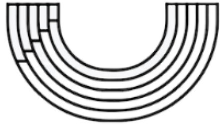

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SELECT COMMITTEE INTO THE PROVISION OF AND ACCESS TO DENTAL SERVICES IN AUSTRALIA.

Response from the OneOneTwelve Initiative
Associate Professor (Hon) Mina Borromeo
Sunday May 21, 2023.

SUMMARY STATEMENT

The OneOneTwelve Initiative would like to thank the Senate Committee for the opportunity to provide our thoughts on the state of oral health in Australia and potential ways to improve the oral health outcomes for all Australians but, in particular, the most vulnerable and in greatest need.

When we established The OneOneTwelve initiative, it was with two aims in mind: (i) to improve workforce capability, and (ii) to improve the oral health outcomes for people with disability (PwD). In order to do so, the initiative connects PwD with oral health professionals who are supported through a "dental champions" program, which includes mentorship and a professional development program, for the 12-month period that they provide pro bono care to this PwD. The initiative results in the upskilling of the oral health workforce and building of collaborations within the dental profession, between the dental sector and the wider disability sectors, and more broadly thereby promoting advocacy in this space.

In light of what I have seen throughout my career as a specialist in special needs dentistry, and now that I have moved into the advocacy space with The OneOneTwelve Initiative, I will discuss three key areas where we feel real change can be made in improving the oral health of not only people with disabilities, but the Australian population at large:

1. Provision of dental services as part of Medicare
2. Oral health education in dentistry and the disability sector, and
3. Collaborations to build capacity

ONE person with a disability ONE dental practitioner TWELVE months pro bono

INTRODUCTION

My name is Mina Borromeo and I am a retired specialist in Special Needs Dentistry and Associate Professor (Hon) at the Melbourne Dental School, University of Melbourne and have spent my career managing and training others about the oral health of people with special needs. Throughout my career I developed the first fully accredited training program in Special Need Dentistry in the Southern Hemisphere. I have published and spoken extensively both Nationally and Internationally on why we have the conundrum of poor oral health amongst people with challenging health issues. I was awarded the David White Award for teaching excellence recognising my innovations in teaching special needs dentistry. In addition I received a Citation for outstanding contribution to student learning, Office of Teaching and Learning, Australian Federal Government.

I am the cofounder of the oneonetwelve initiative alongside my husband, John. My career and expertise have focused on the oral health of marginalised groups in our community. Of these, it has become apparent that people with disabilities (PwD) are the most vulnerable and suffer the greatest of injustices when it comes to achieving what we would consider an acceptable level of oral health and regular dental care, even in a developed and prosperous country such as ours.

The Household, Income and Labour Dynamics in Australia (HILDA) study has provided us with the best population level evidence of this. Based on the responses of 17,501 participants, it showed that individuals with disabilities were more likely to be non-regular dental attenders[1]. Ability to access services and financial constraints were cited as common barriers. Interestingly, age was also found to play a significant factor in oral health inequity, particularly for people with disability, providing a unique opportunity for early interventions of targeted preventative strategies to significantly prevent, reduce, or delay the burden of prolonged and untreated, and often unmet, dental need into adulthood.

In terms of providing adequate oral care on a broader platform, considering people with disability at the core of all initiatives would provide key elements that would benefit all those seeking dental care. This would include other groups of concern, such as the socially disadvantaged, indigenous communities in rural and remote locations, the homeless, and those from cultural and language diverse backgrounds.

Let me take you on a journey.

The current oral healthcare system for people with disability is broken and the dreadful experiences they can face are often heartbreaking and in many instances unnecessary. Let me take you on one such journey that shows how things that appear somewhat simple can go so drastically wrong. One day, Patrick, who lives with Autism, had 16 teeth removed under general anaesthesia without being warned beforehand. A concerned dentist thought that they were “taking out too many teeth”. When questioned, they were unable to tell me his name, family situation, who came with him, what his life was like, whether he attended school, how was his life impacted by his lack of oral care and so much more. They could, however, highlight everything written on the referral letter and that this person was “on the spectrum”. They couldn’t tell me the circumstances that led to the individual being referred for dental treatment under a general anaesthetic, what had been attempted previously or anything about his dental journey to this point. I asked about the carers who attended and

what information was obtained from then – again nothing but silence. After a conversation with Patrick's mother, it was evident he had had some issues related to management in a dental setting, most likely due to a whole range of issues. Some, but not all, related to autism and some too challenging life circumstances. One feature that stood out was that his mother said that under no circumstances did he want any teeth extracted. Clearly, we had a difficult way forward.

