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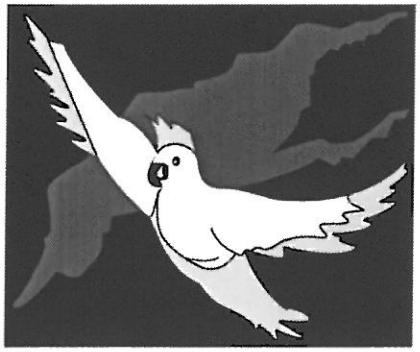

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Services for Australian
Rural and Remote Allied Health

Submission to the
House of Representatives Standing Committee on Health and Ageing

Inquiry into adult dental services in Australia

March 2013

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Introduction

SARRAH (Services for Australian Rural and Remote Allied Health) welcomes the opportunity to provide a submission to the House of Representatives Standing Committee on Health and Ageing inquiry into adult dental services in Australia.

SARRAH is nationally recognised as a peak body representing rural and remote AHPs (allied health professionals) working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These AHPs provide a range of clinical and health education services to individuals who live in rural and remote Australian communities. AHPs are critical for the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and core to Australians' health care and wellbeing.

General comments

The National Health and Hospitals Reform Commission (NHHRC) final report (June 2009) *A Healthier Future for all Australia* presents the need to have a national "health system with teeth". The report highlights the worsening dental health of our children, the costs of accessing dental care particularly for those who cannot afford private cover, and the lengthening waiting lists in both the public and the private sectors. These issues are compounded for those living in rural and remote locations and even more so for Indigenous populations.

Poor dental health has an impact on dietary intake, health and wellbeing and social functioning. Poor oral health has been identified as a risk factor for the development of a number of chronic health conditions including diabetes, cancer and cardiovascular disease. Poor dental health means that people in disadvantaged groups, often Indigenous and remote and rural populations are living with painful and possibly unsightly dental issues. Poor dental health also can affect a persons' ability to obtain and retain employment.

The NHHRC made a number of recommendations relating to improving dental health care including a proposal for all Australians to have universal access to preventative and restorative dental care through the establishment of the 'Denticare Australia' scheme.

Australians in rural and remote Australia require access to dental services now. They cannot afford to wait until a program such as 'Denticare Australia' evolves.

Major issues for rural and remote oral health care include oral health workforce shortages, lack of access to and cost of both preventative and restorative oral health care, together with limited water fluoridation.

In the report *Australia: the Healthiest Country by 2020 – National Preventative Health Strategy* (Commonwealth of Australia 2009) a number of strategic directions are discussed including:

- Contributing to 'Close the Gap' for Indigenous Australians.
- Refocusing primary healthcare towards prevention.
- Reducing inequity through targeting disadvantage – especially low socioeconomic status (SES) population groups.
- Acting early and throughout life – working with individuals, families and communities.
- Engaging communities – act and engage with people where they live, work and play: at home, in schools workplaces and the community.
- Informing, enabling and supporting people to make healthy choices.

All Governments must act in a coordinated manner and fill the gaps in oral health care for rural, remote and Indigenous populations by building local workforce capacity. The Productivity Commission Research report into the Australian Health Workforce recommended the development of a flexible, competent health workforce in order to use the current workforce to better meet the needs of rural and remote populations.

Comments against the Terms of Reference for the Inquiry

a) Demand for dental services across Australia and issues associated with waiting lists.

SARRAH suggests that the Inquiry, when focussing on adult dental services, must not lose sight of prevention measures. It has been proven that smoking is linked with periodontal (gum) health and fluoride exposure with tooth decay. The US-based Centers for Disease Control and Prevention (CDC) and the World Health Organisation placed water fluoridation in the top ten public health achievements of the 20th Century.

Current guidelines recommend that water fluoridation should be expended to as many people as possible including those residing in rural and/or remote Australia. It would not be an exaggeration to state that the major contributor towards preventing oral disease in the latter half of the twentieth century has been the use of water fluoridation and of fluoridated toothpastes. Recent research has indicated that the poorer oral health in rural and remote communities compared to metropolitan areas may be explained by lower lifetime fluoride exposure.

SARRAH believes that a condition of any Commonwealth dental service funding provided to the States/Territories should be that all communities, where it is cost-effective, have fluoridated water supplies. Evidence indicates that this would include all communities with a population of 500 or more that have reticulated water supplies.

SARRAH suggests that the Inquiry should focus on the need, rather than demand, for dental care. There is a difference:

- Demand is influenced by people's capacity to pay and on their outlook on life. If, as some contend, the socioeconomic status is lower in rural and remote settings than in metropolitan areas, then demand for regular dental care per head of population

would be lower in rural areas as compared to metropolitan areas. However, the need, as defined by a dental practitioner looking into a person's mouth, for dental care would be greater.

