Health
Western NSW
Local Health District

Submission No. 033
(Dental Services)
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Committee Secretariat
Standing Committee on Health and Ageing
House or Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600

Email: haa.reps@aph.gov.au

Dear Sir / Madam

Re: Inquiry into Adult Dental Services in Australia

Please find enclosed the Western NSW Local Health District submission to the House of Representatives Standing Committee on Health and Ageing in relation to its Inquiry into Adult Dental Services in Australia. I understand that an extension to the closing date has been granted for this submission.

If you require any further information please do not hesitate to contact Ms Jennifer Floyd, Director Oral Health Services. Ms Floyd can be contacted on telephone (02) 6841 2343 or by email at Jennifer.Floyd@gwahs.health.nsw.gov.au .

Yours sincerely

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March 2013

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

Inquiry into Adult Dental Services in Australia

This submission is made on behalf of:

Western NSW Local Health District

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This submission is authorised by:

Mr Scott McLachlan

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Western NSW Local Health District

About Western NSW Local Health District

Western NSW Local Health District is part of the NSW Health system and provides health care services for a rural, regional and remote population of 261,748 people in an area spanning 250,000 square kilometres. The Local Health District includes 23 Local Government Areas and stretches from Oberon in the East, to the Queensland border in the North, and to Wanaaring and Cobar in the West. Within the Western NSW Local Health District population, 24,428 people identified as Aboriginal in the 2011 Census.

Adults holding a Centrelink concession card (Pensioner Concession Card, Health Care Concession Card or Commonwealth Seniors Card) are eligible for public dental care and no co-payments are charged, as per the policies of the NSW Ministry of Health.

Western NSW Local Health District provides public dental services through a range of service models including direct service provision through Local Health District dental clinics, through Oral Health Fee For Service (voucher) arrangements with private dental practitioners, and through partnerships with other not for profit services including Aboriginal Community Controlled Health Organisations, University run dental clinics, and the Royal Flying Doctor Service.

Like all public dental services, Western NSW Local Health District has strong demand for services but financial resources to meet this demand are limited.

Response to the Inquiry Terms of Reference:

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

There is strong demand for both private and public dental services across the Western NSW Local Health District. However, much of the real demand for public dental care is not shown through current waiting lists. Where services are not available locally, where services are not highly visible, and where long waiting lists exist, many people in need of public dental care will not register their needs on Local Health District waiting lists.

Despite this, Western NSW Local Health District, like other public dental services, does have waiting lists and as a result must currently prioritise access to services. The recent National Partnership Agreement funding will enable the Western NSW Local Health District to reduce waiting times for many clients on current waiting lists. However it is anticipated that new demand for services will quickly emerge as those currently unable to afford private dental care learn of increased opportunities to access free dental care. It could be said that current waiting lists in the public dental system are only 'the tip of the iceberg' of potential demand. The National Partnership Agreement funding will bring significant benefits to those most disadvantaged in the community, but only if this funding is sustained, and public dental services are given confidence that funding will not be withdrawn; at least not until a universal access scheme is implemented, such as through Medicare.

It is well documented that the majority of dental conditions are preventable, and that early intervention and treatment will provide better outcomes. For example, a tooth with a small cavity requires a small filling but if it is left untreated it will ultimately require extraction. It is clear that long waiting lists will equate to poorer oral health outcomes, as teeth continue to deteriorate whilst patients wait to be seen. This in turn increases the demand for emergency or "relief of pain" dentistry where the focus for both the patient and the clinician is resolution of the problem, and not on education, prevention and early intervention. The solution is to provide adequate resourcing to meet the preventive and general dental treatment needs, in a timely manner, for those Australians least able to afford care in the private dental system.

2. The mix and coverage of dental services supported by state and territory governments and the Australian government

Western NSW Local Health District is part of the NSW Health system and provides services for both children and adults. There is very limited provision of specialist dental services.

Services are provided by Western NSW Local Health District dental practitioners in Community Dental Clinics, smaller child dental clinics, and at outreach sites.

