Attn: Advisory Panel – Early Years Strategy
GPO Box 9820
Department of Social Services
Canberra ACT 2601
earlyyearsengagement@dss.gov.au

Dear **Advisory Panel for The Early Years Strategy,**

Thank you for including [redacted] in the list of relevant stakeholders and for the opportunity to submit feedback on the Consultation Paper for the discussion paper on **The Early Years Strategy.**

I am writing on behalf of [redacted]

Below are [redacted] responses to the questions stated in the consultation paper:

1. Do you have any comments on the proposed structure of the Strategy?

The [redacted] supports the development and endorses the need for a new Early Years Strategy. The [redacted] agrees with the overall structure and purpose of the Strategy, to give the first standard for ***"the approach to the early years and prioritise the wellbeing, education and development of Australia's children"*** **and furthermore Closing the Gap and reduce inequality in the hopes of reducing impacts in further life. The [redacted] provides overall discussion and recommendations on the further development of the Strategy.** With significance evidence detailing oral health having a major impact on overall health and wellbeing, self-esteem and quality of life for any person. The OHP profession has a vested interest in childhood development especially in establishing optimal lifelong oral health. In Australia, the majority of dental care within state-based public dental services are provided by dental therapists and oral health therapists [5]. It is also worth noting there are higher percentages of OHPs within regional, rural and remote communities than that of Dentists who favour metropolitan areas [2].

OHP's encompass a paradigm of prevention and early intervention and can improve access to oral health care in dental clinics and the wider community through oral health promotion initiatives. They may also engage with institutions such as early childhood learning centres, educational facilities, hospitals, and residential aged care facilities. Oral health practitioners can provide care to residents, patients and pupils, as well as support and training to staff to better identify oral health needs and prevent disease. Facilities should support the versatility of oral health practitioners to provide care, and capabilities may be extended through the establishment of mobile dental delivery systems to improve access to care.

2. What vision should our nation have for Australia's youngest children?

Regular provision of dental care can have important benefits on the oral health of an individual child. The [redacted] agrees *"Every child deserves the opportunity for the best start to life; a chance to achieve their goals and dreams"*. Prevention focus is imperative in the avoidance of dental disease since are largely driven by modifiable factors such as oral hygiene behaviours and diet, therefore the earlier to encourage these measures within childhood development the more favourable the

outcome. Frequent treatment will promote positive oral health attitudes and will be focused on the maintenance of existing teeth. There is also an increased likelihood of early detection of dental disease before significant damage occurs to the teeth and gums. In the incidence of disease, the provision of dental care will result in treatment and rehabilitation of effected teeth and gums.

Children who are making dental visits on the onset of oral health issues are more likely to lose teeth to caries, have poorer standards of oral health, and have issues with everyday activities such as eating, talking and sleeping [2]. There is ever increasing amounts of children with complex or special needs, developmental disorders including that of dental, trauma and phobia. Treatment performed under a general anaesthetic is not available under the Child Dental Benefits Schedule (CDBS), unless the patient incurs the costs out of pocket or sits on lengthy waiting lists for public services. Regular attendance for routine dental check-ups and prevention in childhood has been shown to result in a better standard of oral health in adulthood.

The discussion paper reinforces children living outside major cities and of whom have disadvantaged backgrounds are more likely to be developmentally vulnerable. The same gaps are seen within oral health status, including limits to access to and delivery of dental services, increased dental disease incidence, decreased understanding for treatment and prevention of such diseases, etc. when comparing those from disadvantaged backgrounds and residing outside major cities to those with metropolitan areas [1]. The CDBS has been an initiative by the Commonwealth has been the aimed at improving the oral health of children aged 0 to 18. Currently State and Territory governments in Australia have a good history of providing oral health and dental services to eligible children through community dental services or school-based dental services. The majority of this dental care was provided by dental therapists and oral health therapists. However, it has only been from July 2022, that OHP's have been able to apply for Medicare Provider Numbers for the provision of services under the CDBS. This will improve the understanding of data on access to and delivery of dental services to the community across by an OHP. There imposes another issue of utilisation of the program that in many cases will rely on the proactivity and motivation of parents or guardians to access such care. School based initiatives cast a net on ages 6 to 17 and in some case 5 and 18, however still rely on parental consent or attendance with child to provide services. With relevance to the Strategy, there lies the same difficulties and relies on promotion within the Early Childhood Education and Care (ECEC) sector.

