NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

Provision of and Access to Dental Services in Australia

Submission to Select Committee

June 2023

ABOUT NACCHO

NACCHO is the national peak body representing 145 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Recommendations

NACCHO recommends:

1. any interventions to address oral health be implemented in accordance with the National Agreement and its four Priority Reform Areas.
2. needs-based funding for ACCHOs to deliver oral health services to Aboriginal and Torres Strait Islander communities.
3. the Department work with NACCHO to determine the level of unmet demand for dental services in ACCHOs.
4. the National Oral Health Plan be reviewed and refreshed for the coming decade.
5. Aboriginal and Torres Strait Islander Health Practitioners and other key staff have access to the CDBS items for fluoride applications and other preventative measures.
6. development of culturally appropriate oral health promotion materials that can be locally tailored to respond to the particular needs and knowledge gaps within Aboriginal and Torres Strait Islander communities.
7. an increased remote loading for the CDBS to address the higher costs of remote service provision.
8. expansion of PBS criteria to provide access to tranexamic acid for dentists.
9. ACCHOs and ACCHRTOs are resourced to co-design and deliver training to support Aboriginal and Torres Strait Islander Health Practitioners to deliver preventive dental services.
10. the Commonwealth increase the number, and financial value, of the Puggy Hunter Memorial Scholarship to ensure sufficient financial support for Aboriginal and Torres Strait Islander people studying to become dental practitioners.
11. greater accountability of mainstream service providers to deliver culturally safe services to Aboriginal and Torres Strait Islander people and communities.

Acknowledgements

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Introduction

Aboriginal and Torres Strait Islander people have higher rates of dental disease, multiple caries, and gum disease than their non-Indigenous counterparts across Australia, which can be largely attributed to the social determinants of health. Moreover, Aboriginal and Torres Strait Islander people are less likely to receive the dental care they need. Poor oral health impacts overall health outcomes, including comorbidities such as heart disease and diabetes, which already disproportionately effect Aboriginal and Torres Strait Islander people.

Policy interventions should respond to and be implemented in accord with the National Agreement on Closing the Gap (National Agreement). They should be designed in partnership with Aboriginal and Torres Strait Islander people, support the Aboriginal and Torres Strait Islander community-controlled sector, address racism, support culturally-safe service provision and improve data availability to Aboriginal and Torres Strait Islander people and organisations.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term:

Priority Reform Area 1 – Formal partnerships and shared decision-making
This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector
This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making
This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

NACCHO recommends that any interventions to address oral health be implemented in accordance with the National Agreement and its four Priority Reform Areas.

Good oral health is fundamental to overall health and wellbeing and can reduce the risk of comorbidities such as heart disease, diabetes, and cancer. The most apparent benefit of having good oral hygiene is the prevention of cavities, tooth loss, and gum disease. Dental caries and periodontal (gum) disease can cause significant morbidity through pain, infection and tooth loss, and may result in deteriorating function.[1] Caries and gum disease can lead to lasting tissue damage and may impact appearance and self-esteem. Tooth loss can impact a person's ability to chew and swallow leading to comprised nutrition. The impacts of poor oral health and oral disease on Aboriginal and Torres Strait Islander people's lives are especially pervasive given higher rates of comorbidity which impact on quality of life and increase risk of mortality.[2]

Cardiovascular disease is a recognised comorbidity to oral disease. Research has shown that gum disease can increase an individual's risk of heart attack by nearly 50 per cent. Similarly, studies have shown that having high blood sugar can increase a person's risk of developing gum disease, and in turn, people with gum disease are up to 50% more likely to develop Type 2 diabetes than those with healthy gums. Oral disease contributes to the chronic disease burden through worsening of cardiovascular disease[3] and diabetes mellitus[4] outcomes – two prevalent causes of death and disability among Aboriginal and Torres Strait Islander people.[5]

For Aboriginal and Torres Strait Islander adults, data from the 2018–19 Health Survey shows 6% of people aged 15 and over were reported to have complete tooth loss, and a further 45% having lost at least one tooth.[6] Moreover, data shows Aboriginal and Torres Strait Islander adults aged 15 and

