Submission
No 172

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

Committee Social Issues - Draft submission to Inquiry into Dental Services in NSW

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Date: 10/06/2005 4:12 PM
Subject: Draft submission to Inquiry into Dental Services in NSW

The Director,
Standing Committee on Social Issues,
Legislative Council,
Parliament House,
Macquarie Street
Sydney NSW 2000

Dear Director

Please find attached the Local Government Association of NSW and Shires Association of NSW draft submission to *Inquiry into Dental Services in NSW* conducted by Legislative Council Standing Committee on Social Issues.

A formal copy will be submitted by mail in the near future.

Please note that this a draft submission until the Executives of each Association have the opportunity to endorse it during the next round of meetings. If there are any changes we will let you know, as soon as possible after the Executives have considered the draft report.

Regards

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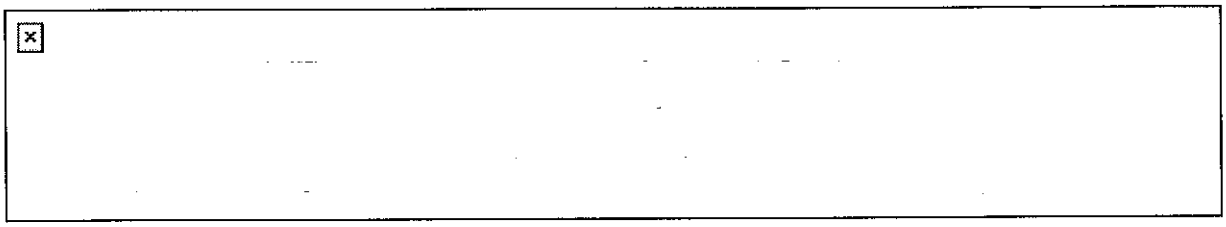

Draft submission to
Inquiry into Dental Services in NSW
conducted by Legislative Council Standing Committee on Social Issues

Introduction

The Local Government Association of NSW and the Shires Association of NSW welcome the opportunity to offer comment to the Legislative Council Standing Committee on Social Issues *Inquiry into Dental Services in NSW.*

The Local Government Association of NSW and the Shires Association of NSW represent general purpose councils, county councils and Regional Aboriginal Land Councils in NSW. The Associations aim to be credible, professional organisations representing Local Government, providing services to councils and facilitating the development of an efficient, effective, responsive, community-based system of Local Government in NSW.

The Associations understand that the Terms of Reference are as follows:

1. That the Standing Committee on Social Issues inquire into and report on dental services in New South Wales and in particular:
   (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) the funding and availability of dental services, including the impact of private health insurance,
   (d) access to public dental health services, including issues relevant to people living in rural and regional areas of New South Wales
   (e) the dental services workforce including issues relating to the training of dental clinicians and specialists,
   (f) preventative dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and
   (g) any other relevant matter

2. That the Committee report by Friday 31 March 2006.

The Associations are not in a position to address all the points set out in the Terms of Reference. We will limit comment to (b) demand for dental services, (c) funding and availability (d) access especially in rural areas (e) dental services workforce and (f) preventative dental initiatives.

The Associations have expressed concerns about unmet demand for dental services especially in rural areas, dental workforce issues, preventative dental initiatives and therefore ultimately funding over recent years (see Appendix1: Recent Conference resolutions on dental health matters).

The Associations note that although overall dental health in NSW has improved greatly over the past 30 years and more people than ever are growing up cavity free, a disparity has emerged (Ryle and Pearlman, 15 February, 2005). The situation is uneven with children from socio-economic disadvantaged groups experiencing greater dental problems than their wealthier counterparts. Children outside major cities have on average more decayed, missing or filled teeth (Australian Institute of Health and Welfare, 11 May 2005). The people at most risk and least able

to afford things have the highest amount of disease. The Australian Institute of Health and Welfare Dental Statistics and Research Unit says that low-income adults without private dental insurance are 25 times more likely to have had all their teeth extracted than high-income adults with insurance (Ryle and Pearlman, 15 February, 2005). Concession cardholders also have 3 less teeth on average than non-cardholders (Ryle and Pearlman, 15 February, 2005).

