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South Australia oral health workforce projections barriers: The importance of data

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Disclaimer

This Brief does not reflect the views of the Australian Government or indicate a commitment to a particular course of action.

Background

Our lives comprise of decisions made with months and years of research and life experiences, whether they are as minuscule as what to have for lunch or as significant as buying your forever home. We use evidence and data to help us make decisions regardless of whether they are insignificant or life changing. Similarly, major policy decisions are made with years of experience and data informing policy makers, however, these decisions are made from historical data which can be inadequate and misleading in determining such things as the future population, especially so after a major event such as the pandemic and the unexpected consequences of such an event.

South Australia's oral health sector has had issues for many years with recruitment and retention of clinical staff in both the public and private sector and especially so in the regional, rural, and remote areas (SA Health , 2022). Opinions differ about why this is the case.

Some say that the pandemic affected motivations of the young to work so we have the same headcounts but reduced FTE, and that the pandemic also encouraged some to retire earlier than expected. Some have also argued that while the number of international students has increased, they are all returning to their home countries after graduation, leaving Australia with fewer workforce numbers even though on paper, the Universities are training more oral health practitioners each year.

Instead of speculating, and to find targeted solutions, in 2022, SA Dental undertook the immense task of projecting the oral health workforce in South Australia. The purpose was to determine if the current workforce level in South Australia across both public and private sectors were meeting population needs and projections into the future.

SA Dental obtained workforce data from Aphra and publicly available data from the Department of Education and built-up different projections and scenarios with the data that could be obtained. However, it was found that with each iteration of collaborative workforce planning endeavour, the capacity to predict future changes with available historical data decreased.

Further exploration uncovered that workforce data was highly reliant on individuals renewing their registration providing accurate and timely information in addition to the base Aphra requirements. Apart from information needed for registration, the provision of any other information is optional. Data published are also often lagging by a couple of years.

These workforce numbers are the best source of data we have presently, and they have been used to contribute to decisions on resource allocations, labor market regulations, immigration policies, education and training policies and economic development policies.

The flow on effect of this data is massive and yet most of it is optional, possibly inaccurate but certainly incomplete and lagging in years. Recent data analytics advancement has meant that it is timely to reexamine how we can plan better and use data to make more educated and time efficient decisions.

The Oral Health Landscape

Disciplines across the Oral Health Workforce

Outside of the oral health sector, there is little understanding of the oral health professions and how they contribute to the health of their patients.

These professions are detailed in appendix 1, noting this list is not intended to be exhaustive and are listed below:

- Dental Specialists
- Dentists
- Dental Prosthetists
- Dental Therapists/Oral Health Therapists
- Dental Hygienists
- Dental Assistants
- Dental Technicians

Each of these professions plays an instrumental role in the oral health care of the patient and the overall oral health sector.

It should be noted that Dental Assistants and Dental Technicians play important roles in the dental team however, are not registered professions which makes workforce planning additionally difficult for these two professions.

Anecdotal discussion with stakeholders has recognised that the turnover rate and recruitment of dental assistants are especially difficult and similar strategies have been used to attract and retain an unquantifiable workforce.

Oral Health Care Providers

A range of approaches are used to provide access to oral health care in South Australia with different business and employment models.

Most consistently, across South Australia, a dental practice could be either an owner run small business or part of a franchise owned by corporate groups or major insurance providers such as Bupa and Health Partners. In recent years, smaller private practices are slowly being bought out by bigger franchises and private health insurances (Evans, 2019). This could be due to a myriad of reasons but most likely, the difficulty with workforce recruitment, and the cost of the maintenance of equipment, especially so in regional, rural and remote areas where it has become challenging to coordinate. Corporate groups have become more and more attractive for new graduates due to the benefits of not having to worry about overheads, back-end administration support, work life balance and having professional support among other things (Academy of General Dentistry, 2013).

The private sector accounts for approximately 83% of the services provided nationally (Australian Institute of Health and Welfare, 2023), and provides dental services with a fee for service mechanism, either paid for by patients out of pocket or their private insurance fund covers their treatment. A limited number of adult patients who may also be seen by the private sector could be funded by the public sector's schemes program.

