Aboriginal Health Council of Western Australia

Aboriginal Community Controlled Health Sector Options Paper

Dental Services in the Aboriginal Community Controlled Health Sector

1 May 2023

Introduction

The Aboriginal Community Controlled Health Services (ACCHS) Sector CEO Network has raised issues with dental care provision in WA on a number of occasions. As a result of these concerns, a survey was disseminated in February 2021 by the Aboriginal Health Council WA (AHCWA) Business Development unit to gain a greater understanding of the current dental care situation in ACCHS and associated communities throughout WA – this included questions in relation to the current provision of services, funding for staffing, consumables and equipment, gaps in, and barriers to service provision, and water fluoridation.

Following this, it was agreed there was a need for qualitative engagement to gain a greater understanding, particularly into service gaps and funding. ACCHS CEOs recommended meeting with the ACCHS Clinical Leadership Group (CLG) in the first instance. The AHCWA Policy team attended a CLG meeting in February 2022 to outline the proposed research. It was apparent from this meeting that the need for advocacy in this area was great. Consequently, CLG participants provided appropriate contacts in their services in relation to dental service provision.

The Policy team met with 15 ACCHS regarding the broader dental care advocacy piece and 5 ACCHS regarding the Child Dental Benefits Schedule (this consultation was initiated by the Federal Department of Health and Aged Care). AHCWA also consulted with the Royal Flying Doctor Service (RFDS) Western Operations and RFDS Central Operations, the WA Dental Health Service, and the Office of the Chief Dental Officer to discuss their role in dental service provision in WA. AHCWA also met with a number of private dentists that operate in regional and remote areas, and with ACCHS dentists from South Australia and New South Wales to understand dental service provision models in other jurisdictions.

This paper will outline the role of adequate dental services in primary health care provision; the role dental health care plays in prevention and early intervention; examine dental health service provision in other jurisdictions; outline dental service provision across WA by region (metropolitan, regional, remote and very remote); and finally provide a number of options to CEOs to consider and inform advocacy to both the Commonwealth and State Governments.

Background

The need for dental

The Australian Medical Association (AMA) recognises that oral health care is an important part of primary health care.[1] Good oral health can impact many facets of a person's life; issues extend beyond immediate pain, infection and tooth loss to impacting nutrition by affecting the ability to swallow and chew, confidence and life opportunities, social and emotional wellbeing, and chronic diseases such as cardiovascular disease (including rheumatic heart disease) and diabetes. For people with diabetes, gum diseases impact the control of blood sugar and increases the risk of diabetic complications. Poor oral health is also associated with a number of heart and lung infections, strokes and pneumonia.[2]

Poor oral health can impact general health and cause tooth loss or impaired functionality making chewing and swallowing more difficult and often leading to reduced nutrition.[3] Dental issues can also negatively impact a person's appearance, speech and self-esteem, leading to reduced involvement at school, work or other social settings.[4] A dental health exam is also required as part of the kidney transplant evaluation process with ACCHS reporting that transplant approval has been denied to some patients due to poor oral health[5].

Aboriginal people are impacted by dental disease at up to three times the rate of non-Aboriginal people across metro, regional and remote areas.[6] Data from 2018 showed that oral health issues accounted for 2.1% of the total disease burden, and 3.9% of non-fatal burden for Aboriginal people.[7] However it is worth noting, that oral health impacts and exacerbates other chronic health conditions, and that these figures may be underreported due to a lack of access to dental services and therefore a lack of data. The majority of burden of disease due to oral health issues was caused by dental caries (63%), followed by periodontal (gum) disease (22%) and severe tooth loss (15%).[8] Barriers to dental include cost, shame, lack of access to services and long waiting lists.

