Accessing oral health care in Australia

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Why try a doctor when you need a dentist?

Oral conditions have some of the highest prevalence and incidence rates of all health problems in Australia.[1] They are frequently associated with pain, functional limitations and interference with usual activities. Most people experiencing oral symptoms will visit, or at least contemplate visiting, a dentist. But why are some patients with oral conditions presenting to general practitioners?

While signs and symptoms associated with dental caries and periodontal diseases are usually understood to be problems for dentists, sequelae of these conditions, such as abscesses, facial swelling, altered taste and halitosis, may sometimes be considered more of a medical than an oral problem. Furthermore, differences in the way dental and medical services are organised and delivered may provide a greater incentive for patients to present to GPs rather than dentists. This applies not only to conditions for which an ill-defined boundary exists, but also for management of acute symptoms of common oral conditions. Mansour and Cox outline some of these common oral conditions in this issue of the Journal (*page 64*).[2]

One result of the evolution of the medical and dental professions over the past century is a "separateness" that has diminished both professions' understanding of the other's discipline. While it is highly desirable to reduce this knowledge gap, it seems unlikely to be readily closed, given the existing curriculum pressures created by scientific and technological advances.

A logical response to the inappropriate presentation of patients with oral conditions to GPs would be to both remove the incentives for this type of presentation and to provide more certain pathways for dental referral when they do occur. Indeed, Mansour and Cox recommended dental referral for most of the cases described and for all possible outcomes of their decision-making algorithm. But while the need for referral to dentists is generally well recognised, the ability to refer may be limited.

Both the initial presentation to a GP and the difficulties in referral to a dentist are shaped by problems in accessing dental care in Australia. There are only about 9000 practising dentists in Australia (approximately 50 per 100 000 population),[3] the vast majority of whom work in either the central business districts or middle-class residential suburbs of the major population centres, leading to significant maldistribution. Equally important is the fact that 86% of dentists work in the private sector, where they alone determine location, hours worked and fees charged. Outside normal business hours, the number of available dentists is very limited, and access is frequently restricted to existing patients of a practice.

In some instances, major public hospitals and the limited number of dental hospitals do provide after-hours access to on-call dentists, but this is the exception rather than the rule. Publicly-funded dental care is usually restricted to holders of concession cards, which reduces those eligible to about 34% of the adult population. Further rationing of dental treatment occurs because of the limited facilities and shortage of dentists in the public sector. Only 19% of eligible dentate adults (ie, those with natural teeth) receive any dental care from public dental services in any year.[4]

An overall shortage of dentists makes access to dental treatment even more difficult. Within 4 years, Australia is predicted to be short of some 1500 dental care providers, mostly dentists.[5] This shortage creates a bottleneck in the supply of dental treatment. It is most harshly felt by people already having difficulty obtaining dental treatment — low income Australians and those living in rural areas. However, the bottleneck also extends to dentistry in the "main street"; that is, private general dentists in middle-class residential areas. Increasing the number of positions in our universities for dental students may eventually overcome this problem — assuming there are academics to teach them and funding to competitively employ some of them in the public sector at the completion of their education. However, the current national output of less than 250 graduates a year does not begin to address the shortfall. Increased education of auxiliary dental personnel (hygienists and therapists) should lead to increased prevention programs, but is unlikely to address the problem of adults presenting with acute conditions.

Cost is another significant barrier to accessing dental care. An estimated 25% of dental patients delay seeking treatment because of the expense.[6] Public funding for dental treatment is dramatically less than for medical treatment. At present, public funding from the federal government is directed at the 30% private health insurance rebate, while state and territory government public funding is directed at low income adults and schoolchildren. The outcome is an inequitable pattern of public assistance in accessing dental treatment. Ironically, the average taxpayer may well pay the most and receive the least in terms of support in accessing dental treatment.

The majority of patients will face the full cost of any dental treatment. The current average hourly rate for dental practices is $350 (of which overheads represent 73%).[7] Thus it is likely that any substantial care (be it diagnostic or therapeutic) will represent a significant financial burden to the patient. The incentive for patients with oral conditions to present to a GP is obvious. GPs are more available, obtainable out of hours, and can be seen without the need to pay substantial out-of-pocket costs. The corollaries of these same issues are often the substantial barriers to dental referral for patients presenting to GPs.

Recently, the federal government recognised the need for dental care among patients with a GP Management Plan and Team Care Arrangements or an Enhanced Primary Care multidisciplinary care plan. Essentially, approved patients may be referred to a dentist for an assessment and two other services within a 12-month period. In 2005, there were only 2055 referrals for dental assessment (Item 10975),[8] and these resulted in 2500 items of treatment or referral to a dental specialist (Items 10976, 10977). The total cost of dental diagnostic and treatment procedures was just over $500 000 (or $250 per 100 000 population). These data indicate a negligible level of referral under these plans.

Specific issues within these plans act as further barriers to referral for dental care. For GPs, the cost and time involved with administrative requirements far exceed the value of the remuneration. Referral cannot proceed until the original care plan has been completed and paid for, which largely negates treatment of acute conditions. The relatively small number of appointments permitted, dentists' unfamiliarity with the Medicare remuneration system, and the level of remuneration make dentist participation professionally and financially unrewarding. The result is that current referral plans available under Medicare are unlikely to provide a simple or effective pathway for dental referral and treatment.

Currently, patients with acute oral conditions should hope that the problem occurs during normal hours in a major population centre, that the condition is not part of a larger problem, and that they are wealthy enough to have a regular dentist who has the time to see them. For patients who are not so fortunate, presentation to a GP is likely to remain an option. As outlined by Mansour and Cox, on most occasions, little, if any, effective help can be offered beyond referral to a dentist. The short-term results are frequently only palliative, at best, and without appropriate follow-up care — resulting in increased costs to the public purse and ongoing suffering to the patient.

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