Australian Dental Association Inc.

Submission to the Productivity Commission

Disability Care and Support

September 2010

Authorised by

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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing around 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and 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.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

Thank you for the opportunity to respond to the Productivity Commission's Disability and Support Issues Paper. Should you wish to discuss any of the matters raised in this response, please contact the Association.

Introduction

The ADA commends the Productivity Commission for undertaking this review as it demonstrates an important stage in a concerted effort to improve the quality of life of the disabled and those with special needs who for too long have had to endure not only general health issues but also poor oral health and a poor quality of life including dental pain and discomfort. People with special needs experience much higher levels of oral disease, with considerably less access to treatment and not enough is being done by governments to redress this.

Oral diseases are one of the most common health problems in Australia – yet the majority of oral health problems are preventable. People with disabilities, the disadvantaged and low income earners have significantly worse oral health than the general population and they have the greatest difficulty accessing services.

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Poor oral health can have a significant impact on a person's health and wellbeing. A 2010 report by the Brotherhood of St Laurence found that of people with oral health problems:

- 90% experienced pain or discomfort;
- 80% had difficulty eating; and
- 86% were affected in their ability to go about daily activities; and 90% experienced embarrassment due to their teeth, contributing to poor self-image, reducing their social interactions and limiting employment prospects.[1]

This problem has been one that the ADA has been asking the governments to address for some time. To date those who are faced with some kind of disability have limited access to dental facilities to adequately address their oral health problems. Those who do have access to such facilities find they are not resourced to deal with the dental issues confronting them.

Generally, there are too few dental practitioners working to improve the oral hygiene of those with special needs. Additionally, the facilities are inadequate and staff lack awareness of oral health matters so for too long these oral health problems were ignored. Maintaining good oral hygiene and access to dental care for those with a disability was, and still is, often non-existent – especially when compared to the general population.

This review is a significant step in the right direction for people with disabilities. When implemented, it should bring about a much improved oral health status for this group. To have staff better educated to care for those with disabilities, provide oral hygiene and be educated to screen for oral health problems will assist in allowing early intervention by dentists.

The ADA remains committed to supporting the development of physical and human resources to ensure that regular dental assessments of the disabled and those with special needs take place. It is willing to provide ongoing advice and support to governments in this area.

1 Brotherhood of St Laurence 2010, *Public dental care and the Teeth First Trial: A history of decay*, Accessed 16 August 2010.
<http://www.bsl.org.au/pdfs/Bond_Public_dental_care_and_the_Teeth_First_trial_2010.pdf,>.

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ADA Recommendations

- In accordance with the ADA's 2010–11 pre-budget submission to Government, the Association recommends the following budget items for consideration:

Recommendation	Item Cost
Upskilling/Training carers/health workers	$2,000,000
Funding for provision of services to the value of $450 per patient and provision to 50,000 patients per year	$22,500,000
Subsidising dental treatment in private practice ($175 per patient to 10,000 patients per annum)	$1,750,000
Building special facilities in public clinics and funding for portable vans/equipment to address access issues	$2,500,000
Educating and developing the capacity of the dental workforce	$1,000,000
TOTAL	**$29,750,000**

- Provision of increased funding to ensure disadvantaged people with special needs enjoy improved oral health, by:
  - Training carers/health workers in oral hygiene and diet for people with special needs;
  - Funding dentists and hygienists working under their supervision to provide dental services for people with special needs in clinics, institutions and in their homes;
  - Subsidising such dental treatment for disadvantaged Australians in private practice;
  - Building special needs dental clinics in public community health facilities and increasing access to portable dental units;
  - Educating and developing the capacity of the health workforce (including fostering of a multidisciplinary approach) to provide suitable care to people with special needs;
  - Provision of services to this group could form an additional subset to a Commonwealth Dental Health Program as identified in the ADA 2010-11 Pre-Budget Submission and
  - Funding allocated for people with disabilities to access private dental clinics.

