

**Increasing Dental and Oral health
training in rural and remote Australia:
Feasibility study**

**Technical paper: Summary of the
Strategies and associated cost**

6th September 2022



Australia

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LIST OF ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
ADA	Australian Dental Association
AIDA	Australian Indigenous Doctors Association
ARHEN	Australian Rural Health Education Network
CCCI	Cordell Construction Cost Index
CEO	Chief Executive Officer
CPD	Continuing Professional Development
CQU	Central Queensland University
CSU	Charles Sturt University
DTERP	Dental Training Expanding Rural Placement Program
EOI	Expression of Interest
FRAME	Federation of Rural Australian Medical Educators
FTE	Full Time Equivalent
GP	General Practitioner
IAHA	Indigenous Allied Health Australia
IDAA	Indigenous Dental Association of Australia
JCU	James Cook University
KBC	Kristine Battye Consulting
LHN	Local Health Network
MMM	Modified Monash Model
NAATSIHWP	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
OAMS	Orange Aboriginal Medical Service
PGY	Postgraduate year
RCS	Rural Clinical School
RFDS	Royal Flying Doctors Service
RHMT	Rural Health Multidisciplinary Training
UDRH	University Department of Rural Health
VDGP	Voluntary Dental Graduate Program

EXECUTIVE SUMMARY

Purpose of this study

The Department of Health commissioned KBC Australia to determine the feasibility of and identify best approaches to increasing dental and oral health training through the Rural Health Multidisciplinary Training (RHMT) program including expanding into more rural and remote locations in Australia. This technical paper accompanies the *Increasing Dental and Oral health training in rural and remote Australia: Feasibility study Final Report* and provides an indicative cost for each of the options proposed in the Final Report.

Study approach

The methodology that was applied to complete the study included:

- An *environmental scan* completed January–February 2022
- A *survey* of the 12 universities offering oral health and/or dental training completed February–March 2022
- *Consultations* with key stakeholders completed late March–end April 2022
- *Information synthesis workshop* completed end April 2022
- A *meeting with the Department and Expert Reference Group* to identify the preferred options completed early June 2022
- *Costing of the preferred options* completed May–June 2022
- The final project stage – *the writing of the final report* with identified options completed end July 2022.

Summary of proposed options and associated cost

Strategy 1: National rural and remote dental and oral health workforce and training summit – Under the leadership of the Office of the National Rural Health Commissioner, hold a national summit to engage leaders and stakeholders in rural health education training, dental and oral health education and training, rural and remote workforce development and rural service delivery to:

- Raise the profile of the poor status of rural and remote oral health and need for a national approach to developing the rural and remote dental and oral health workforce
- Review the workforce development strategies outlined in this study and provide advice on mechanisms to progress these strategies in the short to medium term
- Develop an overarching vision and identify key components required for a national rural and remote dental and oral health workforce and training strategy.

The first summit would seek broad industry representation with an estimated cost of \$155,100. Summits scheduled in subsequent years would comprise a smaller working group at a cost of \$176,000. The total cost of this strategy between 2023–24 and 2026–27 would equate to \$683,700.

Strategy 2: Requirements of dental and oral health training aligned with evidence for rural practice – through enhanced reporting processes, the Department should ensure that RHMT funding is used to factor in rural interest as part of the student selection process for rural placements and that the curriculum and approaches to rural training aligns with the evidence base. Additionally, supervisor

engagement and capacity development should become a focus of the training strategy to ensure that students are adequately supported in their rural exposure. To incentivise compliance with the proposed reporting measures, the Department could consider additional annual payments in the range of \$50,000–\$100,000 per university. With a total of twelve universities offering dental and oral health courses the total cost for this strategy between 2023–24 and 2026–27 would be \$4.8 M.

Strategy 3: Rural Graduate and Early Career Program – this strategy describes a rural graduate program targeting new or recent dental and oral health graduates that have undertaken extended rural placement(s) during their undergraduate course. In PGY 1 the graduate has 10 days available for clinical rotation/ training in a clinical area identified by their supervisor and themselves as an area for further development, as well as quarantined time for weekly mentoring. In PGY 2 and 3 the graduate undertakes a series of rotations to obtain a breadth of skills in areas relevant to rural clinical practice and to meet local service needs, completes a structured professional development program and participates in a regular mentoring program. A total of 20 days per annum is available to the graduate for these activities. An estimated cost for the Rural Graduate and Early Career Program is \$33.5 M between the 2023–24 and 2024–25 FYs.

Strategy 4: Supervision capacity building – supervision capacity has emerged as a key challenge to sustain or expand rural training. Therefore, a supervision capacity building framework is put forward to enable the early career practitioner to develop the breadth of clinical skills required for supervision and accesses opportunities with a university dental or oral health school to tutor and teach in Simulation Labs, progressing to student supervision in university clinics or under buddy arrangements with senior dentists for students on rural placement. The Supervision Capacity Building Framework has the same cost structure as the Rural Graduate and Early Career Program strategy, with a total cost of \$33.5 M between 2023–24 and 2024–25 FYs.

Strategy 5: Academic capacity building – Developing academic capacity is a priority for dental schools and is particularly challenging in regional areas. Academic capacity building could be a pathway within the Supervision Capacity Building Framework where a graduate has a joint appointment between the university and the public dental service. Within the university component, the graduate could pursue a teaching strand or combined teaching and research. Adding one additional FTE of dental academic capacity for each university with a dental and / or oral health department per year (12 schools in total), the cost of this strategy is estimated to be \$2 M per year.

Strategy 6: Embedding oral health in University Departments of Rural Health – UDRHs would be resourced to employ an oral health therapist or dentist academic to work in a way similar to other UDRH academics, i.e., pharmacy, nursing, etc. Their role would be to: identify and develop placement opportunities in various service settings such as aged care, childcare, schools, public dental clinics and ACCHOs; develop rural dental networks; provide orientation of students to rural communities; provide supervision and guidance as required; undertake research; work as part of a rural multidisciplinary team; and provide student support. The total estimated cost for this strategy is \$14.3 M between the 2023–24 and 2024–25 FY period.

Strategy 7: Rural Dental and Oral Health Clinical School – The intent of this strategy is to build on the concept of the medical Rural Clinical School, where possible using existing RCS human capital infrastructure, to develop a rural clinical and teaching dental and oral health hub that would build clinical, teaching, supervision and research capacity and capability to support placements and service

delivery to smaller 'spoke' communities. The Rural Dental and Oral Health Clinical School strategy is estimated to incur a total cost of \$ 27.5 M between the 2023–24 and 2024–25 FY period.