The Associations are generally concerned by the lack of adequate services to relieve pain associated with dental problems and restore people lives to normal. We understand that many people suffer significant pain and disability from poor dental health. We understand that tooth ache and the lack of proper dentures for those missing teeth are not only painful but also prevent consumption of a normal diet essential for good health. We understand that there are further links between general and dental health, so that poor dental health is making our community sicker in more ways than one. Poor oral health has been linked to diabetes, strokes, cancer and low-birthweight babies. We understand that in this society where personal appearance is important, badly degraded teeth cause psychological problems.

From the Associations' brief information gathering on dentist shortages two years ago we know that the maldistribution of dentists, potential undersupply with the ageing of dentists and waiting lists/times seem to be increasing world wide phenomena.

Demand for dental services including issues relating to waiting times for treatment in public services

We understand that there is reason for concern because public dental services are patchy, with some areas receiving comparatively good care and most of the eligible population unable to access routine dental care in a reasonable time.

Rural councils raise with the Associations anecdotal information from their constituents concerning the difficulty in accessing public dental services in any reasonable time frame. The most common concern relates to waiting times and to children needing emergency care after mild teeth problems develop into serious medical conditions.

Media coverage supports this anecdotal information with Ryle and Pearlman highlighting the following:

- there were 162,303 patients on waiting lists in August 2004 - 84,866 for assessment and 77,437 for care (figures supplied by NSW Health)
- with some patients waiting eight years for attention
- the average wait for an extraction or filling at Westmead standing at nine months and
- the number of children needing hospital treatment doubling over the past decade (15 February, 2005)

Peter Hill, until recently NSW Health's Acting Chief Dental Officer, made the following points:

- The public system is fighting to provide a service under limited funds
- If people are in pain or they have an emergency they are seen straight away.
- 90 per cent of the public system's time around the state is spent treating people with dental pain and immediate dental problems

- If they need routine work they are put on waiting lists (Ryle and Pearlman, 15 February, 2005).

We understand of the 4245 dentists registered in NSW, only about 240 work for Area Health Services. Therefore there are only 240 public dentists to cater for more than 2.5 million health card holders and children. We also understand the public dental system is unable to fill about 60 full-time positions for dentists. (Ryle and Pearlman, 15 February, 2005).

To an extent one would expect this to be balanced by the system where the State Government assists with access to private dentists for eligible people. Twenty five percent of private dentists can accept State Government vouchers which allow public patients to be treated privately when public care is not available. However, private dentists are less inclined to accept the vouchers because the remuneration is so far below what they would normally charge. Again Dr Hill was reported as saying: "They may only take one or two patients a day at most. If you flood the market with vouchers they will say they can't do it anymore... If you are down a dentist or don't have a dentist participating in the fee-for-service scheme, it becomes immeasurably harder to get all those people seen." (Ryle and Pearlman, 15 February, 2005).

Funding and availability of dental services, including the impact of private health insurance

The Associations note that the dental services problem seems relatively worse in NSW, which we understand spends less on public dental treatments per head of population than any other state (Ryle and Pearlman, 15 February, 2005). Further last year only one per cent of the NSW health budget was spent on a public dental system that 40 per cent of the population relies on. The Associations believe the NSW Government should provide for a significant funding boost to the public dental system.

However, the Associations also understand the debates about the respective roles of the Australian and NSW Governments in funding dental services and the widely held view that the decline in public dental services can be traced to the Australian Government's decision to abolish the short-lived Commonwealth Dental Health Program in 1997, which had provided the states with an extra $100 million each year. But arguments about blame shifting between the Australian and NSW Government in oral health are no more productive than they are in the wider health debate.

As the Associations argued in our submission to the House of Representatives Standing Committee on Health and Ageing *Inquiry into Health Funding* we agree with the public health experts that assert that the Commonwealth/State split-system of funding and administration with ongoing conflict and confusion is a management nightmare. It leads to duplication of services, poor coordination between services and cost shifting, where patients are shifted from a state to federally funded services or the reverse for financial reasons. The end result is poor services that cost more than they should (Lavelle, 2004).

We noted in that submission that Professor Dwyer, Australian Healthcare Reform Alliance has argued for a coordinated national policy that integrates all the various elements in health, not just hospitals. Professor Dwyer argues it would address the Australian Government/State and

Territory Government divide, by setting up independent regional statutory bodies, funded by both spheres of Government that would take responsibility for health services (Lavelle, 2004).