In addition to funding services, the public sector, SA Dental, also deliver services to eligible health care card and pensioner concession card holders at a subsidised cost (SA Dental, 2024). Children from aged 0-17 years old are provided with universal access to primary services in oral health care.

SA Dental also has a 30-year partnership agreement with the University of Adelaide, providing clinical placement for both Bachelor of Oral Health and Bachelor of Dental Surgery students who also provide care for public patients.

In the public sector, SA Dental, all staff are employees of the organisation, similar to a large corporation, employees enjoy fixed working hours, work life balance and a salaried wage and is attractive to some for these reasons.

SA Dental conducted workforce planning internally and found that workforce distribution to the public sector has always fluctuated but has increasingly become more difficult in recent years, especially in the regional, rural and remote clinics. In addition, in recent years, new and prospective employees have favoured working part time instead of full time which has affected workforce availability and capacity.

SA Dental had a fair understanding of the demographics and where the public sector workforce was headed and the nuances behind why some areas found recruitment difficult. However, the public sector is a small employer of the oral health workforce nationally and in South Australia, and their data was only a small niche cohort of the population of the oral health workforce.

The multiple other data points were few and far between.

Changes to major policies in the oral health sector

Major policy changes have a flow on effect on services, workforce, funding structures, wages and can in turn affect data presented.

Not unique to the dental sector, there have been frequent changes to health policies over the last 20 years that have resulted in increasing uncertainty of long-term service provision and therefore workforce requirements. In particular, the ongoing funding for dental services in the public sector, with multiple federal funding sources introduced and ceased (Grattan, page 29).

Government policies and interventions have guided and affected the oral health sector and now to achieve sustainable and accurate workforce planning, government interventions are crucial. However, throughout the 20 years of changes, there has been minimal consideration of the longitudinal data that could provide a long-term picture/roadmap.

Table 1: Australian health policies affecting oral health care (2004 – 2022).

Year	Policy initiative	Outcome
2004-12	Federal – Medicare Plus (2004) and subsequently, Medicare Chronic Disease Dental Scheme (2007)	Increase in accessible funding to both private and public sector to provide oral health services to a specific cohort, increase in need for oral health workforce to deliver these services. However, unintended consequences of allegations of over-servicing and rorting of the system meant the Medicare scheme for dental was ceased in 2012 (Biggs, 2012).
2005	Public Sector Dental Workforce Scheme (PSDWS) was established by State and Territories Ministers as a response to public sector shortage, especially in rural and remote areas.	South Australia utilised the scheme to recruit to regional and rural locations such as Mount Gambier, Port Augusta and Wallaroo and from 2010 – 2017 has had 32 registrants under the scheme.
2008	Dental Benefits Act 2008 (the Act) commenced. Federal – Medicare Teen Dental Plan introduced.	Introduction of both policies meant an increase in funding availability for both public and private providers, indirectly, another increased need in workforce to provide the services.
	Council of Australian Governments agreed on National Partnership Agreement on Hospital and Health Workforce Reform and the Health Workforce Australia (HWA) was set up (Parliament of Australia, 2014).	The HWA's goal was to be provide more effective, streamlined and integrated clinical training arrangements to support workforce reform initiatives, to support health workforce research and planning and to further new workforce models and reforms (Parliament of Australia, 2014). Oral health workforce planning was part of HWA's remit.

Year	Policy initiative	Outcome
2009	James Cook University (JCU) rural dental school commenced and had their first intake (BOH and BDS)	New dental school meant permanent increase in students being trained locally in Australia, resulting in increase in future workforce.
2010	Ahpra was formed, all responsibility for professional registration and data transferred to National database	Positive change in data management with a central repository, however, multiple issues identified, such as entries with registrations "started on 1 July 2010" though graduated/profession started years ago.
2012	Charles Sturt University dental school commenced and had their first intake (BOH and BDS)	Similar to JCU, new dental school meant permanent increase in students being trained locally in Australia, resulting in increase in future workforce.
	Commonwealth introduced National Partnership Agreement (NPA) on treating more public dental patients	Welcomed initiative by public sector to ease long waitlist, need to increase long term funding and workforce in the public sector to deliver the services to the public patients.
	Federal – Chronic Disease Dental Scheme ceased	Cessation of funding meant workforce need reduced
2013	Federal – Medicare Teen Dental Plan ceased	Replaced by Child Dental Benefits Scheme which is of much higher value at just over $1000 for every 2 calendar years for eligible children as compared to the Medicare Teen Dental Plan at $150 annual for teens aged 12- to 15-year-olds. Welcomed funding reform by both the public and private sector.

