AUSTRALIAN DENTAL ASSOCIATION

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Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
PO Box 483
Darlinghurst NSW 1300

By email: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan

Re: Consultation on Pricing Framework for Australian Residential Aged Care Services 2024-25

Thank you for considering the Australian Dental Association's (ADA) comments on the Independent Health and Aged Care Pricing Authority's (IHACPA) consultation on the pricing framework for Australian residential aged care services 2024–25. Please see below our responses to questions raised in the consultation.

Consultation Questions

Do the current Australian National Aged Care Classification (AN-ACC) classes group residents in a manner that is relevant to both care and resource utilisation? (That is, require the same degree of resources to support their care delivery). What evidence is there to support your answer?

The Australian National Aged Care Classification (AN-ACC) classes *do not include oral health considerations*. This is a concern to the ADA. We believe that oral health screening should be incorporated into the AN-ACC model, encompassing assessments, care plans, and preventive measures.

Oral health is the foundation of overall health, happiness, and quality of life. People who have a healthy mouth can eat, speak, and interact with others without experiencing discomfort.[1] Poor oral health is more pronounced in residents of aged care facilities due to limited access to dental care.

Tooth loss can affect the process of chewing and swallowing, which can in turn, affect proper nutrition intake and can exacerbate pre-existing health issues. Poor oral health can affect mental health, leading to anxiety, depression, and poor self-esteem.

More seniors are keeping their natural teeth longer, leading to more fixed and partial dental replacements in this age group. Cleaning these teeth requires complex and time-consuming methods. However, caregiving staff often find these methods difficult to perform within patients' allocated oral hygiene time. Seniors might not cooperate due to other health and behavioural issues and may lack the skills and vision to maintain oral hygiene by themselves.

[1] Australian Institute of Health and Welfare. (2023). Oral Health and Dental Care in Australia: Introduction. Australian Institute of Health and Welfare. [https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction]

Consequently, bacteria accumulate in their mouths, heightening the risk of infections like aspiration pneumonia.[2] Evidence also demonstrates links between poor oral health and chronic conditions like diabetes and cardiac disease in older populations.[3]

The Aged Care Royal Commission's final report emphasised the importance of oral health. Relevant recommendations from the final report, which we commend to IHACPA's consideration, are discussed further below.

What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

The AN-ACC assessment tool considers assessing residents on physical, cognitive, behavioural, and mental health abilities. It lacks provision for assessing oral health requirements of residents, which drives a lack of funding to meet the oral health needs of aged care residents.

The assessment process should incorporate oral health screening and enable comprehensive oral health care plan development.[4] Ideally, an oral health practitioner with appropriate training in evaluating the oral health of elderly populations should conduct the assessment and develop the care plan. To complement this, physicians, nurses, and pharmacists could play a helpful role in the early detection, prevention, and referral of oral health issues.

AN-ACC independent assessors, primarily comprising registered nurses, physiotherapists, or occupational therapists providing clinical services in aged care settings, often have minimal knowledge about oral health. Assessors should have an appropriate understanding of how to assess the oral health of elderly Australians, and complete training on such where needed. More emphasis should be placed on promoting, educating, and raising awareness about oral health for residents and aged care staff.

Few personal caregivers possess the skills necessary to properly clean teeth, gums, and dentures. Caregivers also often have a limited understanding of the correct timing and process for referring individuals for dental consultations or necessary treatments. Caregivers and family members would benefit from further education on these points. They should undergo training to acquire skills relevant to oral health and funding should be available for continuing education and training.[5]

What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

Individuals who – have multiple health conditions, take multiple medications, or experience cognitive challenges, or physical limitations – often have complex dentitions and, as such, require significantly greater support from dental professionals and personal caregivers.

We understand that IHACPA's pricing advice will predominantly be based on historical cost data. We suggest IHACPA explore whether data relating to comorbidity trends, including those discussed above, is available and might be useful to inform the indexation methodology.

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[2] Müller F. Oral hygiene reduces the mortality from aspiration pneumonia in frail elders. J Dent Res. 2015 Mar;94(3 Suppl):14S-16S. doi: 10.1177/0022034514552494. Epub 2014 Oct 7. PMID: 25294365; PMCID: PMC4541086.