Further we noted that we support a mechanism such as an Australian Health Reform Commission to thoroughly investigate tangible long-term options for reforming the health system. This Commission should involve all spheres of government and other critical health stakeholders. This Commission should be required to report within a reasonable period on improved funding and delivery of health (viewed as an integrated paradigm). In terms of improved funding and delivery of health the investigation should include hospitals, specialists, GPs, community health services, health related aspects of aged care, population health strategies, regulatory health protection activities and health promotion programs. In the present context the Associations argue that the funding of public dental services needs to be added into that mix.

In supporting such an integrated exercise in looking for new solutions for the health funding and service delivery system, the Associations are not leaping to support of the idea of pooling all funds. We are advocating that the health system be rigorously re-examined to establish what legislative, regulatory, policy, program and funding settings can be altered to improve the system.

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

The Associations are vitally concerned about the lack of access to public or private dental health services for people in rural and remote NSW. The Associations are very concerned that people living in rural areas are often unable to find a dentist even if they are able to pay for the service.

We have addressed the point that the public system is struggling to provide services with limited funds in the previous section on demand and this struggle is often raised with the Associations by rural councils. We shall now turn to other elements of rural access.

The Associations have been concerned in the past that there does not appear to be easily accessible NSW information available to non-specialist organisations, on private and public sector dentist numbers and shortages in numbers, on ages of dentists (a relatively reliable indicator of future supply problems), and/or other information such as waiting lists or periods.

But from the Associations information gathering on emerging dentist shortages two years ago we know that the maldistribution of dentists, potential undersupply with the ageing of dentists and waiting lists/times seem to be increasing world wide phenomena. In the US we found that there are concerns and studies in California, Kansas, Missouri, Tennessee, New Hampshire, Virginia and Minnesota. In the UK we found that there are concerns and schemes to redress those concerns in the Midlands and in Scotland. In Australia we found that it was briefly an issue in the 2002 Victorian Election with Dr David Curnow, President of the Victorian Branch of the Australian Dental Association (ADAVB) running with a media release on public dental services.

According to AIHW in 1992 from data collected on all dentists registered in each State and Territory, there were an estimated 7,493 dentists practising in Australia. In terms of geographic distribution the following was revealed:

- There were 42.8 practising dentists per 100,000 population in Australia
- There were 28.6 practising dentists per 100,000 population in areas outside capital cities
- There were 51.0 practising dentists per 100,000 population in Australian Capital Cities
- There were 44.5 practising dentists per 100,000 population in NSW
- Contrasting to 41.4 in Victoria, 42.4 in Queensland, 53.7 in ACT, and 34.1 in Northern Territory
- There were 29.8 practising dentists per 100,000 population in areas outside Sydney in NSW
- Contrasting to 25.9 in Victoria, 35.1 in Queensland, and 21.1 in Northern Territory
- There were 53.5 practising dentists per 100,000 population in Sydney
- Contrasting to 47.6 in Melbourne, 51.0 in Brisbane, 53.7 in Canberra and 49.1 in Darwin (AIHW/University of Adelaide *Australia's oral health and dental services* 1998)

In terms of this supply data it is clear that areas outside capital cities across Australia had access to less practising dentists than Capital cities. Generally the number of practising dentists compared to population was almost double in Capital cities to areas outside capital cities. The picture is not quite as stark in NSW with 29.8 per 100,000 in areas outside Sydney compared to 53.5 per 100,000 in Sydney.

Nonetheless, the foregoing information suggests a long-term systemic imbalance and undersupply in regional rural and remote areas.

Clearly to mitigate this long-term systemic imbalance and undersupply in regional rural and remote areas, whether in public or private dentistry, needs further central government intervention. Local Government recognises the need to provide equitable and accessible health services across all areas of the state.

In recognising the problems faced by regional, rural and isolated communities in obtaining and retaining dental services, Local Government seeks the examination of the following strategies:

- The establishment of infrastructure funds for Local Government (see next sub-section on rural councils roles in supporting dental services)
- The implementation of whole of government strategies toward increasing exposure of all dental professions to rural areas during both their undergraduate and vocational training years, including: expanding programs to supply accommodation, expanding HECS reimbursement schemes (in return for rural service), extend compulsory periods of rural training to all health professions, with financial assistance for accommodation and travel for all students and preference, and adequate resources, being given to rural hospitals for new training posts created for dental professions
- A range of incentives for dental professionals working in rural areas including financial incentives such as award structures, taxation concessions and retention payments; career incentives such as preferential entry into training positions and programs; and family assistance such as childcare and spouse retraining opportunities

Another indicator of poor rural supply of dental services is the extent that Local Government is required to support these services when the market fails and/or other spheres of government cannot or have not provided such services. Whilst Local Government's role is not overwhelming it further illustrates the problem.

