Submission No 170

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation: NSW Rural Health Priority Taskforce

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Position: Co Chair

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Theme:

Summary

NSW HEALTH

NSW Rural Health Priority Taskforce

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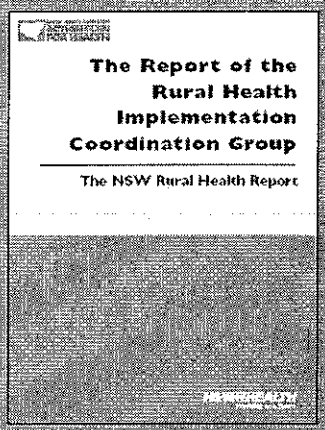
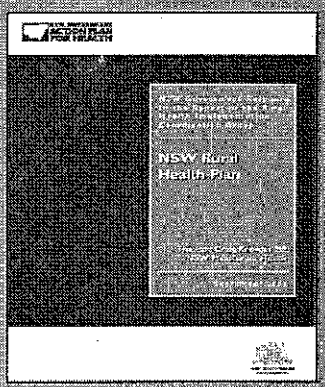
Ms Susan Want
Director
Standing Committee on Social Issues
Parliament House
Macquarie Street
SYDNEY 2000





Dear Ms Want

Find enclosed a submission from the Rural Health Priority Taskforce for the Legislative Committee on Social Issues Inquiry into Dental Services.

The Rural Health Priority Taskforce has been established to monitor and advise on the implementation of the NSW Rural Health Report and NSW Rural Health Plan released in 2002. In addition the Taskforce advises the NSW Department of Health and the NSW Minister for Health on rural health issues.

Should you require any further information on the submission please contact Ms Ros Johnson on (02) 9391 9003 in the first instance.

Yours sincerely

Dr W Hunter
Co Chair

Liz Rummery
Co Chair

www.health.nsw.gov.au/rural/taskforce/

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NSW Rural Health Priority Taskforce

SUBMISSION TO THE LEGISLATIVE COUNCIL INQUIRY INTO DENTAL SERVICES IN NSW

BACKGROUND

The NSW Rural Health Priority Taskforce provides advice to the NSW Department of Health and the NSW Minister for Health on rural health issues and monitors progress on the *NSW Rural Health Plan*.

The NSW Rural Health Report was released in 2002 and identified a range of issues facing the delivery of health services in rural NSW. In response to the Report, the NSW Government released the *NSW Rural Health Plan* which outlined strategies to address the issues raised including strategies to recruit and retain health professionals, to provide greater certainty for rural health services and to provide, where possible, more services closer to where people live.

Oral Health was recognised as an area for action in *The NSW Rural Health Report* and the *NSW Rural Health Plan* announced the establishment of three rural Oral Health Centres to provide specialist dental care in regional centres.

Demographics

NSW is highly urbanised. In 2001, approximately 71% of the NSW population lived in metropolitan areas, 21% lived in inner regional areas, and 8% in outer regional and remote areas. Less than 1% of the total population live in areas classified as 'remote' or 'very remote', according to the Accessibility-Remoteness Index of Australia Plus (ARIA+). Indigenous people comprise almost one-third of the population of very remote areas.[i]

Rural NSW had an estimated rural resident population in 1999 of 1,447,164. The rural population is not homogeneous comprising regional centres, large towns, small towns and remote localities. Population densities, age structure characteristics and population growth vary. There is a greater proportion of people aged 0 – 14 years (22.3%) compared to NSW as a whole (20.5%) and a greater proportion of older people aged over 65 (14.8%) compared to NSW as a whole (12.8%) For example there is significant population growth in coastal areas with the population on the North Coast expected to increase by 19% by 2011 and an anticipated decrease of 12% in the Far West. .[ii]

Income is one indicator of socio-economic disadvantage. In 2001, 273,015 households in NSW (12.2%) had a weekly income of less than $300. Metropolitan areas had a larger proportion of high-income households above $1,500 per week (26.2%) and a smaller proportion of low-income households (10.8%) when compared to households in inner regional areas (18.0% and 12.9%) and outer regional and remote areas (9.4% and 16.3%). The North Coast Health Area had the largest proportion of households with a weekly income of less than $300 (17.5%).

