

KEY POINTS

- The dental profession agrees with the US Surgeon General when he says “(W)e ignore signs and symptoms of oral disease and dysfunction to our detriment. ... You cannot be healthy without oral health.”
- Notwithstanding the efficiency that may be achieved by maintaining a consolidated health record about a patient, the liability issues affecting dental practice mean that dentists will inevitably want to take their own medical history on each patient.
- “(P)athways/protocols for guiding consumers through the service system” (p.11), are likely to become protocols by which to deny patients access to care when they need it.
- The current dental demand levels are artificially reduced, because GPs and others involved in the PCPs are not well informed about symptoms requiring referral for dental treatment and where to go to obtain it.
- Patient confidentiality concerns, and risks associated with patients misreading records designed for professional rather than lay reference, may further impede use of the internet for health information management.

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1. INTRODUCTION

The Victorian Branch of the Australian Dental Association (ADAVB) is pleased to provide this feedback on the Discussion Paper re Information Management in connection with Primary Care Partnerships. This submission is a companion to the one provided on Better Access to Services (Attachment A), in which we argue strongly that dental services have been somewhat neglected in the development of Strategic Directions for the PCP. The other recent Branch submission relevant to the issues covered herein is that concerning the Draft Health Records Bill (Attachment B).

The ADAVB represents most dentists in Victoria, since we have over 95% of private sector and around 60% of public sector dentists as members. We therefore have an interest in proposed arrangements for referral of patients to dentists, and the information management processes accompanying such referrals. Dental services are mentioned in passing within the PCP papers, but only as a minor component of the Primary Health area (refer Table 1 p.7 of the Information Management Discussion Paper).

2. DENTISTRY AND THE PCP

It was a stated intention in the Department's previous publication "Primary Care Partnerships: Going Forward" (April 2000) that "programs would aim to improve people's health and wellbeing, and reduce the preventable use of hospital, medical and residential services by early identification of people's needs, and by coordinating care for people with complex or chronic conditions" (page V). The Draft Policy Framework for Better Access to Services also notes that:

"... partnerships need to actively involve the broad range of community providers in the development and implementation of local service models. Particular consideration needs to be given to the issues of smaller, specialist, regional and Statewide services, and the opportunity these services provide in influencing and strengthening local mainstream services".

Clearly, the dental service area is one of the key specialist services requiring attention in this undertaking. Our submission assumes that this will be recognised, as will the need for adequate funding to address the unacceptable waiting lists for basic dental care. The key arguments regarding the importance of including dental services more prominently in the PCP strategy are contained in the companion submission regarding Better Access to Services, and the reader is referred to that paper for statistical and other arguments in support of this proposition.

To reinforce the significance of including dental assessment referral diagnosis and treatment in the PCP, we draw attention to the recent U.S. Surgeon General's Report "Oral Health in America", which emphasises that "oral health is essential to the general health and wellbeing of all Americans, and can be achieved by all Americans" (p.1). This is equally true of all Australians.

The Surgeon General also highlights

- the capacity of a thorough oral examination to “detect signs of nutritional deficiencies as well as a number of systemic diseases, including microbial infections, immune disorders, injuries and some cancers” (p.1)
- new research that “is pointing to associations between chronic oral infections and heart and lung diseases, stroke, and low birthweight premature births” (p.2).

The most compelling message in the Surgeon General’s report is that **“we ignore signs and symptoms of oral disease and dysfunction to our detriment. ... You cannot be healthy without oral health.”** (p.2)

This submission addresses the importance of access to dental services in the context of the draft policy framework, and in the belief that there is an obvious need for measures that will genuinely assist needy Victorians in either gaining the dental treatment they require, or implementing preventive measures that reduce the need for such treatment.

Recognising the direct relationship between oral health and general health, the information management processes employed in initial assessment of dental treatment needs, and referral of patients to dentists for appropriate care, need to be examined.

3. DENTAL REFERRALS

As emphasised in our submission to the Better Access to Services Discussion Paper, dentists should be involved in the diagnosis and treatment planning for patients with oral diseases or conditions requiring treatment. Initially however, we recognise that medical practitioners, nurses and other Primary Care practitioners are likely to be involved in screening processes that may lead to referral to a dentist.

The information required by the dentists when a referral occurs is essentially that which would normally be obtained by taking a patient history (see ADAVB Patient History Sheet at Attachment C). This would alert the dentist to any medications the patient might be taking requiring consideration in the types of treatment undertaken, and the other medications to be prescribed in connection with the dental treatment. It would also address immune status, infectivity, whether the patient has had heart valve or hip replacement surgery, and other conditions significant for any dental treatment proposed.

If the referring practitioner provides this information, time and inconvenience can be saved, and possible oversights of significant information by the patient may be avoided. All other information regarding the dental diagnosis should be quickly established by the dentist upon examination of the patient.