Previously, programmes that have endorsed promotion of oral health were adopted into curriculum within ECEC and antenatal settings, which in certain areas may still exist, however are not compulsory so responsibility falls to local dental practitioners who may not have the time to be able to establish or deliver such programmes. The School Dental Service of Queensland had a former program where employed OHP's were to enter all ECEC or relevant centres to deliver oral health promotion and education sessions and materials for both staff and attending children. There was also an initiative where children attending ECEC kept a toothbrush at the ECEC to complete staff supervised brushing session following lunch times. Such initiatives are scarce within these settings, especially due to the volunteer basis for this and high privatisation for oral health services, although there are universities with oral health courses who do educate, encourage and deliver oral health promotion and education to ECEC, community-based services such as 'Mums and Bubs', Aged-Care Facilities, etc. through student assessment items for future practitioners.

The [redacted] feels strongly about establishing compulsory programs that target the improvement of oral health for children aged 0 to 5 and therefore increase exposure of preventative approaches and activities within ECEC settings. Consequently, this may increase uptake of CDBS services, where an audit of the schedule by the Australian National Audit Office in 2015 found less than 30% of the eligible

child populations were utilising the program [3]. This may take shape in many different forms and could include training programs and certification of ECEC staff or ECEC centres employing OHPs to be able to complete these services onsite, in which they are already qualified. This is a similar recommendation made to the aged-care review strategy following the royal commission into aged care, for residential facilities to employ OHPs to help in the management and monitoring of oral health for the residents and be able to refer to clinics for any treatment that cannot be completed onsite. There exists already an initiative called '*Senior Smiles*', developed by the University of Newcastle, in which residential aged-care facilities can employ an OHP for such a role. A model for ECEC would be easily adapted from the 'Senior Smiles' program as the goals are mostly transferrable and could also partner with nutritional education.

3. What mix of outcomes are the most important to include in the Strategy?

Investigate access to care barriers to healthcare. Implement meaningful and evidence-based promotion of utilisation of the oral healthcare workforce, including better solicitation of funding such as CDBS for the delivery of services, to then be able to improve and facilitate the development of the Strategy. [redacted] supports an approach to oral health provision which targets relevant children who face barriers to accessing quality oral health services, as well as a universal focus on oral health promotion and prevention in children who are at risk of developing dental disease.

Reduce incidence and experience of dental disease. [redacted] advocates that comprehensive oral health risk assessments, care plans and referrals should be mandatory for all ECEC Centres to identify and address individual child's oral health needs. An appropriate accreditation process, such as a program that could be based off the *Senior Smiles* programme, would ensure ECEC Centres are accountable and dutiful in providing child-centred care encompassing oral health. Increased access to care gives opportunity to address concerns and ailments early and therefore aim to prevent reduce incidence and experience of dental disease.

Change consumer perception of dental office attendance and treatment, and consequently increase access to services without the concept of fear and pain. Literature indicates that attendance to dental services is often symptom or pain orientated, often leading to a more negative outcome for the patients' health and their dental experience. Often meaning because of a less favourable experience in trying to alleviate ones' pain they consequently may defer or avoid treatment for a situation that either could have been prevented through more regular monitoring visits or that may have been more easily treated.

4. What specific areas / policy priorities should be included in the Strategy and why?

Endorsing the requirement for Inter-Professional and Collaborative Practice. Within the first five years of a child's life there are common ailments and development issues such as skeletal, physical and cognitive that they have the possibility of suffering. These conditions often have multifactorial consequences and there is also overlap in the treatment and approaches. There have been shown to be great successes in treatment and care for patients. This is seen easily within patients who are born with a disability or cleft lip and/or palate, who are assigned a team of health professionals participating in case conferencing to manage and align their approaches for treatment options and positive future outcomes for the patient [4]. The same should be encouraged for any child from birth.

