Submission
No 53

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

Inquiry into Dental Services in New South Wales

Comments by Dr John Webster 15 – 25 May 2005

(a) The quality of care received in Dental Services

- Quality of care can be viewed from different angles. Firstly, there is the quality of the work that is done, and secondly the breadth of services provided.
- I am a Senior Dental Officer employed by what is now South Eastern Sydney Illawarra Area Health Service (hereafter abbreviated to SESIAHS). What work we do, we do well. The feedback from our patients is that they don't complain about the work that we do, (and in fact often express their appreciation), but rather other issues which I will address later.
- Where the quality suffers is the types and extent of work able to be done for our patients. Because we are so overrun with patients in pain, we are treating patients on a relief of pain basis almost all the time. This means that we only touch the tip of their needs. A significant proportion of our patients who attend for treatment have many teeth that are causing pain. Then after that, many of them still have many more teeth affected by the two major oral diseases, dental caries and periodontal disease.
- Our appointment system is regulated by a computer program called the Information System for Oral Health, or ISOH. This operates on the premise that patients in general have one problem tooth, which we treat, or remove at the first appointment. There may be other cavities, but they can wait for a while to have these treated. Priority is given to pain. The theory goes like this: if we as dental officers feel they can wait for one month, three months or twelve months, we code them as such. After the prescribed time, they will come off the appropriate list and have general dental treatment.
- The problem with that theory is that they keep sending us new patients, between 4 and 6 per day. 'They' are Centralised Intake, or CI, who book patients in to us all the time because these patients keep ringing them. There are far too many patients for the system to cope with.
- Now back to quality of care. How much do we do for these patients? Well mostly, they require more than the suggested one appointment. If the patient requires an extraction, I can take the medical history, take an X ray and extract the tooth in half an hour, which is the standard appointment time. If a patient requires a filling, because the tooth is able to be saved, this can be done if it's a small one. But usually pain is not caused by small cavities, but rather large and deep ones. This takes more time. To do a permanent filling of medium to large size, after having examined the patient and maybe taking an X ray, is going to run us over time. If the filling can't be done in the time, I will often place a temporary filling, which has the added benefit of being useful for diagnosis. I then have to reappoint this patient.
- Reappointing patients goes through cycles. Our area has a policy, which I support, of not being booked up too far ahead. So we rebook patients while we can, and then when we run out of appointments, we have to put them on a list. When the appointments are opened up again, we contact these patients and book them in. We only have about 2 to 4 follow up appointments available each day for these patients because the rest of the appointments are taken up by new patients.
- Many patients present wanting all their teeth out and full dentures. This has risen sharply lately because of years of not treating them previously. Such a patient might need several appointments to remove a large number of teeth. Sometimes these patients have pain with all their teeth and want them removed without delay. Finding them appointments is a real challenge. If they just want to have them removed because that's the way they want to go, but are not in that much pain, they will have to wait on a waiting list. For example, they might need 12 extractions, but only have pain in 2 or 3 teeth. The ones in pain will be removed soon, and the remainder will probably have to wait. They may have just lost some upper front teeth, but they will just have to wait because the other teeth are not in pain.
- If a patient has pain in a tooth which he or she doesn't wish to lose, then it becomes complicated. If it is a front tooth and the rest of the teeth are in reasonable condition in a

reasonable clean mouth, we are more likely to consider root canal therapy, or RCT. This can take a few hours of clinical time to save one tooth compared with the half hour it takes to remove it. Of course, if we extract a front tooth, have to consider prosthetic replacement of it. If such a patient already has a few teeth missing, or already has a partial denture, we are more likely to extract the tooth and add it to the denture, if that is possible.