Dental caries are the third leading cause of total disease burden for children aged 5-14 years, after asthma and mental health disorders.[9] Rates are even higher among Aboriginal children and those from lower income households. Poor dental health also contributes to oral cancer, which is the eighth most common

[1] Australian Medical Association (2019) AMA Report Card on Indigenous Health: No More Decay: Addressing the Oral Health Needs of Aboriginal and Torres Strait Islander Australians. https://www.ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal.
[2] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[3] Australian Institute of Health and Welfare (2022) Oral health and dental care in Australia, AIHW, Australian Government.
[4] IBID.
[5] https://www.kidney.org/atoz/content/dental-kidney-disease-connection; Consultation with ACCHS
[6] Australian Medical Association (2019) AMA Report Card on Indigenous Health: No More Decay: Addressing the Oral Health Needs of Aboriginal and Torres Strait Islander Australians. https://www.ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal.
[7] Australian Indigenous HealthInfoNet. (2023) Overview of Aboriginal and Torres Strait Islander health status, 2022.
[8] IBID.
[9] Santiago PHR, Milosevic M, Ju X, Cheung, W, Haag D, Jamieson L (2022) A network psychometric validation of the Children Oral Health-Related Quality of Life (COHQoL) questionnaire among Aboriginal and/or Torres Strait Islander children. PLoS ONE 17(8): e0273373.

cancer in Australia. It is more common among older age groups, men and Aboriginal people (three times higher than the rest of the Australian population.[10]

Poor oral health disproportionately impacts Aboriginal people, people from lower socioeconomic areas, and people living in regional and remote areas. As a result, these three cohorts have been identified as priority populations in both the WA *State Oral Health Plan,*[11]and the *National Oral Health Plan.*[12]

Lack of accessibility to services is the most significant factor contributing to the current gap between the oral health of Aboriginal and non-Aboriginal people. Over 22 per cent of Aboriginal people live in regional WA and 40 per cent live in remote areas of WA, with limited local dental services (often reliant on visiting services) and transport options [13] It is also reported that more than two in five Aboriginal people over the age of 15 years defer or avoid dental care due to cost. This is compared with one in eight (12.2 per cent) who delayed or did not go to a GP.[14] Aboriginal 15-year-olds have 50 per cent more tooth decay than non-Aboriginal people of the same age.[15]

The consequences of poor oral health in childhood are wide-ranging, affecting children and their families, with Aboriginal children carrying a greater share of the disease burden and related impacts, including toothache, difficulties concentrating, school absenteeism, poor academic performance, increased likelihood of general anaesthesia and dissatisfaction with dental appearance.[16] The Australian 2012–14 National Child Oral Health Study (NCOHS) discovered that Aboriginal children in Australia aged 5 to 10 years had, on average, almost three times the mean number of decayed, missing and filled tooth surfaces than non-Aboriginal children (3.4 vs 1.2).[17]

In WA, 1 in 3 children aged between 5 and 6 years have experienced dental disease, this occurrence is 5 times higher than asthma for this age group. Amongst this group experiencing disease, 71% have untreated disease which indicates a lack of available service before the age of 5 years. Rates are even higher among Aboriginal children and those from lower income households.[18] Untreated dental disease in early childhood results in ongoing daily dental pain, dental abscesses, the inability to eat comfortably or chew well, embarrassment at discoloured and damaged teeth, anxiety, and functional limitation including distraction from play and learning.[19]

The importance of improving the oral health of Aboriginal people was recognised by the Australian Medical Association in 2019, when they identified actions to improve Aboriginal oral health including increasing the

[10] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[11] WA Department of Health. State Oral Health Plan 2016–2020. Perth: Office of the Chief Dental Officer, Clinical Services and Research, Department of Health, 2016.
[12] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[13] WA Department of Health. State Oral Health Plan 2016–2020. Perth: Office of the Chief Dental Officer, Clinical Services and Research, Department of Health, 2016.
[14] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[15] IBID.
[16] Santiago PHR, Milosevic M, Ju X, Cheung, W, Haag D, Jamieson L (2022) A network psychometric validation of the Children Oral Health-Related Quality of Life (COHQoL) questionnaire among Aboriginal and/or Torres Strait Islander children. PLoS ONE 17(8).
[17] IBID.
[18] IBID.
[19] IBID.

fluoridation of Australia's water supplies; enhancing oral health promotion, growing the Aboriginal workforce and strengthening data collection.[20]

WA context

Most dental conditions can be easily avoided with appropriate preventative care, however high levels of demand, lack of access to services and government funding constraints in WA has led to public dental services focusing on acute dental care rather than preventative care.