Strategy 8: Leadership to grow the Aboriginal and Torres Strait Islanders dental and oral health workforce – The Commonwealth could consider investment in IDAA as the workforce peak body to provide leadership and support for the implementation of the National Workforce Framework for dental and oral health. The cost for this strategy is based on the addition of a new Executive Officer position and an allocation for discretionary funding to support student educational activities. The total cost associated with this new position is estimated to be \$311,000 per year totalling \$1,043,000 between 2023–24 and 2026–27.

1 INTRODUCTION

1.1 Project background

Oral health is fundamental to overall health and wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. However, poor oral health contributes to about 4.5 per cent of all non-fatal burden of disease in Australia. 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. Peer-reviewed evidence demonstrates the importance of rural training immersions for medical, nursing, allied health and dental students in uptake of rural practice upon graduation.

1.2 Project objectives

The Department of Health commissioned KBC Australia to determine the feasibility of and identify best approaches to increasing dental and oral health training, including expanding into more rural and remote locations in Australia. The project has considered:

- The feasibility of and best approaches to increasing dental and oral health training through the RHMT program including expanding into more rural and remote locations
- The benefits of dental and oral health service delivery to local communities
- Future program design and government policy to support Australia's future rural health workforce.

1.3 Project method

The methodology that was applied to complete the study (see Table 1-1) included:

- An *environmental scan* (January–February 2022): to identify key contextual factors that influence and/or determine opportunities for training dental and oral health students in rural, remote and regional locations and highlight areas of interest for investigation. The desktop scan included an overview of the policy context, a brief review of published literature on influence of training strategies on dental and oral health workforce distribution, and analysis of RHMT program reports (where relevant) and historical rural training placement data provided by Australian universities' dental and oral health programs.
- A *survey* of the 12 universities offering oral health and/or dental training (February–March 2022): to map current rural and remote placements. Data was collected for the five-year period 2016–2020.
- *Consultations* with key stakeholders (late March–end April 2022) to identify:
 - Strengths and weaknesses of current dental and oral health rural placements
 - Extent and nature of inter-disciplinary training between dental and oral health professions
 - Barriers and enablers to expanding dental and oral health training to more rural and remote locations
 - Student satisfaction with and feedback on rural placement
 - Opportunities for expanded inter-professional training in rural settings

Consultations were undertaken by site visits to the main campus and rural training sites as well as videoconference interviews. A total of 180 people participated in the consultations.

Table 1-1 Consultation informants by stakeholder group

Informant type	Number
University executive (Deans, academics)	40
University course and placement coordinators	13
LHN Directors/managers of dental services	9
RFDS	1
Dental and oral health supervisors – Public	16
Private practice and ADA members	4
Students – dental	35
ACCHO CEOs, management and oral health staff	10 (includes Orange Aboriginal Medical Service (OAMS), Goondir, Mulungu and Rumbalara)
State Directors of Dental Services, Chief Dentists and policy personnel	12
Department of Health – Dental Section	1
National Rural Health Commissioner	1
UDRH Directors	6
Peak bodies	33 (includes ARHEN board members)
Dental and oral health (national and state)	
Aboriginal and Torres Strait Islander Health Workforce	

- Information synthesis workshop (end April 2022): to synthesise data, draw conclusions and identify approaches and options to increasing dental and oral health training including expanding into more rural and remote locations. *These options are presented in this Technical Report.*
- A meeting with the Department and Expert Reference Group to identify the preferred options (early June 2022)
- Costing of the preferred options (May–June 2022). Which required identifying key cost drivers and formulating program development costs for each option, providing guidance to the Department about the overall funding required for each of the proposed strategies.
- The final project stage – the writing of the final report with identified options (due for completion end July 2022).

1.4 Purpose and structure of this document

This technical paper accompanies the *Increasing Dental and Oral health training in rural and remote Australia: Feasibility study Draft final report* and provides an indicative cost for each of the options proposed in the Draft final report.

2 METHODOLOGY

To establish the cost associated with each option, KBC has:

1. **Used cost data from Australian Dental and Oral Health University Faculties and a state Department of Health.** As part of the consultation process, KBC met with finance representatives from:
 - James Cook University
 - Charles Sturt University
 - University of Adelaide
 - SA Health

We used the data provided by each party to establish benchmarks for common placement expenses (e.g., accommodation, supervision) and to identify where strategies were being employed to ensure sustainability of rural and remote placements that would add to the cost of the proposed options (e.g., rural loadings for clinical staff).

2. **Using desktop research** to identify typical costs for items where data was not able to be provided by universities or health departments (e.g., cost of running a national dental summit).

All data was then used to generate a **direct cost** estimate for each of the options proposed in *the Draft Final Report of the Increasing Dental and Oral health training in rural and remote Australia: Feasibility study*. These cost estimates are presented in Chapter 3.

3 COST OF THE WORKFORCE DEVELOPMENT STRATEGIES

This section provides an overview of each of the workforce development options proposed in the *Draft Final Report of the Increasing Dental and Oral health training in rural and remote Australia: Feasibility study* including their associated cost.

3.1 Strategy 1: National rural and remote dental workforce and training summit

Strategy description

This strategy proposes a national summit to engage dental and oral health stakeholders in education and training, rural and remote workforce development and rural service delivery to develop an overarching vision and identify key components of a national rural and remote dental and oral health workforce and training strategy.

This summit could be led through the Office of the National Rural Health Commissioner. Through the summit a national leadership group would be identified to progress the design of a National Rural Dental and Oral Health Workforce and Training Strategy providing a tangible document to advocate for policy development and/or redesign to develop and sustain this workforce.

It is noted that dental and oral health is outside the current remit of the Office of the Rural Health Commissioner. However, the Office would be well placed to lead discussions and policy development in this area if sufficiently and appropriately resourced to expand the current scope and the cover the costs of the summit as outlined below.

Considerations for the summit should include:

- Using the opportunity to establish a collaborative forum for the dental and oral health schools about rural training, similar to Federation of Rural Australian Medical Educators (FRAME) or Australian Rural Health Education Network (ARHEN). If supported by the dental and oral health schools, the forum could be an ongoing mechanism for supporting collaboration and shared learning across the sector
- Invitations to a wide range of stakeholders including (but not limited to) the university sector, local health services, Aboriginal and Torres Strait Islander workforce peak bodies and health services, students, rural community leaders, professional associations and government. It was noted during the consultations and the RHMT program evaluation that much of the innovative practice that has occurred in medical training has been seeded by people from diverse backgrounds and experience collaborating to bring about change.

