Submission
No 200

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation: Council of Social Service of New South Wales

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Theme:

Summary

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27 June 2005

The Inquiry into Dental Services
The Standing Committee on Social Issues
Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Madam/Sir

Please find attached the Council of Social Service of NSW (NCOSS) submission in response to the dental services inquiry.

NCOSS has been advocating for many years for improvements to the public dental system and looks froward to some positive steps being taken by the NSW Government as a result of this Inquiry.

I hope that you will favourably consider our comments. If further information is required, please contact Samantha Edmonds on ph: 9211 2599 ext 116 or email at samantha@ncoss.org.au

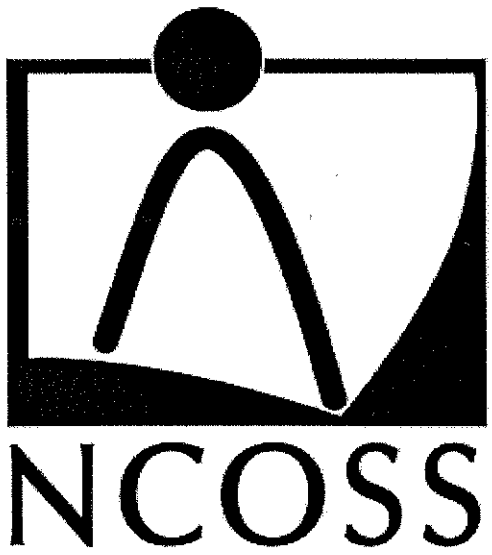
Yours sincerely

Gary Moore
Director

The NCOSS Health Policy Project is funded by NSW Health

Submission to the Legislative Council Standing Committee on Social Issues

Inquiry into Dental Services in NSW



June 2005

Council of Social Service of NSW (NCOSS), 66 Albion Street, Surry Hills 2010
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About NCOSS

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation and is the peak body for the non-government human services sector in NSW. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales.

It was established in 1935 and is part of a national network of Councils of Social Service, which operate in each State and Territory and at Commonwealth level.

NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

Member organisations are diverse; including unfunded self-help groups, children's services, youth services emergency relief agencies, chronic illness and community care organisations, family support agencies, housing and homeless services, mental health, alcohol and other drug organisations, local indigenous community organisations, church groups, and a range of population-specific consumer advocacy agencies.

Introduction

In the Report of the Chief Health Officer of NSW oral health is covered in the section of the report entitled health priorities. However it can be said that oral health as a priority is not reflected in the funding and resources that are committed to oral health care in NSW. As quoted in the report from AHMAC, *"Dental caries is the most prevalent health problem, and periodontal diseases are the fifth most prevalent health problem, in Australia. About 90% of all tooth loss can be attributed to these two health problems and, because they are preventable and treatable, most tooth loss is avoidable" (292)*

There are many reports and studies already available in NSW, nationally and internationally, that provide a clear picture of the oral health needs of the population and the levels of decayed, missing and filled teeth, and oral diseases, that people from low socio-economic backgrounds and other key equity groups face. The committee will most likely receive many submissions that provide this data as well as being aware of this data themselves. Therefore NCOSS in this submission will not repeat this information but would support and encourage the Committee to respond to and address this disparity in oral health and access to dental services across NSW. As Spencer (2004:2) writes, *"What draws greater attention to it today is the evidence of the chasm, between rich and poor in oral health and access to dental care, widening and the apparent acceptance of it and lack of will to bring about change."*

One of the worst examples of poor health policy today is the ongoing separation of the oral health of individuals from all other aspects of their health care. The greatest deficiency of our current health system is that there is no assistance for people to maintain their oral health. Oral health, as with general health, is a right.

The quality of care received in dental services

The loss of a tooth is a reflection of the failure of prevention and of efforts to provide treatments to save the tooth. Therefore an extraction could be said to be a failure of the public dental system to provide adequate preventative care and early intervention. The fact that most public dental treatments are extractions means that the NSW public dental system is failing and while the quality of the people providing the treatments within the system is not under question, the quality of the system itself is poor. The public dental system is only concerned, as a result of its poor resourcing and funding, with immediate emergency care. There is no long term care and there is very little in the way of prevention.

NCOSS was informed during consultations that the public dental system is simply a band aid and while it is acknowledged that public dental professionals are doing the best they can with limited resources, the system dehumanises both the workers and the patients. It was stated that the quality of care currently received is the worst that it has been in years. This is reflected by the long waiting lists and increasing reliance by public dental patients on temporary measures such as antibiotics and pain relief medication from their GP to deal with oral infections and pain while waiting to receive treatment. Though treatments are mostly extractions.

Oral health is not a valued part of the health system, for example in the blue book given to new mothers the section on teeth has been removed. This means that from an early age oral health has become the last issue that people think of in terms of their health. This is exacerbated by a public dental system that cannot meet their needs and that does not provide a similar quality of service compared to that of the private dental system.

Recommendations

1. That an evaluation is made on the quality of dental services in NSW, particularly to the bulk of services provided in the private sector.

2. That current performance and outcome measurements should include improved oral health as a measurement.

The demand for dental services including issues relating to waiting times for treatment in public services

An ongoing issue raised throughout consultations and discussions is the increasing use of antibiotics and pain relief by people who are unable to access the public dental system, either as being ineligible under current criteria (i.e. the working poor who do not have concession or pension cards) or as a result of the long waiting lists. Increasing visits to the GP to seek pain relief places a further financial strain on people who are already struggling to make ends meet. In terms of older people, again many cannot get an appointment or are faced with long waiting lists, as a result they are often given antibiotics to deal with oral infections. However many are already on a number of other medications causing increasing concerns about the interactions between existing medications and antibiotics. Anecdotal information, given to NCOSS, shows that often older people become even more unwell and end up having to be treated for 4 or 5 problems rather than just for the initial oral infection. The use of antibiotics and pain relief is about treating the symptom and not the cause of the problem and this all relates back to waiting lists and lack of services.

Waiting lists are a real issue and some people have indicated that they would have saved their money and gone to a private practitioner if they had known how long the waiting list would be. However this is not a strategy for addressing the ongoing problems with waiting lists as the majority of people would not have enough discretionary income to do this, unless they reduced expenditure on other necessities. It is essential however that public dental providers' are honest with people and inform them if the waiting list is longer than six months. There must be some type of interim service provided so that people's oral health needs are at least given an initial treatment to prevent the problem from becoming worse while on the waiting list.

