Senate Standing Committee on the Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas.

Dental Health Crisis in Rural Australia: A practical solution

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Dental Health Crisis in Rural Australia- An Alternative Solution

Terms of reference being addressed:

1. Factors limiting the supply and distribution of health services in rural areas
2. Incentive programs for recruitment and retention of dentists, particularly in smaller rural communities
3. Other related matters

Components relating to specific terms of reference for terms of reference 1, 2 or 3 will be marked as TR 1, 2 or 3 accordingly.

Introduction:

The provision of dental care in Australia is at a cross roads. OECD reports indicate that rural and regional Australia has the lowest standard of dental care of its 18 member countries. Current numbers of dentists in rural communities are as low as 17.3 per 100,000 population. With such low numbers the provision of services to patients can only be compromised at best and ultimately it is the public's health that suffers as a result. Such a situation has only been able to occur through many years of misallocation of existing resources from the public sector, but more significantly a private dental system keen on maximizing returns on investments while largely treating dentistry as a business rather than what it fundamentally is- a health care service. (TR 1 and 3)

Whilst no one is specifically to blame and nor can fault be attributed to any individual government, state or federal, the inherent apathy of the various councils, advisory bodies and lobby groups with each seeking their own agenda results in the system we have today. (TR 1)

There currently is a stark distinction between the services offered in government-subsidized clinics and those offered at private clinics. The public system is plagued by a constant lack of resources, staffing shortages, low morale and essentially inefficient practices resulting in compromised dental care for the general public, with limited treatment options being provided at a considerable cost to the health budget. The private system conversely is highly funded through patients and private health insurances, resulting in a system that is

efficient, robust at affording patients the best treatment available anywhere in the world. (TR 1)

In rural communities this distinction is even greater with under-resourced public clinics trying to cope with an ever increasing patient load and ever fewer dentists to service the communities. This has resulted in a shift towards and a predominance of emergency procedures and fewer preventative procedures being performed, with at least a two-year waiting list for most treatments being the norm. Private clinics on the other hand cope with an ever-increasing patient base desperate for treatment by charging higher treatment fees accordingly. (TR 1 and 3)

The National Health Advisory Committee has recently indicated a need for a Universal Dental Scheme similar to Medicare to supposedly improve access to dental care. Unfortunately a Medicare type dental scheme will only become an expensive 'White Elephant', serving only to burden the public purse and result in an ever-increasing disparity between Metropolitan dental services and those in rural communities, much like has happened to the medical system.

This submission will demonstrate a new approach to providing dental services to rural communities which will improve access to world class dental care to rural and regional communities and provide private-type clinic care to all patients irrespective of financial status without being a burden on the public purse and provide equity in the provision of dental care for rural communities.

Challenges in Providing Dental Care to Rural Communities

Many challenges currently exist for rural communities and brief synopsis of these include but not limited to:

1. **Geographic Access**--- specifically individuals living in rural centers and more remote locations, where provisions for dental services are scarce and in many parts non-existent. (TR 1)
2. **Physical Access**--- specifically individuals with physical, mental or other impairments, that may be institutionalized or in supervised care facilities, or where transportation is inaccessible. (TR 1)
3. **Waiting Times**--- in public dental systems are well recognized, meaning the focus on treatment becomes relief of pain and emergency care rather than addressing fundamental problems early with a preventative focus on care. Patients in the public system with severe problems that can not wait on waiting lists are forced on to the private system which leads to: (TR 1)
4. **Affordability**--- While many strategies have been implemented to reduce the load on the public system, patients are increasingly being forced to the private system, which has seen significant increase in fees in recent

years 2---3 times the health services average. (TR 1)

5. **Limited range of dental services**--- the public system while in major teaching hospitals are able to provide wider range of dental options to patients, the community centers where the bulk of services are provided offer a basic level of treatment options. This means that lower income earners are financially discriminated against with treatment options available. The current waiting times and eligibility requirements for complex treatment in the public system unfortunately means most patients miss out and have compromised care. (TR 1)
6. **Oral Health awareness and preventative strategies**--- currently public dental services are overwhelmed with relief of pain and emergency type work that implementing preventative and education campaigns are difficult. (TR 1)

