Rural Health Information Paper No: 2

“Fighting Rural Decay - Dental Health in Rural Communities”

June 1998
Rural Health Information Paper No: 2

“Fighting Rural Decay - Dental Health in Rural Communities”

June 1998
National Rural Health Alliance 1998

Rural Health Information Papers
ISSN 1329-9905
ISBN 0 9585263 3 8

This paper is published by the NRHA to promote discussion and understanding of matters which influence the health of people in rural and remote Australia. The views in it may not reflect those of individual Member Bodies of the NRHA.

Reproduction of this work, in part or full, is encouraged, with appropriate attribution to the NRHA.

Price of Paper $10

Enquiries: NRHA (Publications)
PO Box 280
DEAKIN WEST ACT 2600
Telephone: (02) 6285 4660
# Contents

Introduction iv  

Executive Summary 1  

NRHA’s Written Submission to the Senate Inquiry into the Provision of Public Dental Services in Australia 3  

- The National Rural Health Alliance 3  
- Socio-Economic Status and Health 3  
- NRHA Policy on Dental Health 4  
- Developments in 1998 5  
- Recommendations 7  
- Submission to NRHA from Dental Services, WA 8  

NRHA’s Evidence 11  

Media Release: 6 March 1998 21  

Acknowledgments 23  

NRHA Publications 24
Introduction

The National Rural Health Alliance is the peak non-government body working to improve the health of people living and working in rural and remote Australia. It has nineteen Member Bodies, each of which is a national organisation in its own right. They represent the consumers of rural and remote health services and most of the professions involved directly with health services in country areas.

One of the aims of the Alliance’s work is to increase the profile of issues that matter, and the level of discussion and understanding about them. One such issue is the status of dental and oral health and the access to services for it.

The main focus of this Paper is dental health in rural and remote areas and, in particular, how it has been affected by abolition of the Commonwealth Dental Health Program. Those on low incomes in rural and remote areas were among the main beneficiaries of the Program. With its abolition, access to preventive dental care for such people was made even more problematic.

This Paper is also of interest to those concerned with general issues of access to services and of community participation in rural and remote areas. The NRHA’s Evidence to the Senate Inquiry is reprinted here and provides broad views on service delivery to rural and remote communities.

We hope that the ideas and proposals in this Paper will inform the process of providing services in rural areas, including for dental health.
Fighting Rural Decay - Dental Health in Rural Communities

Executive Summary

Dental and oral health are important determinants of overall health. Despite this, they do not always receive the attention they deserve.

Dental health issues in rural and remote areas are dominated by the same factors related to overall rural and remote health services. The key challenges are ensuring access for people in need and providing people, wherever they live, with options which suit their particular circumstances.

It is the Alliance’s view that termination of the Commonwealth Dental Health Program (CDHP) has greatly increased inequities for consumers of dental care. Because its emphasis was on those with least ability to pay and with fewest options, the CDHP was an important part of the safety net in health services. Many of the clients of the CDHP were those in greatest need: people on low incomes who had limited access to dental care and few options for care. Termination of the scheme has created significant disadvantage. This is regrettable, especially given that it was clearly meeting a demonstrated need.

In the health area there are already many challenges which are difficult to meet because of their complexity. It is a pity to create another area of need from a situation where a relatively low cost scheme was meeting its objectives.

The Alliance recommends that the Commonwealth work with the States to put in place a subsidised dental health program for low income people and those with poor access to dental care. People in rural and remote areas, particularly if they have low income, should be prime targets for such a program.
NRHA’s Written Submission

THE NATIONAL RURAL HEALTH ALLIANCE

The National Rural Health Alliance is the peak non-government body working to improve health outcomes for rural and remote health. It has nineteen Member Bodies, each of which is a national organisation in its own right. They include consumer groups and those representing the major professions providing health care in rural areas.

The Alliance uses a broad definition of ‘health’ and has a strong multi-professional focus.

The views in this submission have been collected from Member Bodies of the Alliance.

Further details about the Alliance are provided in its Annual Report and in its other publications, listed on page 24.

SOCIO-ECONOMIC STATUS AND HEALTH

There is a strong correlation between socio-economic status and health. Income level is positively correlated with health status: the lower the income, the lower the status of health. This situation is compounded by the fact that people on low income are less able to buy goods and services related to health and less able to pay the costs involved in accessing them.

This situation is compounded still further in rural areas by the relative lack of availability of goods and services required for good health, including health services themselves, and their relatively high cost (where they are available).

What this means is that poor people in rural areas are amongst the neediest as far as health services are concerned. Although the data are imperfect it is clear that, in general, the more remote a person is (meaning the more isolated is their physical circumstance), the more likely they are to experience poor health. Much of this poor health comprises illnesses and accidents which are avoidable. These facts are shown by data from the Australian Institute of Health and Welfare and are contrary to perceptions about life in country areas being healthy.

The NRHA is an advocate for rural and remote people. It recognises, however, that there are many people in Australia’s major cities who are poor and who have little access to the health services they require. Such people are, in a sociological sense, ‘remote’ despite living in metropolitan areas.

The NRHA spends considerable time and effort in distinguishing issues which are peculiar to rural and remote areas. For dental health there is anecdotal evidence that the situation is proportionately worse in rural and remote areas than in the cities. This is because good dental care of the preventive type is an optional service which is affected by the ease or difficulty of accessing it. Because many country people have to make a special trip for such optional services, there is a tendency for them to be postponed until acute care is required.

