Submission
No 225

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

Inquiry into Dental Services in NSW

Submission from Discipline of Oral Health, University of Newcastle

The Discipline of Oral Health at the University of Newcastle was established in late 2003 through a unique and innovative partnership with the Dental School at the University of Adelaide.

This partnership has facilitated;

- integration of oral health into undergraduate health education with a multi-disciplinary health focus,
- provision of oral health education to practicing doctors and allied health practitioners,
- development of a population health focused Bachelor of Oral Health degree program,
- career pathways for a range of oral health workers through multi-sector education
- extended clinical placements for final year dental students in regional and rural centres, and,
- development of structured recruitment and retention programs that promote professional cooperation.

The Discipline of Oral Health welcomes the opportunity to contribute to the Inquiry into Dental Services in NSW.

Structure of submission

We have aimed to keep our submission brief. The submission is based upon the consistent recommendations made by oral health academics, educators, legislative bodies, clinicians, professional organisations and administrators, to various NSW Health[1 2 3 4] and National reviews[5].

Our opinions are based upon our individual and collective experience of teaching, research, administration and oral health service provision in NSW.

Our recommended actions are based upon the evidence available. The actions represent opinions from a broad range of stakeholders in our activities and refer to our institutional successes to date. These actions are readily achievable.

Quality of care received in dental services

The facts

It is recognised that public dental services are now only able to provide an acute care service, particularly in non-metropolitan areas. There is very limited provision of preventive care. The significantly limited scope of clinical practice has a negative impact on staff recruitment and retention.

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Our opinion

Through experiences with, and evaluation of, student clinical placements in regional and rural areas, it is apparent that the breadth of clinical experience available within the public sector, in regional and rural areas, is a significant barrier to graduate recruitment. Students recognise the expertise and experience of supervising clinicians but, as novice practitioners, they are reluctant to work in an environment where recent skill acquisition cannot be consolidated.

In contrast, employment in the metropolitan teaching hospitals remains an attractive career opportunity for graduates as the scope of treatment in a mentored environment allows graduates to refine and expand their clinical skills with a resultant gain in confidence. Access to specialist care is readily available and educational infrastructure is advantageous for those graduates wishing to undertake postgraduate studies. Graduates in regional centres are not readily able to access specialist support and have limited access to educational support. Mentoring opportunities are limited by virtue of workforce shortages.

Action required

If the public sector wishes to maintain its service provision for adult patients, there should be a willingness to expand the scope of patient care from acute service delivery (extractions or simple restorations) to that of comprehensive care. Implementation of preventive strategies, the remit of preventive focused oral health team members, will improve clinical care outcomes by informing treatment planning options with evidence of personal responsibility and patient motivation, addressing common risk factors (such as diet and smoking) and providing optimal conditions for restorative care.

Metropolitan teaching hospitals should develop support through regional Universities to facilitate specialist access, academic support and postgraduate opportunity. Metropolitan teaching institutions are able to provide comprehensive care for a relatively large number of patients while regional and rural centres are barely able to provide the most basic of dental care.

There is a relative over-supply of private practitioners in metropolitan areas; creative collaborations between the private and public sectors must be a priority.

Demand for dental services including issues relating to waiting times for treatment in public services

The facts

The demand for dental services far exceeds the supply of services. At present, the system is unable to respond to the eligible patients who choose to access care in the public sector; many eligible patients seek care in the private sector, or, more likely, do not receive any dental care.

Our opinion

We believe that quarantining of specific funds and activity in the areas of oral health promotion, preventive oral health care and community-based education would have a significant impact on access patterns. Dental care needs are based on two preventive conditions. We are able to apply

the proverbial 'bandaid' but there seems to be a general reluctance to prioritise preventive care. This is at odds to community perceptions of oral health needs[6]. Currently there is extremely limited recognition of preventive oral health care workers and/or preventive care in the public sector. Preventive activity is not recognised in existing data collection systems.

As an example, one of our Bachelor of Oral Health students worked in a local public clinic as a dental nurse prior to enrolling in our program. She is totally committed to preventive oral health care and wishes to return to the public sector. She will be on a lower pay scale as a preventive practitioner (currently referred to as a Dental Hygienist) than when she left as a dental nurse!

Action required

We believe that there should be a clear focus on preventive care with practitioners ('Preventive Oral Health Care Workers') skilled in all areas of prevention, stabilization and maintenance of oral health. Such practitioners could work in primary health care settings and in multi-disciplinary teams. Their entire focus would be grounded in population health theory and community consultation would be pivotal to their activity. The Bachelor of Oral Health curriculum at the University of Newcastle is based on this vision. There is universal acceptance within those working in oral health that prevention must be the primary focus for oral health care. An appropriate award must be developed.

Funding and availability of dental services, including the impact of private health insurance

The facts

Funding allocation is complex and access to reliable data is limited. The per capita spend on public oral health care in NSW is significantly lower than elsewhere.

Our opinion

We believe that there should be greater transparency in funding for oral health with clear accountability based on valid indicators. There are anomalies that result in inequitable funding, with the major differences existing between the metropolitan and regional centres. Successful initiatives, such as the placement of dental students in regional public clinics, are difficult to implement as funding for transport and accommodation is extremely limited.

Action required

Prior to any additional input, the existing model must be reviewed in light of the consistent findings that non-metropolitan residents do not receive equitable access to oral health care. We have developed a capitation proposal for eligible patients in the Central Coast North Sydney AHS to access preventive oral health care. These patients would also access dietary advice, smoking cessation therapy and risk analysis. We are in the process of establishing an electronic records system for evaluation of both process and outcomes. Through such accountability systems, evidence to support preventive care can be collected, analysed and reported.

