Submission
No 168

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation:	AIDS Council of New South Wales Inc
Name:	Mr Stephen Gallagher
Position:	Treatment Advocate & Policy Adviser
Telephone:	9206 2020

Date Received:	9/06/2005

Theme:

Summary

Submission to the

Inquiry into Dental Services in NSW by the

Legislative Council Standing Committee on Social Issues

May 2005

1. Who We Are

ACON (AIDS Council of NSW Inc) is a health promotion organisation based in the gay, lesbian, bisexual and transgender communities with a central focus on HIV/AIDS. We provide HIV prevention, health promotion, advocacy, care and support services to members of those communities including Indigenous people & people who inject drugs, to sex workers and to all people living with HIV/AIDS. ACON has offices in Sydney, Western Sydney, Illawarra, Northern Rivers, Hunter and Mid North Coast with an extensive range of outreach services. ACON is also home to the Community Support Network (CSN), the Positive Living Centre (PLC), the Lesbian and Gay Anti-Violence Project (AVP) and the Sex Workers' Outreach Project (SWOP).

PLWHA (NSW) strives to be an authentic representative of the voices of the 9,000 HIV positive people living in NSW – over 60% of the Australian HIV positive population.

Together with a range of other non-government agencies, we represent the face of the community-based response to HIV in NSW. Both agencies began as part of the initial crisis response to the Australian epidemic and we have continued to evolve and shape as the epidemic has changed. NSW was and is the epicentre of the Australian epidemic, containing the major part of both infected and at risk populations.

2. Background to our submission

Our comments contained within this submission focus particularly on these Inquiry terms of reference predicated by a brief outline of dental and oral health concerns related to HIV disease.

(a) the quality of care received in dental services,
(b) the demand for dental services including issues relating to waiting times for treatment in public services,
(c) the funding and availability of dental services, including the impact of private health insurance,
(d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,
and
(e) the dental services workforce including issues relating to the training of dental clinicians and specialists.

3. HIV and oral/dental health

It's estimated that 90% of people with HIV will develop at least one oral condition associated with HIV disease. These conditions, like candidiasis and hairy leukoplakia, may be the first indication of immune suppression associated with HIV infection and in many people are the first signals that lead doctors to encourage HIV testing. Most show up as lesions or sores and can be categorized into four types: abnormal cell growth, bacterial, viral and fungal.

The most common oral conditions associated with HIV infection are discussed below.

Oral Hairy Leukoplakia

Oral hairy leukoplakia (OHL) a viral infection similar to Epstein Barr virus (EBV) is one of the most common HIV-related oral conditions. It can occur very early in HIV disease and may indicate an increasing risk of other, more serious illnesses.

Gingivitis and Periodontal Disease

Gingivitis is inflammation of the gums, sometimes accompanied by bleeding and bad breath, caused by a bacterial infection. Periodontal disease includes all diseases of the gums, teeth and underlying bone. People living with HIV are more susceptible to these conditions and may also experience more rapid and severe forms of gingivitis and periodontal disease. These more severe forms include linear gingivitis erythema (LGE) and necrotizing ulcerative periodontitis (NUP), conditions that occur almost exclusively in people living with HIV.
Linear gingivitis erythema, or red band gingivitis, is marked by a profound red banding along the teeth where the gums and teeth meet. Because it's often associated with occasional bleeding, LGE may be difficult to tell from ordinary gingivitis. LGE is related to, and may be a precursor of, other HIV-related NUP. NUP is a serious condition that causes pain, spontaneous bleeding of the gums and rapid destruction of gum tissue and bone, which may ultimately lead to tooth loss.
With the advent of newer pharmacological approaches to the treatment of HIV infection, the incidence and progression of periodontal disease is changing. The incidence of necrotizing periodontitis and gingival diseases of fungal origin appears to be on the decline as a result of these therapies but rates among HIV positive people remain much higher than in the general population. It should also be noted that in cases where these therapies lose their effectiveness and HIV patients relapse into a severely immune suppressed state, these conditions may recur. Recent evidence has shown that HIV patients with more conventional periodontal diseases such as chronic periodontitis may have increased attachment loss and gingival recession when compared to their HIV-negative counterparts. This pattern of loss of periodontal support may be due in part to a diffuse invasion of bacterial infections, viruses, and fungi into the gingival tissue, leading to a more elevated and more destructive response in the periodontal soft and hard tissues.