Health of Rural Residents

Across Australia, people living in rural and remote areas generally have worse health than those living in metropolitan areas. Reasons for this health differential include geographic isolation, socioeconomic disadvantage, shortage of health care providers, greater exposure to injury risks, and poor health among Indigenous people.

Compared with people who live in metropolitan areas, people who live in remote or very remote areas:

- can expect to live 4 years less in remote areas and 10 years less in very remote areas;
- are more likely to die from causes classified as 'avoidable';
- report more visits to community health services and hospital emergency departments;
- are more likely to be hospitalised for conditions for which hospitalisation can be avoided through prevention and early management;
- are more likely to be hospitalised for coronary heart disease;
- are more likely to die in motor vehicle crashes;
- are more likely to die from gun-related injuries.

Oral Health and General Health

There is a growing body of evidence that links oral health to general health. These have been summarised in the 2005 document called "*NSW Oral Health Promotion: A Report on the Literature*"[iii] written by staff in the by the Centre for Oral Health Strategy.

> *There is already well established evidence that links 'general health' risk factors (such as tobacco use and poor dietary practices) to oral and craniofacial health. Further studies are now associating oral infections and conditions with other serious systemic diseases and disorders producing reduced quality of life, general ill-health, and in extreme cases death. For example:*
>
> - *tooth loss is associated with impaired eating and reduced nutritional status, anaemia and gastrointestinal conditions, and diet-related ill health;*
> - *oral infection eg viruses, bacteria, yeasts)with atherosclerosis, cardiovascular and cerebrovascular disease, osteoporosis, otitis media and delayed growth and development, preterm and/or low birth weight babies, pulmonary diseases and disorders, respiratory illness, and renal disease; and*
> - *oral, dental and craniofacial diseases and disorders with arthritis, diabetes, HIV (human immunodeficiency virus), and osteoporosis (AHMAC 2001; Beck et al. 1998; Genco 1998; NSW Department of Health 2002a; Sheiham & Watt 2000; Slavkin 1999; Spencer 2001/02).*

Studies investigating the relationship between oral infections and the risk for cardiovascular disease suggest there is a potential for oral micro-organisms, and their effects, to be linked with heart disease (Beck et al. 1996; Genco et al. 1997; Grau et al. 1997; DeStefano et al. 1993; Joshipura et al. 1996 & 1999; Mattila et al. 1989, 1995 & 2000; Morrison et al. 1999).

Chronic obstructive pulmonary disease (characterised by obstruction of airflow due to chronic bronchitis or emphysema, and by recurrent episodes of respiratory infection) has been associated with poor oral health status (Hayes et al. 1998; Scannapieco et al. 1998).

Oral infections have been investigated as a potential risk factor for preterm labour or premature rupture of membranes, which are major obstetric antecedents to spontaneous preterm births (Dasanayake 1998; Dasanayake et al. 2001; Davenport et al. 1998; Jeffcoat et al. 2001; Offenbacher et al. 1996 & 2001). Although the findings are promising, additional research and intervention trials are necessary to determine whether periodontitis is a risk factor for adverse pregnancy outcomes.

DEMAND FOR SERVICES IN RURAL NSW

Current Demand

Demand for services is driven by health need and expectations. People living in rural and remote areas and indigenous Australians generally have poorer overall health and correlating poor oral health status.

In recent decades, factors such as changes in diet, reduced sugar consumption, exposure to fluoride, and changes in disease management, have contributed to significant improvements in oral health. Australians in all states and territories enjoy a relatively high standard of oral health. However, this high standard is not equally shared among different age and social groups.

Compared with residents of urban areas, residents of rural areas:

- have more tooth decay (children);
- are more likely to have no natural teeth (adults)
- have less frequent dental check-ups;
- have fewer preventive dental treatments; and
- have less access to fluoridated water supplies.

The poorer oral health status of rural residents has been highlighted in a number of reports. A report published by the Australian Institute of Health and Welfare (AIHW) in 2002 detailed the oral health of a representative sample of sample of public dental patients from urban and rural areas in NSW, Queensland, Western Australia and Northern Territory.

