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Proposal to the National Health and Hospitals Reform Commission

for a Rural Australia Dental Undergraduate Scholarship (RADUS) Scheme

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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.

A Rural Australia Dental Undergraduate Scholarship (RADUS) Scheme

The current situation

- Australia has some serious challenges with oral health. The current climate of health reform offers an unprecedented opportunity to meet them, with the Australian Government playing a key role in leading and supporting change.
- Australia's dental labour workforce supply is insufficient, and a serious maldistribution exists between both rural and urban and public and private practice settings. Dentists are one third as prevalent in remote areas as in major cities and only one half as prevalent in rural areas. In 2005 there were just 19.8 dentists for every 100,000 remote Australians compared with 58.6 per 100,000 in the cities.¹
- Over 40 per cent of regional/remote practising dentists are over 50 years of age compared with just under 30 per cent in major cities.²
- 33.7 per cent of regional/remote dentists report themselves busier than they would prefer, compared with 17.0 per cent in major cities.
- The demand for dental care has been predicted to grow by 15 per cent in the period to 2010 and continue to grow thereafter as more people retain their teeth into old age.
- Australia has the second worst adult oral health of all OECD countries.
- Poor oral health increases the incidence of low birthweight babies, demand for GP services and emergency hospitalisations and adversely influences chronic conditions, including diabetes and cardiovascular diseases.
- Over 30 per cent of the population lives in rural Australia where dental services are less accessible, less available and less affordable. Waiting times for an appointment in private practices are 3.9 weeks in regional/remote areas and 1.6 weeks in major cities. People aged 25-44 living outside major cities are only half as likely to visit a dentist as city dwellers.
- Nationally, there are around 650,000 people on waiting lists for public dental care, with an average waiting time of 27 months. Rural people are likely to be over-represented on those waiting lists.
- Lack of access to fluoridated water in many parts of rural and remote Australia has contributed to higher levels of tooth decay and tooth loss.

The solution – grow and diversify the dental workforce; and transform and reform oral health care

Addressing the poor oral health and ensuring the access, efficiency and quality of dental services for all Australians will require a multi-pronged approach which addresses:

- workforce supply, mix and distribution factors;

¹ AIHW Dental Statistics and Research Unit Research Report No 33 Dentist labour force in Australia, 2005
http://www.arcpoh.adelaide.edu.au/publications/report/research/pdf_files/rr33_Dental%202005_Research%20Report%20Final%20PPC.pdf

² AIHW Dental Statistics and Research Unit Research Report No 40 Dental practice activity by geographic location

- service and education and training redesign and innovation to provide team-based delivery of personalised, family and community centred dental care; and
- disease prevention and early intervention through national primary care and public health initiatives.

Workforce

Developing an effective and sustainable rural and remote dental workforce will require national strategic planning and a consequent mix of initiatives that will:

- encourage and enable many more young rural and remote living Australians to enter dental schools and join the dental workforce, for example by scholarship assistance;
- support excellence in rural dental schools and in regional, rural and remote clinical training centres across Australia;
- make positive rural and remote experience a standard element of all undergraduate training;
- match rural community needs with the appropriate mix of dental specialists, dentists, oral and dental therapists, dental hygienists and dental assistants; and
- provide incentives for dentists, dental specialists and oral health professionals from the city to either relocate or provide visiting services in rural and remote areas of need.

Service redesign

Reformation of dental services should include:

- financial assistance to cover the minimum costs of personalised basic and preventive dental care for adults who cannot afford the cost of private fees;
- regular access to public dental care for the nation's eligible health care card holders; and
- universal access to care for children from infancy to the end of secondary school.

Primary care and public health initiatives

- fast tracking of rural and remote fluoridation;
- oral health training for Indigenous Health Workers;
- annual reporting to nation on progress in implementing the 49 Action Areas of Australia's National Oral Health Plan 2004-2013; and
- establishment of a Chief Dental Officer position.

The Alliance believes that the Government's proposed investment of \$290 million in a new Commonwealth Dental Health Program(CDHP) would result in progress in some of these areas. While the introduction of this new scheme has been held up in the Senate, fresh evidence has emerged that the current Medicare Enhanced Primary Care dental program is now trending to run over the budgeted \$385 million over 4 years. Services have been poorly controlled and appear very unevenly distributed, particularly where people in rural and remote areas and people on low incomes are concerned. The delay in implementation of the CDHP further disadvantages people in rural and remote areas relative to those in major cities.

The potential value of Rural Australia Dental Undergraduate Scholarships

There is evidence from the experience of undergraduate medicine and the intake of rural and remote students, that scholarships for such students can significantly enhance the flow of graduates to rural and remote areas. The NRHA has close experience of the Rural Australia Medical Undergraduate Scholarship Scheme, having been the national management agency

of that scheme since its establishment in the year 2000. More recently, a modest scheme has been established under which scholarships are provided to students from rural and remote areas to study a number of allied health disciplines. This scheme has included the capacity for dental students to receive scholarships but in such small numbers that it is unlikely to make a significant difference. For example, in the first round of the Rural Australia Health Undergraduate Scholarships, two of the 60 scholarships were awarded to students of dentistry or oral hygiene.

The NRHA therefore proposes that a specific scholarship scheme be established for students of dentistry and oral health from rural and remote areas. To make a significant difference in the relatively short-term, the scheme could provide 25 scholarships of \$10,000 each in the first year (university calendar year 2010), 25 in the second and 25 in the third - making a cohort of 75 people from rural and remote areas studying dentistry and related therapies. The scholarships should be available to students in both undergraduate and graduate entry courses, and include students undertaking degree courses in oral health.

