Submission
No 25

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation: National Rural Health Alliance

Name: Ms Lexia Smallwood

Position: Council Business Manager

Telephone: 02 6285 4660

Date Received: 18/05/2005

Theme:

Summary

Committee Social Issues - Submission from the NRHA

From: "Lexia Smallwood" <lexia@ruralhealth.org.au>
To: <socialissues@parliament.nsw.gov.au>
Date: 17/05/2005 3:12 PM
Subject: Submission from the NRHA

TO WHOM IT MAY CONCERN

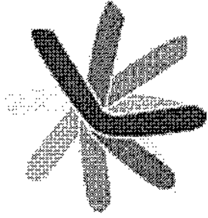
The National Rural Health Alliance is the peak national body for health and well-being in rural and remote areas. It has a long-standing interest in the (poor) state of oral health in rural and remote Australia.

We would be grateful if you would receive two documents and to deem them a submission to the Inquiry into Dental Services in NSW.

Should you require any further information about the Alliance or the status of the attached documents, please contact us.

Lexia Smallwood

Lexia Smallwood
Council Business Manager
Editor, PARTYline
National Rural Health Alliance
10-12 Campion Street
Deakin West, ACT, 2600.
Phone: 02 6285 4660
Email: ajrh@ruralhealth.org.au
Website: www.ruralhealth.org.au



NATIONAL RURAL HEALTH ALLIANCE INC.

Election Charter 2004

ORAL AND DENTAL HEALTH

Poor oral and dental health is preventable and has adverse consequences for a person's overall health status and esteem. It is particularly prevalent among people on low incomes and those in rural and remote areas who have limited access to the services of oral and dental health professionals. The state of oral and dental health is poorest among Aboriginal and Torres Strait Islander people.

This is a blight on Australia's health that is largely avoidable and Governments need to collaborate on the solutions. There is clear evidence that programs like the Commonwealth Dental Health Program (1994-96) can bring significant improvements to the situation.

The Alliance's proposal

The incoming Government will be asked as a matter of urgency to increase its spending on public dental services in rural and remote areas and for people on low incomes in all areas. They should also work with relevant professional organisations on workforce initiatives for oral and dental health.

Background to this issue is in the Alliance's Submission to the Senate Inquiries into Medicare (2003 and 2004), the Hansard records relating to the Hearings of those Inquiries, and in Position Papers 2000-2001 at www.ruralhealth.org.au

National Rural
Health Alliance

ORAL HEALTH IN RURAL COMMUNITIES

This Position Paper represents the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.

ORAL HEALTH IN RURAL COMMUNITIES

As at January 2001

The **National Rural Health Alliance**, the peak non-government rural and remote health organisation, **notes** that:

1. Oral disease, in particular dental caries and periodontal disease, is a significant and costly burden for Australians even though it is mostly preventable.[1] Dental decay is the most costly disease related to diet ahead of coronary health disease, hypertension and diabetes.[2] Aboriginal and Torres Strait Islander communities are at significant risk, experiencing dental decay at twice the rate of non-indigenous populations.[3] Sustainable and comprehensive health promotion and population oral health initiatives could address the significant financial and social burden.

2. There is growing evidence of the links between oral health and systemic health including links to pre-term birth, diabetes and cardiovascular disease.[4] Oral health promotion within a primary health care context is a priority policy area.

3. The Commonwealth Dental Health Program (CDPH) was started in 1994 to provide services to low income people who had been waiting up to three years for dental treatment.

   In the August 1996 Budget, the Federal Government abolished the CDHP. People on low incomes in rural and remote areas were among the main beneficiaries of the Program.

   Queensland has maintained funding of public dental services after the cessation of the CDHP. Since the cessation of the CDHP, the Victorian Government has provided an additional $1.5m for basic dental care in rural and regional communities as well as $1.1m for an 8 chair dental clinic in Bendigo. State Government funding now maintains the mobile van that takes dental care to rural areas.

4. The dental health needs of young adults, the aged, nursing home residents, rural and remote dwellers and those in lower socio-economic groups are not adequately met through either public or private dental practice and their treatment is less comprehensive. An extraction, for example, is more likely if the patient is young and of low socioeconomic status. According to the AIHW (2000)[5] the highest rates of decayed teeth were for rural patients aged between 25 and 34 years. Rural and remote hospital separations for the removal and restoration of teeth for 0-14 year olds in the Far West Area Health Service of NSW are almost 6 times those in central Sydney.[6]

5. Rural people have limited access to routine dental treatment and are often only able to access emergency care and may have to travel long distances to specialist services.

6. One of the reasons for the waiting lists is the under-supply of dentists in rural and remote areas. There are 28.7 practising dentists per 100,000 people in regional and

rural areas compared with 51.2 per 100,000 in capital cities.[5] A major barrier to dental services is the cost of private dental treatment.

