INQUIRY INTO THE PROVISION AND ACCESS TO DENTAL SERVICES IN AUSTRALIA

SUBMISSION FROM THE DEPARTMENT OF HEALTH AND AGED CARE TO THE SELECT COMMITTEE INTO THE PROVISION AND ACCESS OF DENTAL SERVICES IN AUSTRALIA

4 June 2023

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INTRODUCTION

The Department of Health and Aged Care (the Department) and collaborating government agencies, Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS) and Services Australia (SA) welcome the opportunity to make a submission to the Select Committee into the Provision and Access of Dental Services in Australia.

The Primary Care Division within the Department is responsible for providing support and dental policy advice to the Minister for Health and Aged Care, including developing new policy, implementing policies, delivering Commonwealth funded dental programs, and collaborating with states and territories on dental policy and reform. The Department regularly seeks advice from the Commonwealth dental adviser in the Benefits Integrity Division, states and territories and their chief dental officers, and peak bodies to support policy development, coordination, and implementation.

Oral health is fundamental to overall health, wellbeing, and quality of life. Poor oral health has significant adverse impacts at individual, societal, and economic levels.[1]

Traditionally, states and territories have had primary responsibility for delivering public dental services. These services are predominantly targeted at servicing the oral health needs of children, adolescents, and low-income adults who may not otherwise receive oral health care services if not provided publicly. These dental services assist eligible Australians to receive care, either free or at a subsidised cost, who might otherwise find it difficult to access dental care in the private sector. Each jurisdiction determines its service delivery model and there are significant differences between jurisdictions in terms of who is eligible for services and how those services are delivered.

The Commonwealth Government also plays a substantial role in supporting access to dental services. The following section provides more detail on its role.

COMMONWEALTH DENTAL FUNDING

The Commonwealth currently supports public dental service provisions through:

Child Dental Benefits Schedule (CDBS) – The CDBS allows eligible children aged 0 to 17 years to claim up to the benefit cap every two years for basic dental services. The program is means tested; children must be eligible for Medicare and they and/or their family/carer should receive an eligible Australian Government payment at least once in the calendar year.

Federation Funding Agreement (FFA) for adult public dental services – The Commonwealth offers top-up funding to states and territories to provide adult public dental services. This funding is dependent on achieving activity levels above a baseline level, set in 2013-14. The current 2022-23 FFA agreement ends on 30 June 2023. In the 2023-24 Budget the government announced funding of $215.6 million over two years as an interim measure

[1] Oral health and dental care in Australia, Summary - Australian Institute of Health and Welfare.

while decisions on future funding arrangements for dental service provision are finalised through an inter-governmental senior officials working group.

National Health Reform Agreement (NHRA) – The Commonwealth provides funding for public hospital admitted and outpatient dental services.

Private Health Insurance (PHI) rebates – The Commonwealth provides an income-tested private health insurance rebate. The rebate applies to hospital, general treatment (including dental), and ambulance policies.

Grants to the Royal Flying Doctors Service (RFDS) – The Commonwealth funds grants to the RFDS which provides dental outreach services through provision of fly-in/fly-out or drive-in/drive-out outreach dental services, where there are no other private or public dental services in classified areas.

Research – The Department funds population health dental research studies conducted by the Australian Research Centre for Population Oral Health (ARCPOH) at the University of Adelaide. The National Health & Medical Research Centre (NHMRC) and the Medical Research Future Fund (MRFF) also provide other funding opportunities for dental research through competitive processes.

The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) – Since 2007, the Commonwealth Government has helped fund oral health services for Aboriginal and Torres Strait Islander children aged under 16 in the Northern Territory through various iterations of National Partnership Agreements (NPA) since the Northern Territory Emergency Response (NTER) (See Section C).

Table 1: A summary of Commonwealth funding for dental services is provided below#.

	2020-21 ($m)	2021-22 ($m)	2022-23 ($m)	2023-24 ($m)	2024-25 ($m)	2025-26 ($m)	Total ($m)
CDBS^	336.5	281.2	343.7	349.7	357.7	259.2	1928.0
NHRA - Acute Admitted Dental Services	44.3	40.6	n/a	n/a	n/a	n/a	84.9
NHRA - Specialist Outpatient Procedure Clinics	134.5	84.8	n/a	n/a	n/a	n/a	219.3
NPA/FFA	107.8	107.8	107.8	107.8	107.8	-	539.0
Child Oral Health Study	-	-		0.7	-	-	0.7
National Dental Care Survey (NDCS)				0.8	0.6	0.2	1.6
Developmental work to support dental funding reform (costing study & NMDS)^^	-	-	-	1.3	0.7	0.03	2.1
Royal Flying Doctor Service Grant – Dental Services	5.6	5.7	5.8**	5.8**	5.8**	5.8**	34.5
Private Health Insurance Rebates*	775.0	n/a	n/a	n/a	n/a	n/a	775.0

Total	1403.7	520.1	457.3	466.1	472.6	265.2	3585.1

^ Estimated actuals as per relevant Budget Portfolio Statements. Figures for 2023-24 onwards as per Budget 2023-24.
*** From 2022-23 onwards, the RFDS grant allocates funding flexibly across all primary care service delivery, which includes dental services. This figure is the indicative amount for dental services and may be used flexibly to provide other primary care services.*
** PHI Rebates – estimated contribution of PHI rebates being paid out in dental claims. Data from 2021-22 is not available. Source: AIHW.*
^^ Additional funding of $0.02m will be provided in 2026/27.
#The Indigenous Australians' Health Programme Primary Health Care Funding Model provides funding ($34.1m from 2020-21 to 2023-24) to the Wurli-Wurlinjang Aboriginal Corporation which provides a range of primary health care activities, including a dental program. Funding for the dental services cannot be disaggregated.

RESPONSE TO THE INQUIRY TERMS OF REFERENCE

A: THE EXPERIENCE OF CHILDREN AND ADULTS IN ACCESSING AND AFFORDING DENTAL AND RELATED SERVICES.

Many children and adults in Australia struggle to access and pay for dental and related services. In 2021-22, 49.4% of people saw a dentist, which was a small increase from 47.9% in 2020–21.[2] Comparatively, 74.7% of Canadians,[3] 48.9% of New Zealand adults (15 and older),[4] and 62.7% of American adults aged 18-64[5] have seen a dental professional in the past year.

Some people are eligible for publicly funded dental services delivered by the states and territories. Wait lists for public adult dental services differ across Australia because priority, eligibility, and wait time on the list are determined differently in each state and territory. Only 4.9% of dentists currently work in the public sector. The COVID-19 pandemic and workforce shortages have made already lengthy wait times for public adult dental services in every state and territory worse.

ADULTS AND CHILDREN

Table 2: Experience of adults and children accessing dental and related services.

Experience of adults in accessing and affording dental and	• Just over half of the Australian population aged 15 years and over attended a dental provider in the previous 12 months (56.4%), while just over one in ten people had not visited a dentist for five or more years (11.4%). • Just over four in five people reported that their last dental visit was to a private practice dentist (81.8%). Of those that visited a dentist within the previous five years, nearly nine in ten paid for all or part of their dental care (89.4%).