[1] Slade GD et al (2007) 'Australia's Dental Generations: The National Survey of Adult Oral Health 2004-06. Canberra' Australian Institute of Health and Welfare
[2] R Watt, S Serban (2020) 'Multimorbidity: a challenge and opportunity for the dental profession'. Retrieved from: https://www.nature.com/articles/s41415-020-2056-y
[3] Demmer RT et al (2006) 'Periodontal infections and cardiovascular disease: The heart of the matter.' J Am Dent Assoc. 137: pp145-205.
[4] Taylor GW (2008) 'Periodontal disease: Associations with diabetes, glycaemic control and complications.' Oral Dis. 14(3) pp191-203.
[5] Centre for Epidemiology and Evidence (2012) 'The Health of Aboriginal People of NSW: Report of the Chief Health Officer. New South Wales Ministry of Health;
[6] Ibid p6

over are more than twice as likely to have advanced gum disease and are three times more likely to experience tooth decay compared to non-Indigenous adults.[7]

For Aboriginal and Torres Strait Islander children, the effects of oral disease can be long term and carry through to adulthood. Data shows that in 2014-15, an estimated 39% of Aboriginal and Torres Strait Islander children aged 10-14 had gum or teeth problems. More recent research estimates Indigenous children are 73% less likely to have adequate dental visiting habits than non-Indigenous children[8], and that the gap between utilisation of childhood preventive services shows 'persistent inequalities' with no evidence of convergence.[9] Between July 2015 and June 2017, Indigenous children aged 0–4 were hospitalised for dental conditions at 1.7 times the rate of non-Indigenous children (6.2 and 3.7 per 1,000, respectively) and those aged 5–14 were hospitalised at 1.3 times the rate (6.1 and 4.6 per 1,000, respectively).[10]

Insufficient access to dental services is one of the considerable contributors to higher rates of poor oral health for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people access health and care services at far lower rates than other Australians, due in large part to systemic barriers which can include language and cultural barriers, lack of culturally appropriate services and personal and historical experiences of systemic and interpersonal racism.

Importance of ACCHO-led care

ACCHOs play a central role in the provision of culturally safe, trauma-informed care primary health care for Aboriginal and Torres Strait Islander communities. Rooted in self-determination, ACCHOs help overcome many of the barriers to access experienced by Aboriginal and Torres Strait Islander people.

ACCHOs are the preferred model for delivery of Aboriginal and Torres Strait Islander primary health care. Over 50% of Aboriginal and Torres Strait Islander people prefer to attend an ACCHO over a non-Indigenous practice and this number is growing. Though they are nascent, dental services are increasingly offered by ACCHOs.

The limited data NACCHO has available on the provision of dental services indicates that in 2020-21, there were approximately 70,000 ACCHO dental-service client contacts nationally. These services were provided by around 140 paid dentists and dental support staff, of whom around 60 were Aboriginal and/or Torres Strait Islander. However, some 40 unpaid staff also provided dental services.[11] The latter estimate suggests that ACCHOs may be shifting resources from other areas of need to cover high demand for dental-services, and are doing so without any corresponding funding. This is supported by a 2015 study of ACCHO dental services in NSW.[12]

Indeed, the submission provided by Derbarl Yerrigan Health Service states that although they have been delivering a dental clinic for Aboriginal patients for the last thirty-five years, funding remains an issue. Derbarl provides dental care to more than 1000 patients each year including 300 patients from

[7] Australian Government. Health Mouth Healthy Lives – Australia's National Oral Health Plan 2015-2024. Retrieved from: https://www.health.gov.au/sites/default/files/documents/2022/04/healthy-mouths-healthy-lives-australia-s-national-oral-health-plan-2015-2024.pdf

[8] Storman et al (2022) 'Has the Child Dental Benefits Schedule improved access to dental care for Australian children?' Health Soc Care Community.

[9] Orr et al (2021) 'Inequalities in the utilisation of the Child Dental Benefits Schedule between Aboriginal and non-Aboriginal children'. CSIRO

[10] AIHW (2020) op cit, p6

[11] NACCHO (2020) unpublished data.

