POLICY OPTIONS

Relationship of dental practitioners to rural primary care networks

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Policy context

Australia’s National Oral Health Plan 2015-2024 identifies rural and regional residents of Australia as one of the priority populations that continues to experience poorer oral health. Rural Australians experience higher rates of dental caries and are more likely to visit dentists for problems other than check-ups than people residing in metropolitan areas. Complicating these issues is poor access to dental care in rural areas due to the maldistribution of dental practitioners in Australia with the majority of dentists and other dental practitioners practicing in metropolitan areas. Also, many small rural towns do not have the population to support a full-time/resident dentist.

The private sector provides over 85% of dental services in Australia. Public oral health services are provided for children up to 18 years old and adults with health care concession cards. People who have difficulty in accessing dental services may present to hospital emergency departments and medical practices for treatment of their dental problems or seek treatment and advice from pharmacists. However, these services are only used for the temporary relief of pain and do not provide definitive treatment. People who delay treatment are often admitted to hospital to treat serious infections. During 2012–2013, dental conditions accounted for 63,000 avoidable hospital admissions per year in Australia. These rates were lowest for city residents and highest for very remote residents. Consequently, there are strong imperatives to investigate ways in which rural communities can be provided with better oral health services using realistic and cost effective solutions.

Rural communities are served by a range of health care professionals, often working in an extended capacity as a consequence of the needs of the community, workforce shortages and the limited range of health care professionals in these areas. Stronger links and cooperation between rural health care practitioners and dentists/oral health professionals would help improve service provision such that interventions are both timely, effective and result in appropriate follow-up or referral.

This project mapped the oral health service practices in rural communities across primary care providers and assessed the extent to which oral health problems impact on primary health care providers; it also assessed the extent to which primary care networks could be more effectively utilised to improve the provision of oral health services to rural communities and; identified what interventions/strategies were most likely to be effective.
Policy options

The project identified a number of options that could be implemented to improve oral health in rural and remote communities. It should be recognised that rural communities are not all the same; some already receive a range of high quality services and may require only two or three additional measures to improve oral health. Other communities are in much greater need. We also propose more systemic changes that could have a positive impact. These are primarily around the education of health care professionals and removing barriers that limit opportunities for dentists to service both public and private patients.

> Oral health promotion

  o Upstream, preventive strategies were seen as critical to improving the oral health status of rural communities and the most effective way to reduce problem presentations downstream. Prevention is a cornerstone to better oral health and could be facilitated through the delivery of regular oral health promotion programs in schools, reinforcement of good oral hygiene practices by parents and supported by fluoridation of water supplies. Ensuring that the community knows how and where to access oral health information is also important. Primary care providers could play a critical role in providing a higher level of oral health screening and surveillance and education through their regular interactions with patients.

> Develop alternative oral health service delivery models, such as,

  o A mixed public/private funding model that enables dentists to provide services to both public and private patients in smaller communities: a model described by some participants as ‘half public and half private’. Alternatively, establish on-site dental clinics (where population size justifies) in those communities not serviced by a private dental practice. The clinics could be maintained and serviced by a resident dental practitioner who would have clinical, liaison and oral health promotion roles, and support regular visits by both public and private dentists.

> Build the capacity of rural primary care providers through oral health education and training

  o Encourage rural primary care providers to participate in regular short workshops for practical skills and training in dental emergencies and provide more oral health education and training to non-dental health care students during their undergraduate training.

> Overcome barriers that limit the availability of and access to dental services

  o Where there is no resident dentist, increase the number of regular visiting dental services to rural and remote communities. Alternatively, provide affordable travel options for those patients who have to travel long distances to visit a dentist and increase the use of tele-dentistry to better connect the rural primary care providers with a dentist located elsewhere. Encourage the recruitment and retention of dental professionals in rural areas by providing greater mentorship and support to new graduates who locate and practice in more remote communities and by providing new dental graduates with a ‘rural/remote’ rotation as part of their graduate year.

  o Develop a scheme for retiring metropolitan-based dentists who would like to provide their services to rural communities on a part-time or locum basis.

> Improve communication between primary care providers and dental practitioners

  o Initiate and support regular meetings between visiting/regional dental practitioners and local resident primary care providers. Circulate the contact details of the nearest dental clinics and timetables of visiting dental services to the primary care providers. Ensure that dental practitioners provide feedback on the patients referred to them by primary care practitioners.
Key findings

The state of oral health in the rural communities sampled can be summarised as,

> Poor

  o Many of the primary care provider participants especially GPs remarked on the poor oral health in their communities and described it as “so bad”, “very poor”, “never expected” and even “shocking”. Rural and remote residents presented to GPs, local hospitals and pharmacies with a range of oral health problems including toothache, oral infections, sore mouth and trauma. The frequency of presentations varied from “everyday” to “one per month” (GP practices), “very common” to “four in a month” (hospitals) and “10-15 per week” to “one a month” (pharmacies).

> Managed in many cases by generalist primary care providers

  o GPs were most likely to provide short term pain relief and provide prescriptions for antibiotics and many primary care provider participants included as part of their advice a recommendation that the patient see a dentist.

  o Delay or failure to obtain follow-up treatment with a dentist meant that a primary care provider could see the same patient a number of times.

  o Primary care providers acknowledged that they were not always confident in providing oral health advice due to the lack of training, but expressed interest in further developing their oral health knowledge and skills.

> In need of effective communication and referral pathways

  o Although, non-dental care providers commonly advised patients to see a dentist, they rarely communicated with the dental practitioners in the nearest regional town. There was a lack of a clear referral pathway between primary care providers especially GPs and dentists.

  o Many participants did not know who to contact when referring patients and were not always aware or informed of the available and visiting community dental services.

> Needing to overcome the barriers that make patient access to oral health services difficult

  o Affordability (of travel and treatment) and availability of transport are often barriers preventing access to dental care. Travelling to access oral health services was described as “expensive”, “200km each way”, “almost impossible” and “not easy for most of our patients”.

  o Oral health is not seen as a priority: which can result in a reluctance to seek further treatment once the initial pain has gone.