There are arguments being put forward about the rationing of public oral health services with the ability to say 'no' to providing treatment unless the person takes some responsibility to look after their oral health. This presumes that the person has the ability to do this and has access to the necessary tools such as clean water, toothbrushes, tooth paste, etc. which is not always the case. It also assumes that persons can access public dental services for a basic check up and clean, as a preventative measure, and this is not possible under the current public dental system due to the extensive waiting lists. Many public dental patients are faced with a broad range of issues that impact on their oral health including housing, food, chronic conditions that also must be addressed if the person is to be able to care for their oral health.

The funding and availability of dental services, including the impact of private health insurance

The fundamental issue in the delivery of public dental services is the provision of adequate resources to provide services to low income earners in need of dental care. While NCOSS is supportive of increasing efficiency in services, there is little value in engaging in complex debates about improving efficiency when there are insufficient resources to meet even a minimum set of service standards for disadvantaged people.

Commonwealth Responsibilities

The Federal Government axed the Commonwealth Dental Health Program in 1997 and this resulted in waiting lists growing by 20% nationally in just over 12 months. Spencer (2001) comments that there are approximately 500,000 people on waiting lists around Australia and only 11% of people who are eligible for treatment receive it each year.

Many view the Commonwealth Government's denial of responsibility for, and their unwillingness to fund, dental care as being irreconcilable with the operation of the private health insurance rebate. Dental care accounts for 48% of ancillary benefits paid out under private health insurance, amounting to an indirect subsidy in the order of $325 million per year. The Department of Veterans Affairs also subsidises the cost of private dental services for eligible veterans. It was stated to NCOSS that the 30% rebate for ancillary cover, that includes dental services, has encouraged increased demand for dental services across Australia - in fact, business is booming in the private sector. This is especially so for cosmetic treatments to improve appearance such as orthodontia, bleaching and replacement of amalgam fillings or restorations with 'tooth coloured' ones.

In 98/99, $2.57 billion was spent on dental services – 64% from individuals, 20% health insurance and 16% government (AIHW Dental Insurance and Access to Dental Care – Research Report No.5 2002). Therefore an individual's ability to pay is a major factor if

they want or need dental services. It is also projected that the total number of dental visits per year, whole population, will be 28.76 million by 2010. (Oral Health of Australians, Australian Health Ministers Advisory Council, 2001) and that this will outpace the capacity to supply, resulting in a shortfall of approximately 8.6 million visits. It can be estimated that in the future the ability to pay and the limited availability of dental services will result in even greater access problems for people who are socio-economically disadvantaged.

Dental health impacts across a person's life and this combined with an ongoing decrease in the number of bulk billing GPs is resulting in people not only unable to afford a dentist but unable to get temporary relief from the GP. They don't have the money available to pay for scripts and NCOSS was informed that some clinicians are paying out of their own pockets in order to assist people, but this cannot continue indefinitely.

The pressure to establish oral health care under Medicare is also growing. While reinstatement of a Public Dental Scheme would certainly reduce the pain and suffering of many disadvantaged people, it is clear that a program funded at the previous level was insufficient to meet need.

However while NCOSS would argue that the Commonwealth does have a responsibility to fund dental care and that dental care should be provided under Medicare, the reality of this happening under the current Commonwealth Government is low. Therefore this should not be used as an excuse by the NSW Government to rely on the old and well used strategy of blame shifting for the state of current public dental services. Instead the NSW Government should focus on improving access to and increasing resources for oral health care in NSW.

At a minimum NSW should bring their oral health funding in line with Queensland's level of funding, as opposed to its current situation of having the lowest level of funding per capita in Australia.

Oral Health Fee For Service Scheme (OHFFSS)

The OHFFSS has been designed to assist with the increasing demands faced by public oral health clinics by providing vouchers that can be used at private dental clinics by people requiring treatment for acute conditions and denture services. Items not covered by this scheme may be provided to the client either at the oral health clinic or paid for by the person at a private clinic. To be eligible for the scheme the person must have a Health Care Card, Pensioner Concession Card or Commonwealth Senior's Card or is a dependant listed on either the Health Care or Pensioner Concession Cards. The person must also be over 18, however the area Oral Health Service can use their discretion in determining if someone under 18 can be given treatment under this scheme.

Only people assessed as Code 1, 2, 3a or 3b using the Information System for Oral Health will be referred under this scheme. There is some flexibility to provide services under the definition of Areas of Need (an area where demand for treatment is very high and there are difficulties in recruiting and retaining oral health care providers).

At present the payment ceiling is $170 for each authorised course of acute care and $780 for denture services. However the levels of funding received within Area Health Services for this scheme means that in reality there is only $40 available per eligible client.

During consultations NCOSS was informed that there are many concerns with the current structure of the OHFFSS, including the low cost of reimbursement for dentures. It was

stated that the fees for the OHFFSS have only increased by inflation over the years that it has been operating, which has meant that the reimbursement costs have fallen well behind the actual costs of providing dentures. The Department of Veteran Affairs (DVA) spends 20% more for the same services and many private practitioners are withdrawing from providing dentures as at the minimum they want to be reimbursed at an equivalent rate to the level that DVA pays for their clients. It has been argued that under current levels of funding the only options available are to increase the rates for denture payments and therefore provide fewer services. For example in the southern area of NSW there is only one person that can do dentures. It would therefore be better to provide fewer dentures at a higher reimbursement rate, in order to maintain the participation of this person in the OHFFSS. Access to this would then also have to be made more equitable so that the fewer services are spread over a greater area by, hopefully, also being able to cover some travel costs for this person. However, this would then increase the number of people without dentures and therefore increase the likelihood of these people developing further serious problems through poor nutrition (no teeth – no chewing) and social isolation from embarrassment at not having teeth.

The DVA is viewed as setting the standard in regards to their oral health program. It is designed to provide comprehensive care as well as being more financially rewarding to dentists. Only some treatments need prior approval before being administered otherwise the practitioner can send their bill directly to the DVA for reimbursement. The OHFFSS, on the other hand, only addresses pain and only up to a fixed amount of dollars. This is unsatisfactory to dentists as they fix the pain but know that the problem will only get worse without further treatment. There is also a lot of paperwork that has to be completed by the private practitioner prior to involvement in the scheme including a signed agreement, proof of registration, indemnity insurance, x-ray license and criminal record checks. Feedback from dentists indicates that the requirements are too onerous and not worth the effort for the remuneration received. While some dentists will do things out of goodwill such as reducing a bill to $170 and attending to a secondary problem with no charge, this eventually has a net effect on the dentists' income and they cannot continue to do this or to do this for everyone.