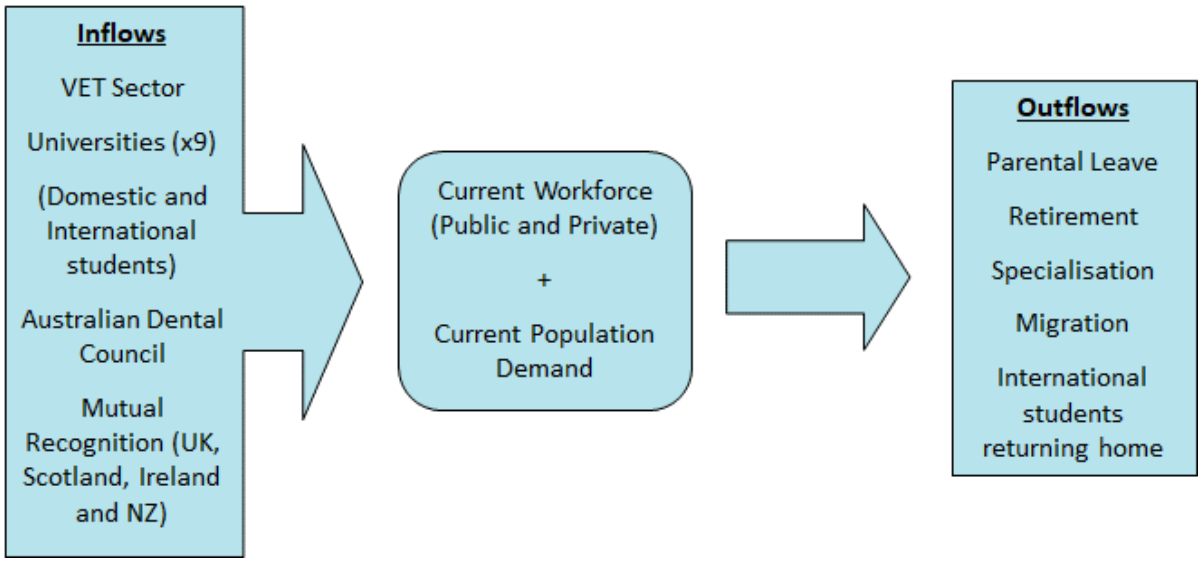
Year	Policy initiative	Outcome
	Voluntary Dental and Oral Health Therapist Graduate Year Program (VDGYP) commenced (Australian Continuous Improvement Group , 2016)	Federal program which provided funding for infrastructure, especially in rural and remote areas and funding to organisations both public and private to run a graduate year program for dentist and oral health therapist. This enhanced the workforce distribution to the rural and remote areas nationally.
2014	Federal - Child Dental Benefits Schedule (CDBS), means tested program for 2-17 years Introduced	See above (see Year 2013) – CDBS replaced Medicare Teen Dental Plan which addressed shortcomings (Australian National Audit Office, 2015)
	Workforce report published by Health Workforce Australia stating an oversupply of dentists in Australia, while highlighting regional, rural and remote and public sector shortages (Australian Government Department of Health and Aged Care, 2014)	The workforce report may have led to multiple changes in policy, though no formal evaluation has been completed for the outcomes of the workforce report. For example: - Removal of "Dentist' from Skilled Occupation List (see Year 2015)
	Health Workforce Australia (HWA) abolished, functions and programs moved into the Commonwealth Department of Health (Parliament of Australia, 2014).	Since abolishment of HWA, engagement of oral health sector in workforce planning has been minimal, resulting in lack of understanding of the oral health workforce and the direction it was headed. SA Dental has attempted to conduct workforce planning on behalf of South Australia however, as this paper discusses, it has been an extremely difficult process due to multiple barriers with data.
	Removal of "Dentist" as a profession on the Skilled	Likely an outcome of the workforce report which stated an oversupply of dentists in Australia but noted

