Submission No 162

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation: Aboriginal Health and Medical Research Council

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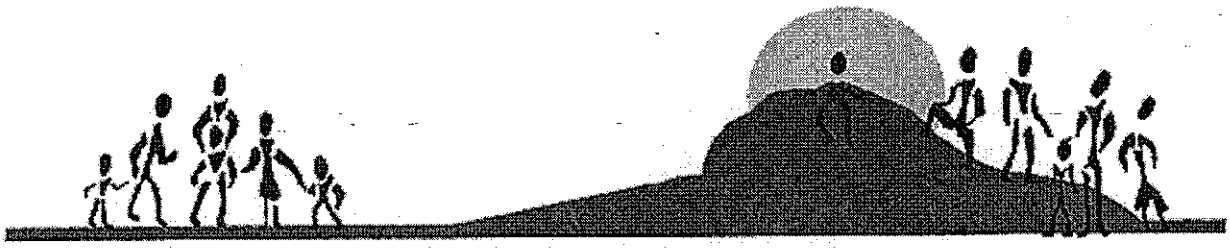
Summary



Aboriginal Health & Medical Research Council

of New South Wales

The Committee Secretary
Legislative Council Standing Committee on Social Issues
Inquiry into Dental Services
NSW Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Sir/Madam,

Re: Legislative Council Standing Committee on Social Issues
Inquiry into Dental Services

Please find enclosed the Aboriginal Health & Medical Service of NSW (AH&MRC) submission to the Legislative Council Standing Committee on Social Issues Inquiry into Dental Services.

If the Committee requires clarification or further information please contact me on **pdelaney@ahmrc.org.au** or 02 9698 1099.

Yours sincerely,

Pat Delaney
Acting CEO
9th June 2005

Submission from

The Aboriginal Health & Medical Research Council of New South Wales

to

Parliament of NSW
Legislative Council Standing Committee on Social Issues

Inquiry into Dental Services

June 2005

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Introduction

The Aboriginal Health and Medical Research Council (AH&MRC) welcomes the enquiry into dental services in New South Wales. Whilst Aboriginal oral health was not one of the terms of reference we believe there are issues specific to Aboriginal communities that need to be addressed. For too long oral health services have been declining and there has been no coordinated effort to address major issues. Aboriginal people are suffering greater burdens of dental disease which, coupled with their higher rates of other chronic diseases, contribute to unnecessary pain, discomfort and strain on already overloaded immune systems. Communities suffer due to lack of appropriate services, and the public health dollar is being spent on treating conditions which can be largely prevented given appropriate planning, support and resources.

The AH&MRC is the recognised peak body and voice of Aboriginal communities on Aboriginal health matters in NSW. Its more than 60 member organisations are comprised of Aboriginal Community Controlled Health Services (ACCHS), also known as Aboriginal Medical Services (AMS), Aboriginal Community Controlled Health Related Services (ACCHRS) and Aboriginal Community Controlled Health Committees (ACCHC).

The activities of the Council focus on the provision of support and assistance to member organisations to provide culturally appropriate holistic primary health care for the improvement of Aboriginal health. The AH&MRC has been operating since 1985 and as an advocate of health policy and programs has an extensive corporate knowledge in this area in particular, it has monitored numerous successive policies over many years and advised Governments and Ministers, directly or indirectly through input at forums, committees and other processes, in relation to their effectiveness.

Council has witnessed the deterioration of dental care over the past 20 years. This has occurred despite numerous reviews and reports identifying issues and proposing solutions. Communities are experiencing increasing frustration at this situation and would welcome some recognition of their plight as well as seeing some evidence of action arising from all their input into successive review processes.

The poor situation of Indigenous oral health has been well documented in recent reports such as *Healthy Mouths Healthy Lives. Australia's National Oral Health Plan 2004-2013* (AHMC 2004), the *Aboriginal Oral Health Strategic Planning Project* (NSW 2002) and the *National Aboriginal and Torres Strait Islander Oral Health Workshop. Adelaide, 10-11 September 2002. Workshop report and action plan* (Department of Health and Ageing 2003). Key recurrent issues include greater oral health needs, poor access to dental services, appropriate workforce and oral health promotion. Each of the reports suggests actions, but communities have witnessed very little activity. The situation is reaching crisis point where, even if new funds are allocated to services, recruitment of appropriate dental personnel is extremely difficult particularly in rural and remote regions. Fresh approaches must be considered.