It has been proposed that there is a tender or Expression of Interest process for dentists to apply to the OHFFS in areas where there are difficulties in getting dentists to participate in the scheme. The costs to be reimbursed could include travel costs as well as treatment costs. However the Area Health Service would need to be broken down into smaller regions on the basis that the dentist would be informed this is the rate of reimbursement available and this is the area to be covered. This may be of benefit to newly accredited dentists who could go into a 2 year contract providing treatments under the OHFFSS prior to establishing their own practices. It has to be remembered that at this point in time, and well into the future, no practicing dentist will be dependent on work from the public oral health services as they will have a continual source of income from private practice.

Another key issue is the perception of public clients by private dentists. A comment was made that in one Area Health Service private dentists do not want to participate because of their perceptions of public clients. Those that do step in to provide treatments under the OHFFSS will drop the program as soon as a public dental officer is employed. The reality is that the majority of clients seen by dentists under this scheme are the same as any other client. In another area clients that are identified as difficult are not given access to the program and must wait for public dental services. This was also reflected in private dentist attitudes towards public patients that failed to show for appointments, though this has been addressed to some extent by the local oral health network asking dentists to

contact them about a client that does not attend an appointment. They then flag their system so that those that fail to attend will be treated in-house rather than under the OHFFSS. Part of the problem is that patients shop around trying to get an earlier appointment and then do not cancel appointments that they have already made. Some may even not seek treatment if pain is gone, due to their phobia of dental treatment. However there must also be private patients that fail to attend appointments. Therefore it would be encouraging to see dentists receive training in working with specific population groups to overcome some of these issues.

Recommendations:

3. That NSW Health funds a public dental health system that adequately meets the following characteristics and standards:

    - Focus on preventive dental services such as appropriate oral hygiene practices, access to and information on a healthy diet, regular check-ups, cleaning and scaling, fillings and restoration rather than extractions.

    - Ensures that treatment for decayed teeth and oral health diseases is appropriate, timely and evidence based. Taking remedial action when problems arise to prevent expensive, complicated dental care or tooth loss.

    - That no person should have to wait more than 24 hours to receive emergency dental care.

4. That the Dental Health Program should be funded at a minimum of $270m per annum with an ideal amount of $700m per annum to provide the same level of services to the socio-economically disadvantaged as the rest of the population and to cover subsidies to the private sector for public dental treatment.

5. That appropriate funding is provided to ensure that comprehensive oral health programs are operated through Aboriginal Community Controlled Health Services.

6. That the NSW State Government lobbies the Commonwealth Government to provide oral health care under Medicare.

7. That the State Government lobbies the Commonwealth Government to remove the 30% private health insurance rebate and the funding utilised for this put back into public health and oral health services.

8. That private health insurance funds should be lobbied to give rebates directly for dental services performed by dental therapists and dental hygienists. These rebates could be at a lower rate than that for dental services performed by dentists and specialists. As cost is a major barrier for access to dental services, reducing the cost of dental services should increase access to dental services.

9. That under the Oral Health Fee For Service Scheme the minimum payment made to dentists is equivalent to that offered under the Department of Veteran Affairs.

Access to public dental services, including issues relevant to people living in rural and regional areas of NSW

It was stated at a recent NCOSS consultation that eventually it will not matter whether you are rich or poor and living in a rural area as you will not be able to find someone to treat you regardless of the money you have. Historically there used to be a dentist in every town however this is no longer the case. For example on the Central Coast there are waiting lists for both GPs and Dentists, in Broken Hill dentists cannot take on anymore clients as they are over-booked and in some areas there may only be a bus once a week into town so getting an appointment is very difficult unless you are willing to wait (and this is not always possible).

Lack of uniformity across Area Health Services was also an issue in terms of access and this is despite the introduction of the ISOH and call centres. A question was raised as to why there is a wide spread of public hospitals across rural, regional and remote NSW and yet there are only two metropolitan based public dental hospitals (Sydney Dental Hospital and Westmead Centre for Oral Health). It was also mentioned that the Sydney Dental Hospital was focusing primarily on people living in the geographic area that they cover (eastern and central suburbs), thus further reducing access to public dental services.

NCOSS was also informed that having a Health Care Card or Pension Card does not always mean that the person is socio-economically disadvantaged. It was commented that "clever accountants' have enabled people to obtain the necessary card even though they would not normally be considered eligible. (Please note that this does not mean that the majority are not genuine card holders with genuine needs). This made many workers angry as it meant that those most in need were missing out. It was felt that there was no distinction made between the very poor and those that run their own business and that there needed to be better targeting of services for those that do not have a choice and those that may have some discretionary income that they could use for some dental treatments.

There is also a decreasing availability of public dental clinics as one person commented: *"I'm now advised that my closest dental clinic is located in Queanbeyan, which means staying overnight somewhere unless one can manage to drive 450 klms in a day, half of it following an extraction, which is about the only therapy they offer now - the emergency response to toothache being the only procedure they offer. We can't even get vouchers for emergency work in private practice down here now."*

One related issue of access is actual physical access into the Dentist. Quite often dentist's are in offices that are not accessible to people with mobility problems, use wheelchairs or have sight impairments. The other concern is that if there is a dentist in an area they are often in town centres and there may not be appropriate transport, or frequent enough transport, to enable access.

The following sections outline issues of access for specific groups, the majority of whom are priorities in the National Oral Health Plan – Health mouths Health Lives. These groups need to be considered in any strategy to increase and improve health promotion and early intervention services and to improve access to public dental services in NSW.

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people have a markedly different experience of oral health than other Australians.

Aboriginal and Torres Strait Islander people are more likely than non-Indigenous Australians to have lost all their teeth, have gum diseases and receive less caries treatment. Severe periodontal disease is more prevalent for Aboriginal and Torres Strait Islander people for all ages above 35 years. The early stages of poorer periodontal health are evident in Aboriginal and Torres Strait Islander people aged 18-24 years. Older Aboriginal and Torres Strait Islander people provide an important example of the crucial relationship between oral health and other diseases.

