Australian Dental Association Inc.

Senate Community Affairs Committee Submission

Inquiry into the factors affecting the supply of health services and medical professionals in rural areas

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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 12,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are to:

- Encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and
- To support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are ADA Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

Introduction

The ADA would like to thank the Senate Committee on Community Affairs for its invitation to provide comment in relation to the factors affecting the supply of health services and medical professionals in rural areas.

The ADA's submission is structured in accordance with the Terms of Reference of this inquiry.

Executive Summary

The ADA agrees with the Senate Committee's Terms of Reference's assertion that there are factors which limit the supply of dentist practitioners in rural/regional areas. While the ADA does not believe there is or will be an undersupply of dental practitioners in Australia in the short to medium term, there is a maldistribution of where this supply is currently placed. There are significantly lower numbers of dental practitioners per head of population within rural/regional areas compared to metropolitan centres. If the factors limiting the recruitment and retention of dental practitioners are not addressed, the provision of oral health care to rural/regional Australians will diminish.

a. Factors limiting supply of dentist practitioners to rural/regional centres

The factors that limit the supply of dentist practitioners to rural/regional areas encompass not only financial constraints (such as high capital costs) but lack of resources and professional support; coupled with the lack of social and local infrastructure in the community. These factors not only make attracting dentist practitioners to rural/regional areas difficult, but impact on the likelihood that those who work in rural/regional areas stay and continue to practise in those areas. Suggestions to change the scope of practice of allied dental personnel will not address the dental health needs of rural/regional Australians as it does not address the disincentives that exist for rural/regional health practise generally. Incentives therefore need not only address the financial needs of current and prospective rural/regional dentist practitioners, but also their professional and social/community needs as well.

b. The introduction of Medicare Locals

Medicare Locals in rural/regional Australia to date has been implemented hastily and has excluded dentistry which will affect dental care delivery for Australians in these areas. Dentistry must be adequately included in the development of primary health care responses to ensure that activities such as dental health promotion and oral disease prevention are undertaken in these vulnerable communities.

c. Current incentive programmes

The ADA makes the following recommendations to be adopted by government in its current and future incentive programmes for dentist practitioners to practise in rural/regional Australia:

Recommendation 1: As an overall approach government incentive programmes should be targeted towards encouraging those dentists in private practise to best enable the delivery of dental care to rural/regional Australians.

The prospective rural/regional dentist practitioner (student/intern)

Recommendation 2: Develop similar rural placement programmes that are currently available to medical students to apply to dentist students.

Recommendation 3: Provide assistance for university and clinical schools for rural health to better enable their support for dentist students.

Recommendation 4: Provide collaborative undergraduate and vocational rural placements for dentist students and prospective practitioners; including support for ongoing mentoring of recent graduates.

The dentist practitioner in rural/regional practice

Recommendation 5: Apply the same incentive programmes for recruitment and retention of medical practitioners to dentist practitioners.

Recommendation 6: Provide support programmes in educational institutions and dental practices which have clear educational and career pathways.

Recommendation 7: Provide a national system of local orientation, induction, and support for dentist practitioners to work within the rural/regional community.

Recommendation 8: Increase resources to and streamlining of, the use of a salaried professional health provider model for dentist practitioners.

Incentives nominated by the dentist profession as relevant to making rural/regional practice more attractive

Recommendation 9: The ADA's member survey recommends the provision of the following monetary and education incentives:

- Monetary: preferential tax treatment; government capital contributions; relocation assistance; set up grants/government bonuses; monetary assistance; and higher pay;
- Educational: accessible training/internship and education; HECS debt forgiveness; and rural health informatics to assist in professional exchange on clinical matters and continuing education issues.

Recommendation 10: Target incentives to those dentist practitioners who practised dentistry for five years or less; are in the public sector; and are based in practices with 5 or more dentists.

Application of the current Australian Standard Geographical Classification

Recommendation 11: The ADA does not have a specific position on the Australian Standard Geographical Classification (ASGC) Remoteness Areas classification scheme except to note that to ensure that adequate dental care is provided to rural/regional areas resources need to be targeted towards programmes and incentives which attract and retain dentist practitioners as well as strengthen the overall social and community infrastructure of these areas.

Further to this point government must ensure it takes into account what distances between dentists and their prospective patients constitute significant remoteness. Such a classification regime should rely on distance from a major capital city and a group according to population size and factoring in distances from a major regional centre.

