



AUSTRALIAN DENTAL
ASSOCIATION



2019-2020 Pre-budget Submission

Australian Dental Association

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Executive Summary



As the peak body for dentistry in Australia, the Australian Dental Association (ADA) understands the oral health of the community, the shortcomings in dental care delivery and the factors that are influencing delivery of sustainable, safe quality services.

Oral health is an achievable goal for many Australians. It is an essential component of general health and wellbeing, but more than that, it is critical to how an individual breathes, eats and speaks and their acceptance in society.

Everyone in Australia regardless of their ability to pay should be able to receive dental care. Currently, state and territory governments provide some level of service to those with health care concession cards as well as children in some areas but predominantly services are provided within the private sector. Attendance by those who can afford to pay is reasonably frequent and this is reflected in the low level of oral disease in a large proportion of the Australian population.

The same is not true of those unable to pay because of genuine extenuating circumstances. Within the Australian population, there are certain groups who suffer from poor oral health, including tooth decay, gum disease and tooth loss. The extremely limited access to private dental treatment currently provided through Medicare, and limited state and federal government funding for public sector dental services mean that many Australians who cannot afford private dental services face extended periods—often, years—waiting to receive basic dental care.

The National Oral Health Plan 2015-24 (NOHP) identified the groups with most need and nominated them as a priority for care.¹ They include:

- People who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander people
- People living in regional and remote areas
- People with additional and/or specialised health care needs

In 2011, oral diseases made up 2.2% of the total health burden and 4.4% of all non-fatal burden.² Forty-two per cent (42%) of all children aged between 5 and 10 have experienced tooth decay in their baby teeth; 25% of children aged between 6 and 14 have suffered decay in their permanent teeth and 43% have moderate levels of plaque on their teeth. Indigenous children are 43% more likely to have decay than non-Indigenous Australians.³

¹ COAG Health Council. (2004). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan (2005-2014)*; and (2015). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan (2015-2024)*.

² AIHW. (2018). *Oral health and dental care in Australia*. Web report. Cat no. DEN 231. <https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/dental-care>

³ Ibid.

A wide variety of structural and social factors contribute to the prevalence of untreated oral and dental disease amongst this cohort. However, the incidence of untreated decay is far greater for those in the community whose access to timely preventive and remedial oral health care is constrained by their general health, inability to afford private dental services and long waiting times for public dental services.

The ADA has repeatedly called on the Federal Government to address the urgent need for additional, targeted and sustainable funding to meet the oral and dental health care needs of these groups because everyone in Australia regardless of their ability to pay should be able to receive dental care.

The ADA wishes to work with government to develop sustainable measures that will ensure those most at risk of poor oral health have access to screening, prevention and treatment when they need it and believes that by incorporating affordable and sustainable oral health care into the Medicare system, the Commonwealth can play a significant role in supporting states and territories in the provision of oral health services.

The evidence linking oral health status to systemic disease is growing with increasing reports of the impact of poor oral health on conditions such as diabetes, heart disease, stroke, respiratory problems and the development of Alzheimer's disease.⁴ The ADA is therefore recommending the following proposals be introduced as part of the 2019 Federal Budget Measures to embed oral health as part of our existing health system under Medicare. These proposals directly target priority populations recognised in the NOHP; aged Australians, Indigenous Australians and those socially disadvantaged or on low incomes who do not have the means to pay for private health insurance but are ineligible for a concession card and public dental care.

The ADA recognises the investment already committed to the delivery of dental care by the Australian Government through the National Partnership Agreements, the Cleft Lip and Cleft Palate Scheme, the Child Dental Benefits Schedule and to veterans through the Department of Veterans' Affairs Schedule of Dental Services. Despite this investment, and the efforts of state and territory governments, many are falling through this system.

This 2019–20 Federal Budget submission proposes initiatives that are targeted, sustainable and cost effective and will assist in meeting that gap.

In addition, the ADA calls on the Federal Government to link funding provided for dental services through the National Partnership Agreement to a reporting framework which includes details on the elective dental waiting lists in each state and territory.



Dr Carmelo Bonanno
Federal President
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⁴ <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction>;
<https://www.perio.org/consumer/alzheimers-and-periodontal-disease>.