[12] Campbell et al (2015) 'The oral health care experiences of NSW Aboriginal Community Controlled Health Services' Australian and NZ J. of Public Health.

rural or remote areas. Despite this, approximately one in three patients are turned away due to unavailability of appointments. Derbarl note they have no funding to provide services to children, and most work provided is palliative dentistry as they do not have sufficient capacity to provide preventative dental care. Whilst Derbarl provides a model of culturally appropriate and holistic dental care, there remain concerns that there is no long-term, sustainable funding for the services they provide.

A lack of infrastructure and the poor condition of existing infrastructure also impacts the quality and extent of dental services able to be delivered to Aboriginal and Torres Strait Islander people. The increased costs to build and maintain infrastructure areas with small populations impacts the viability of and access to health care services, including dental services for Aboriginal and Torres Strait Islander people.[13] An adequate funding model is needed to ensure core clinical services can address unmet community need for dental treatment and dental hygiene. If this demand could be adequately satisfied by ACCHOs like Derbarl, it would significantly improve access and health outcomes for their communities.

Improving the resourcing of and access to ACCHO dental services and preventive care activities contribute the Government's commitment to Priority Reform 2 under the National Agreement, and support Objective 5.2 of the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*, to deliver activities to improve oral health, particularly for children. It will also align with the recommendations of the *National Oral Health Plan 2015-2024* which identifies Aboriginal and Torres Strait Islander people as a priority population group, and with NACCHO's Core Services and Outcomes Framework which identifies oral health as a high priority within its domains of 'community health promotion and empowerment' and, 'evidence-based clinical services'.[14]

NACCHO recommends needs-based funding for ACCHOs to deliver oral health services to Aboriginal and Torres Strait Islander communities.

NACCHO recommends the Department work with NACCHO to determine the level of unmet demand for dental services in ACCHOs.

NACCHO recommend the National Oral Health Plan be reviewed and refreshed for the coming decade.

Workforce shortages

ACCHOs are currently facing critical workforce shortages, which are exacerbated in remote areas. Workforce data reported to the AIHW shows a decrease of FTE clinical staff per 1,000 population of around 20 – 30% in ACCHOs and a 50% increase in the number of unfilled positions since the start of the COVID-19 pandemic in 2020.

For many ACCHOs, recruitment of dentists remains a key challenge, and not just rural and remote areas. While some services in Aboriginal and Torres Strait Islander communities have the necessary infrastructure to deliver dental care (including a room with a dental chair) they are unable to use this facility due to lack of dentists and other dental health care workers. There are ongoing difficulties in attracting and retaining oral health staff in regional and remote areas which makes providing regular accessible dental services to these communities an ongoing challenge.[15] For example, in Ceduna, a

[13] Australian Government Infrastructure Australia (2019) Retrieved from: https://www.infrastructureaustralia.gov.au/publications/australian-infrastructure-audit-2019
[14] NACCHO Core Services and Outcomes Framework, https://csof.naccho.org.au/
[15] Australian Dental Association (2022) Retrieved from: https://www.ada.org.au/News-Media/News-and-Release/Latest-News/Rural-and-remote-dentistry-19122022

town in South Australia where Aboriginal and Torres Strait Islander people make up 22.4% of the population, there is currently no operating dentist (public or private).

Recruitment of dental practitioners to regional and rural areas has been reported to be affected by a lack of incentives in establishing dental services in these regions. We know that the growth needs of the health and care sector are significant and demand for services is growing rapidly. Australia's dental workforce has been increasing in numbers, although the per capita numbers have decreased slightly, and demand for dental services is expected to continue to increase. Dental practitioners overwhelmingly work in the private sector, while in 2020, only 57 of over 18,000 dental practitioners worked in Aboriginal health services.

