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Improving access to dental care in rural and remote Australia

Supplementary Submission in response to NHHRC Interim Report

April 2009

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Improving access to dental care in rural and remote Australia

Supplementary Submission in response to NHHRC Interim Report

The Alliance gives strong but qualified support to the Commission's proposals for improving the nation's oral health. It hopes that in its final recommendations to the Government the Commission will comprehensively address all major barriers to Denticare's successful implementation and to improved oral health outcomes.

Australians who live in rural and remote areas have significantly poorer oral health and levels of access to dental services than those who live in the major cities. The Alliance therefore welcomes the Commission's invitation to submit specific proposals to improve rural oral health.

This paper outlines relevant issues and provides recommendations on improving oral health in rural areas.

Issues

The Alliance has identified seven major barriers within the current oral healthcare system that the Commission needs to address to effectively deliver on its aim of improving oral health and providing universal access to dental care:

- 1. The high cost of private dental care.**
- 2. Limited supply of public dental services.** Over 30 per cent of Australian adults are eligible for care through the public dental system, but less than 25 per cent of this group can access public services in any 12 month period, and a high proportion of these receive emergency care only.
- 3. Dental workforce shortages and maldistribution, especially in rural and remote areas.** Shortages apply to all oral health practitioners. Data available reveal that:
 - in 2005, there were 57.6 practising dentists per 100,000 population in major cities, compared with 28.5 in outer regional and 19.8 in remote Australia;
 - 33.7 per cent of regional/remote dentists are busier than they would prefer, compared to 17.0 per cent in major cities;
 - around 73 per cent of all regional/remote dentists are 40 years or over, compared with 60 per cent in major cities. Conversely only 27 per cent of dentists working in regional/remote areas are under 40 years of age, compared with around 40 per cent in major cities; and
 - unlike dentists and dental hygienists, dental therapists are distributed relatively evenly across regions defined by remoteness but there are only around 6.3 therapists per 100,000 population. This even distribution is an important finding, not unlike the position of nurses in the rural workforce.
- 4. Under-funding of undergraduate education.** University dental schools are being forced to take in significant numbers of overseas full fee-paying students in order to operate. Only a

small proportion of the Commonwealth funding to Universities for dental education is passed on to dental schools.

5. **The majority of Australians have a predominantly problem-based culture of dental attendance and poor oral health literacy.** Currently, only around 40 per cent of Australians regularly attend their dentist for check-ups focussed on prevention. The majority generally make only irregular one-off appointments for treatment of specific dental problems or have an ‘intermediate’ pattern of dental attendance.
6. **Dentists’ strong preference for providing a siloed, biomedical model of care** that targets motivated, compliant paying patients and is mostly oriented to treatment. Dentists are generally highly concerned with their independence and right to provide care and develop a business relationship with their patients free of outside influence. Patients similarly appreciate freedom of choice and continuity of care with their preferred dentist.
7. **The broader health system has poor oral health literacy and low involvement in oral health** because of a long history of separateness.

Recommendations

Broad strategy

Over time, Denticare has the potential to significantly improve Australia’s oral health. However, to be effective, Denticare must be complemented by appropriate workforce supply, mix, distribution and infrastructure, and a new culture of oral healthcare with wide acceptance.

Three integrated and complementary approaches seem essential to improve the oral healthcare culture and change related attitudes, expectations and behaviours in both providers and consumers. Firstly, the nation needs to seriously address socio-economic disadvantage; secondly, oral health must be well integrated into a multidisciplinary primary health care sector; and, thirdly, dental healthcare itself must become highly person- and population-centred.

It is critical that education and training skills and experiences aimed at promoting social justice and reducing inequity should become a common feature of all undergraduate health courses, including oral health and dentistry.

The specific challenge will be to reform the dental healthcare system through a paradigm shift to a primary health care model that integrates oral health within a system-wide focus on health and wellbeing. Responsibility for oral health must be embraced by the dental workforce, the broader health and aged care workforce, other sectors and the general public.

The Alliance supports the bringing together under the Commonwealth Government of all primary health care funding and responsibility for policy formation, system design and performance improvement based upon the Commission’s 15 design principles. The Alliance considers that the challenges of addressing the inequities in oral health are best managed through its inclusion in systematic system-wide primary health care reform.

