COTA SOUTH AUSTRALIA
For older Australians

COTA SA SUBMISSION

SOUTH AUSTRALIA'S ORAL HEALTH PLAN 2019-2026 – first draft

Prepared by
COTA SA

24 April 2019

COTA SA

16 Hutt Street
Adelaide SA 5000
(08) 8232 0422
www.cotasa.org.au

Authorised by:
Name Jane Mussared
Title Chief Executive
Email address jmussared@cotasa.org.au
(08) 8232 0422

Prepared by:
Name Nicola Thurston
Title Policy Coordinator
Email address nthurston@cotasa.org.au
(08) 8232 0422

Who is COTA SA? COTA SA is an older people's movement run by, for and with older people. We represent the aspirations, interests and rights of 633,000 older South Australians. COTA SA reflects the diversity of modern ageing in terms of living arrangements, relationships, income, health, ambitions and aspirations. COTA SA connects with thousands of older people each year throughout SA. COTA SA's social enterprise, The Plug-in is available to facilitate access to older people with lived experience and feedback about health in SA.

INTRODUCTION

COTA SA welcomes the opportunity to comment on the first draft *South Australian Oral Health Plan 2019-2026*. Our comments build on those made in our response to the *Oral Health Consultation Paper* in June 2018.

The COTA Federation's 2018 comprehensive national survey *The State of the (Older) Nation* found that health was the most important factor – just ahead of cost of living – affecting older people's quality of life. Both well and truly impact wellbeing. Oral health is part of the health picture, but traditionally has been considered separately even though dental decay is the third highest cause of preventable hospital admissions. Poor oral health is as debilitating as any other chronic health condition and often occurs in conjunction with (and contributing to) other chronic conditions.

Our comments on the first draft naturally reference the community we are most concerned about – people aged 50+ on low incomes. We note that SA Government spending on public dental care in 2016-7 as reported by the Australian Institute of Health and Welfare is one of the lowest in the Commonwealth.

Q1. Do the action areas outlined in the Draft SA Oral Health Plan address the areas of service need and/or service gaps?

Oral Health Promotion

1.2b Improve the oral health literacy of priority populations and build their capacity to make healthy choices

COTA SA notes the plethora of information already available through the oral health promotion unit in the form of simple diagrams and pictures. Future promotion must look at using a broader range of media – radio, TV and social media – as well as opportunities to target information to priority groups. Further to the COTA SA June 2018 submission, we reiterate that partnerships have the potential to offer a cost-effective way to reach a far greater proportion of individuals over the age of 50 including through COTA SA's well established volunteer peer support programs.

The selected use of real images of oral disease should be tested for their impact on oral health behaviour.

1.3b Promote the benefits of and advocate for affordable nutritious foods and oral hygiene products in regional and remote communities

Given that the dental status of older adults on low incomes is likely to be worse than others in the community, priority should be given to the promotion and affordability of oral hygiene products in all areas, including regional and rural areas. People living in regional and remote communities must also have access to services and treatments which resolve their immediate dental distress.

The effects of medications on oral health needs specific attention – for example, dry mouth as a side effect of some medications has adverse impacts on oral health and particularly affects older adults. A peer education program about what good oral health looks like, linked with particular strategies for adults on medications which may impact their oral health, has the potential to help people manage their own oral health more effectively

1.5 Advocate for the integration of oral health in general health and education policies and plans at the local, state and national level.

The recent Grattan report notes: "The separation of oral health from general health is the biggest gap in Australian health care coverage. The integration of oral health with general health is something everyone would support … The phased introduction of Medicare cover for dentistry would mean that the oral health-general health nexus has been recognised."[1]

However, in the situation we have now it remains hard to see how oral health will be integrated into general health plans without further and high level policy development which mandates the integration of the two separate health systems.

In the interim, governments must mandate the inclusion in general medicine and nursing education programs some specific aspects of dentistry and oral health.

Accessible Oral Health Services

2.3b Work with the Australian Government to ensure low income earners are able to receive regular dental check-ups and timely treatment

The provision of regular check-ups and timely treatment – particularly for people who have a high risk of developing oral health problems, or of those problems worsening over time – is highly recommended. The Productivity Commission recommended that public dental services should benchmark waiting times for different types of users to ensure dental care can be accessed in an appropriate time fame.[2]

The current wait times for treatment through the SA Dental Service remain too long; a target should be set for reduction of wait times for non-urgent treatment of three months.

The picture around prevention has been mainly through promotion. Provision of subsidised dental services as part of the prevention picture, rather than only at the acute stage of treatment, has the potential to deliver significant benefits for both oral and general health.

Systems Alignment and Integration

3.2b Incorporate dental health into existing screening, care planning and care processes for carers and care workers of frail older people

The effective and proactive management of the oral health of older people (particularly for people with frailty or dementia) should be of the highest priority but it is frequently poorly understood and often neglected.