Because of the lack of dentist in communities, there is often a corresponding lack of appropriate and clear access and referral pathways. A consequence of this is that Aboriginal and Torres Strait Islander people will often use primary care medical services[16] and emergency departments for dental issues that require immediate treatment and referral. The problem is exacerbated given these issues are not best suited to medical doctors as they do not have adequate dental training and are unable to offer definitive treatment. This results in situations such as giving oral pain relief or antibiotics unnecessarily as there is no other treatment available in that setting. Funded access to preventative and basic acute dental is needed as many Aboriginal and Torres Strait Islander are simply not able to access dental care when they need it. There is also a need for culturally safe and affordable referral pathways to dental services for Aboriginal and Torres Strait Islander people.

Affordability of dental services is one of the biggest challenges for Aboriginal and Torres Strait Islander people. While Medicare provides rebate for the provision of dental services under the Child Dental Benefits Schedule (CDBS), there are no rebates for adult treatment. Dental services are largely paid for by patients through private health insurance. Data shows that 85% of dental services in Australia are provided by the private sector. However, Aboriginal and Torres Strait Islander people are less likely to have health insurance and therefore may incur more out of pocket expenses. This cost model may also contribute to an unwillingness to access care and may increase the utilisation of GP and hospital emergency services for urgent care. In order to respond to, and lower the incidence emergency presentations, a focus on preventive care is essential.

Health promotion and prevention

It is evident that community-based health promotion education plays a critical role in reducing oral disease. However, some member services have commented on the limited and in some areas non-existent education about oral health and the prevention of dental disease. Low levels of oral health literacy within communities has serious consequences for oral health outcomes including for those people with comorbidities. This results in a reduced uptake of oral health services and engagement in preventative strategies.

We know that levels of utilisation of preventative dental measures are significantly lower among Aboriginal and Torres Strait Islander people than non-Indigenous people across all child years.[17] In addition, numerous studies have found early oral health screening by non-dental professionals to be effective in the prevention of early childhood caries.[18] Central to the ACCHO holistic model of care is

[16] T Barnett et all (2016) "Sorry, I'm not a dentist": perspectives of rural GPs on oral health in the bush. Retrieved from: https://www.mja.com.au/journal/2016/204/1/sorry-im-not-dentist-perspectives-rural-gps-oral-health-bush

[17] Orr et al (2021) 'Inequalities in the utilisation of the Child Dental Benefits Schedule between Aboriginal and non-Aboriginal children'. CSIRO

[18] Heilbrunn-Lang et al (2019) 'Family-centred oral health promotion through Victorian child-health services: A pilot.' Health Promotion International, 35(2), 279–289.

the critical and trusted role of the Aboriginal and Torres Strait Islander Health Worker and Health Practitioner in supporting preventative care and improving community health literacy. Building the capacity and capability of existing ACCHO workforce to deliver screening and preventative oral care services would improve access and preventive behaviours. Services such as topical application of remineralisation and cariostatic agents could be provided by an Aboriginal and Torres Strait Islander Health Practitioners, speech pathologists and other early childhood practitioners.[19] Yet, access to these critical CDBS items is restricted to dental practitioners (dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists) reducing access for Aboriginal and Torres Strait Islander people.

NACCHO recommends Aboriginal and Torres Strait Islander Health Practitioners and other key staff have access to the CDBS items for fluoride applications and other preventative measures.

Building community oral health literacy is also critical. For Aboriginal and Torres Strait Islander communities in particular, information and communications campaigns must be developed in partnership with the community. We saw though the early stages of the COVID pandemic how successful ACCHOs were in developing targeted resources for their communities to limit the transmission of disease. We also saw that the use of (often poorly) translated whole of population resources for multicultural communities was not as successful. Reliance on translation as a communication tool for non-English speaking communities is not effective. Communications must be tailored, culturally appropriate and accessible, and where required, in language. A place-based approach must be integrated to ensure localised messages can be delivered by ACCHOs, who are trusted members of the community. This can only be achieved by direct funding to the sector.

NACCHO recommends development of culturally appropriate oral health promotion materials that can be locally tailored to respond to the particular needs and knowledge gaps within Aboriginal and Torres Strait Islander communities.

Improving community perception of need through health promotion is also critical for the enhancement of access the CDBS[20] and can be achieved by leveraging the work done in other health programs.