- Demand is a movable beast. Teeth are not extracted at the levels that they were in the 1950s. The more teeth there are out there the greater the demand for dental care.
- As dental practitioners improve what they can do in the dental clinic, for example dental implants, the greater will be the demand for that care.
- Demand for dental care will vary depending on the amount of State/Territory or Commonwealth Government funding that is allocated to dental care. For example, if a Denticare scheme was introduced tomorrow, the demand for dental care would increase significantly.

SARRAH believes it is time that political parties of all persuasions realise that waiting lists are a political measure, not a measure of access to dental care. Waiting lists times and lengths can be manipulable to suit political ends. For example, methods of creating a short waiting list may include instructing dental practitioners:

- not to do to full oral examinations and provide a very limited range of dental services;
- not to inform patients that there is a waiting list;
- to inform patients who become aware of a waiting list that it is many years long;
- to audit the waiting list by contacting patients and removing those who do not respond within a short time period from the list; and
- to redefine the waiting list into a number of lists such as placing those who have had treatment in the last year on a recall list, not a waiting list.

SARRAH recommends that:

- a condition of any Commonwealth dental service funding provided to the States/Territories should be that all communities, where it is cost-effective, have fluoridated water supplies;
- the inquiry should focus on the need, rather than demand, for dental care;
- instead of focussing on dental waiting list numbers or times, governments should focus first on preventing dental diseases, and then on the number and types of dental services that need to be delivered;
- dental services are reoriented towards preventive dental care and a fully funded and coordinated national oral health promotion strategy; and
- a dedicated rural and remote oral health action area is formed, with expert rural, remote and Indigenous oral health input, in the new National Oral Health Plan due in 2014.

b) The mix and coverage of dental services supported by state and territory governments, and the Australian Government.

Australia is in the interesting situation where eligibility for a health care card, and hence access to public sector dental care, is decided by the Commonwealth Government. However, dental care is largely funded by the State/Territory Governments. Consequently political pressure is on the Commonwealth Government to increase the number of eligible people, whilst funding limitations suggest State/Territory Governments would like to reduce the number of people eligible for public dental care.

Some argue that a universal dental scheme would be beyond the financial capabilities of the Australian Government. If so, this suggests, at least in the shorter term, that Governments need to decide who is eligible for public dental care and who is not. Whether all adult health care card holders should have access to limited public dental care, largely based on emergency care, or whether a smaller number of eligible adults should have access to basic but regular dental care, is a difficult political decisions that Governments need to face.

SARRAH recommends that:

- the longer term goal should be for a universal dental scheme, but in the interim, Governments should plan for a coordinated dental scheme that utilises both the private and public dental sectors; and
- all dental practitioners place emphasis on providing services to the people in the Australian community who currently have poor access to dental care.

c) Availability and affordability of dental services for people with special dental health needs.

If ever there were a group of people who should have access to comprehensive public dental care, preferably supplied by special needs dentists, this is it. This is one area that has been seriously affected by the cessation of the Chronic Disease Dental Scheme in late 2012. The Inquiry outcome should recommend that funding and the available dental workforce for this sector is grossly inadequate.

If a person lives in a rural or remote area, and they have a physical or intellectual disability, issues with access to regular dental care is compounded. There is a great need for special needs dentistry in rural and remote areas.

SARRAH recommends that:

- the Government develops and implements a fully funded replacement program for the Chronic Disease Dental Scheme; or
- the proposed National Disability Insurance Scheme improves access to dental care for people who live in a rural or remote area, and have a physical or intellectual disability.

d) Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations.

For those who can afford it, excellent dental care is available in Australia. However, many people do not have adequate access to dental care, including frail and older people, rural and remote Australians, Indigenous Australians, people with physical and intellectual disabilities, and people of low socio-economic status. If a person lives in a rural or remote area, and is either frail or older, Indigenous, has a physical or intellectual disability, or is of low socio-economic status, problems with accessing dental care is compounded.

None of these people can afford to wait until a program such as 'Denticare Australia' evolves. With respect to rural and remote areas, with the recent large increase in dental practitioner training places, and the increase in the number of dentists coming from overseas, finding dental practitioners willing to practice in rural and remote areas should become easier.

However, SARRAH acknowledges that improving access to dental care is expensive. The cost of providing such a scheme has been estimated by the NHHRC to be in the order of anywhere between $7 and $11 billion per annum. As a consequence, until a universal dental service program is affordable, SARRAH encourages the Government to focus on improving access for people who currently do not have adequate access to dental care.

Recent evidence indicates that the difference in dental care between rural and metropolitan areas can be explained by differing fluoride exposure. SARRAH notes with concern the recent developments in Queensland where some municipal councils have removed fluoride from their water supplies. As noted above, as many rural communities as possible with reticulated water supplies should have fluoridation.