Oral Candidiasis

Also known as thrush, oral candidiasis is perhaps the most common oral condition in people with HIV. A healthy immune system can suppress the growth of this fungus, but even a mildly compromised immune system may not keep the fungus in check. Most outbreaks occur when the CD4+ cell count falls below 400. But other factors may cause candidiasis, such as prolonged stress, depression, and use of antibiotics. A trained dental professional can identify and distinguish the most common types of

candidiasis that affect people with HIV. Symptoms may include red patches, white patches and clefts or grooves. They may or may not cause minor pain. Early detection and intervention is crucial as protracted Candidiasis will result in significant taste disturbance, loss of appetite and subsequent weight loss and debilitation.

Dry Mouth (Xerostomia)

Dry mouth, or xerostomia, is a common condition in HIV disease that may have a variety of causes. HIV disease itself may cause dry mouth because HIV-related salivary disease causes swollen salivary glands. That, in turn, reduces the amount of saliva in the mouth. A dry mouth is also a side effect of some anti-HIV drugs and other medications like antihistamines and antidepressants. Allergies and infections may also cause dry mouth. Leaving dry mouth untreated may lead to problems. Without enough saliva, food can build up in the mouth, between the teeth and gums and promote tooth decay, periodontal disease and candidiasis. Furthermore, a lower flow of saliva can cause high acid levels to persist long after eating, which can wear out the enamel on the teeth leaving them more susceptible to cavities and other problems.

Oral Ulcers (Aphthous Ulcers)

Occur on the mucous membranes and present as painful, red inflamed open sores. They are commonly caused by reinvigorated immune response following therapy-based immune reconstitution, though a significantly suppressed immune system, HIV medication side effects and trauma to the area may also lead to oral ulcers. They may also be a symptom of other viruses such as the Herpes Simplex Virus (HSV) or Cytomegalovirus (CMV), both of which are much more prevalent in HIV positive people than in the general population.

Angular Cheilitis

A mixed fungal and bacterial causing inflamed red patches and cracks in the corners of the mouth and very commonly experienced by HIV positive people.

Other Indications

Many HIV positive people experience marked hypertension as a result of treatment which frequently militates against the ability to perform extractions or other oral surgery procedures at the appropriate time. It's also of note that research is currently being conducted into possible linkages between oral disease burden and increased cardiovascular risk. Given that many HIV positive people are at increased risk of cardiovascular disease, as a therapy side-effect, the outcome of this study may be very topical.

Poor oral health presentation incorporating decayed and missing teeth, periodontal disease and other gum disorders conveys an unmistakable social stigma on the person so inflicted. Many HIV positive people present in this way at enormous cost to self-esteem and job prospects in an era when benefit entitlement scope is rapidly shrinking. Many PLWHA who would like to return to work face an often overwhelming dentistry reparative barrier, in terms of time, access and cost before they perceive themselves to be competitive candidates in the employment market. Indeed in many cases, normal social interaction is impaired by dental problems that impact HIV positive people with very specific effect.

4. ***The early intervention imperative***

Many of the conditions outlined are eminently treatable but treatment is reliant on the sort of regular dental checkups/professional interventions that are increasingly difficult for HIV positive people to access and sustain. With waiting times in public dentistry extending out to several months in many cases and given an increasingly variable HIV-specific response the chances of achieving effective intervention inevitably lessens. It's worthy of note that HIV positive people report themselves less rather than more likely to seek treatment as oral health deteriorates given the scale of the treatment challenge they perceive. This is particularly so in the case of people who may have been able to return to the workforce as a result of treatments-led wellness. In low paying, often part-time or casual work and without access to health care concession, access to dental services is often an unaffordable luxury that tends to occur sporadically and generally in unavoidable emergency. It needs to be emphasised that very few HIV positive people have access to private health insurance given that HIV clinical services are almost entirely publicly provided in Australia and relatively few PLWHA have the resources – or incentive – to apply for private health cover.

