

POLICY OPTIONS

Dental practitioners: Rural work movements

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Policy context

Poor oral health is a critical factor in many health conditions, including diabetes, low birth weight and premature births, arthritis, heart problems, and respiratory conditions. It effects a person's quality of life with concerns when smiling, difficulty eating, pain, and limited employability. Other than low fluoride exposure, the causes of poor oral health, i.e. poor hygiene, poor diet, smoking, lack of access to oral health care and social determinants, are the same as the causes of poor systemic health. Unlike medicine, the vast majority of dental services are supplied in the private sector and are funded fee-for-service by the patient.

Oral health is poorer in rural than in urban areas of Australia. Although the oral health of Australians has improved over the last 30 years, the gap in oral health outcomes between rural and urban populations has not diminished. The poor oral health of the rural urban population is due to a number of factors including: poor access to dental care (caused by distance to dental practitioners, a historic undersupply of dental practitioners in rural areas and cost of treatment); rural attitudes to health that are more focused on treatment than prevention; low socioeconomic status (education, household income); the proportion of Indigenous Australians and elderly people; and low exposure to fluoridated water due to a reliance on tank water and un-fluoridated town water.

Dental practitioner (dentists, dental therapists, dental hygienists, oral health therapists and dental prosthetists/technicians) recruitment and retention issues lead to poor oral health outcomes in rural communities. Though the projected increasing oversupply of dental practitioners in Australia has seen a solving of rural recruitment problems, there is a potential for increased workforce turnover ("rural dental workforce churn"), as recent dental graduates gain work experience in rural areas and then move to urban areas after they become experienced employees. Rural dental practitioners need to have a broader scope of practice as there are often no professional help or dental specialists nearby. They often treat emergency patients with complicated conditions such as broken and exfoliated teeth and broken jaws after trauma, undertake oral surgical procedures and supply molar root fillings, orthodontic care, and advanced restorative care. They also act as leaders of their communities. The "rural dental workforce churn" has the potential to lead to lack of experienced and socially aware dental practitioners in rural areas. Another issue with improving access to dental care is the high fixed costs of running a dental practice making many rural and remote towns too small for a viable privately operated dental practice.

Equity suggests that everyone should be able to access dental treatment in Australia. A concern is that unless dental funding is targeted, people in rural areas may continue to miss out on appropriate dental care, while people in urban areas will receive more elaborate care than currently received with an associated risk of over servicing.

Policy options

Policy options to prevent dental diseases:

- > In all areas with reticulated water supplies that can feasibly be fluoridated, ensure that Commonwealth funding for State Government supplied dental care is linked to the local water supply being fluoridated.
- > The responsibility for water fluoridation be made the responsibility of State and not Local Governments.
- > Oral health promotion in rural areas be included as part of systemic health promotion (hygiene, diet, anti-smoking, regularly visiting health practitioners).
- > Improve education levels in rural areas to decrease the influence of social determinants of health on both oral and systemic health.

Policy options to improve access to dental care:

- > Focus on long-term retention rather than short-term recruitment of the rural dental workforce.
Ways to do this include:
 - a) Restructuring the Dental Relocation Infrastructure Support Scheme (DRISS) to:
 - include dental specialists, allied dental practitioners, and existing rurally-based dentists (so they can expand their dental practices),
 - allow the dental practitioners buy existing rural practices,
 - give a greater consideration of the long- term viability of new rural dental practices and their effect on existing rural dental practices prior to support being given, and
 - include assistance for social and community integration of new dental practitioners into the local rural community.
 - b) Before removing existing Commonwealth dental schemes, policymakers could investigate the effect of such removal on the viability of retaining dental services for people in rural areas.
 - c) Encourage universities to develop postgraduate programs specifically for rural dental practitioners, but also open to urban dental practitioners, to undertake procedures at subspecialist level, mentoring less experienced dental practitioners, and to gain an understanding of population oral and systemic health.
 - d) Encourage universities and training institutions to select women with Australian rural backgrounds for undergraduate dental programs as this cohort is more likely to work in rural practice after graduation.
 - e) In small rural and remote towns encourage public dental services to utilise local rural private-sector dental practitioners to supply dental care to eligible children and adults.
 - f) Facilitate mentoring and networking of less experienced dental practitioners by senior dental practitioners by supporting professional association, professional networking and peer group support in rural areas.
- > In remote areas where a dental practice is not viable, local physicians, nurses, Aboriginal health workers and pharmacists could be taught to:
 - a) undertake dental screening for dental diseases and oral cancer,
 - b) understand which oral conditions:
 - require urgent dental practitioner referral and how to establish such referral pathways,
 - can be treated by antibiotics and other medical procedures,
 - can be treated using minimally-invasive dental techniques, and how to
 - undertake minimally-invasive dental techniques.
- > Encourage further research into improving rural oral health and on the key retention factors of dental practitioners in Australian rural areas.

Key Findings

The study investigated the attitudes, barriers and enablers of Australian dental practitioners towards living and working in rural areas.

- > The long-term income security of a private rural practice was the overriding factor that encouraged dental practitioners to move to and more importantly, stay in, rural areas. It was the “hurdle” that had to be satisfied before other any factors were considered.
Factors influencing the long term financial viability of private dental practice were:
 - The small population size in rural towns.
 - Rural populations were considered to be less likely than urban populations to seek preventative and routine dental treatment. Problem-based dental care was considered to be of low profitability for a private dental practice.
 - There was a greater need for dental care in rural than urban areas, but when approximately 80% of dental services are funded by the client, demand for dental care was seen to be much lower in rural than urban areas.
- > Growing up in a rural area was positively associated with rural practice for women. This is known as the rural background effect; female Australian rural background practitioners were more than twice as likely as those who had an Australian urban background to work in rural practice.
- > Lifestyle, the life stage of the dental practitioner and family concerns influenced rural retention. Retention of dental practitioners in rural areas was based on a combination of the ability to assimilate into the local community, personal/family satisfaction, and job satisfaction within the rural context. Rural areas may not be able to provide the lifestyle necessities for some practitioners given their particular life stage. Hence, some were unable to remain in rural practice despite their wishes to do so. One example is education for children, especially high school age and older.
- > Financial incentives, such as the Dental Relocation and Infrastructure Support Scheme (DRISS), may encourage dental practitioners to move to rural areas, but did not necessarily encourage them to stay in rural areas.
- > The increasing oversupply of dental practitioners in Australia has solved the historic rural recruitment problems but retention was still a problem. This may be creating a high turnover of dental practitioners, where new graduates and young dental practitioners enter rural areas to gain experience because they cannot find work in urban areas, and then move back to urban areas once that experience was obtained. This “rural dental workforce churn” may result in a concentration of less experienced dental practitioners who require mentoring and on-the-job training from often difficult to acquire senior dental practitioners.
- > Rural dental practitioners needed to have a broader scope of practice as there was often no professional support or dental specialists nearby. They often treat emergency patients with complicated conditions such as broken and exfoliated teeth and broken jaws after trauma, undertake oral surgical procedures and supply molar root fillings, orthodontic care, and advanced restorative care.
- > Rural practice was considered by some to be a limiting factor to career progression and advancement.
- > Rural practitioners felt valued for their services to the local community and had a great sense of clinical pride and job satisfaction.
- > Support from professional associations, professional networking and peer group support was considered by dental practitioners to be harder to access in rural than in urban areas.

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