

NATIONAL RURAL HEALTH ALLIANCE INC

PUBLIC SEMINAR

'KEY ISSUES IN RURAL AND REMOTE HEALTH'

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DISCUSSION

JOHN WAKERMAN: Thank you very for those presentations. We will have about 15 minutes or so for discussion. I might just make one comment, and I'm gratified to hear that it's not going to take huge numbers. I just wanted to remind the audience that the best predictor of rural practice is rural origin, and also to let you know that, whilst we've asked the Minister for some specific dental undergraduate scholarships, thus far without success, but we have asked again, the Rural Allied Health Undergraduate Scholarship Scheme which is run by SARRAH, Services for Australian Rural and Remote Allied Health and assisted by the Alliance, we had 900 applications for those scholarships in the last round for 65 scholarships, and five of those were dental scholarships that were awarded. So there are a small number of undergraduate scholarships going to dental students of rural origin, but clearly we need some more.

Okay, I'll open it now for any comments. John.

JOHN [off mic]: If I could I just ask John to comment. John, your statistics are very revealing, but I think perhaps they don't actually disclose how bad the problem is by grouping them in the regions you've done. With something like accessibility to dental services, it's actually the distance that they have to go to a particular region, so your inner regional and outer is this average this effect. What we've got is socioeconomically disadvantaged groups who are geographically separated away from regional centres, so the double whammy comes in and I think that if you actually teased out those statistics you'd find there's a group of severely disadvantaged in terms of access and more greatly maybe kind of not knowing the data, to ask you to comment on that.

JOHN SPENCER: We could have sort of increased the complexity of the analysis, and you're absolutely right, there's compounding basically interaction effects that occur in terms of not only people's geographic location, but then their socioeconomic position, other enabling or barriers to accessing dental care that all come into play. By the time you look at particular subgroups of the community that you might define by the presence of two or three factors which you think are inhibiting their access to services, you're really talking about a very steep falling away of people's use of dental services. What I did basically today was simply stick to the same basic classification pattern through the presentation that we use for looking at the labour force to use that for access as well, but it's clearly not the only way you can go about making the comparisons.

MICHAEL [off mic]: Thank you very much for your presentations. I want to make a comment that it's much for all areas health provision that the sourcing of undergraduate students from the rural schools, they're much more likely to go back and work in the rural areas. Now, other professions have been very creative with their undergraduate schools in places by geographical means or by the mark of their HSC results. companies in Australia encompassed this idea yet?

JOHN SPENCER: I think that certainly there is active consideration of those sorts of issues across all of the six now dental schools in Australia, and none more so than in Adelaide at present where the issue of even state origin students entering medicine and, to a lesser extent, dentistry, has become a fairly significant local political issue.

But I think there's been far less progress than what one would hope and in a sense it reflects the fact that the key actors in the education of dental students are both the tertiary university sector, and dental schools feel under a great deal of pressure in terms of the financing of the education of dental students. But there are also the public dental services within each state and territory which tend to provide the clinical facilities in which dental students obtain their clinical experience, and the also are under a great deal of resource pressure.

The eye has not been on the ball because survival in a pretty tough environment for the last decade has been the main game in both sort of areas. The University of Adelaide only moved this year to create the opportunities which you're alluding to in medicine, and it is likely to create those same opportunities in dentistry next year.

MALE SPEAKER [off mic]: Actually, Michael, in partial answer to your question, I think Charles Sturt University have entered into a relationship with the University of Sydney where the University of Sydney's dental school will allocate 10 places to Charles Sturt graduates to enter into the dental school faculty.

SHARON [off mic]: This is a question for Mark. Mark, my name is Sharon from the Rural Health Branch of the Department of Health and Ageing. We run a program called the Rural Private Access Program that seeks to increase the range

of private insurable health services in rural and remote areas, and of course that would include dental. But what I was wanting to remark on was that we've had an incredibly low uptake from dentists in respect of this program, and I wondered if you think that that could be put down to the issues you raised of workforce being one, and the other one perhaps being infrastructure in terms of in the long run dental practice, because these grants can be up to \$500,000 for capital.

MARK HUTTON: Well, firstly I didn't know anything about them, so I wonder how much the profession actually knows about the grants. There certainly would be a workforce issue involved with it. As I say, right now practices are being closed. They can't even be sold, let alone anything new done, and practices that are on the market aren't even getting people coming along and kicking the tyres. So yes, I believe that probably it's firstly a publicity of that scheme issue, and secondly, a workforce one. There was a second part to your question that I - - -

SHARON: No, it was mainly I was interested in whether you thought it was a viability issue in terms of the long-term I guess point in investing in infrastructure for dentists, so that might be one reason why they might not apply, and the other one being because of the workforce. But the other point that I would make – and I guess this is just a bit of an advertisement – is that the grants are for equipment as well infrastructure and also for service But if you think it's just an issue of people not knowing about it, we need to take that on board.