Another characteristic of rural and remote areas which affects dental health is diet. In some areas there is a limited range of affordable fresh produce, including fruit and vegetables,
Despite the fact that the bulk of such products overall come from country areas. This affects the health of people in remote Aboriginal communities in particular.

Also, many people in rural and remote areas have water supplies which are not fluoridated.

Available evidence about the Commonwealth Dental Health Program shows that many of its clients lived in rural and remote areas. It is clear that it filled an area of real need for country communities.

**NRHA POLICY ON DENTAL HEALTH**

**Background**

Oral diseases, in particular dental caries and periodontal disease, are a significant and costly burden for Australians even though most of them are caused by individuals’ lifestyles and can be significantly reduced or prevented. Dental caries is the second most costly disease related to diet after disease related to alcohol.

Eighty-eight percent of dental services are provided in the private sector through dental surgeries and denture clinics, and the remainder through public dental services, like the school dental service, hospital dental services, community health services and Aboriginal medical services. Both sectors provide services under the Pensioner Denture Scheme and through Veterans Affairs. The Commonwealth Dental Health Program also involved both private and public sectors. Of the ancillary benefits paid through private health insurance, 56% are for dental services and this figure has been rising steadily since 1989.

Rural and remote dwellers attend dentists slightly less often than other Australians (51% against 55% attending in the last year and 15% against 19% attending twice in the last year). They have to deal with much longer waiting times for routine service at public and private surgeries - up to 2.5 years in rural NSW against 7.5 months in Sydney - and may have to travel long distances to specialist services.

One of the reasons for the waiting lists is the undersupply of dentists in rural and remote areas. For example, 18% of Victorian dentists work outside Melbourne where 29% of the population live.

Eighty percent of private sector dentists work in solo practice which increases the sense of professional isolation and hinders the development of quality assurance through peer review and professional support.

There is no uniformity in the training, role definition and even the presence of the various groups within the dental health workforce. In particular the educational preparation, conventional role and statutory restrictions on dental therapists, hygienists and prosthetists constitute a rigidity in the system and a possible barrier to efficient service delivery.

The Commonwealth Dental Health Program was started in 1994 to provide services through the private sector to low income earners who had been waiting up to three years for dental treatment. It was effectively terminated at the end of 1996. Queensland is currently the only State in which the program has been continued with funding from the State Government.
Issues

- There is broad agreement that the dental health needs of young adults, the aged, rural and remote dwellers and those in lower socioeconomic groups are not met through either public or private dental practice and get less comprehensive treatment. For example, an extraction is more likely if the patient is young and of low socioeconomic status.

- Dentists’ reasons for not taking up rural practice parallel those of doctors ie lower earning capacities (private sector dentists are one of the highest paid professions in metropolitan areas), lack of professional support (including from specialists), lack of continuing education (especially for assistants, technicians and prosthetists) and lack of employment, health and educational opportunities for spouses and children.

- Dental health care still focuses on sporadic pain relief (or extraction, for people in a low socioeconomic group) rather than broader and preventive oral health care. Continuity of oral health care is important but there is a financial barrier to children shifting from the primary school dental clinic to private sector treatment. The way through the financial barrier is to demonstrate that you have been in need of care for a considerable period of time.

- There is an attempt to meet current demand for professional development for the rural dental workforce through continuing education programs in universities, professional associations and through companies. However, there remains unmet need for the kinds of training other rural health professionals want, that is clinical expertise, health promotion and training in communication with clients.

- Because so many dentists work as sole practitioners, there is a severe problem with professional isolation. A teamwork approach involving the dental surgery, support from specialists, networking with other health and with schools and local government will break down the isolation of rural dentists and result in better oral health care.

- Fluoridation of the water supply has been one of the most effective public health programs in Australia. It has resulted in significantly lower numbers of dental caries in the young population in areas with fluoridated water. This program should be continued where it exists and extended to those areas where it has not been implemented.

DEVELOPMENTS IN 1998

The Alliance was not formally represented at the Melbourne seminar convened by Dental Health Services Victoria in January 1998. However, the Alliance was involved with that meeting and supports the ‘Call for Action’ which resulted from it.

The following comment was received in late 1997 from the Australian Dental Association Inc in response to one of the Alliance’s publications:

“It is noted that the submission does not refer specifically to dental health. In rural and remote areas, the provision of dental services suffers from shortages of dental workforce and specific needs for high risk groups, particularly aboriginal people. It is important that any targets set include the attainment of dental health for the rural population.”
The following comment was provided from the Queensland Medical Superintendent of the Royal Flying Doctor Service:

“Certainly every need analysis I have read including those done by the Far North Queensland and Northern Rural Divisions of General Practice (relating to our Cairns and Mt Isa Bases respectively) has dental services as a priority. I expect similar from the Central Division needs analysis currently in progress in encompassing our Charleville Base.”

Information from AIHW shows that city dentists outnumber rural dentists by nearly two to one. There are 29 practising dentists per 100,000 population in regional and rural areas compared to 51 per 100,000 population in capital cities.

The Alliance notes and supports the submissions made to the Senate Inquiry by the Australian Council of Social Service (ACOSS)/Public Health Association of Australia (PHAA), and the Council on the Ageing.