[2] ABS Patient Experience Survey (PEx) 2021-22.
[3] Statistics Canada, *Dental Care, 2018.* Published 16 September 2019. Dental Care, 2018 (statcan.gc.ca). Accessed 31 May 2023.
[4] Ministry of Health (New Zealand). *New Zealand Health Survey*. https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/_w_e952e348/#!/explore-indicators. Accessed 31 May 2023.
[5] Centers for Disease Control and Prevention (United States of America). *QuickStats*: *Percentage of Adults Aged 18–64 Years Who Had a Dental Visit in the Past 12 Months, by Dental Insurance and Year — National Health Interview Survey, United States, 2019–2020*. Published 22 April 2022. https://www.cdc.gov/mmwr/volumes/71/wr/mm7116a3.htm Accessed 31 May 2023.

related services[6,7,8]	• People aged 25-34 years were more likely to delay or not see a dental professional when needed than those aged 85 years and over (41.3% compared to 18.3%). • People with a long-term health condition were more likely to delay or not see a dental professional when needed than those without a long-term health condition (36.7% compared to 27.4%). • Aboriginal and Torres Strait Islander people were less likely to have attended a private practice and less likely to have paid for their last dental visit than non- Aboriginal and Torres Strait Islander people (0.73 and 0.74 times, respectively). • Uninsured people were 0.62 times less likely than insured persons to have visited in the past 12 months, and those eligible for public dental care were 0.63 times less likely than those ineligible for public care to have paid for their dental care. • The proportion of adults who last saw a dentist five or more years ago was lower for people with Year 10 or less schooling than for people who completed Year 11 or more (15% and 9.8%, respectively). • Adults without an educational qualification were 1.8 times more likely to have not visited a dentist for five or more years, when compared to adults with a degree or above. • Adults without dental insurance were more likely to have visited a dentist five or more years ago (17.8%) than people with dental insurance (5%). • One in five people had unfavourable visiting patterns (22.0%), in that they visited less than once every two years (and usually for a problem) or visited once every two years (usually for a problem) and without a regular dental provider. • People living in areas of least socio-economic disadvantage were more likely than those living in areas of most disadvantage to see a dental professional (58.8% compared to 37.9%). • People living in major cities were more likely than those living in outer regional, remote, or very remote areas to see a dental professional (51.3% compared to 43.1%). • People living in areas of most socio-economic disadvantage were more likely to delay or not see a dental professional when needed than those living in areas of least disadvantage (41.1% compared to 27.5%). • People living in outer regional, remote, or very remote areas were more likely to delay or not use dental professionals when needed than those living in major cities (36.3% compared to 31.8%).

[6] ABS Patient Experience Survey (PEx) 2021-22.
[7] The ABS National Health Survey 2020–21.
[8] National Study of Adult Oral Health 2017–18.

	• In 2021-22 around one in six (16.4%) Australians aged 15 years and over delayed or did not see a dental professional when needed due to cost compared to 14.8% in 2020-21. • In 2021-22, around one in six (15%) Australians aged 15 years and over living in Major cities delayed or did not see a dental professional when needed due to cost compared to one in five (19%) living in inner regional areas and one in five (21%) living in outer regional, remote or very remote areas. • In 2020-21, around one in four (24%) Australians last consulted a dentist or dental professional 1-2 years ago.
Experience of children in accessing and affording dental and related services[9],[10],[11]	• Just over 57% of children have made a visit before the age of 5 years. This was higher for children in households where the parents had higher education and income, and lower among Aboriginal and Torres Strait Islander children and children who made their last dental visit for a dental problem. This also varied across states and territories. • One in ten children aged 5-14 years had never made a dental visit; one in four among children aged 5-6 years. This was lower in states and territories where school dental service had greater coverage. • Just over one-fifth of children had an irregular visiting pattern. This was higher among those children from households where parents had less education or low income. It was also higher among those children whose reason for their last dental visit was a dental problem. • Over 56% of Australian children who had ever made a dental visit last attended private dental services. The remaining proportion made their last dental visit at public dental services, which was dominated by school dental services. • The use of private dental services was socially patterned with a lower percentage of parents with less education and low-income reporting that their child last visited a private practice. • The percentage of children visiting a private dental practice varied greatly across states and territories. This percentage was highest in NSW and Victoria and lowest in Northern Territory and Tasmania. • Between 2.6 million and 3.1 million children are eligible each year for the CDBS, however less than 40% of eligible children participate. • Most CDBS services (83%) are provided by private dental services, while only 17% are provided by public dentists. • In 2020-21, around one in two (54%) children aged 0-14 years had consulted a dentist or dental professional in the last 12 months.

[9] ABS Patient Experience Survey (PEx) 2021-22.
[10] The ABS National Health Survey 2020–21.
[11] National Child Oral Health Study (NCOHS) 2012-14.

	• In 2020–21, around one in four (27%) children aged 2–14 years last consulted a dentist or dental professional 1–2 years ago, around one in 24 (4.2%) last consulted a dentist or dental professional more than two years ago and around one in six (16%) have either never consulted a dentist or dental professional, or the time since they last consulted a dentist or dental professional was not known.

BARRIERS TO ACCESS

Overall, 59% of the total cost of dental services was directly funded by individuals in 2020–21.[12]

Table 3: Financial barriers to access.

People who avoided or delayed visiting a dentist due to cost[13]	• Around four in ten (39%) people aged 15 years and over avoided or delayed visiting a dentist due to cost. • Females had higher rates of avoidance due to cost than males, 43% compared to 35%. • Aboriginal and Torres Strait Islander people (49%) had higher rates of avoidance due to cost than non- Aboriginal and Torres Strait Islander people (39%). • People with insurance had lower rates of avoidance due to cost than those without insurance, 26% and 52% respectively. • People who usually visit the dentist for a problem (58%) were more than twice as likely than those who usually visit for a check-up (27%) to avoid or delay visiting a dentist due to cost.
People who reported that cost prevented recommend-ed dental treatment[14]	• Around one in four (23%) dentate adults aged 15 years and over who visited a dentist in the last 12 months reported that cost prevented recommended dental treatment. • Adults aged 35-54 years were most likely to not receive recommended dental treatment due to cost (29%). • People without insurance (30%) were more likely to report that cost prevented recommended dental treatment than those with insurance (18%). • People who usually visit the dentist for a problem (44%) reported higher rates of cost preventing recommended dental treatment than those who usually visit for a check-up (16%).
People who stated they would have	• Around one-quarter (24%) of adults aged 15 years and over, stated they would have difficulty paying a $200 dental bill.

[12] The ABS National Health Survey 2020–21.
[13] National Study of Adult Oral Health 2017–18.
[14] National Study of Adult Oral Health 2017–18.

a lot of difficulty paying for a basic preventive visit[15]	• The proportion of females (28%) reporting difficulty paying for a basic preventive visit was greater than the proportion of males (20%). • Aboriginal and Torres Strait Islander people (40%) were more likely than non-Aboriginal and Torres Strait Islander people (24%) to report difficulty paying a $200 dental bill. • A lower proportion of people with a degree or higher (15%) reported they would have difficulty paying for a basic preventive visit than those with other or no qualifications (27%). • More than twice as many people without insurance (33%) stated they would have difficulty paying for a basic preventive visit than those with insurance (15%).

AGED CARE RECIPIENTS

The Royal Commission into Aged Care Quality and Safety found that oral and dental health care needs of people living in residential aged care are not treated as a priority. Daily oral health care is often not undertaken and access to oral and dental health practitioners is limited.

The Aged Care Royal Commission Recommendation 60 called for the establishment of a Seniors' Dental Benefits Scheme for Commonwealth Seniors Health Card holders by 2023. The Department has done some preliminary analysis of options for a Seniors Dental Benefit Program. Options are being considered as part of the inter-governmental officials working group on long term dental reform. This is expected to be presented to Health Ministers for consideration and an initial discussion in June 2023.