Recommendation 12: Create a more systematic comprehensive research capacity to better collate data on dental workforce provision within rural/regional areas.

(a) Factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres

No undersupply but a maldistribution of dental practitioners

In recent years there has been an increase in the supply of dental professionals in Australia. The ADA Inc.'s National Dental Update of August 2011 (see **Attachment A**) notes that by 2013, the number of new dentists entering the workforce, including new graduates and overseas trained dentists, will be double the number of new entrants in 2006.[1] Between 2004 and 2011 the number of registered allied dental personnel including dental therapists, hygienists and oral health therapists increased by 91 per cent to 3,943.

However there remains a considerable maldistribution of dental professionals whereby smaller regional and rural centres still lack adequate access to dental practitioners. According to the most recent report available on dental workforce distribution,[2] the number of practising dental practitioners per 100,000 population ranged from 59.5 in major cities to 17.9 in remote/very remote areas based on the remoteness areas defined by the ASGC.

As the Terms of Reference of this inquiry suggest, consideration needs to be made into the factors that are limiting the supply of dentist practitioners to smaller rural/regional areas.

Factors to attract the supply of dentists in rural/regional centres

The ADA acknowledges there are perceived benefits to working in rural/regional practice:

- A broader scope and variety of work;
- Community ties;
- Comprehensiveness and continuity of care;
- Autonomy; and
- Rural lifestyle.[3]

The ADA's member survey conducted in September 2011 found that 17% of its metropolitan based members indicated a willingness to seriously consider relocating to rural/regional areas to practise dentistry.[4]

The ADA member survey confirmed the factors that would most encourage dentists into rural practice were: 44% of members nominated the quiet/rural lifestyle; 23% the demand for services and 21% the greater employment opportunities that rural/regional dental practice provides.

These factors identify what has to be marketed by government to encourage a greater number of dentist practitioners to work in rural/regional areas. They also identify what it is that has to be addressed by initiatives to ensure that these factors continue to exist and thus attract practitioners to work in these areas.

Factors that limit the supply of dentists in rural/regional centres

However in spite of the motivating factors outlined above the ADA submits that there are a multitude of factors that make attracting and retaining dentist practitioners to work in regional/rural areas difficult. These factors can be divided into professional and social/community categories.

Social/Community

- Lack of access to quality secondary schooling;
- Spouse or partner's unhappiness in rural setting/ employment opportunities for partners;[5]
- Lack of community resources; and
- Lack of cultural fit with the local community.

Professional

- Lack of financial incentive to compensate for a more isolated lifestyle;
- Heavy workload and overinflated community expectations;
- Professional isolation/inability to access continuing education;[6]
    - Lack of access to General Anaesthetic facilities in hospitals;
    - Lack of mentoring for recent graduates and inexperienced operators;
    - Lack of access to specialist services/support; and
- Lack of leave cover for holidays.[7]

The ADA member survey identified that out of those members that would consider relocating to rural/regional centres, more than half nominated government funding and cost of compliance with regulation to be of greatest concern to their ability to practise dentistry in these areas. An average 43% of respondents nominated education, the public perception of dentistry and practice accreditation as their next areas of concern.

Changing the scope of practice of allied dental personnel will not address the dental health needs of rural/regional Australia

It has been suggested that one way to address the rural/regional undersupply of dentist practitioners is to expand the scope of practise of allied dental personnel.

There is no evidence that there is indeed a ready supply of such allied dental personnel to enable the option of expanding the scope of practises of allied dental personnel in a way which delivers quality oral care to rural/regional Australians. In fact maldistribution issues also apply to allied dental practitioners.[8] Broadening the scope of dental practice for allied dental personnel will not per se transfer those providers to rural/regional centres.

Furthermore, broadening the scope of practise by allied dental personnel will detract them from performing their primary function, which is to ensure there is

adequate oral health promotion and dental disease prevention within the community. In other words, not only would the dental practitioner maldistribution issue in rural/regional areas remain, but the health promotion/dental disease prevention needs of the community will be negatively impacted as well.

Government needs to address the workforce issues first, namely the incentives available to assist in attracting and retaining dentist practitioners in regional and rural areas before considering scope of practice arrangements beyond that of the primary oral health care provider, dentists.