CDBS covers full or partial cost for children for Aboriginal children up to the age of 0-17 years old. In 2015, some 45,396 Indigenous children received dental services under the CDBS, representing 20% of those eligible for these services. In comparison, 35% of eligible non-Indigenous children had received these services.[21] A 2019 study reported a decline in service utilisation by 16.3% after the first year of the CDBS. [22]

These data are not unknown to the Department, yet there remain significant and persistent issues around access to the CDBS for Aboriginal and Torres Strait Islander children. These issues are compounded for people in regional, rural and remote areas where access to professional services is limited, and the cost of delivering services increased. Improvements are urgently needed and requires a partnership approach with Aboriginal and Torres Strait Islander people and organisations.

[19] Storman et al (2022) 'Has the Child Dental Benefits Schedule improved access to dental care for Australian children?' Health Soc Care Community.
[20] Storman et al (2022) 'Has the Child Dental Benefits Schedule improved access to dental care for Australian children?' Health Soc Care Community.
[21] AIHW (2020) 'Indigenous Health Performance Report' p5
[22] Putri et al (2019) 'Retrospective analysis of utilisation of the Australian Child Dental Benefit Scheme.' Australian Health Review, 44(2), pp 304–309.

ACCHOs' roles in improving Aboriginal oral health would be strengthened by the development of transparent, long-term funding solutions that respond to community need,[23] including recognition of the higher costs of delivering services in rural and remote areas.

NACCHO recommends an increased remote loading for the CDBS to address the higher costs of remote service provision.

Access to MBS and PBS

Access to tranexamic acid (TXA) for Dentists through the Pharmaceutical Benefits Scheme (PBS) is a key measure that will support more effective dental care in Aboriginal and Torres Strait Islander communities.

TXA is typically used as a haemostatic agent, for example to stop persistent oral/dental bleeding during and after minor dental procedures, particularly for those who may be taking blood thinners. While dentists can access the medication privately, it is more costly and requires preparation of a mouthwash or solution for oral use.[24] This is a potential barrier to use and may discourage dental practitioners from prescribing or carrying this medication, and may also create situations where dental practitioners are less comfortable with performing dental procedures on patients who are on anticoagulant medications.

Many ACCHOs across Australia deliver dental services as part of their comprehensive models of primary care. Feedback from member services have suggested that the PBS restriction of tranexamic acid to nurses and doctors only impinges on their ability to provide effective and appropriate services to their dental clients. Expanding the PBS criteria to include dentists for tranexamic acid would help address this gap in dental health.

NACCHO recommends expansion of PBS criteria to provide access to tranexamic acid for dentists.

The beneficial health outcomes for Aboriginal and Torres Strait Islander patients who are cared for by Aboriginal and Torres Strait Islander health staff are well documented and recognised in key policy documents, including the National Aboriginal and Torres Strait Islander Health Plan, and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.

However, representation of Aboriginal and Torres Strait Islander dentists and dental hygienists to provide preventative care remains very low. There is a need to build a workforce of suitably skilled and job ready Aboriginal and Torres Strait Islander employees to help improve access to culturally safe, effective and efficient support and assistance.

VET is the sector of choice for post-school education for Aboriginal and Torres Strait Islander students. VET training provides important entry-level pathways and skill-set development for local people, particularly in Aboriginal and Torres Strait Islander communities, including Aboriginal Health Workers and Health Practitioners who play an important public health role. Moreover, VET qualifications offer excellent work ready pathways and provide opportunities to build multidisciplinary teams via upskilling.