While funding of the summit would be outside the direct remit of the RHMT program, its delivery along with development of a National Rural Dental and Oral Health Workforce and Training Strategy would bring significant benefit to the RHMT program including increased collaboration and innovation.

Indicative cost

Table 3-1 provides the estimated cost for running a national rural and remote dental workforce summit in 2023–24 with quarterly follow up working group meetings between 2024–25 and 2026–27.

The first summit would seek broad industry representation (of approximately 80 participants) with an estimated cost of \$155,100. Summits scheduled in subsequent years would comprise a smaller working group of approximately 20 attendees at a cost of \$176,200 each. Over the 2023–24 to 2026–27 financial year period the total cost of this strategy would equate to approximately \$683,700.

Table 3-1 Cost of a national rural and remote dental workforce summit

Item	Description	Cost breakdown	2023–24	2024–25	2025–26	2026–27	Total
Venue							
Venue hire	CBD conference venue for: - 80 people for a two-day summit in 2023–24 - 20 people for a quarterly two-day working group meeting between 2024/25 – 2026–27	N/A	\$4,000	\$6,000	\$6,000	\$6,000	\$22,000
Event incidentals							
Food and Beverages	All meals for attendees including breakfast, lunch, afternoon tea, dinner and coffee.	\$500 per person per conference	\$40,000	\$40,000	\$40,000	\$40,000	\$160,000
Conference materials	Materials required for summit attendees.	\$50 per person	\$4,000	\$4,000	\$4,000	\$4,000	\$16,000
Staff							
Event organiser	Four days required to organise event logistics for initial summit and three days per follow up summit.	\$1,500 per day	\$6,000	\$18,000	\$18,000	\$18,000	\$60,000
Event facilitator (external)	Four days for initial summit. Three days for recurring annual summit.	\$1,500 per day	\$6,000	\$18,000	\$18,000	\$18,000	\$60,000
Travel expense and hotel accommodation							
Airline tickets	<ul style="list-style-type: none"> 72 out of 80 attendees for the initial summit 17 out of 20 attendees for ongoing working groups summit 	\$1,000 per person	\$72,000	\$68,000	\$68,000	\$68,000	\$276,000
Hotel accommodation	4-star hotel	\$300 per person (one night)	\$21,600	\$20,400	\$20,400	\$20,400	\$82,800
Advertising							
Event promotion	Administrative staff time to send reminder emails	\$500	\$500	\$1,000	\$1,000	\$1,000	\$3,500
Signage during event	Printing costs	N/A	\$1,000	\$800	\$800	\$800	\$3,400
Total			\$155,100	\$176,200	\$176,200	\$176,200	\$683,700

3.2 Strategy 2: Requirements of dental and oral health training aligned with evidence for rural practice

There is a good evidence base to inform the design of university education and training to improve rural workforce outcomes (Appendix 1). This includes:

- Student factors – rural origin students are two to three times more likely to work rurally
- Rural exposure – multiple exposures during undergraduate training result in more rural work
- Longer duration rural placements – result in students being two times more likely to work rurally
- Location of placement –students are 1.3 times more likely to work rurally when placement is in MM 2–3 increasing to 1.8 times in MM 4–7
- Placement setting – rural work is three times more likely where placement setting is reflective of rural practice
- First job/internship in a rural location – nearly four times more likely to work rurally.

In addition, learnings from the RHMT program evaluation have identified the quality elements of rural placements to support rural work intent.

While DTERP is a specific funding stream under the RHMT program, this proposed strategy applies across the whole RHMT program. It is noted that James Cook University, Charles Sturt University, La Trobe University and Curtin University are not in receipt of DTERP funding. However, they do receive funding under the RHMT program for UDRH and/or RCS activities.

Central Queensland University (CQU) is currently not a recipient of RHMT program funding for any activity but is the only university in Queensland offering Oral Health Therapy.

It is also noteworthy that under the rules of the RHMT program, funding should not be directed to supporting international students on rural placements.

Therefore, universities participating in the RHMT program should demonstrate:

Student and curriculum

- Student selection and admissions process to identify and increase the intake of rural students to meet or exceed rural origin targets
- Student selection and admissions process to identify and increase the intake of Aboriginal and Torres Strait Islander students
- Educational and support strategies available to, and accessed by Aboriginal and Torres Strait Islander students studying dental or oral health therapy to assist them to complete their degree
- How/where rural and remote health and Aboriginal and Torres Strait Islander health is scaffolded into the curriculum in a strengths based and culturally responsive way
- Option(s) available for rural exposure for students prior to the final year
- EOI processes for the selection of rural origin students or those with a **demonstrated interest** in rural, remote or Aboriginal and Torres Strait Islander health for rural and remote placements (*note that this means not all students have or should have a rural placement*)

- Rural placement length of a minimum of 12 weeks for dental students to ensure students complete a clinical cycle of care, with planning to extend placements for dental students to full semester or longer where they have opportunities to develop professional skills in alternate settings and/or more remote locations
- Rural placement length of a minimum of eight weeks for oral health students to ensure students complete a cycle of care and have opportunities to develop professional skills in alternate settings
- Active engagement with UDRHs and/or RCSs to link dental and oral health students to cultural, social and pastoral supports
- Develop and update written and online pre-placement information for students about patient cohort and community, accommodation, transport options to community, clinical and professional skills they will develop
- Ensure a level of subsidised accommodation and travel for students on rural placements, including specific strategies to support disadvantaged students

Supervisor engagement and capacity development (external and internal)

- Develop and update a supervision manual to ensure supervisors are familiar with curriculum and assessment requirements
- Development and delivery (face to face and online) of training for supervisors, e.g., Teaching On The Run, giving feedback
- Recognition of supervisors, e.g., through adjunct appointments, library access
- Engagement with supervisors and on-site staff at least annually
- Cultural training for supervisors
- Supervisor mentoring and networking opportunities with other supervisors
- At commencement of student placement – provision of individualised information about student competencies and areas for skill development while on placement
- Ongoing program of continuing professional development
- Joint appointments and adjunct positions with the relevant universities

It is acknowledged that universities receiving RHMT program funding are at different stages of being able to meet these requirements for dental and oral health students and that the funding provided through DTERP is relatively small, in comparison with other strands of the RHMT program.

Therefore, it is likely the Department will need to take a collaborative approach with universities to realign rural placement design and delivery, and supervision support with available evidence for rural workforce outcomes.

Implementing change

The Department could take several approaches to ensuring universities improve their performance against the suggested minimum standards specified above, either with or without additional funding (see Table 3-2). New contracts should build in more robust performance monitoring and reporting against these requirements, irrespective of changes to funding.