Dental care is fragmented across the State with a reliance on a mix of visiting services from RFDS, WA Dental Health Service (DHS) and in the Kimberley, a philanthropic dental organisation. In some regions, both DHS and RFDS partner with and operate out of ACCHS to ensure Aboriginal people are receiving culturally safe dental care.

DHS runs the School Dental Service providing free general dental care to students who attend a WA Department of Education recognised school aged 5 to 16 years or until the end of year 11. It is delivered state-wide through fixed and mobile dental therapy centres co-located with some schools.[21]

RFDS will see all clients regardless of income or access to concession cards, however DHS will only support people that have a current health care card or pension concession card. Treatment is only subsidised by the WA Government up to a maximum of 75 per cent of the cost of the treatment, with the actual level of dental subsidy based upon a person's Centrelink income which is assessed by DHS. In remote locations, where DHS is the sole dental provider, all patients are able to access dental care at the public dental clinic with those patients not eligible for subsidised care required to pay the full fee. Waiting lists can be long and clients are seen in a first come, first served manner.

Despite RFDS attending regional and remote sites on a fly-in, fly-out (FIFO) basis, it is considered a supplementary service and does not address the full dental need of clients. RFDS struggle to find workforce and accommodation in regional areas[22]. Their services ceased through COVID-19, so a number of locations did not have access to dental treatment for approximately two years with a backlog of clients to attend to now. Out of necessity, they prioritise acute treatment (generally in the form of extractions), rather than preventative care.

Early Childhood Dental Program

In Western Australia, there is currently no State funded dental program for children aged 0-4 years, and children in this age group have minimal access to appropriate community based dental care. The State Government has recognised the need for preventative dental for children until 5 years (when it is assumed they will be covered by the School Dental Service), as often dental health is not prioritised until it reaches crisis point, and then often results in emergency department and hospital admissions. These admissions are

[20] Australian Medical Association (2019) AMA Report Card on Indigenous Health: No More Decay: Addressing the Oral Health Needs of Aboriginal and Torres Strait Islander Australians. https://www.ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal.
[21] https://www.dental.wa.gov.au/About-us/Quick-Guide-to-Dental-Health-Services.
[22] ACCHS participant feedback.

categorised as potentially preventable hospitalisations (PPHs), and WA has the highest rate of early childhood PPHs of all Australian States and Territories.[23]

Following the release of the *Sustainable Health Review*[24] in 2019, which includes a priority for implementation under Recommendation 8 to *"[expand] the School Dental Service to include at-risk 0-4 year olds and continue to work with the Commonwealth to achieve fair, long-term public dental funding arrangements"*, the Office of the Chief Dental Officer (OCDO) proposed a dental Business Case for this age group recommending that children in WA should have access to a free dental assessment and oral health promotion in a non-clinical environment from 6 months on. In the 2021/22 Budget, the State Government confirmed $11.5 million funding over four years for this project, which is now in the planning and scoping stage, with rollout commencing in 2024.

Child Dental Benefit Schedule (CDBS)

This is a Commonwealth initiative that covers part of or the full cost of certain dental procedures for children if a parent is receiving certain Centrelink payments. The CDBS covers up to $1,052 over two calendar years for basic dental services (including check-ups; X-rays; cleaning; fissure sealing; fillings; root canals and; extractions) and assumes access to a dentist. It does not cover orthodontic dental work; cosmetic dental work or any dental services in a hospital.[25]

For children with low dental disease (less than two decayed teeth) providing preventive and restorative treatment under the biennial cap is achievable in some circumstances. However, the CDBS is insufficient to pay for the cost of operating a preventative and comprehensive early intervention child dental program. It is also insufficient to pay for travel, accommodation and costs associated with travelling to a town/city for treatment or operating a regional/remote dental program for children.

It is underutilised by Aboriginal people and ACCHS, as it is an activity based fee-for-service model, which assumes pre-existing capacity in the area to deliver child dental by bulk billing and families then receiving reimbursement. Where an ACCHS does utilise the CDBS, for complex clients, ACCHS are often reliant on Medicare revenue from Primary Health Care provision to top up the CDBS (although some services do not use the CDBS due to the onerous nature of the paperwork, low cap amount and lack of flexibility).

