LA TROBE UNIVERSITY

Select Committee

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Provision of and Access to Dental Services in Australia

ENQUIRIES
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A. INTRODUCTION

La Trobe University welcomes the opportunity to submit this response to the Select Committee into the Provision of and Access to Dental Services in Australia.

Crucial to a person's overall health, well-being and quality of life, oral health has quite unique characteristics. While it is one of the most expensive health conditions to treat[1], it is also one of the most easily preventable chronic non-communicable diseases (NCDs) worldwide. In other words, investing in public dental health care not only improves the well-being of the population but would also reduce the amount of money spent on preventable hospitalisations due to dental conditions.

As confirmed in a recent **KBC report**, the dental and oral health workforce in Australia has grown over the years in terms of absolute numbers and on a per capita basis. However, there are significant geographic discrepancies in access to dental practitioners between metropolitan and non-metropolitan Australia. This is one of the contributing factors to the fact that "overall people living in regional and remote areas have poorer oral health than those in cities, with limited access to dental practitioners a key factor." According to the report, the number of dentists decreases from 65.1 per 100,000 in major cities to 27.7 in remote and very remote regions. Similarly, the rates of both dental hygienists and oral health therapists decrease with increasing remoteness.

La Trobe's Dentistry and Oral Health courses make a significant contribution in improving the rural oral health workforce, thereby aiding in the delivery of oral health care services in rural and regional areas. Our Bachelor of Dental Science (Honors) and Bachelor of Oral Health Science courses are delivered from our Bendigo campus with students undergoing clinical training predominantly in Bendigo, Mildura, Melton and Wodonga along with several other inner regional and remote locations in Victoria.

Regrettably, despite being the only university in Victoria offering predominantly rural training pathways, dental education is not recognised within La Trobe's 'University Department of Rural Health' (UDRH) funding. Further, La Trobe receives only 50 per cent of what other UDRHs receive under the Rural Health Multidisciplinary Training (RHMT) program for nursing and allied health disciplines more broadly. Defying logic, while metro-based dental schools are eligible for funding for placements through the Dental Training Expanding Rural Placement Program (DTERP), rurally-based schools like La Trobe (which have more rural enrolments), are not eligible for DTERP funding. This means that despite increasing demand from rural students, we are currently unable to increase our enrolments owing to constraints on pre-clinical simulation places and clinical placement supervision capacity in regional and rural locations. Evidence[2] shows that providing opportunities for regional and rural students is a more efficient way of addressing regional long-term workforce challenges rather than programs that solely pushes metro-based students out to regional Australia for clinical rotations. **With more adequate funding and robust policy reform, La Trobe would be in a position to make a significant contribution to increasing the rural dental workforce in Victoria.**

In addition to addressing the workforce training challenges that would increase access to dental services across Australia, La Trobe is of the view that there should be stronger efforts (at both Federal and State levels) to focus on the prevention of oral disease – this includes ensuring access to water fluoridation (proven to prevent dental caries) across Australia and evidence-based public health campaigns to improve oral health outcomes.

La Trobe looks forward to working with the Select Committee particularly with regard to improving the provision of, and access to, dental services in regional Australia.

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[1] According to the **Oral health and dental care in Australia** 2023 report, dental caries ($4.5 billion) had the second highest expenditure among ABDS-listed conditions (excluding all 'other' conditions within groups) behind falls ($4.7 billion).
[2] Skinner TC, Semmens L, Versace V, Bish M, Skinner IK. Does undertaking rural placements add to place of origin as a predictor of where health graduates work? Aust J Rural Health. 2022;00:1– 7. **https://doi.org/10.1111/ajr.12864**

B. SUMMARY OF KEY RECOMMENDATIONS

Reaching vulnerable parts of the populations

1. Revise the eligibility criteria for the Child Dental Benefits Schedule (CDBS) to ensure that no families are in a position where they are not being covered by the CDBS but also not able to afford private health insurance

2. In line with the recommendations of the **Aged Care Royal Commission Final report** (Recommendation 60), which reported poor oral health among aged care residents, establish a Senior Dental Benefits Scheme

Improving dental and oral health outcomes in regional, rural and remote Australia

3. In line with the recommendations of the National Oral Health Plan, ensure regional, rural and remote communities have access to community water fluoridation on the same level as their metropolitan counterparts

4. Include dental and oral health within the health workforce scope of the Australian Government and within the scope of the Office of the Rural Health Commissioner

5. Enable rural communities to access public student-led dental services

Rural dental and oral health workforce

6. Extend RHMT funding to account for dental and oral health students

7. Work with state governments to find alternative ways of funding university-led dental clinics to treat public patients

8. a) Incentivise and fund an increase in the intake of rural students in the dental schools, especially in rural dental schools – extend DTERP funding to rural dental schools

   b) Given the impact of student origin and the location of placements on regional workforce retention, rural/regional students placements should, as a priority, be given to students in end-to-end regional/rural programs and to students from a regional/rural background.

9. Improve supervision capability in rural public dental clinics through innovative approaches, such as a rural graduate program, where senior dentists could mentor graduates while the latter supervise university students.