The following specific points were made to the Alliance by Health Consumers of Rural and Remote Australia, one of the nineteen Member Bodies of the Alliance:

- in remote areas, the operation of a public dental practice is not often economically viable due to the access issues of the constituents;
- rural areas need subsidised care to ensure the commercial viability of the service;
- the CDHP allowed for many areas in rural Australia to have a public dental care service for the first time. With its abolition, rural and remote Australians will be without ready access to dental care;
- families will only visit the dentist when their problem reaches crisis point;
- as a result, the general health and wellbeing of the individual and the whole family will suffer;
- the increased waiting time that now exists is only set to increase with the cessation of funding for CDHP;
- the limited transport available means that families must travel for a substantial time for their long-awaited appointment and must incur additional accommodation and out-of-pocket expenses. These expenses, including the increased real cost of dental services, will be too great for those on low incomes.
RECOMMENDATIONS

1. The Commonwealth should work with the States to put in place a subsidised and targeted dental health program for low income people and others with poor access to dental care. People in rural and remote areas, particularly if they have low income, would be prime beneficiaries of such a program.

2. The Commonwealth and State Governments should adopt the minimum national service targets for dental care, and the actions to meet them, specified in the communique from the national seminar held in Melbourne on 16 January 1998 and convened by Dental Health Services Victoria.

3. Public health strategies for dental and oral health should be developed by governments, including through the Public Health Partnership. Such strategies could include oral health promotion programs in schools and workplaces, fluoridation, appropriate regulation in food and drink industries, and targeted outreach programs to people in special need.

4. The professional development needs of dental health workers must be met by collaborative action between governments, the profession and consumers, and should be planned in conjunction with professional associations, dental service managers, corporate partners and consumers.

5. There is a continuing role for the Rural Health Support, Education and Training (RHSET) Program to help develop collaborative approaches to improving the availability of dental health and oral hygiene workers in rural areas. The emphasis should be on finding those approaches which work well in rural and remote areas.

6. A more equitably distributed dental workforce could be achieved by the establishment of a Rural Dental Practice Incentive Program along similar lines to the General Practice Rural Incentives Program (GPRIP).

7. To support this program and bring about greater co-ordination of dental practice and a greater standardisation of dental training two further things are needed. First, a review of dental training education and accreditation should be promoted by AMHAC to integrate the national oral health workforce. Second, there needs to be a Dental Practice Evaluation Program (like the General Practice Evaluation Program for doctors) to enable the oral health workforce to evaluate current practice, consider networked forms of practice and to consider major issues for the future of dental practice.
The Senate Inquiry on Dental Services for Low Income Earners - The Rural Implications

- Dental disease affects most older adults.
- Those who are the poorest in our society cannot afford private dental care and frequently receive no routine care, attending only for the relief of pain and sepsis.
- WA has had a program providing subsidised basic care for many years for those who cannot afford to pay the full cost. The level of subsidy has varied with co-payments of 20-25%.
- WA has a program providing care for those in rural and remote areas where private practice does not exist. Those who are eligible receive subsidised care, those who are not, pay 100% of the fee. The fee schedule is based on the Department of Veterans Affairs’ LDO Schedule, and is substantially lower than private practice fees.
- In rural areas where private practice exists, and the practitioner is prepared to participate, eligible patients’ treatment is subsidised to 75 or 80% of the fee. The fee schedule for the program (The Country Patients’ Dental Subsidy Scheme - CPDSS) is again based on the DVA schedule.
- The Commonwealth Dental Health Program (CDHP) which co-existed with State programs provided a limited range of treatment free of charge to Health Care Card Holders. That care was up to $100/annum for emergency care or $400/annum for general care.
- The CDHP ran from July 1993 to December 1996 in WA.
- About $10 million/annum was allocated to WA.
- The funds were used to support care through government clinics and private practice.
- The emphasis of the CDHP was to restore and save teeth. This changed many people’s expectations and this expectation continues.
- The CDHP was available to about 400,000 people in WA. This would equate to about 100,000 in rural and remote WA.
- The State adult dental programs have more stringent eligibility criteria and are available to about 65,000 rural people.
- The School Dental Service covers the whole of WA and provides general dental care, free of charge to all children from pre school to Year 11.
- With the cessation of the CDHP, waiting lists have grown in all adult programs from about 3 months to an average of about 9 months. They continue to grow.
- Funding for the CDHP amounted to about 40% of funding for adult services since its inception.
- This reduced funding will be reflected in the amount available for the CPDSS.
- The current level of co-payment (25%) is well accepted and permits further service provisions.
There is currently a national push to have the Commonwealth participate in the funding of oral health care initiatives. Some of those targeted program proposals are:

- Pre school children
- 18-25 year olds
- The elderly, including home bound and institutionalised aged
- Rural and remote communities
- Indigenous Australians

Specific Rural Outcomes of Loss of CDHP

1. Reduction from 100,000 to 65,000 people eligible for subsidised dental care.
2. Significant reduction of services to rural and remote people with family income of $22,000 or less. The majority of these people will need to seek care at the full private fee.
3. Waiting times growing significantly.
4. Expectation of tooth retention and ongoing preventive care unable to be met.
5. Funds for new services to developing communities not available.
6. Funds to provide services where private practitioners have ceased in country towns not available.

