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23/03/2020

Sarah Bohmer
Lawyer
Royal Commission into Aged Care Quality and Safety
Via Email: [redacted]

Dear Sarah

Re: ADA NSW Response to Adelaide Hearing 5 Draft Propositions

Thank you for sending a copy of the Draft Propositions in preparation for the Adelaide Hearing on Oral Health Services. As this hearing has now been postponed indefinitely and you have indicated that Counsel plans to develop recommendations from the information received via the various witness statements, I would like to offer the following additional responses to the draft propositions:

- I fully support the overall concept of Proposition D1 (p8) and have no further comment to make on points 30-35.
- With regard to point 36, I would like to make the point that proposed method of funding utilising the DWAU measurement needs further consideration. This measurement does not take into consideration the complexity of providing services for this special population or of the provision of oral health services in an outreach environment. Ideally, in the future, oral health service provision will move towards an outcome-based funding model that focuses on patient-centred care rather than item-based funding but until this time, the Commission should note that funding based on DWAU's derived from the ADA item numbers will be a gross underestimation of the actual costs of service provision to this population, especially in outreach services.
- Point 37, recommending that all funded services are provided by the public oral health services (either directly or via outsourcing to private providers) will lead to a great deal of additional paper work and double-handling. Patients will need to be screened or examined by the public service and then examined again by the allocated provider. To avoid this red tape and double-handling a funding model similar to the Child Dental Benefits Schedule (CDBS) allows for a public/private delivery model.
- Point 38 on waiting lists. Although, the separate funding stream may avoid any waiting lists for the elderly, as it would take considerable time to scale up public services to meet the necessary workforce numbers, it would most likely need to be met by diverting resources from the care of the eligible adult and child services. So, it is likely that this would increase waiting lists for these other important populations at risk.
- I am in full agreement with Proposition D2. Point 43 poses the question of mandatory ongoing oral health training for personal care workers. I recommend that training is mandatory, particularly in light of 44 that highlights that this workforce has a high turn-over rate.
- I am in full agreement with Proposition D3.

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- With regard to Proposition D4, it is important to re-emphasize that the dental profession works as a team, with all members (Dentists, Dental Hygienists, Dental and Oral Health Therapists and Dental Prosthetists) all having a valuable role in working to the extent of their scope of practice. For this reason, I cannot support a funding model that excludes two important registered dental practitioners – Dentists and Dental Prosthetists.
- I draw your attention to point 53, that is inaccurate. Dental Hygienists and Oral Health Therapists with adult scope of practice are unable to perform extractions of permanent teeth. Their training does not include extractions in the elderly where there are additional considerations of frailty (fragile alveolar and mandibular bone) and complex medical histories including multiple prescribed medications. Dental Hygienists do not perform restorations at all. There may be a small number of Dental therapists trained before 2002, who have gained adult scope of practice, for extractions of permanent teeth, but they certainly would not be experienced in providing this treatment for the frail elderly. This treatment must be provided by Dentists and Oral Surgeons. Similarly Dental Hygienists, Oral and Dental therapists cannot provide any services to maintain or repair existing dentures or provide new ones as required, these services must be provided by Dental Prosthetists and Dentists.
- Point 54, I support the proposition for the funding to be to Dental Practitioners and not to RACF and re-iterate that a CDBS-like model is the model of choice. It is Dental practitioners who are trained in oral health service provision and not RACF staff.
- Point 56, whilst oral health assessments do not directly improve the oral health outcomes of the elderly they are the essential key to improvements. Oral health assessments inform all involved, carers, family and RACF staff of the oral health status and the daily maintenance, prevention and treatment requirements. So without them there can be no improvements.

Finally, I would like to make a comment on the Canberra hearing proposition on primary health care services. It is essential that registered dental practitioners are part of the multi-disciplinary services. I support the concept in CH17 of Care Co-ordinators, but these new members of the aged care team must also be educated about oral health and be able to ensure that oral health services are provided as part of the overall care for the older adults under their care.

I thank you for the opportunity to provide these further comments. If I can be of any further assistance I would be very willing to meet with Counsel via teleconference in the near future.

With kind regards

Dr Kathleen Matthews
President

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