While the Aboriginal population comprises approximately 2% of the total population of Australia, they make up a higher percentage of the rural population. Therefore access to dental services is a major concern. The National Aboriginal and Torres Strait Islander Survey in 1994, reported that only 46% of Aboriginal and Torres Strait Islander people in rural areas had access to dental services.

An Ageing Population

Oral health problems are common in older people. In the 1989/90 National Health Survey people aged 65 and over, with teeth, had a lower rate of dental visits in the previous 12 months and a higher rate of tooth extraction within the previous 2 weeks. However older people are more likely to have reported avoiding or delaying a dental visit because of cost or that cost prevented recommended or wanted dental treatment (especially where there are predominantly private dental practices).

The increasing demand for dental services, as edentulism decreases amongst older people, is a challenge for the public dental system. A qualitative survey using the Dental Satisfaction Survey Questionnaires (AIHW Dental Statistics and Research Unit, November 2000) to assess satisfaction with dental health care indicates that older adults have concerns about affordability of services (levels of dental insurance decrease as age increases) physical access to dental services, long waiting times and the lack of respect shown by some providers to pension or other government card holders.

Older people also face difficulties in accessing dental services because of a functional disability and, for some, their inability to travel alone has a significant link to an increased likelihood of oral health problems. As a result oral ill health is an increasing problem for older people.

It has been projected that the total demand for dental visits in people over 65 will reach 5.2m visits in 2010 (AIHW Demand for Dental Care Research Report 8, 2003).

Child Abuse

Improved access to public dental health services would be valuable in detecting child abuse. It is estimated that less than 1/3 of actual child abuse cases are reported each year (Mills 2001) and as much as 75% of physical abuse in children involves injury to the head and neck (Colangelo, CareFirst, 2001). The oral cavity is a central focus for physical abuse in children because of its significance in communication and nutrition. Blunt instruments, eating utensils, hands or fingers, scalding liquids, caustic substances or gags, are

commonly used to inflict oral injuries. The oral cavity is also a frequent site for sexual abuse in children. Research shows that many abusing parents avoid returning to the same physician, however they will return to the same dental office (Colangelo, CareFirst, 2001)

Culturally and Linguistically Diverse Backgrounds

Dental studies indicate that migrant groups are disadvantaged in their use of dental services and have the least favourable oral health results compared with other groups.

In the 94 – 96 National Dental Telephone Interview Survey– 18% of those aged 65 and over who were born overseas and spoke a language other than English at home reported toothache, sometimes, often and very often in the previous 12 months compared with 6% in Australian born older people. The report indicates that the ability of migrants to access dental care is limited by the availability of dental services in terms of affordability and accessibility, and that language may also present a barrier.

A particular issue around access for people from CALD backgrounds was the use of interpreters. In an example given to NCOSS in regards to a specific dental hospital it appears that it was not the attitude of the public dentist, who is happy to use an interpreter, but difficulties with frontline staff and upper management: *"It's the receptionist, first point of contact who refused to arrange interpreters. Top management likewise did not sound interested in addressing difficulties of CALD patients to access their service."*

Refugees

Refugees experience chronic infection and severe caries as a result of substandard oral health care in refugee camps and disruption to traditional hygiene and diet practices. These issues are similar to people who are seeking asylum as many have no resources and are traveling long distances in order to reach a place of safety.

Many refugees commonly experience torture and trauma to the mouth, making dental visits frightening and potentially causing further psychological harm by renewing the memories of torture.

There is also a high need for interpreters in order to access health services.

Given the waiting list situation in NSW, people of refugee background with significant dental pathology and a history of poor access to care are again faced with an inability to access help for their teeth. This is despite the fact that these individuals and families are brought to Australia on humanitarian grounds having suffered extreme circumstances. Other barriers to care include insufficient dental staff awareness of refugee health issues, and poor usage of qualified health care interpreters.

People with a Disability

Desai et al's study of 390 children, aged 9 – 13 years, with disabilities found a significant association between function level and dental health status – a decrease in function was associated with an increase in dental caries and periodontal disease. This is attributed to factors such as medication, diet, inadequate oral hygiene and variable access to dental care. However, there is general agreement that people with disabilities have higher rates of dental disease than the general population, and particularly problems of poor oral hygiene, gingivitis and periodontitis. Utilisation of dental services by people with disabilities

is compromised by limited physical access to buildings, limited practitioner willingness to provide care and associated financial difficulties (Fiske and Shafik 2001).

People Living with HIV/Aids

Access to oral health care is extremely important for those affected with HIV as oral findings can lead to early detection and improvement in management of infections. Oral lesions associated with HIV are often debilitating, causing discomfort or pain, difficulty with swallowing or eating, and psychological distress, however they can be managed effectively with proper oral care.

Under-use of dental services is related more to a person's socio-economic status than to infection, and the subsequent unmet need for dental services contributes to problems in the quality of life of people and impacts on the course of HIV (Marcus, Freed et.al. 2000) Robinson and Croucher's 1993 study of 50 asymptomatic HIV people found that of the 76% who disclosed their HIV status at a medical care clinic that they had previously been attending, 87% were refused treatment by either the dentist or dental hygienist (cited in Coulter, Marcus, Freed and Der Martirosian 2000).

People with a Substance Dependency

People with a substance dependency are likely to experience more dental problems than non-dependent people, have difficulty accessing treatment; especially if there is a cost involved and may not consider dental health issues to be of great importance.

Sheridan et al.'s 2001 study of 125 people with a substance dependency and 129 people who were non-dependent revealed that people with a substance dependency self-report considerably more difficulty in accessing dental treatment, are less likely to have visited the dentist in the previous 12 months and have a higher level of self-assessed oral health problems than the non-dependent group. These findings are similar to a Dutch study conducted by Sheridan, Aggleton and Carson in 2001.

Pre-term and low birth-weight babies

Pre-term low birth-weight is one of the major causes of perinatal mortality and morbidity. Low birth weight babies have a greater risk of dying, require a longer period of hospitalisation after birth, have higher rates of abnormal growth and development, and are more likely to develop long term disabilities (Locker & Matear 2000). Pregnant women with severe periodontal diseases are at about 7 times greater risk of giving birth to pre-term low birth-weight babies (Locker & Matear 2000). The highest population with the lowest birth weight babies was mothers of Aboriginal and Torres Strait Islander origin (AIHW 2002a).