- The Federal Government must accept some responsibility for public dental services in the absence of national reform, and commit to reducing oral health inequalities via targeted schemes to work towards equity in obtaining timely dental care for all Australians;

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- Immediate priority must be given to appropriate incentives for the public oral health workforce and investment in public dental infrastructure – particularly in rural and remote areas; and
- Governments must ensure that special needs patients have access to resources which are targeted for publicly funded dental services as this group deserves and requires the best possible health and dental care.

Conclusion

Consideration needs to be given to a range of factors when developing and planning services for people with special needs – in particular those with physical or intellectual disabilities. An understanding of the impact of disability and its impact on oral health and access to services is essential. Dental services should be appropriate and sensitive to the needs of individuals whilst respecting privacy. Services need to take account of the views, varying needs and demands of clients, families and carers. Standards of care should be in accordance with the principles of positive choice, enhanced quality of life, retention of dignity and, wherever possible, self-care.

Changes are required for dental services for Australians with special needs. Dental services need to be reconfigured in a way that ensures the focus is on regular review so as to ensure early detection and intervention. Doing this will help alleviate some of the burden placed on the overall health system by reducing, among other things, the need for surgical intervention and hospital admissions.

The following pages have further background information on dentistry that should be of value to the Productivity Commission.

Thank you for the opportunity to contribute to this inquiry.

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Background Information

Snapshot of Oral Health in Australia

- In 2003, an estimated 3.9 million Australians had some degree of disability, of whom 1.2 million (6% of the population) had severe of profound core activity limitations (ABS 2004);
- Disability rates and severity of limitation by restriction varied with age. In particular, the prevalence of severe or profound core activity limitation (referred to in this section as 'severe disability') increased from around 2% of young adults to 12% of people aged 65–74 years and 58% of those aged 85 years and over;
- Disability in older adults can often overlap with chronic medical conditions such as cardiovascular disease and diabetes – both of which have links to poor oral health; and
- It is projected that, by 2030, the number of Australian living with severe disability will have increased to 2.3 million because of population growth and ageing. Expert opinion estimates that around 1 million people would be in the 'special needs' category for oral health.

Dentistry is Different

Dentistry is unique in the health sector and so requires special consideration. All too often the differences are not recognised and inappropriate models (such as those created for the medical service delivery model) are proposed to be applied to dentistry.

A common misperception is that dentistry is very similar to general healthcare delivery and so medical consultations may be mistakenly regarded as similar to dental visits.

Dental practice:

- is procedural in nature and routinely involves invasive and irreversible procedures;
- is labour-intensive, in that it requires the presence of specific staff to assist the dentist;
- requires a high capital investment; and
- has high overheads, as a dental practice is akin to a mini operating theatre.

Therefore, matters such as infection control, clinical waste disposal, and staffing requirements make dentistry vastly different to other health services. Dentistry is also practised mainly in a small office-based setting within local communities. A dental visit usually involves procedures that one would expect in a mini hospital setting and thus requires very different consideration to the consultative-only procedures most often encountered in a medical or other consultation setting. This setting then needs to be duplicated to some extent wherever dental care is provided to patients as dental care delivery requires specialised equipment and materials. Dental health delivery is also very different to the many large institutionalised settings that exist in health elsewhere.

The challenge for health policy makers is to identify and embrace the fact that 'dentistry is different' while at the same time advancing health policy.

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Definition of Special Needs Dentistry[2]

Special Needs Dentistry is that part of dentistry which deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

The National Oral Health Plan 2004-2013

Australia's National Oral Health Plan highlights the following points:

- People with special needs experience higher levels of oral health disease and poorer access to oral health care than the general population;
- For many people with special needs, socio-economic disadvantage adds to their risk of oral disease and difficulties in accessing dental care;
- Access to dental care is difficult for those with special needs, particularly for those in community-based housing;
- Treatment can also be more difficult when care is obtained – due to complex medical conditions, physical and behavioural barriers to oral health;
- The dental profession's limited ability to provide care to certain special needs groups (due to the physical limitations of the private surgery setting) exacerbates this inequity in access to dental care;
- Currently, special needs groups are predominantly receiving emergency care, not general dental care;
- Many patients with disabilities may require dental treatment through under general anaesthesia (GA). Public sector health services information has revealed there is limited access to GA facilities/theatre sessions/specialist anaesthetist staff often required to provide such treatment; and
- There are many special needs patients who are best treated in a hospital setting or a dedicated clinic. There is a need for both the public and private sectors to work together to improve access to care for these patients.

Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013 (the Plan) was prepared by the National Advisory Committee on Oral Health (NACOH), established by the Australian Health Ministers' Conference in August 2001, comprising representatives from the Commonwealth, State and Territory governments, professional and consumer groups, and academic and educational bodies.

The purpose of the Plan is to improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of oral disease. The Plan aims to help all Australians to retain as many

[2] For the purposes of this submission the terms 'disabled' and 'special needs' will be used interchangeably.

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of their teeth as possible throughout their lives, have good oral health as part of their general good health, and have access to affordable and quality oral health services.

The National Oral Health Plan identified Australians with special needs as one of seven key action items. The outcomes desired from the plan entail good oral health for people with special needs, to support their overall health, independence and quality of life to be achieved through:

- collaborative approaches across health, community services and peak bodies for people with special needs;
- supportive oral health care settings that are physically and geographically accessible;
- improved capacity among service providers and oral health practitioners to meet the oral health needs of people with special needs;
- access according to need (including priority access where appropriate), supported by appropriate funding/resourcing arrangements;
- targeted programs for specific and/or high needs groups; and
- an oral health promotion and preventive approach.

There are three national actions that have been identified in the National Oral Health Plan. These are detailed below:

Table 1: National Actions identified for special needs in the National Oral Health Plan

Action Area		**Time-frame**
5.1	Develop and implement mechanisms to identify people with special needs at their first point of contact with health services so that the implications for oral health services can be managed.	Short
5.2	Include appropriate oral health indicators in the intake, assessment and case planning processes for those people with special needs, as well as appropriate referral pathways and mechanisms to ensure continuity of care across service systems.	Medium
5.3	Implement targeted 'access according to need' policies, including: • priority access for identified groups, and • proactive identification and follow-up of young people with special needs to provide continuity of care after School Dental Service involvement.	Long

In a recent Report of the Workshop on Monitoring of Australia's National Oral Health Plan, a midpoint analysis of the Plan, only some progress was found to be made in two of these National Actions, namely 5.1 and 5.3.

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Table 2: Progress on National Actions

Action Area	Description	Progress
5.1	Mechanisms to identify people with special needs.	Special needs professional advocacy groups formed.
5.3	Targeted access according to need policies.	Referral pathways for special needs clinics. Medicare Chronic Disease Dental Services Program.

While there have been overall improvements in oral health across the Australian population over the last two decades, the gap between the oral health status of the advantaged and the disadvantaged is substantial and increasing. People with special needs experience substantially higher levels of oral disease, with considerably less access to treatment.

How many people are affected?

There are 2.39 million people aged under 65 years with at least one disability (AIHW 2003a). The following provides numbers categorised by main disability:

- intellectual – 0.21 million;
- psychiatric – 0.20 million;
- sensory/speech – 0.24 million;
- acquired brain injury – 0.04 million; and
- physical/diverse – 1.71 million.

There are no published data to support accurate estimates of the numbers whose disability would increase the risk of oral health problems or the complexity of oral healthcare. Based on the above figures and consultation with clinicians, it is estimated that more than one million people would be in the 'special needs' category for oral health. In developing more detailed plans in the future, it will be important that research is undertaken to identify more accurately the numbers of people in this category and their treatment needs.

The impacts of medications that people with disability take and the impact of these medications on oral health, in particular salivary flow, have also been found to have a link between dental decay and reduced salivary flow.