Services are also provided through an Oral Health Fee For Service Scheme, where a voucher is provided to a patient to have their dental treatment completed by a participating private dental practitioner. This scheme works well for patients who live some distance from a public dental clinic but who have a nearby private dental practice. In Western NSW Local Health District there is very good participation by private sector dentists with the majority accepting emergency vouchers, but with many also accepting non-emergency (general) and denture vouchers. Under this scheme patient co-payments are not permitted. The scheme is well controlled in terms of administrative and audit processes and has been successfully in operation for over ten years. The scheme has been limited by the funds available for public dental care, and by the absence of local private dental practitioners within many smaller rural communities.

Some Aboriginal Community Controlled Health Organisations (ACCHOs) operate dental services and receive financial support from the NSW Ministry of Health. This funding is not consistent across all ACCHOs and is often historically based. Western NSW Local Health District is able to provide in kind support in some cases, by providing visiting staff. Examples include Walgett Aboriginal Medical Service, Bourke Aboriginal Health Service, and Coonamble Aboriginal Health Service, where a visiting dental / oral health therapist is provided. Whilst these visiting staff provide a service to children, the model shows the level of cooperation that can be realised between public dental services and community based service providers.

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

In responding to this term of reference, Western NSW Local Health District identifies the following groups as having special dental health needs:

- Patients with significant disabilities
- Patients who identify as Aboriginal
- Patients with chronic and complex health problems
- Patients in residential care
- Patients in rural and remote communities

Patients with significant disabilities are often reliant on the public health system for dental care, which may need to be provided under general anaesthetic, or by specialist dentists. This type of care is usually only available in major centres. Whilst the public dental system allocates a high priority to these patients there are none the less barriers, including transport and access to preventive dental care.

Many patients who identify as Aboriginal live in rural and remote communities with poor access to dental care. Affordability of dental care is seen as a major issue amongst the wider Aboriginal community, and not just for those eligible for public dental care. Rates of chronic disease are also higher in the Aboriginal community. There is a need for greater funding to services meeting the

needs of the Aboriginal community, with recognition of the higher cost of providing services in rural and remote areas. Commonwealth funding to specifically support the provision of dental services for Aboriginal people should be considered, whether this be through an eligibility scheme (similar to Grow up Smiling), a referral scheme linked to Aboriginal Health Checks (similar to the Medicare Chronic Disease Dental Scheme), or block funding to organisations that can provide culturally appropriate care.

Patients with chronic and complex health problems, who are eligible for public dental care, are already prioritised within the NSW Health system. Adequate resourcing is required to ensure state public dental services can provide timely care to this group of patients, which is large in number.

Patients in residential care have special needs related to the ability of the patient to access mainstream services. These patients may be reliant on public dental care or private dental care, but need access to appropriate treatment within their care facility and/or transport to nearby services. Patients in residential care have special dental needs and further training in this area needs to be provided for both public and private sector dental practitioners.

Patients living in rural and remote communities have a special need which is directly related to the lack of access to local dental services. It is often compounded by a life time lack of exposure to fluoridated water and preventive dental care. Patients living in rural and remote communities need access to a better network of locally delivered services, and support to travel to services where a local option is not available. It is important that private and public sector models of delivery co-exist successfully in rural communities, to ensure that private dental practice remains viable. However those who cannot afford private dental care also need a way to access these local private dental services. Oral Health Fee For Service Scheme vouchers can be used to provide care through the private dental system to those eligible for public dental care. The vouchers can effectively support private practice in small rural communities, rather than threaten its viability.

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

Affordability of dental care is a common issue across Australia, particularly for those with lower income. This includes the "working poor" who may not hold a Centrelink concession card but who struggle to pay for dental care. For many of these people, all but emergency dentistry is seen as an unaffordable luxury.

It is well documented that residents of rural and remote communities tend to have greater socio-economic disadvantage. However, there is not only the challenge of affordability of dental care, but the challenge of little or no availability. The need to travel to another town for dental care means further costs for travel, greater lost time away from work or carer responsibilities, and additional difficulties for the frail and elderly.

Even where free dental care can be accessed, for those who are eligible, there are still the costs and challenges associated with travel for many clients. In the Australian health system there is often recognition of travel costs, with patient assistance schemes in place offering some level of patient

subsidy when accessing medical care. However, these schemes do not recognise the burden of cost for patients accessing general dental care which is not available locally.

