Submission No 45

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation: Australian Dental and Oral Health Therapists' Association Inc (Formally ADTA)

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Theme:

Summary

Submission to the Review of Public Dental Services in NSW

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Introduction

Dentistry is currently in crisis in NSW. In the public sector, waiting lists for dental treatment in NSW are escalating (ref) and the costs to the health of individuals, the community, and consequently the economy is contributing to spiralling health care costs and a poorer quality of life. Dental treatment is being provided in an ad hoc manner, with the management of emergency care dominating the public sector resulting in 'patch up' solutions to a long term, entrenched problems of poor access and lack of funds. The private sector fares a little better, as anecdotal evidence suggests that many practices have had to refuse new patients because of the increasing demand for services.

Currently there are three tiers of dental care recipient; those in upper income groups who can afford to purchase dental care, those in low income groups who are eligible for **rationed** public sector services, and those low to middle income groups who largely cannot afford care and attend only for emergency care. These problems are compounded by extreme labour shortages across all dental practitioner disciplines in both the public and private sector, across most age groups and in rural and urban areas (NACOH 2003). Dental health is in crisis in most parts of NSW and is in need of serious attention to its workforce, funding and service delivery models.

This submission represents the views of the Australian Dental and Oral Health Therapist Association Inc (ADOTHA) and directly addresses to the following terms of reference:

A) The quality of care received in dental services

B) The demand for dental services including issues relating to waiting times for treatment in public services

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

D) The dental services workforce including issues relating to the training of dental clinicians and specialists

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

A) The quality of care received in dental services

Quality of care has many definitions and is dependent on the perspective of the assessment. Consumers would define quality of care as accessible, timely, culturally relevant, appropriate to their needs, affordable and clinically effective. Long waits for care would compromise this view of quality. Practitioners may put more emphasis on technological and clinical effectiveness and appropriate choices of interventions and an ability to refer patients to team members with appropriate skills. Managers may be more interested in cost effectiveness, equity and providing the most services with available resources. High cost services and limits on the ability to alter service inputs would compromise this view of quality.

The ADOHTA takes the view that in a time of spiralling health costs, quality of care will rely on the full use of all members of the dental team to maximise efficiency and cost effectiveness, enable best use of scarce resources and provide for flexible dental care services able to respond to local needs. Given the evidence of the effectiveness and quality of care provided by dental therapists (Barmes 1987, Gaughwin et al 1996, Galloway et al, 2003), we believe that there is a great deal of potential improve both the quality and number of services that are provided by the dental sector with the wider employment of these practitioners. Where employment, skills or services are prescriptively listed, the ability to provide cost-effective services, adapt practice to suit local needs or population groups and changes in technology is restricted (Liang & Ogur 1987). For these reasons we believe that it is inappropriate to limit the utilisation of dental therapists and hygienists and that service delivery models must position these practitioners to provide their services wherever there is a need for them in order to provide better quality services.

B) The demand for dental services including issues relating to waiting times for treatment in public services

The distribution of the dental workforce in NSW is skewed to private practice with approximately 85% of practitioners working in private practices. This problem is further compounded by the predilection of many practices to focus on aesthetic and elective dental care for those with less experience of active dental disease. This means that the majority of services in NSW are delivered to middle and upper income people leaving the bulk of dental care needs to be dealt with by the public sector.

Specific groups are particularly disadvantaged by these patterns of service, for example children and young adults, from low socio-economic groups, indigenous people, the aged, new migrants and refugees, rural and remote population groups and special needs patients (NACOH 2004). There is an urgent need to review the models of service delivery and the funding basis for the provision of public sector services. The wider utilisation of the services of dental therapists and dental hygienists would increase the capacity of both the public and private sectors to maximise the provision of services in a cost effective manner.(Millsteed 1995, Christiansen 1995). Both types of practitioner could and should be utilised in primary care and treatment roles as members of a dental team in almost any setting that provide oral health services.

