Submission to the Senate Standing Committee on Community Affairs: The factors affecting the supply of health services and medical professionals in rural areas

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Purpose: The aim of this submission is to draw to the attention of the Standing Committee the disparities in oral health needs of, and access to oral health services, particularly for older and indigenous Australians in rural areas. The submission is weighted heavily on data and experience of rural and regional oral health needs and services in New South Wales. In essence, the Submission argues that oral health, and the oral health workforce, must be considered an integral, joined-up, part of the health service system in rural and regional areas of Australia.

Background: Recent national[1] and NSW oral health surveys [2,3] have shown the major disparities in both oral health status and access to dental services between metropolitan and rural areas. People of all ages in rural and regional areas have a greater prevalence of unmet dental need, higher rates of adults with inadequate functional dentitions (fewer than 21 teeth) and higher rates of dental decay in children from remote and very remote areas.

The Australian population-based and residential care oral health surveys[1,2] have starkly indicated also major changes in the oral health status of older Australians who are maintaining more teeth for life. The irony of this improvement in oral health is that these teeth and supporting tissues become a high risk to rapid deterioration should an individual's personal skills decline as a result of physical or mental capacity.

Prevention: Water fluoridation delivers the most effective, cost effective and socially equitable means of achieving community wide exposure to the dental caries preventive effects of fluoride. The advantage of water fluoridation is that the entire community benefits from the preventive measure, regardless of age, socioeconomic level, educational achievement, individual motivation, or the availability of a dental workforce.

The National Oral Health Plan recommended the extension of fluoridation to non-fluoridated communities with a population of more than 1,000. Although priority for fluoridation has focused to date on communities with more than 1,000 populations, rural and regional towns with populations less than 1,000 – could benefit also through the new technologies available for water fluoridation. Recently, fluoridation has been implemented in communities with a population as small as 400 persons through improved technology and new designs of fluoridation plants using 5 kg sodium fluoride bottles within small saturator plants (personal communication, NSW Office of Water, 2011).

Oral health workforce and distribution issues: The oral health workforce is made up not only of dentists and dental specialists, but oral health therapists, dental therapists, dental hygienists, dental prosthetists dental assistants and allied health workers and carers involved in preventive dental care.

Oral health workforce shortages have been noted by a number of studies including that by Teusner et al in 2008.[4] Teusner and her colleagues argue that on projected demand for dental services in Australia, there would be a shortfall in the supply of dental services of around 38.8 million dental visits by 2010. This would equate with an undersupply of around 1,000 to 1,100 dental practitioners.

Many reports have identified greater access barriers to rural families accessing to dental care than metropolitan families, and dental workforce distribution is the most significant of these barriers. [5, 6] The 2007 Profile of the Oral Health Workforce[7] reported dentists per 100,000 residents working in NSW in the Greater Western and Greater Southern Area Health Service regions as approximately 21.6 per 100,000, compared with Northern Sydney Central Coast at 74.2 per 100,000, and South Eastern Sydney Illawarra Area Health Service regions at 55.5 per 100,000 populations.

In recent years there has been an increase in the number of Universities providing dental and oral health courses with La Trobe University, Newcastle University, Charles Sturt University and James Cook University all taking up new programs for dentists and/or oral health therapists or dental hygienists. The supply of Australian domestic dental (dentist) graduates has risen from 210 in 2001 to 284 in 2007. Allied dental practitioners (dental therapists/dental hygienists or dual qualified) practitioners has increased Australia wide from 99 in 2003 to 206 in 2007.

In addition, the successful completion rates of the Australian Dental Council Examinations by international dental graduates (the registration licensing hurdle for overseas qualified dentists) has risen from 52 in 2001 to 204 in 2009. The trend in the supply side of dental services appears to be moving in the appropriate direction, to meet the increases in the projected demand for dental services.

Trend data on dental practitioners by region (city, inner regional, outer regional, remote)[8] across Australia, show slight improvements in the 2009 distributions in outer regional and remote areas. Between 2003 and 2006 practising dentists per population in major cities increased from 57.6 to 59.5 dentists per 100,000 while the ratios remain static in outer regional (approx 27.6/100,000) and remote areas (approx 18.1/100,000). In 2009 the major cities ratio had risen to 62.4 /100,000 and the outer regional and remote areas to 30.4/100,000 and 23.1/100,000 respectively. The stark mal-distributions by regions remain.

Therefore, greater opportunities should be created across an integrated rural health workforce for the employment within public and private settings (including Medicare Locals) for dentists, dental and oral health therapists.

