Oral and Dental Health stream, as one of several parallel streams, may take place if I can organise 4 speakers and get a sponsor. A pointless exercise as the only attendees, when several parallel streams are on offer, will be the speakers themselves and a handful of others with an interest in oral and dental health. To get the message out to all involved in the Aged Care industry Key Note speakers on oral and dental health must be involved in Plenary Sessions.

In late May 2010 I presented a paper at the 19th Nordic Conference on Gerontology in Reykjavik, Iceland (abstract follows).

Back to the Future - Oral Health and the Aged Care Conundrum Dr Peter Foltyn, Consultant Dentist Dental Department St Vincent's Hospital Sydney AUSTRALIA. Email: pfoltyn@lstvincents.com.au

Abstract:

Fluoridation, higher levels of oral health education and recognition that a clean, healthy mouth and unblemished smile is desirable have led to exponential increased sales of dental consumer products and the provision of cosmetic procedures by dentists. This has seen unprecedented improvement in oral health over the past 50 years. Whereas nursing home residents in the 1950/60's were primarily edentulous, today's resident is partially dentate, often with complex dentistry in-situ and an equally complex medical history. Sadly dental care for many nursing home residents may revert back to the 1950's when extractions were the most common treatment provided.

In late 2009 the Commonwealth Government of Australia released its long awaited Oral Health strategy for elderly Australians 'Better Oral Health in Residential Care'. The cornerstone of this initiative is OHAT - 'Oral Health Assessment Tool'. OHAT is intended to assist in the early identification of oral health deficits in the elderly and is one of many training resources available in the Australian Government's strategy. In 2007 a group of dentists championed the establishment of a Dental Clinic with an employed Dental Hygienist on the grounds of a newly built 295 bed Nursing Home close to the Sydney CBD. As the Home is Australia's leading aged care provider with a proud history spanning 120 years it was receptive to the argument put by the dentists that poor oral health in the elderly is directly linked to systemic health and potentially increased

morbidity. A modified version of OHAT was used for assessing all residents as well as providing dental care in the dedicated dental clinic. As the residents included many with dementia and other cognitive impairments some alarming patterns and trends emerged and many logistical and functional issues were encountered in trying to assist the communities most vulnerable and marginalised members.

Although my paper was well received the reality is that in Scandinavia RACFs are a rarity. The elderly are encouraged to remain in their own homes with families taking a more active role in elder care. The equivalent of our local councils have a far greater role in the delivery of services for the aged in the community. Nurses and aids are deployed regularly to assist the elderly in their daily chores including getting to appointments, social activities and helping around the house. Keeping an elderly person in their own home is both cheaper for the State and healthier for the individual.

NSW Health - Strategic Directions Workshop

In September 2010 NSW Health, through the Centre for Oral Health Strategy held an excellent Strategic Directions workshop with over 65 attendees from within and outside the dental profession. The following are the consensus goals for Aged Care to come out of this workshop.

Short term

- Establish a population-based health promotion strategy that raises the awareness and understanding of older persons and where appropriate, their carers, of the impact of the ageing process on their oral health status
- Provide nursing, medical and allied health personnel with information, knowledge and skills to ensure the recognition of oral health as an integral component of general health
- Provide staff who work with older people in Nursing Homes with expert advice and assistance in implementing the oral health care plans prepared for residents

Medium Term

- Introduce dental teams with a range of appropriate skills to meet the needs of older people, who will provide services in Nursing Homes, dental clinics and through home visits
- Incorporate an evidence-based preventive and therapeutic approach to service provision, including timely oral assessments and provision of individual oral health care
- Develop and implement an infrastructure for the delivery of preventive and treatment services for older people that incorporates a "hub and spoke" approach at the state level and within groups of health networks. This would involve one or more Gerodontic Centres as the hubs

Long Term

- Ensure that Nursing Homes with 100+ places have a treatment room that can be modified to provide dental services. This may include having a permanent dental chair located in the treatment room

- Establish an integrated system that assists older persons, who are "in transition" between the private and public systems as a consequence of changed financial circumstances, to maintain their oral health by providing opportunity for continuity of care through partnerships with the private health insurance industry and public health services

- Develop a workforce with an illness prevention and health maintenance focus to provide both direct, practical, delivery of oral health prevention programs to those at greatest risk, as well as practical support to carers, nursing staff, allied

Summary

I acknowledge that there are no easy answers; however, there are several things that a caring and responsible government can do which involve minimal expenditure:

- Dental assessments to become a mandatory component of an ACAT assessment.

- The Commonwealth to produce an information brochure or pamphlet on the interrelationship between oral health and ageing. To be available through all medical GP clinics, hospital geriatric units and community centres.

- Broaden the scope of practice for dental hygienists and dental therapists and allow them to treat the aged without direct supervision of a dentist.

- Compulsory placement for at least 100 hours at aged care facilities as part of a student's undergraduate training for all Commonwealth registrable dental health workers (dentists, dental hygienists, dental therapists, dental prosthetists). This time would be spent in educating nursing home staff, residents, family members, carers etc in oral health, tooth brush instruction, denture care and maintenance etc.

- The Commonwealth should consider issuing provisional provider numbers for all registrable dental health care workers until they have completed at least 100 days working in a public dental facility. This commitment could be completed in a single block or part-time over the first two years following graduation. This provision should also apply to foreign trained dental health care workers seeking Australian registration. This additional manpower will enable an improvement to public dental facilities and for

regional centres to take responsibility for RACFs either by setting up dental services within the RACF, if it is big enough, or enable bussing of the residents who need treatment to the public dental facility.

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