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1 Build oral health into General Practice

General medical practitioner (GPs) are often the first point of contact for individuals who have a health problem. GPs are therefore 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. More than 70,000 potentially preventable hospitalisations in 2016-17 were for dental conditions.⁵

There are a number of MBS items which are designed to reimburse a medical practitioner to undertake a health assessment of target groups within the Australian community.⁶ These include, certain 'at risk' groups in the population. These health assessments are designed to detect common and treatable conditions that require further management. These include:

- (MBS Item 715) Health assessment for Aboriginal and Torres Strait Islander peoples
- (MBS 701; 703; 705;707) Health Assessment for:
 - people aged 75 years and older
 - a comprehensive medical assessment for permanent residents of residential aged care facilities
 - people aged 45-49 years who are at risk of developing chronic disease
 - people with an intellectual disability
 - refugees and other humanitarian entrants

The specific components of the health assessment vary according to the situation but generally include:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- making an overall assessment of the patient;
- recommending appropriate interventions;
- providing advice and information to the patient;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Some of these assessments include an oral health component but others leave it up to the practitioner to decide if that is relevant.

Consideration of the oral health needs of the patient is either not mentioned or is listed as optional. For example, the assessment for people aged 75 years and older states:

The health professional undertaking the health assessment may also consider:

⁵ AIHW. (2018). *Oral health and dental care in Australia*. Web report. Cat no. DEN 231.

<https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/dental-care>

⁶ Australian Government, Department of Health, Health Assessments

- any need the patient may have for community services;
- whether the patient is socially isolated;
- the patient's oral health and dentition; and
- the patient's nutrition status.

There were almost 790,000 services claimed under Medicare item numbers 701,703,705 & 707 and almost 240,000 under item number 715 between July 2017 and June 2018. If general practitioners could identify at an early stage if the patient's oral health is deteriorating, there is a greater chance that this deterioration can be halted or in some cases even reversed. The longer that oral and dental disease goes untreated, the greater its negative flow-on impact on general health and well-being, the greater the associated direct and indirect costs to the publicly funded health system, and the greater the economic cost to individuals and the nation through decreased human capital and productivity.⁷

Therefore, the ADA calls on the Federal Government to:

- **include the assessment of the patient's oral health and dentition as a specific and reportable component of MBS Items 715, 701, 703, 705 and 707 health assessment process rather than optional;**
- **upon finding disease the general practitioner should make a referral for the patient to see a dentist.**

⁷ National Advisory Council on Dental Health (NACDH). (2012). *Final report of the National Advisory Council on Dental Health*, Department of Health and Ageing, Canberra; COAG Health Council. (2015). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2015-2024*.

2 Provide access for adults to care

While the proposed measures above will improve awareness among GPs of the need to monitor oral health status and alert at risk patients of the need to take action, this in itself is insufficient to meet the needs of some of this patient group. Many of those who need treatment will be unable to pay for the services they require and therefore, require financial assistance.

Dental services in Australia are generally not covered under Medicare.

All state and territory governments offer public dental services. However, access to these services is variable at individual state/territory level. Most provide services to children but services to adults are generally restricted to concession card holders.

In 2013, 84% of all people who made a dental visit in the previous 12 months had visited a private provider.⁸ These figures reflect the distribution of all dental practitioners in Australia. Solutions to improved access must therefore consider the use of this important sector.

Over the years there have been a number of programs introduced at a Federal level designed to address some of the gaps, but these initiatives have often been discontinued when there is a change of government. The exception is the current Child Dental Benefits Schedule (CDBS), the Cleft Lip and Cleft Palate Scheme (CLCPS) and the Department of Veterans' Affairs Dental Schedule (DVA). With the exception of the CLCPS, these schemes are not embedded in the Medicare system which makes them more vulnerable to political influence.

There is increasing evidence of the need for greater access for adults in the community who are socially disadvantaged or on low incomes. Latest data from the AIHWⁱ shows that:

- Three in 10 adults between the ages of 25 and 44 have untreated tooth decay.
- Adults aged 15 years and over had an average of 12.8 decayed, missing and filled teeth.
- Less than 1 in 10 (9.9%) adults have never had dental decay in their permanent teeth.

The CDBS is an example of a program which, while underutilised, provides the framework for a similar scheme for adults who are not able to afford care but can't access public dental services.

The eligibility for the CDBS includes any child who is part of a family that receives Family Tax Benefit Part A and/or a range of other Federal Government payments. This eligibility criteria could also be applied in a dental scheme directed to adults.