10. Improve access to the most remote locations by exploring hub and spoke models of service provision and mobile dental services

11. Provide funding to employ rural clinical educators in rural dental schools

C. LA TROBE'S RESPONSE TO INQUIRY'S TERMS OF REFERENCE

Terms of Reference a, d and f

a. the experience of children and adults in accessing and affording dental and related services

d. the provision of dental services under Medicare, including the Child Dental Benefits Schedule

f. the impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services

- The current schemes for public health care are not reaching parts of the population that have the highest needs. For instance, the Child Dental Benefits Schedule (CDBS) is only available to those families receiving the family tax Benefit A payment (i.e. families with less than $80, 000 annual income). With the increases in cost-of-living expenditure, families with income levels of around $100, 000 are not eligible for the CDBS but are certainly not in a position to afford private dental care. This means that there is a significant number of children who are not receiving adequate dental care. Further, evidence[3] shows that the COVID-19 pandemic had a significant impact on the provision of dental services to children from lower socioeconomic backgrounds who already experience higher levels of dental disease and disadvantage in accessing dental care. Although the restriction of dental services was deemed necessary in order to minimize the risk of transmission of COVID-19 in the dental setting, the impact of these restrictions on oral health will be long lasting. Action is needed now to reverse this trend.

- The oral health of older Australians is a significant issue as highlighted in the Aged Care Royal Commission Final Report. Several organisations including the National Oral Health Alliance, the Public Health Association of Australia, the Australian Council of Social Service and the Council on the Ageing (Victoria) are supporting the call for a Seniors Dental Benefits Scheme. Such a scheme should alleviate the problems older people are facing in accessing oral health care.

- 'Out of pocket' costs for oral health care continue to be a major barrier for accessing care and the situation has worsened given the increase in cost-of-living expenditure. The lack of access to this care leads to oral disease, which is very expensive to treat, hence adding to an increased cycle of impoverishment and economic hardship.

Recommendations

1. *Revise the eligibility criteria for the Child Dental Benefits Schedule (CDBS) to ensure that no families are in a position where they are not being covered by the CDBS but also not able to afford private health insurance.*

2. *In line with the recommendations of the Aged Care Royal Commission Final Report (Recommendation 60), which reported poor oral health among aged care residents, establish a Senior Dental Benefits Scheme.*

Terms of Reference b and c

b. the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;

[3] https://onlinelibrary.wiley.com/doi/abs/10.1111/cdoe.12611

c. the interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services;

- Australia's National Oral Health Plan identifies Aboriginal and Torres Strait Island people, regional and remote Australians, and people who are socially disadvantaged or on low incomes as priority populations who experience the most significant barriers to accessing dental and oral health care and have the greatest burden of oral disease.

- Australians living in rural and remote areas have consistently been identified as a priority group across consecutive Australian National Oral Health Plans and poor oral health is one of the most common health problems affecting rural and remote Australians. Overall, regional, rural and remote Australians have poorer oral health, lower incomes and lower rates of dental visits – meaning that they were already more prone to sub-optimal oral health outcomes – which have been exacerbated by the increase in cost-of-living expenditure.

- As outlined in the KBC report, "overall, people living in regional and remote areas have poorer oral health than those in cities, with limited access to dental practitioners a key factor." In rural Australia, children aged 5-14 years have a higher prevalence of dental cavities in both their primary and permanent teacher teeth and higher preventable hospital admissions for oral health conditions than children living in major urban areas of Australia.

- The latest **National Oral Health Survey**, which was conducted in 2017-18, highlighted the disparity in oral disease by remoteness, with people living in Australian cities less likely to suffer from dental caries/tooth loss, more frequently able to visit the dentist, and having access to higher rates of employed dentists when compared to people living in rural and remote areas.

- There are a number of factors that contribute to poor oral health status for rural communities, including access to and availability of adequate oral health services, retention of the oral health workforce in rural areas and reduced access to preventative measures such as fluoridated water. Combined with other social determinants of ill health – poverty, low levels of education, smoking and poor access to nutritious food at reasonable prices puts rural Australians at high risk for poor oral health.

    - According to Finding 9 of the KBC report, student-led dental and oral health service provision is well accepted by patients eligible to access public services and add to the clinical capacity of health services. However, low income workers and their families who are not eligible for public dental services are generally unable to access student-led dental and oral health services in public clinics in rural communities.

- Water fluoridation is a cost effective and equitable public health initiative that can prevent dental disease.

    - Despite recommendations for community water fluoridation for towns with 1000 population or more in the National Oral Health Plan (Healthy Mouths- Healthy Lives) many rural people still do not have access to fluoridated water. A recent **study**[4] showed that in

[4]Virginia Dickson‐Swift, Leonard Crocombe, Silvana Bettiol, Stacey Bracksley‐O'Grady, Access to community water fluoridation in rural Victoria: It depends where you live⋯, Australian Journal of Rural Health, 10.1111/ajr.12973.

rural Victoria, sixty-six (33%) of the 203 Victorian rural towns with >1000 population, representing 149,251 people, did not have access to fluoridated water. The majority of the towns without water fluoridation in rural Victoria (n=66, 87%) were located in an MMM5+ (this shows that the further you are located from the metro centres, the less oral health promoting infrastructure there is and the worse the oral health status).