Recommendation

- The Commonwealth again provide program specific funding to the States for the public dental program for the financially disadvantaged.
- The new program to include a co-payment of 25%.
- That the States and Territories continue to fund existing dental health programs.
- National goals for oral health be set. WA to participate in the process.
- WA support national moves for highly targeted additional programs for the following Commonwealth Health Card groups.

- Pre school children
- 18-25 year olds
- The elderly, including home bound and institutionalised aged
- Rural and remote communities
- Indigenous Australians

P V JARMAN
ACTING DIRECTOR
DENTAL SERVICES
NRHA’s Evidence

Friday, 6 March 1998 SENATE—References CA 59
[1.33 p.m.]

BROWN, Ms Margaret Irene, Chairperson, Health Consumers of Rural and Remote Australia, PO Box 280, Deakin West, Australian Capital Territory 2600

FOLEY, Ms Michele Anne, Project Officer, Health Consumers of Rural and Remote Australia, PO Box 280, Deakin West, Australian Capital Territory 2600

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance, PO Box 280, Deakin West, Australian Capital Territory 2600

SHORT, Ms Leonie, Convenor, Oral Health Special Interest Group, Public Health Association of Australia, and friend of the NRHA, c/- PO Box 280, Deakin West, Australian Capital Territory 2600

CHAIR—Welcome. Ms Short, do you have any comment to make on the capacity in which you now appear?

Ms Short—I am a co-opted member as someone who has done some rural oral health research.

CHAIR—The committee has before it submissions from your organisations. Do you wish to make any alterations to those submissions?

Mr Gregory—We do not, thank you.

CHAIR—I now invite you to make a short opening statement and, at the conclusion of your remarks, I will invite members of the committee to put questions to you.

Mr Gregory—Thank you, Senator. We propose, with your permission, to do it in three sections if we may: first of all, a brief submission from Margaret Brown, then one from me and, finally, one from Leonie Short.

CHAIR—Certainly.

Ms Brown—Thank you for the opportunity of coming here today. Our organisation strives to ensure that people living in rural and remote Australia have the opportunity to have input and to have a say, so this is one such opportunity. We believe that Australians’ basic right is to have dental services which are affordable and accessible. Ready access must be available specifically in times of crisis and on an ongoing basis for preventive treatment and care. I believe that this really is a vital issue, particularly in the more remote areas of Australia. I will just cite you an example which I was told yesterday. One particular family living on a station between Port Augusta and Alice Springs at this very time have a child with
an abscess. The nearest major town is Coober Pedy, which is 350 kilometres away but is unable to retain a dentist. The Health Commission in South Australia, in conjunction with the RFDS, have a monthly allied health fly-out from Port Augusta, and that used to include a dentist, but at this stage they cannot provide that service either because of the lack of dentists. There is a dental technician in Port Augusta, which is 900 kilometres away from this particular station. So just giving you the picture, you have a child who is in a great deal of pain; yet the distance to travel to access the service is really quite incredible. And I do not think that people realise sometimes the circumstances that these families are in.

You may well say that, as I have been told before, this is a State issue, but if that is the case then people in the community need to know. One of the things I have been noticing lately is that people do not know which things the State or the Commonwealth is responsible for. So I think that somehow we need to get that information out too. We believe that the Commonwealth, in collaboration with the States, should subsidise a quality dental health care program and that a thorough investigation of the gaps in the dental program should be made, and then programs targeted to meet the needs of people in rural and remote Australia. I know Leonie was talking about preventive care, and I believe that when we look into the services in rural and remote Australia we also need to find out whether there is a preventive health care program going through from family day care right through kindergarten and the schools, because nutrition and preventive health have a great deal to do with the care of people’s teeth.

I think that is where I will end. I just believe that people need to be aware that there are no 24-hour services; there is no crisis care when there is an accident or anything like that. Like most people, I would have to travel 2½ hours from where I live to obtain any sort of dental care. I am not knocking the really remote but I am isolated. So it is an issue.

CHAIR—Thank you, Ms Brown. Mr Gregory.

Mr Gregory—Thank you, Senator. The National Rural Health Alliance is the peak non-government body for rural and remote health. It is comprised of nineteen Member Bodies, each of which is a national organisation.

The Alliance represents both consumers of rural health services and all of the major professional providers. Its members include:
• three consumers’ organisations - the Country Women’s Association of Australia, HCRRA and the Isolated Children’s Parents’ Association;
• two indigenous health organisations;
• three representing rural doctors;
• three representing rural or remote nurses;
• two rural allied health professional organisations;
• rural pharmacists;
• health service managers;
• the Royal Flying Doctor Service;
• the National Association of Rural Health Training Units;
• the rural policy group of the Australian Healthcare Association; and
• a community health interest group.
The Alliance has a very broad definition of health and is interested in the social and economic determinants of health status, as well as health policies and programs directly.

Overall, the status of rural health is worse than in the major cities. In general, the more remote the individual, the worse his or her health is likely to be. This situation is exacerbated by relatively poor access to health services, few options, higher costs, and an adverse cultural approach to health matters in country areas.

Poverty is one of the strongest determinants of poor health. The NRHA supports the submission made in Melbourne in January 1998 by the Australian Council of Social Service. Those in rural areas who are poor are doubly disadvantaged.