MARK HUTTON: It certainly is an issue of people simply not knowing about it. In fact, it raised its head in South Australia at the meeting of the Oral Health Advisory Committee only two weeks ago and except for a representative from DOHA, for the state office of DOHA in South Australia, no one in the room had ever heard of them, and that included both the representatives of the Australian Dental Association in South Australia, but also the South Australian Dental Service.

And I think actually that sort of issue really was what lay behind my comment at the end of my presentation about a full participation. The reality is – and no offence to the members of DOHA that are here that have a sort of a watching brief on dental issues – there is simply no focus of activity within DOHA that would be interacting on a regular basis with states and territories about opportunities for dentistry to even participate in those programs that exist in rural health or aged care or any other area where advantage could be taken of that sort of program.

FEMALE SPEAKER [off mic]: I'm just wondering with such a shortage of dentists, what your views are on the roles of the dental nurse and dental hygienist and how they fit into the scheme of access to dental services.

JOHN SPENCER: Mark wants to be more the politician I think. Very clearly there's a tremendous role for auxiliaries. We saw from the data on five to 11 year olds that a great deal can be achieved in particular program areas with the involvement of dental hygienists, dental therapists, maybe even dental

prosthetists. But in the main auxiliaries will play the greatest role in specifically targeted programs for subgroups of the population. When it comes to the great bulk of the Australian community, we're still highly reliant upon dentists to provide most of that dental care.

MARK HUTTON: If I could just comment on the use of auxiliaries, I really think the dental profession of all the health providers have really encompassed the use of auxiliaries far in excess of anyone else and, I mean, we really have cutting auxiliaries. A dental therapist, for example, can extract primary teeth and cut cavities, and hygienists – that's a person who cleans teeth - can give local anaesthetic and really rip into someone's gums in a pretty aggressive way with a curette.

JOHN WAKERMAN: Thanks, that sounds highly attractive.

MARK HUTTON: That's why of course we've got them, so dentists don't have to do it – no. So I think the dental profession can really pat itself on the back for the way that we have encompassed the use of auxiliaries to provide dental treatment in this country, and of course as John mentioned too, the prosthetist who make dentures. So there already is wide use of auxiliaries. There still has to be a leader of the dental team, as it were; there will always need to be a dentist. So you're always going to need a decent number of dental graduates in proportion to the number of auxiliaries.

DAVID [off mic]: My name is David from the Department of Health and Ageing.. Mark, in your presentation you referred to calls to Medicare funded type scheme for dentistry. There are some existing arrangements for people with chronic conditions. I just wanted to ask you to maybe expand on your comment on the role of Medicare in dentistry.

MARK HUTTON: I can't remember who the architect of Medicare was now. Can - - -

FEMALE SPEAKER [off mic]: Deeble and

MARK HUTTON: Yes. They actually said, if you go back and read their original documentation, that Medicare wouldn't work for dentistry, or they didn't see Medicare as being part of dentistry, and I did put up there Medicare type scheme rather than Medicare. As you say there are a few numbers that can be used on a fairly limited scheme, but I think it's reasonable to say overall that Medicare virtually funds in real terms no dental services. You'll remember that a few years ago under the last Labor government we had a Commonwealth Health Dental Scheme, I think it was called, and a large number of people were treated by that. It's my understanding that that's what the current Labor Party platform is that Julia Gillard has recently been talking about.

My comment to the Medicare scheme was just from something I heard on the news that the National Party were recently saying that Medicare should fund

dentistry. You know, it's a great catchcry, but dentistry is very, very complex. It's different to medicine. It's uninsurable. You can insure against someone getting appendicitis because only a certain percentage of people in the community will get appendicitis. Everyone pretty much will need dental treatment. So in that case certainly check-ups and scale and cleans, and so on, are not insurable. Everyone is going to need them. So just in any of those schemes, we need to be very careful in the way that they're introduced and approached.

JOHN SPENCER: If I take your question to be that under the Enhanced Primary Care Program there's an opportunity for dentists to participate and people with chronic diseases and complex needs for a rebate to be provided to dentists to assist with the cost of the care that they're receiving, I think the real issue with regard to that program is that the straight out mechanics of the funding arrangements are really at odds with the way in which dentists have predominantly gone about practising dentistry in terms of fee for service practice. The Enhanced Primary Care Program uses basically a consultation rebate sort of approach which doesn't really fit with the way in which dentists itemise and bill for their work.

It might seem an issue that one should be able to move past relatively quickly, but I think it just shows that if you really want these things to work, you have to actually have a reasonable level of consultation between whoever the funding party is and practising dentists, so that you make arrangements which will be taken up and will work in the favour of patients seeking care from them.

MARK HUTTON: And it was that program that I was referring to though, John, that it's still in terms of overall dental treatment in Australia exceptionally limited.

FEMALE SPEAKER [off mic]: this question is to the lady from the department. Are those grants only available if you have a dentist?

SHARON [off mic]: The

FEMALE SPEAKER [off mic]: yes.