We will address these key issues with consideration of the needs of Aboriginal people in New South Wales, followed by recommendations. It is to be hoped that this Inquiry will lead to some improvement in dental care in NSW, and not just another collection of ideas.

Oral health needs of Aboriginal people

Aboriginal people suffer from greater levels of dental disease. Compared to the overall Australian population:

- Aboriginal children have more than twice the dental caries experience, with a greater proportion of untreated caries;
- Aboriginal adults have more missing teeth;
- periodontal health is worse, exacerbated by the higher incidence of Type 2 diabetes;
- poorer periodontal health is evident in younger populations.

Community-based health checks have recently been conducted in the far west of NSW, and these programs include oral health checks and follow up care. In one small town more than 90% of the children (mostly Aboriginal) had dental caries in their primary teeth and for most this was their first dental visit.

Poor diet coupled with inadequate oral hygiene practices are the greatest contributors to dental disease particularly dental caries. However other risk factors include poor water quality and no fluoridation (particularly relevant in smaller rural communities), smoking (negative impact on periodontal health), alcohol (contributing risk factor for oral cancer), stress, cost and availability of oral hygiene items, affordability and availability of dental services and transport to those services that do exist.

As well there is emerging evidence that links oral diseases and other conditions. Those that are unfortunately pertinent in Aboriginal communities include cardiovascular disease, cerebrovascular disease, diabetes, preterm and low birth weight babies, blood borne disease, infective endocarditis, otitis media and nutritional deficiencies in children and older adults. The association between periodontal disease and Type 2 diabetes is well known and dentists working in Aboriginal communities extract many of loose and infected teeth in diabetic people. All these have a major bearing on the quality of life and wellbeing[1]

Lack of appropriate services causes many Aboriginal people to endure pain and infection until they are no longer able to bear it. This can lead to a cycle of extraction-only dental visits, with little scope for routine or preventive treatment. Future program planning must consider greater emphasis on promotion and community-based programs such as school-based tooth brushing with involvement of families where possible, early screening with appropriate follow up care and advice, and greater involvement of non-dental personnel in oral health promotion activities.

A further significant barrier is the cost to the client of dental services. Where the person does not have a health care card they are ineligible for either public or private health services unless they pay the costs. For most Aboriginal people these are prohibitive, and therefore the dental services in ACCHS are again overburdened.

Culturally appropriate oral health service management and delivery

Delivery of oral health care to Aboriginal people in New South Wales is achieved through various dental programs, principally by Aboriginal Community Controlled Health Services (ACCHSs) or the public dental sector for those who have concession health care cards. Access to care through the private sector is limited. The inadequacy of the public dental sector to cope with demand is well known. ACCHSs such as AMS, Redfern have dental waiting lists of 2 years and more.

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[1] Telethon Institute for Child Health Research, The Social and Emotional Wellbeing of Aboriginal Children and Young People, 2005. Available at: <www.ichr.uwa.edu.au>

There is no overall coordination for oral health service delivery, leading to wide variation in the levels of service provided across the State. It has been stated repeatedly that Aboriginal people feel more comfortable seeking health care in an Aboriginal community-focussed environment, and may feel disenfranchised from "mainstream" services. Dental clinics in ACCHSs are extremely busy and well-accepted. However since 1995 ACCHSs have been struggling to deliver appropriate oral health care. Decisions made by the Commonwealth government in 1995/96 led to a cessation of Commonwealth funding for public dental programs and this was extended to include dental programs in ACCHSs. This has exacerbated a chronic situation of under funding for public dental services as a whole and Aboriginal oral health in particular. Those ACCHSs which had Commonwealth-funded dental programs prior to 1995 maintained their level of funding, although the Commonwealth does not specifically allocate funds to dental programs. Rather the Commonwealth provides general allocations of funds, and ACCHS management determines which programs, such as dental, will be funded specifically.

In some rural towns the AMS dental clinic may be the only dental provider in that community, servicing both Aboriginal and non-Aboriginal people - provided of course they are able to recruit a dentist. Increasingly dental clinics are sitting idle with trained dental assisting staff unemployed, or being directed to other duties. With limited budgets and no extra support to attract staff, it is difficult to offer incentives to dentists in a market of increasing undersupply of dentists and attractive remuneration possibilities in the cities.