Jurisdictional Review

South Australia

The *2019-2026 South Australian Oral Health Plan* identifies Aboriginal people as a priority population. This plan suggests legislative change to enable non dental practitioners, such as Aboriginal Health workers to apply fluoride varnish, and that this would also be particularly useful in communities with limited or no access to water fluoridation.[26] It also adds that "culturally appropriate, acceptable and safe dental services, integrated and co-located with primary health systems, are required to close the oral health gap".[27]

[23] The Early Childhood Dental Program: Business Case Proposal by the Officer of the Chief Dental Officer (2022)
[24] Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia.
[25] https://www.servicesaustralia.gov.au/whats-covered-child-dental-benefits-schedule?context=22426
[26] IBID.
[27] South Australian Oral Health Plan 2019 - 2026. SA Dental Service, Central Adelaide Local Health Network, SA Health, Government of South Australia, Adelaide, South Australia.

Nonetheless dental service provision throughout the state is inconsistent, with Aboriginal people disproportionately lacking access to services.[28]

The RFDS Central Operations offers a mobile oral health care clinic to communities throughout rural and remote South Australia and Northern Territory. They work from clinics, vans and other temporary infrastructure to provide both preventative programs and emergency treatment[29]. RFDS Central Operations services are free and referrals are not required. This service is funded by the Commonwealth Government.

There is also a South Australian Aboriginal Oral Health Program that provides emergency and general dental care for both metro and country clients. However, to access this, a person must hold a Centrelink concession card. It is also open to babies, children and young people under 18 years. There are no 'out-of-pocket' costs for children who are not yet at school or not eligible for the Child Dental Benefits Schedule.[30]

Dental service provision varies across ACCHS in the State, with the majority of ACCHS only facilitating off-site dental services, a number providing on-site dental and a few having no access to dental care.

One ACCHS in the APY Lands has an embedded dental service that is funded by the South Australian Department of Health and provided at two fixed clinics and a mobile dental clinic.[31] In 2011, the program also received funding to provide dental treatment to patients who have a disability or are in aged care. The mobile dental clinic and portable dental equipment were funded by the Commonwealth Department of Health.[32] The program:

- supports school children;
- provides emergency and adult care;
- supports people with diabetes and chronic illness;
- provides dentures and also undertakes health promotion to young adults and;
- works with schools to promote daily tooth brushing and dental education.

New South Wales (NSW)

New South Wales has an *Aboriginal Oral Health Plan 2014-2020*[33] that aims to improve the oral health of the NSW Aboriginal population through primary prevention access to oral health services for Aboriginal people in NSW and; reducing disparities in the oral health status of Aboriginal people in NSW.

Strategic directions of the Plan include:

- Increase access to fluoridated water and fluoride programs to assist in the reduction of dental caries;
- Develop and implement sustainable oral health promotion and prevention programs;

[28] Poirier B, Tang S, Haag DG, Sethi S, Hedges J, Jamieson L. Oral health promotion and programming provided by Aboriginal Community Controlled Health Organisations in South Australia. Health Promot J Austral. 2022;33(S1):255–61.

[29] https://www.flyingdoctor.org.au/sant/what-we-do/oral-health/

[30] https://www.dental.sa.gov.au/professionals/programs/aohp

[31] https://www.nganampahealth.com.au/nganampa-health-dental

[32] IBID.

[33] The Centre for Oral Health Strategy, Sydney, NSW Ministry of Health, New South Wales Aboriginal Oral Health Plan 2014–2020 (2014).

- Improve access to appropriate dental services for Aboriginal people in NSW in culturally safe environments (primarily through ACCHS);
- Develop and implement sustainable programs to increase the number of Aboriginal people in the oral health workforce in NSW;
- Strengthen the capacity of the existing and future health and oral health workforce to provide appropriate oral health care in Aboriginal communities and;
- Improve oral health for Aboriginal people through supported action-oriented research and improved oral data collections for evaluating both service delivery and oral health outcomes.