Rural/regional dentists continue to provide quality dental care in spite of constraints

The ADA member survey showed that dentists in rural/regional areas offer a higher mean number of services at a discounted rate on average compared to metropolitan based services (approximately 39% and 9% respectively). Rural/regional dentist practitioners similarly offered a higher mean number of free consultations compared to their metropolitan counterparts (63% and 50% respectively). These results suggest that in spite of the additional challenges and constraints facing rural/regional dental practice, dentist practitioners in these areas strive to provide a quality service at a reasonable rate in the interests of their patients.

However if the factors limiting the supply of dentists to rural/regional areas outlined above are not addressed, pressure over time would force dentist practitioners to limit if not remove their practices from rural/regional communities altogether. This would further detrimentally affect the quality and continuity of dental care for rural/regional Australians.

(b) The effect of the introduction of Medicare Locals on the provision of medical services in rural areas;

Medicare Locals' exclusion of dentists will affect dental care delivery for rural/regional Australians

In a previous submission to Health Workforce Australia's (HWA) Draft Rural and Remote Workforce Innovation and Reform Strategy Background Draft Paper ("Background Draft Paper"), the ADA stated that while it supports the need for locally planned, needs-based service models, it views with concern the hasty establishment of Medicare Local facilities without adequate consultation with local dentist practitioners.[9]

The ADA notes that dentistry has been generally excluded from the Medicare Locals model. The majority (85%) of dental services in Australia are provided by the private sector.[10] Without private sector dentists there would be virtually no dental services in rural/regional Australia. These practitioners need to be fully consulted and become part of any change in dental care delivery. Otherwise, there is a risk that rural/regional areas will lose the dental care they already receive.

The next section of this submission will outline ADA's recommendations on current and future incentive arrangements that would best ensure that dentist practitioners are attracted but also continue to stay in rural/regional practice.

(c) Current incentive programmes for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:

(i) Their role, structure and effectiveness,

(ii) The appropriateness of the delivery model, and

(iii) Whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes;

The ADA's submission does not provide commentary on specific incentive programmes currently in place for dentists. However this submission outlines general principles that current and future programmes should adopt.

The ADA's following recommendations are grouped in the following manner:

- The prospective rural/regional dentist practitioner (student/intern); and
- The dentist practitioner in rural/regional practice.

Government is encouraged to engage with the ADA, the peak body for the dentist profession, to inform members about the existing incentives available and seek further feedback on how future incentive programmes could be best developed.

Recommendation 1: As an overall approach government incentive programmes should be targeted towards encouraging those dentists in private practise to best enable the delivery of dental care to rural/regional Australians.

Incentive programs need to be directed towards the fact that dentists operate on a different business model than the hospital/medical model. The ADA submits that there is little incentive for dentists to work in rural/regional hospitals where they are managed by a system that has little or no knowledge of dentistry. The result therefore is high turnover generating further inefficiencies in the public system. The public dentist has no investment in their practise and is more likely to move on.

The ADA submits that most health services are best provided in an environment where there are long term relationships between the clinician and the patient. This is best provided on a private practise model, particularly in rural/regional areas. The private model allows for the creation of private practises that have the following value propositions:

- The clinician has clinical independence;
- The clinician can build and invest in a business;

- The private practise has the potential to generate a higher income than what would be earned in the public system;
- The clinician can better select and target their dental care resources to patients; and
- The community is more likely to embrace the dentist who has shown a commitment to the community by setting up private practise.

The private practise model of dentistry (adopted by the vast majority of dentists) better delivers positive dental health outcomes for rural/regional patients.

The prospective rural/regional dentist practitioner (student/intern)

Recommendation 2: Develop similar rural placement programmes that are currently available to medical students to apply to dentist students.

Rural placement programmes for dentist students should be modelled after those that currently apply for medical students; with priority of access given to those of a rural/regional background (particularly from rural communities of under 5,000 people) and those who indicate a willingness to dedicate the first period of their life in practice to the area. Studies have shown that students more likely to continue to practise dentistry in regional/rural areas are those who have a background from those communities.[11] This is understandable as these people who originate from regional/rural areas naturally have pre-existing attachments to these areas, and a greater understanding and appreciation for the needs of these communities. The survival and health of these communities would be better assured by having these students return as skilled professionals.

Recommendation 3: Provide assistance for university and clinical schools for rural health to better enable their support for dentist students.