- Oral health profiles (produced at the LGA level) in rural Victoria show that 62% of LGAs over >1000 population without water fluoridation have higher than the Victorian average of preventable hospital admissions due to dental conditions in children aged 0-9 years. In some LGAs the hospitalisation rates are almost three times the state average

- Over 50% of children aged 0-12 years living in rural non-fluoridated LGAs in Victoria have above the state average rates of decayed, missing and filled teeth (dmft/DMFT). In those aged 0-5 years this is the highest with 78% above the state average.

- According to the KBC report, "unlike medicine, nursing and allied health, there is an absence of a national rural focus on dentistry and oral health training, workforce development and distribution." Moreover, "the dental profession is not featured within the health workforce policy arm of the Australian Government" while "dental and oral health care are outside the current remit of the Office of the Rural Health Commissioner".

Recommendations

3. *In line with the recommendations of the National Oral Health Plan, ensure regional, rural and remote communities have access to community water fluoridation on the same level as their metropolitan counterparts*

4. *Include dental and oral health within the health workforce scope of the Australian Government and within the scope of the Office of the Rural Health Commissioner*

5. *Enable all rural communities to access public student-led services.*

Term of Reference e:

e. the social and economic impact of improved dental healthcare;

The WHO Global Burden of Disease report highlights that oral diseases disproportionally affect the poor and socially disadvantaged members of society. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases. This association exists from early childhood to older age and across populations in high-, middle- and low-income countries.

Term of Reference h:

h. the adequacy of data collection, including access to dental care and oral health outcomes;

- Overall, there is scope for significant improvements in data collection relating to dental care and oral health outcomes. A clear example is that currently only the data for public dental visits are collected with practitioners having no access to overall data including private dental visits.

Term of Reference i:

i. workforce and training matters relevant to the provision of dental services;

- Long waiting lists in public services and limited availability of private dentists in rural and remote regions of Australia have been perennial problems. Despite the establishment of rural dental schools (such as La Trobe's school in Bendigo), the rural oral health workforce is still a significant concern, and rural schools have been facing problems that impact their ability to train practitioners who would potentially practice in rural and remote locations. These problems include:

    - the inability to find and sustain rural placements due to the shortage of dental educators;

    - increasing costs to maintain clinical placements;

    - reliance on community health services due to the inability of university dental schools to run their own clinics. There are a number of reasons for this:

        - Federal level: There is no funding from the RHMT for dental and oral health as well as no funding from the Dental Training Expanding Rural Placement Program (DTERP) for rural dental schools. **This means that a metro-based dental school receives funding through the DTERP to place its students in rural locations whereas a rural dental school (such as La Trobe) which is more likely to have rural students does <u>not</u> receive funding to place students in rural/remote locations.** To cite the La Trobe example, 61% of enrolments in La Trobe's dentistry program were from rural students, exceeding the rural origin target. Yet La Trobe is not eligible for DTERP funding.

        - State level: Legislative barriers prevent universities from being able to access funding to provide public dental health services. For instance, in Victoria, unlike in other states, there are no university-led dental clinics. This means that universities are not able to access funding through Dental Health Services Victoria to treat public patients.

- Evidence[5] shows that providing opportunities for regional and rural students is a more efficient way of addressing regional long-term workforce challenges rather than programs that solely pushes metro-based students out to regional Australia for clinical rotations. As outlined in the cited report, end- to- end training in regional/rural areas has proven to be an effective approach to retaining a regional/rural workforce. Student origin is a strong predictor of whether a graduate is working rural and regionally. Another key factor which has an impact on the place of work is whether a student has undertaken placements in rural areas. On the basis of these findings, La Trobe recommends that rural/regional students placements should, as a

[5] Skinner TC, Semmens L, Versace V, Bish M, Skinner IK. Does undertaking rural placements add to place of origin as a predictor of where health graduates work? Aust J Rural Health. 2022;00:1– 7. **https://doi.org/10.1111/ajr.12864**

priority, be given to students in end-to-end regional/rural programs and to students from a regional/rural background.

Recommendations: (Note that some of these recommendations have been addressed in the KBC report)

6. *Extend RHMT funding to account for dental and oral health students*

7. *Work with state governments to find alternative ways of funding university-led dental clinics to treat public patients*

8. *a) Incentivise and fund an increase in the intake of rural students in the dental schools, especially in rural dental schools – extend DTERP funding to rural dental schools*

   b) Given the impact of student origin and the location of placements on regional workforce retention, rural/regional students placements should, as a priority, be given to students in end-to-end regional/rural programs and to students from a regional/rural background.

9. *Improve supervision capability in rural public dental clinics through innovative approaches, such as a rural graduate program, where senior dentists could mentor graduates while the latter supervise university students.*

10. *Improve access to the most remote locations by exploring hub and spoke models of service provision and mobile dental services*

11. *Provide funding to employ rural clinical educators in rural dental schools*