Australian Dental Association
NSW Branch

9 September 2021

The Hon. Greg Donnelly MLC
Chair, Portfolio Committee No.2 – Health
Parliament of New South Wales
Email: portfoliocommittee2@parliament.nsw.gov.au

Dear Mr Donnelly,

RE: NSW PARLIAMENTARY INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO THE HEALTH AND HOSPITAL SERVICES IN REGIONAL, REMOTE AND RURAL NEW SOUTH WALES

The Australian Dental Association NSW Branch thanks the NSW Government for the opportunity to provide a submission to this Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW. We wish to highlight specific dental and oral health outcomes, patient experiences, wait-times and quality of dental and oral health care for people who live in rural, regional and remote NSW.

Our submission has been prepared with the input of our members who have experience working in rural, regional, and remote clinics. These include published research and anecdotal evidence or observations as a result of experiences from student dental practitioners through to experienced dental clinicians. We believe this is the most reliable and current evidence of the status of dental and oral health services in regional, rural, and remote communities.

The Australian Institute of Health and Welfare (AIHW) identifies that poor oral health consequences of tooth decay, gum disease and tooth loss, result in a person experiencing pain, discomfort, embarrassment and choosing to avoid eating some foods or take part in certain activities. A recent publication by AIHW revealed that in 2018-19, $5.1 billion was spent on managing and treating tooth decay in Australia and that tooth decay was the most common chronic disease worldwide.[1] Poor oral health is also associated with a range of serious chronic conditions, such as heart disease and diabetes. Tooth loss can affect oral function, appearance and psychosocial function, all of which negatively impact a person's quality of life.[2]

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Historically, oral health has been separated from general health in education programs, delivery of services, health policy and funding. To reduce costs and improve health outcomes, spending on dental and oral health requires a paradigm shift from a surgical focus (such as fillings and root canal treatments) to early intervention and prevention (such as dietary counselling and fluorides). Contemporary dental experts are exploring the role of an 'oral physician', adopting a therapeutic preventative approach to treating dental disease, to improve oral health and support early management of linked systemic conditions. Oral health must be integrated into general health with all health professionals sharing responsibility for oral health promotion and prevention. This huge shift challenges traditional dental practises, requires leadership through change, and capacity building for consumers and the wider healthcare sector.[3]

Multiple factors affect the oral health of people living in regional, rural and remote communities within NSW. These include availability of dental and oral health practitioners, geographical location, costs of treatment, water fluoridation and patient preferences and attitudes toward dentistry and oral health. A lack of effective policy and health system commitment towards oral health in rural regions is problematic, resulting in significant oral health disparities experienced by those living in regional, rural and remote communities.[3,4,5] People living in regional and remote areas have poorer oral health than those in major cities, with oral health status generally declining as remoteness increases. Patients that attended regular appointments displayed better oral health overall, however they usually had a higher income, lived in urban areas and possessed adequate transport to attend appointments.[4,5,6] In NSW the Oral Health Fee For Service Scheme (OHFFSS) provides a dollar amount for eligible patients to seek specific dental treatment in the private sector. Administration of this scheme varies considerably within NSW Local Health Districts, with patients often experiencing frustrations as they navigate between the public and private sectors to use the OHFFSS vouchers. Additionally, as the public dental services are funded proportionately to the size of the population, urban locations gain considerably more funding than their regional and rural counterparts. Redesigning the OHFFSS funding to rural and regional areas to provide greater support for eligible patients to access private practitioners in a public/private partnership model needs to be considered. Recent discussions around oral health workforce looks promising, with the OHFFSS possibly being extended to enable Oral Health Therapists and Hygienists to provide services under this scheme in future. Affordable and accessible dental treatment is required to enable people in rural, regional and remote locations to experience optimum oral health.[7]

Substantial updated evidence confirms that Indigenous Australians living in rural, regional and remote locations suffer a significant disadvantage across a range of socioeconomic indicators such as lack of education, low income, unemployment, low self-efficacy, low health literacy and limited cultural connection, all contributing to a greater burden of dental and oral disease.[8] Multifaceted Indigenous student recruitment and retention strategies, as well as integrating cultural safety curricula into dentistry education, are required to provide appropriate clinicians and safe practices to improve the oral health and well-being of Indigenous people in Australia.[9]

Rural Australians have access to fewer dental practitioners than city dwellers. AIHW data showed that in 2020 the rate of dental practitioners per 100,000 population in major cities was nearly triple

that in very remote areas.[10] Major cities had the highest rate (per 100,000 population) of dental practitioners at 82.3 compared with 61.2 in inner regional, 53.7 in outer regional, 43.2 in remote and 25.8 in very remote areas.[10] This reduced access to professional oral health care services is a major contributor to poor oral health, due to the missed opportunities for people to receive the positive oral health care messages - such as brushing twice daily with fluoride toothpaste and limiting sugary foods, that are delivered routinely at regular preventive appointments. Rural, regional and remote community members are also not able to access adequate dental and oral health diagnosis and care, which further increases oral health disparities.[11] As with all areas of health, delayed diagnosis and management of the most common oral diseases - tooth decay, gum disease and oral cancer, leads to poor oral health outcomes. But further, it is widely accepted that these poor oral health outcomes contribute to the chronic systemic disease burden impacting on, for example, diabetes, heart disease and adverse pregnancy outcomes.[3]