The AMS in Redfern was the first AMS with a dental clinic, established in 1978. It supplemented its urban-based service with dental vans that travelled to rural and remote communities in NSW. As rural AMSs were established and built their own dental clinics, the AMS in Redfern gradually devolved its rural services to these AMSs. However with declining numbers of dentists prepared to work rurally, country people are now travelling to Sydney for their dental care. It is not uncommon for people to travel great distances from places such as Menindee and Wilcannia. They have difficulty accessing public dental services locally due to the long waiting lists (or no public dental program at all in the case of Broken Hill), are not able to afford private dental care and, importantly, seek dental treatment in an environment they can trust. This of course is now placing a great strain on the capacity of Redfern and other Sydney-based clinics such as Daruk at Mount Druitt and Tharawal at Campbelltown.

The needs of Aboriginal children are also not being met. The budgets of rural AMSs do not stretch to cover the costs of employing both dentists and dental therapists (who can only work under the supervision of a dentist) and the School Dental Service in rural and remote regions is itself understaffed and in danger of collapse unless serious planning is given to future staffing and management needs.

Another issue affecting access to dental care of Aboriginal children in NSW is that of the consent procedure in the School Dental Service. There are two stages of consent for dental care - one for dental screening, then another for any necessary dental care. These consent forms can only be signed by a parent or legal guardian. "Guardianship" takes on a different meaning in Aboriginal communities which place greater emphasis on families and shared responsibilities. The "guardian" of a child or children may not be the parent but more than likely will also not be registered as a "legal guardian". This issue has been raised several times and some enlightened staff in Areas have modified the consent procedures to allow Aboriginal children to access dental care. However systemically this issue must be addressed.

Much of the dental care provided, particularly in the bush, is emergency care and it is generally tooth extraction. Aboriginal adults experience greater tooth loss and much of this is due to diabetes-related periodontal disease. They do not have access to appropriate oral health advice and support and suffer unnecessary pain and infection as a consequence.

Where there are no dentists, medical GPs are called on more and more frequently to deal with dental emergencies. They are not trained in management of dental conditions and there is a tendency to an over-prescription of antibiotics. This can potentially cause antibiotic resistance in people suffering repeated infections due to poor health.

Partnership agreements between the ACCHS sector and Area Health Services have varying effectiveness and success in terms of improving access to dental care. These should be strengthened, with particular emphasis on overcoming racist attitudes that still exist in several "mainstream" organisations, and recognition of those partnerships that are working well.

Aboriginal people also have difficulty in accessing specialist dental care, due to high costs, and availability. There is limited access to orthodontic care - again the AMS at Redfern has a part time orthodontist, but his waiting list extends to four years, and people are coming in from all across the State. This waiting list consists of only the most serious cases thus demonstrating the overwhelming demand for these services. The alternatives are private orthodontic care which can be prohibitively expensive, or the public dental system which is very constrained in its ability to offer orthodontic services. Other services such as oral surgery and periodontal specialty services can be difficult to access particularly for populations in rural areas. These issues need to be addressed in the broader picture of specialist dental care generally in NSW.

To summarise, some of the key issues affecting access to appropriate dental care by Aboriginal people are:

- lack of funds and resources to develop appropriate primary health care models particularly in the ACCHS sector;
- a need to have Aboriginal input into any dental program planning, implementation and evaluation, with greater support for Aboriginal management;
- a sense of disempowerment and disenfranchisement in "mainstream" services which often respond poorly to the particular needs of Aboriginal communities;
- Aboriginal children are missing out on dental care particularly in rural areas;
- the signed consent procedure to access dental care in the School Dental Service can be prohibitive for many Aboriginal families;
- there is difficult access for low income earners i.e. those who do not qualify for health care cards, yet are not able to afford private dental care;
- lack of transport and funds in rural areas, exacerbated by no IPTAAS support for dental referrals;
- industrial award salary rates which are not realistic in today's competitive market, and which negatively affect recruitment and retention of dental staff;
- a continuing emphasis on clinical dental service provision, with no programs addressing oral health education and community-based preventive strategies; and
- lack of recognition of oral health issues in chronic disease strategies and programs.

An appropriate dental workforce

As already mentioned, the recruitment and retention of dental personnel is becoming increasingly difficult in all organisations, and particularly in rural regions where a substantial proportion of Aboriginal people live. As also mentioned, industrial issues need to be reviewed, and incentives must be developed to attract practitioners to bush communities.