PEOPLE WITH DISABILITY

Some people with disability may require general anaesthesia to be able to access basic dental services. The Commonwealth provides states and territories with funding under the National Health Reform Agreement (NHRA) for public hospital in-patient dental services, however most states and territories have strict eligibility restrictions and waiting lists.[16]

Outside the public system, accessing general anaesthesia and paying for associated dental work is costly, with a 2018 qualitative study indicating that such admissions leave patients with out-of-pocket costs of between $3,500 and $5,000. Cost barriers, challenges in accessing preventive and/or less invasive care, and lack of specialised experience compound barriers for people with disability in accessing dental services. There were 24 practising special needs dentistry specialists across Australia in 2022.[17]

[15] National Study of Adult Oral Health 2017–18.

[16] See Section H for more information on the development of a new public dental National Minimum Data Set (NMDS) to collect nationally consistent activity and waiting times data.

[17] '*Special Needs Dental Spotlight Part 1*', Australian Dental Association, April 2022.

B: THE ADEQUACY AND AVAILABILITY OF PUBLIC DENTAL SERVICES IN AUSTRALIA, INCLUDING IN OUTER-METROPOLITAN, RURAL, REGIONAL AND REMOTE AREAS.

PUBLIC DENTAL SERVICES AVAILABLE

CDBS

Over 45% of children are eligible for the CDBS, however only one in three children access the program. Access to the program is lower for children in remote and Aboriginal and Torres Strait Islander communities. In 2021, there were around 71,000 children eligible for the CDBS in remote communities, and very remote communities. Respectively, 23.8% and 15.1% of these children accessed services under the program. Less than one in ten eligible Aboriginal and Torres Strait Islander children living in remote and very remote areas accessed the program.

The Fifth Review of the *Dental Benefits Act (2008)* looked at the uptake of the program for vulnerable cohorts. The Report is currently being finalised and is expected to be tabled in the Parliament later in 2023.

State and territory programs

As described in Terms of Reference A, each state and territory run its own public dental program and determines its service delivery model. Eligibility typically includes Health Care Card and Pension Concession Card holders, with some states and territories also including Commonwealth Seniors card holders. Using these eligibility criteria, there are approximately 5.9 million adults eligible for public dental services nationally. However, capacity of the public dental programs does not meet these demands and as a result, there are substantial wait lists. Priority is usually determined by clinical need.

Royal Flying Doctor Service (RFDS)

The Australian Government has a strategic partnership with the RFDS who operate mobile and outreach services to service remote communities. In 2021-22, the RFDS delivered a total 58,976 dental services over 507 site visits. Between 1 July 2022 and 31 December 2022, the RFDS conducted 30,149 dental services through 350 site visits. Table 1 provides funding details for the RFDS.

ACCESS TO DENTAL SERVICES IN REMOTE AND ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

In general, oral health declines as remoteness increases because people in rural areas have less access to a dentist than those in cities. People from remote areas also have less access to fluoridated water and tend to have higher risk health behaviours.

Compared to people living in major cities, people who live in outer regional, remote, or very remote areas were more likely to have received public dental care (8.3% vs 16.9%). People who live in areas with the greatest socioeconomic disadvantage are also more likely to have

received public dental care compared to those who live in areas with the least disadvantage (22.1% vs. 4.1%).[18]

Being placed on the public dental waiting list is more likely for residents of areas with the greatest socioeconomic disadvantage than for residents of areas with the least disadvantage (10.9% vs. 1.1%). A similar difference is seen between residents of major cities and those who live in outer regional, rural, or very distant areas (7.5% vs. 3.4%). An additional indicator for being added to a public dentistry waiting list is having a long-term health problem.[19]

A recent study showed that despite 90% of communities in Victoria having access to fluoridated water, 33% of rural towns with more than 1,000 people did not have access to fluoridated water, with many having higher than average preventable hospital admissions especially for children aged 0-9 years. Literature has indicated similar trends in other jurisdictions.[20]

An estimated 19% of Aboriginal and Torres Strait Islander people did not go to a dentist when they needed to in the previous 12 months, based on data from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey. Reasons included: cost (42%), too busy (24%), disliking service or professional, or feeling embarrassed or afraid (22%), and waiting time too long or not available at time required (15%).[21]

WORKFORCE ISSUES

In 2021, total clinical Full Time Equivalent (FTE) for dental practitioners was 17,584.7, including 2,134.9 in the public sector. This equates to 12.14% of clinical FTE in the public sector for dental practitioners.[22] In Australia, there are 57.9 dentists per 100,000 population,[23] compared to 65 dentists per 100,000 Canadians[24] and 61 dentists per 100,000 Americans.[25] Competition with the private sector for skilled dental professionals makes it challenging for the public sector to meet demand.

[18] ABS Patient Experience Survey (PEx) 2021-22.
[19] ABS Patient Experience Survey (PEx) 2021-22.
[20] The National Oral Health Plan 2015-24.
[21] National Aboriginal and Torres Strait Islander Health Survey, 2018-2019.
[22] National Health Workforce Dataset.
[23] Oral health and dental care in Australia. Dental workforce. Australian Institute of Health and Welfare. Updated 17 March 2023. Oral health and dental care in Australia, Dental workforce - Australian Institute of Health and Welfare (aihw.gov.au). Accessed 31 May 2023.
[24] The Canadian Dental Association Welcomes the Federal Government's Commitment To Increase Access to Dental Care. The Canadian Dental Association. Published 7 April 2022. Canadian Dental Association (cda-adc.ca). Accessed 31 May 2023.
[25] Projected Supply of Dentists in the United States, 2020 – 2040. Munson B, Vujicic M. Published May 2021. Projected Supply of Dentists in the United States, 2020-2040 (ada.org). Accessed 31 May 2021.

C: THE INTERACTION BETWEEN COMMONWEALTH, STATE AND TERRITORY GOVERNMENT LEGISLATION, STRATEGIES AND PROGRAMS IN MEETING COMMUNITY NEED FOR DENTAL SERVICES.

To provide dental care to Australians, the Commonwealth has significant interactions with state and territory governments on a variety of strategies, legislation, policies, and programs.

STRATEGY

Australia's National Oral Health Plan 2015-2024

Australia's National Oral Health Plan 2015–2024 was prepared by the Oral Health Monitoring Group (OHMG), a subcommittee of the Community Care and Population Health Principal Committee, which reported through the Australian Health Ministers' Advisory Council (AHMAC) to the Council of Australian Governments (COAG) Health Council. All states and territories endorsed the plan.

The Six Foundation Areas in the Plan include:

- Oral health promotion
- Access
- Systems alignment and integration
- Safety and quality
- Workforce
- Research and evaluation

Government officials intend to seek Health Ministers' views on next steps in June 2023.

LEGISLATION

The *Dental Benefits Act (2008)*

The *Dental Benefits Act 2008* and *Dental Benefits Rules 2014* provide the Commonwealth's legislative framework for the payment of dental benefits under the Child Dental Benefits Schedule (CDBS). Under the CDBS, state and territory public sector dental providers can claim for eligible benefits provided to eligible children until 31 December 2026. State and territory governments are broadly subject to the same legislative requirements as private providers except for more flexible claiming arrangements for the public sector that allow for figurehead claiming, and the requirement that services claimed must be bulk billed.

Figurehead claiming allows a Representative Public Dentist (RPD) to use their Medicare provider number to claim for services rendered by other public sector dental providers, effectively streamlining administration associated with claiming of CDBS benefits paid to state and territory accounts. The Commissioner of Taxation has published a Class Ruling[26] in

[26] Available online: www.ato.gov.au/law/view/pdf/pbr/cr2022-100.pdf

respect to RPDs, which outlines income taxation arrangements associated with benefits paid to state and territory governments via individual RPDs.