Patrick went from being a vibrant young man with ambitions to pursue a career at university to someone who refused to leave the confines of his bedroom. His life could have been so different if his care had been different. We can only imagine the journey for someone with a toothache or dreadful bad breath who has no means of accessing a dentist. Not only do they often linger in pain and, in many instances, maybe in silence. But what impact does this have on their ability to smile and function in society, seek meaningful employment, pull themselves out of social disadvantage, better their own lives and those within their communities, and so much more?

We, at the OneOneTwelve Initiative, have spoken to many people with disability who, like Patrick, have provided heart breaking accounts about their oral health journey. Or worse still, the total lack of such a journey through barriers such as lack of access, costs of services, economic pressure and lack of a sector that can cater for or is prepared to support their oral health needs. Perceptions such as 'all people with disability are part of the public system', 'they or their carers are to blame for the poor oral health and lifestyle choices', 'they have no ability to access oral care services' and so forth are what we hear every day from the people we speak to.

The answer is not simple, nor is it something with a quick fix solution. However, a careful concerted approach, involving all key stakeholders, from the dental practitioner to government, economic decision makers, educators, lobby groups and people with lived experience (the patient), is needed to ensure any interventions are well resourced, fluid in nature and sustainable in the long term. We, at OneOneTwelve, think it is critical and urgent that oral health practitioners are supported to move to a service model which recognises dignity and centres on a concept of inclusive equality.

KEY AREA 1: MEDICARE AND DENTISTRY

1. Bringing dentistry into Medicare

There is often a discussion around including dentistry as part of Medicare and this is certainly an admirable feature of Greens discussions even as recent as the Greens Leader, Adam Bandt's National Press Club address. I believe many can comment more adequately on the role Medicare could play within dentistry, but the conversation needs to extend beyond dentistry just being placed as part of the Medicare system. The National Roadmap for Improving the Oral Health of People with Intellectual Disability 2021 states that oral health should be "brought into general healthcare"[2]. Whilst I am not totally opposed to the idea as the mouth is part of the body, I feel that in order for real and meaningful uptake within the profession some further considerations are required.

Dental health can be impacted by multiple factors in those who face significant healthcare and economic challenges. Complex and chronic medical histories, impaired and limited mobility, variations in cognitive ability, inability to access dental care in a timely fashion, polypharmacy, and marginalisation all impact dental care which in turn can place significant impacts in general health and wellbeing. We cannot escape the fact that there is a close association between medicine and dentistry beyond the mouth being part of the body. Dental status impacts significantly on oral health related quality of life. There are clear links between poor dental health and poor general health. Aspiration pneumonia, triggered by poor oral health (plaque accumulation in the mouth), for example, is a significant factor in poor outcomes for elderly residents in aged care facilities and, in fact, those who are immobilised or have difficulty with a simple cough reflex. Dental plaque, which is flooded with bacteria, can easily be dislodged and inhaled into the warm safety of the lungs. If someone cannot cough well, the bacteria can multiply and lead to pneumonia and potentially death if not treated early. Improving oral care through regular assessments and tooth cleaning can significantly reduce the level of death associated with aspiration pneumonia alone.

The medical profession has raised significant issues with the Medicare system and its use within their profession. It was a highly welcomed announcement that Medicare rebates for doctors would rise. But the real issue becomes how do you encourage dental practitioners to then utilise the Medicare system for their patients? The renumeration for services is an issue that creates significant concerns within the practice of dentistry. Despite this, there is certainly scope to move forward.

At the core of dentistry is an ethos centered on prevention in order to improve long term oral health outcomes for individuals and, in particular, for people with disabilities. Implementing Medicare rebates for preventive items, such as routine examinations, oral hygiene instruction, x-rays and fissure sealant application to protect the surfaces of teeth from decay, could be a first step. It should be highlighted that it is not feasible to expect Medicare rebates to be available for more complex aspects of dental services, such as implants, at this early stage as the costs of such services would make the scheme prohibitive long term (Table 1). A dental practice would not be able to be sustainable on, for example, the Department of Veterans Affairs fee schedules as the overheads would exceed any feasible remuneration that could be provided by government without there being significant cost blow outs over time. There would also need to be a consideration of out-of-pocket expenses that could be incurred by patients for more complex dental treatment. At the very least, there should be a mechanism introduced that allows for effective annual dental health assessments to ensure any issues in dental health are captured and managed early before they develop into more complex problems. Assessments currently covered under Medicare are proving ineffective thus far possibly related to the lack of oral health teaching that currently sits within medical curricula[3,4]. Again, for this alone to be successful there needs to be significant injection of targeted government funding.

