HIGHER EDUCATION FUNDING FOR THE DENTAL WORKFORCE[1]

1 Introduction

1.1 Population growth, the retention of teeth, and an ageing population are likely to lead to an increase in demand for dental services. Australia is experiencing a dental workforce mal-distribution. The public sector and regional, rural and remote areas are generally under-supplied with dental providers. Hence, developing and maintaining a sustainable Australian dental workforce is a fundamental issue.

1.2 Higher education funding to dental schools is insufficient and staffing levels are inadequate. Dentists assist in overcoming this funding shortfall by providing voluntary unpaid clinical supervision, with the situation arising where some dental schools must rely heavily on this donated service.

1.3 The Australian Health Ministers' Conference 2004 has determined a National Health Workforce Strategic Framework. The first, guiding principle of this framework ascertains that 'Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.'

1.4 The higher education sector via Australian university dental schools provides all education and training for dentists, and most of the training for dental therapists and dental hygienists. Courses in dental therapy and dental hygiene are included in the category "dentistry", although most universities use the sub-heading "oral health".

1.5 The cost of dental undergraduate education and training is high due to the length of time of study, cost of providing and maintaining clinical and laboratory facilities and equipment, and support staff. The dental student's liability is significant compared to most other students.

2 Principles

2.1 Maintaining and improving oral health relies to a large extent on access to equitable oral health care services which, in turn, is reliant on an adequate dental workforce.

2.2 Australia must be largely self sufficient with regard to the training of the dental workforce.

2.3 In order to maintain an adequate and sustainable dental workforce, it is critical that the Federal Government fund existing dental schools to ensure they remain viable to promote excellence in teaching, learning, scholarship and research in dentistry.

2.4 Federal Government funding should be at levels such that viability of dental schools is not reliant on fee-paying students.

2.5 Fostering an interest in rural, remote and public sector practice is a responsibility of dental schools.

[1] This Policy Statement is linked to other Policy Statements: *1.1 National Oral Health, 2.1 Dental Workforce, 2.2 Dentists, 2.3 Allied Dental Personnel, 2.8 Overseas Trained Dentists & 4.7 Regulatory Authorities*

2.6 Incentives to encourage rural, remote and public sector practice will improve the distribution of Australia's dental workforce.

2.7 The services provided by dentists, dental therapists, and dental hygienists are largely complementary and substitution does not necessarily reduce demand.

2.8 The provision and maintenance of dental facilities and workplaces appropriate for use in the clinical supervision of dental and allied dental students is a State government responsibility.

3 Policy

3.1 It is imperative that the establishment of new dental schools or the expansion of dental school training numbers is based upon demonstrable need.

3.2 The Federal Government must adequately fund the university dental schools to ensure viability and appropriate staffing levels while keeping dental training within the reach of all who qualify for entry by maximising Commonwealth Supported Places [CSPs].

3.3 The funding level for dental training should be determined separately from other courses, recognising the uniquely high costs of dental training and the high retention rates in dental courses.

3.4 The establishment of new dental schools is resource intensive and costly. Wherever possible, Governments should take advantage of economies of scale and existing infrastructure by expanding places at established dental schools.

3.5 Where a new dental school is proposed, it must be demonstrable that it will have appropriate infrastructure, patient pool and staffing available to support students and that it is located in a region of workforce need, with an appropriate student mix that may assist in addressing the long term workforce needs of that region.

3.6 The distribution of any additional dental undergraduate places should take into account the demography and oral disease prevalence needs of the community. It is important to develop strategies to improve the geographic distribution of dentists.

3.7 Undergraduate education models should foster an interest in rural/remote dentistry and also equip dental graduates to face the challenges of rural/remote dentistry.

3.8 Undergraduate education models should provide dental school students with strong early exposure to rural/remote dentistry. The dental schools should maximise the potential for rural rotations during undergraduate study as one strategy to address the geographic distribution of dentists between urban and rural locations.

3.9 Existing dental schools should establish rural/remote clinics in partnership with rural/remote communities.

3.10 Allocation of CSPs must ensure the correct mix between dentist and allied dental personnel places. The correct mix is dependent on factors including:

- dentists are the dental team leader;
- allied dental personnel roles are complimentary and should not be substitutional;
- rural and remote dental practice requires the full knowledge and skills of dentists.

3.11 Additional focus should be given to the establishment of scholarships from the Australian and State governments for students from rural and remote areas at a level appropriate to the total level of student contributions. Similarly, strategies to increase the dental workforce in the public sector are required.

3.12 Options to encourage Australian graduates to take up positions in rural and remote area for specified periods should be linked to HELP debts incurred during undergraduate years [either full fee or CSPs]. Some of these options may include:

3.12.1 Reimbursement of loans be on the basis of one year's debt relief for every year spent working in a rural area and two years' debt relief for every year spent in a remote area;

3.12.2 Increasing the number of dedicated university places supported by scholarships for Indigenous students and students from rural and remote backgrounds;

3.12.3 Graduate incentive programs offering supported employment pathway into rural and remote areas.

3.13 Options to encourage Australian dental graduates to take up positions in the public sector for specified periods should be considered in ways similar to encouraging graduates to work in rural and remote areas for periods of time. Some of these options may include:

3.13.1 Financial incentives such as payment of CSP loans as part of a recruitment package for periods of service, and ensuring the provision of oral health services by full fee paying graduates for periods of time within Australia following graduation;

3.13.2 Graduate incentive programmes that offer a supported employment pathway into the public dental service.

3.14 The fee repayment for dental graduates must not commence until graduates with a CSP-HELP loan earn an income in excess of $75,000 per annum.