The extent of need vs. service provision

As previously mentioned over 60% of Australians living with HIV/AIDS reside in NSW, of whom approximately half are in receipt of social security benefit, placing approximately 4-5,000 people in need of public dental services, the capacity of which has reduced dramatically since the cessation of Commonwealth funding in 1997. Currently, NSW allocates approximately $260,000 per annum to assist in the provision of public dentistry for HIV positive people. This funding – referred to as the NSW HIV/AIDS Dental Program (program 2.3) – is allocated each year across three area health services (South East Sydney and Illawarra; Southwest Sydney; and North Coast). The funding was never meant to cover the cost of all the dental needs of PLWHA in these Areas but, rather, it was meant to supplement public dental services to improve access for PLWHA. There is however no empirical evidence to suggest that access has improved and a significant body of anecdotal evidence that might suggest entirely the opposite. In Southwest Sydney for instance the funding is provided to the United Dental Hospital which closed its specialist HIV unit some years ago. HIV positive patients are now 'mainstreamed' within the hospital and have experienced greatly increased waiting times as a result,

despite a demonstrated oral disease burden greatly in excess of that within the general population. St Vincent's Hospital does provide HIV-specific outpatient dental services but the service is very heavily subscribed and is specific to South East and Illawarra Area Health Service only.

Clearly, the longer the waiting interval the greater the chance of suboptimal outcomes and the less likely it is that effective intervention will occur.

6. ***The terms of reference***

The following terms of reference are addressed in this section;

(a) The quality of care received in dental services;

The dental and oral health conditions related to HIV disease as demonstrated in the preceding section of this submission are wide ranging and complex. The number of people living with HIV/AIDS in need of public dental services in NSW – and their geographical spread - has meant that comprehensive expertise in HIV dental care has been sub-optimal, particularly in most non-metropolitan areas of NSW.

A perceived loss of expertise has occurred following the dilution and mainstreaming of HIV-specific dentistry expertise in some areas and services other than tooth extraction and fillings are in particularly short supply everywhere. While overseas data show that HIV-specific health promotion initiatives can have significant benefits in achieving better oral health standards amongst HIV positive people, the state currently provides very little program funding aimed at so doing.

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

The lengthy waiting times for basic dental services for people with a chronic illness such as HIV can have significant detrimental effect on dental and oral health as well as other systemic health conditions exacerbated by infection or late diagnosis. Delayed treatment also has serious implications for the quality of life of people with HIV/AIDS and for added cost in other areas of the public health system.

The system of triage currently utilised by public dental services often fails to adequately take into account the unique nature of oral and dental health conditions related to HIV, relegating patients to periods of undue pain and infection. Furthermore inconsistent basic assessments offered to people with chronic conditions by most public facilities in NSW results in inappropriate triage.

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

Outside the Areas currently covered by program 2.3, HIV specific funding is highly variable and often non-existent.

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

In the early years of the epidemic, much adverse publicity focussed on the specific dangers of dentistry-related HIV transmission - albeit no such cases have ever been recorded. Nevertheless, the impact was sufficient to leave an aura of heightened trepidation about the risks amongst both oral health practitioners and HIV positive patients. While there is much more awareness of the importance of standard infection control procedures in reducing procedure risk across the full spectrum of blood-borne viruses, an educative mission remains to ensure total understanding. A recent incident at the United Dental Hospital is illustrative of this. An elderly HIV positive man – whose serostatus was known to the dental staff – was contacted at home following an extraction. The dentist informed him that he, the patient, had bitten a dental technician during the procedure and that the patient's medical records were required for perusal in order to "decide what to do." After advocacy intervention it was revealed that the technician had not been bitten, was wearing a double thickness of latex gloves and had "over-reacted." In the meantime, the patient had been made to feel responsible for what (hadn't) occurred to the point that he feared prosecution. We don't suggest that this case is indicative of general practice standards at UDH but it does provide an insight into the need for continuing education in this area. This is particularly so in public dental provision where turnover is high and foreign-trained practitioners form a high proportion of the workforce.

It's also worthy of note that HIV positive people frequently report feeling a heightened responsibility around transmission risk in dental settings, a responsibility sourced in the same historical scare campaigns referred to above. It's clear that any factors which might contribute to an already suboptimal oral health attendance rate should be resolved by specifically targeted education programs.

7. Conclusion

We acknowledge that HIV related issues are but one relatively small part of the public health challenge in relation to Oral Health service delivery in NSW. We also acknowledge that HIV service delivery in NSW is generally best practice, comparatively speaking, in the Australian context. Further we don't underestimate the challenge posed by the Commonwealth's unilateral decision to frame publicly-funded oral health delivery as solely a state issue.

However, in the nine years since Commonwealth funding ceased – nine years in which the HIV oral disease burden appears to have increased substantially - there has been little attempt to address HIV oral health needs in NSW in any significant way. We would contend that relatively minor adjustments in funding and service delivery and particularly the provision of preventative health promotion could make a substantial difference. We would be enthusiastic participants in any exercise or endeavour aimed at rectifying the situation.