In this context it is worth highlighting what we know about NSW Local Government's direct provision of or support of other organisations in the provision of dental services. In 2004 Associations researched councils' roles in rural and remote medical and related health services generally and found rural and remote NSW councils are called upon by their communities to deal with a variety of medical and related health services (Baum, 2004). Eighty five (85) councils responded to the survey in this research. This was just over 80% of all members and associate members of the Shires Association at December 2003 (amalgamations have changed the make-up and number of councils since then).

The most significant efforts of responding councils in providing medical and related health services in rural and remote communities were as follows:

- 30 councils provided 45 centres for 59 doctors at an annual cost of $465,065
- 26 councils provided 48 houses for 53 doctors at an annual cost of $541,528
- *12 councils provided 13 centres for 13 dentists at an annual cost of $228,800*
- 10 councils provided equipment for 18 doctors at an annual cost of $63,500

It was also worth noting other council effort included *housing for dentists (2 councils) and relocation expenses for dentists (1 council).*

The most significant efforts of responding councils in supporting medical and related health services run by others in rural and remote communities involved GPs – i.e. subsidised houses for GPs (11 councils), subsidised centres for GPs (9 councils), subsidised pre-service training for GPs (8 councils), subsidised equipment for GPs(4 councils) and salary subsidies for GPs (3 councils). But again it is also worth highlighting other council effort included *subsidising Centres/surgeries for Dentists (3 councils)* and *subsidising equipment for Dentists (2 councils).*

The obvious point is that rural and remote councils are having to meet costs associated with dental health services because the private market and/or the public dental system are not delivering the services those communities expect. Arguably meeting these costs is not the appropriate role of Local Government, if one takes the normal constitutional view of Australian and NSW Government health responsibilities and if one accepts the well established revenue raising challenges rural councils face. Nonetheless having accepted the challenge, NSW Local Government needs enhanced financial assistance from the Australian Government and/or the NSW Government to carry out its established roles in providing or supporting dental services in regional, rural and remote areas. This could be built from the platform created by the Rural Medical Infrastructure Fund (RMIF) or something similar for dentist services alone given that RMIF is focused solely on GPs.

Dental services workforce including issues relating to the training of dental clinicians and specialists

The Associations understand there is an increasing shortage of trained dental clinicians, with significant shortfalls predicted by 2010. The workforce shortage appears in part to be due to a lack of sufficient training positions for dentists, dental therapists, hygienists, technicians and prosthetists. The Associations are concerned that despite the fact that there are young people who

wishing to enter these professions, and the significant community need, the necessary training positions have not been created.

From the Associations previous research, according to the ABS in 1997-98 the private practice Dental Services workforce was as follows:

- Across Australia there were 7,134 dental practitioners working in private practice of whom 6,299 were general practitioners and 835 were specialists
- Fifty six per cent of general practitioners were less than 45 years of age
- Forty five per cent of specialists were less than 45 years of age
- Seventy nine per cent of general practitioners were male. The gender imbalance varied with age with 58 % of practitioners less than 35 years of age being male whilst 93% of those 55 years and older being male.
- There were 2668 private general practitioners and specialists in NSW (representing 37.4% of the numbers across the nation)
- Contrasting to Victoria with 1,708 (representing 23.9%), Queensland with 1,103 (representing 15.5%), ACT with 181 (representing 2.5%) and Northern Territory with 35 (representing 0.5%)
- There was one dental practitioner in private practice for every 2377 persons in NSW
- Contrasting to Victoria with one for every 2729, Queensland with one for every 3134, ACT with one for every 1704 and Northern Territory with one for every 5428.
- There was one general dental practitioner in private practice for every 2670 persons in NSW (i.e. excluding specialists)
- Contrasting to Victoria with one for every 3056, Queensland with one for every 3642, ACT with one for every 2016 and Northern Territory with one for every 5937. (ABS *Dental Services 8551.0* 1997-98)

This data suggests that Australia may be facing the issue of an ageing dental workforce in a way that is of concern internationally and especially in the US.

The Associations support the views of the Rural Dental Action Group which we understand from the media has put forward a submission outlining the lack of dentists indicating the need for the Australian and State Governments to provide more university places to train more young dentists to replace an aging number of dentists who are leaving the industry through retirement.