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

Limits on client groups have been an issue that has reduced access to services. This is particularly so with dental therapists where age or geography have been used to limit access- both arbitrary limits without empirical foundation. Canadian dental therapists have been treating adults in first nations communities for over 20 years and similarly New Zealand dental therapists with Maori communities since 1988 (Manitoba DTA 1999, NZMOH 1998). Rural and remote areas would also benefit from the removal of restrictions on practice ownership and unnecessary gatekeeper controls such as supervision of practice or practice ownership limits. Experience in the USA shows that where practice restrictions (ownership, supervision) are removed, access to care for underserved populations is improved (Perry et al, 1987, Astroth and Cross-Poline 1998)

Where services are bundled together such as those of dentists and dental therapists or hygienists, clientele populations need to be large enough to provide a viable practice income to support two providers. This can preclude service provision and therefore access for smaller markets (population groups)- for example in small towns, rural and remote areas, domiciliary and outreach settings and low income populations. Direct pathway access for consumers to, for example dental therapists, hygienists, or prosthetists who can provide services at lower cost will mean lower threshold incomes for practice viability. This not only separates (spreads out) the providers in terms of numbers, but also in terms of geography and health care settings and consequently increases access to dental services. ADOTHA holds the view that access to oral health services would be increased by removing practice restrictions on dental therapists client groups and dispensing with prescriptive intra-professional relationships and business ownership limits.

D) The dental services workforce including issues relating to the training of dental clinicians and specialists

One of the key issues that relate to the crisis in oral health care has been identified in research conducted by the Australian Institute of Health and Welfare (AIHW 2003, NACOH 2004) as workforce related. The Dental Therapy profession has been established in NSW for approximately 30 years dedicated to providing primary dental care to the community, including clinical dentistry and oral health education and promotion. Dental Therapists work as part of a team, in a collaborative and referral relationship with a dentist that does not require the presence of, but does require access to a dentist. The profession comprises many experienced practitioners, predominantly female, providing a wide range of dental services to children and adolescents. Their professional skills have developed over this time in line with contemporary dental practice.

Dental Therapists are currently restricted to the public sector as historically, training was funded by the NSW Department of Health. This is no longer the case. The

Faculty of Dentistry at Sydney University is currently offering the Bachelor of Oral Health (BOH), which has replaced the training, previously provided by the College of Dental Therapy, and practitioners are also drawn from university programs delivered interstate such as the University of Melbourne and Adelaide. **As the education of dental therapists is no longer provided by the state, there is no longer a viable argument that their employment be restricted to state government services.** ADOTHA recommends that limits on employment be removed from the regulation of NSW dental therapists.

As a result of the review of the Dentists Act in 2001, dental therapists were deemed to require registration in order to practice, to bring them in line with other health professionals and with their counterparts in other Australian states. As a consequence, the title of dental therapist was also protected under the Act. However, this is where the similarities end. **In all of Australia's other states, the limitations imposed by employment restrictions on dental therapists has been recognised as both anti-competitive and detrimental to access to dental care for the public.** The Australian Dental Association has continuously lobbied to ensure that these restrictions are maintained, despite the demonstrated capabilities and demand for services of dental therapists.

NSW dental therapists are the only dental occupational group or health profession restricted to working within the public sector, in contrast with dentists, dental assistants, dental technicians, dental prosthetists, dental hygienists, nurses, podiatrists, physiotherapists, occupational therapists and optometrists.

Over the past 30 years over approximately 752 dental therapists have been trained by the colleges of dental therapy in NSW. In NSW in 2000, there were 216 working dental therapists representing only 28.7% of the qualified dental therapists potentially available to the dental workforce (AIHW 2000). This unutilised workforce represents a significant loss to the community of both investment and expertise. The reasons for their absence are many, including:

- Restrictions of practice to the public sector
- Wage issues
- Availability of a range of both full time and part time positions
- Disenchantment with the lack of professional advancement opportunities
- Lack of recognition and respect for the contribution made by dental therapists
- Family or personal reasons.

