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RURAL AND REMOTE ORAL AND DENTAL HEALTH

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MARK HUTTON: I would also like to thank the National Rural Health Alliance for the invitation to talk today. I have the privilege of living about three minutes' walk from that very beautiful lake. The blue lake is the signature of Mt Gambier and this is going to be therefore a very blue presentation. I think that Tudor Hart back in 1971 coined up that inverse care law and the italics is mine, but nevertheless that's very true for rural areas, isn't it, not only with dental health but perhaps all health, that the availability of good medical care tends to vary inversely with the needs of the population served, as John has just said. Rural areas have a great need and of course we've got a very diminished workforce.

I just thought before I talked a lot about rural health specifically that it would be worth going through why would you want really good dental health in any community, but particular a rural community? You can see there that in 2002 and 2003 there were 223 hospitalisations per hundred thousand for dental-related causes in Australia, and in 2003 and 2004 there were 2000 admissions for Aboriginal and Torres Strait Islander people due to oral conditions. I think that's a pretty worrying figure.

Also in the past five years we've had two deaths in South Australia and there's been one in Western Australia and three in Tasmania directly related to dental infections. It's been certainly publicised more recently in the media that certainly untreated periodontal or gum disease results in higher rates – and they're much higher rates – of coronary artery disease, strokes and low birth weight prem

babies, unstable diabetes, and we I think really don't know how many people are dying in nursing homes from aspirational pneumonias from the muck in their mouths being aspirated down into their lungs.

John has really I think to some extent covered the poor old health, functional limitations and psychological discomfort and social disability. And just your one rural practice – and it's a big year, I have to admit – but I found 10 suspicious areas inside people's mouths that needed referral off to oral surgeons for biopsy. So dental health really has a profound effect on general health.

I just thought I'd talk a little bit about the pressures that are on the rural workforce. Most rural practitioners see a large number of patients per day and work long hours, much larger numbers of patients than city practitioners. Once again, John pointed out that we have a heavy emphasis on emergency treatment which is often quite difficult treatment. We have an emerging pattern in some areas of external servicing, of dentists flying to rural areas and just working a few days a week in both the public and the private sector.

In fact, the area I come from the public sector is totally serviced by dentists flying in, which is really great. It's tremendous that the government has gone to that effort. But of course after hours it's just the few remaining people in the area who handle all the emergencies. So your workload goes up tremendously. You have a lack of specialist support in dentistry, as you do in a lot of medical services, and I've got there the buck stops with the rural practitioner. It just makes treatment per day a bit tougher.

The bottom one is an arising problem. There's a real uncertainty with the sale of rural practices, and that means capital expenditure really needs to be very carefully planned and the practice can't be counted as a retirement asset. Three practices in rural South Australia were closed in the last couple years. The practitioners haven't been able to sell them. It's anecdotal but you talk around meetings, guys are saying, "Well, I'm really starting to wonder whether I'm going to spend \$50,000 or \$70,000 on a dental unit. I've got five years to go. Will I ever be able to sell that equipment?", because if you can't sell it in the working practice, you just cart it off to the rubbish dump.

This has been fairly well covered, but it's worth just summarising that we have higher dental disease levels in rural areas than in metropolitan areas. Rural patients really are exposed to very long waiting lists. Once again, in the area I come from you will wait several months in the private sector for an examination and couple of months to receive the treatment that's found at that examination. In the public sector, you're talking years.

We have very poor access to specialist services with no travel assistance for either public or private patients. Now, I know that varies a bit from state to state and it's been talked about a lot today, but if you have a dental problem, if you have an infected wisdom tooth which needs to be extracted, a typical pattern would be several infections around the wisdom tooth, several courses of antibiotics and

eventually a referral off to a metropolitan specialist. If it's just that, there is no travel assistance. You pay for that out of your own pocket. And that's also the case for a public patient.

The public patient receives no assistance either. Often the cost of travel from a rural area to the city and accommodation and travel back is greater than the cost of having the treatment done privately in the rural area. If you happen to be unlucky enough to have a spreading with a big swollen face that needs an external incision and drains put in and all that sort of thing, suddenly you would become eligible to receive travel assistance because that then of course becomes a medical problem.

I didn't quite know where to drop this in. There have been a lot of calls made for dentistry to be funded by the federal government with a Medicare type scheme and we've heard recently the National Party putting that in their platform and the Labor Party have it and certainly the Australian Dental Association is calling for it, and quite properly so. There is a lot of untreated dental disease, particularly for eligible patients that could be assisted by such a scheme. I can tell you for certain that in many rural and remote areas that treatment wouldn't get through because we just don't have the workforce to provide it. There are no dentists, for example, in the south east of South Australia taking on new patients at present, so even if you're a private patient you can have trouble getting in to see someone. So if there's a sudden influx of many more patients, there just isn't the workforce to treat them.

You've seen this slide before but much more elegantly from John, and you look at those numbers and they look terrible. But I thought I would just go on to what the problem really is when you just crunch it down away from percentages and people per hundred thousand and so on. The actual number of practitioners to fix some of these problems isn't that great. An extra 10 dentists would make a huge difference in rural South Australia, for example, because you're dealing with low numbers of patients, so one or two patients can make a big difference to that number of dentists per hundred thousand in the area that you're in.

Then if you really break that down and say, well, if you could get two extra dentists into the rural area over five years, that would be your 10. If you got three, it would be 15. That would be fantastic. And I really think that would be the situation in other states. I suspect that if you popped another 30 or 40 dentists into rural Victoria and another 30 or 40 dentists into rural New South Wales and Queensland, you would make a tremendous difference to the services that could be provided. So as I go on to talk about solutions, I don't think we need to be, like John, super pessimistic about perhaps being able to fix some of this.