Access to care

For people in supported accommodation, the move from institutions to community-based housing has meant that many cannot access public dental services which, in the past, cared for residents in institutions. These people now encounter many barriers when trying to access either private or public dental care (Chalmers, 1999).

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Potential approaches

Two complementary approaches have emerged to improve the overall oral health outcomes for special needs groups:

1. a strengthening of the priority given to policies and programs that target those groups in the population who are most vulnerable;
2. a preventive approach through the integration of dental and other healthcare, and regular oral health promotion/prevention and maintenance care activities, with recall according to need, initially targeting younger vulnerable people.

A disabling condition may place people at increased risk both of oral disease itself, and/or during treatment for that disease. There is, therefore, a compelling need to give priority to their oral healthcare, to ensure effective preventive care and early intervention.

Workforce skills

There is a need to develop the capacity of the oral health workforce to meet the needs (including oral health promotion) of people with special needs. A multidisciplinary team approach is needed, involving a range of oral health practitioners and other primary healthcare providers (medical and allied health) (Chalmers 2003).

Appropriate training must first be provided to this sector so that such members of the workforce can, under the supervision and oversight of a dentist, provide suitable basic treatment to those in need. This suitably trained sector should also be trained to provide suitable oral health instruction.

The need to increase the skilled 'special needs' dental workforce is also something which has been identified in the National Oral Health Plan.[3]

Evaluation

In order to achieve improved oral health-related quality of life, the adequate recording of oral health indicators at the initial assessment of people with special needs must occur. Identification of and contact with a dental care provider in the case management of those with special needs must be a priority. The implementation of priority access for people with special needs within public dental services is also paramount. Furthermore, the implementation of a program targeting younger, vulnerable people with special needs, including recall according to need, is a necessity.

[3] Australian Health Ministers' Conference 2004, *Australia's National Oral Health Plan 2004–2013*, South Australian Department of Health

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People with Intellectual Disability

- People with intellectual disability, face stark health inequalities which are also reflected in their oral health outcomes;
- Dental disease is the most common health problem faced by people with intellectual disability. It is estimated to be experienced by around 86% of people with intellectual disability;
- People with intellectual disability have a rate of dental disease up to seven times higher than the general population;
    - People with an intellectual disability often need assistance with oral hygiene. Carers (both informal carers and formal carers in residential settings) often lack the understanding, training, time, and/or resources to assist the person to maintain good oral health. This low level of awareness of oral health problems and how to access dental services for people with intellectual disability leaves these people in this group vulnerable and this needs to be addressed.

- Access to appropriate dental treatment is a significant issue for people with an intellectual disability. This is due to a range of factors including:

    - Insufficient numbers of dental practitioners trained and skilled in working with people with intellectual disability;
    - Communication difficulties between the dental practitioner and the person with an intellectual disability; and
    - Insufficient time scheduled in routine appointments to adequately address the needs of people with an intellectual disability. Particularly when considering some of the complexities in providing care, e.g., consent issues, accuracy of medical history, polypharmacy issues etc.

People with Special Needs

- People with special needs experience substantially higher levels of oral disease, with considerably less access to treatment;
- A disabling condition may place people at increased risk both of oral disease itself, and/or during treatment for that disease;
- Smoking and use of methadone and other opioids can also lead to a worsening of gum conditions;
- Some medications for chronic conditions can cause a reduction in saliva production resulting in a dry mouth and contribute to dental problems;
- Some people, including those on Interferon, have a lower resistance to gum infection than others;
- People with Hepatitis C may experience additional teeth and mouth problems. These can include dry mouth, tooth sensitivity and decay, gum infections and mouth ulcerations;
- Residential settings, such as supported accommodation, can act as a barrier to accessing either private or public dental care;
- The oral health workforce require further skills and capacity to provide appropriate care to meet the needs of people with special needs;
- People with physical disabilities have difficulty in accessing care, e.g., wheelchair access, access cabs etc;

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- People with physical disabilities have difficulty in providing their own oral health care; and
- There are more studies showing increasing links between oral health and general health, in particular cardiovascular disease, respiratory disease and diabetes.

