Submission
No 75

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation:

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Date Received: 27/05/2005

Theme:

Summary

We are dentists with 20 years experience in private dental practise in Liverpool NSW. We would like to make the following submission 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 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 those practitioners who have a higher qualification for example fellowship of the 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 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. There is in fact no specialist endodontist employed within the NSW public dental sector.

Therefore the quality of care offered to patients of private dental practitioners is very high, but there is a low quality of care offered to those who need to access publicly funded dental services due to inadequate funding.

I have personally referred patients to Westmead Dental Clinic for treatment only to see them receive inadequate care due to the low funding levels available. As an example one patient was sent in late 2002, my radiographs showed 3 interproximal carious lesions. When the lady returned to me in 2005 after numerous frustrations experienced at the clinic only one of these lesions had been treated. The other 2 lesions had remained and grown in the 2 1/2 year gap.

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. The existing 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 if large corporations decide to 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 institute 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 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.

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.

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.) 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.

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 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.

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 must 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 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.)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. Personally approximately 60% of the work I perform each day could be done by a dental hygienist, however, hygienists are in such short supply I cannot obtain one.

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.

There is absolutely no need to train more dentists. Dentists undertake long and expensive training programs and then upon graduation spend a large proportion of their time performing work which can be performed by hygienists. As the graduates of the current dental hygiene programmes enter the work force dentists time will be able to be used more efficiently in the areas of treatment planning and performing complex treatment. Dentists should be the team leaders managing dental hygienists who perform simpler hygiene and oral health education tasks while dentists plan and co-ordinate treatment.

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.

f.) 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.

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" the 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.

Similarly pre-natal visits could be used to inform pregnant women about the link between low birth weight babies and periodontal disease.

Recommendations

1. Institute a system whereby patients eligible for publicly funded dentistry can access care from the private practitioner of their choice where the treatment is partially funded by the government and the gap between the governments payment and the dentists normal fee is paid by the patient.
   This would relieve stress on public dental waiting lists and allow those who could afford to partially fund their dental care access to a wider range of service providers.

2. Use the existing network of baby health centres and pre-natal clinics to educate new mothers about the importance of oral health care.

3. **Train more dental hygienists** so that dentists can use their skills more economically by allowing dental hygienists to take over simpler tasks and dentists can become team leaders in the area of oral health. **There is no necessity to train more dentists.** Dental disease is preventable it is false economy to train more practitioners who treat disease funds should be directed to preventing disease.

4. Encourage the federal government to remove the 30% rebate on ancillary insurance and redirect it to publicly funded dental care.

5. Institute financial incentives to encourage dentists to work in public sector clinics in rural areas. A rural loading of $100,000 per annum would immediately solve the employment crisis in public sector in rural areas.

6. The government should assist small rural communities to offer financial incentives to encourage dentists to practice in rural communities. Private practice in a small rural community is unviable, if local government could offer a sufficient subsidy to make dental practice in small rural communities attractive dentists would relocate to these areas.

Leone Hutchinson and Andrew Howe