There is no doubt that for some procedures, such as more complex fillings, out-of-pocket expenses could be a real concern for individuals and have the potential to mount substantially. The Chronic Diseases Dental Scheme (CDDS) was set up to address the impact of oral health on those with chronic health conditions. However, it quickly ran into

problems[5]. To ensure that we do not see a repeat of the problems that ensued following the roll out of the CDDS, tight guidelines and training would be required. A Medicare scheme within dentistry could be similar to the already developed Child Dental Benefits Scheme[6]. The reasons for similarity, rather than a carbon copy, relate to the greater complexity of dental care that is required within the adult population.

The current Child Dental Benefits Scheme allows children (0-17 years of age) to access dental treatment to the value of $1050 every 2 years. This is making a huge impact in terms of oral care within this group. The scheme is available for those from families with disability and those on Family Tax Benefit A. However, this only captures approximately 50% of children. Unfortunately, uptake has been slow with reports of only 30-40% of the eligible population taking up dental care under the scheme. Implementing such a scheme more broadly may be an alternative to introducing dentistry into Medicare. But in the long term, I feel a better approach would be adding to Medicare, as long as it can be projected to be sustainable. As previously mentioned, the best way to achieve sustainability would be to tailor it to specific groups, such as those with high needs as described under the National Oral Health Plan (2015-2025)[7].

2. Is there a role for the NDIS?

At present there is very little the National Disability Insurance Scheme (NDIS) offers in terms of dental care for people with disability. Whilst it is accepted that just over 500,000 individuals with disability access the NDIS, from the total 4.4 million Australians living with a disability, there is some potential scope to incorporate meaningful oral health measures to benefit users and potentially assist those currently not accessing the services.

For example, Allowing for simple oral health procedures, such as dental reviews and simple dental cleans, to form part of an individual's care plan would greatly improve the potential for a more comprehensive health care plan in general. If prevention is at the centre of oral healthcare, it would significantly reduce the burden of care in the health system because potential problems can be identified early and managed before they become so significant. This outcome, for people with disabilities, results in them having to join long waiting lists, often in considerable pain. This could then result in general anesthesia becoming the only outcome for treatment. As an individual, especially one with an intellectual disability, it becomes increasingly difficult to manage advanced dental problems in a dental chair setting. The waiting list for potential theatre time is a growing problem for people with disability seeking oral health care. However, if they are managed early, when problems are more manageable, the burden on the general anesthesia waiting list can be significantly reduced and kept for cases where true management within a traditional dental setting is difficult[8].

In order to fully evaluate if placing dentistry into Medicare is going to be truly effective and benefit all Australians, there needs to be clear guidelines set out in the preliminary stages to ensure adequate metrics are collected. Such metrics need to be gathered from all the stakeholders, including the dental profession, government bodies and disability and advocacy groups. The information collected should not only include metrics around dental procedures and costings (although clearly beneficial for long-term sustainability), but also what benefits have been achieved at the individual level (patient and dental practitioner).

Data collection should be broad and encompass all areas of the community from metropolitan to rural and remote communities. Who conducts such data gathering would best be left to collaborations between the Australian Bureau of Statistics, and Educational bodies such as the Melbourne Institute - Applied Economic and Social Research where the Household, Income and Labour Dynamics in Australia (HILDA) Survey was performed.

Whist this is not an answer in and of itself, it could provide some relief and reduce the burden on the health system regardless of whether dentistry is added to the Medicare system or not. While it would not cater to all those in need of dental care, it would significantly impact a proportion of those who are waiting a long time to receive dental care.

KEY AREA 2: EDUCATION ACROSS THE ENTIRE ORAL HEALTH SPECTRUM

1. Workforce

At present there are a total of 24,143 registered oral health practitioners in Australia of whom 18,061 are dentists (Table 2). The remainder (6,082) consist of oral health therapists, dental therapists, dental hygienists, and prosthetists. In addition, there are numerous educational facilities where different facets of oral health education are taught, ranging from Specialty training through to dental assisting and technician level (Table 3). Hence, there is not a shortfall overall in the number of clinicians to service the oral healthcare needs of the community. What is potentially problematic is the number of those with oral health skills employed in the public versus private sector.

85% of oral health practitioners work in private practice. This provides a unique opportunity to alleviate some of the burden on the public system, especially when considering those with advanced healthcare needs or other disadvantaged backgrounds. In 2012, I wrote about the challenges around workforce issues for the Aged Care sector[9]. The recent Royal Commission into Aged Care has shown that still some ten years later we are still grappling with issues around adequate oral healthcare for residents primarily due to staffing but also education in oral health.