Barriers to Oral Healthcare

- Individual
  - Lack of perceived need;
  - Perceived lack of importance compared to other more significant health issues;
  - Anxiety/fear;
  - Financial considerations; and
  - Lack of access.

- Dental
  - More specialist training required; and
  - Uneven geographical location – maldistribution of services.

- Society
  - Insufficient public support/transport;
  - Inadequate healthcare facilities;
  - Inadequate oral health manpower planning; and
  - Insufficient support for research.

- Government
  - Lack of resources provided; and
  - Low priority.

Goals for Oral Health Delivery to the Disabled

There are five important goals to achieve in the provision of appropriate oral healthcare for people with disabilities:

1. Enabling patients to care for their own oral health with/without assistance;
2. Keeping patients free from oral pain and acute oral disease;
3. Maintaining effective oral function;
4. Retaining aesthetics; and
5. Causing no harm.

Provision of oral healthcare for individuals with disabilities involves:

- Delivery of safe and effective appropriate dental care;
- Focus on the need to improve and maintain oral health; and
- Employing preventive measures.

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For this to be achieved, a multidisciplinary approach is paramount. This involves the following people in the person's oral health care plan:

- Parents/carers;
- General medical practitioners;
- Dental team, under supervision of the dentist, and in particular the hygienist; and
- Facility management, Government health service managers etc.

Oral Health Care Plans

These are integral for people with disabilities who live in the community in supported residential care. An oral health care plan should include the following key elements:

- Recognition of medical conditions and medications which impact on oral health;
- Oro-dental factors;
  - Dental status and function;
  - Dental disease and risk factors;
  - Oral habits;
  - Safety of airway;
- Previous dental history;
- Oral hygiene skills;
  - Ability to provide own oral hygiene;
  - Cooperation/compliance for oral healthcare/oral hygiene;
  - Factors influencing patient cooperation;
  - Behaviour during oral hygiene practices;
- Carer assessment;
  - Current knowledge of oral hygiene techniques, equipment and materials;
  - Health literacy of carer/family.[4]

Oral Health Status

- People with intellectual and physical disabilities have poorer oral health compared to the general population;
- People with intellectual and physical disabilities may have additional general health issues, or medications which have the potential to impact deleteriously on oral health;

[4] "Health literacy is about being competent to search for and find [with help] good relevant and timely information from a variety of sources within an environment, which promotes health and wellbeing."

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- Intellectually disabled people may require assistance or support from carers to maintain their oral health;
- Intellectually disabled people may also engage in behaviour than can adversely affect their oral health, e.g., lip biting, tongue thrusting, parafunctional habits such as grinding/bruxing;
- Although the quality of life for people with intellectual disabilities has improved with smaller group living arrangements, dental care is often now more difficult to access than it was in a centralised institution with its own on-site dental facilities; and
- Specialised care such as sedation or general anaesthesia (GA) may be required because of the severity of oral disease or the patient's inability to cooperate with treatment. Therapy has often been extraction, resulting in a low number of restored teeth and a high number of missing teeth.

Dental Aspects

- People with disabilities tend to have the same pattern of dental caries/disease but statistics have shown that compared to the rest of the population they have:
    - more teeth that are decayed/missing;
    - fewer teeth filled.
- Oral hygiene is frequently difficult, and sometimes impossible to maintain, because of impaired cognition, mobility and manual dexterity issues, especially with respect to plaque control;
- If a GA is required, patients will often require escort to treatment;
- Patients who become edentulous and cannot wear dentures, end up becoming dentally impaired.