Policy Statement 2.6

Adopted by ADA Federal Council, April 7/8, 2005.
Amended by ADA Federal Council, April 12/13, 2007.

APPENDIX A TO POLICY STATEMENT 2.6

GLOSSARY OF TERMS RELATING TO HIGHER EDUCATION FUNDING

Commonwealth Learning Scholarships

These are scholarships available to assist students from regional and rural areas, low socioeconomic background and those who are indigenous. There are two scholarships – Commonwealth Education costs [CEC] and Commonwealth Accommodation Scholarship [CAS]. The scholarships are distributed to the individual universities for allocation to students.

Commonwealth Supported Place

On average, the Australian Government contributes about three-quarters of the total funding for educational costs provided for "Commonwealth supported students"; these students paying a "student contribution". Student contributions may vary between dental schools and fall into four bands determined by the Australian Government. Student contributions rise incrementally from the lowest contributions for the recognised national priority workforce areas ($3,998 for education and nursing)[2] to the highest ($8,333 for law, dentistry, medicine, veterinary science)[2] indexed to CPI p.a.

Domestic and Overseas Students

Domestic students are Australian citizens, New Zealand citizens or holders of a permanent visa. All other students are considered overseas students. Australian citizens and holders of a permanent humanitarian visa may pay their student contribution up front or they may request a Higher Education Loan Programme (HELP) loan tuition fee.

Fee-Paying Students

The Australian Government does not contribute to course costs for fee-paying students; these students pay a 'tuition fee'. Each higher education provider sets its own tuition fees for each course, so the tuition fees will vary between providers and courses. The government sets a ***minimum limit*** on tuition fees. Tuition fees will not be less than the student contributions paid by Commonwealth supported students in the same course. Under new arrangements, dental schools can raise the cap of domestic full fee paying students to 50% (if an institution has met its undergraduate student target load).

Higher Education Funding

This funding is applicable to payment of tuition fees for university level undergraduate education and training for dentists, dental therapists and dental hygienists and is not usually applicable to education and training for specialisation in dentistry, continuing education or postgraduate qualifications. Although funding arrangements are subject to Australian government regulatory legislation, there is considerable variation in fees for dental courses between States and between institutions within the states.

For entry into undergraduate study, the university dental schools offer domestic students either a 'Commonwealth supported place' or a 'fee paying place'. Each university dental school independently determines the level of tuition fees and the number of places that are fully funded (up to a possible 50%) or partly funded by students. The financial amounts for 'Commonwealth supported places' must be within maximum levels according to discipline. This applies to student and public contributions; length of time students will have access to student loans and percentage of students that are full fee paying per year. The reforms commence in 2005, with universities in 2004 receiving $15,422 per 'Commonwealth supported' student place per year. Student contributions in the vicinity of $8000 make up the remainder

[2] Figures quoted for 2005. These maximum student contributions are for full-time students for a full year. The maximum is indexed each year according to movements in the Consumer Price Index (CPI).

of the costs provided for 'Commonwealth supported' dental students, which may fall short of estimated costs for full fee paying students.

Higher Education Loan Programme (HELP)

There are two main types of HELP loans:

Higher Education Contributory Scheme

HECS-HELP is for eligible Commonwealth supported students to pay their student contribution; and FEE-HELP is for eligible fee paying students to pay their tuition fees up to $50,000.

All HELP debts are indexed each year according to movements in the Consumer Price Index (CPI) to maintain their real value but are otherwise interest free.

Supported Employment Pathway

The term 'supported employment pathway' is taken from the large number of documents and sources, including the Department of Health and Ageing website, describing the Australian government's incentives which are made available to doctors to enhance rural and remote recruitment and retention, and which are mostly linked to Medicare [e.g. encouraging doctors to bulk bill concession card holders and children under 16 years by giving the rural doctor's more rebate on Medicare]. Supported employment pathways make it easier or more attractive to work in rural and remote areas (and the public sector) using a variety of innovative models.

There are 573 results to a search for graduate incentive programmes for doctors on the DOHA website. Some of the incentives in medicine include:

- Making extra payments (linked to Medicare) and giving extra support and training to GPs, e.g. Rural Workforce agencies to help with locum relief, continuing education, spousal support, social networks etc.

- Encouraging and attracting more graduate doctors to work in rural and remote areas whilst learning from experienced GPs, e.g. by paying mentors, linking to FRGP programmes.

- Increasing the number of overseas qualified doctors through international recruitment with improved training and support programmes (linked to the Colleges) and opportunities for permanent residency in Australia.

- Introducing refresher programmes to help GPs and specialists return to work after leaving the workforce (for a variety of reasons).

- Introducing 250 medical school places each year, dedicated to producing doctors who will work in areas where there are doctor shortages e.g. scholarship programmes such as Medically Bonded Scholarships.