Therefore, the ADA calls on the Federal Government to:

- **introduce a targeted dental benefits scheme for those adults who receive Family Tax Benefit A and/or a range of other Federal Government payments.**

⁸ AIHW. (2018). *Oral health and dental care in Australia*. Web report. Cat no. DEN 231.
<https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/dental-care>

3 Provide access for older Australians

Our aged and frail need special care. Increasing longevity and the increasing proportion of older people who have managed to retain their natural teeth are changing the oral health needs of this population compared to those of previous generations. Dentures are often easier for the frail aged and their carers to look after than natural teeth. However, an increasing proportion of aged care consumers who retain some or all of their natural teeth have had complex restorative treatment that requires a relatively high level of maintenance. Many older people with complex health conditions take medications which reduce the flow of saliva; this significantly increases the risk of dental caries and periodontal (gum) disease unless daily attention is given to oral hygiene.

Australian Institute of Health and Welfare (AIHW) statistics suggest that:

- 61% of people over the age of 75 have moderate or severe periodontal disease;
- 55% of people aged 75 years and older have retained less than 21 teeth.

Compared to younger Australians, older people—particularly older low-income people—also have high rates of tooth decay, which often goes untreated for significant lengths of time.

The 2010/11 National Dental Telephone Interview Survey, a nationally representative survey conducted for the AIHW, found that 9% of Australians aged 65 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.⁹

Difficulties meeting the financial costs of routine dental care are a key reason for this. 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 amongst pensioners and part-pensioners who cannot afford expensive private health insurance policies that offer rebates for dental care, albeit with restrictions on rebates, qualifying periods and exclusions.

Long waiting lists for anything but emergency dental treatment through the public system reportedly leave many aged pensioners suffering “immense pain and diminished quality of life” for significant periods of time.

As a corollary of increasing longevity, the proportion of aged care consumers with dementia, mild cognitive impairment and communication disorders is also increasing.¹⁰ 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. Taken together, these factors mean that provision of high-quality oral care is a more complex and challenging responsibility for residential and home/community aged care workers than in the past.¹¹

⁹ Lewis et al., p. 97.

¹⁰ Healthy 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, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions

¹¹ Ibid.

There is considerable evidence that many aged care facilities in Australia, as elsewhere, are failing to rise to these challenges.¹²

It is common for residents of Australian aged care facilities to be found to have “poor oral hygiene with a high accumulation of plaque and calculus” that increases the risk (or severity) of periodontal disease and infections in or around their teeth and dentures.¹³ Other studies suggest that the oral health of older people tends to decline significantly in the year or so before they enter residential care, and then “rapidly worsens following admission”.¹⁴

A recent survey of residential aged care nursing and care staff part-funded by the National Health and Medical Research Council of Australia noted that in the large facility in which they work, many residents unable to brush their own teeth might only have their teeth brushed by staff “once a week”. 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.¹⁵ In this modern era this is an appalling problem that needs immediate attention and action.

As noted earlier, MBS items for a comprehensive medical assessment for residents of aged care facilities exists and includes an oral health assessment. Without access to oral health care, an assessment by a GP that a resident’s oral health needs attention, is unlikely to result in the resident receiving care unless they have private health insurance or the financial means to pay privately, assuming they can either attend a dental practice or find a dentist to provide the care at the facility.

The most common immediate consequences of poor oral health — pain, infection and tooth loss — have flow-on effects that significantly add to costs in the broader health system. Tooth decay, oral cancer and periodontal disease are linked with the onset or worsening of other chronic health conditions like cardiovascular, cerebrovascular and respiratory diseases.

Older people are over-represented amongst potentially avoidable hospital admissions, and untreated oral health conditions are often the cause or causal factors in those admissions.¹⁶

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.¹⁷

Aged care residents with poor oral health are also more at risk of bacterial infections of the blood and aspiration pneumonia,¹⁸ which is a major cause of morbidity and mortality amongst the frail elderly.¹⁹

¹² <https://theconversation.com/the-shocking-state-of-oral-health-in-our-nursing-homes-and-how-family-members-can-help-77473> <https://www.agedcarecomplaints.gov.au/wp-content/uploads/2015/12/Industry-Feedback-Alert-Oral-Health-and-Dental-Hygiene.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; Hilton, S. et al. (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. et al. (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>.

¹³ 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.

¹⁴ Lewis et al., op. cit., p.97.

¹⁵ Hilton et al., op. cit., p. 9.

¹⁶ Lewis et al., op. cit., p.96; AIHW, op. cit. p.5.

¹⁷ Ibid, p. 96.

For these reasons, budget measures focussed on the prevention of poor oral health and dental disease amongst the aged population are important to reduce the wider economic impact of poor oral health amongst older Australians.