- The percentage of edentulous adults (i.e., having no natural teeth) was higher in rural (9.2%) compared with urban areas (5.5%). Higher percentages of rural (20.9%) compared with urban (16.4%) patients had full upper dentures and, conversely, lower percentages had partial dentures (11.8% and 17.8% respectively).

- In terms of caries (dental decay) experience, rural adults had more missing teeth (6.3) compared with urban patients (5.2) but fewer filled teeth (5.4) than urban patients (6.5). Moreover, rural patients seeking emergency care had a higher number of decayed teeth (4.1) than urban patients (3.0), but the number of filled teeth was lower for rural (4.8) compared with urban emergency care patients (5.7). [iv]

Indigenous Australians also suffer greater levels of dental disease than non-indigenous Australians generally. Indigenous populations experience a higher percentage of people with no natural teeth (16%, compared with 10% non-Indigenous) and periodontal disease, both of which are associated with type 2 diabetes, which is more prevalent in Indigenous populations[v].

In June 2004 the National Oral Health Plan[vi] was released. It identified disparities in the oral health status of metropolitan and rural adults:

> *Profound disparities exist across socio-economic groups in Australia in respect to oral and general health. People of lowest socio-economic status—the poor and disadvantaged—carry the highest burden of disease. In particular, the incidence of caries and periodontal disease increases as socio-economic status decreases. ……Socio-economically disadvantaged groups include Indigenous Australians, a significant proportion of people living in rural and remote areas……(Page 27/28)*

Aboriginal and Torres Strait Islander peoples comprise 2.4 percent of the total Australian population, based on 1996 Census figures, with almost 26.5 percent living in areas classified as rural and remote, compared to 2 percent of the total population (ABS and AIHW 2003).(Page 34)

Compared to the overall Australian population of similar age, among Aboriginal and Torres Strait Islander peoples:

children generally have more than twice the caries experience and a greater proportion of untreated caries;
adults have more missing teeth; and
periodontal health is worse, with poor periodontal health evident in younger populations. (page 34)

Future Demand

The National Oral Health Plan predicted that demand for oral health services would increase:

Demand for oral health care services will continue to grow, in response to population growth and ageing, increased tooth retention into older age, greater awareness of the importance of oral health, and more advanced restorative procedures and technologies. (Page 3).

AVAILABILITY OF ORAL HEALTH SERVICES

In general, as with a number of health services, oral health services are less available in rural Areas. Health Workforce availability is a significant limitation to service provision, and models of care which are more appropriate to smaller, distributed populations need to be assessed and supported. Table 1 details the number of dentists per 100,000 as illustrated by the availability of dental staff in rural NSW .

Table 1: Estimated Number of Dentists per 100,000

New AHS	Dentists 2002	Population 2001	Dentists per 100,000
Sydney South West	475	1,278,148	37.2
South Eastern Sydney and Illawarra	793	1,145,262	69.2
Sydney West	364	1,044,200	34.9
Northern Sydney and Central Coast	606	1,081,340	56.0
North Coast *	164	451,830	36.3
Hunter New England *	209	814,180	25.7
Greater Southern *	114	455,630	25.0
Greater Western *	69	304,720	22.6
NSW	**2794**	**6,575,310**	**42.5**

* Rural AHS

Note: The Dentist Labour Force in NSW - 2002 reported the number of dentists registered in NSW in the period from February 2002 to January 2003 in the public and private sectors. Table 1 applies the 2002 number of dentists to the new AHSs, and taking the Area populations as at 2001 provides an estimate of number of public and private sector dentists per 100,000 population.

Table 2 outlines the number of rural staff (FTE) on a Public Dental Award was as at December 2004. There is considerable variation in the numbers and proportion of dental staff working in the public sector in rural and metropolitan NSW.

Table 2: Number of Public Sector Dental Staff

Public Sector Staff December 2004	*Rural*	*Whole NSW*
Dentists	27.23	213
Dentist - Specialists	None	22
Dental Therapists	38.77	131
Dental Hygienists	None	1.3
Dental Assistants	82.11	555
Dental Technicians	3.87	70

Notes

1. Numbers have been rounded

2. Numbers for December are lower because some Area data has not been entered into the Health Information Exchange.

ACCESS TO DENTAL SERVICES INCLUDING ISSUES RELEVANT TO PEOPLE LIVING IN RURAL NSW

Access by Rural Residents

The Australian Institute of Health and Welfare, in their 1998 publication *Adult Access to Dental Care – Rural and Remote Dwellers*, stated that in comparison to their metropolitan counterparts, rural and remote residents are disadvantaged in terms of their oral health status, access to oral health services, and services received.