Appropriate non-accredited training is required to support effective delivery of preventive dental services, as well as strong pathways to accredited VET and tertiary training to support workforce

[23] Campbell et al (2015) 'The oral health care experiences of NSW Aboriginal Community Controlled Health Services' Australian and NZ J. of Public Health, p1

[24] Fotios Ambados (2003). Preparing tranexamic acid 4.8% mouthwash. Retrieved from: https://www.nps.org.au/australian-prescriber/articles/preparing-tranexamic-acid-4-8-mouthwash

development. Stronger pathways from VET qualifications into higher education are required if we are to increase the number of Aboriginal and Torres Strait Islander dental practitioners across the ACCHO sector. According to the National Health Workforce Dataset in 2018, the total registered dental workforce in Australia was 23,730. Of these, just 108, or less than 0.5%, identified as Aboriginal or Torres Strait Islander.[25]

There is opportunity to expand the skills of current ACCHO workforce, and to provide pathways into the profession for local communities to build a strong workforce that includes both cultural and clinical experts. Up-skilling, re-training, utilising the existing workforce and creating strong VET and higher education pathways to build capacity is key. Building genuine partnerships with the community controlled health RTO sector (ACCHRTOs) is pivotal to ensure there are culturally supportive and clearly articulated education pathways for Aboriginal and Torres Strait Islander students within a health context.

NACCHO recommends ACCHOs and ACCHRTOs are resourced to co-design and deliver training to support Aboriginal and Torres Strait Islander Health Practitioners to deliver preventive dental services.

The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan outlines a number of initiatives to support Aboriginal and Torres Strait Islander students wishing to become dental practitioners.[26] However, support for Aboriginal and Torres Strait Islander dental students remains patchy. Despite a range of available scholarships, accessing them can be complex and their support insufficient to meet rising costs. Between 2010 and 2019, only 29 Aboriginal and Torres Strait Islander students graduated as dental practitioners with support from the Puggy Hunter Memorial Scholarship (PHMS). Each year, half the dental students who apply for a PHMS miss out because there are insufficient scholarships available, and these are spread across the health sector.[27]

NACCHO recommends the Commonwealth increase the number, and financial value, of the Puggy Hunter Memorial Scholarship to ensure sufficient financial support for Aboriginal and Torres Strait Islander people studying to become dental practitioners.

ACCHOs are clearly best placed to provide dental services for Aboriginal and Torres Strait Islander peoples, and the focus should be on increasing their capacity and capability to do so. However, whilst Aboriginal and Torres Strait Islander people have a clear preference for using Aboriginal and Torres Strait Islander services, the reality is that the limited availability and access to ACCHO dental services will mean that many will need to access a mainstream service. We know that Aboriginal and Torres Strait Islander people experience racism and discrimination across the health system[28], resulting in reluctance of community members to access mainstream dental services except as needed for emergency treatment**.**

[25] J. Bourke, C., McAuliffe, A., & Jamieson, L. (2021). Addressing the oral health workforce needs of Aboriginal and Torres Strait Islander Australians. CSIRO Publishing, 407–410. Retrieved from: https://www.publish.csiro.au/ah/pdf/AH20295
[26] National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, https://www.health.gov.au/sites/default/files/documents/2022/03/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031.pdf
[27] Ibid p46
[28] C Kairuz et al (2021) 'Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review'

Mainstream workforces must therefore be appropriately culturally competent to provide services to Aboriginal and Torres Strait Islander peoples. While NACCHO is encouraged to note that in 2020, the Australian Dental Council introduced a new domain of cultural safety to the accreditation standards for dental practitioner programs in Australian dental schools, additional catalysts are needed to ensure dental practitioners deliver culturally safe care.[29]

NACCHO recommends greater accountability of mainstream service providers to deliver culturally safe services to Aboriginal and Torres Strait Islander people and communities.

There remain a range of broader structural and social factors (social determinants) that influence oral health for Aboriginal and Torres Strait Islander people. These are often considered to be 'modifiable' risk factors. This suggests that behavioural factors are within the control of the individual to change, whereas behaviours are influenced by myriad factors outside the control of the individual. Many Aboriginal and Torres Strait Islander people experience poverty, overcrowding, insecure housing, homelessness and food insecurity to a much higher degree than other Australians, as well as a far higher burden of disease. This is true across urban, regional and remote areas.

The correlation between oral disease, poor nutrition and consumption of diets high in sugar is well-documented. For many Aboriginal and Torres Strait Islander communities, poor diet is a direct result of poor food security. In 2012-13, it was estimated up to 31% of Aboriginal and Torres Strait Islander people experience food insecurity.[30] This figure is outdated and, due to underreporting, likely underrepresents the number of Aboriginal and Torres Strait Islander people experiencing some level of food insecurity.