Consideration needs to be given to how CQU students are actively supported to access RHMT funded placements, for example by requiring Queensland UDRHs and / or RCSs to facilitate a certain number of placements for CQU students.

Table 3-2 Options, Advantages and Disadvantages

Option	Advantages	Disadvantages
Amendments to next RHMT program contract with all universities	No funding required	Placement and supervision support delayed until next contract period commencement
		No leverage with CQU
	Retains universities with active commitment to rural training	Some universities may choose to disengage from rural training which may be more disadvantageous to clinical activity in some jurisdictions
Provide an increase in recurrent funding to all DTERP funded universities for specific activities related to these requirements.	Acknowledges limitations of existing DTERP funding	Potential for funding to be consolidated with no discernible improvement in performance
	Potential incentive for universities to improve performance	Excludes universities not funded for DTERP
		Focussed only on dental not oral health
Provide incentive funding for universities to improve their performance in relation to the specified requirements, based on an application process and with a clear performance monitoring mechanism to assess progress annually.	Open to all universities providing dental and oral health training (not just DTERP)	Some universities may choose to disengage from rural training
	Focus on both dental and oral health	
	Encourages universities to be proactive in meeting program requirements	
	Acknowledges limited funding currently available through DTERP	

Indicative cost: to incentivise compliance with the proposed reporting measures, recommended placement structures, and alignment of rural and remote placements with the evidence base, the Department could consider additional annual payments in the range of \$50,000–\$100,000 per university. Greater incentivisation to achieve the standards could be introduced by a tiered funding mechanism (e.g., \$50k for demonstrated proof of realising 5 standards; a further \$50k for demonstrated realisation of a second tier of standards, etc.)

3.3 Strategies 3: Rural Graduate and Early Career Program

Strategy description

There is now good evidence to show that a key predictor of longer-term rural practice is a rural medical internship, or for nursing and allied health professionals, their first job in a rural location. Furthermore, professional factors that influence a dental graduate’s decision to work rurally includes job availability, access to mentoring and clinical training and experience on offer. Supporting the transition of medical students to rural and regional prevocational and vocational training pathways is also a feature of the RHMT program through the establishment of Regional Training Hubs with a focus on supporting

development of new training capacity; developing linkages and partnerships to promote development of rural training pathways and supporting medical students and junior doctors into regional training.

This strategy describes a rural graduate program targeting new or recent graduates who have undertaken extended rural placement(s) during their undergraduate course.

The Department of Health has previously backed a Voluntary Dental Graduate Year Program (AICG, 2016)¹ which supported 50 graduates working in the public sector to undertake a structured integrated enhanced practice and professional development program and enabled access to mentoring support. The Department of Health paid the graduates' salary and a financial bonus for successful completion of the program. In addition, service providers hosting graduates could access dental infrastructure grants. The VDGP operated for three years with the aim of increasing recruitment into the public sector.

This strategy draws on elements of the VDGP and Regional Training Hubs with modifications to target the dental graduate program to rural, remote and regional locations with an extension of the time period to three years to:

- Provide sufficient length of time for an early career practitioner to become more embedded in a rural community and rural service
- Complete a structured clinical skills and professional development program for enhanced rural practice providing a strong foundation toward becoming a supervisor for ongoing dental and oral health workforce training and development
- Provide mentoring, vocational planning and career guidance.

This longitudinal rural graduate program is part of the rural dental and oral health pathway.

The Rural Graduate and Early Career Program is a partnership between the Australian Government, Department of Health and the state and territory governments. The state or territory government contributes the graduate's salary, and the Department of Health provides funding to offset the graduate's non-clinical time for mentoring and participation in clinical rotations and professional development activities. The Department of Health also funds clinical mentoring, travel and accommodation expenses for graduates to attend clinical placements.

The graduate works in public dental clinic(s) located in MM 3–7 under the supervision of one or more local senior dentists.

An overview of the type of clinical rotations dental graduates may undertake across the program is outlined in the Graduate Supervision Capacity Building Framework. Clinical rotations for oral health graduates would be informed in consultation with industry.

Postgraduate year (PGY) 1 recognises that graduates are still developing and consolidating clinical skills and professional skills. In PGY 1 the graduate has 10 days available for clinical rotation/ training in a clinical area identified by their supervisor and themselves as an area for further development, as well as quarantined time for weekly mentoring.

¹ Australian Continuous Improvement Group (2016). Voluntary Dental Graduate Program. Program Evaluation. Final Report.

In PGY 2 and 3 the graduate undertakes a series of rotations to obtain a breadth of skills in areas relevant to rural clinical practice and to meet local service needs, completes a structured professional development program and participates in a regular mentoring program. A total of 20 days per annum is available to the graduate for these activities.

The Rural Graduate and Early Career program could also be applied under a hybrid employment model where the early career dentist is employed part-time in a rural public dental service and part-time in rural private practice. Early career dental graduates working across both settings would have the experience of working with more complex patients more commonly seen in public clinics and opportunities to perform a broader range of treatments available in private practice. The clinical rotations would be reflective of the skills needed in both settings.

Enrolment in relevant post-graduate study – e.g., graduate certificate in health or tracking toward fellowship of the Royal Australian College of Dental Surgeons – could be additional benefits to participation as well as encourage longer term engagement in the program and retention in rural practice.

Implementing the Strategy

In 2022, South Australia Dental Service commenced a one-year Recent Graduate Dentistry Program (five participants), and Tasmanian Dental Service is establishing a graduate program for dental and oral health therapists in 2023 (six dentists and five oral health therapists).

The Rural Graduate and Early Career Program would seek to augment (not duplicate) these programs and offer potential to trial the program over a longer timeframe. Furthermore, the state programs can provide advice on priority clinical rotations, continuing professional development (CPD) topics and design and delivery of mentoring.

While it is recognised that early career health professionals can be highly mobile to develop the learning opportunities for career progression, this strategy seeks to meet these training and experience requirements. Through employment with a local health network (LHN), it is anticipated that there could be portability of the training support whilst the graduate/early career practitioner continues to work in the public sector in MM 3–7 geographies. Portability arrangements for leave under the hybrid employment model requires investigation.

If this strategy were to be adopted by the Department, further work with the industry is required to identify key rotations, content of professional development program and structure of mentoring arrangements tailored to early career dental and oral health therapy practitioners.

Indicative cost

An estimated total cost for the Rural Graduate and Early Career Program is \$33.5 M between 2023–24 and 2026–27 based on a target of 20% of domestic dental and oral health graduates participating in the program by 2026–27 (approximately 80 participants per year for dentists and 60 per year for oral health therapists over a three-year program (i.e. around 420 total participants nationally by 2026–

27)).² A breakdown of the cost estimate is provided in Table 3-3 and Table 3-4 which accounts for the cost of establishing the program in 2023–24 and a phasing in of participants between 2024–25 and 2026–27.