Supporting the link between periodontal disease and pre-term birth, Offenbacher and colleagues' (1996) study of 124 pregnant or post-partum women found that mothers of pre-term or low birth-weight babies had significantly worse periodontal disease than the control group who delivered babies at full term.

Access to affordable public dental services in order to get early treatment of periodontal disease is therefore essential for expectant mothers.

The Homeless

A Council to Homeless Persons Australia study found people who are homeless tend to have very poor oral health, with over half of those surveyed having tooth decay. A further 80 per cent of those surveyed had some form of oral disease, of whom 62 per cent had severe periodontal disease.

People who are homeless with multiple health issues (for example, mental illness and problematic drug and alcohol use) are likely to have very poor oral health and to require extensive restorative dental work. Their oral health status is linked to such factors as cariogenic medications (particularly psychotropic drugs and the cordial used with methadone), lack of interest, skills and resources in maintaining regular oral hygiene practices, and significant personal difficulties in accessing support services.

Because of the reduction in public dental health care and the transient circumstances of people who are homeless 'living rough', consideration should be given to their receiving priority access to basic general care in public dental clinics. Priority access could occur on recommendation from a service provider, to avoid being placed on a waiting list.

(Taken from Australian Federation of Homelessness Organisations, Policy Platform – Health Issues and Homelessness)

Recommendations

10. That all oral health providers are given cultural awareness training to increase the number of mainstream dental services that are able provide culturally appropriate services.

11. That there is ongoing training and education about the risks and preventative dental care for people who have a substance dependency, HIV/Aids, Hepatitis C, and the dental workforce that provides services to these groups.

12. That a dental unit, consisting of a dental therapist and support staff, is established in each public hospital (or at a minimum base hospitals) to provide emergency dental treatment and referral for ongoing treatment to the public dental system.

The dental services workforce including issues relating to the training of dentists

There is little or no recognition that the medical profession does not accept responsibility for diagnosis and management of diseases of the mouth and jaws. Instead this has become the sole responsibility of the dental profession, which does this through its generalist and specialist services. Combined with this is the problem that there is no medical specialty training in oral disease, despite the fact that there are numerous medical conditions that present first in the mouth. The impact is that people's oral and general health suffers because there is little or no overlap of training and the mouth has been separated from the body.

It is recognised that insufficient numbers of dentists are graduating to replace those currently leaving the workforce and there are few incentives for general and specialist dental practitioners to join the public system. For example in the 1970's approximately 20 – 30 dental therapists would graduate compared to 9 in 2004. For dentists there used to

be 120 per year about 25 years ago and now there are only 80 (a quarter of which are international students who have to leave the country on completion of their course of studies).The limited resources available to Australian universities, limited research opportunities and world shortage of dental academics is making it increasingly difficult to attract educational staff with the necessary specialist clinical and academic skills to deliver education and training programs. There are no full time academics for endodontics, crown and bridge work and periodontics. This would never be allowed to happen in general medical training – we could all imagine the outcry if there was only one cardiologist left in the medical system. There is also no prescribed internship or pre registration vocational training as with doctors.

One proposal to address workforce issues is to place a dental unit within public hospitals as it was noted that hospital emergency departments are confronted with a large number of oral injuries and do not know how to treat them. This could be available 24 hours a day, 7 days a week and staffed with a dental therapist and support staff with a dentist on call for more complex treatments. This would address immediate issues and decrease the need for more complex and expensive dental treatment later on. After all if a person can get their throat, nose or eye problems addressed (and now mental health through the introduction of psychiatric emergency care units) in an emergency department, then why shouldn't someone be able to have their oral health needs taken care of as well.

Another suggestion is to increase and broaden the utilisation of other members of the dental team, including dental assistants, dental hygienists and especially dental therapists, in the same way that nurse practitioners are now a part of the health workforce. A team of 2 – 3 therapists and hygienists working with a dentist would be a better use of resources as it is currently felt that therapists and hygienists are under utilised. For example waiting times could be reduced if dental therapists were allowed to work in the private sector where the bulk of dentistry is performed. NSW has to come in line with the other states and territories of Australia whereby dental therapists should be able to work in private practice as well as in public practice. The dental therapists will just work in the private sector as hygienists for higher wages and less stress than work as a dental therapist for low salaries with high stress in the public sector only. A more flexible workforce will mean that dental therapists will keep working as dental therapists doing restorative and preventive Dentistry part-time in the private sector or full-time in the public sector instead of working for specialist orthodontists and periodontists in the private sector only. Dental therapists and hygienists can reduce the cost of dentistry by doing dental procedures at a lower hourly rate than dentists. Moreover, dental therapists and hygienists can do more routine dentistry to free dentists and specialists up to perform more complicated procedures. Dental therapists should (with appropriate training) be able to treat adults as well as children and adolescents. The former came into effect in Queensland in late 2003 and the latter is currently under consideration by Queensland Health's Innovation and Workforce Reform Directorate which is lead by Dr Mark Waters. In this way dentists would be freed up to more invasive or complex treatments. The British model for dental therapists was felt to be a good example of a way forward.

It was agreed during consultations that the oral health workforce is not as valued as the general health workforce, especially the public oral health workforce. Remuneration is fairly low and in the reality dentists are choosing between a private practice at a decent level of pay or public practice at low levels of pay. In Oral health of Australians, AHMAC 2001 states, "*private sector dentists incomes are also likely to increase, leading to a greater differential between dentists incomes in the public and private sector. Public sector dentists may be even more difficult to recruit and retain, diminishing the public dental*

services' capacity to service the growing requirement for its services. Dental officer vacancies in public dental services already run as high as 10%." P90.

Recommendations

13. That GPs are trained in basics of oral health care as part of their undergraduate studies. (If a GP can provide care for an ulcer on the leg then surely they should also be able to provide care for an ulcer in the mouth.)

14. That the oral health workforce mix consists of health promotion, education, treatment and prevention staff.

15. That part of the education of the dental workforce would include a 12 – 18 month internship in the public dental system, which would include ongoing education and practical experience and would include rural rotations.

16. That there is better utilisation of dental assistants, dental therapists and dental hygienists, including allowing dental therapists to work in private practice.