In addition, this public sector workforce is variably supported to manage the eligible population they serve. While this part of our healthcare sectors is primarily targeted towards those with backgrounds of socioeconomic disadvantage, it also includes other vulnerable groups, such as those with disability.

A key point to acknowledge here is that factors, such as socioeconomic disadvantage and disability, do not occur in isolation. In fact, the impacts of these often overlap, and compound each other, to result in higher levels of disadvantage. And much like other chronic diseases, we see higher levels of dental disease in these population groups as a result. As such, it can be assumed that clinicians working in the public sector are often treating the most disadvantaged individuals, and those with the most complex presentations and highest levels of dental disease.

Unfortunately, our research has demonstrated that many clinicians working in the public sector do not feel empowered or supported to treat those with the most complex needs[10]. In fact, they feel more inclined to refer these individuals, such as people with disability, due to productivity pressures placed on them, lack of equipment and facilities, and because they are not given the support to care for them[10]. These oral health professionals spoke about being unprepared; having insufficient experience or training to understand and manage those with the most complex needs. Quite often, these comments were in relation to the most vulnerable populations, such as those with disabilities. The fact that these are barriers faced by our public sector dental workforce; those entrusted with the care of people with disability and other vulnerable groups, is problematic and a vital issue to be addressed[10].

2. <u>Oral Health Education across all sectors:</u>

2.1 *The Higher Education Sector*:
There is enormous opportunity to rethink how we teach oral health in Australia that is guided by all key stakeholders: from the person suffering poor oral health through no fault of their own, through to the highest echelons of the higher education sector. There needs to be a rethink in the current climate where teaching and research are restricted by competing curricula, staffing levels and financial constraints. The higher education sector is not immune to the economic burdens that we face in our current climate. In fact, there is evidence to suggest that they are in greater need of a financial injection of funds if we are to realise true, significant and long-lasting change.

This injection of funds needs to facilitate not only issues pertaining to teaching itself but research and, in particular, but not restricted to, translational research. If we do not assist our highest thinkers and researchers to solve the problems associated with poor oral health, from the laboratory to the clinical setting and population at large, how will we, as potential leaders in education and research, maintain our standing worldwide let alone better the communities in which we live. I will leave others to more fully elucidate on the importance of research in the dental landscape in Australia except to promote the significant challenges faced by my specialist colleagues in obtaining sufficient funding to support addressing these crucial gaps in our knowledge and evidence.

There also needs to be a significant change in the approach to education in oral health to remove the ingrained siloed approach that has existed to date. To make sure the person needing oral health interventions is always at the core of decision making. There will, no doubt, be some level of overlap once discussions begin, but this would add to the robust nature of discussions that ensue. It is only once we know what others are being taught that we can be fully informed and implement changes with the students under our charge. How different the life of Patrick, in the case described at the outset, would have been if there was a better understanding from the level of the dentist all the way down to the understanding from the carers and the individual themselves.

Education should also not be limited to the dental sector. Lessons can be learnt from the teaching of disability as part of medicine, dentistry and health sciences within universities which can then be further extrapolated to overall teaching of oral healthcare. The National Disability Roadmap suggests the need for the tertiary sector to “work on courses” to

improve oral care for people with disability[2]. Deans of Dental Schools within Australia were surveyed, and it was found that there were insufficient suitably qualified people with training in oral health and disability (that is, Specialists in Special Needs Dentistry) to make real change, especially for people with disability[11]. However, since then, when the Specialty was in its infancy, there has been a little shift in increasing numbers of suitably-qualified specialists to cater for these with advanced, high care oral health needs. This becomes problematic when considering a Medicare system to target vulnerable groups. If we do not have those trained to manage and guide clinicians across multiple oral health platforms, we may struggle to avoid significant costing blowouts.

A key feature of the OneOneTwelve Initiative was to attempt to address this disparity in workforce and bring private practitioners and people with disability together. What has been a key message from the dentists who have signed onto the program was that despite completing their dental degrees, their level of teaching in disability oral health, or dentistry for marginalised communities, was lacking. Furthermore, there were concerns about taking on aspects of dental care for individuals with conditions or problems which they were unfamiliar.

A two-pronged approach to address their concerns was to provide continuing professional development around disability, and what it means to be part of a community that struggles to access dental care, and to provide mentors who were able to help address concerns on a one to one basis. The mentors are being drawn from the twenty-five specialists in special needs dentistry who have signed onto the program, plus the small handful of more experienced general dentists. One feature that has been a concern for us has been the significant paucity of oral health practitioners who are more experienced and can raise their hands to act as mentors, but also the few who are prepared to put themselves out there and increase their skill set.