Table 3-3 Cost of a dental rural graduate and early career program

Item	Description	Cost breakdown	2023–24 (000's)	2024–25 (000's)	2025–26 (000's)	2026–27 (000's)	Total (000's)
Graduate time							
Dental graduate non-clinical time	Based on an average of 0.08 FTE time for professional development activities per year. 80 participants per year. Three-year program.	\$11,811 per graduate per year	N/A	\$945	\$1,890	\$2,835	\$5,670
Supporting staff							
Program coordination	0.05 FTE per graduate per year	\$5,670 per graduate per year	\$454	\$454	\$908	\$1,361	\$2,723
Clinical lead	0.05 FTE per graduate per year	\$10,640 per graduate per year	N/A	\$851	\$1,703	\$2,554	\$5,108
Mentor	0.05 FTE per graduate per year	\$9,700 per graduate per year	N/A	\$775	\$1,551	\$2,326	\$4,652
Travel and accommodation							
Travel	Travel required to attend courses and placements. Students must apply for funding.	Up to \$800 per participant per year	N/A	\$64,000	\$128,000	\$192,000	\$384,000
Accommodation	10 days accommodation allowance per participant per year. Students must apply for funding.	\$300 per night per student	N/A	\$320	\$640	\$960	\$1,920
Total			\$454	\$3,409	\$6,820	\$10,228	\$20,457

² The cost of this option in the establishment phase and inception phase would be significantly lower due to a lower number of participants until the target is met. A cost estimate for these early years has not been provided.

Table 3-4 Cost of an oral health rural graduate and early career program

Item	Description	Cost breakdown	2023–24 (000's)	2024–25 (000's)	2025–26 (000's)	2026–27 (000's)	Total (000's)
Graduate time							
Oral health graduate non-clinical time	Based on an average of 0.08 FTE time for professional development activities per year. 60 participants per year. Three-year program.	\$5,400 per graduate per year	N/A	\$324	\$648	\$972	\$1,944
Supporting staff							
Program coordination	0.05 FTE per graduate	\$5,700 per graduate per year	\$340	\$340	\$681	\$1,021	\$2,042
Clinical lead	0.05 FTE per graduate	\$10,700 per graduate per year	N/A	\$639	\$1,277	\$1,916	\$3,832
Mentor	0.05 FTE per graduate	\$9,700 per graduate per year	N/A	\$581	\$1,163	\$1,744	\$3,488
Travel and accommodation							
Travel	Travel required to attend courses and placements. Students must apply for funding.	Up to \$800 per participant per year	N/A	\$48	\$96	\$144	\$288
Accommodation	10 days accommodation allowance per participant per year. Students must apply for funding.	\$300 per night per student	N/A	\$240	\$480	\$720	\$1,440
Total			\$340	\$2,172	\$4,345	\$6,517	\$13,034

3.4 Strategy 4: Supervision capacity building

Supervision capacity has emerged as a key challenge to sustain or expand rural training. There is shared responsibility and shared benefit for the universities to partner with the LHNs / public sector dental services as well as private and Aboriginal and Community Controlled Health Organisation (ACCHO) providers to develop supervision capability and capacity.

We suggest a supervision capacity building framework (see Table 3-5) to provide a structure for consideration and adaptation by the universities, state dental services and the wider profession.

Supervision frameworks for other professions could also be identified, reviewed and adapted to the needs of the dental profession.

The development of a framework could be progressed by the leadership group identified as part of the national summit (Strategy 1). Alternatively, one or more universities could nominate to undertake development of the framework in conjunction with their relevant jurisdiction or LHNs. The Department could consider supporting this work with a grant through the RHMT program.

As outlined above, the Rural Graduate and Early Career Program should be embedded within the Supervision Capacity Building Framework. Within the framework, the early career practitioner would develop the breadth of clinical skills required for supervision and accesses opportunities, including: a university dental or oral health school to tutor and teach in Simulation Labs; progressing to student supervision in university clinics; or under buddy arrangements with senior dentists for students on rural placement.

Components of the Graduate Supervision Capacity Building Framework are under the remit of the RHMT program. As outlined in Strategy 2, universities have a responsibility to develop and support external supervisors who oversight dental and oral health students on rural placement. This includes development and provision of supervision resources such as a supervision handbook, providing training sessions to supervisors on teaching and feedback techniques and mentoring new supervisors, including cultural mentoring. In addition, it is important to recognise the contribution of external supervisors to student teaching through adjunct appointments and continuing professional development opportunities.

Partnering with LHNs to offer joint appointments to supervisors offers a broader range of professional work such as teaching, tutoring or research, which can contribute to recruitment and/or retention.

The supervision capacity building framework also identifies an entry mechanism for private dentists or oral health professionals to become supervisors recognising that extended time in private practice may limit exposure to complex patients and some upskilling may be required to join the supervision roster for graduate dentists working in the public sector.

Table 3-5 Graduate Supervision Capacity Building Framework

Clinical experience		Supervision experience		Private practitioner entry	Supervisor training	Employment Remuneration
PGY		Uni clinic	Remote site			
1	Core clinical and professional skills consolidation relevant to rural practice					1 FTE LHN
2	Rural public clinics and rotations through: <ul style="list-style-type: none"> head and neck clinics, special needs clinics, prison/ youth detention, theatre and general anaesthetic 	Supervise students in Sim lab or Yr 2 students in student clinic (sessional basis)	Short supervision intensive at uni clinic once or twice year		Access to supervision resources Teaching on the run Giving feedback	Joint appointment dependent on supervision time e.g. 0.8 FTE LHN and 0.2 FTE (Uni) Plus: <ul style="list-style-type: none"> Adjunct appointment Access to uni library
3	<ul style="list-style-type: none"> shadow visiting specialists when in region intensives to develop oral surgery skills manage medical emergencies exposure to geriatrics management of Aboriginal and Torres Strait Islander patients 	Supervise Yr 3 and 4 students in clinic	Buddy with senior dentist to supervise students on placement	Placement or sessional work in uni clinic/public clinic to assess skills to manage complex patients Intensive for skill development Join supervision roster at appropriate level	Mentoring	University provides CPD program to external supervisors
4	Supervise final year students with senior available (6/12)					
5	Independent supervisor					

Indicative cost

The Supervision Capacity Building Framework has the same cost structure as the Rural Graduate and Early Career Program strategy, with a total cost of \$33.5 M between 2023–24 and 2026–27. The cost breakdown is provided in Table 3-3 and Table 3-4.