[3] Australian Institute of Health and Welfare. (2023). Oral Health and Dental Care in Australia: Introduction. Australian Institute of Health and Welfare. [https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction]

[4] Royal Commission on Aged Care Quality and Safety. (2021). Final Report Recommendations – recommendation 38. Retrieved from Aged Care Royal Commission Final Report: Recommendations

[5] Royal Commission on Aged Care Quality and Safety. (2021). Final Report Recommendations – recommendation 114. Retrieved from Aged Care Royal Commission Final Report: Recommendations

What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?

This category comprises individuals with mental health conditions, those with physical, intellectual, and developmental disabilities, individuals with intricate medical requirements, and frail older individuals.[6] This group is more susceptible to oral health problems.

Residents with complex needs due to developmental disabilities and medical conditions often need hospital treatment under general anaesthesia (GA) for specialised services and dental care. However, the 'catch-all' arrangement of DRG D40Z is contributing to hospitals choosing not to make theatre space available for special needs patients who need dental treatment under GA. This is discussed further under 'other comments' below.

What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?

Oral health outcomes of individuals residing in rural and remote regions, in aggregate, tend to trail those living in metropolitan and larger urban areas. Probable contributors to causation include scarcity of dental professionals, inadequate affordable transportation options, and reduced access to fluoride. This tends to suggest that where ambition to close the gap on health outcomes exists, greater funding for individuals residing in rural and remote regions is often needed.

The Royal Commission on Aged Care Quality and Safety relevantly recommended providing funding to approved providers for the engagement of allied health professionals through a blended funding model, including:

- a capped base payment per resident designed to cover about half of the costs of establishing ongoing engagement of allied health professionals
- an activity-based payment for each item of direct care provided

with the Pricing Authority determining the quantum of funding for the base payment and the level of activity-based payments, including by considering the extra costs of providing services in regional, rural, and remote areas.[7]

We suggest that the Royal Commission recommendation discussed immediately above, pertaining to care-related costs and impact by service location be considered, as well as the Royal Commission's other recommendations pertaining to funding for oral health – which are summarised below.

What, if any, evidence or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?

Oral health is a key issue highlighted in the final report of the Aged Care Royal Commission. Recommendations from the final report that are relevant to oral health, and which we consider will help inform IHACPA's considerations are:

- Recommendation 19: Urgent review of the Aged Care Quality Standards, particularly focusing on optimal oral care, with comprehensive clarification of the requirements and strategies for achieving them.
- Recommendation 38: Residential aged care to include allied health care including employ or retain an oral health practitioner.
- Recommendation 60: Establishment of a Senior Dental Benefits Scheme

[6] Australian Institute of Health and Welfare. (2023). Oral Health and Dental Care in Australia: Introduction. Australian Institute of Health and Welfare. [https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction]

[7] Royal Commission on Aged Care Quality and Safety. (2021). Final Report Recommendations – recommendation 38. Retrieved from Aged Care Royal Commission Final Report: Recommendations

- Recommendation 79: Evaluation of Certificate III and IV courses to potentially incorporate oral health as an essential skill.
- Recommendation 114: Immediate allocation of funds for education and training to enhance care quality, including a specific focus on improving oral health.

How could, or should the AN-ACC model be modified to be used for National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?

We note the likely interaction between the AN-ACC model and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, and that there can be challenges inherent with attempting to harmonise or incorporate different models and programs.

An important step, for all residents, involves conducting oral health assessments and establishing individualised oral health care plans facilitated by dental practitioners. Emphasising preventive oral health measures is also vital. And as discussed earlier, staff training is important for effectively addressing residents' oral health needs, including identifying potential issues.

Other comments

Complexity split of AR-DRG D40Z

Under the Australian Refined Diagnosis Related Groups Version 10.0 (AR-DRG Version 10.0), DRG D40Z Dental Extractions and Restorations is the single 'catch-all' DRG used to classify dental treatment under general anaesthetic. This DRG fails to capture complexity. The 'catch-all' arrangement of DRG D40Z is contributing to hospitals choosing not to make theatre space available for special needs patients who need dental treatment under GA.

We request IHACPA consider creating a complexity split in future versions of the DRG. We have highlighted this theme in other contexts and would be happy to discuss it in more detail, upon request.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact [redacted].

Yours sincerely,

Dr Scott Davis
Vice-President