

Rural and regional dental care scheme

Providing better access for all



People in rural areas, particularly those in remote areas, often have poorer overall health status than those in metropolitan areas. This is reflected in their higher rates of mortality, disease and health risk factors.¹ In addition, people in rural and remote areas show greater socioeconomic disadvantage, have fewer educational and employment opportunities and particularly, in remote areas, have less access to fresh fruit and vegetables.

Distance and poor access to health care facilities and services are also seen to be barriers to accessing appropriate and timely health care.² People living in rural and remote areas have worse oral health status, less access to dental care and fewer dentists.

Nationally, more than 500,000 people on dental waiting lists with an average wait for basic dental care taking 27 months. Apart from the individual health and psychological costs associated with poor dental health, it is estimated that oral disease results in around one million lost work days per year and costs the economy approximately \$2 billion in direct costs and lost productivity.³

The Greens' integrated primary health care centres will include dental care. This will be funded by an investment of \$4.3bn pa in Denticare, a universal dental care scheme and the creation of dental Medicare provisions to provide basic dental care for the total population.

The Greens Rural and Regional Dental Care Scheme outlines specific measures in addition to our universal dental care scheme, Denticare, to address these problems.

The Greens will:

- **Provide rural incentives by**
 - Establishing Medicare schedule fees supplemented by incentive payments for dentists, dental hygienists, dental therapists, oral health therapists and GPs working together to provide access and services in rural areas.
 - Ensure that the new rural Medicare Locals provide similar recruitment and retention incentives for dental and oral health professionals as GPs currently receive.

¹ Australian Institute of Health and Welfare, Australia's health 2008, AIHW, Canberra, 2008, p. 80, viewed 28 May 2010,

² Ibid, pp. 81–82.

³ 'Dental and Oral Health Policy Paper by Professor Stephen Leeder and Dr Lesley Russell, Menzies Centre for Health Policy, (September 2007)

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- Introduce a HECS rebate for new graduates for every 12 months of work completed in rural/remote private or public dental positions similar to the arrangement for doctors.⁴ This will be set at a rate of one fifth of their HECS medical fees reimbursed for each year of service similar to the HECS Reimbursement Scheme for doctors which aims to promote careers in rural medicine.⁵
- Integrate continuous learning and personal development for dental providers as part of primary healthcare services to include:
 - Person and family-centred oral health care
 - Addressing inequities in oral health outcomes and access to dental care in at-risk groups
 - Community development addressing the social determinants of health
 - Cultural awareness in service delivery
- Develop a National Rural Dental Workforce Policy⁶ that:
 - Determines a target number and mix of rural dental professionals, based on appropriate provider population ratios linked to the risk-adjusted needs of rural and remote populations
 - Synthesises and disseminates research into best practice models of service that integrate public, private and dental specialist care, promote recruitment and retention of professional staff and link with the primary care system.

4 Improving access to dental care in rural and remote Australia Supplementary Submission in response to NHHRC Interim Report April 2009, viewed 28 May 2010

5 The doctor's HECS Reimbursement Scheme is administered by Medicare: the latest annual report states 699 payments were made to 450 medical graduates in 2008-09 at a cost of \$4.2 million. (Source: Medicare Australia, Annual report 2008-09, p 61)

6 Improving access to dental care in rural and remote Australia Supplementary Submission in response to NHHRC Interim Report April 2009, viewed 28 May 2010

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Poor oral health status in rural and remote areas

There is considerable evidence to show that consistent with general health status, people outside of capital cities also experience poorer oral health. The National Survey of Adult Oral Health 2004–06 found that:

- Complete tooth loss was more prevalent among older age groups and non–capital-city residents
- Inadequate natural dentition (having less than 21 teeth) was more prevalent among non–capital-city residents
- Untreated decay was more prevalent among residents of non–capital-city areas than capital-city dwellers
- People living in non–capital-city areas were:
 - less likely to visit for check-ups (ie preventative measures)
 - less likely to make an annual dental visit
 - less likely to have a particular dentist that they usually visit.
- People living in non–capital-city areas were less likely to have made a dental visit within the previous 12 months, and those who had visited were:
 - more likely to have had one or more teeth extracted
 - less likely to have received a professional clean and polish.⁷

Lack of dentists in rural and remote areas

Consistent with general health, the uneven distribution of the dental labour force also appears linked to variations in oral health status and access to dental services across regions. In 2003, 78.4% of all employed dentists worked in 'Major City' areas. 'Major City' areas have a higher rate of practicing dentists, 57.6 dentists per 100,000 population compared to 18.1

⁷ Geographic variation in oral health and use of dental services in the Australian population 2004–06, AIHW Dental Statistics and Research Unit, Adelaide, January 2009, http://www.arcpoh.adelaide.edu.au/publications/report/research/pdf_files/rr41_geographic.pdf

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in 'Remote' areas'. In terms of timeliness of access to quality dental care, people in rural and regional areas were more likely to have to wait longer for a dentist appointment than those in major cities.⁸ The average waiting time in capital cities was 1.6 weeks; for rural and regional areas the average waiting time was 3.9 weeks. The distribution of the allied dental health workforce follows a similar pattern to the dentist workforce.

One recent survey of rural and regional health professionals in Western Australia found that unlike other medical professionals, insufficient demand for services could prompt rural dentists to leave rural practice. If patients cannot afford dental care they go without. It was suggested that the lack of ongoing education, support and services reimbursable under Medicare were the significant contributory factors.⁹

⁸ D N Teusner, S Chrisopoulos, D S Brennan, Geographic distribution of the Australian dental labour force, 2003, AIHW Dental Statistics and Research Unit, Adelaide, 2007, p. 27, viewed 28 May 2010, http://www.arcpoh.adelaide.edu.au/publications/report/statistics/pdf_07/dlf_2003.pdf

⁹ Estie Kruger and Mark Tennant, 'Oral health workforce in rural and remote Western Australia: Practice perceptions', Australian Journal of Rural Health, (2005) 13, 321–326, viewed 28 May 2010, www.aurha.org.au/wpcontent/uploads/2008/05/oralhealthworkforcerural.pdf