Recruitment and retention of dental practitioners to rural communities is a significant barrier to accessing oral health care in rural NSW. Dental students participating in rural clinical placements gain substantial experiences in professional competencies and skills. However, during their placements they often experience suboptimal internet connections and fewer amenities and activities to participate in during their spare time or on weekends. This can negatively impact dental practitioners decision to work in a rural location upon graduation.[12] Many dental and oral health students and graduates live in the city, with family connections and support networks being in major centres, requiring considerable adjustments to live and work in a rural community away from their families. Lack of access to mentorship and feelings of professional isolation are ever-increasing in this complex landscape. [13,14]

Professional networks available to dental practitioners working in rural locations are harder to access compared to working in the city. There can be limited laboratory support available and few dental specialists for referral to provide optimal patient care.[12] New technology is promising to solve some issues encountered in more isolated regions, both in facilitating better connectivity to professional networks and in dental services. Creating effective community access to tertiary dental specialist services via outreach models in partnership with private sector and public services in regional and rural communities, will improve access for the whole of the community. This would enable and support the delivery of specialist services to improve the oral health disparities experienced by people living in rural, regional and remote locations, as expressed by one of our members working in Far Western NSW.

'Access to dental specialists is hard for private patients and even worse for public ones. We luckily have visiting orthodontists to Dubbo and a visiting Oral-Maxillo-Facial Surgeons but that's it! No periodontists, endodontists, oral med specialists etc. There're no real incentives for them to come west of Penrith.'

A greater desire to work in private dental practice compared to the public sector exists partly due to potential earning capacity as well as the clinical setting. With limited government funds available for dentistry and oral health, public dental facility equipment may be older, less well maintained

and in some cases utilising outdated technology compared to the private sector. Challenges faced in recruiting and maintaining dental practitioners, especially in the public sector, can lead to a higher turnover which can ultimately have an impact on the continuity of treatment for patients.[12,13]

ADA NSW is pleased that improving access to health services in small rural communities is a priority for the Australian Government, with an ongoing budget to provide funding for infrastructure to strengthen the Rural Health Multidisciplinary Training Program (RHMT).[15] Building more multipurpose dental facilities in regional communities will provide collaborative support and increase the likelihood of dental professionals working long term in these locations. Continuation of targeted rural residents' student recruitment into dental and oral health program is vital. Additionally, student placement programs need to be adequately resourced in consultation with oral health and dentistry program coordinators in NSW to ensure continuation of effective student rural placement programs. Up to 40% of surveyed dental students who participate in rural placements during their training indicated that they were likely to practice in rural areas upon graduation.[13]

Geographical distances create a substantial barrier in accessing oral health services, with public services being less utilized when compared to the urban centres, as patients are reluctant or unable to travel the long distances required to attend the closest public clinic. Dentists have often been reluctant to move from urban areas to practice in regional or remote practices, primarily because of the distance from family and established community and lifestyle factors. This lack of long-term retention of practitioners in rural communities leads to more experienced practitioners working in urban areas with new graduate dentists being more likely to practise in rural locations.[16,17] One of our members in Western NSW highlights another barrier based on their experiences:

'Part of the retention issue is related to access to Continuing Professional Development (CPD). Speaking for myself, we have a minimum of 60 hours CPD required over three years and 99% of them are run in Sydney. Adding up the cost of the course plus the day or two off work each way, accounting, food etc. it makes living out here all that more unattractive than ducking into St Leonards on a Friday night or Saturday morning.'

More complex dental treatments may require several appointments to complete. A Western Australian study found that in many instances, patients in rural and remote communities elected to have teeth taken out rather than having more comprehensive dental procedures to retain their teeth, as travelling time was excessive and treatment too expensive.[16,17]

A study conducted by AIHW showed that fewer dentists were located in areas of lower socioeconomic status and the greatest density of private practices were in the urban areas. Eighty-four per cent of practices were located in wealthier areas, in contrast to 74 townships with a population of greater than 500 people lacking dental access for 104, 000 people.[16,17] Costs associated with establishing dental clinics in rural locations and the ongoing running costs to maintain these facilities also need to be considered when exploring the best way to address these disparities.

A greater proportion of children in rural areas experienced lengthy travel times to receive dental and oral care, leading to delayed and neglected management compared with urban counterparts. This results in the progression of many dental problems adding further strain to the rural dental and oral health services.[18] The oral health status of a child has been shown to be a good indicator of the oral health status of an adult, with the consequences of poor oral health in children extending throughout the lifespan into older adulthood where it ultimately places a significant strain on an already over-burdened health system.