3.5 Strategy 5: Academic capacity building

Strategy description

Developing academic capacity is a priority for dental schools and is particularly challenging in regional areas. Medical general practice has established GP registrar academic positions through the Australian General Practice Training Program where a GP registrar has a half time appointment with a university to progress a research study and trains half time in their usual general practice. Charles Sturt University dental program has previously had an intern program where the graduate dentist worked half time in a teaching capacity with dental students and half time in the public dental system.

Academic capacity building could be a pathway within the supervision capacity building framework where a graduate has a joint appointment between the university and the public dental service. Within the university component the graduate could pursue a teaching strand or combined teaching and research.

Rural dental academic capacity building can be strengthened through research collaborations with UDRHs and RCSs.

Indicative cost

To build rural dental and oral health academic capacity within the UDRH / RCS program, the Department of Health could provide funding for half-time early career academics on a rolling basis. Each position would be for a two-year timeframe to enable the development and implementation of a research project and/or completion of postgraduate course.

Two positions could be allocated per annum for each dental or oral health school, with the positions located in a regional, rural or remote location and linked with a UDRH or RCS.

Based on a target of adding one additional FTE of dental or oral health academic capacity for each university with a dental and / or oral health department per year (12 schools in total), the cost of this strategy is estimated to be \$2 M per year³.

3.6 Strategy 6: Embedding oral health in University Departments of Rural Health

This strategy utilises the existing UDRH network and their intrinsic capabilities in developing effective service-learning placements to increase rural training and service opportunities for oral health and dental students.

Under this option, UDRHs would be resourced to employ an oral health therapist or dentist academic to work in a way similar to other UDRH academic disciplines, i.e., pharmacy, nursing, etc. Their role

³ Cost based on the Higher Education Industry. – Academic Staff – Award 2020. Level D academic with a 22% clinical loading and 20% rural loading.

would be to: identify and develop placement opportunities in various service settings such as aged care, childcare, schools, public dental clinics and ACCHOs; develop rural dental networks; provide orientation of students to rural communities; provide supervision and guidance as required; undertake research; work as part of a rural multidisciplinary team; and provide student support. UDRHs already have capacity and capability to coordinate placements, manage students on placements (from multiple universities) and develop placements that align with the learning objectives of different universities across a range of professions. In addition, they provide students with structured and locally contextualised cultural orientation, interprofessional learning and teaching relevant to rural practice and rural and remote health. UDRHs also have experience in developing academic capacity within the local health professional workforce. Many of the teaching and research academics working with UDRHs live in rural community and have been developed 'in-situ', which is a requirement of the RHMT program.

The intent of the oral health service-learning placements would be to enable students to develop skills across their full scope of practice and hence include health promotion, oral health behaviour modification, as well as clinical skills. Where dental placements were developed, the emphasis would be on clinical skills development, with activity in alternate settings and additional experience in health promotion where appropriate. Intra-professional learning through pairing of dental, oral health and other allied health students would be a valuable feature of these placements.

Implementation options

Funding should be for a minimum of three years to enable UDRHs to demonstrate success in increasing quantity and quality of oral health and dental placements and to embed these into their ongoing operations.

The Department could consider funding all UDRHs or to fund a limited number based on a competitive application process. A pros and cons analysis of both options is presented in Table 3-6.

UDRHs would need to demonstrate:

- Capacity and capability to deliver high-quality, culturally safe placements
- Formal partnerships with health services (public, private, community controlled) to provide appropriate supervision for students on placement
- Supervision capacity and capability building
- Availability of placements in more rural areas (MM3–7)
- Interprofessional learning opportunities available for students on placement

Table 3-6 Pros and cons analysis of funding all UDRHs compared to a competitive application process

	Advantages	Disadvantages
Funding for ALL UDRHs	Open to all RHMT universities	Does not differentiate between high and low performing universities
	Focus on both dental and oral health	More funding required (than competitive application process)
	Builds on existing infrastructure and expertise	May require funding for additional accommodation to expand placement capacity
Competitive funding application process	Open to all RHMT universities	May require funding for additional accommodation to expand placement capacity
	Incentivises universities to demonstrate good performance against quality placement and supervision requirements	
	Focus on both dental and oral health	
	Builds on existing infrastructure and expertise	

Indicative cost

The key resourcing requirements for this option include a Clinical Educator (oral health or dental) with oncosts and additional accommodation allowance, contribution to placement coordination and management administration costs, additional resourcing for vehicle and travel within the UDRH footprint, infrastructure funds to support the purchase of portable dental equipment or re-purposing/upgrading dental chairs or equipment and allocation to ‘purchase’ supervision capacity to support placements. These appointments could be joint between the university and the LHD or private dentists. Adjunct status with the feeder university could be an incentive for participation by private practices.

UDRHs own and/or manage student accommodation, however additional accommodation may be required.

The strategy begins with a pilot of three sites established in 2023–24 with clinical educators to commence in 2024–25 and further four sites added in 2025–26 with clinical educators for those sites commencing in 2026–27.

The total estimated cost for this strategy is \$14.3 M over the 2023–24 to 2026–27 FYs. The assumptions underlying this estimate are provided in Table 3-7.

Table 3-7 Embedding oral health in University Departments of Rural Health

Item	Description	Cost breakdown	2023–24 (\$000)	2024–25 (\$000)	2025–26 (\$000)	2026–27 (\$000)	Total (\$000)
Establishment costs							
Office furniture and supplies	Initial office setup and ongoing office supplies	\$3k per FTE plus \$500 per subsequent year	9	2	14	4	29
Construction costs	Expansion of UDRH site.	Increase in accommodation capacity for students / academics. 3 sites in 2023–24 and a further four sites in 2025–26. Source: Expansion of the Rural Health Multidisciplinary Training Program in Aged Care Services Grant Opportunity Guidelines and inflated by 10 per cent per year to account for construction inflation. 30% added to cost to account for higher costs of regional / rural construction.	2,595		4,187		6,782
Portable dental equipment	Equipment required to run portable dental clinics	Based on CSU portable dental model	360	120	120	280	880
Staff							
Dental academic		Higher Education Industry – Academic Staff – Award 2020. Dental Academic level D plus a 20% rural loading fee.		497	497	1,159	2,153
Administration support		Admin + placement support based on HEWL award level 5.1		89	89	208	386
Supervision capacity	Contracting of private dentists to supplement supervision capacity	Based on average hourly revenue from 2019 ADA survey and inflated using CPI. 1 day per week across a 52-week work year.		786	786	1,834	3,406
Travel							
Car		Based on lease rates for a Mazda CX-5 SUV. \$1,063 on a 3-year lease. Plus \$3,000 per year for fuel based on 15,000 kms of travel.		47	47	110	204
Accommodation site							
Maintenance		\$1,600 per site per annum. Based on JCU costs for student accommodation cleaning, gardening and incidentals.		5	5	11	21
Utilities		\$6,000 per site per annum		18	18	42	78
Ad- hoc furniture		\$500 per site per annum based on cost data from JCU		12	12	28	52
Staff travel and time to inspect / maintain sites		\$2,000 per site per annum based on cost data from JCU		48	48	112	208
Software		\$500 per site per year based on cost data from JCU		12	12	28	52
Total			2,964	1,636	5,835	3,816	14,251