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 amongst older Australians to be more than \$750 million per annum.²⁰

A decade later, this total cost figure is likely to be closer to \$1 billion, given ongoing increases in the aged population and the real costs of medical services over the past decade.

The ADA has developed the Australian Dental Health Plan to facilitate government's thinking on how schemes to provide care to adults and older Australians could be implemented (see Attachment A).

Therefore, the ADA calls on the federal government to:

- **introduce a targeted dental benefits scheme for aged pensioners.**

¹⁸ Hopcraft, M S. op. cit., p.3.

¹⁹ Tada, A & Miura, H. (2012). 'Prevention of aspiration pneumonia with oral care', *Archives of Gerontology and Geriatrics*, 55(1), pp. 16-21.

²⁰ Econtech, cited in Lewis et al., op cit., p. 96.

4 Equity for patients for diagnostic imaging services under Medicare

Medicare is Australia's universal health scheme that guarantees all eligible Australians access to health care by providing free or subsidised treatment to out of hospital medical services, selected diagnostic imaging and pathology and public hospital treatment. Dentists and dental specialists are recognised for the purposes of Medicare. There are thirteen dental specialties in Australia, which are approved and recognised by the Dental Board of Australia (DBA) The DBA Specialist Registration Standard List has also been approved by the COAG Health Council. The specialties are listed below:

- Dento-maxillofacial radiology
- Endodontics
- Forensic odontology
- Oral & maxillofacial surgery
- Oral medicine
- Oral pathology
- Oral surgery
- Orthodontics
- Paediatric dentistry
- Periodontics
- Prosthodontics
- Public health (Community dentistry)
- Special Needs Dentistry

All but two of the groups outlined above are recognised under Category 5 of the Medicare Benefits Schedule (MBS) – Oral Surgeon and Special Needs Dentists. There is no published reason or reasonable justification for the restrictions, which seem to be the product of a misunderstanding by government about the nature of dental specialties in Australia. But while this exclusion exists, patients who are sent for diagnostic imaging procedures by these specialists are unable to receive a Medicare rebate.

The ADA submits that the current restrictions are arbitrary, discriminatory and inconsistent with the principles underpinning access to universal health care. The inability to obtain Medicare subsidised imaging potentially compromises quality of care and cannot be justified by reference to any cost savings as patients requiring subsidised imaging are required to visit their medical general practitioner to obtain a referral which their specialist dentist could have given them. These discriminatory restrictions need to be addressed urgently.

Therefore, the ADA calls on the federal government to urgently:

- **recognise oral surgeons and special needs dentists for the purposes of Medicare rebates for diagnostic imaging services.**

5 Elective Waiting Lists

The AIHW compiles data on waiting times for adults who are placed on public dental waiting lists, on an annual basis to enable monitoring of those waiting times. However, the data collected cannot be compared across jurisdictions due to the variability and availability of data. Despite the lack of comparability, the data show that some people wait a considerable time before receiving care (or an offer of care).²¹

In 2016-17, there were approximately 132,700 dental procedures provided under general anaesthetic in hospital. Over 70,000 of these hospitalisations were due to dental conditions that could have been potentially preventable if the patient had received timely and appropriate care. Tooth decay is also the leading cause of preventable hospitalisations in children under the age of five. Alarming, the number of children aged under nine years requiring a general anaesthetic for dental treatment dramatically increased to 2200 in 2017/18, up 39% since 2013/14. Add to this the estimated cost of poor oral health in terms of lost productivity, exceeding \$200 million each year and the need for further action cannot be ignored.

National figures also show that oral health tends to deteriorate as people get older. That's why it's so important that people of all ages who need public dental care can gain timely access.

Monitoring of public dental waiting lists is critical to ensuring that access to services is timely.

Therefore, the ADA calls on the federal government to urgently:

- **Commence work to develop a national minimum data set on public dental waiting times and that monitoring and reporting against this data set be a condition of public dental funding under the National Partnership Agreements.**

²¹ AIHW. (2018.) *A discussion of public dental waiting times information in Australia: 2013–14 to 2016–17*. Cat. no. DEN 230. <https://www.aihw.gov.au/getmedia/df234a9a-5c47-4483-9cf7-15ce162d3461/aihw-den-230.pdf.aspx?inline=true>

6 About the Australian Dental Association

The Australian Dental Association is the peak national professional body representing dentists in Australia. ADA members work in both the public and private sectors, in academia, research and policy. It has branches in each state and territory.

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.

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