Submission
No 76

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

The Royal Australasian College of Dental Surgeons
NSW Regional Committee

The Royal Australasian College of Dental Surgeons is a postgraduate education body established primarily to improve the knowledge and skills of dental practitioners.

Recognising the professional responsibility of dentists to the community and the advantages of postgraduate study at an appropriate level as an aid to the better fulfilment of this responsibility, the College was established to encourage this activity within the profession. This objective is promoted through the establishment of Primary and Final examinations. Successful completion of these examinations provides evidence of improved knowledge and skills by the candidate who is then elected to Fellowship in the College.

The College has a particular role in providing a type of postgraduate education alternative to the study required for higher degrees in universities which is not always possible for those engaged in the private practice of dentistry.

The NSW Regional Committee of the college would like to make the following submission regarding dental services in NSW to the Standing Committee on Social Issues.

a.) Quality of Care

Dental surgeons in NSW have a high level of training and competence and are recognised among the most advanced practitioners in the world. Those members of the community capable of accessing dental care in the private sector have the ability to receive a wide range of treatment options which include complex procedures such as implant replacement of teeth and endodontic treatments.

Most dentists currently practising in NSW maintain their high level of skills by participating in continuing education, however, there is at the moment no financial incentive for dentists to undertake continuing education. On the contrary there is considerable disincentive to do so due to the cost of courses, cost of overheads in private dental practice and lack of recognition of the higher skills and knowledge possessed by those who choose to avail themselves of continuing education.

Therefore, it is essential that those practitioners who participate in continuing education are recognised and rewarded for their greater commitment to best practice in delivering patient care. As an example private health funds should be encouraged to provide a higher rebate to the patients of those practitioners who have a higher qualification for example fellowship of this college. Similarly the Oral Health Fee for Service Scheme should pay a higher rate to those dental practitioners with higher qualifications.

Care should be taken when accrediting overseas trained dentists. As stated above the training provided to dentists in NSW is among the best in the world, standards of expertise should not be lowered to accommodate overseas trained professionals. Current events in Queensland relating to an overseas trained doctor show the problems which may arise if professionals are allowed to practise in this country when their overseas training does not equate to that of a locally trained graduate. Moreover, as dental disease is a disease of lifestyle different communities world - wide suffer different patterns of dental disease therefore dental qualifications obtained in countries with socio-economic conditions which differ widely from those of Australia's may be particularly ill equipped to provide the level of care expected by the Australian consumer of dental health care.

The RACDS is concerned that the quality of care offered to clients of public sector dental clinics is being adversely impacted by the inadequacy of funding provided to the public sector. Financial restrictions placed on public dental clinics combined with demand for services means that only the most basic of dental treatments can be provided to those members of the community dependant on publicly funded dental treatment. As an example most public dental clinics operate on a system based on degree of need which results in emergency treatment only being provided. Modern best practice recommends that teeth be retained where possible yet in the public sector many teeth are extracted which could be saved if endodontic treatments were employed. For example there is in fact no specialist endodontist employed within the NSW public dental sector.

b.) Demand for Dental Services

Currently the demand for dental services is growing due to the aging of the population and the increasing proportion of the population remaining at least partially dentate into old age. Currently waiting times for treatment in public sector dental clinics are totally unacceptable. The cause of the large waiting lists is lack of funding and inadequate staffing of public dental clinics.

The government needs to act immediately to make employment in the public sector more attractive to dentists. Historically dentists who preferred not to work in private practice would be employed by the public dental clinics. With the advent of private health fund dental clinics the public dental clinics have lost this pool of workers. Dentists who choose a different mode of practice to private practice can now access

better pay and conditions in private health fund clinics than in the public sector. This situation will worsen as large corporations enter the dental field.

Inadequate staffing due to loss of dental staff from the public sector to private health fund dental clinics or other corporate providers of dental care will increase waiting lists for publicly funded dental care.

The Oral Health Fee for Service Scheme was introduced in an attempt to alleviate the waiting times for public dental treatment and to deal with emergencies which could not adequately be accommodated in the public sector. This scheme has not addressed the problems as the fees offered to the private practitioner are inadequate and the range of services available is too narrow. Moreover the practitioner has no right to charge a co-payment to the patient in order to adequately fund the services required.