3.7 Strategy 7: Rural Dental and Oral Health Clinical School

The intent of this strategy is to build on the concept of the medical Rural Clinical School, where possible using existing RCS human capital infrastructure, to develop a rural clinical and teaching dental and oral health hub that would build clinical, teaching, supervision and research capacity and capability to support placements and service delivery to smaller 'spoke' communities. The key elements of the strategy are to:

- Establish and support longitudinal rural immersion (semester to full year placements)
- Establish a dental and oral health community of practice inclusive of local practitioners working in public and private sectors – utilising structured supervision capacity building strategies (supervision capacity building framework), CPD, networking and mentoring among other mechanisms. This offers an opportunity to engage private practitioners in professional development, teaching or shadowing placements and develop a 'pool' for teaching and supervision recognising there will be varying levels of flexibility to support students in clinics in the hub-and-spoke communities
- Utilise existing RCS infrastructure and resources where available (note that there is congruence with established university dental clinics and LHN dental facilities in many RCS locations across jurisdictions). This may include teaching facilities, libraries, placement coordination and support staff, research staff and academics.
- In conjunction with LHN and/or ACCHOs, identify opportunities to develop student-led clinics in rural spoke communities where there are under-utilised chairs and draw on pool of supervisors to oversee and supervise students. The supervisor pool could include private practitioners working on a part-time or sessional basis with the university to travel to sites to supervise students and provide clinical services
- Students participating in the long placements could transition to the graduate/early career program within the 'hub and spoke' catchment.

In determining where Rural Dental and Oral Health Clinical Schools would be progressed, key considerations would include:

- Dental and oral health workforce need
- Oral health needs of the catchment population
- Partnerships between Universities, LHNs and other providers including ACCHOs and private practitioners to develop and sustain training capacity.

In progressing one or more Rural Dental and Oral Health Clinical Schools, it is likely that universities will need to collaborate to attract and select a sustainable cohort of students, particularly in the development of this concept. Applications to participate in the program would need to demonstrate capacity to fill student placements, noting that this could be from both their own university and others. In doing so, participating universities would need formal agreements about appropriate experience and assessment to meet the requirements of their individual degrees. It is noted that, while assessment criteria may currently differ between universities, there is considerable congruence between the clinical placement experience of final year students across dental schools.

Implementation

The establishment of a dental and oral health clinical school could be trialled in at least two sites. The purpose of the trial would be to test the concept, highlight challenges and enablers and to assist in the development of guidelines for expansion to additional sites, if appropriate. Sufficient time (at least three years) should be allowed prior to assessing the success of the trial, given there will be a considerable start-up period for establishment. Trialling in two sites would enable different approaches based on the local context and service environment and would provide the opportunity for the new schools to collaborate and share their learning.

Assessment of funding applications should consider:

- Community need for oral health services
- Strong partnership model with the existing RCS (or UDRH) demonstrating how dental and oral health students and supervisors will be integrated into the operating model
- Written partnership agreements with local health services including, where appropriate, ACCHOs and private practices with commitment to support sustainable student placements
- Governance arrangements
- Quality of proposed placement experiences (as described in the placement quality rubric)
- Availability and sustainability of supervision
- Support for supervisors
- Student selection processes (i.e., preferencing rural origin students and those with demonstrated rural intent and Aboriginal and Torres Strait Islander students)
- Rurality of placement experiences (favouring more rural and remote placements)
- Written agreements with partner universities (where appropriate)
- Opportunities for academic and joint appointments

Indicative cost

Indicative resourcing requirements to establish the hub-and-spoke model to support 10 students and build the local community of practice at each site includes:

Hub level

- Dental academic (1.5 FTE)
- Potentially dental infrastructure (5 chairs and equipment) mostly exists
- 2 Dental assistants
- Student accommodation (10 beds)
- Contribution to placement coordination, administration and teaching

Spoke site

- Supervisor 1 FTE
- Dental assistant 1 FTE
- Vehicle and travel
- Accommodation costs for students and supervisor

The strategy can be phased in with a pilot of three sites commencing in 2024–25 and further four sites commencing in 2026–27. The total cost for this strategy is \$27.5 M with the cost breakdown given in Table 3-8.

Table 3-8 Cost of a Rural Dental and Oral Health Clinical School

Item	Description	Cost breakdown	2023–24 (\$000's)	2024–25 (\$000's)	2025–26 (\$000's)	2026–27 (\$000's)	Total (\$000's)
Establishment costs							
Office furniture and supplies	Initial office setup and ongoing office supplies	\$3k per FTE plus \$500 per subsequent year	9	2	14	4	29
Project management costs	Initial cost of setting up relationships in the community + placement structure. Ongoing cost of maintaining relationships.	10 days' time for a placement coordinator. 10 days for a dental academic. 5 days per year to maintain relationship. <ul style="list-style-type: none"> DA – Higher Education Industry – Academic Staff – Award 2020 Dental Academic level D plus a 20% rural loading fee. Admin support – HEWL level 6.1 award 	26	4	39	10	68
Construction costs	Cost of housing 10 additional students at RCS sites plus staff.	Increase accommodation capacity for students / academics. 3 sites in 2023–24 and a further four sites added in 2025–26. Source: Expansion of the Rural Health Multidisciplinary Training Program in Aged Care Services Grant Opportunity Guidelines and inflated by 10 per cent per year to account for construction inflation. 30% added to cost to account for higher costs of regional / rural construction.	5,191		8,375		13,566
Staff							
Dental academic		1.5 FTE per site. Higher Education Industry – Academic Staff – Award 2020. Dental Academic level D plus a 20% rural loading fee.		745	745	1,739	3,229
Supervisor		1 FTE per site. Higher Education Industry – Academic Staff – Award 2020. Dental Academic		342	342	797	1,481