- If it is a back tooth, the few hours taken to do RCT may be doubled or tripled. There just isn't time in our system to do that for one tooth. Then there's the added complication that such teeth often fail anyway, if not restored with a full crown, and we don't do crowns.
- We have far too many patients to spend much time on each one. We give the patients the option of going privately for such treatment to save one tooth, but they usually can't afford that. If we are to provide dentures, they are usually acrylic, rather than chrome cobalt cast metal dentures. The acrylic ones are cheaper than the cast metal dentures, and that is generally all we can provide. The waiting list is so long for dentures, that more patients will get dentures if we provide acrylic. Acrylic dentures are generally considered inferior to chrome cobalt and will destroy the remaining teeth more quickly than metal frameworks. The upside of acrylic, apart from cost, is that they are easier to add to, but then they are more likely to need an addition repair (as a consequence of extracting teeth), especially in our service (I mean NSW as a whole). We are unable to provide comprehensive care, and so the remaining teeth will deteriorate.
- There are other methods of tooth replacement, i.e. crown and bridgework, and implants, which we don't provide because they are too expensive and time consuming.
- We put patients onto waiting lists from which they do not emerge. The exception is the short term list I mentioned earlier. But that one is just for very limited work. They are only on that list because at the time there were no appointments left. That's the code B list. Code A is not used. If we put someone on code C because they need more work, they are supposed to be seen in about 3 months. The reality is that they will never come off this list because we keep adding patients to it and never take them off. The system can't work. The designers of the system either didn't see this, or didn't care.
- As I mentioned earlier, the two main oral diseases are dental caries, or tooth decay, and periodontal disease, or gum disease. The reality is that we merely scratch the surface of the population which we are given to treat. The system is not designed to deal with the problem at all. How many other parts of the body are treated with such neglect by our governments? In other areas, patients are given treatment for all sorts of conditions, and at great expense. They usually have to wait, but they do get it. If they die before coming off a waiting list, this is considered not a satisfactory outcome. If our patients do not ever receive the treatment they need, then that is just too bad. They might not die of it, but neither may they be able to eat. They might die of something else, because they can't eat. But it seems that policy makers and politicians don't consider that not having satisfactory teeth is important. The problem is that the policy makers and politicians can afford private dental treatment and have no idea how these people suffer. They don't know what toothaches are or what it's like to eat without any teeth. They don't stand up in Parliament and make speeches with missing front teeth. To them, this is all theoretical and unimportant. Well it's not to our patients.
- Another area of neglect is orthodontics. Whilst I agree that much of this is cosmetic, there are some malocclusions, or conditions that are beyond unsightly and more into the realm of disfiguring. Not all cases should be treated, i.e. for free at the public's expense, but more than what we are doing now should be done. This is very hard to quantify, but it needs considering.
- If we assume that we should provide more orthodontic treatment, then who would do it? In the Illawarra, we have one Dental Officer who is an overseas trained Orthodontist, but not registered to practise in NSW. She works under supervision and is paid as a Dental Officer. You can't get fully qualified and registered specialist Orthodontists to work in the public system, because we don't pay enough, especially compared to what they can earn in the private sector. The only way to gain their services is while they are training and to compel them to do it. This way we have registered Dentists who are undergoing post graduate training in Orthodontics. Maybe we could intern them for a year after graduation to work in rural areas (as well as metropolitan) in return for subsidising their training.

- Oral surgery. We do provide this service, but the waiting times can be excessive, especially if treatment is to be done under general anaesthetic. The same applies to treatment under GA for the dental phobics and young children.
- If then we consider the extent of the treatment for each patient, in general, it is very little. Very few will get what they need. Most do not get routine restorative treatment, so in that sense, the quality of provision is poor.

(b) The demand for dental services including issues relating to waiting times for treatment in public services.