As with other aspects of overall health, the majority of oral and dental problems could be significantly reduced or prevented with appropriate care and early treatment. The Commonwealth Dental Health Program (CDHP) was clearly meeting a need for people on low incomes, including many in rural and remote areas.

Evidence from Western Australia is that the CDHP was available to about 100,000 people in rural and remote parts of that State. Since its termination in December 1996, the number of people in country parts of Western Australia eligible for subsidised dental care has fallen to 65,000.

There are already a large number of ‘challenges’ for governments in rural and remote health. Notable among these are:
- improving indigenous health;
- providing mental health services to country areas in a time of de-institutionalisation;
- care of the elderly;
- securing an adequate supply of well-trained health professionals; and
- providing continuity of acute care in an environment of overall cost-savings and rationalisation.

All of these are important but complex issues with which governments, community groups and professional organisations are currently grappling. There is an opportunity for Commonwealth and State Governments to collaborate to broaden the availability of dental health services for needy people, and the previous program shows how this can be achieved.

The NRHA therefore hopes that the major political parties will both use their electoral platforms to announce a new program to meet this urgent and fundamental health need. The NRHA also supports the broader long-term proposals, including those relating to the oral and dental health workforce and to health promotion, presented to the Inquiry by the Public Health Association of Australia.

CHAIR—Thank you, Mr Gregory. Does anyone else have anything to contribute at this stage?

Ms Short—Yes. I would like to just build on what Gordon Gregory has said. Particularly when I have worked in the public health field, we have seen many incentive programs there for medical practitioners. The lobby groups like the rural doctors association, rural nurses, etcetera have done a good job, but there is still a lot more to be done to highlight the issues
and the disadvantages that our rural consumers face. However, the Commonwealth has actually set up many programs for medical services. We have got general practice evaluation programs. We have got general practice rural incentive programs. We have many RHSET—Rural Health Support Education and Training—programs for medical and nursing and allied health professionals. Only about two or three of these RHSET programs have actually been for oral health. The Commonwealth government invests millions in particular programs to improve general medical practice in Australia. There are specific programs for rural medical practice. I am calling on the inquiry to consider similar programs to improve rural dental practice to help support the rural oral health work force and to support those rural oral health workers out there throughout Australia. So it would be on very similar lines to what the Commonwealth is already doing for general medical practice.

CHAIR—Thank you, Ms Short.

Senator KNOWLES—As two Senators who come from Western Australia, we sympathise and empathise with you a lot in terms of the difficulties of remote parts of Australia. I noticed, Mr Gregory, that you said that the more remote, the worse the health, and that that can be addressed with appropriate care and early treatment. I do not think anyone would disagree with that philosophical position. How do you believe that that can be best delivered? If you like, you can treat it even as a more general question and not just relating to dentistry. No-one would say that in an ideal world we would not want access by rural and remote people to every single, solitary service facility that someone would have in a metropolitan area. That would be the ideal world. But it comes down to what Ms Brown was saying about her son: no-one would want a child to go through what your son is obviously going through at the moment. How do you see that we would be able to deliver better services to rural and remote areas, and at what cost?

Mr Gregory—Thank you, Senator. I have three comments. First of all, on health promotion, the Alliance believes that we have yet to find out the best means of implementing health promotion in rural and remote areas. In other words, it is clear from the National Rural Public Health Forum which the Alliance organised in Adelaide in October 1997 that there are some good things going on in country communities related to health promotion. It does not matter how small a community is, if they have the right characteristics of leadership, ability, activities, options and perhaps access to telephone calls for up to maybe a couple of hundred dollars, they are able to involve themselves in useful health promotion activities. The challenge for governments is to try to find out how the communities do this and to support them and foster them in health promotion activity which will succeed in having individuals and families, however remote, looking after their own health better than they are currently doing it.

Secondly, in relation to health promotion campaigns, Australia has a good record of health promotion campaigns on a number of selected fronts. The Alliance believes, however, that there is some value added to be gained from those campaigns in rural and remote areas. In other words, however successful the campaigns have been, whether we are looking at immunisation, smoking or HIV-AIDS, there is a positive suggestion that they could be tailored, perhaps at the edges, to fit better with the circumstances of rural and remote areas.

Senator KNOWLES—But how do you suggest that that is done?
Mr Gregory—The first thing to do is to ensure that the people designing, evaluating and managing the program talk to the people out there in remote areas and understand the real characteristics of remote communities. Let us talk about the remote ones because they are the most needy if you like. We need to ensure that there is good communication. Currently, the situation, as you would well know, is that remote people are deprived, not only in terms of health services, but in terms of access and information. It costs a lot more for an agency of health or any other to genuinely collaborate with a remote community than it does with a metropolitan community. But that is a cost which the Alliance believes has to be borne.

Senator KNOWLES—Do you think that the role of the Internet, for example, is going to be greater and enhance what you are trying to strive for in the foreseeable future? I realise a lot of people in the country are not on the Internet.

Mr Gregory—That is exactly the point. The Alliance regards electronic communications as being a double-edged sword. It is certainly enhancing the ability of people who have access to communicate, but as you have just said, Senator, there are large numbers of people who, through no fault of their own, cannot access it because of the quality of the telephone line or whatever it is. While we are dependent upon landlines, we have to be very careful, in the Alliance’s view, that we do not actually increase the bipolar situation in terms of information and communications. It would be a mistake, the Alliance believes, to push all of our information and all the results of our research down the wire because it will make the position of those who do not have access to the wire even less equitable than it is currently. But, yes, there are some good things happening, as we all know, in telehealth. I guess the big breakthrough for the people with whom you are concerned in remote areas will be when we escape from landlines of copper wires or whatever they are made of.