As regards the information that may need to be recorded for reference by other practitioners subsequent to the dental treatment, the key data will relate to any medications prescribed. In some cases, where for example a patient has periodontitis, the dentist may feel this should be drawn to the attention of a medical practitioner, since this condition is often associated with heart problems, stroke and other serious conditions.

Notwithstanding the efficiency that may be achieved by maintaining a consolidated health record about a patient, the liability issues affecting dental practice mean that dentists will inevitably want to take their own medical history. They will want to satisfy themselves by direct enquiry of the patients regarding any factors affecting their diagnosis and treatment planning.

Dentists are often able to diagnose systemic illnesses because oral symptoms are among the first to indicate that the patient has such a problem: symptoms that can be first identified by a dentist, and lead to medical referrals to help the patient gain access to appropriate medical diagnosis and treatment, include:

- Oral cancers
- xerostomia (dry mouth)
- arterio-sclerosis (Dental X-rays can sometimes be used to identify sclerotic conditions in neck arteries)

General dentist practitioners have a responsibility to plan and provide treatment which maintains the optimum health of patients. The Dental Practice Board of Victoria recognises 10 special branches of dentistry. General dentist practitioners will routinely provide some or all of these areas of dentistry for their patients. However there will be times when, as part of an optimal treatment plan, the expertise of a registered specialist dentist, medical practitioner or specialist medical practitioner will not only be in the interest of the patient, but also the referring general dentist.

Broadly, the following reasons for referral may occur. The general dentist may:

- believe the patient has medical complications
- not like to treat certain conditions
- not be properly trained to treat
- perceive some conditions as too difficult
- not have the time to treat
- not have the facilities or equipment to treat
- believe the dental condition of the patient is not becoming optimal, despite best endeavours
- want to obtain advice on a specific problem, or on an overall treatment plan
- fear the legal consequences of any problems that may develop after treatment
- want to 'make good' a failed treatment
- be requested by a patient for a referral.

4. DENTAL AND GENERAL HEALTH

It is well recognised that assorted abnormalities in the mouth can play “health detective” as indicators of more serious health conditions. Because a general dental practitioner is examining the mouth on a regular basis, changes in oral health tissues can be detected which could possibly prove to be life-saving discoveries.

A dentist’s suspicions of abnormal tissues and subsequent referral to the appropriate dental or medical practitioner may be the first indication of a developing condition or disease. For example, cancer and leukaemia can sometimes be detected first by a dentist.

- Oral cancers can appear in any part of the mouth as a white or red patch, change in texture or oral tissues or swelling, sudden unexplained speech patterns, swallowing difficulty, or excessive bleeding.
- Leukaemia may worsen a case of gingivitis or periodontitis (mild and advanced gum disease respectively), as evidenced by red, swollen gums, which bleed easily. The condition may not improve, even when care is provided.

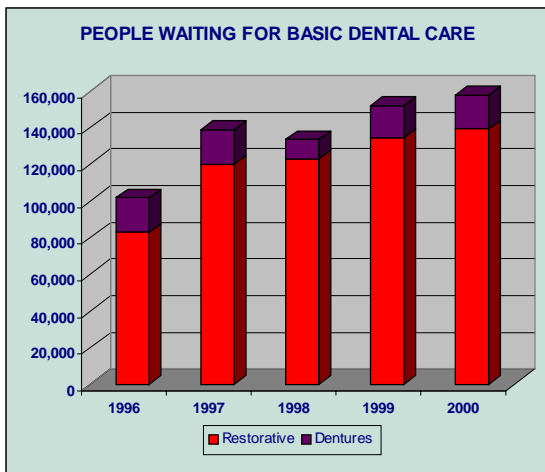
The following information further demonstrates the need for dentists and medical practitioners to work co-operatively in identifying symptoms of underlying conditions or diseases.

- Diabetes can cause rapid loss of bone supporting the teeth, if periodontitis is already present. Symptoms of shrinking and swollen gums, repeated gum abscesses and feeling tired and thirsty may provide indicators for a general dentist to refer a patient to their general medico for diagnosis and possible specialist referral.
- Researchers around the world have been investigating the link between coronary heart disease and oral health. Evidence suggests that dental health, particularly gum disease, may be a significant factor, in addition to diet, smoking and alcohol consumption, in the development of coronary heart disease and heart attacks, especially in men aged 40-50 years.
- Dentists are often able to detect many of the early and subtle signs of HIV/AIDS as they may occur in or around the mouth before anywhere else in the body. Failure to treat everyday dental problems may cause an immune system disorder to worsen.
- Prior to chemotherapy, a patient’s dentist should be in contact with his/her doctor, as 40% of people who undergo chemotherapy develop oral complications. Sufferers of cancer should have a dental check-up two to four weeks before beginning chemotherapy, with extensive dental treatment being delayed until the therapy is completed.
- Radiotherapy to the head and neck can cause direct and indirect damage in and around the mouth, which may have immediate to long-term consequences. To reduce the impact of complications, patients should have a comprehensive oral and dental examination before radiotherapy. All dental treatment needs to be completed two to three weeks before radiotherapy.
- The health of a pregnant woman’s gums can affect the health of her baby. Women experiencing Pregnancy Gingivitis (early gum disease) from the 2nd or 3rd month, increasing in severity to the 8th month increase their chances of having a low-birth baby by seven times, compared with a woman with healthy gums.