The only way to structure a system which works for both dentists and clients of the scheme is to promote the institution of a medicare type scheme where dentists are free to charge the client the extra fee above the "scheduled fee". The problem at the moment is that the fees paid are so low that they do not cover operating costs. The result of this is that very few dentists participate in the scheme. The advantage of a scheme which allows dentists to charge their normal fee is that more dentists would become involved due to the removal of the financial disincentive. The advantage to the eligible population would be that they would have easier access to a greater number of providers. This would be particularly advantageous in those areas such as small country towns were there are currently no participating dentists.

Similarly in a suburban environment there may be a situation were only one dentist out of a pool of perhaps ten is willing to participate in the scheme. The eligible person in this situation currently has the choice of accessing care free of charge from a practitioner they do not wish to consult or seeing the dentist of their choice but receiving no financial assistance.

A patient co-payment also gives dental patients an incentive to maintain their dental health. It must be remembered that dental disease is largely preventable.

If a scheme was instituted which allowed private practitioners to treat people eligible for publicly funded care at their normal fee levels many eligible patients would be removed from the waiting lists and treated in private practice. This would allow the public sector to concentrate on treating those patients who really could not afford to contribute financially to their dental care at all, while those who could afford to partially fund their dental care would be given the opportunity to increase there choice of practitioner by self funding a proportion of their own dental care.

c.) Funding and Availability of Dental Services.

Availability of dental services in NSW is adequate for the large proportion of the community who self fund their dental treatment. There is an adequate private practice dental work force to provide dental care to those able to access private dental treatment in city, suburban and coastal areas. Surveys completed by the Australian Dental Association of dental practice show that the average dental practitioner in private dental practice has approximately 90 minutes of unbooked office time per week. Health economists show that the most efficient use of dental surgery capital equipment requires a reasonable waiting list, therefore, there is a relative oversupply of dentists in the private dental sector in large cities and some coastal areas. This leads to inefficiencies which result in an increase in cost to the consumer.

In contrast some rural areas and the public sector currently experience a severe shortage of dental manpower. Rural dental practice is seen as unattractive by the dental graduate due to issues of social and professional isolation and standard of treatment modalities available.

Modern dental practitioners are trained to provide a high level of care involving complex technical and diagnostic treatment modalities. It is considered important by most dentists to achieve job satisfaction and to maintain professional competence that all of their skills are used in the course of their work schedule. Rural communities have relatively higher levels of low socio-economic groups. The result of this is that dentists practising in rural communities have fewer opportunities to practice their professional skills at a higher level this leads to dissatisfaction with rural dental practice. Many young dentists who commence practise in a rural area fail to remain in these communities for this reason.

Private health insurance impacts on the delivery of dental services within the community in many ways. Many health economists have shown that private health insurance is an inefficient way of funding dental care. The federal government's 30% rebate on private health insurance ancillary cover is a particularly inefficient method of funding dental services. It is important to note that the original Senate Committee report which resulted in the introduction of the 30% rebate for private health insurance, specifically recommended against applying the rebate to ancillary cover.

Private health insurance clinics negatively impact on the provision of dental services to those members of the community who need to access care from publicly funded dental clinics. Many public dental clinics have unfilled positions for dentists available and therefore suffer a severe workforce crisis. Public dental clinics compete for dentists with health fund dental clinics who provide better salaries and conditions and allow for provision of a wider range of treatment options.

Interviews with focus groups from the public sector and private health insurance clinics show that dentists choose to work in private health insurance clinics in preference to public dental clinics due to the higher salaries, (typically 25% more), better working conditions, for example new equipment and better materials, and the

ability to provide a wider range of treatment options to patients treated in health fund clinics compared to public dental clinics. It is particularly inequitable that health fund dental clinics are subsidised by government funding through the 30% rebate.

d.) Access to public dental services.

Access to public dental services is inadequate for those members of the community eligible for public dental treatment. The funding of dental services in NSW is inadequate to provide quality dental care to those members of the community eligible for publicly funded dental treatment. Consequently treatment is directed towards alleviating acute pain conditions in the most economical manner possible rather than instituting treatment modalities which provide for optimal dental health.