Year	Policy initiative	Outcome
2015	Occupation List meaning international graduates from all dental schools in Australia were no longer able to apply for a visa directly to stay in metropolitan Australia and practice as a dentist. "Dentists" were however moved to the regional occupation list.	shortages in disadvantaged and rural and remote areas.
	Graduate Certificate in Oral Health Science introduced by University of Adelaide for Dental Therapy and Oral Health Therapy graduates. Completion of this 6-month certificate allowed for extended scope of practice to include adults' treatment.	Expanding the scope of practice for dental and oral health therapists to include patients of all ages increased the workforce available to treat adults. However, this change has reduced the number of clinicians dedicated to treating children. While it appears to improve access for adults, without an increase in new OHT graduates, it has not addressed the underlying workforce shortages in South Australia.
2016	Voluntary Dental Graduate Year Program (VDGYP) ceased	Independent evaluation of the VDGYP Program was conducted (Australian Government Department of Health, 2020), with positive feedback by States, service providers, mentors, and participants. The program provided much needed infrastructure and workforce funding. The closure of the scheme impacted SA significantly and affected recruitment and attractiveness of the public sector. In 2022, SA Dental revitalised part of the VDGYP (structured early career mentorship), funded internally to improve attractiveness of working in the public sector.

Year	Policy initiative	Outcome
2020	Covid19 ongoing Closure of Limited Registration of Dentists - Public Sector Dental Workforce scheme	Worldwide, National and Statewide effect on workforce and service provision capacity. Due to reduction in demand for the PSWDS, Ahpra conducted an analysis and consultation (Dental Board of Australia, 2018) with relevant stakeholders which resulted in the closure of the stream. South Australia still utilised the pathway in areas of need and the closure did reduce ability to recruit to rural and remote areas for SA.
2022	Ongoing workforce recruitment issues (especially in rural and remote and public sector)	Ongoing issues highlighted in Rural Oral Health Workforce Plan 2021-26, part of South Australia's Rural Health Strategy to identify barriers and strategies to increase SA's rural health workforce (SA Health, 2022).
	CDBS provider numbers expanded to Dental Therapist, Oral Health Therapist, Dental Hygienists (DT/OHT/DH)	DT/OHT/DH can provide services and directly claim under CDBS with their own provider numbers, increasing autonomy and workforce available to provider services to children under CDBS.
	CDBS extended to include 0-2 years old	Positive change to allow all eligible children under 18 be seen by an oral health practitioner.

Policy Issue

Figure 1: Inflows and outflows of SA oral health workforce



In 2022, SA Dental attempted to determine the inflow and outflow of potential oral health workforce and modelled and predicted future numbers (Figure 1).

The data that SA Dental tried to obtain were spread across different data sources; VET and University sectors, international graduates who have passed the Australian Dental Council examination and practitioners who have had their qualification recognised via the Mutual Recognition agreement. The outflows included people who have taken parental leave, retirement, and migration.

However, what was initially envisioned to be a straightforward process of contacting relevant agencies and obtaining the data for forecasting was not as simple as it seemed. Multiple data sources had to be explored with varying levels of access and time and cost investment to obtain the data.

In addition, quantifying both dental assistants and technicians have only been possible in the public sector and not the private sector due to the two professions not requiring to be registered and no available data for them.

Ultimately, deidentified Aphra registration data on the oral health workforce (not including dental assistant and technicians) which was lagging two years behind was used for the predictions. This meant that data available only allowed for predictions to be formulated on historical data and averages drawn from the National Health Workforce Dataset (NHWDS) (Australian Government, Department of Health and Aged Care, 2023) to determine future supply and demand.

Consideration of external influencers such as cost of living pressures, value-based healthcare, professional skills and confidence were not able to be part of the equation.

These influencers can impact workforce availability and needs, and if reliance is placed upon retrospective data or anecdote then the belief that there is an adequate workforce to meet the populations' needs will lead to a perpetuation of subjective and potentially unreliable data and ultimately policies.