5. PUBLIC OR PRIVATE PATIENTS?

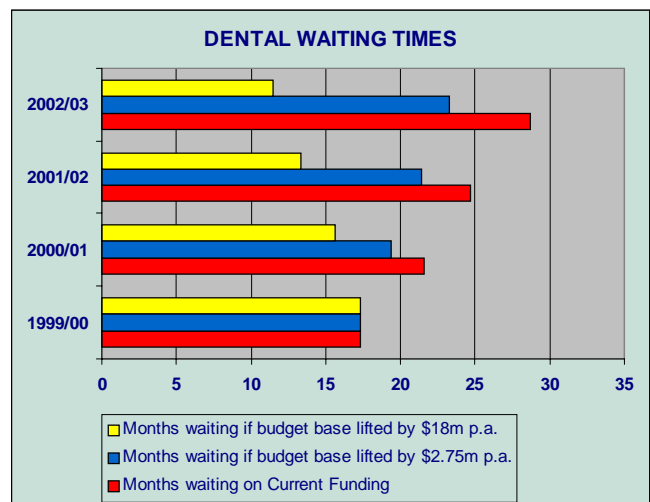
We made the point in our submission regarding the Health Records Bill, that patients can move in and out of eligibility for publicly funded care, and this can lead to discontinuity in management of records regarding their treatment. This mobility factor may require attention in any information management initiative.

6. VISION FOR THE PCP SECTOR



The vision outlined for PCPs in the Information Management Discussion Paper (pp. 11-12) is a rosy and unrealistic one, especially as regards the dental service area. The notion that dental services within “the primary care sector will fully accommodate consumer demand for participation in decision making and governance based on better information about service options and availability” is fanciful. The State Government has shown no intention of publishing waiting lists for dental services, which now stand at 158,000 people. It is hardly likely to want the public to become aware that the waiting lists are growing longer each year due to inadequate funding.

According to Dental Health Services Victoria (refer the two graphs on this page), more and more people each year are being added to the waiting list for basic dental care. This inevitably leads to longer waiting times before the treatment can be accessed. Dentists in both the public and private sector have shown that they can work very effectively together in providing the care required for eligible patients, when the Government provides the necessary funding. The PCP vision will actually promote more people seeking care, since more of them will be formally assessed, and this will reveal that larger numbers of people actually require dental treatment. This increase in demand will not be met by current or projected Government funding, and there is little chance that they will want attention drawn to this by publication of service availability data on the Internet. Indeed, the “pathways/protocols for guiding consumers through the service system” (p.11), are likely to become **protocols by which to deny patients access to care** when they need it.



If current waiting lists would require an extra \$18m p.a. (not indexed) to reduce waiting times below 12 months, then by 2005, with the increased demand likely to arise from better assessment and initial needs identification, around \$30m p.a. extra will be required. The current funding of dental services is a mere \$58m p.a., and the evidence is already available to suggest that it should be \$76m this year.

By 2005, a sum between \$90m and \$100m will be necessary to actually meet the extra demand stimulated by PCP. The current dental demand levels are artificially reduced, because GPs and others involved in the PCPs are not well informed about symptoms requiring referral for dental treatment and where to go to obtain it.

7. DENTISTS AND INFORMATION TECHNOLOGY

While significant efforts are being made to ensure that general medical practitioners make effective use of information technology, and certain leverage measures are available to enlist their cooperation to some extent, this is not true for dentists.

The ADA's own surveys indicate that over 73% of dental practices have internet access, however this does not mean that dentists would willingly use such facilities for transfer of information about patients and their treatment.

8. DISCUSSION PAPER ISSUES

The Discussion Paper posed a number of issues on which response was sought, however these were generally targeted at partnerships within the PCP. Since the ADAVB is not a direct participant in the PCP, it is not appropriate for us to comment upon them.

9. CONCLUSION

An emphasis on resources required for information management would constitute a further misdirection of funds away from direct service delivery to patients in need.

Dentists are not going to rely on patient records they have not generated from their own professional enquiries.

Patient confidentiality concerns, and risks associated with patients misreading records designed for professional rather than lay reference, may further impede use of the internet for health information management.

ATTACHMENTS

- A. ADAVB Submission re Better Access to Services
- B. ADAVB Submission re Draft Health Records Bill
- C. ADAVB Patient History Sheet