Ms Short—Many years ago at a rural health conference in Armidale that I was attending, the head of the Country Women’s Association got up and said that the two things we want for rural health are a telephone line and a sealed road. I do not think much has changed today.

Senator KNOWLES—I think much is changing. I think we have seen a lot changing over the last four or five years in particular but there is still a long way to go and anyone would have to recognise that. I know that these questions are far more general but, considering the Democrats called the thing on just dental health and they are not here, I thought I would just actually come across and—

Senator FORSHAW—we have got that on the record.

Senator KNOWLES—They put us through this but they do not turn up. I have a longstanding interest in health care issues, particularly in rural and remote areas, and that is why I am asking you these general questions, so could you forgive me for that. I still want to know where you are directing your efforts as to the best way we can deliver those services. It is worrying me. Forgive me for personalising it to Western Australia. If you look at remote areas in the Kimberley like Halls Creek and Fitzroy Crossing, then you come down to areas in the Pilbara and in the desert and if you get out to the goldfields and so forth, those people are squillions of miles away from anywhere. You are the people who are really focusing on this all the time and I am interested to know how you suggest we get that up-to-date information to people. I think prevention matters are as important as anything else. From my trip through the
Kimberley and so forth last year, I understood that there was more information getting out there than previously.

Ms Brown—One of the things that we use is the local media. A lot of the schools and things like that have school newsletters that go out. Sometimes the local hospitals or community health services have their own little bulletins. In South Australia where I live there are the Stock Journal and the farmers’ papers and we use those too because the farmer does not read anything else. The whole family seems to read these to see where the cattle sales are and all the rest of it. If you slot them in there, they often pick them up. We also use local radio.

Senator KNOWLES—Are you suggesting that government should be involved in that more so?

Ms Brown—Yes, I think so. I think everybody should be. I do not think that it needs to be an organisation. I think that we are all concerned with these issues, so therefore we all should be doing something about it.

Mr Gregory—An important general response to your general question is that the Alliance observes that whenever you look at a recommendation for improving rural and health services, somewhere in its preamble there will be the statement, ‘It is critical to involve the local community in the design, evaluation, implementation and management of the local health service.’ We all believe this and it is usually encapsulated through the use of the term ‘a community development approach’ and it works for even the most remote area. But the Alliance believes that we have not yet gone sufficiently far down the track of actually establishing what this means for government agencies. We have not established what this means for professional organisations.

It is lazy—I guess that is a fairly emotive word—or it is a mistake. It is insufficient—that is a better word—for us to say we have got to involve the community without enabling the community to be involved and working out what it means from the central end. In other words, what does it mean for the government agency in Perth or the Rural Doctors Association of Western Australia to engage actively in the community development approach to new health services?

This is just as applicable to oral health and dental health as it is to women’s and babies’ health or whatever.

What the Alliance would like to see is all of us working together to find out how we do this. The last part of your question, a long time ago now, was costs. There is a significant cost involved in this community development approach but the long-term result is beneficial because if you can get the community involved, you, as it were, look after health promotion and you also will have a better program. You will have a program that you know fits. There is an up-front cost in terms of doing it this different way but, in the long term, the Alliance is sure that this is the best and most effective way to go.

Senator KNOWLES—I have never seen a decreasing wish list; that is human nature. I have never seen a decreasing wish list where people are saying, ‘Look, we need to ration but get a broader mix, say, for example of specialists or dentists or whatever coming through country towns.’ I have been in the Senate for 13 years and every time I go to a country town, nothing
has changed in the response that you get. People say, ‘We want more dentists and more specialists to come through.’ We know the practical problems of that.

Mr Gregory—The key phrase you mentioned is ‘coming through’. In other words, it is the way we design our mobile outreach services: they have to be funded; they have to be collaborated so they go together. In other words, we all know that there are some crazy examples of outreach services going to Halls Creek. I am not being intentionally critical of the Western Australian government, but I bet you if you go to Halls Creek you will find that there is an imperfect collaboration between those services and agencies which visit. That is clearly one area where we could save some money immediately.

Ms Short—for example, the dentist going along with the Royal Flying Doctor Service, working together. Instead of the dentist flying in, extracting all the teeth and flying out with the teeth in the bag—which is what happens—we actually want the community working there. The debate in the inquiry might be about Federal and State governments; if you were to ask me, it is about local governments.

Senator KNOWLES—Does the tooth fairy fly when the ambulance does?

Ms Short—they are really good things to think about—good work, Senator.

Senator KNOWLES—I have one final question that I would like to ask both Mr Gregory and Ms Brown. Have Lawrie Groom and Associates, acting on behalf of the Dental Health Services of Victoria, contacted either of you?

Mr Gregory—the National Rural Health Alliance has been contacted by them, yes.

Ms Brown—No.

Senator KNOWLES—Thank you for your latitude in allowing my questions across a broad range, Mr Chairman.

Senator FORSHAW—Can I rely on the same leniency from the chair and also take some latitude here to pick up on some of the issues that Senator Knowles has raised, because the discussion about the problems of access and distance is very important here?