Food insecurity is linked to overall poorer health in adults and children and can increase the risk of non-communicable diseases, such as type two diabetes and cardiovascular disease, which account for 80% of the mortality gap between Aboriginal and Torres Strait Islander people and other Australians.[31] It is important to note that food security can only be achieved when there is access to nutritionally adequate foods.

Data has shown 41% of total energy intake among Aboriginal and Torres Strait Islander people is derived from discretionary food and drink items, which are high in saturated fat, salt, and sugar.[32] Consumption of carbohydrate-based foods, sugar-sweetened beverages, less fruit and vegetables, and processed meat, result in sub-optimal dietary intake.[33] Therefore, to address the high rates of oral and dental disease, the encouragement of healthier diets such as reducing the consumption of sugary drinks is essential.

Inadequate access to clean water often encourages the consumption of sugary drinks, which is a major risk factor for oral disease. A small co-designed infrastructure project is delivering fresh drinking water to communities without clean water to help reduce intake of sugary drinks in

[29] Bourke, C et al (2021) 'Addressing the oral health workforce needs of Aboriginal and Torres Strait Islander Australians' Australian Health Review, p45

[30] Australian Bureau of Statistics (2015) *Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients, 2012–13.* Canberra: Australian Bureau of Statistics

[31] Australian Institute of Family Studies. *Healthy lifestyle programs for physical activity and nutrition.* Melbourne: Australian Institute of Family Studies; 2011

[32] Australian Bureau of Statistics (2015) *Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients, 2012–13*. Canberra: Australian Bureau of Statistics

[33] Lindberg, R.; McNaughton, S.A.; Abbott, G.; Pollard, C.M.; Yaroch, A.L.; Livingstone, K.M. (2022) *The Diet Quality of Food-Insecure Australian Adults—A Nationally Representative Cross-Sectional Analysis*. *Nutrients 14*

children.[34] The project installs refrigerated, filtered water fountains in schools and communities. In just four years, there has been a significant improvement in oral health behaviours, a reduction in tooth decay, and notably, a dramatic reduction in the proportion of children with severe gingivitis from 43% in 2014 to 3% in 2018.

A major investment in adequate water systems is required from Commonwealth and jurisdictional governments as a critical primordial prevention measure to address endemic health and oral health issues in communities. A recent study showed 250,000 Aboriginal and Torres Strait Islander people are not able to access safe drinking water in their remote communities.[35]

Water fluoridation can help to reduce tooth decay. Access to fluoridated water in Australia varies and it has not been implemented consistently across the country. Aboriginal and Torres Strait Islander communities are more likely to live in areas where water fluoridation stopped after 2012, or in areas where it was never implemented. For example, in the Northern Territory, only communities with a population of 600 or more are eligible for water fluoridation. Smaller remote communities have increased risk of oral disease and more limited access to dental services, therefore water fluoridation is an important protective measure for oral disease and health in these communities.

In 2018–19, Indigenous Australians were 3.7 times as likely to be living in overcrowded conditions as non-Indigenous Australians.[36] In many Aboriginal and Torres Strait Islander communities, especially in rural and remote communities, access to clean and adequate water in wet areas such kitchens and bathrooms is limited or non-existent. This often makes it difficult for people to maintain good habits such as brushing their teeth.

Addressing inadequate housing infrastructure, ensuring Aboriginal and Torres Strait Islander people have access to safe and affordable housing and improving access to clean water is key to reducing the burden of hygiene-related disease such as oral disease, and improving health outcomes.

[34] The Conversation, July 23, 2020, https://theconversation.com/collaborating-with-communities-delivers-better-oral-health-for-indigenous-kids-in-rural-australia-141038

[35] The Conversation, https://theconversation.com/countless-reports-show-water-is-undrinkable-in-many-indigenous-communities-why-has-nothing-changed-194447

[36] AIHW, 2.01 Housing https://www.indigenoushpf.gov.au/measures/2-01-housing#implications