POLICY

Long-Term Funding Reform

At their meeting of 30 April 2021, Health Ministers identified long-term dental policy as a priority for 2021-22. Health Ministers asked the Health Chief Executive Forum (HCEF) to establish a National Dental Reform Working Group (the Working Group). The membership of the Working Group consisted of senior officials from the Commonwealth and states and territory governments.

On 18 November 2022 Health Ministers noted the Options Paper presented by the Working Group and agreed that more work should be done on proposed options.

The Dental Reform Oversight Group, membership consisting of senior officials from the Commonwealth and states and territories, is now progressing this work and will provide an update to Health Ministers' Meeting in June 2023.

FUNDING PROGRAMS

Federation Funding Agreement (FFA)

The Commonwealth supports states and territories to deliver additional adult public dental services through top-up funding. This funding was provided through the both the National Partnership Agreement (NPA) for the period from 2013 to 2021 and then through the Federation Funding Agreement (FFA) – Schedule on Public Dental Services for Adults for 2021-2023.

In the 2023-24 Budget the government announced funding of $215.6 million over two years as an interim measure while decisions on future funding arrangements are finalised. This will enable states and territories to provide services to around 360,000 additional public dental patients above 2013-14 baseline activity levels.

National Health Reform Agreement (NHRA)

In 2021-2022, the Commonwealth contributed $125.4 million for dental services under the National Health Reform Agreement (NHRA). This includes:

- $40.6 million for acute admitted dental services in Australian public hospitals; and
- $84.8 million specialist dental outpatient procedure clinics in Australian public hospitals.

The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP)

Since 2007, the Australian Government has helped fund oral health services for Aboriginal and Torres Strait Islander children aged under 16 in the Northern Territory through various iterations of National Partnership Agreements (NPA) since the Northern Territory Emergency Response (NTER).

Currently, funding for the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) is provided under an NPA which began in July 2015 and provides $26.94 million until 30 June 2024 for preventive and clinical services. The NTRAI OHP is implemented by the Northern Territory Department of Health and designed to complement and support existing public dental services, such as the Northern Territory Government Child Oral Health Program. The program works with primary health-care providers to incorporate primary prevention into their services and deliver clinical oral health treatments to Aboriginal and Torres Strait Islander children.

A co-design process is under way to determine future NTRAI arrangements past the end of current funding on 30 June 2024. This process takes a partnership approach consistent with Priority Reform One of the National Agreement on Closing the Gap. The National Indigenous Australians Agency (NIAA) is leading the co-design process in partnership with the Department of Health and Aged Care, Aboriginal Peak Organisations in the Northern Territory (APO NT), and the NTG to design options for future investment in remote Aboriginal communities in line with the Closing the Gap Priority Reforms.

D: THE PROVISION OF DENTAL SERVICES UNDER MEDICARE, INCLUDING THE CHILD DENTAL BENEFITS SCHEDULE

CHILD DENTAL BENEFITS SCHEDULE (CDBS)

This is a means tested program that offers up to $1,052 (2023 figure, indexed annually each calendar year) in benefits over two consecutive calendar years. Eligibility is assessed automatically and is valid for that full calendar year. To be eligible a child must:

- be eligible for Medicare,
- receive (or their parent/ guardian) an eligible Australian Government payment[27] at some point in that calendar year, and
- be aged under 18 years at some point in that calendar year.

Services Australia administers the CDBS program and related payments on behalf of the Department. Under Bilateral Management Arrangements with the Department and the Department of Veterans Affairs (DVA), Services Australia is responsible for the delivery of services and payments, including:

- matching a customer's Centrelink or DVA information against their Medicare information to determine their CDBS entitlement
- notifying customers in writing of their CDBS eligibility via their myGov inbox or mail, and providing advice via the Medicare general enquiry telephone line for customers

[27] Family Tax Benefit (FTB) Part A, Parenting Payment, Youth Allowance, ABSTUDY, Disability Support Pension, Special Benefit, Carer Payment, Double Orphan Pension or Department of Veterans' Affairs education allowances under the Veterans' Children Education Scheme (if aged 16-17), and the Military Rehabilitation and Compensation Act Education and Training Scheme (if aged 16-17).

- providing health professionals information about the operation of the CDBS and advice via a Medicare CDBS provider enquiries telephone line
- conducting assessment of eligibility of dental practitioners as dental providers
- carrying out assessment, processing, and payment of claims under the CDBS.

Services Australia also has a role in communicating information about the CDBS that includes:

- information for customers that are hosted on the Services Australia website about eligibility, what dental services are covered, and how to get and claim dental services under the schedule[28]
- information for dental practitioners that are hosted on the 'Health Professionals' page on the Services Australia website about the schedule, patient eligibility and dental practitioner requirements[29]
- Health professional education resource materials, including eLearning modules[30]
- translated CDBS information for people from diverse cultural and linguistic backgrounds[31]
- ability to perform patient eligibility checks, patient cap balance checks, and eligibility to claim for CDBS service for Health professionals through Health Professional Online Services[32]
- CDBS information and promotion materials for dentals providers, available as downloadable products from the Services Australia website[33]

In 2021, the Australian Government paid benefits of $298.9 million under CDBS arrangements in respect of 4.96 million dental services across Australia, averaging $60.06 in benefits per service.[34]

DENTAL SERVICES UNDER MEDICARE

The Government provides Medicare benefits for privately rendered medical services listed on the Medicare Benefits Schedule (MBS). The MBS lists certain oral and maxillofacial services that attract benefits when performed by a medical practitioner or an approved oral and maxillofacial surgeon within both private and public dental services. For benefits to apply, a service must be clinically relevant and all elements of the MBS item descriptor must be satisfied.

There are also benefits payable for eligible children and young people under the Cleft Lip and Cleft Palate Scheme.

[28] https://www.servicesaustralia.gov.au/child-dental-benefits-schedule
[29] https://www.servicesaustralia.gov.au/about-child-dental-benefits-schedule-for-health-professionals?context=23006
[30] https://hpe.servicesaustralia.gov.au/child-dental-benefits-scheme.html
[31] https://www.servicesaustralia.gov.au/child-dental-benefits-schedule-translation
[32] https://www.servicesaustralia.gov.au/hpos?context=22786; and https://hpe.servicesaustralia.gov.au/HPOS_information.html
[33] https://www.servicesaustralia.gov.au/promote-child-dental-benefits-schedule-your-practice?context=23006
[34] Oral health and dental care in Australia, Summary - Australian Institute of Health and Welfare.

Information on all MBS services subsidised by the Government are listed on the Australian Government's MBS Online website.[35]

Services Australia administers the Cleft Lip and Cleft Palate Scheme, and related payments, on behalf of the Department, and also has a role in communicating information about the schemes.

E: THE SOCIAL AND ECONOMIC IMPACT OF IMPROVED DENTAL HEALTHCARE.

Poor oral health has a significant impact on individuals, the health system, and society. On an individual level, poor oral health can go beyond physical health and include mental health and social impacts such as poor appearance, low self-esteem, and decreased quality of life.[36] On a health system level, there are both direct and broader costs associated with poor oral health.[37]

SOCIAL IMPACT

Data presented earlier (under 'A: Term of Reference') shows that access to dental care is inequitable. Oral health outcomes, particularly in vulnerable cohorts, such as people from low socio-economic backgrounds, older Australians, and Aboriginal and Torres Strait Islander communities, are also inequitable. It is generally accepted that 80% of the oral disease in Australia is experienced by 20% of the population, lending weight to a risked based approach to public dental services.[38]

Some of the social impacts of dental care are evidenced below.