Specific recommendations

1. Expand the dental workforce

Boost the rural dental workforce (dentist/oral health therapist/dental therapist/hygienist) through:

- 1.1 Boosting Australian undergraduate numbers by:
 - a. significantly increasing the number of Commonwealth-supported Bachelor of Oral Health places, particularly to address needs in currently underserviced areas; and
 - b. increasing local student places in all courses by reducing places for full fee-paying overseas students via adequate funding for dental schools (see recommendation 2).

- 1.2 Boosting rural student selection and support by:
 - a. selecting more rural students for all courses in both capital city and regional dental schools;
 - b. providing specific rural scholarships (see the Alliance's RADUS Submission);
 - c. providing living away from home allowances for rural students; and
 - d. promoting Indigenous students and providing them appropriate support.

- 1.3 Supporting more rural clinical placements for students by funding:
 - a. travel and living away from home support to students that encourage substantial rural placements;
 - b. a national strategy for providing rural experience, education and training of students that aligns with the proposed intern year;
 - c. relocation incentives, training and support for more rurally-placed academics, tutors and senior clinicians; and
 - d. a minimum of 15 'pilot' networked and accredited centres of dental team-based training excellence in rural areas across Australia along the lines of Shepparton, Victoria (see attached), but reflecting a range of regional situations.

- 1.4 Fund a national scheme to support, monitor and evaluate the integration of overseas trained Competent Authorities approved dentists, dental therapists, dental hygienists and oral health therapists. Ensure opportunities for them to undertake at least a part of their intern year in accredited rural dental training centres of excellence.

2. Provide adequate funding for dental education

Provide additional funding to all dental schools for developing curricula and academic excellence in undergraduate training that induces within dental schools a primary health care service culture with competencies in:

- adult centred learning;
- person- and family-centred oral health care;
- addressing inequities in oral health outcomes and access to dental care in at-risk groups;
- community development, addressing the social determinants of health;
- team centred dental care delivery;
- integration within a multidisciplinary primary care system; and
- cultural awareness in service delivery.

3. Introduce new workforce roles

- 3.1 Review scopes of practice for dental hygienists, dental therapists and three year trained oral health therapists based on both current training and opportunities for further training and upskilling.
- 3.2 Through appropriate trials, develop the oral health practitioner equivalent of the nurse practitioner, able to provide an appropriate range of diagnostic, preventive and treatment services to both children and adults.
- 3.3 Create an expanded dental assistant qualification with a ‘train the trainer’ component to support routine preventive oral health care in primary health and aged care facilities. Training could include dental screening (eg “Lift the Lip”), oral health education and provision of limited topical preventive therapies.

4. Provide rural incentives

- 4.1 Introduce a significant and increasing HECS rebate for new graduates for every 12 months of work completed in rural/remote private or public dental service positions.
- 4.2 Introduce rewards for rural and remote public dental service placements including bonuses for length of service and for providing remote and visiting outreach services. Salaries need to be sufficiently high to reasonably compete with urban private practice incomes and conditions.
- 4.3 Ensure that the new rural Divisions of Primary Care provide similar recruitment and retention incentives to dental and oral health professionals as GPs currently receive.

5. Develop a National Rural Dental Workforce Policy

Encourage the Commonwealth, State and Territory governments to commit to a national rural dental workforce policy that:

- determines and aspires to a target number and mix of rural dental professionals, based on appropriate provider:population ratios linked to the risk-adjusted needs of rural and remote populations; and
- synthesises and disseminates research into best practice models of service that integrate public, private and dental specialist care, promote recruitment and retention of professional staff and link with the primary care system.

6. Establish an electronic dental clinical data system, initially for all public dental services, followed by private dental practices that will enable electronic record transfers and optimise use of the proposed personal electronic health record.

7. Include acute dental care referrals under PATS.

8. Incorporate public oral health expertise into the Department of Health and Ageing’s mainstream workforce and policy areas.