Preventative dental treatments and initiatives, including fluoridation and the optimum method of delivering such services

Although the Associations have a long history of participation on the Fluoridation of Public Water Supplies Advisory Committee, we do not have a formal up-to-date position on the issue of water fluoridation. The Associations are currently in the process of developing a policy for consideration by the Executives and member councils, as resolved by the 2004 Local Government Association Conference (see Appendix 1).

The Associations are keenly aware of the arguments for and against water fluoridation. We regognise that on the balance the fluoridation of public water supplies has been shown to be an effective oral health measure, both with regard to the prevention of caries and maintaining teeth

throughout life (NHMRC: 1991; McDonagh: 2000; Spencer: 2004). It is supported by the World Health Organization (WHO), the National Health and Medical Research Council, the Australian Medical Association, the Australian Dental Association and all Australian Government Health Authorities.

Under the NSW *Fluoridation of Public Water Supplies Act 1957* and Regulation, NSW councils have responsibility for deciding whether or not to fluoridate the public water supply, with the approval of NSW Health. They may also refer this matter to NSW Health for a decision as to whether the water supply should be fluoridated, the Minister making a decision on the advice of the Fluoridation of Public Water Supplies Advisory Committee (of which the Associations is a member). Councils often make decisions whether or not to fluoridate after consulting the community on this issue, among whom there may be varying views as to whether this course of action should be adopted.

Just over 100 of the 152 councils in NSW are responsible for water supply. On the basis of information supplied by NSW Health, in May 2003 57 NSW councils responsible for water supplies did not fluoridate (8 had high naturally occurring levels that made it unnecessary), 23 fluoridated some parts of their area and not others and the remainder fluoridated all parts of their area. Whilst there have been amalgamations since then, it remains clear the majority councils who do not fluoridate all of the water supply in their localities represent a significant proportion of rural and regional councils.

The Associations would also like to draw the Committee's attention to the issue of the cost of the establishment, maintenance and operation of fluoridation plants. At present NSW Health is offering a 100% subsidy for new capital works associated with the building of fluoridation plants, an increase of 50%. This subsidy has also been extended to the replacement and upgrade costs of fluoridation buildings, where councils have to comply with the conditions of the Fluoridation Code of Practice 2002. Despite representations by the Associations following the resolution of the 2004 Local Government Association Conference (see Appendix 1), NSW Health indicated in March 2005 that funding is not available to cover the recurrent costs of maintaining a fluoridation plant, although local area health services may occasionally assist in defraying these costs. It is a debatable point as to whether Local Government should in fact be responsible for the costs of operating and maintaining a fluoridation plant, given that constitutional responsibility for oral health rests with other spheres of government. Coffs Harbour Council has estimated that the operation of their new plant will cost council $70,000 per annum, although the AHS has offered a $20,000 subsidy as a special arrangement. Over time such costs may represent an impost on the finances of regional and rural councils many of which have low rate bases. Again, while the Associations do not have a formal policy on this issue, there is a case for a full Australian or NSW government subsidy for the total cost of establishing and running a fluoridation plant on an ongoing basis.

Recent Conference resolutions on dental health matters

That the Shires Association of NSW request the Minister for Health to take immediate steps to provide increased funding for the purposes of improvement of dental health services in rural NSW (Shires Association of NSW Annual Conference 2005 Resolution No 17).

That the NSW Government help address the critical need for dental services in the western areas of the state by declaring dental positions in those towns unable to attract a resident dentist as area of needs positions (Shires Association of NSW Annual Conference 2004 Resolution No 24.1).

That the Shires Association of NSW lobby the Federal Government to implement strategies such as provision of grants to encourage rural students/applicants into Universities to assist in addressing the critical shortage of dentists in rural areas (Shires Association of NSW Annual Conference 2003 Resolution No 8).

That the Shires Association seek further financial assistance from the Federal and State Governments to encourage doctors, nurses, dentists and allied medical professionals to relocate to rural areas (Shires Association of NSW Annual Conference 2002 Resolution No196).

That the Local Government Association petition the Minister for Health, The Hon. Morris Iemma MP to provide funding for the ongoing maintenance of fluoridation systems (Local Government Association of NSW Annual Conference 2004 resoluton no 34).

That the LGA review its position and policy on the fluoridation of public water supplies with respect to public health and environmental impact and the review be undertaken in consultation with local councils (Local Government Association of NSW Annual Conference 2004 resoluton no 194.2).

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