Studies have shown that dentate adults from rural or remote locations were less likely to have visited an oral heath professional in the last 12 months than people from urban locations. They were also more likely to have a period of five years or more elapse since their last dental visit. People living in rural areas were most likely to have last visited a dentist because of a problem, rather than for a check-up and were more likely to lack private health insurance

Reduced access to services has long term effects as children and young people in particular may not receive preventive and early treatment which would improve their oral health status for the future.[vii] In the 2001 NSW Child Health Survey, more than half of children aged 5-12 years (55.8%) were reported to have had a dental visit or treatment in the previous 12 months. The most frequent dental treatments reported were check-up (48.9%) scale and clean (19.4%), fillings (17.2%), fluoride treatment (15.4%), removal of teeth (7.3%) and orthodontics (5.6%). Fillings were more commonly reported among children resident in inner regional, outer regional and remote areas, while preventive treatments (scale and clean and fluoride treatment) were more frequently reported among children resident in metropolitan areas. Children resident in metropolitan areas were also more likely to receive orthodontic treatment.

The loss of a tooth indicates failure of all preventive and restorative efforts and loss of all natural teeth (edentulism) often indicates failure of conservative care. In the 2002 National Dental Telephone Survey, residents of outer regional areas received more extractions (21.6% compared to 17.0% for major cities, 17.8% for inner regional and 17.7% for remote/very remote areas) (AIHW, 2003). In 2003, the proportion of respondents reporting having all their natural teeth missing was significantly lower in urban areas (5%) than in rural areas (8.8%)[viii].

Ambulatory care sensitive (ACS) conditions are those for which hospitalisation is considered potentially avoidable through preventive medical care and early disease management, usually delivered in an ambulatory setting, such as primary health care (for example by general practitioners or community health centres). Improving access to primary health care increases the use of ambulatory care and prevents unnecessary hospitalisations.

Dental conditions which are defined as ambulatory care sensitive include diseases of hard tissues of teeth; dental caries; diseases of pulp and periapical tissues, gingival and periodontal diseases; other diseases and conditions of the teeth and supporting structures; diseases of the oral soft tissues excluding lesions specific for gingiva and tongue; cyst of oral region; stomatitis and related lesions and other diseases of lip and oral mucosa.

In NSW during the period 2000-01 to 2002-03 dental conditions accounted for 32,369 hospitalisations and a rate of 163.91 per 100,000 population were ranked eighth for all ACS conditions. The hospitalisation rates for dental conditions were almost twice as high in inner and outer regional, remote and very remote areas in NSW compared with metropolitan areas.[ix] This could reflect a number of factors, which include the tendency for extractions rather than conservative treatments in areas where fewer conservative treatment options are available.

Access by Indigenous Australians

Indigenous populations experience a higher percentage of people with no natural teeth (16%, compared with 10% non-Indigenous) and periodontal disease, both of which are associated with type 2 diabetes, which is more prevalent in Indigenous populations (AIHW, 2003).

Between 1993-94 and 2002-03 the rate of hospitalisation for the removal or restoration of teeth in Indigenous persons was consistently lower than that of non-Indigenous persons. In 2002-03, the Indigenous rate was about half that of the non-Indigenous (217 compared with 425 per 100,000 population). Although there is likely to be substantial under-reporting of Aboriginality in hospital data, hospitalisation rates for many other conditions tend to be higher in Indigenous persons.

Indicators of access to dental services include the time since last dental visit, the number of dental visits, visiting the dentist for a problem rather than a check-up and experiencing toothache. National data show that, based on these indicators, Indigenous people have poorer access to dental services, which may explain the lower rates of hospitalisation (Brennan & Carter, 1998)

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. A draft Aboriginal oral health planning paper commissioned by NSW Health in 2001 identified that, while the delivery of oral health care to Aboriginal people in NSW is provided by dental programs principally managed by Aboriginal Community Controlled Health Organisations (ACCHs), there is wide variation in the level of service provided across the State.