SARRAH understands that the incentive programs for physicians to move and stay in rural areas have had limited success. Similarly, it cannot be assumed that dental practitioners will respond to the same incentives to move into rural areas as physicians.

SARRAH believes that a systematic literature review will be published soon on why dental practitioners do, or do not, move to rural areas, indicating that there is very little evidence on what works and what does not.

SARRAH recommends that the Government considers the following:

- Evidence through research to develop rural incentive programs that will work for dental practitioners to move and remain practising in rural settings.
- Education and training initiatives such as university enrolment practices which increase the number of dental and oral health students from regional and remote areas and students who identify as Aboriginal or Torres Strait Islander. Initiatives such as:
  - rural origin scholarship schemes and selective placement of rural students in dental and oral health courses;
  - clinical placements of dental and oral health students to rural practice; and
  - access to ongoing and appropriate continuing education for rurally-based dental and oral health practitioners.
- Local community support incentives such as:
  - education of prospective rural dentists and oral health practitioners about rural and remote communities; and
  - assistance to integrate into the community including accommodation for dentists and oral health practitioners, their spouses and families.
- Working condition incentives such as:
  - relocation grants and retention payments;
  - Higher Education Contribution Scheme exemptions;
  - enhanced locum schemes and mentor support programs delivered by experienced practitioners;
  - provision of surgery rooms, equipment and other service delivery facilities; and
  - introduction of rural health informatics to assist in professional exchange on clinical matters.

e) The coordination of dental services between the two tiers of government and with privately funded dental services; and workforce issues relevant to the provision of dental services.

There is limited coordination of dental services between the Commonwealth and State/Territory tiers of government. For example, the Voluntary Dental Graduate Year Program (VDGYP) that was designed to provide new graduate dentists experience in real life dentistry and to improve access to dental care, was established by the Commonwealth Government with little consultation with the States and Territories.

SARRAH believes that the VDGYP is a very good program and may encourage dental practitioners to work in the public sector and in rural and remote areas, but the lack of consultation with the States and Territories caused some unnecessary confusion during its implementation stage.

There also is limited coordination of dental services between State and Territory Governments. The State and Territory Governments have different rules and systems for supplying public dental care. A meeting between these government oral health administrators is needed to develop a consistent set of rules for supplying public dental care across Australia.

The issue of coordination between private and public sector dental services in rural and remote areas is important. A minimum number of people residing in a community is required before a dental practice becomes viable otherwise market failure occurs. As a consequence, the number of dental practitioners per head of population reduces the more remote the community. In addition, a small practice in a town of 3,000 people does not need a part-time government dental clinic to be set up in the same town. This makes the dental practice unviable, the practitioner leaves and that community loses the availability of local full-time dental care. Rather than duplicating services, the Government should arrange for dental care for eligible people to be provided in consultation with the existing private dental practice.

Another issue for small towns is that the practitioner needs to be able to handle many areas of dentistry that would be referred by dental practitioners in the cities to dental specialists. SARRAH suggests that rural dentistry should be recognised as a speciality in itself, and encourages universities to design rural dental practitioner courses.

Where comprehensive dental care is not available within the local community, SARRAH supports the Australian Dental Association's recommendation to provide greater Government investment to assist geographically disadvantage patients to travel to larger regional centres to access dental care. Similar Government assistance is provided for geographically disadvantaged patients to access medical care.

SARRAH notes with concern the ongoing disagreement between the differing dental practitioners, such as dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists, over who should do what dental procedure on what patient. Whilst SARRAH does not want to become involved in this debate, it is hoped that the differing dental practitioner groups can come together to sort out these differences enabling dental teams to deliver the best dental care possible to all Australian communities.

SARRAH recommends that:

- the Commonwealth Government consults with State/Territory Governments before introducing new oral health programs;
- the Commonwealth Government facilitates a meeting between State/Territory oral health administrators to develop a consistent set of rules for providing public dental care across Australia;
- Governments promote a coordinated approach between the private and public dental sectors for the provision of dental services to people in rural and remote areas who are eligible for public dental care;
- Governments recognise rural dentistry as a speciality and encourage universities to design rural dental practitioner courses;
- the Patient Assisted Travel Scheme be extended to include financial support for travel to access oral health care where local services are not available; and
- dental and oral health practitioner groups collectively design a system on how dental teams can provide the best dental care possible to all Australian communities.

Conclusion

SARRAH, as the peak body representing AHPs delivering health services to people residing in rural and remote communities across Australia, is well positioned to work with Governments and other stakeholders to address the factors that impact on the supply of adult dental services in these settings.