Recommendations on Commission's reform directions for oral health

Reform directions 1 to 3 - Denticare Australia

Comments

- Strong but qualified support.
- A phased implementation would appear to be required given current workforce shortages and maldistribution. Otherwise more advantaged groups would be likely to be the immediate beneficiaries, thus increasing inequalities.
- There will be a significant increase in demand for public dental services from rural people with the proposed increase to public dental eligibility.
- Public dental services will need to be better resourced to ensure that timely and preventively focused dental services can be provided to the most disadvantaged. Groups with high dental care needs include:
 - low income families
 - Indigenous people
 - low income pregnant women
 - people with disabilities
 - people with chronic illnesses
 - people living in residential care
 - many rural and remote people disadvantaged by distance and waiting times for services.
- The range of services offered could be marginally enlarged eg to include root canal treatment for anterior teeth to maintain an aesthetic and functional dentition.
- Issues highlighted in the costing report will need to be considered carefully eg impact on demand (page 29), scope creep (page 12), and price inflation (page 33).
- Workforce reforms to increase capacity to provide more preventive dental care include:
 - expanding the scope of practice for three year trained oral health therapists; and
 - creating an expanded dental assistant qualification to support routine preventive oral health care in primary health and aged care facilities.
- Undergraduate dental training should address the Commission's identified need for significant cultural reformation and new competencies within the health system to deliver patient centred care with an overarching equity and prevention focus. Dental schools are already underfunded. Their funding should be boosted, including the means for appropriate curricula redevelopment.

Recommendations

- Develop a detailed implementation study prior to the finalisation of the Commission's Report.
- Incorporate key action items from the 2004-2013 National Oral Health Plan within the detailed implementation study and establish at least annual publicly accountable monitoring and reporting processes.
- Increase the number of Commonwealth-supported Bachelor of Oral Health places.
- Increase funding for dental schools to allow for more comprehensive training in people-centred care.
- If feasible, ration Denticare provider numbers in urban areas.
- Include dental workers within regional Divisions of Primary Care

Reform direction 4 – Internship Scheme

Comments

- Qualified support.
- To address the current lack of rural dental services, many more clinical facilities as well as many more experienced public sector staff will be required. It has been estimated that there will be 500 dentist graduates in 2014, plus about a 100 accredited overseas trained dentists. Oral health therapists should also be part of the intern scheme.
- The scheme will need to be well-funded, with a mentored clinical component, CPD, and options for research and oral health promotion.
- The scheme would need to be phased in as public infrastructure (capital works and experienced workforce to mentor graduates) is developed.
- A constant turnover of first year graduates will reduce the public sector's ability to offer continuity of provider to clients. Such continuity is a key factor in client satisfaction with dental care. Client centred care would need to be an essential operational culture.
- Establishing an attractive voluntary intern scheme that would include greater opportunities for continuing on in the same rural location would be an alternative option to a compulsory scheme.
- Integrated practice in both public and private dental clinics could be a feature in rural locations.

Recommendation

Phase in the scheme as public sector infrastructure is expanded.

Reform direction 5 – National expansion of pre-school and school dental programs

Comments

- Support.
- Programs for children will need to have a family focus with integration with adult services. In many rural communities the existing private practices may be a good alternative to public services.
- Programs need to be closely integrated with other primary health services.
- The proposed increase in BOH student numbers and expansion of the scope of practice would facilitate this reform, which would be especially valuable in rural and remote areas.

Reform direction 6 – Additional funding for oral health promotion

Comments

- Strong support.

Recommendations

- Fast track the rolling out of rural/remote water fluoridation.
- Support the development of a national Indigenous oral health promotion strategy.
- Integrate oral health promotion into general health promotion via a common risk factor approach eg via diabetes education, smoking cessation etc.
- Fund community based oral health promotion targeted at populations with a high proportion of people at high risk to oral disease.
- Include the promotion of oral health as a core task for the proposed National Health Promotion and Prevention Agency.

- Include routine oral health screening questions within the health checks undertaken by GPs for groups identified as at risk eg Indigenous, aged and chronically ill people and pregnant mothers.
- Consider funding paediatricians, GPs, child welfare nurses, Aboriginal Health Workers etc to 'Lift the Lip', provide advice, and apply fluoride varnish where there is early childhood caries, plus refer to a dental provider.

Conclusion

The Alliance supports the Commission's oral health reforms, but it is very concerned that the reforms will have quite limited application, especially in rural and remote Australia, unless policy and funding decisions address the systemic barriers to their effective implementation.

Reform will clearly take many years and require considerable capital and recurrent funding. There will be major challenges in managing unrealistic public expectations and much scepticism and resistance from the dental workforce. Overcoming these barriers seems to demand a detailed implementation study and then committed and accountable follow up by Government.

Notwithstanding these concerns, it is important that this great opportunity to improve oral health and address the major inequalities in oral health care is not lost.