There is an urgent need to address these issues of retention to prevent the further erosion of the oral health workforce and to attract new BOH graduates to the public sector into the future. Further, there is great potential to offer re-employment opportunities should these retention issues be resolved and the opportunity to participate in workforce re-entry be made available.

In many areas, dental therapists are the only dental professionals that children see throughout the early years of life, particularly for low income families for whom the cost of visiting a dentist is prohibitive.

While the Australian Dental Association NSW Branch advocate that dental decay in children is declining, they are only seeing a small group of children who for the most part are not from underprivileged groups. The ADOTHA takes the view that it is inappropriate to base the assumptions underpinning service delivery models and workforce planning on the experiences of one group of dental practitioners whose patients are drawn from the middle to upper income groups who can afford to purchase care. Research evidence shows that '...dental decay is prevalent and increasing, in children, for example in the 0 to 5 age groups' (AIHW 2003).

Current restrictions placed on dental therapists' are said to be in place to ensure the Dental Board has control over the profession. This is an erroneous argument in that registration ensures the ability of the Dental Board (as a proxy for the state of NSW) to apply standards for the protection of the public in relation to the risks inherent in the delivery of dental care services (MacFarlane, 2000). The reality is that **there is no evidence to support the requirement for limitations to the employment of dental therapists** (Victorian Department of Human Services 1999, Satur 2003, Galloway *et al* 2003). **Further, there is evidence to support the view that these restrictions are in place to maintain the subordination of this professional group and protect the monopoly that the dentist profession has over dental practice and income. This is a professional dominance issue that serves no group in our community other than dentists** (Satur 2003).

These limits to employment **limit the attractiveness of the profession to potential students**, reduces the range of experiences and professional development opportunities for existing practitioners and diminishes the workforce's expertise and flexibility. This also **limits the profile of dental therapists to members of the public**, reduces their trust in this profession through lack of knowledge and experience of their services and as a consequence, their lack of trust in the School Dental Service. Naturally it also reduces their ability to provide an equitable service to those members of the public who have a need for and desire to access their services. This is not only **discriminatory in terms of equal employment opportunity but also in terms of the public's ability to equitably access dental care and anti-competitive** in light of both the National Competition Policy and the experiences interstate.

Experiences in other states has shown that broader employment of dental therapists has improved the relationships between dentists and dental therapists as their skills have become more widely understood and trusted. This has led to better team relationships, more collegial approaches to dental policy issues and continuing professional development and more collaborative approaches across the dental workforce. Further, anecdotal evidence suggests that most dental therapists maintain a commitment to public sector work in combination with private sector work; this combination has been of benefit to the public sector because it has allowed dental therapists to broaden and develop their practice without the need for public sector organisations to restructure career hierarchies. This more diverse practice has also contributed to a broader culture within the dental therapy profession.

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

Re-orienting health services to more preventive and primary care models has also been recognised as an important aspect of reducing demand and improving health (NACOH 2004). Dental therapists are well equipped to not only provide these services but also to do so more cost-effectively than dentists; they have been providing such services to limited population groups in Australia for over thirty years. There is much evidence to support this role with wider population groups: to match their skills with the high dental care needs of many groups (Millsteed 1996, Coombes 2002).

Dental treatment is not always synonymous with oral health. While access to services is an important aspect of achieving oral health, it is not the treatment alone that is important. Access to care and in particular primary care that incorporates health promotion in all its facets, is particularly important. Increasing access to preventive services and advice and allowing the health promoting approach to oral health to be incorporated as a full and critical component of oral care is also important. Shifting the heavy emphasis from the technical and biomedical toward the social is also critical to the improvement of oral health in the community. Dental therapists' and hygienists' education incorporates a much greater proportion of this theoretical area than does dentist education and as such, a greater emphasis is placed on public health. Shifting funding and service access is important but shifting dentistry philosophically toward public dental health is critical to developing better oral health for all sectors of the community.

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