Access to Dental Care

- Access to dental care is often an issue related to the dental workforce, with few dentists/hygienists treating patients with complex disabilities. Recommendations, with respect to access to care, have included:
    - Access to a tailored, high-quality health service designed around the individual's needs
    - Appropriately skilled, trained and qualified staff to work with people with learning disabilities
    - People with disabilities still benefit from a healthy dentition in order to look good, raise self esteem and to be socially acceptable. In addition, they need their mouths to be comfortable and to be able to enjoy their food.
- Factors which contribute to the inaccessibility of dental services to this patient population include:
    - Poor information regarding available dental services;
    - Physical access issues, transport or the dental surgery;
    - Access to appropriate oral health information;
    - The reliance on a third party/carer;
    - Potentially negative attitudes to the need to oral healthcare by either the individual and/or their carers;
    - Anxiety and fear;
    - Cost in emotional, financial, psychological and social terms; and
    - Professionals' attitudes to providing care.

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Dental Management of Patients with Learning Impairment

Although in many cases the use of behavioural techniques and anxiety management may result in adequate cooperation for dental procedures to be undertaken, sometimes patients lack the ability to cooperate and exhibit aggressive, antagonistic behaviour which may require either additional skills, time, or the use of sedation or GA facilities.

- The ability to obtain informed consent is more complex and time consuming particularly if the person is unable to provide their own consent;
- Patients with learning difficulties often require carer support/an escort nurse to facilitate dental treatment;
- Communication can occasionally be difficult or time consuming especially if the patient has visual problems or hearing impairment.

Treatment modifications include:

- To address increasing plaque levels caused by poor patient understanding/motivation/limitations, either physical or intellectual;
- Either an electric toothbrush/CHX sprays or gels/ high fluoride concentration toothpastes may be of benefit;

- Prosthetics:
  - Patients are often rendered edentulous early; and
  - Dentures may not be practical if clinical prosthetics are unfeasible or if patients cannot tolerate dentures in their mouth.

Carers

A carer, for the purposes of this submission, is any individual who provides care and support to a family member or friend who has a disability, mental illness, drug and/or alcohol dependencies, chronic condition, terminal illness or who is frail.

Carers play a central role in the delivery of oral hygiene and the maintenance of oral health of the people for whom they care. Unfortunately, there is a lack of data about oral health of carers in Australia. As carers may have higher rates of risk indicators such as poor oral health, chronic disease and poverty, it is reasonable to assume that they have worse oral health than the general population. Moreover, family carers often overlook their own healthcare, including oral health, as their primary concern is the wellbeing of the person they are caring for.

The financial cost of dental services is a significant barrier for carers to maintain their oral health. Carers have an average income 25% lower than non-carers and around 44% of primary carers live in low-income households compared to 17% of non-carers.[5] Carers will often allocate a significant proportion of their

[5] Australian Bureau of Statistics, *A profile of Carers in Australia*, Cat No 4448.0, Canberra 2008.

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personal income towards the people that they care for and have little resources remaining to attend to their own healthcare needs.[6]

Finally, accessing dental services can be difficult for carers – particularly those with full-time caring responsibilities. There is a lack of adequate respite services for carers to attend to their own health needs, such as attending dental appointments.

Workforce and Training

During 2003n the United Kingdom, the Joint Advisory Committee for Special Care Dentistry released a document regarding training in Special Needs Dentistry. Two key aims of training programs in Special Needs Dentistry should be to enable trainees to "acquire the appropriate knowledge, skills, attitudes and judgement to meet the oral health needs of individuals and groups in society who have physical, sensory, intellectual, mental, medical, emotional or social impairment or disability" and secondly to "obtain a sense of professional interest and enquiry, encouraging the Specialist in SND to maintain competency and proficiency throughout his/her career by continuing professional education."[7]

Additional training and experience is also required in other dental workers, for example, hygienists, dental assistants etc so that the whole dental team is addressed.

Workforce is an issue and staff of residential facilities for the disabled need to be adequately trained to maintain good oral hygiene and perform dental screening of residents. Moreover, recruiting staff for rural and remote dental health services is a major problem, with the overwhelming bulk of dentists and allied health practitioners employed in urban areas.