Some ACCHSs have adult dental services, including the Walgett Aboriginal Medical Service, the Riverina Aboriginal Medical and Dental Service in Wagga, Moree Aboriginal Medical Service (part time) and Armidale and District Services Inc Aboriginal Medical Service. Several ACCHSs have funding to employ dental therapists and assisting staff only, such as Katungal Medical Service in Narooma, Durri Aboriginal Corporation in Kempsey, Biripi Aboriginal Medical Service in Taree and Bulgarr Ngaru Medical Aboriginal Corporation in Grafton with others having both dental therapists and adult services.

Other ACCHSs may have funding to employ a dentist but have had difficulties in recruitment, or have developed a service agreement with local dental personnel, for example Thubbo Aboriginal Medical Co-op in Dubbo. Bourke Aboriginal Community Health Service in Bourke has an agreement with the local private dentist, who also has a contract with the Area Health Service (AHS) to treat eligible patients.

In the Far West there is a service agreement whereby the Royal Flying Doctor Service (RFDS) provides a visiting dental service to the Maari Ma Health Aboriginal Corporation and to some rural and remote towns and communities. This service is only able to offer short occasional visits to communities, with the emphasis on immediate clinical care.

Some ACCHSs offer free dental care, others collect fees, being a minor co-payment contribution or a percentage of Department of Veterans Affairs (DVA) rates. Eligibility for dental care in ACCHSs and any required co-payments are decisions made by respective boards of management. Generally all dental care is available for Aboriginal people and their spouses. In rural locations eg Walgett, Aboriginal and non-Aboriginal people access the dental service as it is the only one in the shire. Co-payments are charged.

Most care is clinically-based, with very few programs being able to offer a more primary health care and preventive focus for example targeting priority groups such as diabetics, those with chronic diseases, the elderly, and young adults. Some of the barriers to accessing oral health services include:

- Cost of private services / lack of public services.
- No knowledge about available dental services.
- Long waiting lists, with the average waiting time for public dental care.
- Accessing people on waiting lists is based on their remaining at the same address.
- Lack of available transport to access services.
- Isolated Patients Travel and Assistance Scheme not covering dental referrals.
- Public dental facilities are inflexible and are not user-friendly.
- People are required to have a couple of forms of identification to be eligible for public dental care and Aboriginal people may not have the appropriate documentation.
- Consent for children requires the signature of a parent/guardian which can be difficult with Aboriginal extended families.
- Aboriginal people have other priorities over oral health eg diabetes, smoking, sexual abuse, drug use.
- Difficult access for low income earners - people may not be on health care cards yet they can't afford private dental care.

Access to Public Sector Services

Public sector services are available to children aged 0-15 years and holders of Health Care Card, Pensioner Concession Card or Commonwealth Seniors Health Card. The proportion of people on aged pension, disability and sickness benefits in NSW was higher in inner regional (9.8%) and outer regional and remote (9.8%) than metropolitan areas (6.6%) which would indicate that a greater proportion of rural residents will rely on public dental services in comparison to metropolitan

Table 3: Number of residents eligible for public sector oral health services.

New Rural AHS*	Eligible Population Including Children
South Eastern Sydney and Illawarra*	441,317
North Coast	358,129
Hunter New England	399,700
Greater Southern	209,386
Greater Western	221,296
***Rural NSW table includes the metropolitan and rural sectors of South Eastern Illawarra AH**	**1,629,828**

Public sector services are provided in a number of settings, which include school based and hospital clinics, community health centres, as well as mobile vans and domiciliary services. Historically services were predominantly based around the school dental service with numerous small clinics built on school grounds from the late 1970's. This service delivery model has contributed to the number and proportion of individual dental clinics (86) operating in rural areas, or 50% of the total fixed and mobile dental facilities statewide (170). Closer analysis of the number of rural dental chairs available (173) shows closer approximation to staffing ratios and relative populations served at 22% of the 775 dental chairs currently in use.