Oral health services in NSW are provided by private dentists, public oral health services and a number of ACCHS. NSW Health supports 21 ACCHS to provide dental care for clients with a variety of different models for providing oral health care across NSW ACCHS.[34] Services offered include oral health promotion programs; screening programs at schools; preventative care including cleaning and scaling; acute and emergency treatment; restorations and root canal; surgery including procedures under general anaesthetic and; provision of oral hygiene products, dentures and mouth guards.[35] Staff vary from one or two oral health staff, who mainly offer acute oral care to larger teams including Aboriginal Health Workers (AHWS) who have received specific oral health training and/or specialists.[36]

One of the ACCHS has a partnership with a local health district, and uses their facilities. Generally funding comes from the Centre for Oral Health Strategy, NSW Ministry of Health, core ACCHS funding, patient co-payments and private health insurance. ACCHS in NSW primarily appear to rely on patient co-payments which are calculated to take account of Aboriginality, age, employment status and ability to pay.[37]

Funding (often short term and intermittent) and workforce are the main challenges identified as a barrier to ACCHS providing oral health care and services.[38]

Tasmania

Tasmania does not appear to have any dental programs specifically aimed at Aboriginal people. The Tasmanian Health Department provides child dental programs that are funded through the Child Dental Benefit Schedule.[39] Once a person, turns 18 years old, they must have a current Health Care Card or Pensioner Concession Card to access free dental treatment, otherwise people need to attend a private provider.[40]

Since 2017, through funding from the Commonwealth Government, RFDS Tasmania provides a dental outreach program that provides dental treatments for children and adults in rural and remote areas of Tasmania.[41] They have a mobile dental van that enables access to more remote towns and also provide a

[34] Campbell, M.A., Hunt, J., Walker, D. and Williams, R. (2015), The oral health care experiences of NSW Aboriginal Community Controlled Health Services. Australian and New Zealand Journal of Public Health, 39: 21-25; https://www.health.nsw.gov.au/oralhealth/Pages/about.aspx
[35] IBID.
[36] IBID.
[37] IBID.
[38] IBID.
[39] https://www.health.tas.gov.au/health-topics/dental-health/dental-health-services/dental-health-service-babies-children-and-teens
[40] https://www.health.tas.gov.au/health-topics/dental-health/dental-health-services/dental-health-service-adults
[41] https://www.flyingdoctor.org.au/tas/what-we-do/oral-health-care/

school dental program. In one area they work with an Aboriginal organisation to provide culturally safe dental care.[42]

Northern Territory

Dental services are free for children under 18 years, and people with a Centrelink Pensioner Concession Card, Centrelink Health Care Card or, for those that live more than 100 km away from the nearest dental service, and need emergency dental care but don't have access to private dental services via a visiting service.[43] One ACCHS provides dental treatment in Arnhem Land in collaboration with University of Melbourne students in an attempt to bridge gaps in dental service provision, however it is not clear if this has been an ongoing or one-off program.[44]

Between 2015 and 2022, the Commonwealth Government helped fund oral health services for Aboriginal children aged under 16 years in the Northern Territory. This program supported application of preventative treatment through the application of fluoride varnish and fissure sealants and clinical (tooth extractions, diagnostics, restorations and examinations) services.[45] There is currently an ongoing School Based Fluoride Varnish Program which is being implemented in a number of remote Northern Territory schools.[46]

Finally, the RFDS Central Operations offers a mobile oral health care clinic to a handful of communities in the Northern Territory, similar to South Australia. They work from clinics, vans and other temporary infrastructure to provide both preventative programs and emergency treatment.[47]

Queensland

Queensland ACCHS experiences similar geographic related issues to WA ACCHS as there are limited local services and transport options, workforce shortages, with a high staff turnover and a lack of access to resources and equipment, in addition to a lack of access to affordable healthy food. Oral health services are also not routinely integrated into ACCHS, and there are often inconsistent partnerships, inadequate funding and long waiting lists for state health services[48].

To meet this need, many Queensland ACCHS have embedded self-funded oral health services (including mobile outreach vans) and/or have partnerships with universities, Queensland Health Dental or private providers.