CHAIR—not as much, Senator Forshaw.

Senator FORSHAW—it seems to me from my experience and contact with rural and regional areas—and that is essentially in New South Wales, but also in other States—that a lot of this is driven by where the local council or local government entity is located. I am not necessarily talking about a State like Western Australia which has those huge distances—New South Wales has some fairly isolated places—but you have that and you also have the problem of where the public hospital is located. As you get further away from the town where the hospital is or where the local council is, the problems get greater. The point I wanted to then raise is that for instance in New South Wales you have area health boards. It seems to me, at least, that maybe a lot of the focus is always on what are the hospital services and what are the problems with the hospital services—and that is important for dental health, of course.
Do those area health boards in New South Wales or the equivalent in other States focus on the needs in dental care, or are they spending all their time on GPs and specialists and medicine?

Ms Brown—In South Australia we have not had regional boards for all that long, so they are going through an awful lot of internal things, and also the smaller hospitals that are sort of on the outside of the spoke of the wheel are feeling very isolated and not like they are all part of that regional concept yet. But no, there isn’t any thought in respect of dental care.

Senator FORSHAW—I can see that the issue, say, in a town where you have problems of not enough GPs, or no GPs or GP services, always relates back to the hospital system, but dentists do not necessarily relate to the hospital system and that is what I am trying to get at.

Ms Short—In New South Wales, with the area health boards, dental services—as they are called—would come under the community health sector in community health centres, and the dental clinics were either at schools, for the children, or are now in hospitals or community health sectors. The big struggle in New South Wales is that illness focus and not the health focus. When the hospital in the country town is running out of money, they try to take a bit away from community health. So community health and dental services shrink to support the hospital, to keep the hospital running. That is what we talk about: reorienting the health service, getting away from that illness treatment focus to the promotion of oral health.

Senator FORSHAW—that then leads me back to your comments in your opening remarks, that is that we need specific programs. Can you elaborate on that? We have programs, for instance, on breast cancer, on immunisation and on AIDS. Is that what you are talking about for dental health, or are you talking about something different?

Mr Gregory—The Alliance supports the longer term solutions to this issue, but believes that it is so urgent that it is imperative that an access program be established for those on low income, in great need—and in particular from our point of view in the Alliance—those in rural and remote areas. Sure, there is a cost involved, but this not an unstructured suggestion. The Alliance would make two points. The Commonwealth Dental Health Program clearly worked. What I said in my opening remarks was supposed to connote the ‘more in sorrow than in anger’ feeling of the Alliance, that we have plenty of challenges in rural and remote health, some of which have been covered by Senator Knowles. We created another important one by abolishing the CDHP, because it was something that was clearly working and it was an urgent area.

So the Alliance is saying quite unequivocally that we believe that there should be a program in collaboration between the Commonwealth and the States to do just that—that is, to provide preventive care on oral and dental health for those in great need, because they are poor and some of those are in rural and remote areas. The context within which this should be done—and this is my second point—has probably changed. We believe now that thought is being given to doing this within the National Public Health Partnership. We have no quarrel with that, obviously, as long as the Public Health Partnership is sufficiently resourced and gives a sufficient emphasis to this. The National Public Health Partnership is being widely touted as being the vehicle for this program. We support that, as long as it has a high priority and is properly resourced, which will presumably mean increased funds through and to the public health partnership.
Ms Short—I would wholeheartedly agree.

Senator FORSHAW—I was wondering if you might be able to provide structure or an outline of how you see that type of program?

Mr Gregory—You mean in terms of eligibility?

Senator FORSHAW—Whatever issues you would want to cover, such as eligibility or access. I am talking particularly about rural and regional Australia, if that is not too difficult a task or too time consuming.

Ms Short—In the National Public Health Partnership there would be an agreement between the Commonwealth and the States on what was actually going to happen. Particularly we need somebody to be looking at tracking oral diseases, the surveillance of it, the policy and the oral health promotion programs. I am intimately involved in the Breast Screen Australia program. That was a good one for you to suggest. It could be run along similar lines. In that program you are screening healthy women, looking for breast cancer. In rural areas or in other areas of Australia we could be doing some other screening.

Senator FORSHAW—that program is working well in rural and regional Australia, is it?

Ms Short—Yes. There are examples of national programs out there and running that we could run with. In fact, I would like to say that one of the reasons why Breast Screen Australia is so successful is that it has the support of Australians and many consumers involved at the advisory level, the quality management level, et cetera.

Mr Gregory—The breast screening program is certainly a success story in rural and remote areas, as has been said. But the Alliance is concerned that in the longer term the changes through COAG, resulting in rationalisation of activity between the Commonwealth and the States, may endanger some of those special purpose programs like breast screening. In other words, in an environment where both the States and the Commonwealth are trying to reduce their expenditures, including on health, the Alliance is concerned that the framework of agreements agreed to by COAG and which affect the Public Health Partnership, as well as women’s health and other things, should not be allowed to adversely affect the availability of that sort of program to rural areas.

Senator FORSHAW—that is the message for the government on another issue, but it is relevant. Could I ask one final question, and this is something that we can no doubt check with the department? Are you aware whether or not the National Health and Medical Research Council has a specialist representative on the Council with respect to dental care?