17. That the Dental Practice Act 2001 is revised to allow Dental Therapists to practice in private practice in NSW.

18. That the Dental Practice Regulation 2004 is revised to allow Dental Therapists with appropriate training to provide treatment to adults.

19. That the recommendations of the Association for the Promotion of Oral Health submission on dental health workforce measures should be considered by this inquiry.

Preventative dental treatments and initiatives, including fluoridation and the optimum method of delivering such services

There are a number of ways to address the ongoing concerns of improving oral health for all people, especially the most disadvantaged. These do not necessarily have to be treatments and range from oral health promotion strategies through to such things as fluoridation. Following are some key ways in which oral health can be improved.

Oral Health Promotion

Health promotion as defined by the Ottawa Charter particularly refers to the process of enabling people to increase control over the determinants of health (WHO,1986). The implementation of this definition requires that health promotion initiatives should be empowering, participatory, holistic, equitable, sustainable, and multistrategy (WHO, 1998).

In the document "NSW Oral Health Promotion: A Report on the Literature" from the NSW Oral Health Promotion Statewide Steering Committee, of which NCOSS was a member, a good description is given of the impact of the social determinants of health on oral health and oral health promotion. The following is taken from that document.

The determinants (or causes) of health status at the individual and population level, are multiple and interactive and can include a range of psychosocial and environmental factors

including income, employment, poverty, education and access to community resources, as well as demographic factors such as gender, age and ethnicity (Baum 1998; Kawachi & Marmot 1998; McLennan 1998; Nutbeam 1998b; Petersen 1990; Yen & Syme 1999).

A detailed understanding of the determinants of good health and ill health is essential for generating effective action (National Public Health Partnership [NPHP] 2000). Rose (1992) argues because the primary determinants of disease are mainly economic and social, so its remedies must also be economic and social (Rose 1992).

Oral health-related quality of life (OHRQoL) is one indicator of oral health. Results of the AIHW DSRU (2003c) Research Report No. 9: *Social Determinants of Oral Health* shows that the distribution of population OHRQoL follows a socioeconomic gradient. That is, health inequalities mirror social inequalities. Results showed personal control, stress, and social support were linked to income, dentally relevant behaviours, and OHRQoL (AIHW DSRU 2003c).

These findings have implications for oral health promotion at both the individual and societal levels. Understanding the factors that influence self-care and the use of dental services can inform behavioural interventions. In addition, the finding that *social determinants of general health are also associated with oral health* has implications for a common risk factor approach that takes a broader socio-environmental view of the factors influencing health (AIHW DSRU 2003c).

There are a number of obstacles restricting the ability of the present health system to reduce social inequality in oral health:

- the uncoordinated and fragmented nature of dental services
- inequitable distribution of resources
- limited scope of insurance cover
- clinical (rather than preventive) orientation to oral health (AHMAC 2001).

Other constraints include:

- the separateness of oral health from general health
- the lack of consumer involvement
- inadequate understanding of the underlying determinants of oral health to inform interventions to reduce inequality (Spencer & Sanders 2002).

The use of oral health promotion strategies are one aspect of a preventative focus on oral health. They are designed to prevent and/or reduce the incidence of oral diseases before they reach a stage that requires more intensive, invasive and costly procedures. International research shows that health promotion activities are very effective in addressing health needs yet the NSW Government continues to focus it's funding into acute services. While there is a need to continue with acute care there must also be appropriate funding focused on prevention and early intervention. Many would argue that an increased focus on health promotion and early intervention activities would reduce costs in the long term. However in order to improve health promotion activities the NSW Government would need to address the constraints as listed above and provide a more equitable funding mix for oral health.

It is important that partnerships with others also interested in improving oral health be vigorously encouraged. This may mean, in some cases, reviewing sponsorship arrangements to ensure the best result for communities most in need of appropriate interventions.

Bottle Caries

A particularly damaging form of caries (*bottle caries* or *early childhood caries* (ECC)) can begin early, when developing primary teeth are especially vulnerable. ECC is a serious dental condition occurring during the first three years of life and is associated with early intake of sugary foods, drinks and snacks and may occur in young children who are given pacifying bottles of juice, milk or formula, and soft drink or cordial to drink for prolonged periods during the day or overnight (USDHHS 2000a). It can be a devastating condition often requiring a hospital visit with general anaesthesia for treatment (Horowitz 1998; Milnes 1996). The pain, psychological trauma, health risks, and costs associated with restoration of these carious teeth for children affected by ECC can be substantial (Reisine & Douglass 1998).

In some cultures baby teeth are not considered important so good oral hygiene practices are not starting early on. The belief is that these teeth will fall out anyway no matter what you do. Therefore parents need to be educated at early childhood groups about good oral hygiene practices with babies and young children and on the impact of bottle caries. There also needs to be a public campaign, this could include 'warning' labels on bottles, soothers and formulas that it is not recommended that babies are given sugary liquids for prolonged periods, especially at night.

Fluoridation

Equity in health recognises that not everyone has the same level of health or access to resources, which can improve their health. It is about reducing or removing factors that prevent access and providing both a universal and targeted response in order to improve the health of those that are most disadvantaged while continuing to improve the health of all people. Water fluoridation is one such response as it as accessible to and available to all members of the community.

Water fluoridation has long been established as an effective method of preventing and controlling dental caries (Greene et al. 1989; Kay & Locker 1997; Murray 1996; NHMRC 1991; Sprod et al. 1996). It is effective, equitable and efficient and caries reduction ranges from 40-49 per cent in permanent teeth and 50-59 per cent for deciduous teeth (Murray 1996).

The only side effect of concern with water containing 1 part per million fluoride is dental staining or fluorosis, which occurs in only a small proportion of the population (<3%) and is only usually detectable by trained dental workers. Fluorosis is more commonly caused by inappropriate use of other discretionary fluorides, such as children eating toothpaste. In Australia, no cases of skeletal fluorosis have been reported, despite widespread water fluoridation and some areas with naturally high water fluoride levels. Only five cases of crippling skeletal fluorosis have been reported in the United States, and these involved exposure to natural levels of fluoride in water four to eight times higher than optimal levels for community water fluoridation programs.

Water fluoridation is in place in most parts of Australia, though it is not in place in all States and neither is it available in many rural and remote communities. Incomplete water fluoridation remains a public health issue, especially within some regions of NSW.