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Access to public dental services, including issues relevant to people living in rural and regional areas of NSW

The facts

Rural residents are significantly disadvantaged. Workforce shortages are particularly acute in these areas. Access to information and education is extremely limited [6]. Community consultation is lacking.

Our opinion

Community empowerment is an essential element in provision of oral health care in rural communities. We have recently received additional funding to develop the project funded by the NH&MRC in 2003 [6]. We aim to expand this further in 2005 and 2006 and are currently seeking support from the NH&MRC. This project will result in an increased awareness of preventive oral health strategies as determined by community members.

Regional and rural placements have significant potential to increase patient care, provide educational experience and positively influence career direction. While metropolitan facilities have a defined commitment to teaching and learning, there is inadequate support in regional and rural areas for such activity.

Action required

Again, clear support for preventive oral health care must be the number one priority. We advocate the establishment of a primary preventive focus with a fixed percentage of the budget allocated to preventive activities. We suggest that reporting mechanisms are developed to reflect this change.

In addition, additional funding for student placements is required. Both Bachelor of Oral Health and Bachelor of Dentistry students can supplement existing services. All other health students are able to access either Federal or State grants for rural placements; dentistry is the exception. Detailed proposals for such funding have been developed.

Dental services workforce including issues relating to the training of dental clinicians and specialists

The facts

Workforce reports indicate that there will be a significant shortfall in the number of dentists providing care by 2010. Such workforce projections are based on current models of care. Access to specialist services in both the private and public sectors outside metropolitan areas is extremely limited.

Our opinion

We believe that the current 'crisis' presents the ideal opportunity to review existing care models, career pathways and educational opportunities. At present, we have a 'dental team' that comprises;

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- a range of specialist dentists,
- general dentists who work in the public and private sectors,
- academic dentists,
- dental therapists,
- dental hygienists,
- dental prosthetists,
- dental technicians, and
- dental nurses.

Each of these team members has different roles and responsibilities, largely defined on an historical basis. Predicted oral health care needs indicate polarization to very high treatment needs, and low demand/maintenance care. While each of these groups has different opinions of oral health care needs and their role in the provision of this care, there is universal acceptance that preventive care is of the highest priority.

It is recognised that practitioners have a tendency to work to the upper limits of their education and training. As examples, many dentists prefer the advanced treatment planning and clinical work (such as bridges, implants) rather than preventive care. Therapists wish to provide restorative treatment to children and seek to provide care for adults, based on the higher-level clinical skills. We believe that graduates devoted to preventive care will work within their chosen field with commitment and enthusiasm.

Action required

The 'Oral Health Team' must be re-defined and opportunities for career pathways must be developed. The education of a dedicated preventive practitioner will ensure that education, preventive care, stabilization and maintenance are prioritised. We have developed career pathways based on credit transfer and recognition of clinical experience that allow dental therapists, dental hygienists and dental prosthetists to graduate from our Bachelor of Oral Health program. We have been overwhelmed by the demand for this flexible approach. Dental therapists wishing to expand their scope of clinical activity should seek consideration of accelerated progression through the Bachelor of Dentistry program.

We would be happy to provide additional information on career pathways if required.

Preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services

The facts

Water fluoridation has been highly successful in reducing dental caries experience. Additional fluoride therapies are available and proven to be effective in reducing dental caries. Effective risk assessment tools are available.

Periodontal disease is not prioritised. Links between periodontal health and systemic ill-health are attracting increasing attention. Periodontal disease is preventable.

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Our opinion

It is lamentable that the two most common dental diseases, caries and periodontal disease, are still prevalent within our society. These diseases have a significant impact on individuals through pain, adverse effects on general health, financial burden and the effects of tooth loss on quality of life. These diseases also have a significant impact on the community through effects on employment, social stigma and diversion of limited resources away from preventive care.

While the primary focus is on addressing acute problems, there will be no positive impact on long-term oral health outcomes. It is interesting to consider the impact that other health problems, such as melanoma or HIV, would have on our healthcare system if preventive strategies had not been prioritised.

We acknowledge that acute symptoms require treatment, however we believe that all opportunities for preventive care must be optimised. While we treat these acute symptoms, but miss the opportunity for education and prevention, we are not empowering individuals or the community with the information and care required to prevent, or stabilize, caries or periodontal disease. This results in the pain, extraction, pain, extraction, dentures (PEPED) cycle.

There is universal acceptance that prevention is the key to long-term improvement in oral health, and general health, outcomes.

Action required

We believe that preventive oral health practitioners, with skills in education, preventive care and stabilization of disease, should be the basis of care delivery. In addition to oral heath care settings, such practitioners should be integrated within a wide range of health care settings. Access to preventive care and education would be a key element of services such as prenatal care, antenatal care, diabetic care, oncology care, cardiovascular care and mental health care. In addition, such practitioners would have the opportunity to educate other health professionals in oral health, thus building on undergraduate program input.

Summary

We are committed to a preventive approach to oral health care in NSW. We have 52 committed students who are educated within a multi-disciplinary health framework. Our students work with other health students in the areas of Indigenous health, communication skills, evidence-based practice and research skills. This core curriculum provides significant opportunity for information exchange for mutual gain.

We believe that preventive oral health care is the key to improved oral health care for residents of NSW. We would welcome the opportunity to discuss our submission further.

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[1] NSW Health Workforce Review 2003
[2] NSW Health Indigenous Oral Health Plan 2002
[3] NSW Health Education and Training Review Working Party 2003
[4] NSW Health Access to Specialist Services 2003
[5] NACOH National Oral Health Plan 2004
[6] Cockrell DJ, Meihubers SM. Self-perceived oral health needs in small rural communities in NSW. August 2003.Supported by National Health & Medical Research Council funding

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