- I can only speak for my area. The demand is huge. I don't have access to numbers waiting in pain for treatment, but it seems to take 2 or 3 weeks for patients to get appointments for relief of pain treatment. That's not to say that all who ring our Centralised Intake call centre get appointments. We are each given about 5 or 6 new patients each day to assess and treat.
- If each of these patients only had one problem, the system might work. However, because the system hasn't been keeping up with the demand since its inception, the number of problems that each patient has is increasing.
- Most patients have multiple problems, many of them involving pain and the remainder important issues that need treatment, but are as yet symptom free. I might mention here that pain is a late symptom in dental caries. Pain is often an indicator that the tooth is terminal. We should be doing better than this. Imagine treating cancer this way, where you don't treat someone diagnosed with cancer until it is too late to do anything for them. But this is the attitude of the government towards dental disease.
- Many times the tooth cannot be definitively treated at the first appointment. The patient may require antibiotics to reduce the infection before extracting the tooth, or may need an OPG (full mouth panoramic X ray), or a referral to an oral surgeon. The system does not cater for this.
- If a patient requires multiple appointments in order to render him/her pain free, then he/she may need to go on the code B waiting list. The intention is to take him/her off this list in a couple of weeks, but this might not be possible.
- If a patient has been relieved of pain, he/she can be placed on code C. The theory is that patients should come off this list in about 3 months, but that won't happen. If we were to maintain the status quo with treating those patients in pain, then no-one will ever come off the code C list, because we are only working off the code B waiting list.
- As it is, the code B waiting list is growing, so it is even more hopeless for code C. As for codes D, E and F, forget them. They are irrelevant.
- The only way patients are seen off code C is when they ring up Centralised Intake because they are in pain. Then they go through it all again and will end up on code C again to languish there. Of course, if more teeth are deteriorating, as they do, they will need more treatment and may get it. But we will be removing teeth that a while back were suitable for filling. This can be described as organised neglect. Consider what this does to the morale of Dental Officers working in the system, knowing that while we are relieving pain for a number of patients each day, there are many more who are neglected by the system and we can do nothing for them.

(c) The funding and availability of dental services, including the impact of private health insurance

- I don't know how much the funding is, but it's way too low. If you look at the funding of dental services compared to the funding of other health services, I'm quite sure we would be somewhere down the bottom of the barrel. Look at the percentage of the total health budget. The look at our budget (dental) compared to other health budgets.
- Another problem with funding is eligibility. As a state service, we have decided to base eligibility on Federal guidelines, i.e. Health Care Card or Pension Card, and yet the Federal Government does not fund us. Basically there are too many eligible patients for the service to treat. Maybe we could tighten up the eligibility and only be responsible for a fraction of the number of patients we have now. This could be done with no increase in funding, but it would

leave a large group of patients that we don't cover, but who maybe couldn't afford private treatment either. As it is, most of the patients just wait on waiting lists anyway.

- Why do we insist on providing free treatment? What about co-payment? Any income would have to be paid into the dental budget and not into general revenue, or worse still reduce the budget. Of course, there is the problem of collecting money, but hospitals seem to be able to do that.
- Private health insurance is quite irrelevant to this issue. It is there to assist patients who have money and who can afford it, to be able to afford private dental treatment. Private dental treatment is expensive because it is costly to run the business and those who invest in this endeavour deserve a decent return.

(d) Access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales

- For us, the main issue of access is the waiting times. In the main, people can get to our clinics. Of course, there can be transport issues for those who don't drive. These days we are more flexible with which clinic patients can attend, to fit in with the very limited public transport we have in Wollongong. That's another issue.
- Access would be harder in the Shoalhaven because of the greater distances involved.

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

- We are grossly understaffed so far as dentists go. It is very difficult to recruit and we keep losing dentists for many reasons. We have lost about 6 in the last couple of years.
- Compared to private practice, it's just not attractive. Why?
- Salaries. They are too low. The differential between medical officers and dental officers is huge. We should be paid close to what they are paid. The differential between public dental officers and private dentists is similarly large. This is a significant reason why many of our dental officers have left and why we can't attract them.
- Scope of clinical experience. So far as being interesting work, ours is appalling. We just do the same thing day in day out. We see individuals once or twice and that's it. Complete courses of treatment are rare. Medical officers can work in a variety of fields. Not so with us. We have a staff specialist oral surgeon who gets to specialise in oral surgery, but for most of us, it's pretty basic stuff. In general, working in this system deskills us, especially compared to our colleagues in private practice.
- Training. There's not much of that at all. The budget for ongoing education is very tight. Not only that; what's the use of learning about stuff you will never get to do? It's all quite depressing. Once I was offered the opportunity to specialise in a dental field only to find out that they didn't really mean specialise, as in being trained to become a specialist, but rather something much less than that.
- There is a program that has been going for a couple of years where a paediatric dentist has been coming down one day per month, but this only involves one dental officer at a time.

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

- Prevention is a joke. We do our best within our half hour appointments to shoe horn in some oral hygiene instruction and often I will clean and scale to help with periodontal disease.
- We are so flat out with treating toothaches that there is no time for preventive programs. The only way to get serious about prevention is to spend less time on relief of pain and actually organise something preventive. But that won't happen under the current climate.
- We have an Oral Health Promotion officer, but there is no communication as to what she might be doing.