Item	Description	Cost breakdown	2023– 24 (\$000's)	2024– 25 (\$000's)	2025– 26 (\$000's)	2026– 27 (\$000's)	Total (\$000's)
		level B2 plus a 20% rural loading fee.					
Dental assistants		Higher Education Industry – Academic Staff – Award Dental assistant level 3 + 20% rural loading		377	377	879	1,633
Administration support		0.5 FTE per site. based on HEWL award level 5.1		106	106	248	460
Private dental supervision		Based on average hourly rate from ADA survey and inflated to today's dollars. 1 day per week private clinical rates across a 52-week work year.		786	786	1,834	3,406
Travel							
Car		Based on lease rates for a Mazda CX-5 SUV. \$1,063 on a 3-year lease. Plus \$3,000 per year for fuel based on 15,000 kms of travel.		47	47	110	204
Accommodation site							
Maintenance		\$1,600 per site per annum. Based on JCU costs for student accommodation cleaning, gardening and incidentals.		5	5	11	21
Utilities		\$6,000 per site per annum		18	18	42	78
Ad- hoc furniture		\$500 per site per annum based on cost data from JCU		2	2	4	8
Staff travel and time to inspect / maintain sites		\$2,000 per site per annum based on cost data from JCU		6	6	14	26
Software		\$500 per site per year based on cost data from JCU		2	2	4	8
Discretionary funding							
Equipment and consumables		\$50k per site per year		150	150	350	650
Infrastructure fund	Sites apply for funding to make major upgrades to the RCS or H&S site	Average of \$150k per site per year.		600	600	1,400	2,600
Total			\$5.2 M	\$3.2 M	\$11.6 M	\$ 7.5 M	\$27.5M

3.8 Strategy 8: Leadership to grow the Aboriginal and Torres Strait Islanders dental and oral health workforce

The strategic directions and implementation strategies identified in *The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan (2021–2031)*

provide mechanisms to grow the Aboriginal and Torres Strait Islander dental and oral health workforce using a pathway approach from school students to tertiary qualified practitioners.

However, the focus on the dental and oral health workforce is not as obvious as it is for medicine, nursing, allied health and Aboriginal and Torres Strait Islander Health workers and practitioners, which is largely driven by the Aboriginal and Torres Strait Islander Professional Organisations, i.e., Australian Indigenous Doctors Association (AIDA), CATSINaM, IAHA and National and Torres Strait Islander Health Workers and Practitioners (NATSIHWP). Key priorities for these organisations relate to:

- Improving cultural safety
- Supporting professional development and mentoring
- Developing leadership
- Enhancing student engagement and support.

The Commonwealth could consider investment in the Indigenous Dental Association of Australia as a workforce peak body to provide leadership and support for the implementation of the *National Aboriginal and Torres Strait Health Workforce Framework* for dental and oral health.

In recognition of the small number of Aboriginal Torres Strait Islander dental and oral health practitioners and the recency of incorporation of IDAA, the Department could discuss options for IDAA to initially link with another AIHPO for a time-limited period while it establishes its membership base and develops organisation capacity. It is noted that IAHA has a formal partnership agreement with IDAA (to be renewed in 2022) and that currently much of the existing Aboriginal and Torres Strait Islander dental and oral health workforce are members of IAHA.

Indicative cost

The cost for this strategy is based on the addition of a new Executive Officer position. This executive officer would have responsibility within the peak body for developing and actioning strategies to grow the Aboriginal and Torres Strait Islanders Dental and Oral Health Workforce. The total cost associated with this new position is estimated to be \$311,000 per annum inclusive of an allocation of \$100,000 per annum as discretionary funding. This could be used for student support activities that would be determined by the association but could include student scholarships, access to additional tutoring or mentoring, supporting student attendance at conferences. The total strategy cost over the 2023–2024 to 2026–2027 FY period to \$1,044,000 (see Table 3-9).

Table 3-9 Estimated cost of Option 8: Leadership to grow the Aboriginal and Torres Strait Islanders Dental and Oral Health Workforce

Item	Cost breakdown	2023–24 (\$000's)	2024–25 (\$000's)	2025–26 (\$000's)	2026–27 (\$000's)	Total (\$000's)
Office expenses						
Rent	Based upon 10 sqm per head and \$500 per m ²	3	5	5	5	15
Office set up	\$3,000 per FTE	3				3
Ongoing office expenses. Stationery, printing costs, etc.	\$500	0.5	0.5	0.5	0.5	2
IT support		3	5	5	5	15
Staff						
Executive officer	New FT position – includes salary + oncosts	75	150	150	150	450
Admin support	0.2 FTE x Private sector clerks award rate lvl 3	6	11	11	11	33
Travel						

Flights	\$800 per month	5	10	10	10	29
Accommodation	\$300 per night. 5 nights per month.	9	18	18	18	54
Meal allowance	\$200 per day. 5 days per month	6	12	12	12	36
Discretionary funding						
Initiative funds			100	100	100	300
Total		110	311	311	311	1,043

4 CONCLUSION

This technical paper has provided an overview and cost estimate for each workforce development option put forth as part of the *Increasing Dental and Oral health training in rural and remote Australia: Feasibility study*. A summary of the costs for each option by financial year is provided below in Table 4-1.

Table 4-1: Summary of workforce development strategy costs

Strategy	2023–24	2024–25	2025–26	2026–27	Total
1 - National rural and remote dental workforce and training summit	\$155,000	\$176,000	\$176,000	\$176,000	\$683,000
2 - Requirements of dental and oral health training aligned with evidence for rural practice	\$1,200,000	\$1,200,000	\$1,200,000	\$1,200,000	\$4,800,000
3 - Rural Graduate and Early Career Program / 4 - Supervision capacity building	\$794,000	\$5,581,000	\$11,165,000	\$16,745,000	\$34,285,000
5 - Academic capacity building	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$8,000,000
6 - Embedding oral health in University Departments of Rural Health	\$2,964,000	\$1,636,000	\$5,835,000	\$3,816,000	\$14,251,000
7 - Rural Dental and Oral Health Clinical School	\$5,215,000	\$3,190,000	\$11,612,000	\$7,444,000	\$27,461,000
8 - Leadership to grow the Aboriginal and Torres Strait Islanders dental and oral health workforce	\$110,000	\$311,000	\$311,000	\$311,000	\$1,043,000
Total	\$12,438,000	\$14,094,000	\$32,299,000	\$31,692,000	\$90,525,000

The costs provided in this paper are intended to serve as a guide only. Prior to commissioning, the Department should develop a detailed line-item budget to give a more detailed and accurate estimate of the cost associated with each strategy.