It has been documented that these interfaces are crucial for providing the support and integration for those who are considering rural practice to work there. As a result assistance to university/clinical schools of rural health should be given to ensure that their oral health disciplines and practices are able to support the development of prospective dentist practitioners in rural/regional areas.

Recommendation 4: Provide collaborative undergraduate and vocational rural placements for dentist students and prospective practitioners; including support for ongoing mentoring of recent graduates.

The ADA supports the National Rural Health Alliance's (NRHA) proposals for the development of collaborative undergraduate rural placement and vocational placements. These placements will consist of scholarships, infrastructure and mentoring to ensure there is continuity of learning and training across the academic and vocational skilling of prospective dentist practitioners in rural/regional areas. The ADA is already proactively urging its members to 'grow their own' future workforce, by encouraging collaboration with local work experience programs and careers counsellors in regional/rural communities.

Graduates need quite a few years' experience before being able to independently practise in rural/regional areas. Mentoring provides not only the assistance and supervision on the practise of dentistry, but also provides the support to how to

deal with the particularly unique situations that arise with patients in rural/regional areas. This mentoring is particularly useful especially when in rural/regional areas there are usually no specialists at for which issues could be referred.

The dentist practitioner in rural/regional practice

Recommendation 5: Apply the same incentive programmes for recruitment and retention of medical practitioners to dentist practitioners.

The existing incentive programmes for recruitment and retention of medical practitioners in smaller regional/rural communities should be similarly applied to dentist practitioners. In doing this the ADA urges that government develops these programmes in a way that recognises that dentists do not fit within a medical/hospital model of service delivery. Dentists operate in individual surgical practices and are predominantly private sector based, which therefore requires a significant amount of cost for the necessary equipment, specialised staff and infrastructure. These considerations need to be taken into account when framing incentive programs to assist the setup and operation of such practices within rural areas. The ADA is in a prime position to be able to advise on how such incentive programmes can be developed.

Recommendation 6: Provide support programmes in educational institutions and dental practices which have clear educational and career pathways.

Support programmes that provide clear educational and career pathways should also be developed within educational institutions and dental practices for dentist practitioners. These programmes should recognise that dental practise is different from medicine, where oral health care is usually provided within a private practice setting rather than a hospital. This could be done for instance through the development of general guidelines rather than set curricula to be administered by prospective mentor/supervisors, who themselves would be provided with some form of financial assistance to perform this role.

Recommendation 7: Provide a national system of local orientation, induction, and support for dentist practitioners to work within the rural/regional community.

The ADA's member survey showed that dentists in rural/regional areas were more likely to have utilised several forms of professional development offered by the ADA than their metropolitan counterparts. Any incentives need to consider addressing rural/regional dentists' high engagement with continuing professional development, education and training and their desire to continue with and expand this engagement.

Recommendation 8: Increase resources to and streamlining of, the use of a salaried professional health provider model for dentist practitioners.

The ADA recognises that salaried professional health providers as opposed to the fee for service/mixed funding models used in more metropolitan areas are increasingly being used in rural/regional areas to attract and retain dentist practitioners.

However these salaried professional health providers appear to currently be provided within the context of multidisciplinary primary health care teams which are usually supported by local government. The ADA recommends that consideration be given to better resource and streamline the provision of professional salaried dentist practitioners because the availability for this funding model would vary to local government to local government.

Incentives identified by the dentist profession as relevant to making rural/regional practise more attractive

Recommendation 9: The ADA's member survey recommends the provision of the following monetary and education incentives:

- Monetary: preferential tax treatment; government capital contributions; relocation assistance; housing incentives; set up grants/government bonuses; monetary assistance; and higher pay.
- Educational: accessible training/internship and education.

The ADA's Policy Statement 2.3.4 on "Delivery of Oral health Care – Special Groups: Rural/Remove Areas" (see **Attachment B**) further expands on these recommendations:

- HECS debt forgiveness;
- Better locum schemes;
- Provision of equipment and other facilities for service delivery; and
- Rural health informatics to assist in professional exchange on clinical matters and continuing education issues.

With the ADA's member survey results in mind, government should consider whether existing incentives are adequate in nature or adequately communicated to dentists to facilitate actual relocations to occur.

Recommendation 10: Target incentives to those dentist practitioners who practised dentistry for five years or less; are in the public sector; and are based in practices with 5 or more dentists.