Funding for dental services in Queensland ACCHS comes from a variety of different sources – Queensland Health, the Child Dental Benefit Schedule, Indigenous Australians Health Program funding, Medicare income and universities, including co-investment from the University of Queensland School of Dentistry, along with

[42] IBID.
[43] https://nt.gov.au/wellbeing/hospitals-health-services/dental-services
[44] https://mdhs.unimelb.edu.au/about/indigenous-development/our-work/dental-care-in-the-northern-territory
[45] Australian Institute of Health and Welfare 2019. Northern Territory Remote Aboriginal Investment: Oral Health Program July 2012 to December 2018.
[46] https://health.nt.gov.au/professionals/oral-health-information-for-health-professionals
[47] https://www.flyingdoctor.org.au/sant/what-we-do/oral-health/
[48] Queensland Aboriginal and Islander Health Council: Aboriginal and Torres Strait Islander Oral Health Care in Queensland - Aboriginal and Torres Strait Islander Community Controlled Health Organisations oral health case studies literature scan (2020).

the Australian Government Department of Health, Rural Health Multidisciplinary Training Fund and the Dental Training Expanding Rural Placements programs.

Regional Summaries

Metropolitan WA

The ACCHS in the metropolitan area has a very distinct dental model of care, being one of the few ACCHS in WA to provide a comprehensive dental service that includes prophylactic treatment through to full mouth rehabilitation, including root canals, crowns and dentures. This service is free of cost to all Aboriginal people aged 13 years and above.

There is funding for three dentists, however at the time of this research and consultation, they were hiring only 1.8 FTE dentists. The ACCHS reports that it is difficult to recruit due to the short-term nature of funding received and lack of sustainability for staff in these positions. Short-term funding also makes it harder to recruit experienced dentists, and the service cannot hire dentists early in their career due to the burden of disease.

Funding is through the WA Department of Health under the National Partnership Agreement, which was renamed the Federation Funding Agreement in 2021.[49] This is annual funding provided by the Commonwealth to the State and disseminated to four different services (two ACCHS, the Kimberley Dental Team and St Patrick's Community Support Centre in Fremantle). Funding is current until June 2023, but no funding agreement has been confirmed for July 2023 making it difficult to plan for the future.

Despite the metropolitan area having a number of private dental clinics and hospitals (with catchment areas in Perth for public dentistry), clients prefer to come to the ACCHS as it is culturally secure and provided at no cost to the client.

Due to the dental service being integrated into primary health care and the impact of poor oral health on a number of health problems, dental health is often included as part of a larger health care plan. This enables the service to continue to provide a holistic model of care. When someone wishes to attend for a dental health check, they are also provided with a full health check (715) catching a number of health issues at an early stage.

In terms of infrastructure, this ACCHS has three dental chairs and rooms, are fully accredited to 2024, and have a sterilisation space. They link in with an external lab for dentures and crowns. However, maintenance and the provision of a dental nurse are extra expenses that come from the ACCHS core funding. The dental service currently does not bring in revenue, but it is a service that is valued by clients.

This ACCHS reports the need for investment into health promotion and preventative measures with a lack of access to dental care provision for children. This clinic reported that school dental coverage is not sufficient, even in metropolitan areas explaining that many Aboriginal people 'fly under the radar'.

[49] https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-12/Signed%20-%20Public%20Dental%20Services%20for%20Adults.pdf

Many children require care at Perth Children's hospital, particularly if they have complex needs and require general anaesthetic. This is a particular area of concern for the ACCHS that explains there should be access to a paediatric dentist for all children, rather than needing to attend the hospital for this care. They also added that the hospital relies heavily on the ACCHS to support the children attending.

This ACCHS also detailed that they are inundated with hospital requests requiring dental support before procedures and reports of complications due to poor oral health. They reported that there has been a number of pregnant women with pre-eclampsia who have needed teeth removed. It has been proven that poor dental health in pregnant women can lead to preeclampsia and preterm deliveries[50]. They also provide support to people from regional and remote areas requiring urgent dental care. One case study includes a pregnant woman who had a toothache and infection. They were airlifted from community, brought to the clinic and treated immediately as there were concerns the infection could cause pregnancy complications.