In years gone by, each small local government area of around 4000 residents had a local full-time private dental practitioner. Today this is not the case with these same communities having no dentist or a part-time visiting service only. Examples include Bourke, Gilgandra, Walgett, Lightning Ridge and Oberon. These communities have a need for full-time experienced dentists who can deal with common dental problems but in a sole or small practice environment.

In larger regional communities, there has been an increase in new graduates over the past two years, as a direct result of additional dentistry places in Australian Universities. However, many of these graduates return to major metropolitan areas after gaining 1-2 years of experience. There is still a significant need for dentists willing to work and permanently reside in regional and rural settings, and in particular for those with suitable clinical experience. The current 'experienced' dental workforce in regional and rural areas is ageing with the majority of these dentists nearing retirement.

There is a clear need to ensure that new University programs which target rural and regional students, and which can offer undergraduate programs delivered in regional areas, are maintained and supported.

5. The coordination of dental services between the two tiers of government and with privately funded dental services

Western NSW Local Health District recently received a share of the National Partnership Agreement funding allocated to the NSW Ministry of Health, and is actively working to provide additional services to the eligible population. In the current financial year the primary focus will be provision of services to those on denture waiting lists. The majority of these denture services will be provided through the NSW Oral Health Fee For Service Scheme, where patients are issued a voucher to have their treatment provided by a private dental practitioner. This generally enables patients to access services closer to home and no co-payments are permitted except where the patient elects to have a metal partial denture constructed instead of a standard acrylic denture. In these cases, the patient can be asked to pay an amount equal to the additional laboratory fee incurred by the private dental practitioner.

The Medicare Chronic Disease Dental Scheme, as a Commonwealth funded program, provided a range of dental services to those with chronic disease. Whilst this scheme has now closed, there was clear evidence during the scheme's operation that it worked in complete isolation to State public dental services and that it did not support the provision of care to some of the most disadvantaged patients with chronic disease.

In Western NSW Local Health District the following could be observed during the operation of the Medicare Chronic Disease Dental Scheme:

- Patients with chronic disease, who had already been accessing dental treatment in the private system, were now able to enjoy a Medicare rebate.
- In an area of under supply of dentists, the majority of dentists in Western NSW Local Health District would not bulk bill patients even if they held a Centrelink concession card. At least one dentist who initially bulk billed opted out after being caught between the Medicare paperwork and the patient, and having a claim for a denture refused by Medicare. The dentist was left carrying the bill for the laboratory work and was significantly out of pocket.
- Most patients with chronic disease on the Western NSW Local Health District waiting lists were unable to access the Medicare Chronic Disease Dental Scheme because they could not pay for their treatment up front, and because they could not afford the out of pocket gap between the private practice fee and the Medicare rebate. These patients remained reliant on the public dental system.
- For the few on the waiting lists that could afford to access the Medicare Chronic Disease Dental Scheme, there was reluctance from these patients to remove their name from the public dental waiting list. This created potential for duplication of service provision, particularly for dentures.
- Patients were confused about who was providing which service: State or Commonwealth. Western NSW Local Health District fielded many enquiries (and complaints) about the Commonwealth program. However the only information the Western NSW Local Health District had in relation to the scheme was sourced publicly via the internet. Since the closure of the Medicare Chronic Disease Dental Scheme, the Western NSW Local Health District has fielded further enquiries from clients, many of whom have been confused about which level of government is responsible for which service.
- Patients with the most complex and chronic diseases or disability, who could only be cared for in the public dental system, could not access the Medicare Chronic Disease Dental Scheme because the Commonwealth had specifically excluded state delivered public dental services from bulk billing under the scheme.
- Had the Medicare Chronic Disease Dental Scheme rebates been available through public dental services, increased services could have been delivered to the most vulnerable and financially disadvantaged patients with chronic disease.
- State run public dental services continued to struggle with the overwhelming demand from patients without chronic disease, but who had poor oral health and were unable to afford private dental care.
- The Medicare Chronic Disease Dental Scheme did work well for Aboriginal Community Controlled Health Organisations and it is disappointing to see the scheme no longer available to support these organisations in the provision of dental care to their Aboriginal clients living with chronic disease.