With each iteration of our workforce planning endeavour, our capacity to predict future changes with available data and the more distant the prediction is from the current year, the less accurate the information will be. Unpredictable events such as Covid-19 or change of government policies could upset and change multiple levers which could affect the workforce and population patterns. The introduction of Ahpra in 2010 with consolidated workforce numbers gave us an opportunity to undertake workforce planning and thorough research. The Ahpra dataset is heavily relied upon to make such workforce calculations and planning. However, it is reliant upon registrants voluntarily responding on non-essential information.

For example: Information such as Principal Place of Practice (PPP) does not need to be updated if it changes and practitioners who works across sites usually use their home address as PPP. This is important as in regional, rural and remote locations, having one practitioner alone registered in the region as practicing could mean that these areas are overlooked for incentives or that there are "sufficient" practitioners in the area.

What does this mean for policymakers?

Policymakers should provide leadership to this issue with two broad lenses for oral health workforce planning, 1) Long term planning and2) Immediate problem solving.

Long-Term Planning

Invest in Data Collection and Infrastructure

Current data infrastructure such as surveys and workforce registrations are inconsistent and outdated. This leads to inefficiencies and outdated workforce data. By investing in appropriate and centralised data collection methods, policymakers can encourage better data and greater insights.

It is important to ensure these data collection systems are able to be used across sectors and governments, allowing for integration of education data, employment records and even social services.

This can be achieved by funding, mandating and incentivising collaboration of public and private sectors and education sectors to share data and insights. In addition to establishing this infrastructure, it is also important to provide ongoing support to maintain hardware, software and staff training.

Crucially, this ensures the workforce, both clinical and administrative has the knowledge and understanding of the importance of workforce data records.

Policy makers should establish infrastructure to facilitate such cross-sector collaborations, building trust and useful data sharing for enhanced workforce planning in all sectors.

The latest report on oral health workforce planning was published in August 2014 (Oral Health – Australia's Future Health Workforce reports | Australian Government Department of Health and Aged Care), predicting an oversupply of the dental workforce by 2025. However, in 2024, we are writing this report because of a serious workforce shortage and our inability to extract sufficient data to motivate stakeholders and policymakers to take action.

Immediate Problem Solving

The most pressing concern facing the SA and national oral health sector is the distribution of clinicians to regional, rural and remote regions and to the public sector. This is especially significant in the Monash Modified Model (Australian Government, Department of Health and Aged Care, 2021) Level 6 and 7 shown in the data extracted from Ahpra displaying the distribution of oral health workforce.

There is a need to distribute more workforce development efforts to regional, rural and remote areas and to the oral health sector, benchmarked against work done for other health sector workforce such as medicine and nursing:

- Collaborate with Department for Education, universities and VET sector to develop tailored training programs that address specific needs of and identify and foster local oral health practitioners.

- The likelihood of working in rural practice is approximately twice greater among doctors with a rural background (Laven & Wilkinson, 2004). This can include specifically quarantined positions for relevant courses and apprenticeship programs for regional, rural and remote students and a return of service initiative.
- Strategies to reduce social barriers and professional isolation have also been successful in retention. Therefore, establishment of targeted initiatives to attract and retain talent in regional areas would be helpful. This could include offering financial incentives and providing affordable housing options. Creating networking and mentorship programs that connect regional oral health practitioners with industry professionals, allowing them to build relationships, gain insights, and enhance their career prospects could also be considered.
- Investment in digital infrastructure and technology to bridge the geographical gap and enable remote work and telecommuting opportunities for regional oral health workers will help overcome issues with lack of local providers. Transport payments could also potentially assist patients to access services in metropolitan areas where possible.
- The Commonwealth Department of Health and Aged Care (DoHAC) released in September 2022 - Increasing Dental and Oral Health Training in Rural and Remote Australia: Feasibility Study Technical Paper (Technical Paper: Summary of the Strategies and Associated Cost) which provided 8 strategies to increase dental and oral health training through the Rural Health Multidisciplinary Training (RHMT) program including expanding into more rural and remote locations in Australia (Kristine Battye Consulting Pty Ltd, 2022).
- Further strategies to attract, retain, grow and support the oral health workforce have been discussed in the SA Rural Oral Health Workforce Plan 2021-26 released in 2021 (SA Health, 2022).