The ADA has worked with the Industry Skills Councils and their oral health competency units to ensure that training for care workers is to an adequate level to relieve some of the current workforce issues. This work is ongoing and advice is regularly sought by the ADA to ensure the competency units are effectively developed and updated for the delivery of oral health.

DentalAccess

In November 2009, the ADA responded to the National Health and Hospitals Reform Commission's Denticare Australia with a counter proposal and a better solution - *DentalAccess*.

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6 NSW Oral Health Alliance (OHA) 2010, *Issues in Oral Health for Low Income and Disadvantaged Groups in NSW 2010*.

7 University of Melbourne 2010, http://www.dent.unimelb.edu.au/dsweb/future_students/postgrad/snd.html, Accessed 14 July 2010.

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DentalAccess is a targeted model to provide for the 30% plus of Australians who cannot access dental care. It is a targeted, equitable, cost-effective fair go for Australians who suffer a double-disadvantage when it comes to oral health.

On one hand, disabled and disadvantaged Australians cannot access quality dental services largely because the public system is so profoundly underfunded and lacking in infrastructure. On the other hand, financial and social disadvantage is a recognised precondition to a complex array of health problems – among them poorer oral health and wellbeing. The social determinants of oral health and general health is impacted by these and, with increasing links, identified between oral health and general health.

DentalAccess will provide dental care for those who currently cannot afford or gain access to dental services without the impracticality of Denticare Australia.

The ADA has long argued for more resources to be applied to the oral healthcare of disabled and disadvantaged Australians and it has been pleasing to see the National Health and Hospitals Reform Commission [NHHRC] give the matter of oral health serious consideration. The ADA believes equitable access to dental care is an essential requirement of the Australian health system. This document sets out how such access can be most effectively achieved without the collateral damage likely to occur to the delivery of high quality effective dental care by going down the uncharted path of 'Denticare Australia'.

The ADA calls for the abolition of the Enhanced Primary Care (EPC) – Medicare Chronic Disease Dental Scheme presently funded by the Commonwealth Government. The EPC program utilises medical practitioners as the gatekeepers, is not means-tested and so does not target the needy and is administratively complex. It is incongruous that the Government is funding crowns for people who may be millionaires under this scheme yet it is not able to provide even basic treatment such as fillings for many disabled and disadvantaged people.

The ADA wishes to play a constructive role in delivering a successful dental scheme or system for disabled and disadvantaged Australians and suggests that their Submission entitled *'Dental Access Proposal: Proposal to The Australian Government for a Scheme to Assist Disadvantaged Australians Obtain Improved Access to Dental Care'* which is available on the ADA website at www.ada.org.au be used as a basis for that process. While increased funding is required, significant dental care for the disabled and disadvantaged should be able to be implemented relatively quickly as part of a staged process at the same time as public dental infrastructure and workforce are augmented.

More importantly, as disabled care facilities cannot physically come to these centres and there is considerable expense in putting dental facilities in disabled care settings, some extra funding should be considered to overcome this additional barrier. One of the problems is that many disabled care residents are chair-bound and cannot move into a standard dental chair, so there is a need for extra portable equipment or for a method to facilitate treating them in wheelchairs or mobile chairs.

The public infrastructure would include dental hospitals, university clinical teaching facilities and community health centres. By introduction of these measures all Australians will have improved access to a high standard

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of dental care without the need to introduce a scheme which will enhance 'middle class welfare' whilst doing little to assist the disadvantaged.

Infrastructure

The current system is not equipped to meet future challenges in relation to oral health for the disabled. This could change if specilised facilities were identified which had dental surgeries with the appropriate infrastructure to accommodate wheelchairs.

Infrastructure is itself an issue. Many people with disabilities are being moved out of supported facilities and into community based housing meaning that they now have to access dental care in their local area. This is creating problems with physical access, financial cost and even just finding a dentist who has the appropriate skills to manage their physical disability.

There remain issues in relation to disability, special needs and access. If the infrastructure isn't there, then transport is needed to move patients to and from the dental surgery.