[35] Available online: www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home.
[36] Oral health and dental care in Australia, Healthy lives - Australian Institute of Health and Welfare.
[37] AIHW Health Expenditure Database.
[38] Oral health and dental care in Australia, Healthy lives - Australian Institute of Health and Welfare.

Table 4: Social impacts of dental care.

Health and disease[39,40,41]	• In 2022, oral disorders made up 2.3% of total health burden and 4.5% of all nonfatal burden. • Around one in five (20%) dentate adults aged 15 years and over had experienced toothache in the previous 12 months. • Around one in four (24%) dentate adults aged 15 years and over had avoided eating certain foods in the previous 12 months due to problems with their teeth. This is higher for people eligible for public dental care and lower for people with dental insurance. • Around one in four (24%) dentate adults aged 15 years and overrated their oral health as fair or poor. • Avoiding food due to dental problems is an impact of poor oral health and may reflect an inability to chew properly. This reduces enjoyment of food and can affect the ability to maintain a healthy nutritional status. • Toothache can be caused by dental diseases, including dental decay and gum disease that cause pain directly, or that create a painful infection. Other causes of toothache include broken (fractured) teeth, or severe sensitivity of the nerves inside the tooth to hot or cold foods or drinks. While some forms of toothache are short-lived, others can persist and become disabling.
Appearance and behaviour[42]	• Overall, 35.2% of Australians aged 15 years and over reported being uncomfortable about their dental appearance in the last 12 months. • The 35-54 years age group had the highest percentage uncomfortable about their dental appearance (38.9%), while the lowest percentage was observed in the 75 years and over age group (26.2%). • Poor dental health results in lost time from work or school and this affects disadvantaged groups disproportionally. However, due to a lack of recent population-based data, estimates on lost productivity associated with dental problems cannot be made.[43]

[39] The National Study of Adult Oral Health 2017–18.
[40] Oral health and dental care in Australia, Healthy lives - Australian Institute of Health and Welfare.
[41] Oral health and dental care in Australia, Healthy lives - Australian Institute of Health and Welfare.
[42] The National Study of Adult Oral Health 2017–18.
[43] Harford, J. Productivity losses from dental problems. Aust Dent J. 2012 Sep;57(3):393-7.

ECONOMIC IMPACT

Poor oral health can disrupt speech, sleep, and productivity, erode self-esteem, psychological, and social wellbeing, and impact relationships and general quality of life. This can lead to restricted participation at school, the workplace, and home, and result in loss of school or work hours. On a societal level, this results in the loss of millions of workdays each year.[44]

The AIHW's '*Health Expenditure Australia 2020-21'* report found that in 2020-21, $11.1 billion was spent on dental services; with individuals contributing around $6.5 billion, or 59% of this total; while in 2019-20, $9.7 billion was spent on dental services, with individuals contributing around $5.6 billion, or 58% of this total.[45]

The AIHW's *Disease expenditure in Australia 2018-19* report found that in 2018-19, the average health system spending per case for all oral disorders was $315.

In relation to government expenditure on dental services: [46]

- Australian Government expenditure fluctuated over the decade to 2020-21, from a high of $1.8 billion in 2011-12 to a low of $1.2 billion in 2019-2020 with expenditure remaining relatively stable between 2014-15 and 2020-21 at around $1.3 billion. Across the period, expenditure declined at an average annual rate of 1.6%.
- Overall, state and territory government expenditure on dental services grew at an average annual rate of 0.7%. Expenditure fluctuated over the decade; ranging from lowest expenses of $711 million in 2012–13 to highest expenses of $946 million in 2020-21.
- Between 2010-1 and 2020-21, Australian Government per capita expenditure on dental services fluctuated between $49 in 2019-2020 and $82 in 2011-2012, declining overall at an average annual rate of 3%.
- State/territory and local government per capita expenditure fluctuated during the period 2010-11 to 2020-21, ranging from $31 in 2012-13 to $40 in 2010-11. Across the period, expenditure declined at an average annual rate of 0.8%.

In relation to non-government expenditure on dental services:[47]

- This increased steadily overall, from $6.3 billion in 2010-11 to $8.8 billion in 2020-21. This represented an average annual growth rate of 3.4%.
- Total non-government expenditure on dental services increased from $7.6 billion in 2019-20 to $8.8 billion in 2020-21.

[44] Oral health and dental care in Australia, Healthy lives - Australian Institute of Health and Welfare.
[45] Section F outlines the impact of the COVID-19 pandemic on dental services.
[46] AIHW Health Expenditure Database.
[47] AIHW Health Expenditure Database.

- Expenditure on dental services by individuals accounted for most of the non-government expenditure, increasing from $5.0 billion in 2010–11 to $6.5 billion in 2020–21 at an average annual growth rate of 2.6%.
- Health insurance funds' expenditure on dental services increased at an average annual growth rate of 6.2%, from $1.2 billion in 2010–11 to $2.2 billion in 2020–21.
- Per capita expenditure on dental services by the non-government sector increased from $284 in 2010–11 to $343 in 2020–21. Across the period, per capita expenditure grew at an average annual rate of 1.9%.

F: THE IMPACT OF THE COVID-19 PANDEMIC AND COST-OF-LIVING CRISIS ON ACCESS TO DENTAL AND RELATED SERVICES.

THE COVID-19 PANDEMIC

The COVID-19 pandemic has impacted every aspect of the Australian health system, including the provision of dental care services. It has had an impact on both patients and dental professionals in terms of the number of services, type of services, and the way in which services are delivered.[48]

Early in the pandemic, the Australian Health Protection Principal Committee (AHPPC) issued advice to National Cabinet that recommended dental practices implement restrictions whereby dental professionals should only perform dental treatments that do not generate aerosols, or where treatment generating aerosols is limited, and that all routine examinations and treatments should be deferred. These types of restrictions have been implemented and eased at various times over the course of the pandemic.

In April 2020, the Australian Health Practitioner Regulation Agency (Ahpra) and National Boards established a temporary pandemic response sub-register for up to 12 months to help fast track the return to the workforce of experienced and qualified health practitioners to assist with the COVID-19 pandemic. In early April 2021, the Commonwealth Health Minister requested that dental practitioners (as well as nurses, midwives, pharmacists, and Aboriginal and Torres Strait Islander health practitioners) be added to the sub-register for up to 12 months to help with the COVID-19 response.

Events that may have impacted on service use over the period March 2020 to October 2021 across Australia, are included in the table below.

Table 5: Lockdown dates for Australia.

March 2020	National lockdown introduced
June 2020	Second wave of COVID-19 cases in Victoria

[48] Oral health and dental care in Australia, Summary - Australian Institute of Health and Welfare.

August 2020	Lockdown in Victoria
October 2020	Victorian lockdown eased
December 2020	Outbreak of cases in Sydney's Northern Beaches
January 2021 – 20 March 2021	Brief snap lockdowns in some states and territories to contain COVID-19 spread
July 2021 – October 2021	A series of extensive lockdowns and/or extended lockdowns in New South Wales, Victoria, and the Australian Capital Territory.

In 2020-21, around one in eight (12%) adults aged 15 years and over delayed seeing or did not see a dental professional at least once in the last 12 months due to COVID-19. The proportion of adults aged 15 years and over who delayed seeing or did not see a dental professional in the last 12 months due to COVID-19 was:

- higher for females (14%) than males (9.4%)
- higher for people living in major cities (13%) than people living in inner regional (9.8%) or outer regional, remote or very remote areas (7.4%)
- higher for people who self-assessed their health as fair/poor (15%) than people who self-assessed their health as excellent/very good/good (12%)
- higher for people with a long-term health condition (14%) than people without a long-term health condition (11%).