There is an overall shortage of dentists working in the public dental sector in rural and remote regions. For example the public sector dental clinics in Orange have unfilled positions for dentists. There needs to be more incentives for dentists to relocate to rural areas. Financial incentives would encourage some new graduates to accept employment in the public sector in rural areas. However, due to the cost of dental capital equipment it is economically irrational to locate public dental clinics in small rural areas. Better funded and more flexible fee for service schemes would allow private dentists in small country towns to serve the needs of both the privately funded dental patients and those reliant on publicly funded dentistry. The inadequate funding for the Oral Health Fee for Service Scheme combined with the large proportion of the community in rural areas who are reliant on publicly funded dental care has made private dental practice in small rural communities unviable. The Oral Health Fee for Service Scheme was introduced in an attempt to alleviate the waiting times for public dental treatment and to deal with emergencies which could not adequately be accommodated in the public sector. This scheme has not addressed the problems as the fees offered to the private practitioner are inadequate and the range of services available is too narrow. Moreover the practitioner has no right to charge a co-payment to the patient in order to adequately fund the services required.

The only way to structure a system which be viable for both dentists and clients of the scheme is to promote the institution of a medicare type scheme where dentists are free to charge the client the extra fee above the "scheduled fee". If a private practitioner does provide care under the Oral Health Fee for Service Scheme to a larger proportion of patients within their practice there will inevitably be some cross-subsidization of public sector patients by the pool of private patients in the practice. This increases the cost of care to the private dental patient. At the moment is that the fees paid under the Oral Health Fee for Service Scheme are so low that they barely and in some cases do not cover operating costs. The result of this is that very few dentists participate in the scheme. The advantage of a scheme which allows the dentists to charge their normal fee is that more dentists would become involved due

to the removal of the financial disincentive. The advantage to the eligible population would be that they would have easier access to a greater number of providers. This would be particularly advantageous in those areas such as small country towns were there are currently no participating dentists.

e.) Dental services workforce issues.

The dental services workforce currently suffers from an inefficient distribution of dental health care providers. There is a relative oversupply of dentists and other dental health care workers in the Sydney area and a relative shortage of dental health care workers in regional and rural areas. Similarly there is an oversupply of dentists in the private sector and a severe shortage in the public sector.

This situation can only be corrected by improving the attractiveness of both rural and public practice for all members of the oral health workforce.

There is currently also an imbalance in the number and type of oral health care workers in NSW due to historical factors affecting training of different types of oral health care workers.

In NSW at the moment there is a relative oversupply of dentists, dental therapists and prosthetists compared to dental hygienists. This imbalance is a result of past legislation pertaining to dental hygienists combined with training which still responds more to outmoded considerations regarding the patterns of dental disease.

Modern knowledge regarding preventive dental treatments means that dental disease for the majority of the population is a completely preventable disease. Despite this there are many more dentists in NSW than dental hygienists. The result of this workforce imbalance is that highly trained dentists currently spend much of their clinical time performing dental hygiene services which could be performed more cost effectively by well trained dental hygienists. However, the current shortage of dental hygienists means that demand for their services is so great that salary levels in some cases outstrip those of dentists, thus negating their cost effectiveness.

This imbalance is being addressed by both Newcastle University and to a lesser extent Sydney University with their new Bachelor of Oral Health programmes. These programmes combined could deliver 80 new oral health care providers each year commencing in 2007. If these new graduates take up careers in dental hygiene this will allow dentists to use their higher skills and training more efficiently by supervising the hygienists and using their time to provide more complex treatment needs and formulating effective treatment plans which address all aspects of oral health requirements. This is particularly pertinent as the dentate population ages and becomes more susceptible to dental and periodontal disease due to medications and other health related problems.

Dental therapists are an anachronistic remnant of the pre-fluoridation era. Dental therapists were initially introduced to the dental workforce when the knowledge of and institution of preventive dentistry initiatives was minimal. During the 1950's, 1960's and early 1970's dental decay was rampant and dentists struggled to keep pace with treatment needs. Dental therapists were introduced to address this excessive demand. However, with the advances in modern preventive dentistry it is far more important to train dental hygienists who can institute preventive measures rather than wait for decay to occur and then treat the problem. Similarly dental therapists are an unnecessary duplication of skills as all operative dental needs can be delivered by qualified dentists.

Specialists.

The current method of training dental specialists is not only a disincentive to dentists to embark on specialist training but is also a significant disincentive for dentists to remain in the public sector after training or to train in areas which are not financially lucrative.

As an example a dentist who trains as a specialist pays $60,000 in university fees to obtain their specialist qualifications, this is in addition to he HECS debt already incurred by the practitioner for their undergraduate degree. The result of this is firstly that there is a major disincentive for dentists to enter specialist fields which are not well remunerated for example oral medicine and special needs dentistry. These are areas of specialisation which impact on those members of the community with the most complex needs and often the least financial resources.