The coverage of Aboriginal or Torres Strait Islander issues in dental training in NSW is negligible, despite this issue repeatedly being raised in various reviews. There is also little focus on public health issues in dental curricula. Similarly, it is important that oral health

issues are addressed in Aboriginal Health Worker curricula, particularly prevention approaches, and the links between oral health and general health.

Recently an Australian Indigenous Dental Association has been formed, with four members. Indigenous participation in dental training is extremely low and support needs to be provided to encourage Aboriginal students to consider a dental career.

Traditionally dentists provide the bulk of dental care, with dental therapists providing dental care and education for children. There are also dental hygienists who are preventive clinicians, and dental prosthetists who can provide dentures directly to the public. Greater use must be made of the dental team, especially in Aboriginal communities with higher periodontal and preventive needs, and greater needs for dentures. Enhanced use of a dental team requires a change in focus both for communities and funding bodies, who are often difficult to shift into newer approaches to care.

Dentistry has traditionally focussed on clinical dental care, however as we are now in an era of reduced numbers of available dental practitioners there is an urgent need to look at more "non-traditional" approaches to dental care and prevention. Non-dental personnel can be trained to screen for early signs of dental disease, and perhaps apply fluoride varnishes to susceptible teeth, in coordinated screening and oral health education programs. These types of programs have been in existence for many years in the United States, and this could be an opportunity for further skills for Aboriginal Health Workers. It is important however that Health Workers are not overloaded with extra duties. Rather this could be an area of "specialisation" for Health Workers, with a designated position that offers appropriate training and support.

To summarise the key issues on workforce:

- new dental officer positions need to be created in ACCHS as a matter of absolute urgency;
- there are decreasing numbers of available dentists and dental therapists;
- salary structures in ACCHSs and the public dental sector need to be improved, with appropriate accommodation in the funding of programs to enable meeting the requirements of the salary structures;
- structured scholarship schemes must be developed for Aboriginal people to study dentistry;
- dental curricula generally in NSW have very little information on Aboriginal health and oral health issues;
- there is a need to ensure oral health is included in Aboriginal Health Worker education programs; and
- consideration needs to be given to expanding oral health knowledge and skills of non-dental personnel especially Aboriginal Health Workers.

Oral health promotion

This is an area that requires development. As mentioned previously greater emphasis must be placed on preventive and education efforts. The New South Wales Department of Health has developed a draft oral health promotion framework, with a section specifically for "Aboriginal and Torres Strait Islander Peoples". The initiatives are generally sound, but no program will be successful without strong Aboriginal community input and support.

Considering the greater oral health needs of Aboriginal people, some of the initiatives that could be developed include:

- introduction of water fluoridation to rural communities;

- implementation of school-based tooth brushing programs (this has already commenced in one small town in north west NSW, initiated by the local Aboriginal Medical Service following a health screening and care program);
- incorporation of oral health into other health and community programs such as women's groups, youth programs, young mothers groups, diabetes programs and elders groups;
- improving oral health skills and knowledge of Aboriginal Health Workers, and to utilise these skills in oral screening and prevention programs; and
- development of culturally appropriate educational materials to accompany the preceding programs.

However the above suggestions will only be successful with coordinated planning driven by Aboriginal community health and oral health representatives and commitment to ongoing funding and support.

Recommendations

Whilst acknowledging that numerous reports have made several recommendations, the AH&MRC recommends that:

- ACCHSs be supported in developing coordinated oral health programs through increased funding to attract appropriate staff and support for oral health promotion programs relevant to their communities.
- the programs have a strong focus on child oral health, utilising dental therapists, and targeting those children most at risk including pre-schoolers.
- in regions with no or limited ACCHS dental programs, Areas work closely with Aboriginal communities through Partnership agreements to address barriers to access to care and to develop appropriate community-based oral health promotion activities.
- ACCHSs be supported to develop appropriate workforce models that use a dental team approach, with appropriate funding to attract staff.
- dental students be given greater exposure to Aboriginal health and oral health issues in undergraduate programs.
- Aboriginal Health Worker education programs include oral health issues, with a focus on preventive and community based programs.
- the restrictions on dental referrals under IPTAAS be reviewed.
- scholarship schemes be developed to attract and support Aboriginal students to study dentistry.
- a State-wide designated Aboriginal Oral Health Coordinator be appointed to support the above activities.

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