Variability in clinical and didactic teaching still exists today, as does a lack of suitably qualified workforce. But how can this be increased when the number of suitably-qualified specialists still numbers less that 30 and most of these focus their work on private and public sector clinical dental practice in major capital cities? Furthermore, people with disability and carers worry about the level of competency and training dental professionals have in managing their oral health needs, understanding their needs or even understanding the complexities of disability and how it impacts on everyday life (i.e. the lived experience).

These problems are not limited to dental training programs. Medical Program Directors and medical students also felt there was poor understanding regarding oral health amongst their cohorts with a major criticism centering on the lack of suitably qualified teaching staff and an already full curriculum[3,4]. The impact of oral health on conditions, such as diabetes, cardiovascular disease, immune conditions such as rheumatoid arthritis and dementia, cannot be underestimated.

To the importance of improving oral health literacy within medical curricula: the numbers of patients, not only those with disability, presenting to medical emergency departments with oral health-related conditions is increasing, especially as the costs of seeking dental care within the community are becoming prohibitive for many people. Educating medical

professionals around oral health conditions and promotion of positive oral health outcomes is vital if we are to see real and long-lasting change and eventually reduce the burden of oral disease within the community together with its high economic and social costs.

However, the appetite for introducing oral health teaching within medical curricula in Australia is poor at best[3,4]. Medical schools, not unlike dental schools, report common barriers facing many health-related tertiary education courses such as curriculum overload, lack of teaching expertise, lack of educational resources and facilities, lack of patients, lack of awareness, a siloed nature to healthcare practice, lack of guidance in curriculum design, and most concerning, a lack of priority. Aiming to target medical curricula, in an attempt to broaden the knowledge base as to the importance of oral health within general health parameters is crucial in a population that is ageing and where chronicity of disease is also increasing.

In addition, the role and benefits of interfaculty collaboration, as well as collaboration between the medical, dental and allied health professionals at all levels of health and disability, is vital. Oral health and its interrelationship to general health must form some aspect of competency standard for graduating health practitioners and all those working in the disability sector to ensure that oral health literacy is improved regardless of whether it is a doctor, dentist, oral health practitioner, allied health professional or carer. If such aspects are mandated at all levels of health education through competency standards it strengthens the knowledge base at its very core and allows for further continuing professional development programs to grow and expand.

A common platform of understanding where all key stakeholders have had responsibility in contributing, and being front and centre at the discussion table as equals, allows for consensus on issues that are important in terms of promoting high quality oral health for all, including those with disability. Whilst I appreciate that bringing everyone together can be a long and costly process, the benefits towards real and meaningful change cannot be overlooked. A stronger collaboration across all disciplines would result in the same standards of oral healthcare for all individuals and a much more robust discussions around appropriate management plans at all levels. The benefits in terms of long-term oral health and general health outcomes would outweigh the initial economic costs.

An example of where bringing people together has worked effectively to improve outcomes for oral health sits with the International Association of Disability and Oral Health. In 2012, a three stage international Delphi study was conducted where all key stakeholders in oral health disability education were brought together to develop an international undergraduate curriculum in Special Care Dentistry [12,13]. The overarching aim was to standardise tertiary education in oral healthcare for people with complex healthcare needs. The aim of these curricula were not to hold a big stick to all countries to follow specific guidelines, but rather to take what had been developed as a universal understanding of what was considered important in managing the oral health of people with disabilities and how this relates to general health and wellbeing and tailoring it to the specific demographics of university education and healthcare systems in each country.

2.2 *The TAFE Sector*:
Interventions need to take place at multiple levels across the education sector, from the universities through to TAFE and Certificate III/IV levels, to ensure all stakeholders have a presence at the table and are fully cognisant of the changes taking place above and below their level of training. Introducing competencies around oral health care in Certificate III (individual support) and Certificate IV (Ageing support) courses would certainly address the issues raised within the Aged Care Royal Commission report. As such, funding to those institutions to ensure not only the teaching itself, but that it is delivered by adequately trained and well-informed oral health practitioners, would be a positive fundamental step forward.

At present, educational standards set out to meet competency standards are set at multiple levels. These include higher education, government-led bodies such as Australian Health Practitioner Regulatory Agency, and the Australian Skills Quality Authority. Alignment of competency standards in line with educational institutions (Higher Education and the TAFE Sector), governing bodies (AHPRA) and professional bodies will help ensure that oral health, and its impact on general health, is better understood, and hence the disparities we see in, for example, aged and disability care can be alleviated.

2.3 *People with lived experience, carers and disability advocacy groups*
A key element in these stakeholder discussions must also include people with lived experience who bring a unique skill set to best inform what is required from their perspective. The phrase “nothing about us without us” is hugely impactful when it comes to planning and preparing for a seismic change in the way oral health and oral health education is delivered in this country.