There is an anomaly between the training of medical and dental specialists in that there is no system of paid registrar positions in dentistry. This should be addressed immediately as an incentive for more dentists to take up the option of specialist training.

There should be an intern year for new graduate dentists where they could be mentored within the public sector by more experienced dentists. The registrars could then oversee new graduate dentists undertaking an intern year within the public sector dental clinics. This system would improve the professional competence of new graduate dentists while assisting to alleviate the shortage of manpower within the public sector.

f.) Preventive dental treatments and initiatives.

It is important to remember that in dental decay is a preventable disease. Similarly in most instances periodontal disease is preventable. Despite this dental disease still creates a large cost to the community.

It is essential to implement preventive measures to minimize dental and periodontal disease within the community.

Obviously fluoridation of all community water supplies through NSW should be a priority.

The government should also use any means available to disseminated information regarding preventive dental care, dietary advice and recommended oral hygiene measures.

Prenatal visits should be utilised to educate expectant mothers above the link between low birth weight babies and periodontal disease.

As an example the largest cause for general anaesthetic admissions to hospital in NSW for those under 5 years of age is for treatment of dental disease. Most of this disease could be prevented. There is already in place a network of baby health centres which has frequent contact with all new mothers in NSW. As a large proportion of those children admitted to hospital for dental treatment suffer from "bottle caries". Early childhood nurses should be utilized to disseminate the message that babies should not be put to bed with a bottle. This simple measure if acted upon by parents could save much money and suffering.

Recommendations

A.) Regarding the quality of care:

1. Provide financial incentives for dental practitioners to undertake further study and continuing education.
2. Implement compulsory continuing education for dentists the content being overseen by the Royal Australasian College of Dental Surgeons, the Dental Board of NSW and the Australian Dental Council.
3. Ensure overseas trained dentists have equivalent training to locally trained dentists for their overseas qualifications to be recognized. Ensure that the overseas training included training relating to populations with similar patterns of dental disease to those encountered in Australia.

B.) Regarding the demand for dental services and waiting times for public sector treatment:

1. Act immediately to make employment in the public sector more attractive to dentists.
2. Increase funding to public sector dental facilities. Ensure that increased funding is used to provide increased and improved dental care. Minimize administrative costs.
3. Make the Oral Health Fee for Service Scheme more attractive to private dental practitioners by allowing them to charge an additional fee to the patient above the set fee so that the remuneration they receive equates to their normal fee.

C. (i.) Regarding the Funding and Availability of Dental Services

1. Provide financial incentives for dentists to relocate to rural areas including assistance with relocation costs, government funding of HECS debt, and significant rural placement loadings.
2. Institute an intern year for new graduate dentists.
3. Create paid registrar positions for specialists in training which require the specialists to supervise interns and rotate through rural areas.

C. (ii.) Regarding the Impact of Private Health Insurance

1. Discuss with the federal government the necessity of removing the 30% rebate on ancillary cover for private health insurance and allocate the funds saved to public sector dentistry.
2. Immediately improve pay and conditions in public sector dental clinics so that they match those of the private health fund dental clinics.

D.) Regarding Access to Public Dental Services

1. Immediately increase funding to the public dental sector.
2. Improve access and choice of practitioner for clients of the public dental sector by creating a rebate type scheme similar to medicare. The private dentist should be free to either "bulk bill" or charge their normal fee and allow the patient to obtain a refund of the "scheduled fee".
3. Make public sector employment more attractive by matching the pay rates and conditions of the private health fund dental clinics.
4. Provide a rural loading for dentists willing to relocate to the country.

E.) Regarding Workforce Issues.

1. Cease training dental therapists and redirect the funding towards the training of dental hygienists.
2. Implement an intern year for new graduate dentists.

3. Create paid registrar positions for trainee specialists.
4. Ensure qualifications of overseas trained dentists are equivalent to those of locally trained graduates. Particularly assess the qualifications of dentists entering from New Zealand who were not trained in New Zealand.

F.) Regarding Preventive Dental Treatments

1. Fluoridate all public water supplies.
2. Use the established network of baby health centres to educate new mothers about preventive dentistry.
3. Use pre-natal visits to educate pregnant women about the link between periodontal disease and low birth weight babies.

Yours truly,

Leone Hutchinson

Chair NSW Regional Committee
Royal Australasian College of Dental Surgeons.