- Fluoridation is a good thing, but it has nothing to do with us. The problem though is that it is dependent on children actually drinking tap water. Drinking bottled water and soft drinks lessens the impact of water fluoridation. Also, a lot of the fluoride put into the water ends up on gardens, showers and down the toilet.
- A couple of years ago, we were sent to a seminar on Minimal Intervention Dentistry, which is all well and good, but we can't implement it because we're flat out dealing with the end stage of dental caries and periodontal disease.

(g) Any other relevant matter.

- The public provision of dental services is in crisis and it will only get worse. More and more dentists will exit the system in frustration and this will just exacerbate the problem.
- Simple mathematics make it clear that if we do nothing to improve the situation that as we have more patients in pain than we can treat now, that waiting lists will grow. Such people on these lists are not there for treatment, as they will never get it. They are there so that we can have a record of how the system is failing.
- When ISOH was introduced, we were told that pain was not a priority, and that only emergencies would be considered priority. These included trauma, bleeding and swelling. That's code 1. Code 2 is treatment for medical reasons, such as to prepare someone for major surgery. It's hard to give these people priority when we are already fully booked seeing code 3 patients.
- The idea was going to be that patients would be prioritised and after waiting a while, they would be treated. This was never properly thought out and didn't really relate to the real world of enormous demand for treatment and miniscule funding. The result has been that relief of pain has all the attention and everything else misses out.
- What's the alternative? If you were to ignore pain as a priority and get involved with serious preventative strategies, you would eventually make some headway. But no-one's got the guts to tell the public that they have to go privately for relief of pain and that there will be no vouchers for it either.
- What happened to patients before the clinics opened up in the Illawarra? They either went privately or up to the Dental Hospital. What would happen if the public system closed down? The patients would go privately or nowhere at all. Somehow they managed before, one way or another. Now we have huge numbers on our waiting list who feel it is their right to have free dental treatment. Mostly they don't get it, they just wait for it.
- Dental treatment seems a lot more popular when it's free. If there were some cost to the patient, i.e. co-payment, this would reduce demand on the system, and inject money into it. Take the case of orthodontic treatment. For parents who have to pay for this, there has to be a good reason for forking out thousands of dollars for this treatment. Many parents in the system who are trying to request orthodontic treatment for their children insist that their child must have this treatment. If they had to pay, it becomes different. As it is, only a few are treated and most miss out anyway.
- What would happen if the government increased funding for vouchers dramatically? It has become clear in the Illawarra that the private dentists have all the voucher patients they can handle. This is because the fees paid by the government are too low. If the government were to pay around 90% of average private fees, then participation rates might increase.
- When patients don't get what they want, they often ring their local member. This is a useless activity for the service as the local members are self-serving. They are interested in votes. Not one of them does anything useful for improving the service, but they merely apply pressure to managers and clinical directors to give appointments to the complainants. This helps only one patient, rather than all. Various Ministers of Health take the same approach of individually assisting complainants by applying pressure to managers, who in turn apply pressure down the line and not doing anything useful towards improving the service. The end result is always more pressure on the service and the dental officers
- Members of consumer committees are in it for their own benefit rather than the benefit of the community as a whole.

- Much more can be said, but there needs to be dialogue between those conducting this inquiry and public dental officers and also the public. I am prepared to be interviewed regarding clarification of what I have written and any other questions you many have.

Summary

- The summary following this point is what will be copied into the summary box on the online form.
- I am a Senior Dental Officer employed by South Eastern Sydney Illawarra Area Health Service. The public dental service in NSW is seriously overloaded. Waiting times are somewhere between excessive and infinite. Most patients will never receive comprehensive dental treatment at even a basic level. The main priority is relief of pain and the level of dental disease is so high that we cannot cope with it. Dental treatment needs to have an increased profile in NSW Health and much higher funding. Careful planning with extensive consultation, especially of publicly employed dentists is crucial. Attached is a 6 page document. I do not request my submission to be kept confidential as I am prepared to have this followed up with dialogue.