In addition, where possible, other stakeholders from the oral health sector (e.g. policy makers, government, disability sector, oral health and allied health organisations) should be given an opportunity to comment in terms of where they feel their respective sectors can have an input. Whilst these groups would be directly involved in teaching on a day-to-day basis, building community around oral health and knowing who else can provide further skill sets that the profession can draw on to develop appropriate learning objectives is invaluable. Change can occur at any level across the education spectrum. Any development of teaching materials must be fluid and allow for change in the most succinct manner. There should also be regular feedback from all the different stakeholders to allow for change that occurs within the oral health sector as we see changes in the economic and political landscape together with improvements in oral health guided by significant peer reviewed scientific literature.

A significant shift is required in oral health education in all its facets if we are to see significant shifts on oral health care outcomes for all Australians, and particularly marginalised groups. A key feature that is often neglected in oral health teaching (and I suspect in other areas of health) is around a more holistic approach to care. Not only the elements specific to the discipline itself, such as how to do a filling, for example, but to understand the economic landscape for both the clinician and patient alike. Understanding what disability means, the NDIS or other important legislation should form part of the learning outcomes and competencies for all graduates regardless of the sector in which they

will work and especially if they are entering a health profession. The same can be said for carers and advocacy groups when it comes to understanding elements of dental care and best dental health practice for their respective cohorts. This is a key feature of the OneOneTwelve Initiative.

Oral health education is integral to preventive care for all Australians, but more so for people with disabilities. For people with disability such problems can arise and spiral quickly, impacting not only oral care but also general health and well-being. There should be funding in place to aid and maintain good oral healthcare education programs across the board, from the dental setting to public settings, such as aged care and group home facilities. Oral health education within the community can be performed by the dentist or oral health therapists.

The Royal Commission into Aged Care highlighted the need for improved training in oral healthcare to address outcomes for residents. Extending oral healthcare education to aged care facilities or group home settings is important because it allows for assessment of what care is provided to residents on a day-to-day basis, together with discussions around meal plans and the impact of factors such as diet on oral care, all of which can be more fully evaluated. In many settings the impacts of oral health are only at the forefront when accreditation looms. This results in ad hoc and ill thought out measures being put in place. If such measures are carefully planned with oral health practitioners at the discussion table, such measures would be more cost-effective and can be rolled out and maintained on a day-to-day basis. This is not meant to be a criticism of the Aged Care Sector because, as with the education sector, there are often more balls to juggle than there are hands to catch them. The government is seeking to push for nurses to be in all aged care facilities 24/7 which has led to discussions around workforce availability. Perhaps there needs to also be discussions around having oral health care practitioners visiting every aged care facility on a routine basis to identify problems and address care when required. This could be tied into the Medicare funding that is developed for oral health.

Another approach that could also be taken could be to link oral health education into the NDIS for individuals in group home settings or advocacy groups. Allowing for provision of dentally-qualified individuals to provide ongoing continuing professional development to staff in these setting; from carers and unpaid carers through to those involved in meal preparations; could go a long way to ensuring oral health is maintained in accordance with best practice standards. If we can ensure that meals are prepared that are less likely to cause tooth decay, staff are educated on how assist residents clean their teeth and so forth, we can go a long way towards improving dental care at the grassroots level.

KEY AREA 3: INFORMAL COLLABORATIONS AND THE POTENTIAL BENEFIT IN ESTABLISHING A MORE FORMAL OVERARCHING BODY

The establishment of a National Centre of Excellence for People with Intellectual Disability (National Roadmap 2021) is a unique opportunity for real change within the dental sector, provided dentistry is at the table during the creation process and not considered as an afterthought[2]. The support such a Centre could provide along the many aspects of oral health promotion, linkage between specialists, general dentists, oral health therapists,

carers, non-dental professionals, government bodies and the disability sector more broadly are enormous. This is provided that it is set up in a way that focuses on those potential linkages being established to achieve the desired outcomes of improved oral health for people with disability. The development of a national digital platform is also highlighted to bring key stakeholders together, whilst admirable, needs to realise that it relies on special needs dentistry support. What does such support actually look like in the current climate where there are only a handful of registered specialist across the country and there are significant educational sector challenges in oral health education?

Sitting within this Centre of Excellence there must be an approach to improve oral health for all people with disability. Whatever we put in place for people with intellectual disability will have far reaching benefits for all, whether they have intellectual disability or not. The strategies put in place here can no doubt be extended to all those in need of improved oral healthcare.