I just think though that you have to be careful about what the solutions are. It's very easy to say, "Well, look, we'll import a pile of dentists. They'll all go there". There's been work done at Flinders University by I think Professor Richardson to say that people don't automatically move to a rural area because there's a need. They'll move perhaps to where they have social support or where their family is,

and so on. And I know that John will cringe at those statistics because it's sort of a phone-in poll or something, but it's rather worrying when you see that, and that of course just wasn't for dental, but people are not prepared to just get up and move to rural areas, and of course we know that because we've got a depleted rural workforce.

The Australian Dental Association has suggested a whole raft of things that perhaps might be done. They've suggested that perhaps HECS debts be forgiven for graduates who are willing to work in an area, the extension of the fee help scheme, Commonwealth education and accommodation scholarships be increased for dental students from rural and remote areas and lower socioeconomic background indigenous students, and other programs have been suggested for nursing and education students. That perhaps might have an immediate effect and, as I say, the numbers aren't that great. You might get one or two in South Australia per year from that, and perhaps an extension of the medical or one of the scholarship schemes to apply to dental graduates.

Already there's a fair bit of money floating about for rural dental students and the Australian Dental Association, to its enormous credit – this is money out of the pockets of dentists – in 2006 gave four grants of \$5000 for dental students from rural and remote regions, and there were a couple of Aboriginal study grants and in fact I think that may have been increased a bit. There's another scholarship up to \$60,000 I think for people wanting to do some postgraduate work. Just in New South Wales, the New South Wales ADA branch has given \$25,000 annually over seven years for rural placement programs to send students out in their final years to areas like Broken Hill and spots like that.

I was really impressed to see in some documents that the National Rural Health Alliance has been in to bat before for us. That was from your party line in December 2005 where Tony Abbott was asked to consider a rural Australian medical scholarship type scheme, asked to increase the number of places at dental school and the possibility of a dentist rural relocation allowance discussed. So that was really great to read.

I think when you look at that money that's available - and in South Australia too just our state government gives \$5000 a year for rural students – one of the things we've really got to do is encourage rural students to apply, because sometimes all of these scholarships aren't taken up. It's tragic, but the state government one, they're not all taken up, and I think there was trouble filling one of the Australian Dental Association ones too. So if we train rural students - at Charles Sturt in their pharmacy program they've got 70 per cent of their students remaining in a rural area, and they would suggest that they've had similar success with podiatry and radiotherapy and so on.

But while this is happening, you really do need to dedicate places – well, firstly you need to dedicate places for rural students to get them in. But they also need to be really mentored while they study and those with their rural area kept on the way through with placements. Suggestions have been made that perhaps we

could introduce an intern year. There's no intern year in dentistry, and perhaps students could be encouraged or placed in a rural area.

I think the last point I've got there is very important. It's no use just saying to them, "Go to the rural area". You really have to have jobs with imaginative contracts available in the public and private sector, perhaps allowing them to work in both sectors. They need support when they're out there and they need good clinics to work in and good equipment and good remuneration. Really though, as John said, we really need a national approach to all this, with dentistry being included in overall rural health planning, not separate dentistry out, but it needs to be included in all rural health planning.

And this has been already mentioned today, that we've really got to stop this buck passing between state and Commonwealth. You go to the state and state says that's a Commonwealth problem. You go to the Commonwealth and they say that's a state problem. It's just got to stop. The same buck passing goes on between the Departments of Health and Education and so on.

We do have a national oral health plan. This is a very impressive document and it was prepared by the National Advisory Committee on Oral Health and that was established by the Australian Health Ministers Conference and it has representatives from all over Australia and from many, many groups. That's been signed off by all the states. All the state ministers have signed off on that plan. That plan if you look at the bottom, that's the overall plan, and there's need to go into the complexity of it, but you'll notice that the actions area 7 at the bottom is the workforce, and many of the things that I've been talking about today are recommended in that plan.

I just almost in finishing just wanted to talk about what we've done in our own area. Now, we really had a lot of problems in the area I come from. To say that people were a bit unhappy with each other wouldn't be an understatement. There were troubles with after hours emergency treatment of public patients. The private guys were expected to do it, the private guys didn't like doing that, and so it went on. So we got together and had a meeting and really at that meeting all those groups within half an hour realised that really we all had the same aims and really what we wanted was to give quality service to our patients. So there was a resolution that we work together on that and some of those imaginative contracts came out of it, placing dental students in Mt Gambier came out of it, and also we resolved to hold a professional development seminar, because that's another issue for rural practitioners – you're very separated from professional development – and to support rural practitioners and their staff.

But the most important thing about that is it does what we've been saying today we need to do; it gets everyone together. And this year it will be attended by the Dental of the Dental School, the CEO of SADS, the South Australia Dental Service, the President, the General Manager of the Australian Dental Association, the incoming Federal President of the ADA, and we're going to have 70 attendees so far with about 10 dentists in the area. So that's been a resounding success in

support and perhaps that's something that rural areas need to do themselves, is to set up something where people support each other.

So my final comment is that it can be done. There's a huge amount that can be done, but it can't be done alone. It's like the comment that yesterday a meeting was held between a large number of groups that included of course the Rural Health Alliance, the Nurses Federation, Diabetes Australia, Health Issues Centre, the Hygienists Association, QUIT, the Victorian Oral Health Alliance and the AMA, the Division of General Practitioners and of course John Spencer was there, and ACOSS, and perhaps there were some other groups, but that will give you an idea of the groups that attended to perhaps start addressing these problems. Apparently out of that meeting really came an enormous goodwill and a resolve to move forward on these issues.

So I would just say in closing remember the actual numbers to fix all this aren't great. All we really need is the will to do it. Thanks.