As previously stated, poor access to oral care is an issue for those with special needs. The lack of access to practical and affordable portable dental equipment is also a barrier. Mechanisms are needed to support the transportation of those with special needs to dental appointments.

Funding is required to increase the availability of portable dental units and, in the longer term, an investigation needs to be undertaken into the feasibility of ensuring all new-built designs for relevant facilities, or those undergoing a major upgrade, integrate a multi-purpose health room for use by health professionals, including dentists, if not a clinic of their own.

Regional and Remote

As mentioned above, transport is a major issue for both dentists and special needs patients alike. There needs to be an increased emphasis on oral health in rural health infrastructure programs, including mobile services; and increasing outreach services by visiting dental team workforce members and extending patient eligibility for PATS (patient assisted travel) to urgent dental care.

Private vs. Public

The majority of dental care in Australia is provided in the private sector, with approximately 85% of dentists working in private practice.[8]

[8] BMC Health Services Research, *Dental Service Practice patterns amongst private and public adult patients in Australia*, Published 3 January 2008, p 1.

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Disadvantaged Australians, including those with special needs, are only able to access dental care via the public sector. The Government has a duty of care to these people and needs to bring funding up to an appropriate standard (see Table 2).

In a report by the Australian Institute of Health and Welfare,[9] it was reported that public dental care patients who attend for emergency care typically attend for relief of pain, while general care patients have appointments after coming off a general care waiting list.

The results of the report were mixed. It demonstrated:

- A higher percentage of patients attending for emergency care had no natural teeth (8.1%) compared to general care patients (3.9%);
- Among patients with teeth, a higher proportion of those attending for general care had fewer than 21 teeth (38.6%) compared to those attending for emergency care (35.3%);
- Patients attending for emergency care were more likely to have decayed teeth (49.9% compared to 42.2% for general care) and had a higher average number of decayed teeth (average of 1.9 compared with 1.3);
- General care patients, however, had a higher average DMFT (number of decayed, missing and filled teeth) – 15.9 compared to 13.0 for emergency care patients;
- There was no difference between emergency and general care public dental patients in the prevalence of 6+ mm periodontal pockets; but general care patients had a higher prevalence of 4+ mm periodontal pockets (30.5% compared with 24.4%);
- Public dental patients were much more likely than the Australian population in general to have fewer than 21 teeth – 35.3% of public dental patients attending for emergency care, and 38.6% of those attending for general care, compared with 11.4% for the Australian population;
- The prevalence of dental decay was also higher for public dental patients – 49.9% of those attending for emergency care and 42.2% of those attending for general care, compared with 25.5% of the Australian population; and
- Public dental patients were more likely to have periodontal pockets of 4+ mm – 24.4% of emergency care patients and 30.5% general care patients, compared with 19.8% for the Australian population.

Funding

ADA strongly supports Commonwealth Government participation in ensuring greater equality and funding of State and Territory public dental facilities. As can be seen from the table below, State and Territory funding is completely misaligned. This needs to be addressed as a matter of urgency in order to provide services for those with special needs and indeed all disadvantaged Australians.

[9] Australian Institute of Health and Welfare 2009, Oral health of health cardholders attending for dental care in the private and public sectors, Dental Statistics and Research Series, Number 50.

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Table 3: State and Territory Public Oral Health Budgets 2008/09

	208/2009 State & territory Dental Budgets ($)	Population as at June 2008	Per capita dental expenditure
Tasmania	$23,084,000	498,200	$46.33
Northern Territory	$9,480,000	219,900	$43.11
Queensland	$150,000,000	4,279,400	$35.05
South Australia	$56,000,000	1,601,800	$34.96
Western Australia	$63,380,000	2,163,200	$20.30
Victoria	$139,300,000	5,297,600	$26.29
Australian Capital Territory	$8,491,599	344,200	$24.67
New South Wales	$150,000,000	6,967,200	$21.53
TOTAL	**$599,735,599**	**$21,374,000**	**$28.06**

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