In my role with the OneOneTwelve Initiative I have been fortunate to take my dental knowledge and inform those in the disability space. But more importantly, I have learnt a tremendous amount from the disability sector as well. These informal collaborations that have developed have been invaluable because they have allowed for robust discussions across all the different facets of oral health care more broadly. The benefit of lived experience as well as the dental perspective cannot be underestimated.

We cannot underestimate the potential benefit of such transdisciplinary collaborations and where they can take oral care for people in greatest need into the future. In addition, whatever we put in place for this group extends further to benefit the entire community. The challenges are not unique to the disability sector, as I have learnt through my dental journey, but they are unique to an individual.

I believe one of the key outcomes of this Senate inquiry should focus on the potential benefit of both informal and formal collaborations. These can only serve to improve the state of oral health education across all the sectors together with informing appropriate and well-guided and targeted changes to the Medicare system itself. An effective part of education centres around people knowing when to access dental care and its importance. This can only be effective if there is access to a scheme where early intervention and prevention are provided for. This then keeps everyone on track and potentially circumvents deeper problems and tooth loss down the track which impacts on the economy at many different levels.

If the Government can develop a well-structured round table committee as an overarching body with representatives for all key stakeholders, where everyone is equal, it will go miles in improving oral care. This group can bring all equal voices together, regularly inform government, inform each other (and the groups they represent) with the sole aim of improving oral health access for all Australians regardless of disability, socioeconomic status, residential location and all other metrics that can impact excellent oral healthcare. This will also provide a real way forward to remove the current siloed approach to oral healthcare in this country and ensure accurate and appropriate funding strategies are in place that produce real and meaningful oral health outcomes. Furthermore, it will reduce

the need for people presenting to emergency departments with dental problems that could be either avoided or managed in the dental sector, and potentially reduce public sector wait times thereby reducing burden of disease plus burden of spending in the public sector.

Cooperation across the community, the health sector, the education sector and government (Federal, State and Territories, Local) is the key to the success of any changes to improve oral health outcomes in this country.

Finally, I would like you to consider once again how different the trajectory for someone like Patrick could have been if we could realise a true and equitable oral healthcare system for all Australians.

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Table 1: Diagnostic services (Child Dental Benefits Scheme (CDBS) – version 11, Jan 2023) (truncated – limits apply per item number)[6]

	ITEM NUMBER (88…) AND NAME	SERVICE	COST/BENEFIT ($)
EXAMINATION	011 – Comprehensive oral Exam	• Evaluation of teeth, supporting tissues • Medical History • Other relevant information	55.45
	012 – periodic oral exam	• Evaluation on patient • Changes from 011/012	46.00
	013 – limited oral exam	• Limited oral problem-focused evaluation	28.90
RADIOLOGICAL	022 – intraoral periapical or bitewing radiograph	• Taking/interpreting a radiograph with film inside the mouth	32.05
	025	• Intraoral radiograph – occlusal, maxillary, mandibular	64.75
PREVENTITIVE	111	• Plaque/stain removal (all teeth)	56.60
	114	• Removal of calculus – first visit	94.35
	115	• Removal of calculus – subsequent visit	61.35
REMINERALISING AGENTS	121	Topical application of remineralising/cariostatic agent	36.35
	161	• Fissure sealant	48.45
	162	• Fissure sealant – subsequent services	24.25
PERIODONTICS	213	• Treatment of acute periodontal infection	73.30
	221	• Clinical periodontal examination	55.70
ORAL SURGERY	311	• Single tooth extraction	138.10
	314	• Sectional tooth removal • (limit 1/day)	176.50
	316	• Additional extractions	87.05
	322, 323, 324, 325, 326	• Surgical tooth extraction (vary according to complexity)	224.10 – 344.95
	384	• Repositioning displaced tooth	200.75
	386, 387	• Displaced tooth splinting +/or replantation	207.10 – 405.55

	392	• Drainage of abscess	101.90
ENDODONTICS	411	• Direct pulp capping	36.65
	412	• Incomplete endodontic therapy	125.55
	414	• Pulpotomy	80.00
	415, 416, 417, 418	• Root canal treatment (dependent on number of canals in a tooth)	225.25-219.40
	419	• Emergency pulp removal	145.05
	458	• Interim root filling	148.25
RESTORATIVE	511-515	• Metallic restorations (surfaces dependent)	109.60-208.75
	521-524	• Adhesive restorations (Surface dependent)	121.40-201.80
	525	• Adhesive restorations – 5 surfaces, anterior tooth – direct	237.15
	531-535	• Adhesive restorations – 5 surfaces, posterior tooth – direct	129.65-254.75
	572	• Temporary restoration	51.30
DENTURES	721-724	• Partial dentures	344.40-459.25
	731	• Retainer – per tooth	46.35
	741	• Denture adjustment	55.25
	761-768	• Denture repair	151.65-160.40
EMERGENCIES	911	• Palliative care (relieve pain, infection, bleeding etc)	71.90
SEDATION	942	• Intravenous sedation	140.95
		• Inhalation sedation	70.45

Table 2: Workforce in Oral Health compared to population data. (Source: Australian Institute of Health and Welfare (2022) Oral health and dental care in Australia, AIHW, Australian Government, accessed 12 April 2023.)