NCOSS supports the introduction of water fluoridation in those areas within NSW that currently do not contain fluoride based on the evidence available from numerous research

studies and as a public health measure that addresses socio-economic disadvantage. Water fluoridation is an equity measure that benefits all.

One of the major barriers to implementation of fluoridation of public water supplies is that local councils and water authorities can display a lack of robustness when considering the matter, to the detriment of their communities. Legislation mandating water fluoridation would overcome this problem and is a strategy strongly supported by NCOSS.

Nutrition

Good oral health is not just about good oral health practices and access to treatment it is also about access to quality healthy and nutritious food. It is not just about treating the teeth but about what people are eating that can cause decay. This is of specific concern amongst people with transient lifestyles and for some people living in rural and remote communities where access to fresh fruit and vegetables can be difficult. There is also a trend of decreasing ownership of fridges for those that are on a very low socio-economic level. People from a low socio-economic background may only have enough disposable income to live one day at a time and so purchase junk food rather than trying to plan meals and purchase food 5 – 6 days ahead, which requires a substantial initial pay out. There is also a misconception amongst many disadvantaged groups that fast food such as McDonalds is cheaper than purchasing and preparing food from the supermarket.

Therefore any discussion about prevention strategies must also include the consideration of nutrition.

Recommendations

20. That the provision of health promotion to refugee and other equity groups including improving heath literacy through culturally appropriate targeted projects needs to occur. These may include education relating to adequate nutrition such as reduction in energy dense food and drinks, oral hygienic practices such as flossing, and how to seek services when needed.

21. That funding to assist the NSW Oral Health Branch to implement the NSW Oral Health Promotion Framework for Action Plan 2010 would enable broad strategies to be implemented in relation to oral health.

22. That water fluoridation should be fully supported with the Government funding start up costs and the Councils' having responsibility for running costs.

23. That legislation is passed mandating water fluoridation.

Any other relevant matter

Chronic and Complex Conditions

Oral health has been found to be linked to a number of chronic health conditions such as arthritis, cancer, coronary heart disease and diabetes. Therefore in improving services for and access to public dental services the needs of these specific groups must be taken into consideration, especially in terms of health promotion and early intervention.

- The cause of rheumatoid arthritis is unknown, however, research has shown that oral bacterial antigens can cause chronic infectious disease in the articular cavity of a joint and induce an immune response that results in arthritis due to inflammation (Okudo et al 1998). Ongoing oral health care is important as long-term use of medications for arthritis can cause gingivitis.

- Cancer, a health priority in Australia, is the leading cause of death in Australia. Early detection of oral or pharyngeal cancer, especially before it has metastasised, reduces illness and death. The survival rate for early stage cancer is 81% but only 22% for persons diagnosed with advanced stage cancer (Health People 2010). With early detection treatment is less complicated, functional and cosmetic results are better and survival is improved.

- Longitudinal studies conducted in the United States provide strong evidence that dental disease, usually periodontal disease, is a risk factor rather than an indicator of Chronic Heart Disease. The Dental longitudinal study on 1147 male veterans conducted over 18 years by the US Department of veteran affairs from 1968 to 1986 found that subjects with a high score for dental disease had almost twice the incidence of chronic heart disease compared to subjects with low dental disease scores (Loesche 2000). A health professional follow-up of 44,119 men aged 45 – 75 years found that individuals with pre-existing periodontal disease and less than 10 teeth were more likely to have chronic heart disease compared to men with more than 25 teeth (Loesche 2000).

- Albrecht et al. (1989) shows a higher prevalence of periodontal disease in people with diabetes than those without diabetes and research shows that people with periodontal disease have more difficulty controlling their blood sugar levels.

  Thorstensson quoted in Loesche (2000) has shown that among people with diabetes who have comparable blood sugar levels and insulin requirements that those with periodontal disease are more likely to have strokes than those without periodontal disease. Other longitudinal studies have shown that people with diabetes and advanced forms of periodontal disease were significantly more likely to develop angina, heart failure, myocardial infarction or stroke than those with a milder form of periodontal disease.

Dementia

Persons with dementia have had their oral health neglected, both in the community and in residential aged care settings.

In the Australian Institute of Health and Welfare, Adelaide Dental Study of Nursing Homes, Research Report 1999, the majority of whom were cognitively impaired, showed that there was:

- Low provision of care to nursing homes by dentists accompanied by low interest in this group
- Inadequacy of residential facility based dental treatment rooms and equipment to enable treatment of disabled and confused residents
- High prevalence of edentulism, coronal and root caries, and large accumulations of plaque and food debris

Two major reasons have been identified as then cause for the neglect of oral health of people with dementia. These are:

- Specialist skills are needed in maintaining the oral health of people with dementia, and these skills have not been adequately taught and integrated into care practices of family, carer, community and residential care staff and dental professionals
- Limited availability of dental services for those on low incomes or who are housebound or have cognitive deficits.

Untreated oral health problems have serious implications for people with dementia. This includes untreated pain from oral problems can cause behavioural symptoms with the result that often there is inappropriate use of psychotropic medicines and plaque accumulation is now known to be a cause of aspiration pneumonia which can lead to death

Methadone Programs

Methadone has assisted many people with an illicit substance dependency however it does have a side effect of causing a reduction in the production of saliva, which over a period of time leads to extensive tooth decay. NCOSS was informed that as methadone is seen as a long term treatment, it has meant that many people who have been assisted by the program now require dentures. Obviously the loss of teeth and poor oral health also leads to poor nutrition (from inability to eat a range of food) and recurrent infections (from lack of oral care).

Prisoners

According to the 2001 NSW Inmate Health Survey 43% of those whose last visit was to a prison dentist had a tooth extracted compared to 35% of those that visited a community dentist. It was also estimated that 87% of women and 70% of men surveyed felt that they needed an examination or filling. It goes on to comment, "*imprisonment represents an opportunity in which to intervene and remedy some of the deleterious lifestyle impacts on oral health*" (60). Therefore improving dental services within the prison system will address some of the demand for public dental treatments in the community

The impact on Socio-economically disadvantaged people

Poor oral health often impacts on a person's self-esteem and presentation, which significantly impacts on their ability to gain employment. A person with extensive dental decay and missing teeth is unlikely to get a job position over someone who has a 'great smile'. It has been suggested to NCOSS that there is a huge and as yet unexplored nexus between poor dental health and social disadvantage. Often "bad teeth" are associated with the poor, but there has never really been an evaluation of the impact of poor oral

health in the perpetuation of social disadvantage. NCOSS is unaware of any studies on the topic, yet it is a certainty that people with poor oral health (or worse, no teeth, as is often the case) have next to no chance of getting a job. Men may have the edge as they can grow a beard and moustache as a cover, but women do not have that option. It was stated to NCOSS that "*as a result self esteem plummets to zero and people no longer apply for a job or even train or educate themselves if they're embarrassed to be seen in public.*"

Hepatitis C

Evidence shows that people with Hepatitis C are prone to tooth decay resulting in low self-esteem and nutrition difficulties. They have an increased incidence of Xerostomia or dry mouth resulting in widespread dental decay and infections.