SHARON [off mic]: It's the allied health professional. All the dentists

FEMALE SPEAKER [off mic]: So if you were a country town with only auxiliary services, could you apply for those grants?

SHARON [off mic]: It's got to be the actual practitioner that applies for the grants – the provider of the services.

FEMALE SPEAKER [off mic]: Yes, but providing the service it might be a dental hygienist.

SHARON [off mic]: Yes

FEMALE SPEAKER [off mic]: So they could apply for it?

SHARON [off mic]: Yes, they could, yes. If they are providing privately insurable health services.

FEMALE SPEAKER [off mic]: Only if they're private?

SHARON [off mic]: Private, yes, privately insurable.

FEMALE SPEAKER [off mic]: Okay, thank you. My second question is to Mark. Mark, you mentioned that the dentist had to be the leader of the team, and I'm just wondering if there's really a need for the leader of the team to be always present in a rural setting, because yesterday we heard an interesting study or pilot program that's been happening in Queensland where the dental hygienist was able to examine the mouth of the patient using a camera and then that was relayed down to the dentist in Brisbane or something like that. So I'm wondering really does a leader have to be there?

MARK HUTTON: Well, in South Australia in the South Australian dental services, the government system, in the rural areas they're almost routinely not there. For example, Mt Gambier is about 400 kilometres from Murray Bridge, and that was where the therapist at Mt Gambier was supervised from for a quite a long time when we didn't have a resident dentist. So that situation has already existed. I'm actually fascinated by the suggestion that you could use a camera and transmit that information. That's been done with ECG from rural areas and things like that in other sectors, and is probably well worth a look at, I'd say.

JOHN WAKERMAN: We're going to have to wind up. I want to ask one last question. I'd like you to comment on alternative models. Mark, you talked a little bit about fly-in fly-out visits, and at the Alliance council we were talking about something like a dental outreach service, a fly-in fly-out if we can't get dentists in rural areas. So I'd like to hear some comments on the feasibility of that sort of service.

The other thing that sparked my thinking related to the infrastructure costs that you were talking about. There are GP models in other states, sort of walk-in walk-out models where GPs don't have to buy into practices or sell the practices. Local government and others get together and create the infrastructure and the doctor can walk in and walk out fairly easily. I just wonder if either of you would like to comment on that model and its feasibility in terms of dental practices as well.

MARK HUTTON: To take the second bit first, it's certainly feasible and I know one of the students that I supervised a few years ago when he was in Mt Gambier went to a practice I believe in Cobar which is owned by the local community or local council – I'm not a hundred per cent sure – and at some very reasonable rent. He went there to practice, and good on them for getting one of

our Adelaide graduates in New South Wales. In Victoria, in Hamilton, for example, they're allowing some of the hospital facilities, some of the public hospital facilities to be used by a private dentist coming in. So there are obviously some very imaginative ways in which the local communities could attract private practitioners to towns, because often the infrastructure is already in place.

My comment with the guys flying in and flying out was I'm quite concerned about the workload and stress on rural practitioners, and once again I've got no evidence on it and it's only anecdotal, but you have people say, "Look, I've just about had enough of this. I worked flat out for 20 years or 25 years. I'm going to head back to a major city and have a quieter life". And I'm concerned that we don't burn out people in rural areas. My telephone, for example, just goes berserk on the weekends from areas – not my patients, but from areas around. When the phone rings everyone just sort of sighs and wonders what it's going to be. It's not a great way to live. So that's the other side of it.

But of course if you're in a really remote area then that may be the only way you're going to get a service. I know it's not good dentistry, but if a patient gets an abscess, what I'm about to say, it's not ideal, but certainly a course of antibiotics and some decent painkillers will tide them over to the next visit. So that may be the only way that many communities can get services.

JOHN SPENCER: It's tempting to say build it and they will come, but I think it's actually – we know it's more complicated than that and I think we really have to recognise that it's not just build it and they will come; it's build it, support it and sustain that support over reasonable periods of time, and maybe they will come and maybe they will stay. We've seen some good evidence of the type of support that seems to matter to primary healthcare providers in rural areas and I think we know some of what is really required to retain people for reasonable periods of time.

The challenge for us in dentistry – in some ways we're in an ideal position – it's not very often I say that – and that is, there's been so much work already with regards to medical practitioners and other health practitioners that we can actually learn a lot from what has been found to be successful there. The challenge for us now is to get the wherewithal in terms of leadership and funding to actually make some of these happen in the dental area.

MARK HUTTON: Yes, I just so heartily agree with that, and of course that's why I described the Limestone Coast Dental Partnership, because that's I believe the sort of stuff you've got to do to keep people in the general area.

JOHN WAKERMAN: Thank you, we might wind things up. The Rural Dental Network of the ADA is a member of the Alliance and oral health and dental health is certainly still and will remain on our list of priorities for quite some time, I think. So would you thank the speakers, please?