5. What could the Commonwealth do to improve outcomes for children – particularly those who are born or raised in more vulnerable and/or disadvantaged circumstances?

As Discussed in Question 3 and 4. [redacted] supports continued review into workforce strategies. It is imperative that health care workers are responsible for a reasonable quantity of patients on any given shift, to ensure health outcomes can be met. OHPs are well positioned to provide Value Based Health Care (VBHC) for patients of diverse backgrounds and circumstances and should be utilised

strategically in a primary care capacity across the health care sector. Full utilisation of oral health practitioners' scopes of practice and appropriate resourcing can reduce the burden of oral disease, which is mostly non-communicable and preventable. In turn, potentially preventable hospitalisations related to oral health problems can be reduced.

Ongoing peer support, mentorship professional development, training and interdisciplinary collaboration with allied and general health service providers would further serve to improve retention of oral health practitioner staff. Investigate a salary package sliding scale based on locality where could be seen as attractive if will get paid considerably more to work and live rural or remotely over metropolitan areas.

A suggestion to attract more First Nation peoples into the health workforce could possibly entail a bonded scholarship program to allow individuals an Education Scholarship for a relevant tertiary qualification and have the expectation at least for same length of study to deliver these services in the community of their origin. Therefore, creating familiar, relatable, culturally safe and comfortable experiences for these children in any setting and may also build community comradery.

6. What areas do you think the Commonwealth could focus on to improve coordination and collaboration in developing policies for children and families?

As Discussed in Question 3, 4 and 5.

7. What principles should be included in the Strategy?

In both Figure 1 and 2, Health is a major topic and has many different aspects anatomically has strong links and factors towards each other key dimensions described. Suggestion of defining health in sub-categories or flow chart to show the interactions with other factors and further highlight the need for inter-collaborative practice. This would enable a more comprehensive way of measuring achieved outcomes from the Strategy, which fails to use statistical data as a measure for health. Example is caries rates were on the decrease amongst public health interventions and programmes were targeting ECEC, however have been on the increase again. A decrease in the rate of caries experience in the form of reinstating decayed, missing, filled teeth (DMFT) data may give measurement to the success for outcomes for dental health.

8. Are there gaps in existing frameworks or other research or evidence that need to be considered for the development of the Strategy?

Summarising [redacted] Recommendations: we believe the following amendments are needed to the Strategy:

- Investigate barries to access to health care
- Develop initiatives to increase catchment of children aged 0 to 5 into the CDBS
- Aid in changing consumer perception of dental office attendance and treatment increase access to services
- Define health in sub-categories or a separate flow chart to establish links between factors.
- Use established links between factors to further promote universal need for inter-professional and collaborative practice for all children.
- Review all workforce strategies to help in aligning with the goals of the Early Years Strategy

Thank you again for the opportunity to provide feedback, please do not hesitate to contact [redacted] for any further clarification.

Yours sincerely,

References:

1. *Oral health and dental care in Australia, Data.* (n.d.). Australian Institute of Health and Welfare. Retrieved November 22, 2022, from https://www/aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/data?page=2
2. Anil, S & Anand, P (2017), 'Early Childhood Caries: Prevalence, Risk Factors, and Prevention', *Frontiers in Pediatrics*, vol. 5, no. 157, pp. 1-7.
3. Stormon, N, Do, L & Sexton, C (2022), 'Has the Child Dental Benefits Schedule improved access to dental care for Australian children?', *Health and Social Care in the community*, vol. 30, no. 6, pp. 4095-4102.
4. Nahai, F, Williams, J, Burstein, F, Martin, J & Thomas, J (2005), 'The Management of Cleft Lip and Palate: Pathways for Treatment and Longitudinal Assessment', *Seminars in Plastic Surgery*, vol. 19, no. 4, pp. 275-285.
5. Satur, J, Gussy, M, Marino, R & Martini, T (2009), 'Patterns of Dental Therapists' Scope of Practice and Employment in Victoria, Australia', *Journal of Dental Education*, vol. 73, no. 3, pp. 416-425.