Our survey found that those who were most likely to consider reallocation practised dentistry for 5 years or less (36%); practised in the public sector (25%); or were based in practices with 5 or more dentists (21%). Incentive programmes should be developed to target these groups.

Application of the current Australian Standard Geographical Classification

Recommendation 11: The ADA does not have a specific position on the ASGC Remoteness Areas classification scheme except to note that to ensure that adequate dental care is provided to rural/regional areas, resources need to be targeted towards programmes and incentives which attract and retain dentist practitioners as well as strengthen the overall social and community infrastructure of these areas.

Further to this point government must ensure it takes into account what distances between dentists and their prospective patients constitute significant remoteness. For example, dentists that live quite close to cities i.e. 20-50 kms away may be classified as rural depending on the circumstances. Therefore the ADA recommends that such a classification regime should rely on distance from a major capital city and a group according to population size and factoring in distances from a major regional centre.

(d) Any other related matters.

Develop a research/data capacity for understanding dental workforce provision in rural/regional areas

Recommendation 12: Create a more systematic comprehensive research capacity to better collate data on dental workforce provision within rural/regional areas.

The ADA's Policy Statement 2.3.4 on "Delivery of Oral health Care – Special Groups: Rural/Remove Areas" states that having a strong research and evidence base is crucial in which to formulate incentive programs to increase the recruitment and retention of dentist practitioners in rural/regional areas.

Conclusion

Over the short to the medium term the ADA does not anticipate an undersupply of dental practitioners in Australia.[12] However there currently exists a maldistribution of dental practitioners, particularly in rural/regional areas. While there are positive aspects of rural/regional practise which ADA's members have said attract them to the idea of relocating, such as the rural lifestyle, autonomy and broad range of dental care roles that could be performed, there are significant inhibiting factors that are yet to be addressed. These factors concern financial constraints, such as difficulties in setting up a viable practice, as well as the lack of resources and social and professional support networks. These factors must be addressed to ensure that not only are dentist practitioners integrated into the community, but are able to perform their roles as providers of oral healthcare in a rural/regional environment which itself has wide ranging needs and pressures. Suggestions to change the scope of practice of allied dental personnel as a means to address this maldistribution will not address the dental health needs of rural/regional Australians.

Medicare Locals have been claimed to be a model from which the primary health care needs of rural/regional communities can be better met. However the ADA submits that Medicare Locals in rural/regional Australia to date have been rolled out in haste, and has excluded dentistry which will affect dental care delivery in these areas. Dentistry must be adequately included in the development of primary health care responses to ensure that activities such as dental health promotion and oral disease prevention are undertaken in these vulnerable communities.

Current and future incentive programmes need to address the needs of the prospective rural/regional dentist practitioners (students and interns), as well as those dentist practitioners that are starting rural/regional practice or are considering settling permanently in these communities. These programmes need to borrow substantially from those that have been provided to medical students and practitioners, naturally framed to meet the particular circumstances and health care provision models that dentist practitioners apply in their craft. There needs to be comprehensive collaborative programmes that seek to integrate and expose prospective and newly graduated dentist practitioners into the unique rural/regional dental care environments at both the educational but also vocational and practice levels to ensure that there is adequate support to maximise the prospect for retention. Furthermore, what should be considered in particular is orientating these incentives and support towards those dentist practitioners who are of rural/regional backgrounds. Alongside comprehensive professional and social support, the ADA recommends financial assistance such as in the form of preferential tax treatment, government capital contributions, relocation assistance, set up grants/government bonuses, monetary assistance, and higher pay.

Underpinning any development and assessment of the efficacy of these incentive programmes the ADA urges government to develop an evidence and research base on the supply and demand of the dental workforce in rural/regional Australia. Only with sufficient data will current and future programmes be adequately assessed and that sufficient resources and investment will deliver for the oral health care needs of our rural/regional Australians.

Dr F Shane Fryer
Federal President
Friday 6 January 2012.

Attachment A

NATIONAL DENTAL UPDATE – August 2011

WORKFORCE SHORTAGES IN DENTISTRY COULD BE A MYTH

Health reform continues to dominate much of the Australian Government's agenda at present and crucial to the success of the reform agenda is an adequate supply of health professionals. There is no shortage of evidence that highlights the problems of supply with particular health disciplines. Dentistry has not escaped from being lumped in with all other health professionals in the discussion but is there really a shortage of dentists?