88% of dental services are provided by the private sector through dental surgeries and denture clinics. The remainder is provided through public dental services like the school dental service, hospital dental services and community dental health services. In 1994, capital cities had 51.2 dentists per 100,000population and the rest of Australia 28.7 per 100,000.[5] Capital cities are more likely to receive diagnostic services. Rural locations have a higher number of patients with prostheses and fewer dentists. Rural men and women are 23% less likely to visit a dentist. [2]

7. The reasons why dentists do not take up the option of practice in rural or regional areas are very similar to those of General Practitioners and other health professionals. These include lower earning capacities, lack of professional support, lack of continuing education and lack of employment, health and educational opportunities for their spouse or children. Professional isolation is a major problem for dentists, who mostly work as sole practitioners. There is also a lack of professional organisation by rural dentists.

   The level of private health insurance and the level of income in rural areas are lower than in metropolitan areas, impacting on the number of visits made by rural people to the dentist. This, in turn, affects dentists' earning capacity.

8. Queensland currently targeting financial assistance at dentists in an attempt to overcome the disincentives of rural dental practice.

   Since 1996 Queensland Health has paid an allowance of up to $20,000 per year to individual dentists to attract them to rural and regional areas. Rural dentists are also eligible to receive seniority payments of up to $7,000 per year. This program has been successful in attracting dentists to rural practice.

9. A few attempts have been made to meet the demands of the rural dental workforce for professional development.

   For example, in Victoria, a professional development program has been designed and established by Dental Health Services Victoria (DHSV) to support all dental professionals, support staff and their managers involved in public dental programs across the State.

   Since 1996, the Victorian Government has also placed more than half of their dental interns in rural areas, all with experienced mentors.

   However, there is still the need for the rural dental workforce to be provided with the kind of training that some other rural health professionals receive.

10. In October 1997, the issue of the Provision of Public Dental Services in Australia was referred to the Senate Community Affairs References Committee. Reference to the Committee resulted primarily from the cessation of the CDHP from 1 January 1997.

137 individuals and organisations made submissions to the Inquiry, many from rural and regional areas.

11. The Committee handed down its Report in May 1998 [7] making 9 recommendations, the key ones being:

Recommendation 5: That the Commonwealth Government assist the States and Territories to establish, conduct and evaluate highly targeted pilot programs to address the priority oral health needs of the following specific disadvantaged groups: pre school-age children (1 – 5 years), young adult Health Card holders (18 –25 years), aged adult Health Card holders (65+ years), the homebound, rural and remote communities and indigenous Australians.

Recommendation 6: That the Commonwealth Government adopt a leadership role in introducing a national oral health policy, and give consideration to the possibility of using the National Public Health Partnership as the vehicle for developing and implementing that policy in partnership with the States and Territories.

The latter recommendation embraces the concept of a National Reform Agenda for Oral Health including a National Oral Health Partnership, put forward in the Queensland Health submission.

12. The responses received from the various State Health Departments in relation to the NRHA's discussion paper "Fighting Rural Decay–Dental Health in Rural Communities" [8] were critical of the termination of the CDHP.

13. Access to affordable and nutritious foods is essential for oral health. Rural and remote communities have less access to quality fresh foods.

14. Fluoridation of the water supply has been one of the most effective public health programs in Australia, resulting in a significantly lower number of dental caries.[3] Most rural and remote communities do not have a fluoridated water supply, often due to the high infrastructure costs. Alternate strategies need to be investigated for those areas, including subsidised fluoridated toothpaste and fluoride supplements.

The **National Rural Health Alliance affirms** that:

15. Member Bodies of the Alliance support the 9 recommendations outlined in the Senate Report on Public Dental Services (see Attachment A).

16. Poor dental and oral health is a major public health issue affecting the general health and social well-being of the person. The dental profession plays an important role not only in maintaining sound teeth and gums, but also in the early diagnosis of certain cancers eg. tongue and salivary glands. Yet little communication occurs between the dental profession and general practitioners. This is more marked in rural areas where there is limited access to dental specialists. There is a need for improved lines of communication between urban

dental professionals and rural general practitioners. Improved communication between these health professionals will lead to improved health outcomes.

17. Lack of access to dental services, fluoridated water and affordable fresh produce are major issues. There is a marked inequity in access to dental services between metropolitan and rural and regional areas.

18. There is a need for a Rural Dental Practice Incentive Program with similar financial and training incentives to the GP Rural Incentives Program to attract and retain dentists in rural and remote communities. However initially the lack of access to an appropriate diet, fluoridated water and socio-economic factors must be addressed. Such oral health outcomes would then be appropriate to the needs of the population and enhance sustainability. Locums, professional development and continuing education in oral health promotion are supporting mechanisms for a broad-based oral health incentive program.