The Commonwealth Government currently offers scholarship to *medical* students to encourage future rural practice:

- The Rural Australia Medical Undergraduate Scholarship (RAMUS). In addition to their rural background, RAMUS scholarship holders are selected on the basis of financial need and demonstrated commitment to working in rural Australia in the future.
- The Medical Rural Bonded Scholarship (MRBS) Scheme is designed to address doctor shortage outside metropolitan areas across Australia. Students accepting

the MRBS commit to working for six continuous years in a rural or remote areas of Australia less any credit obtained through Scaling, after completing their medical training as a specialist

- The Higher Education Commitment Scheme (HECS) Reimbursement Scheme reimburses HECS debts of medical students should they choose to train and work in rural and remote communities. Under the Scheme, doctors are able to reduce the period for reimbursement of the cost of their medical studies from five years to two years, depending on the classification of their training or practice location.

The availability of these scholarships and incentives should be widened to include dental and oral health students and recent dental graduates.

Commonwealth involvement in oral health services: The *Medicare Chronic Diseases Dental Scheme (CDDS)* was introduced in 2004 by the Commonwealth Liberal Government, and expanded in 2007 with the introduction of new Medicare dental items. It provides people with chronic conditions and complex care needs with up to $4,250 worth of dental services in a two calendar year period.

Dental services under the Scheme are provided entirely through private dental providers through referrals from general medical practitioners.

The Scheme is not means tested and public oral health services are excluded from providing care under the Scheme, although they have been active in identifying those patients on public oral health waiting lists who may be eligible and notifying them how to access the Scheme.

The current Commonwealth government has proposed the cessation of the Medicare CDDS. The cessation of the Medicare CDDS would have a significant impact upon the ability of rural and outer regional Aboriginal Medical Services (AMSs) and aged care providers to provide improved access to oral health care.

Rural communities in NSW are strongly supportive of ensuring continuity of the Medicare CDDS but acknowledge that reforms are necessary and that, like the Medicare Teen Dental Plan, it may be better targeted to those on low incomes through some form of Centrelink-determined eligibility requirement (Commonwealth Health Care Card or Pension Benefit Card).

Aboriginal populations experience significantly higher levels of both chronic disease and poor oral health and the Medicare CDDS provides invaluable financial support to AMSs to provide dental services under the Scheme.

Similarly, the Medicare CDDS provides an important avenue for accessing dental treatment identified under the Better Oral Health in Residential Care Program[9]. The oral health needs of older Australians, especially those in residential care, is of increasing significance to improving their general health. This allows residents access to timely dental care rather than relying on access to limited public dental services especially in rural and regional areas.

The *Medicare Teen Dental Plan* (MTDP) was established by the Commonwealth Government in 2008, and provides an annual preventive check for eligible teenagers aged 12-17. The Plan operates by way of a voucher sent to eligible teenagers usually at the start of the calendar year. The voucher is currently worth $159.85 (indexed on 1st January each year), and may be used at either a public or private dental provider.

Approximately 1.3 million teenagers are eligible for the program each year in Australia, out of a population of approximately 2 million 12 to 17 year olds. Eligibility for the MTDP was extended from 1 January 2009, adding a further 15,000 teenagers each year.

A report on a Review of the Dental Benefits Act 2008 legislation which enables the MTDP to operate, was tabled in the Federal Parliament in March 2010. The report found lower than estimated utilisation rates of the vouchers, but concluded that the scheme had been administratively successfully established from a legislative perspective. It has been noted that uptake of vouchers by teenagers in outer regional and remote areas of Australia has been at lower rates than uptake in the major cites and inner regional Australia.

Not all regional communities believe that the MTDP is an appropriate way to use scarce public dental dollars and prefer to see an expansion of the CDDS program, and for greater targeting of oral health promotion activities to adolescents and young adults.

Closer working relationships between medical and dental personnel in rural and regional area should be developed through Medicare Locals and other arrangements which provide infrastructure and critical mass of general and specialist health personnel. Such arrangements would provide closer and more appropriate referral pathways between doctors and dentists and the holistic health management of patients, especially the most vulnerable and dependant within rural and regional communities.

Oral health services in NSW: More than 85 per cent of dental services provided in NSW are through the private dental practices and are delivered by dentists.

NSW Health has a responsibility to providing access to dental care, on a needs priority basis, (NSW Health, Priority Oral Health Program and List Management Protocols, PD2008_056, http://www.health.nsw.gov.au/policies/pd/2008/PD2008_056.html) to eligible (NSW Health, Oral Health - Eligibility of Persons for Public Oral Health Care in NSW, PD2009_074, http://www.health.nsw.gov.au/policies/pd/2009/PD2009_074.html) residents of NSW. In 2010/2011 NSW Health provided more than 290,000 adult dental visits and 125,500 child dental visits. In 2010, there were approximately 166 public dental clinics in NSW with a combined total of 698 dental chairs.