WORKFORCE STUDIES

There have been a number of reports released by the Australian Institute of Health and Welfare (AIHW) recently regarding the dental workforce and while an update on dental workforce numbers is welcomed and well overdue, the report uses data which are five years old and therefore fails to represent the true picture: the likely oversupply of dental practitioners entering the workforce in the next few years.

The AIHW report, *Dentists, specialists and allied practitioners in Australia*[1] uses data collected from the 2006 labour force survey for dentists in all states and territories, with the exception of Western Australia and Tasmania where they are collected directly by the AIHW's Dental Services Research Unit to indicate the number of dental practitioners registered and working in Australia.

The report indicates that there were 12,212 dentists registered in Australia in 2006. This represents a 20.8% increase in the number of registered dentists when compared to 1996 figures. During this decade, there were on average around 250 new dentists entering the workforce each year. This figure mainly represented graduates from Australian university dental programs and a small number of overseas qualified dentists registered to practise in Australia.

FUTURE SUPPLY

Based on Dental Board of Australia figures in May 2011, the number of registered dentists is now 13,750 indicating an average of just over 300 new entrants to the workforce annually since 2006.

In 2013, the number of graduates from Australian university dental programs is expected to be around 450 per annum. This increase is as a result of three new dental schools coming onboard in 2007 and subsequent increases in student intake across existing dental schools. Figures for overseas qualified dentists entering the country under the Australian Dental Council (ADC) pathway suggest an additional 200 applicants are meeting Australian registration requirements each year. When combined, these figures culminate into approximately 650 potential new dentists entering the workforce in 2013.

When compared to 2006 figures, this represents more than double the number of new entrants to the dentist workforce each year. Based on current intakes to

Australian university dental programs, it is projected that Australian graduates alone will match this figure by the year 2016 without including those entering the country under the ADC pathway. The effect of lifting the cap on Commonwealth Supported Places for domestic students will also impact on student intakes.

Compounding workforce entry supply is a decreasing exit rate. A recent report by Schofield2 indicates that dentists are remaining in the workforce longer than was first anticipated.

Coinciding with the increase in numbers commencing dental programs, there has been a substantial increase in the number of universities offering programs in allied oral health. Graduates of these courses are eligible for registration as dental hygienists, dental therapists or oral health therapists.

Graduates of oral health programs will reach in excess of 300 per annum in 2013 and if utilised effectively, could result in significant improvements to the delivery of preventive oral health services and oral health promotion, particularly in the oral health outcomes for children and young persons. However, the impending outcomes of work being undertaken by Health Workforce Australia regarding the scope of practice of allied oral health professionals suggests that rather than using this group of highly skilled professionals in the role for which they were specifically designed, there is a likelihood that their scope of practice will be expanded to treat adults and thus move them away from and creating a void for essential preventive oral care, oral health promotion and treatment of children.

ADDRESSING ACCESS IS THE SOLUTION

In recent years there has been reference to the 'tsunami' of medical graduates who would enter the Australian workforce and how the system would cope with finding them all intern places. A tidal wave of dentists is also heading to shore and that wave will be followed by another as numbers of graduates from allied oral health programs enter the workforce.

The real problem in Australia is not one of workforce shortages, it is about funding and access.

The answer to access is not to change who does what. Rather, government should look to real and lasting solutions that put the most qualified and capable practitioners where they can make the most impact. We now have, and will have in the future, more than enough dentists to provide all of the oral health services Australians need. Do we have the commitment from the Australian and State and Territory Governments to make it happen?

1 Balasubramanian M & Teusner DN 2011. Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006. Dental statistics and research series no. 53. Cat. no. DEN 202. Canberra: AIHW.
2 Schofield et al.: Retirement intentions of dentists in New South Wales, Australia. Human Resources for Health 2010 8:9.

Attachment B

ADA Policy Statement 2.3.4

DELIVERY OF ORAL HEALTH CARE: SPECIAL GROUPS: RURAL/REMOTE AREAS

1 Introduction

1.1 The oral health of people living outside urban areas is frequently compromised because of significant disadvantage in accessing timely and comprehensive oral health care. A major factor is the difficulty in attracting and retaining dentists to rural and remote areas, both general practitioners and specialists.

1.2 Improved oral health delivery and a viable dental workforce in rural/remote areas will result from improved planning by Governments in collaboration with the dental profession and other stakeholders. A co-ordinated approach involving improved education and training, greater local community support, increased incentives, and better work conditions is urgently needed.