19. There is a need for the Commonwealth and the States to work together to put in place a subsidised and targeted oral health program for low income people and others with poor access to dental health care. People in rural and remote areas, particularly if they were on low incomes or social welfare benefits, should be prime beneficiaries of such a program.

20. The fluoridation of water supplies is recognised as one of the most successful public health strategies in Australia. Fluoridation is one of the most effective and safe methods of prevention of dental caries with levels recommended by the NHMRC.

The **National Rural Health Alliance resolves** to:

Political issues

21. Continue to lobby the Commonwealth for the implementation of the recommendations of the Senate Report on Public Dental Services, particularly those relating to improved service delivery to meet the specific needs of rural and remote communities and Indigenous populations.

22. Lobby for the Commonwealth to exercise leadership on public dental services for people with limited means, especially in rural and remote areas.

23. In partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO) lobby the Commonwealth for more oral health resources for the Aboriginal community controlled health sector.

Workforce issues

24. Lobby State or Territory governments that provide incentives to private dentists to take up the option of practice in rural or remote locations.

25. Support the need to meet the professional development needs of dental health workers through collaborative action between governments, the profession and consumers.

26. Support the role of the Rural Health Support, Education and Training Program in developing collaborative approaches to improving access to dental and oral hygiene workers in rural areas.

Population oral health

27. Support the development of public health strategies for dental and oral health, including recognition of the need for oral health promotion initiatives through the National Public Health Partnership Taskforce on Health Promotion for Oral Health.

References:

1. Lester 1H, Australia's food and nutrition, Canberra, AGPS, 1994.
2. Australian Institute of Health and Welfare, 1998, *Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare.* Canberra: AIHW
3. NACCHO National Aboriginal Community Controlled Health Organisation Inc. National Secretariat 2/4 Phipps Close Deakin ACT 2600
4. Patterson, Dr A, NSW Public Health Bulletin, VOL 10, No. 3, Sydney, 1993
5. Australian Institute of Health and Welfare 2000, *Australia's health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare* Canberra: AIHW.
6. Osborn M, Patterson A & Jorm L, Measuring the performance of services for oral health in NSW, NSW Health Department, Sydney, 2001.
7. Senate Community Affairs References Committee. Report On Public Dental Services. 1998. Parliament of Australia, Senate Committee Reports.
8. National Rural Health Alliance, 1998, Fighting Rural Decay- Dental Health in Rural Communities, NRHA, Canberra.

Adopted at the National Rural Health Alliance Council Meeting on 22 January, 2001

Attachment A

Recommendations from the Senate Community Affairs Reference Committee- Report On Public Dental Services.

Recommendation 1: That the Commonwealth, in consultation with the States and Territories and other key stakeholders in the public and private dental sectors, support the development of programs to improve the promotion of oral health throughout Australia.

Recommendation 2: That the Commonwealth Government support the introduction of a vocation training program for new dental graduates, especially to assist in the delivery of oral health services to people in rural and remote areas.

Recommendation 3: That the use of dental auxiliaries such as therapists and hygienists be expanded, particularly to cater for the needs of specific disadvantaged groups and that, to this end, the States and Territories be encouraged to review legislation restricting the employment of such auxiliaries.

Recommendation 4: That support be given to a national oral health training strategy for health workers and carers, specifically including those working in the fields of aged care and Aboriginal health.

Recommendation 5: That the Commonwealth assist the States and Territories to establish, conduct and evaluate highly targeted pilot programs to address the priority oral health needs of the following specific disadvantaged groups: preschool-age children (1 to 5 years), young adult Health Card Holders (18 to 25 years), aged adults Health Card holders (65+ years), the homebound, rural and remote communities and indigenous Australians. Such programs should include a capacity for the individual beneficiary to make a contribution to the treatment costs.

Recommendation 6: That the Commonwealth Government adopt a leadership role in introducing a national oal health policy, and giver consideration to the possibility of using the National Public Health Partnerships as the vehicle for developing and implementing the policy in partnership with the States and Territories.

Recommendation 7: That the national oral health policy include the:

- setting of national oral health goals;
- establishment of national standards for the provision of, and access to, oral health care and the quality of services;
- establishment of a national strategies and priorities for oral health care reform, with an emphasis on preventative dentistry;
- setting of minimum service targets; and
- monitoring national oral health goals through the maintenance of a national data collection and evaluation centre and undertaking research into the current and projected needs.

Recommendation 8: That the Commonwealth allocate resources for a national oral health survey, to be conducted as a priority, to establish data on the oral health status and oral health needs of the Australian community.

Recommendation 9: That the Commonwealth Department of Health and family Services create a dedicated section or appoint an appropriately qualified senior officer with responsibilities for oral health matters, and that the necessary resources to fulfil the role and responsibilities of such an office be provided.