Ms Short—we do not have an oral health person, but we do have public health. I do not think we have rural health.

Mr Gregory—I am not sure.

CHAIR—it has been suggested to the committee that there should be dental postgraduate vocational training, whereby recent dental graduates work with guidance in designated areas.
This morning it was suggested by Professor Klineberg that that would be particularly appropriate in rural and remote areas. Do you have any comment to make on his suggestion?

Mr Gregory—I am not familiar with the specific suggestion, but certainly the general health workforce challenge is being successfully met by the rural placement of health workforce trainees at all stages, undergraduate and postgraduate. Afterwards, as we well know, it works for nursing and medical practitioners.

CHAIR—It would be a placement of six months, 12 months or up to two years.

Mr Gregory—Yes. One of the specific things which works in order to recruit and retain health professionals in rural areas is exposing them to rural areas. Some of them find they like it; some of them find they do not. The downside for these sorts of programs is that it may well reinforce people’s worst fears or prejudices about going to rural areas. In some cases, a six-month or a 12-month placement in a rural area has the result of making that individual realise that it is a good life and that the health practice is more challenging. In some instances it works well and lays the basis for good recruitment and retention in years to come.

Ms Short—As an extension of that, we have Rural Health Training Units throughout Australia for doctors and nurses. It would be very easy for dental to be taken on. What I am trying to get across is that we do not need special programs just for oral health people. We can tap into what is already there in our rural health networks. We just have to be careful that we are not sending—as I was over 20 years ago—the least skilled people to do the most demanding work.

CHAIR—Thank you all for coming along this afternoon.
Media Release

6 March 1998

Peak Body Calls for Dental Services for Low Income Australians

Unless there is an extension of service, people on low incomes in some States will have to wait 3-10 years to obtain low-cost dental care. Some older people will never eat an apple again and stories about young job-seekers not attending job interviews because of their unwillingness to smile will become more common. These issues are particularly important in rural areas and for indigenous people, and the National Rural Health Alliance (NRHA) has called on political parties to include in their election platforms this year plans for providing larger oral and dental care programs for people on low incomes.

“People in rural Australia already have difficulties accessing dental care and prevention services. If they are poor, rural people are doubly disadvantaged. They will therefore be among the beneficiaries of the new service envisaged,” according to NRHA spokesperson, Gordon Gregory.

“A new Public Dental Health partnership will protect and enhance the oral health of low income earners, unemployed people and those in rural and remote areas with poor access to dental care. By this means Commonwealth, State and Territory Governments will be able to co-operate in the delivery of affordable dental services for people on low incomes and others with poor access to dental services. Waiting times for low-cost care can become reasonable again.”

The Public Health Partnership, if it is better funded and becomes accepted in all States, is one of the frameworks for Commonwealth, Territory and State Governments to use for delivering such a service.

Currently Queensland is the only State which has picked up the Commonwealth Dental Health Program (CDHP) model from its own funds. In other States, the amount of low-cost dental care provided by the States themselves fell when the CDHP was first established. The total funds available for low-cost oral and dental health care fell dramatically when the CDHP ended fifteen months ago.

The National Rural Health Alliance (NRHA) was giving evidence to the Senate’s Inquiry into Public Dental Services. It argued that improved workforce policies for oral health workers are also required.

“As is the case with many other illnesses affecting rural people, the majority of oral diseases can be significantly reduced or prevented,” Mr Gregory said. Increased attention to both research and policy development in the area of public dental health is also required. There should be a thorough evaluation of the way oral health services are delivered. Public health principles should be the basis for improvements.”
Marg Brown, Chairperson of health Consumers of Rural and Remote Australia, also presented evidence to the Senate Inquiry. “Because of their isolation from services, people in rural and remote areas are among those penalised by the absence of a subsidised program for dental care. A new program based on a partnership between the Commonwealth and State Governments would help to cover this major gap in the basic health services which should be available to all people, wherever they live and whatever their level of income,” Ms Brown said.

The NRHA represents nineteen national organisations involved with rural and remote health services.
Acknowledgments

The NRHA has a grant from the Rural Health Support, Education and Training (RHSET) Program of the Federal Department of Health and Family Services.

This Rural Health Information Paper is based on work the NRHA undertook for the Senate’s Inquiry into the Provision of Public Dental Services in Australia.
NRHA Publications

Rural Health Information Papers (RHIP):

Best Practice for Rural and Remote Health Services, RHIP 1; NRHA, Canberra, December 1997.

Fighting Rural Decay - Dental Health in Rural Communities, RHIP 2; NRHA, Canberra, June 1998

Community Service Obligations - Meaning, Impact and Application, RHIP 3, NRHA, Canberra, forthcoming

Drugs and Alcohol in Rural Australia: Developing Policy Proposals for Young People, Lifestyles and Prevention of Harm, RHIP 4, NRHA, Canberra, forthcoming

Other Publications:


Workshop Reports and Communique, National Rural Public Health Forum (Adelaide, October 1997); NRHA, Canberra, December 1997.


Forum Overview, National Rural Public Health Forum (Adelaide, October 1997); NRHA, Canberra, 1998.


The NRHA’s Homepage is at <www.ruralhealth.org.au> Included on it are further details about the NRHA, as well as full texts of the papers presented to the 4th National Rural Health Conference in Perth in February 1997 and texts of some other publications.