1.3 Rural and remote areas are defined by the Accessibility/Remoteness Index of Australia (ARIA) as compiled by the Commonwealth Department of Health and Aged Care.

2 Principal

2.1 People in rural and remote areas should enjoy the same oral health as the rest of Australia.

3 Policy

Oral health promotion

3.1 Water supplies in rural and remote areas should be fluoridated wherever practicable.

3.2 Oral health should be promoted through collaboration with other health care, community and education workers and organisations.

3.3 Dentists should be included in rural health associations and organisations.

3.4 Community-centred promotion of oral health and preventive care should be initiated.

Delivery of oral health care

3.5 Every Australian should have access to quality oral health care.

3.6 The specific needs of residents of rural and remote areas, including those with special needs (children, adolescents, elderly, disabled, those with language difficulties and indigenous Australians) should be recognised and supported.

3.7 Efforts to recruit and retain dentists to rural and remote areas are of the highest priority and should include:

3.7.1 Education and training initiatives

• exposure of school students to rural dental practice;

• university enrolment practices which increase the number of rural dental students (such as rural origin scholarship schemes and selective placement of rural students in courses);

• exposure for dental students to rural practice; and

• access to ongoing and appropriate continuing education.

3.7.2 Local community support and incentives

• education of prospective rural dentists about the community; and

• assistance to dentists to integrate into the community including aid in providing surgery rooms and accommodation for dentists, their spouses and families.

3.7.3 Working conditions and incentives

• relocation grants and retention payments;

• financial incentives such as HECS debt forgiveness;

• better locum schemes;

• mentor support from experienced dentists;

• provision of equipment and other facilities for service delivery; and

• rural health informatics to assist in professional exchange on clinical matters and continuing education issues.

3.8 All dental schools should conduct placement programmes for dental students in rural and remote areas.

3.9 Dentists practising in rural and remote areas should have access to professional support and flexible continuing education opportunities.

3.10 A rural and remote dentists' network should be established.

3.11 Government should have initiatives to enhance the recruitment and retention of dentists and allied dental personnel.

3.12 State-based initiatives that promote effective utilisation of existing infrastructure and personnel to improve access to oral health care should be developed.

3.13 The Australian Dental Council should incorporate rural and remote placements into its procedures for assessment of overseas-trained dental graduates seeking Australian qualifications, provided that qualification standards are maintained at the present level.

Research

3.14 National Oral Health Surveys should enable the assessment of the oral health of rural and remote communities.

3.15 National dental workforce reviews, which incorporate rural and remote areas, should be regularly undertaken.

3.16 There should be funding for ongoing studies into strategies that address the recruitment and retention of dentists and allied dental personnel in rural and remote areas. 3.17 Research should be collaborative and should involve Departments of Health, universities and other stakeholders.

ADA Policy Statement 2.3.4 Page 3 of 3 April 16/17, 2009

Policy Statement 2.3.4

Adopted by ADA Federal Council, April 10/11, 2003.

Amended by ADA Federal Council, April 16/17, 2009.

References

[1] Australian Dental Association Inc. National Dental Update, August 2011

[2] Balasubramanian M & Teusner DN 2011. Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006. Dental statistics and research series no. 53. Cat. no. DEN 202. Canberra: AIHW

[3] See for example J. McDonald, L, Bibby and S, Carroll, GPs in Rural Areas: Improving Outcomes through Evidence-based Research and Community Capacity-Building, Centre for Health Research and Practice, University of Ballarat, www.vurhc.org.au, accessed 12 September, 2011.

[4] Australian Dental Association. Membership Survey. Conducted September 2011.

[5] E. Kruger, M. Tennant, A Baseline Study of the Demographics of the Oral Health Workforce in Rural and Remote WA, Australian Dental Journal, 2004: 49, 3.

[6] See also ADA Inc. Federal Budget Submission 2011-2012.

[7] E. Kruger, M. Tennant, A Baseline Study of the Demographics of the Oral Health Workforce in Rural and Remote WA, Australian Dental Journal, 2004: 49, 3.

[8] AIHW/DSRU Dental Labour Force Survey 2007

[9] Australian Dental Association. Submission to Health Workforce Australia's (HWA) Draft Rural and Remote Workforce Innovation and Reform Strategy Background Draft Paper.

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[12] See reference 1.