AUSTRALIAN DEMOCRATS
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…… filling the gaps in **Dental Health**

The huge gap in Labor's health and hospital reforms being rolled out is dental health.

Australia has the third worst adult dental health in the OECD. One in four Australian adults has untreated tooth decay. The oral health of Australian children is near the top but research shows that after many years of improvement, children's oral health is on the decline. 30% of people avoid dental care because of cost and about 20% are stopped from having recommended dental treatment because of cost.

Poor oral health causes pain and difficulty eating, which can mean dependence on medication, nutritional deficiencies and associated health conditions such as diabetes and heart disease.

Visible tooth loss can affect self esteem, restrict social and employment opportunities.

There are 650,000 people on waiting lists for public dental care with an average waiting time of 27 months. A study of public dental health patients from 1995/6 to 2001/2 showed a decline in oral health with increases in the number of decayed, missing and filled teeth, particularly for 25 – 44 year olds.

Whilst each state and territory provides public dental services, per capita spending varies markedly from state to state, services are confined to concession card holders prepared to endure long waiting times and school students.

Each state requires some form of patient co-payment, the introduction of which has led to a decrease in use. Oral dental health is the least subsidised area of state health care at $369m/year. Many adults receive only 'emergency' dental care, teeth are extracted at 122% higher rates than in private dentistry and little is invested in improving adult oral health.

Our Plan

•A **national public dental health program** that is free for concession card holders and special needs groups, and which includes a full dental check-up and basic dental treatment every two years. This program should be funded at per capita levels that will meet the goals of the national oral health plan and delivered in a timely manner, as determined by national benchmarks – with costs to be shared equally between the Commonwealth and the States.

•A much greater focus on **preventive oral health** programs, including dental health promotion and public education campaigns

•**Monitoring the oral health** of Australians, diagnosing and investigating the problems and providing solutions and treatment

•Screening and dental hygiene programs in all **primary schools**

•Dental health assessment and follow-up by dental hygienists in **residential aged care**

•Long range dental health **workforce planning** and more university places for dentists and dental hygienists

•Incentives to encourage graduates to work in geographic **areas of need** and flexible funding options for dental services in those areas

•Improved salaries and conditions for dentists working in the **public sector**

• Outreach services for special need groups, particularly **Indigenous** Australians

• A program of **research** into oral disease prevention and the effect of changing diet patterns on oral health

Authorised by Darren Churchill, 29 Brunswick Circuit, Kaleen, ACT

election 2010

Australian DEMOCRATS

…… humane choices in **Dying**

Our Plan

It is now 13 years since the Federal Government overturned the Northern Territory's Rights of the Terminally Ill Act. The choice to die with dignity remains elusive. Indeed governments have gone to great lengths to suppress information and ideas about voluntary euthanasia for those who are terminally ill. Amendments to the Crimes Act made it illegal to use the telephone, fax, email or internet to share information about end-of-life options.

The so-called "slippery slope" argument suggests that allowing one form of euthanasia will lead to less acceptable forms, e.g. voluntary euthanasia without proper safeguards, or even involuntary euthanasia. There is no evidence where voluntary euthanasia has been legalised such as Oregon, Montana and Washington in the US.

Palliative care cannot ensure that every death is a good death. Conditions such as bone cancer cause great pain for which there is no relief and some deaths bring immense suffering through choking and difficulty in drawing breath.

There is anecdotal evidence that despite the legal risks, some health professionals already assist patients to die, while others ignore their wishes because of fears of being sued or prosecuted. We know that euthanasia is sometimes done at home without medical assistance or by people caring for their loved ones. Some Australians travel overseas to take advantage of voluntary euthanasia laws in other countries.

Surveys consistently show that over 80% of Australians support the right of a competent, terminally ill person to take their own life with medical assistance. The issue is complex and difficult but overseas experience shows that it can be done – sensitively and safely.

•nationally consistent **voluntary euthanasia laws** with sophisticated safeguards for end of life decisions based on the following principles:

> •patients in a state of mental competence, with a terminal or incurable illness that creates unrelievable and profound suffering, would have the right to choose to die in a manner acceptable to themselves and not be compelled to suffer beyond their wishes
>
> •no individual, group or organisation would be compelled to either participate or not participate in the assisted voluntary euthanasia of a sufferer
>
> •providing advice, assistance or support to a sufferer, their relatives or guardian regarding voluntary euthanasia or to be present at the time, would not constitute an offence
>
> •assistance in voluntary euthanasia to be provided in all cases by doctors

•training for health professionals in clinical practice guidelines for communicating prognosis and end-of-life issues

•patients to be given the right to make **advance care directives** (advance care plans provide information on an individual's decisions regarding end-of life choices under a range of circumstances) and to have them respected

•increased funding for and availability of **palliative care**

•recognising that voluntary euthanasia is a complex ethical issue, ensure that legislation that governs it is developed by a representative cross-party Parliamentary committee following **extensive community consultation** and debate and is decided on a conscience vote

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...... caring for our **Aged**

The Democrats want to see the aged live with dignity and have safe and high quality services, regardless of ability to pay. Currently around 160,000 Australians reside in aged care and this figure is set to grow by a whopping 215% over the next 40 years as the population ages.

Residential aged care was largely overlooked in the Labor Government's health and hospitals reforms and there is still no commitment to indexing funding for services in line with rising costs of care. Recent decisions by Fair Work Australia provided welcome wage increases for staff of between 3 and 5% but Commonwealth funding will increase by only 1.7% in 2010.

The Grant Thornton Report showed an alarming decline in profitability of residential aged care, severely limiting the capacity to fund high quality services and the development required to meet growth.

We welcome the recently announced review of aged care services by the Productivity Commission (report due 2011) and hope its recommendations, unlike previous reports, including the Hogan report, are implemented.

Older Australians are now encouraged and supported to stay in their own homes for as long as possible so those entering residential aged care are more frail, more likely to have dementia and require much higher levels of care. This has still not been recognised by current funding arrangements.

It can be difficult to attract specialists, for instance podiatrists, psychologists and physiotherapists with expertise in geriatric care. The incidence of severe oral disease is many times greater for people in residential care than for those in the community and often leads to more serious conditions.

Our Plan

- A **National Institute for the Aged** to provide advice on benchmarks of care, subsidies, responses to the needs of special groups, research needs, bed numbers and workforce planning, to collect data and regularly review accreditation
- Remove the prohibition on **bonds** for residents admitted to high care, to help fund capital works
- National **standards and data** collection by Australian Institute of Health and Welfare on the health of residents
- A transparent process for determining annual **indexation of operational subsidies and fee caps**, that includes a capital component
- Tied funding to support high quality care and **wage consistency** with other health sectors
- Additional funding for **dementia and palliative care** supplements
- More resources for services for those with **short-term medical needs** such as IV therapy and the complex needs of Indigenous and CALD communities
- Greater **integration** of residential aged care and GP, hospital and home-based services, discharge-from-hospital support programs and rehabilitation where possible in residential care
- More **flexibility in funding** and, where appropriate, incentives for rural and remote aged care providers to co-locate with other community services
- A national **workforce strategy** including training in and development of seamless career pathways in aged care and wage incentives for training improvements
- Increase the number of undergraduate **nursing places** to the level recommended by the Hogan report

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