The delivery of oral health services provided under the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) is also likely to have been impacted by COVID-19. Between 2019 and 2020 the number of full-mouth fluoride varnish services, fissure sealant applications, and clinical service visits decreased. This was largely due to a fall in attendances between March and April 2020, coinciding with the introduction of restrictions imposed to control the spread of COVID-19. The services started to increase again in 2021 for full-mouth fluoride applications and for fissure sealant applications; this might be the result of fewer restrictions.

ACTIONS TAKEN BY THE COMMONWEALTH

COVID-19 restrictions had an impact on state and territory governments' ability to deliver dental services under the FFA. To help states and territories achieve their set activity level, the Commonwealth introduced a catch-up period in the 2021-22 FFA. The catch-up period provides an additional period (April to June) to achieve activity targets. While this has helped states and territories to meet their baseline activity and some of their activity over baseline, the agreement prevents them using the same time to meet targets in a subsequent year. Some states and territories have found it challenging to meet activity levels required to

receive the full funding; the performance period for the current agreement is from 1 April 2022 to 31 March 2023.

COST OF LIVING PRESSURES

The impact of recent cost of living pressures on dental services cannot yet be fully assessed. However, as outlined in response to Term of Reference A above, around four in ten (39% people aged 15 years and over avoided or delayed visiting a dentist due to cost.[49] A significant proportion of costs for dental services are borne by individuals, therefore access to services is likely to be impacted by the rising cost of living.

G: PATHWAYS TO IMPROVE ORAL HEALTH OUTCOMES IN AUSTRALIA, INCLUDING A PATH TO UNIVERSAL ACCESS TO DENTAL SERVICES.

LONG-TERM DENTAL REFORM

In working on longer term dental reform with jurisdictions, the Commonwealth prioritises reforms that focus on innovation, prevention, improved access and outcomes for disadvantaged populations, improved patient experience, and more sustainable funding arrangements to improve oral health outcomes in Australia.

The inter-governmental working group has agreed several objectives for reform, including increased equity of access, interface and alignment with the broader health system, financing certainty, transparency, and flexibility. An options paper was delivered to Health Ministers on November 18, 2022, based on these objectives. Further analyses of the options are being carried out and are expected to be presented to Health Ministers at their June 2023 meeting.

DENTAL RESEARCH

The Commonwealth funds several population health dental research studies (see below). The AIHW draws on these research studies for their 'Oral health and dental care in Australia' reports, which are published online and updated as new data becomes available.

Currently funded research:

Table 6: Currently funded research for the period 2023-2026.

University of Adelaide, Australian Research Centre for Population Oral Health	**National Dental Care Survey 2023-24 to 2025-26 (previously National Dental Telephone Interview Survey (NDTIS))** ***(2023 Budget Measure)***	The National Dental Care Survey monitors population trends in access to dental healthcare and self-reported oral health, including frequency of dental visits, patient outcome measures, and loss of work time due to dental problems. This is the only comprehensive time series study undertaken in Australia of this nature. The University of Adelaide has conducted this study on a two-to-three-year cycle since 1994.

[49] National Study of Adult Oral Health 2017–18.

University of Adelaide, Australian Research Centre for Population Oral Health	**National Child Oral Health Study (NCOHS) 24-26** (*2022 Budget Measure*)	The study will provide data on the oral health status of children in the following areas: • The nature and distribution of oral disease – has there been a change since the last child survey? Are the national oral health targets being met? • The study also includes an oral examination, which is provided by states and territories as in-kind support. • Identifying disadvantaged population subgroups to better advise Government policy and service delivery. • Evaluation of existing programs and policies. The study will provide an update on the data collected in the last National Child Oral Health Study of 2012-14.

Previously funded research:

Table 7: Previously funded research.

University of Adelaide, Australian Research Centre for Population Oral Health	**National Dental Telephone Interview Survey (NDTIS) 2019-20 to 2022-23**	The National Dental Telephone Interview Survey 2019-20 to 2022-23 is the continuation of a time series study which monitors population trends in access to dental healthcare and self-reported oral health. The study monitors population trends in access to dental healthcare and self-reported oral health, including frequency of dental visits, patient outcome measures, and loss of work time due to dental problems. The Department is currently reviewing the draft Final Report.
University of Adelaide, Australian Research Centre for Population Oral Health	**National Oral Adult Health Study 2017-18**	The study's findings inform health authorities of the successes and gaps in dental healthcare delivery to adults in Australia. Evidence of what is working (and what is not) and an understanding of the burden of disease facilitate the development of best practice dental healthcare delivery and oral health preventive programs. The study discussed how to reach population sub-groups most at risk of oral disease. The final report is available on the ARCPOH website.

In addition to these research grants, the Medical Research Future Fund has invested $6.08 million in four grants with a focus on dental research between 2015 and 2023.

H: THE ADEQUACY OF DATA COLLECTION, INCLUDING ACCESS TO DENTAL CARE AND ORAL HEALTH OUTCOMES.

There are currently multiple data sources for dental care and oral health outcomes.

DATA SOURCES

States and territories collect their own data against the National Minimum Data Set (NMDS), which was designed by the AIHW to determine wait times for public dental services. However, due to the variability in the scope of the data, it is not possible to gain an understanding of wait time data at the national level.

Several national surveys and studies conducted by the University of Adelaide (Table 6 & 7) provide population health data for adults and children across Australia. Further, the AIHW

regularly produces the 'Oral Health and Dental Care in Australia' online report which collates data from multiple sources, and the ABS collects the following data across population surveys and in the Multi Agency Data Integration Project (MADIP) on the topics of dental care access and oral health outcomes (data items can be found in *Appendix A*):

- *The Patient Experience Survey (PEx),* a topic on the Multipurpose Household Survey (MPHS) conducted throughout Australia annually, contains a dental module answered by people aged 15 years and over. It is restricted to those who usually reside in private dwellings.
- *The National Health Survey (NHS) 2020-21* included a module on health service use. In this, several questions were asked regarding the use of health professionals, including dentists/dental professionals. The scope of this survey includes usual residents in Australia who were living in private dwellings, although only persons aged 2 years and over were asked about the use of dentists/dental professionals.
- *The National Aboriginal and Torres Strait Islander Health Survey* collects information on the use of dental services from Aboriginal and Torres Strait Islander people aged 2 years and over in non-remote and remote areas of Australia, including discrete Aboriginal and Torres Strait Islander communities. However, depending on required geographic levels of disaggregation and grouping of data items, data quality needs to be considered.
- *The Survey of Disability, Ageing and Carers (SDAC)* 2012, 2015 and 2018 included a Dental Services module for people living in households. The questions were answered by people with a disability and primary carers without a disability. Primary carers are aged 15 years and over. The scope of SDAC is limited to those living in households, self-care retirement villages, and health establishments that provided long term accommodation. It excludes people living in very remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities.
- *The Multi-Agency Data Integration Project (MADIP)* is a secure, person-based research data asset combining information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) to create a comprehensive picture of Australia over time.

The NTRAI OHP collects service delivery and health outcome data to monitor access and performance against agreed benchmarks. Performance measures include:

- Occasions of service per annum by clinical and preventative service types and locational spread of services.
- Number of fluoride varnish applications per annum.
- Number of fissure sealants per annum.

NTRAI OHP outcome measures include:

- Percentage of communities receiving a dental service.
- Prioritisation of preventive services.

- Equitable service delivery across HSDAs and by remoteness.