POPULATION DATA	Total Australian population	25,750,198	
	Over 65 year of age		16%
	Over 15 years of age and saw dentist 2021-22*		48%
	2021-22 – preventable dental related hospital admissions	67,000	
DISABILITY	Total	4.4 million	17.1%
	Profound disability		5.7%
	Mental health or behavioural issues		23.2%
	Autism		25.1%
	Over 65 years of age		49.6%
		On public waiting lists	13.1%
		Don't go to the dentist due to costs	28%
CARERS	2021	2.65 million	
	2015 (pre COVID)	2.70 million	
ORAL HEALTH PRACTITIONERS	TOTAL	24,143	
	Dentists (including specialists)	18,061	83% in private practice
	Oral health therapists, dental hygienists, dental therapists, prosthetists	6,082	

*On average Australian adults over 15 years of age had 11.2 decayed, missing, filled teeth which increased to 24.4 affected by dental decay over the age of 75.

Overall 58% of individuals directly fund dental care

Government expenditure on dental services 2019-20: 1.1 billion down an average annual rate of 0.9%
State and Territory government spending increased by an annual rate of 0.8%

Barriers to attending dentist:

- Cost/financial burden as reported by 39% of over 15 years of age
    - Females (43% vs 35%), indigenous (49%) populations and those without dental insurance (52% vs 26%) over represented

Table 3: Breakdown of dental education within Australia by State (various sources)

STATE	UNIVERSITY	COURSE	FEES (not CSP) ($)
NSW	University of Newcastle	Bachelor of Oral Health Therapy	42,335
		Doctor of Philosophy (Dentistry)	45,200
	University of Sydney	Bachelor of Oral Health	53,500
		Bachelor of Dental Science and Medicine	53,500
		Doctor of Clinical Dentistry (Specialty)	75,000
		Doctor of Dental Medicine	86,500
		Graduate Certificate in Clinical Dentistry	37,500
		Graduate Diploma in Clinical Dentistry	75,000
	TAFE NSW	Certificate III Dental Assisting	10,104
		Certificate IV Dental Assisting	12,410
		Diploma of Dental Technology	20,655
QLD	James Cook University	Bachelor Degree	71,960
	University of Queensland	Bachelor of Dental Science (Honours)	74,456
		Doctor of Clinical Dentistry (Specialty)	74,672
	Griffith University	Bachelor of Dental Health Science	11,000
		Master of Dentistry	66,500
		Bachelor of Dental Hygiene	10,500
		Doctor of Clinical Dentistry (Specialty)	54,000
	TAFE Queensland	Bachelor of Dental Prosthetics	26,000
		Certificate III Dental Assisting	8,800
		Diploma of Dental Technology	17,000
VIC	University of Melbourne	Bachelor of Oral Health	67,368
		Doctor of Dental Surgery	92,000
		Doctor of Clinical Dentistry (Specialty)	73,472
		Doctor of Philosophy (Dentistry)	48,224
		Master of Philosophy	48,224
	La Trobe University	Bachelor of Dental Science (Honours)	74,600
		Bachelor of Oral Health Science	43,000
SA	University of Adelaide	Bachelor of Dental Surgery	87,500
		Bachelor of Oral Health	58,500

		Doctor of Clinical Dentistry (Specialty)	65,600
		Doctor of Philosophy (Dentistry)	56,000
		Honours Degree of Bachelor of Science	43,000
		Master of Philosophy (Dentistry)	56,000
WA	Curtin University	Bachelor of Science (Oral Health Therapy)	40,005
	University of Western Australia	Bachelor of Dental Health Science	62,000
		Bachelor of Dental Health Science (Honours)	62,000
		Bachelor of Dental Hygiene	38,500
		Bachelor of Dental Prosthetics	38,500
		Bachelor of Dental Technology	38,500
		Bachelor of Dental Technology (Honours)	38,500
		Bachelor of Dental Technology/ Bachelor of Dental Prosthetics	38,500
		Doctor of Clinical Dentistry (Specialty)	65,000
		Master of Clinical Dentistry	65,000
		Master of Dentistry	86,500