In 2003, NSW Health established three Regional and Rural Oral Health Centres; Northern NSW (at Grafton); Western NSW (at Orange) and Southern NSW (at Queanbeyan). Since that time the Northern Centre has consolidated the Grafton and Coffs Harbour clinical services and the Western NSW Centre has developed two state-of-the-art Centres in cooperation with Charles Sturt University and the University of Sydney at Orange and Dubbo. Further Centres have been developed at Bathurst and Ballina, and a major centre is planned for Wagga Wagga. Consolidation of expertise, the development of a critical mass of dental personnel and strong linkages with the community, Medicare Locals, universities and hospital sectors are the key drivers to regional and rural oral health reforms. These shared and linked-up models of care involving oral health and dental personnel, should be more fully developed and evaluated in rural and regional areas.

Aboriginal oral health in NSW: A further element to the NSW Health regional and rural oral health service program has been the development of public sector led partnership models with Aboriginal Medical Services and the Royal Flying Doctor Service. New

models of care should be promoted also with the organized dental professions including the Australian Dental Association Federal and State Branches

An Aboriginal Oral Health Hub and Spoke program has been set up under the National Partnership Agreement by establishing a dedicated two chair oral health surgery at Sydney Dental Hospital. It has recruited an Aboriginal oral health coordinator, four dentists, Aboriginal dental assistants and trainees and an Aboriginal receptionist. The goal is to have dentists rotate through rural AMS dental clinics that do not have a dentist. The program also sees seeing Aboriginal patients referred to the Sydney Dental Hospital clinic from metropolitan Aboriginal Medical Services. This supplementary model of care to rural and regional communities has been well received by all sectors and provides a model which should be expanded both within NSW and elsewhere. It provides a model of "joined-up" oral health services for communities at special risk

The Aboriginal Oral Health Workforce should be promoted by developing cadetships and scholarships to support Aboriginal people undertaking training in oral health, and by providing incentives for the university sector to establish courses of study for Aboriginal students that lead to acceptance into a dental or oral health degree program.

Technical initiatives to assist rural and regional communities: The development of regional Centres of Oral Health with joined-up services between public-private-university and NGO sectors to provide critical mass and capital infrastructure also permits the greater development of Tele-dentistry, especially for diagnostic, consultation and referral procedures. See for example, The University of Melbourne Tele-Dentistry innovation using the Soprolite© with the 'plug and play' system which permits a minimally trained person to provide real-time images to a specialist based back-up service.

NSW is continuing to develop its e-Health and Telehealth systems. The aims of NSW Telehealth are:

- improving access to clinical services;
- maintaining quality and safety in health service delivery;
- improving networking of services;
- improving clinical effectiveness;
- building collegiate networks; and,
- serving the community.

Funds are available to NSW to expand its Telehealth initiative as part of the COAG Capital Plans program; however the inclusion of oral health Teledentistry has not been advanced. The inclusion of dentistry and oral health services in this and related Telehealth programs would be an important element in meeting both NSW and national goals. It would also play an important role in improving diagnostic and referral pathways to and from residential aged care facilities.

Summary : Oral health is an important component of general health, consequently, the oral health of a community, and access to oral health services should be an integral component of professional health services to rural and remote areas of Australia.

Regrettably it is frequently overlooked in planning and policy for rural and regional Australia.

There is sound epidemiological evidence to demonstrate the disparities in oral health status and access to dental care of rural communities compared with their city counterparts. While efforts are being made to promote the oral health professionals living and working in rural and regional areas far greater work needs to be done reduce disparities and improve the ratio of oral health professionals in rural and regional areas.

It is suggested that there are four key areas which the Commonwealth government must support with respect to oral health care and professional development in rural areas:

1. Continuity in funding dental services under the Medicare CDDS and Medicare Teen Dental Programs – especially with respect to Aboriginal Medical Services and Residential Care Facilities;
2. Alignment of undergraduate and graduate professional incentives for dentists and other oral health professionals with medical and allied health incentives;
3. Joined-up oral health and general health (dental/medical) services in a variety of different rural and regional settings and configurations to support the infrastructure for dental education and dental service delivery;
4. Promotion of IT and tele-communication strategies to support clinical diagnostics and referral networks in dentistry between rural and specialist metropolitan centres.

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