NSW Health also provides oral health funding to a number of organisations which provide oral health services on a statewide basis to identified needs groups in rural areas. Included in these funding arrangements are ACCHs, the RFDS which provides dental services to residents of isolated and remote areas by means of mobile clinics and the Stewart House Preventorium in North Sydney which can provide services to children affected by family dysfunction.[x]

In 1999/00 of the total occasions of service provided by public dental services around 32% were provided in a rural or remote setting. A six-month report to December 2001 shows this has reduced to 27%, quite possibly, as a result of the inability to recruit/retain dental staff.

Access to Private Dental Services

Factors that influence use of private dental services include availability of services and capacity to pay.

As outlined previously the proportion of people in receipt of aged pension, disability and sickness benefits in NSW was higher in inner regional and outer regional and remote areas. Metropolitan areas had a larger proportion of high-income households (26.2%) and a smaller proportion of low-income households (10.8%) when compared to households in inner regional areas (18.0% and 12.9%) and outer regional and remote areas (9.4% and 16.3%). Consequently many rural residents may have less capacity to pay for private services were they available.

Access to Specialist Services

The fundamental principle underpinning *The NSW Rural Health Report* is for services to be provided closer to where people live where quality is not compromised. In keeping with this principle the Report recommended the building up of specialist services in regional centres and the networking of services within and between AHS.

Specialist oral health services include orthodontics, periodontics, endodontics, paedodontics and oral medicine and pathology. Overall, there are very few dental specialists in the NSW public sector with specialist oral health services concentrated in the two dental teaching hospitals

Limited specialist services are provided outside these main centres – mainly orthodontics, oral surgery, prosthodontics and some paediatric dentistry services. Some services (mainly oral surgery) are contracted from local specialist providers and limited outreach services are provided by the dental teaching hospitals. While private sector specialist services are also concentrated within metropolitan areas, there are significant visiting private services to country regions, particularly orthodontic and oral surgery services. In some areas, particularly rural areas, general dentists have developed specialised skills in areas such as oral surgery, endodontics and crown and bridgework and are regarded as core service providers. The Royal Far West Health Service (located in Sydney) also provides orthodontic services to children from rural areas.

Since the release of *The NSW Rural Health Report* strategies have been implemented to improve access to specialist services including:

- *Expansion of outreach programs from dental teaching hospitals for the delivery of specialist services and teaching clinics.*

  Funding has been allocated to the two dental teaching hospitals in NSW to support the recruitment of additional staff thereby facilitating an increase in access to Specialists from these two teaching Centres. Outreach Programs aim to build the capacity of both the public and private local rural oral health services and improve access to training and updates in latest techniques. Outreach programs have been established at Orange (paediatric and orthodontics provided by the Westmead Centre for Oral Health), Dubbo (orthodontics by a privately contracted dentist), Bathurst (oral surgery) Broken Hill (orthodontics on a fee for service basis), Coffs Harbour (monthly paediatric and orthodontic services) and Queanbeyan (paediatrics).

- *Establishment of three oral health centres to provide specialist services and to contribute to research and training.*

  The introduction of Regional and Rural Oral Health Centres within NSW Rural Oral Health Networks provides a focus for delivery of more specialised oral health services, building the capacity of local general oral health services and improved education, training and research opportunities. A total of $1M recurrent funding, was provided to establish centres at Dubbo, Grafton and Queanbeyan. Paediatric, Orthodontic and Oral Maxillofacial Surgery Specialist services are now being provided through the three Rural and Regional Centres for Oral Health. Specialists from both the Teaching Hospitals and some local privately contracted Specialists supply services.

  There is potential for more specialist services to be provided in rural areas. It is recognised that there will always be some specialist services that will only be available in metropolitan areas. The Report also recommended improved networking of services including more formalised referral lines and service networks between rural and metropolitan services to ensure that rural residents are able to access those services when required.

ORAL HEALTH WORKFORCE

As for other health workforce groups, there are significant recruitment and retention issues for oral health workforce. The Oral Health Workforce includes dental officers, dental specialists, dental technicians, dental hygenists, dental therapists and chairside assistants.

The NSW Rural Health Priority Taskforce holds regular meetings with rural clinicians. Issues raised by clinicians (all categories) in relation to recruitment and retention in the public sector include:

- Remuneration.
- Limited career pathways.
- Limited access to training and education.
- Limited access to supervision and support.
- Limited access to specialist advice.
- Lack of incentives to work in rural NSW.
- Limited access to accommodation for staff and students.