Recommendation:

A New Model in Improving Access to Dental Care

There have been many strategies over the years to rectify holes in the provision of affordable dental care to all population bases, the reality is, little actual tangible benefit has been achieved. The public system is unfortunately seen as the poor cousin to the highly funded private system, with increasing inefficiency, a management focused staffing arrangement and increasing bureaucractic input, resulting compromised patient care and dental health. (TR 1 and 3)

Existing private-public partnership models are failing as their focus is on building a business model that contributes only to the bottom line of their respective owners, and the status quo in terms of reinvestment to the public patients care remains lost. This new model aims to provide a private system model to all patients, and using the profitability of private dental care to finance treatment options for all patients, and also establish local community care programs, hence establishing a true Public- Private partnership, rather than the existing public funded private enterprise. (TR 1,2 and 3)

This model relies on the establishment of dental clinics in rural centers where none exist and/or the improvement of existing facilities where public clinics currently operate. Staff at larger regional centers would rotate through smaller satellite clinics in more rural townships that would be established as part of the program, therefore improving access to towns that are currently not being serviced. (TR 2 and 3)

The clinics would operate in the same way as private clinics currently do, with services provided to patients as they attend rather than undergoing assessment first and then being assigned to a particular waiting list category. This will act to reduce administrative red tape and hence reduce associated costs in providing dental care. (TR 2 and 3)

The clinics would be funded by a combination of private insurance rebates, Federal and State government funds (as they currently are) and by private patients directly. The clinics would be focused on preventative care that would ultimately improve dental care for the community, and encourage an improvement in overall dental health. (TR 2 and 3)

The preventative strategy involves, patients with private health insurance with extras cover being completely covered for preventative items and small fillings and conservative periodontal treatment, through negotiation with individual health insurances accordingly, with fixed rebates to be paid for such items for regular attendees. Public patients eligible for public dental care (pensioners, health care card holders and low income earners) would be subsidized for preventative treatment such as check ups, cleans, fillings and conservative periodontal therapy- with a nominal co-payment for these items paid per visit. The copayment amount would be on an incentive basis with patients that attend regularly have a smaller copayment, and the longer patients wait to attend for preventative care the larger the copayment required to be paid. Profit generated by the private health insurance rebates and government subsidies would be reinvested back into the revenue pool for the clinic and allow for reduced cost of services for individuals and families not eligible for government assistance or without any form of private health insurance. The clinics would run at a nominal profit and hence allow for affordable dental care for all sectors of rural communities. (TR 1, 2 and 3)

Staffing for the clinics would occur through the establishment of a dental internship program similar to medicine. A 1 year compulsory internship program for graduate Dentists, Prosthetists, Hygienists and Therapists and all international Dentists to attain full registration under AHPRA would provide a workforce that can be rotated through rural and regional clinics under the supervision of experienced and qualified Dentists. The current theory of increasing numbers of dental graduates and auxiliary staff haven't made a difference in improving rural dental services, whereas this new model guarantees a steady supply of dental professionals to areas of need. (TR 2 and 3)

The clinics would be established in rural local areas depending on population distribution and demand for services. This would allow for movement of staff according to need and demand at centers within the network without any significant changes to existing infrastructure. (TR 1and 3)

The flow on effect of establishing new clinics and the improving of existing facilities, results in improved employment opportunities in rural centers, with an increased need for receptionists, nurses, account staff, managerial staff and like service professions such as technicians, prosthetists. Moreover the clinics can be equipped with Australian Made materials and equipment rather than from foreign sources, which would improve the local economy promote local jobs. (TR 1 and 3)

Conclusion

The establishment of a Medicare style dental scheme would only serve to reduce access to dental care in rural and regional centers in much the same way as Medicare has decimated rural medical services and forced up GP fees for the rural community. A model where individuals are rewarded for having private health insurance will reduce dependence on the public purse and hence ensure the limited public funding is not stressed and hence ensure there are enough resources for all rural communities without exception.

The model I am proposing is preventative care focused and will ultimately improve dental health for rural and regional communities without it being a financial 'white elephant' that universal dental care has been for every single country where it has been introduced, and ensuring dental services will have the resources to continue to be provided for future generations.