Cirrhosis of the liver results in the most significant problem for dental care, which can increase the likelihood of prolonged bleeding after dental procedures, therefore invasive dental treatments require consultation with medical specialists. Some medications are also proscribed for people with severe liver problems and dental professionals also need to be aware of these concerns and their impact on the person.

Dentists need to be made aware if people are on antiviral therapy, which can cause bleeding, so non-urgent invasive dental treatment can be delayed until the therapy has ceased.

Anecdotal information also shows that there are many incidences of discrimination by Dentists and dental practices if people disclose that they have Hepatitis C. One person reported, "*I waited three months to see the dentist. The day came, I had to fill out a form, and it came to Hepatitis C. I didn't know whether to tick it or not because I knew people wouldn't like dealing with it... the dentist made excuses about why he couldn't do the job... its made be really wary about whether to tell the truth and tell people I have Hep C. I feel like I should, so in actual fact I've stopped going to Dentists and Doctors." (C Change – Report of the Inquiry into Hepatitis C Related Discrimination: Anti Discrimination Board of NSW, November 2001, p.42)*

Residential Aged Care

At least half the people entering into residential aged care have some natural teeth; however they have poor oral health, as they have been unable to perform all the activities of daily living. Their oral health deteriorates rapidly once in a residential facility. People in a residential aged care facility develop 2 ½ times as much new dental decay in the residential facility as compared with people of a similar age in the community.

Nursing homes lack adequate equipment for dental services and dentists must compromise themselves financially when providing services to residential aged care patients (time spent on visits and traveling to and from the nursing home, means less time at their practice). The lack of adequate financial reimbursement and a structured system for care provision makes residential care dentistry an unviable option for most private and public sector dental professionals (Chalmers, Hodge, Fuss, Spencer, Carter and Matthew 2001).

Dentists also report being inadequately trained in geriatric and nursing home dentistry, and dentistry professionals provide little educational support to nurses/carers (Chalmers 2001).

Off site dental services for those in residential aged care facilities creates a barrier to the provision of dental care as they are often unable to access these.

Recommendations

24. That in all residential aged care facilities, the immediate availability of training courses to raise the awareness of paid carers and family members of the oral health requirements of ageing people and to implement strategies to maintain the oral hygiene of those that are impaired.

25. That an oral health assessment is made on each individual upon his or her entry into a residential aged care facility and that a checkup is conducted, at a minimum, of every 12 months.

26. That specialist dental treatment is given for people on the methadone program and is provided as a part of that program.

27. That there is ongoing training and education about the risks and preventative dental care for people who have a chronic and complex condition provided to both dentists, the people themselves and their carers.

Summary of Recommendations

1. An evaluation is made on the quality of dental services in NSW, particularly to the bulk of services provided in the private sector.

2. Current performance and outcome measurements should include improved oral health as a measurement.

3. That NSW Health funds a public dental health system that adequately meets the following characteristics and standards:

   - Focus on preventive dental services such as appropriate oral hygiene practices, access to and information on a healthy diet, regular check-ups, cleaning and scaling, fillings and restoration rather than extractions.

   - Ensures that treatment for decayed teeth and oral health diseases is appropriate, timely and evidence based. Taking remedial action when problems arise to prevent expensive, complicated dental care or tooth loss.

   - That no person should have to wait more than 24 hours to receive emergency dental care.

4. That the Dental Health Program should be funded at a minimum of $270m per annum with an ideal amount of $700m per annum to provide the same level of services to the socio-economically disadvantaged as the rest of the population and to cover subsidies to the private sector for public dental treatment.

5. That appropriate funding is provided to ensure that comprehensive oral health programs are operated through Aboriginal Community Controlled Health Services.

6. That the NSW State Government lobbies the Commonwealth Government to provide oral health care under Medicare.

7. That the State Government lobbies the Commonwealth Government to remove the 30% private health insurance rebate and the funding utilised for this put back into public health and oral health services.

8. That private health insurance funds should be lobbied to give rebates directly for dental services performed by dental therapists and dental hygienists. These rebates could be at a lower rate than that for dental services performed by dentists and specialists. As cost is a major barrier for access to dental services, reducing the cost of dental services should increase access to dental services.

9. That under the Oral Health Fee For Service Scheme the minimum payment made to dentists is equivalent to that offered under the Department of Veteran Affairs.

10. That all oral health providers are given cultural awareness training to increase the number of mainstream dental services that are able provide culturally appropriate services.

11. That there is ongoing training and education about the risks and preventative dental care for people who have a substance dependency, HIV/Aids, Hepatitis C, and the dental workforce that provides services to these groups.

12. That a dental unit, consisting of a dental therapist and support staff, is established in each public hospital (or at a minimum base hospitals) to provide emergency dental treatment and referral for ongoing treatment to the public dental system.

13. That GPs are trained in basics of oral health care as part of their undergraduate studies. (If a GP can provide care for an ulcer on the leg then surely they should also be able to provide care for an ulcer in the mouth.)

14. That the oral health workforce mix consists of health promotion, education, treatment and prevention staff.

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19. The recommendations of the Association for the Promotion of Oral Health submission on dental health workforce measures should be considered by this inquiry.

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27. That there is ongoing training and education about the risks and preventative dental care for people who have a chronic and complex condition provided to both dentists, the people themselves and their carers.

Organisations Consulted

Association for the Promotion of Oral Health
Break Thru Employment Solutions
Burnside Uniting Care
Combined Pensioners and Superannuants Association
Dental Therapists Association
Older Women's Network
Tenant Support Network
Tripole and Mena Association
Women's Health NSW

Individual consultations with people working in the public oral health sector and consumers

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