---

[1] Grattan Institute (March 2019) *Filling the gap. A universal dental scheme for Australia.* Stephen Duckett, Matt Cowgill and Hal Swerissen

[2] The Australian Productivity Commission (October 2017) *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*

COTA SA recommends the SA Government work with the Australian Government to make specific reference to oral health in the aged care standards and for the inclusion of training about oral health into certificate courses in aged care.

The statement "oral cancers are commonly experienced by older persons" would appear to be incorrect - while oral cancers are more common in older people, they are not commonly experienced. It is more important to identify dry mouth as a frequent cause of tooth loss, tooth decay and gum disease. Dry mouth occurs largely due to the side effects of medications including those taken for diabetes and cancer; conditions which are more likely in the older population. Dry mouth induces bacterial plaque retention which in combination with lack of simple hygiene and dietary impacts leads to dental breakdown.

3.3 Optimise the use of technology to enhance oral health service delivery and increase health system integration in SA

Dental health is not currently included in the list of telehealth services and it is not currently part of the Medicare system. COTA SA supports government funding for a telehealth style pilot project which focuses on older people's oral health and advocacy for the inclusion of oral health care as part of Medicare.

Workforce Development

5.2b Increase the representation and engagement of Aboriginal and Torres Strait Islander people in the SA oral health workforce.

COTA SA understands that some methods have been tried and failed. We urge the government to adopt methods which have been successful. For example, we understand that clinics in other States which are designated as Aboriginal health centres staffed largely by people from Aboriginal backgrounds have a proven record of success even when the treatment may not be provided by Aboriginal health care staff.

Q2. Are there additional action areas required? If yes, what are they?

Denture care and mouth care for people with dentures has not been addressed. For denture wearers, dry mouth and poor hygiene can lead to persistent fungal infections in the mouth especially where there are other co-morbidities. Stories of nursing home residents suffering from oral thrush are sadly not uncommon, as are stories of nursing home residents being fed pureed food because they cannot chew.

Dental care within aged care is a huge gap. Current and future generations of people who need care and support whether at home or within a care facility are likely to have had more complex dental treatments - including implants - which require continuing oral hygiene to remain viable.

The Productivity Commission recommends that public dental service should start measuring the outcomes of their services in terms of the oral health of their users. They also recommend that public dental services should adopt digital health records to improve linkages with the broader health system and enable greater continuity of care. Both these points go well beyond the routine data collection and reporting statement in the plan.

A substantial proportion of adults in low income households do not hold a Healthcare Card or a Pensioner Concession Card which means they cannot access care through the SA Dental Service clinics. This compromises the good health of some older people and increases their risk of preventable infection.

Q3 Are there action areas included in the draft plan which are not required? If yes, what are they and why are they not required?

There are no action areas which are not required. The question remains how the plans will be actioned and how the efficacy of the actions will be measured to inform future planning.

Q4 What are the barriers to implementing the SAOHP? How can they be overcome?

One of the barriers to implementation lies around the lack of targets for the activities. Another lies in the integration of oral health into general health systems which, as previously noted, will require high level policy implementation.

Q5 What will assist the implementation of the SAOHP?

Implementation will be improved by detailing how progress against the plan and the efficacy of activity will be measured – eg. "improve health literacy of priority populations and build their capacity to make health choices". How will that be measured? The same comment applies to most of the other actions.

Other Comments

Oral cancer is mentioned several times within the document as a major disease and a key contributor to poor oral health, starting with the section "What is oral health?". Our advice is that this statement is not necessarily accurate. Although oral cancer is a serious disease and affects older people more than younger ones, it is not common. Some other general statements within the plan also need refining – for example, periodontal disease is uncommon in children but more prevalent in adults.

Our advice is that the section "What is oral health?" needs to accurately identify which dental conditions are most common in specific groups. We accept that the plan has adopted the National Oral Health Plan definition of what oral health is but suggest that perceptions will vary widely among the general population, including older people.

The plan needs more detail about how oral health initiatives and services will be evaluated – both at a clinical level and patient reported measures.

We acknowledge that it is common for people to think only about dental care when the situation cannot be ignored any longer – that is when pain or compromised quality of life creates an urgency. Clinical advice, as well as effective oral health promotion, is important in raising awareness about oral health and preventing acute conditions.

COTA SA acknowledges the comments of David Wilson in the formation of this submission. David is a former Professor of/registered Specialist in Oral & Maxillofacial Pathology, a former Fellow of the Faculty of Oral &Maxillofacial Pathology, Royal College of Pathologists of Australasia and a former Fellow of the Royal College of Physicians and Surgeons Glasgow.