These issues are equally relevant to oral health staff.

Remuneration

The salaries for public sector staff are low in comparison to the private sector. Table 4 shows the salaries of various oral health professionals during their first year of practice and the maximum salary under existing State Awards.

Table 4: Salaries of Public Sector Oral Health Staff

Grade 1	Dental Assistant	Dental Therapist	Dental Hygienist	Dental Technician	Dental Officer	Dental Specialist
First Year	$36,588	$38,015	$34,130	$40,084	$50,749	$102,408
Maximum	$44,133	$54,284	$37,062	$57,162	$91,287	$118,593

Incentives to Work in Rural NSW

An incentive scheme is available to public sector dental officer in rural area. The Dental Officer Rural Incentive Scheme (DORIS) has two components:

- A remuneration package of up to $20,000 a year that may be paid in salary or used to purchase a car, or pay a mortgage or school fees and
- Limited rights to private practice within a public sector dental clinic up to a maximum of 10% of normal work time. 40% of gross revenue thus generated is taken by the clinic to cover costs of administration, dental assisting and materials.

There are no incentive schemes for other oral health staff.

Access to Training and Education

Post-graduate scholarship schemes are offered to nursing (up to $10,000 to attend courses and undertaken tertiary studies) and allied health (eight scholarships valued at $2,000 for tertiary studies). No such schemes are available for public sector oral health staff.

PREVENTATIVE SERVICES

Fluoridation of drinking water supplies provides a significant dental health benefit by reducing dental caries, along with the associated savings in the cost of treatment. It is carried out under the provisions of the *Fluoridation of Public Water Supplies Act 1957*.

The NSW Rural Health Priority Taskforce is supportive of the introduction of water fluoridation in non-fluoridated areas.

OTHER RELEVANT MATTERS

The NSW Rural Health Priority Taskforce recommends the following strategies for the future:

Improve access to Services

- Expand the range of specialist services available to rural and regional NSW.
- Provide culturally appropriate and accessible oral health services for Aboriginal and Torres Strait Islander people
- Continue and/or expand school dental services to provide regular and timely check-ups and preventively focused oral health care for children and adolescents

Population oral health approaches

- Increase oral health promotion activity and preventive programs for Aboriginal and Torres Strait Islander peoples, and specific socio-economically disadvantaged groups.

Fluoridation

- Extend fluoridation of public water supplies to communities with populations of 1000 or more.

- Support communities, including Aboriginal and Torres Strait Islander communities, to advocate for fluoridation of public water supplies.

Oral health workforce

- Increase the supply of new Australian-trained oral health practitioners and overseas-trained dentists.

- Increase the number of Oral Hygienists employed in the public sector for comprehensive preventive care

- Maintain the number of dental Therapists employed in the public sector for Child Dental Services

- Extend existing undergraduate initiatives to oral health including:

  - Establish an undergraduate scholarship program for oral health students from rural communities
  - Establish a clinical placement program which provides financial assistance to undergraduates undertaking placements in rural areas

- Extend post-graduate scholarship programs to oral health staff

- Establish incentive programs for oral health staff working in rural NSW (with particular consideration given to inland and remote NSW)

- Establish a whole of government approach to provision of accommodation for public sector staff in rural communities

- Develop incentives for working in rural and remote NSW.

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[i] Report of the Chief Health Officer, NSW Department of Health 2004
[ii] NSW Rural Health Report, NSW Department of Health 2002
[iii] *NSW Oral Health Promotion: A Report on the Literature, 2005*
[iv] *Oral health of public dental patients in rural areas* AIHW Dental Statistics and Research Unit Research Report No. 12 2002
[v] Report of the Chief Health Officer, NSW Department of Health 2004
[vi] *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013*
[vii] Senate Community Affairs Reference Committee Submissions: Public Dental Services, May 1998. [70] Dental Health Services Victoria.
[viii] Report of the Chief Health Officer, NSW Department of Health 2004
[ix] Report of the Chief Health Officer, NSW Department of Health 2004
[x] Review of Statewide and Speciality Oral Health Services. Draft. January 2002.