Closing remarks

This Perspectives Brief highlights the current issues with workforce planning of the oral health sector in South Australia and indirectly nationally; and identifies several potential policy options to improve oral health workforce planning.

While data infrastructure and planning are long term policy issues, there are existing significant challenges to ensuring that rural and regional areas and public sector have access to the oral health workforce they need to thrive and to meet the needs of the community.

To address the immediate challenges for South Australia, it is necessary to adopt a strategic multi-prong approach to workforce development that focuses on creating pathways to education and training programs for students with rural background, as well as supporting the growth of the sector in these areas.

Collaboration between government, private sector, and educational institutions is essential to achieving these goals, and there is a need for greater investment in workforce development programs that specifically target rural and regional areas and the oral health sector.

By doing so, South Australia can create a more equitable distribution of oral health workforce and ensure that all residents of the State have access to the dental care where possible.

Key Readings

Australia's National Oral Health Plan

https://www.health.gov.au/resources/publications/healthy-mouths-healthy-lives-australias-national-oral-health-plan-2015-2024?language=en

South Australia Oral Health Plan

https://www.dental.sa.gov.au/assets/downloads/Documents/About/Our-organisation/South-Australian-Oral-Health-Plan-2019-2026.pdf

South Australia Rural Oral Health Workforce Plan

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/sa+rural+oral+health+workforce+plan

Oral Health and Dental Care in Australia

AIHW https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce

Oral Health – Australia's Future Health Workforce Reports

https://www.health.gov.au/resources/publications/oral-health-australias-future-health-workforce-reports?language=en

Looking Back Looking Forward - Oral health in Victoria 1970 to 2022 and beyond

https://figshare.unimelb.edu.au/articles/book/_strong_Looking_Back_Looking_Forward_-_Oral_health_in_Victoria_1970_to_2022_and_beyond_strong_/23721969/2

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Appendix 1

- Dental Specialists - diagnose and treat diseases, injuries, irregularities and malformations of teeth and associated structures in the mouth and jaw using surgery and other specialist techniques. The range of specialty services provided includes oral and maxillofacial surgery, orthodontics, endodontics, periodontics, fixed and removable prosthodontics and special needs dentistry.
- Dentists - Dentists are responsible for providing general and emergency oral health care to eligible clients who present with dental diseases and oral health problems of a complex nature and assisting less skilled practitioners in the treatment of more complex cases. Dentists also provide limited clinical guidance to members of the dental team and work in partnership with team members to achieve oral health outcomes for the patients.
- Dental Prosthetists - are registered practitioners who work independently to provide patient-removable prostheses, including implant-retained overdentures, and flexible mouthguards for sport. Services include taking impressions and records for manufacturing splints, stents, sleep apnoea or anti-snoring devices, and immediate dentures.
- Dental Therapists/Oral Health Therapists - Dental/Oral health therapists focus on provision of oral health services and provide assessment, diagnosis, treatment, management and prevention measures within their scope of practice. Services include restorative treatment, fillings, tooth removal, promotion of oral health and other oral care. Patients mainly include children and adolescents, with some adults receiving services by therapists (with extended care training).
- Dental Hygienist - Dental hygienists focus on provision of oral health services and provide assessment, diagnosis, treatment, management, education to prevent oral disease and promotion of healthy oral behaviours. Services include periodontal or gum treatment, preventive services and other oral care.
- Dental Assistant - Dental assistants (DA) provide dental assisting duties within a dental clinic, including ensuring requirements for infection control and sterilisation, clinic administration and client records are met in accordance with organisational procedures and work practices.
- Dental Technician - construct and repair dentures (false teeth) and other dental appliances including crowns and bridges. Dental technicians work closely with dental prosthetists and dentists in the construction, modification and repair of dentures and other dental appliances.

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AHHA acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA also pays our respect to their Elders past, present, and emerging as the custodians of knowledge