The data provided for these measures by the Northern Territory Government are independently verified, analysed, and published by the AIHW.

LIMITATIONS OF DATA COLLECTION

Private sector

There are limitations in data on dental service provision. One of the main data gaps relates to dental services provided in the private sector, which accounts for most dental services provided. Some basic data is available to governments for services for which a private health insurance claim is paid.

Limited scope

Data collected about public dental services is also limited in scope. The data available is under the Public Dental Waiting Times data collection which has well-recognised limitations and is not considered to be comparable across states and territories. There would be value in working with states and territories and other stakeholders to specify a data collection that captures standard information about characteristics of all clients and all services provided by public dental providers.

Lack of data for services funded by individuals

Systematic data regarding services that are entirely covered by personal funds is not collected.

Working with stakeholders, such as private hospitals and dental practices, to encourage them to report on the cost and percentage of patients who fully funded their own dental care, may partially close this gap.

Limitations of Medicare data for reporting on regional access and the health of Aboriginal and Torres Strait Islander people

Key reporting metrics such as customer location and Aboriginal and Torres Strait Islander status indicators are available in Medicare's systems. This includes customer location categorised against the Department's Modified Monash Model (MMM) that defines whether a location is a city, rural, remote, or very remote. This data can be limited by factors such as the Aboriginal and Torres Strait Islander status indicator being voluntary to provide, and customer location (address) being infrequently updated. This places some restrictions on the utility of Medicare's data to reliably inform reporting on oral health outcomes where demographic factors such as regional access and Aboriginal and Torres Strait Islander health are the focus.

NATIONALLY CONSISTENT DATA DEVELOPMENT

Previous attempts at data development included developing national key performance indicators using a top-down methodology. In a context where each jurisdiction has very different dental systems, this approach has been largely unsuccessful. Different approaches might be needed; for example, a better model might be to take a 'bottom up' approach to data development, commencing first with what each jurisdiction is already capturing and reporting internally.

Over time, reporting may converge in some areas, but in other areas may continue to reflect the differing priorities/models that apply in each jurisdiction. Nevertheless, more consistent availability of data would enable better monitoring of the provision of and access to dental services by populations eligible for public dental care.

In the 2023-24 Budget, the Government announced funding of $442,000 over two years for the development of a new public dental National Minimum Data Set (NMDS) to collect nationally consistent activity and waiting times data. The proposed NMDS is at a national level, while the current AIHW public dental wait times NMDS is at a state and territory level.

I: WORKFORCE AND TRAINING MATTERS RELEVANT TO THE PROVISION OF DENTAL SERVICES.

To meet the population's oral health demands, it is necessary to have an appropriately skilled and distributed workforce that utilises a full range of skills in accordance with relevant legislation and regulation.

WORKFORCE

There were 26,836 registered dental practitioners as of December 2022 (total figure including 29 dental practitioners on the pandemic response sub-register).[50] Dentists employed in Australia predominantly worked in private practices, with only 5.4 per 100,000 employed in the public sector. Some state governments have established public-private partnerships to increase dental services for both adults and children.

Like other health professions, there is a maldistribution of dentists between major cities and rural areas. In 2020, the FTE rate of dentists ranged from 26.3 per 100,000 population in remote and very remote areas to 63.8 per 100,000 population in major cities.[51] There are no workforce initiatives to support recruitment or retention of dental practitioners in rural and remote areas.

[50] Dental Board of Australia Registrant Data, Australian Health Practitioner Regulation Agency.
[51] Oral health and dental care in Australia, Summary - Australian Institute of Health and Welfare.

The ABS Census of Population and Housing 2021 data[52] indicates that 56,814 people reported working in the Dental Services industry in Australia in 2021. There were 15,601 dental practitioners (dentists), 26,438 dental assistants and 7,642 dental hygienists, technicians, and therapists. Within the Dental Services industry, 4,648 people reported working as office managers and program administrators and 5,462 reported they were inquiry clerks and receptionists. The Dental Services industry is represented in all states and territories with 16,856 living in NSW and 274 living in the Northern Territory.

Aboriginal and Torres Strait Islander people are under-represented in the oral health workforce, and many dental services lack cultural sensitivity. For instance, the consumer may be charged if appointment times are inflexible and "failure to attend" policies are rigid. A practice that is typically not supported is that many Aboriginal and Torres Strait Islander people prefer to attend the dentist with family and friends.[53]

Historically, overseas-trained dentists have filled workforce gaps in the public sector, regional and remote areas, and academia. This has occurred through regular targeted migration and employment programs. As the increased number and size of domestic dental schools has produced more graduates, the reliance on overseas-trained clinicians is decreasing.

EDUCATION AND TRAINING

The Rural Health Multidisciplinary Training (RHMT) Program

The government funds education for dentists through the RHMT. The RHMT program and the Murray-Darling Medical Schools Network (MDMSN) have become the Australian Government's key initiatives for supporting medical and allied health students to undertake education and training in rural Australia. Both initiatives (totalling over $220 million per annum) provide expanded settings for health students to study and experience rural training and immersion in rural environments. The program supports medical, nursing, midwifery, allied health, and dental students to undertake rural training through a network of Rural Clinical Schools, Regional Training Hubs, University Departments of Rural Health, dental faculties offering extended rural placements, and the Northern Territory Medical Program.

The RHMT presently supports six metropolitan based dental schools to provide rural placements for dental students through the Dental Training Expanding Rural Placement Program (DTERP). Participating universities include the University of Sydney, University of Western Australia, University of Melbourne, University of Adelaide, University of Queensland, and Griffith University. DTERP universities must deliver extended placements for at least five Australian dental students for each full academic year ranging from a minimum of four weeks up to a year, in ASGS-RA 2 to 5 areas. Placements for dental and oral health students are also supported by University Departments of Rural Health (UDRH). Universities currently

[52] ABS Census of Population and housing 2021 data.
[53] National Oral Health Plan 2015-2024.

supporting placements for dental students through a UDRH include La Trobe, James Cook, Charles Sturt, Newcastle, Monash, and Flinders Universities (South Australia and Northern Territory). Dental placements are offered in addition to DTERP commitments at University of Melbourne, University of Sydney, and University of Adelaide.

In the external evaluation of the RHMT program done in 2020, a recommendation was made to do a feasibility study to find the best approach to increase dental and oral health training in regional locations.

Higher Education Loan Program (HELP) Debt Reduction for Health Practitioners Program

The Government has established the *HELP Debt Reduction for Health Practitioners Program*. The Program will encourage doctors and nurse practitioners to live and work in rural, remote, or very remote areas of Australia by reducing their outstanding HELP debt provided they meet the eligibility criteria and their obligations to complete the required amount of work. The program does not currently cover dental practitioners but is expected to be reviewed in 2025 and 2028 to determine whether expansion to other medical practitioner cohorts (such as dental practitioners) should be considered by Government.

Health Workforce Scholarship Program (HWSP)

The Health Workforce Scholarship Program (HWSP) is a national program administered by Health Workforce Queensland and delivered by all Rural Workforce Agencies. The Program aims to increase the skills, capacity, and/or scope of practice of existing health professionals in rural and remote areas experiencing skill shortages by providing scholarships and bursaries to health professionals committed to rural service, across a range of health disciplines including medicine, nursing, and allied health. Eligible allied health professions include dentistry. The Program is aimed at post-graduate study and skills development and most scholarships include a return of service obligation to provide a return on investment to the Australian community.