Figure 1 below illustrates the lack of a rural student base in Australian dental schools. Figure 2 shows the increase of rural origin students entering medical training following the introduction of the RAMUS Scheme.

The cost

Program	2010	2011	2012	Total 2010-12
25 dental s'hips p.a.	\$250,000	\$500,000	\$750,000	\$1,500,000
Admin	\$ 50,000	\$ 75,000	\$ 90,000	\$ 215,000
Totals	\$0.3m	\$0.57m	\$0.84m	\$1.715m

Rural origin students don't do dentistry

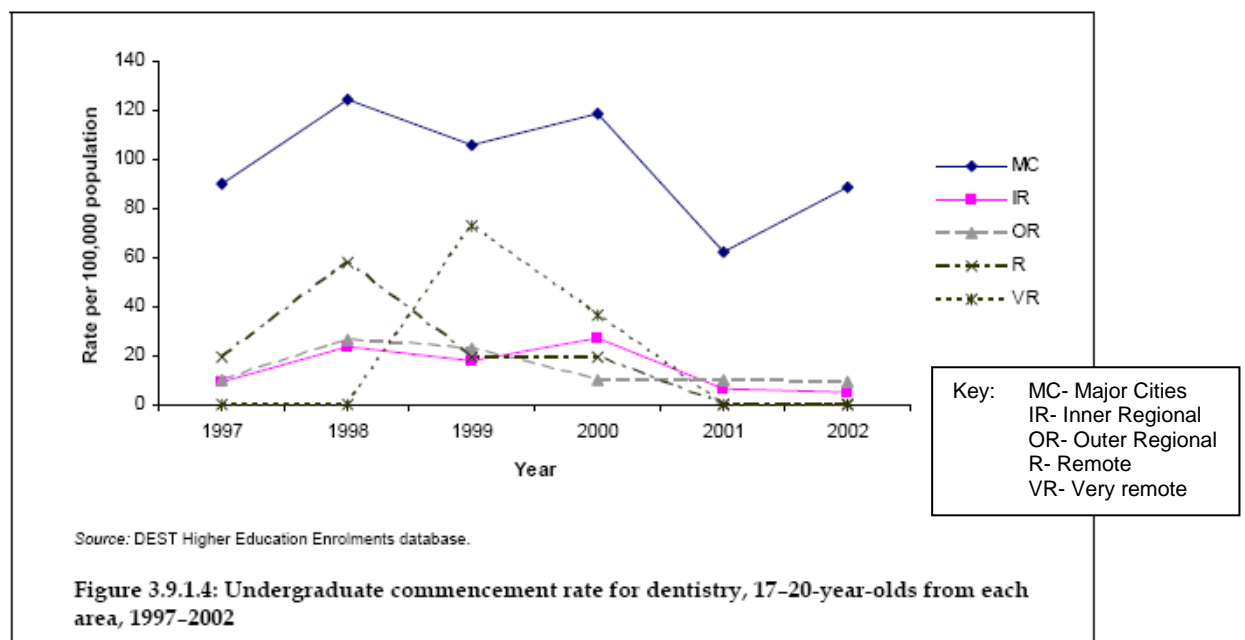


Figure 1

Rural origin students entering medicine

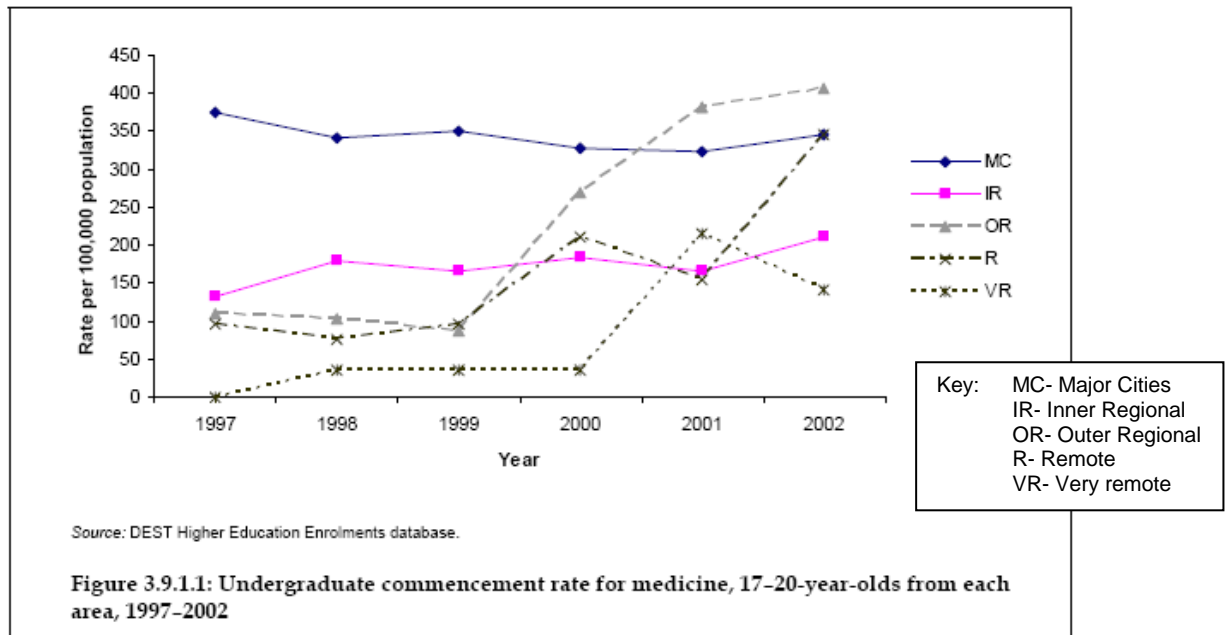


Figure 2