Until there is a universal access program for public dental care, under a Medicare type model, Western NSW Local Health District considers it most appropriate for the Commonwealth to funnel its initiatives through the State operated public dental services. This ensures there is a single access pathway for clients coordinated by one level of government. State operated public dental services have the capacity to contract out a range of services through the private dental sector, to engage with other not for profit dental service providers, and to provide direct patient care in public dental

clinics. They also have the capacity to provide care to patients who cannot be managed in the private system.

There are notable exceptions where Commonwealth programs, which engage directly with private providers, work well and should be maintained, including the successful Department of Veterans' Affairs dental program. This program works well because it targets a discreet group of eligible clients. There is no confusion around eligibility across the two levels of government and service duplication can be avoided.

The Commonwealth could also play a pivotal role in supporting services for Aboriginal people, under a Closing the Gap strategy. A modified Medicare Dental Disease program could be implemented based on a referral following an Aboriginal Health Check.

6. Workforce issues relevant to the provision of dental services

In recent media there has been discussion about the potential over supply of dental graduates in Australia. Western NSW Local Health District notes with concern the trend toward post-graduate fee paying courses in dentistry. These courses are outside the reach of many potential students, particularly those from rural, regional and financially disadvantaged backgrounds. If this trend continues the dentist workforce in Australia is likely to become polarised. Anecdotal evidence suggests that students graduating with high levels of debt are unlikely to work in the public sector, where earnings are less.

Anecdotal evidence also suggests that many rural and regional students in NSW do not wish to study in Sydney; and that students who have only ever lived in Sydney are not interested in relocating to work in rural and regional areas. The importance of dentistry programs delivered from regional campuses cannot be understated. Whilst the first cohort of dentistry students will not graduate from Charles Sturt University (CSU) until the end of this year, it has already been seen through the CSU Bachelor of Oral Health program, that graduates are choosing rural or regional employment as their first choice, with many graduates being from a rural background.

There is a significant opportunity in Australia for better utilisation of Oral Health Therapists, who can provide a range of preventive and restorative dental treatments in both the private and public sectors. These professionals typically undertake three years of undergraduate training, making them a more affordable professional for the community. It is unfortunate to see Universities increasing dentistry places at the expense of oral health therapy places and it is understood this has been partly driven by Health Workforce Australia funding models which under-value the cost of training oral health therapy students.

The Voluntary Dental Graduate Year Program, implemented this year, provides a good foundation for increasing the skill base of new graduate dentists and oral health therapists, and increasing the public sector workforce. However there needs to be greater coordination between the Commonwealth and States in implementing such programs, with full recognition of the costs of employing new graduates under the scheme, and the need for significant infrastructure development. Under the current scheme, grants for infrastructure have had varied uptake because

the lead time and limited funding available are suited mainly to simple renovations or addition of a single dental room. Larger projects which would have better long term outcomes are often not possible within the time constraints and funding options available.

Similarly the expansion and establishment of new public dental facilities is hampered by the availability of significant blocks of funding with adequate lead time for planning and construction. This is significant for workforce development and expansion because a larger purpose built facility supports a range of objectives including co-location of a critical mass of dental professionals, space to employ additional staff, space for new graduates under the Voluntary Dental Graduate Year Program, and opportunities for student dental placements. Where these larger clinics have been established, it has become easier to recruit and retain staff.

There continues to be an undersupply of dental practitioners in rural communities. Practitioners who do consider working in a rural community are usually not willing to invest in infrastructure. This may be addressed initially in the Flexible Grants Program announced by the Commonwealth. It will be important that this type of funding remains available in the future to support current graduates who may first need to obtain approximately five years of experience before being clinically ready to work in a sole practice environment. The Commonwealth should also ensure organisations such as Local Government are eligible to apply for flexible grants. In rural communities it is often Local Government that has, in the past, provided infrastructure to attract both doctors and dentists.

Dental students are also part of the dental workforce, both in public sector clinics and in University operated dental clinics (eg Charles Sturt University, Griffith University). These students can provide a volume of dental care to the population. However arrangements with Medicare and with private health funds have precluded Universities and public sector organisations from accessing any rebates for student delivered care. These rebates would have otherwise been available had the patient been treated in the private sector. This needs to be addressed, to ensure the community has maximum access to all available dental care.