The HWSP utilises the jurisdictionally based Health Workforce Needs Assessment (completed as part of the Rural Health Workforce Support Activity) to identify local health workforce needs. Scholarships and bursaries are prioritised to address local needs and increase the skills, capacity and/or scope of practice of existing health professionals. Most scholarship types include a return of service obligation to provide greater return on investment.

Dental Graduate Year Program

The Voluntary Dental Graduate Year Program (VDGYP), which was part of the 2011-12 Budget, provided $52.6 million over four years (2011-12 to 2014-15) to support 50 dental gradate placements each year commencing from the 2013 calendar year.

The Commonwealth engaged AITEC Corporate Education and Consulting to implement the VDGYP, to increase the oral health workforce in regional and remote areas. AITEC provided the web-based systems and facilities and all management and administration, and paid all

salaries for graduates and mentors, incentives, and substantial dental infrastructure funding under the program.

In the 2012-13 Budget, the scheme was expanded to provide an additional $35.7 million over four years (2012-13 to 2015-16), to increase placements to 75 places in 2015 and 100 places in 2016.

The Department commissioned Australian Continuous Improvement Group (ACIG) to carry out a series of formative and summative evaluations of the VDGYP over the period 2013-2016. Over the course of the program's three years, the value of the VDGYP was shown. The program was continued, with strong support from graduating participants as well as service providers, in a limited format (without access to the formal curriculum or supporting delivery technology), using their own funding. The overarching recommendation was that it would be an efficient and effective use of funds to continue the program, even in a limited capacity, while continuing to achieve benefits from the investment already made.[54]

J: INTERNATIONAL BEST PRACTICE FOR, AND CONSIDERATION OF THE ECONOMIC BENEFIT OF, ACCESS TO DENTAL SERVICES.

Across OECD countries, dental care is more dependent on out-of-pocket expenses than other areas of health care because public funding and insurance is more limited. On average, the out-of-pocket expenses for dental in OECD countries is at 17%. Australia, however, has a large out of pocket expense at 59%. In comparison, Canada and the USA are at 38% and 40%, respectively.

More recently, Canada and the UK have announced significant changes to the way dental services are funded. They have also made legislative amendments to help recruit overseas-qualified dental practitioners. Canada announced an investment of $13 billion over five years to implement a means-tested dental care plan for publicly uninsured Canadians. The newest investment in oral health is targeted at reducing barriers in accessing care for people on low-incomes and people living in rural and remote areas.

The UK has introduced significant changes to the way dental contracts for public dental services are commissioned. These changes include: initiatives to support higher needs patients; establishing a minimum unit price for dental activities; and changes to the workforce including the way overseas qualified dental practitioners are recognised in the UK.

The General Dental Council (GDC) in the UK has also been given more power under the amended *Dentists Act 1984* to address workforce shortages. The changes allow the GDC to create new pathways for overseas qualified dental practitioners to become eligible to practise in the UK.

[54] https://www.health.gov.au/sites/default/files/documents/2020/12/foi-request-1651-voluntary-dental-graduate-year-program-final-evaluation-report-vdgyp-final-evaluation-report.pdf

Similar to Australia, New Zealand offers free basic oral health services for children who are aged 0 to 17 years and meet the criteria for health and disability services. A limited range of services are also available for adults on low-incomes or with disabilities and other medical conditions such as oral cancers.

K: RELATED MATTERS.

COLLABORATING GOVERNMENT AGENCIES ON THIS SUBMISSION

The Australian Institute of Health and Welfare, Australian Bureau of Statistics, and Services Australia have collaborated with the Department of Health and Aged Care to prepare this submission.

APPENDIX A - ABS DATA ACROSS POPULATION SURVEYS AND IN THE MULTI AGENCY DATA INTEGRATION PROJECT (MADIP) ON THE TOPICS OF DENTAL CARE ACCESS AND ORAL HEALTH OUTCOMES.

The Patient Experience Survey (PEx)	• Whether seen a dentist, dental hygienist, or dental specialist for own health in last 12 months • Number of times visited a dental professional for own health in last 12 months • Hasn't seen a dental professional in the last 12 months but needed to • Total population that needed to see a dental professional in last 12 months • Whether accessed any public dental services in last 12 months • Whether been placed on a public dentistry waiting list in last 12 months • Length of most recent time placed on a public dentistry waiting list before receiving care • Whether needed to see a dental professional but didn't at least once in last 12 months • Main reason did not see dental professional when needed to • Whether delayed seeing or did not see a dental professional due to cost in last 12 months • How often dental professional(s) listened carefully in last 12 months • How often dental professional(s) showed respect in last 12 months • How often dental professional(s) spent enough time with person in last 12 months
The National Health Survey (NHS) 2020-21	• Type of health professional consulted in the last 12 months • Number of consultations with dental professional in last 12 months • Time since last consulted a dentist or dental professional.
The National Aboriginal and Torres Strait Islander Health Survey	• Reason/s did not go to dentist in the last 12 months • Time spent on waiting list before receiving non-urgent dental treatment (non-remote only) • Type of health professional last saw about teeth (dentist, doctor/GP, nurse, other) • Time since last consulted a dentist or dental professional • Usual reason for dental consultation (treatment, check-up, both) • Whether most recent visit was for emergency treatment (non-remote only) • Frequency brushes or cleans teeth • Whether have lost any natural teeth (excluding wisdom teeth) / number of natural teeth lost (15 years and over only) • Whether needs dentures or false teeth that can be removed / whether needs to get false teeth to be able to eat properly (15 years and over only) • Whether child had any teeth filled by a dentist / whether child had any teeth pulled by a dentist (2-6 years only).
The Survey of Disability, Ageing and Carers (SDAC)	• Whether seen a dentist, dental hygienist, or dental specialist for own health in last 12 months • Whether had any public dental services in past 12 months • Whether delayed seeing or did not see a dental professional because of cost in last 12 months • Unmet need for dental services in the last 12 months • Main reason did not see dental professional when needed to • Whether been on a public dental waiting list in last 12 months

	• Length of time on public dental waiting list before receiving dental care.
The Multi-Agency Data Integration Project (MADIP)	• Census of Population and Housing • Medicare Benefits Schedule • National Disability Insurance Scheme • Personal Income Tax Return • ATO Client Register The available data on dental and oral health outcomes present in MADIP is contained within the Medicare Benefits Schedule (MBS) module. Items within the MBS are the categories relating to the provision of and access to dental services in Australia. *Category 4 (Oral and Maxillofacial Services)* • General Surgery • Ear, Nose & Throat • Neurosurgical • Temporomandibular joint • Treatment of fractures • Plastic & Reconstructive • Periprosthetic • Consultations • Assistance at operation • Diagnostic procedures and investigations • Regional or field nerve blocks. *Category 7 (Cleft Palate Services)* • Orthodontic services • Oral and Maxillofacial services • General and Prosthodontic services. In MADIP the Data Item List (DIL) contains variables including: • item numbers • benefit paid • bulk billing / patient billed • service classifications • dates • postal delivery area • amount charged • hospital service flag • number of services by a registered provider • referral date • Medicare service provider's location • specialty of the health profession • MBS groups. Other important modules in the MADIP data asset include: • Census of Population and Housing (2011, 2016, 2021) • National Health Survey (2014-15, 2017-18, 2020-21) • Survey of Disability, Ageing and Carers (2018) • ATO client register (2010/11 – 2020/21)

	• Personal Income Tax Return (2010/11-2020/21) • Higher Education Information Management System (2005-2020) • National Disability Insurance Scheme (2019-2022) • Pharmaceutical Benefits Scheme (2011-current) • Medicare Consumer Directory (2006-current) • DOMINO Centrelink Administrative Data (2006-2021)