Oral healthcare utilisation and dental services amongst older Australians in rural areas can often be predicted by the general socio-economic status. Cost related to dental treatment is the greatest barrier to receiving dental care (32.7%), followed by fear (25.8%) and waiting times (18.1%).[19] Living arrangements; level of education; means of transport and access to healthcare card/pensioner card were consistent barriers for older Australians in accessing necessary care. Utilising the expanded scope of practice for Oral Health Therapists would have the potential to solve workforce issues and provide additional support in rural areas.[19]

Tele-dentistry is playing a key role in improving remote access for rural oral health clinicians. Both clinicians and patients have reported a positive acceptance of tele-dentistry and an increased efficiency in delivery of oral health services. Providing additional dental technology support to rural practitioners would be beneficial to patient care.[20] However, unlike medicine, tele-dentistry is not recognised by the private health funds and so they do not pay a benefit to their members for these consultations. This needs to change to improve the way in which dental and oral health services are delivered.[20] Utilising primary health networks such as primary care physicians to assist with dental and oral health services has improved access and travelling time. This would aid in achieving the paradigm shift required to improve dental and oral health outcomes in rural, regional and remote NSW.[3,21]

As the peak body representing the dental professionals in NSW and the ACT, our focus in this inquiry, is to pinpoint improvements that can be made to prevent poor oral health outcomes and what can be done to ensure the regional, rural, and remote communities of NSW have equitable access to adequate and reliable dental and oral health services. We acknowledge the complexity of issues that have been and will be addressed over the coming months, and recognise the importance of all health care services that will be identified, examined and placed under scrutiny.

We would support the development of the following initiatives to improve access to dental and oral health services in regional, rural and remote areas. We acknowledge that these improvements would require a substantial commitment and a coordinated approach involving government and non-government healthcare organisations and educational institutions. Development and implementation of these initiatives would require a significant and ongoing commitment to achieve adequate funding, education and training.

Our submission includes recommendations to improve patient experiences, student recruitment, as well as factors to consider in developing and retaining a well-trained, resourced and supported

dental and oral health workforce in regional, rural and remoted areas. These are summarised in the following:

1. Recommendations to directly improve patient-centred oral health services

(a) A new approach to the OHFFSS voucher scheme that provides a patient-centred service with a seamless interface between public and private sectors and greater access to oral health services.

(b) Increased access and funding to tele-dentistry services to improve access to diagnostic and specialist oral health care.

(c) Continued support and development of the Indigenous oral health workforce for the provision of culturally appropriate care for Indigenous Australians.

2. Recommendations for dental and oral health practitioners and specialists

(a) Ensure adequate dental equipment and resources are available within rural communities to enable dental clinicians to engage in a broad range of clinical experiences to provide job satisfaction.

(b) Adequate funding to create effective public access to tertiary dental specialist services via outreach models involving private/public partnership in regional and rural communities.

(c) Improved availability of continuing professional development (CPD) courses in regional areas and/or funding support to attend urban CPD. Facilitation of professional connections and networks for dental clinicians working in regional locations.

(d) Acceptable renumeration and career incentives to encourage dental practitioners to consider long term employment in regional, rural and remote locations.

(e) A new approach to the OHFFSS voucher system where regional, rural and remote areas receive adequate and ongoing funding to support the growth of sustainable private oral health services and create an improved public/private model of care.

(f) Provision of private health fund benefits for tele-dentistry consultations.

3. Recommendation for dental and oral health students and new graduates

(a) Continue to allocate a targeted percentage of places to students from Indigenous and regional backgrounds into dental and oral health training programs in NSW.

(b) Increase incentives, such as payment of dental and oral health tuition fees if 'bonded' to regional locations upon graduation (e.g. payment of a year's tuition fees for each year of service).

(c) Ensure adequate experienced dental clinicians are available to train and mentor dental or oral health students whilst on rural placements, in conjunction with the RHMT infrastructure program. This requires an integrated private/public model to support ongoing development and success of this program.

(d) Provide allowances and incentives, including transport, accommodation and living expenses, for dental and oral health students to conduct placements in regional facilities.

Summary

Dental and oral health disparities in rural, regional and remote NSW are significant. Incorporating oral health into general health will broaden the role of oral health clinicians beyond dental treatment to the provision of patient-centred preventive primary care, bridging the gap between oral health and general health. The following initiatives are required to adequately address the disproportionate provision of oral health care to people living in rural, regional and remote locations:

- Ongoing targeted student recruitment and retention strategies to increase access to preventive, diagnostic and oral health treatment for rural residents.
- Provision of collaborative rural placement experiences for dental practitioners during training.
- Incentives for dental and oral health graduates to live and work in rural, regional and remote NSW.
- The use of technology to overcome some of the barriers of remoteness.

Only when these barriers are addressed will a dental and oral health workforce be available to deliver the best services in rural, regional and remote NSW and diminish existing oral health disparities.

Yours sincerely,

Dr Kathleen Matthews
President

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