Public Health Association of Australia submission on a potentially preventable hospitalisation indicator specific to general practice

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
PHAA Response to the consultation paper

1. Do you agree with the definition of potentially preventable hospitalization, in light of the purpose of the indicator? Why or why not?

PHAA agrees with the definition as stated: ‘admission to hospital for a condition where the hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative care and other health interventions delivered by general practice teams’.

2. Do you agree with the definition of general practitioner teams? How could it be improved?

PHAA suggests that the definition of general practitioner teams will be improved with the inclusion of oral health professionals ie ‘The general practice team consists of all people who work or provide care within the practice. Practice teams are often multidisciplinary, made up of GP leaders, nurses, oral health professionals and allied health professionals designed to service the unique requirements of each community.’

Oral health professionals include dentists, oral health therapists, hygienists and prosthetists. These professionals should be included because of the high prevalence of oral disease and the close associations between oral health and general health. The mouth should not be excluded from the rest of the body. A team approach is necessary to manage acute and particularly chronic disease.

Oral health is an integral aspect of general health. Oral health is ‘a standard of health of the oral and related tissues that enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and that contributes to general wellbeing’. That is, oral health is more than simply the absence of disease in the oral cavity; it is a standard of oral functioning that enables comfortable participation in everyday activities.

Despite improvements over the last 20-30 years, there is still evidence of poor oral health among Australians:

- More than 90% of adults have experienced tooth decay, over a third (40%) of young children and two out of three older children (64%) have experienced tooth decay. The latter is a prevalence five times higher than asthma.
- Three out of ten adults have untreated tooth decay.
- Approximately 23% of Australian adults have moderate to severe periodontal (gum) disease. The prevalence of periodontal disease increases with age and there are higher rates in people with low income.
- Oral cancer, which may affect lips, tongue, salivary glands, gums, mouth, or throat, is the eighth most common cancer in Australia.
- Only four out of every ten Australian adults (39%) have a favourable visiting pattern, i.e. seeing an oral health professional once a year for a check-up, rather than waiting to treat poor oral health.
- Aboriginal and Torres Strait Islander people and adults who are socially disadvantaged or on low incomes have more than double the rate of poor oral health than their counterparts.
- People with additional or specialised health care needs or those living in regional and remote areas find it more difficult to access oral health care.

Oral conditions are the third highest reason for acute preventable hospital admissions in Australia with more than 63,000 Australians hospitalised each year. Many of these people require dental treatment under general anaesthetic including young children with high levels of dental disease, and adults with complex medical conditions.
In terms of overall health and wellbeing, poor oral health can affect the ability to chew and swallow, thus affecting an individual’s overall nutrition. Poor oral health can also disrupt speech, sleep and productivity, erode self-esteem, psychological and social wellbeing, and impact relationships and general quality of life. This can lead to restricted participation at school, the workplace and home, and result in loss of school or work hours. On a societal level, this results in the loss of millions of work days each year.

Poor oral health is also associated with a number of other diseases. For example, poor oral health is associated with heart and lung infections, stroke, aspiration pneumonia, low birth weight and premature birth, although causality has yet to be proved. For those with diabetes, gum disease can affect the control of blood sugar and increase the risk of diabetic complications. Gum disease is also associated with rheumatoid arthritis.

On a health system level, there are both direct and broader costs associated with poor oral health. A lack of prevention, difficulty in accessing oral health care and delays in receiving treatment often leads to serious infection, pain and poorer long-term health outcomes. As a result, some consumers present to emergency departments and require hospital admission to manage infections. Many consumers also seek the assistance of general practitioners (GPs) for oral health complaints or infections. A more inclusive approach to oral health and prevention may assist in reducing the number of unnecessary antibiotic prescriptions for toothache.

Where expenditure can be allocated to specific disease groups, spending on oral health ranked second highest after cardiovascular disease. Unlike other health services, the cost of oral health falls largely to the individual. In 2011-2012, individuals were responsible for 57% of the total cost of dental care compared with only 12% of the cost of all other health services. This presents a direct barrier to accessing dental care, as evidenced by the poor adherence to regular check-ups and maintenance of good oral health. Integration of oral health care is therefore both sensible from a whole-of-body health perspective, and from a determinants of health and equity perspective.

In addition to the role oral health professionals perform in managing oral disease, they can contribute to the management of general chronic health conditions in partnership and as part of GP teams. Conditions that can be managed in dental clinics include diabetes, hypertension and obesity through for example screening and monitoring of blood pressure and blood glucose. Oral health professionals also contribute to smoking cessation through brief interventions.

### 3. Conditions in scope

Do you have any comments for condition exclusion, or comments in regards to the listed conditions (for example, vaccine-preventable conditions, acute conditions, or chronic conditions)?

PHAA proposes that dental PPHs should be included because they are directly applicable to the care provided by general practice teams. PPDHs are preventable through general practice activity.

General practice teams have a role in reducing dental PPHs through:

- Screening and referral - to detect tooth decay, gum disease and other oral pathology and referring for dental care if required (eg. The health assessment for people aged 75 years and older is part of general practice and includes an oral health component).
- Enhancing oral health literacy – providing oral hygiene and nutrition advice
- Application of fluoride varnish to the teeth of children at high risk of tooth decay.
4. Exclusion of same day and hospital-in-the-home

Do you agree with the proposal to remove same-day hospitalisations to reduce the impact of variations in admission practice?

PHAA does not agree to removing same-day hospitalisations because this will dilute the effectiveness of using potentially preventable hospitalisations as a measure.

5. Population groups

Are there other population groups you would wish to see in greater detail with respect to potentially preventable hospitalisations, either through specialised indicators or through disaggregation?

Focus should be on dental PPH rates for children 0-9-years of age as they have the highest dental PPH rates. Dental PPH rates are the highest of all PPHs for this age group. The principal diagnosis is for tooth decay (dental caries) which is both eminently preventable and amenable to detection and early treatment.

It would also be useful to analyse dental PPH rates by socioeconomic status and by PHNs.

Conclusion

PHAA supports the broad directions of the development of PPH in general practice. However, we are keen to ensure the inclusion of oral health in line with this submission. We are particularly keen that the following points are highlighted:

- The mouth should not be excluded from the rest of the body
- Oral conditions are the third highest reason for acute preventable hospital admissions in Australia
- Dental PPHs should be included because they are directly applicable to the care provided by general practice teams

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to the development of potentially preventable hospitalisation indicators specific to general practice.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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2 November 2018
References


3 Victorian Health Intelligence Information Surveillance System (VHIIS).