Finally, the ACCHS reports that poor oral health impacts on overall mental health, confidence and employment prospects, leading to self-medication. They provided an example of a man that was recently released from prison and drinking to numb pain he was experiencing from a dental infection. This service provides outreach to prisons in Perth and explained that dental treatment is the primary request for support.

Regional WA

For the purposes of this paper, six services are included as regional WA. They are located in the larger regional centres across the state with access to a WACHS hospital that provides dental in their regional town. DHS has MOUs with four of these ACCHS to provide free dental services (although in one service, DHS only treats those with a healthcare card and charges a nominal fee) for adults at the clinic one day a week, with the expectation that the School Dental Service will address children's needs. RFDS provides a supplementary service to two of the clinics based in the Kimberley region.

Many dental clinics were cancelled through COVID so this has led to longer waiting lists.

DHS staff in the regional centres are located at the local WA Country Health Service hospital and provide both a dentist and dental nurse to the six regional ACCHS. However ACCHS provide the clinical room, chair, steriliser and in the majority of clinics (with the exception of one), consumables. ACCHS are responsible for maintenance of equipment and accreditations, despite not receiving funding to undertake this work. ACCHS staff liaise between clients and DHS to arrange appointments, and often transport. These administration and transport costs are also not funded.

DHS generally undertakes check-ups, fillings and extractions, but does not provide crowns, root canals, dentures or cosmetic procedures such as braces. Often clients attend when in acute pain and are triaged depending on urgency. One ACCHS reports that only priority patients are currently treated, particularly those with rheumatic heart disease, and there is little in terms of health promotion. A lack of dental promotion was identified as a key gap area in all ACCHS.

The long waiting lists (one service reports a seven month waiting list, and another explains there are over 1000 doctor referrals on their waiting list) and the infrequency of DHS clinics often leave people in pain

[50] https://hurstpediatricdentistry.com/2020/11/23/pregnancy-and-oral-health-effects-on-babys-teeth/#:~:text=Poor%20dental%20health%20in%20pregnant,increased%20risk%20of%20tooth%20decay.

waiting for treatment. It is impossible to address the great need across the regions, and clients attend DHS at the hospital if treatment is needed urgently on non ACCHS days. However, one ACCHS reports that clients won't attend the hospital dental clinic as it is deemed not culturally safe.

The hospital does not provide appointments and clients may wait all day to be seen. Some ACCHS explained that sometimes people wait all day at the Emergency Department and are turned away at the end of the day due to the demand on the DHS service.

Unfortunately, if a client has to go to the hospital, there are no alerts to ACCHS to let them know this person has been treated or the outcome of that treatment. ACCHS report that there is a need for continuity of care and communication across the systems (ACCHS, DHS and RFDS). If DHS or RFDS dentist treat a client at the ACCHS it is more beneficial as they access communicare/MMEX.

Sometimes, clients need to visit Perth for treatment (e.g. wisdom teeth extraction), however this is not covered by the Patient Assisted Travel Scheme (PATS). PATS is only provided for adults if they need hospital-based dental services and have a significant medical co-morbidity, or if they have special needs and require general anaesthetic.[51]

ACCHS identified that providing a safe space to provide dental was important as many clients are reluctant to attend the dentist, especially in the hospital. They explained that often dentists and dental treatment is associated with fear and pain, especially as many clients are already in acute pain by the time they are able to access a dentist. ACCHS reported that clients are more comfortable at their service and due to established relationships they are able to follow up if a person does not turn up for an appointment.

A number of these regional ACCHS provide outreach into smaller communities and expressed that more dental health services are required in outreach locations. Dental checks in antenatal and postnatal care has also been identified as a priority area.

There is variability across service provision in the ACCHS despite falling under the remit of DHS. One service reports that DHS service has been inconsistent due to staffing. Another ACCHS supplements DHS' one day a week with a MOU with a private dental provider. This cost is covered by the ACCHS MBS billing revenue.

One ACCHS Board has approved a scheme where Medicare profits go into a range of additional health elements such as dental, opticians and dentures. To be eligible a person must be a member of the ACCHS and have a 715 check each year. Each person gets $500 per financial year which can be used at the hospital or private dentist, but sometimes this is often not sufficient to address acute dental needs.

Two ACCHS in regional centres used to have a dentist and dental nurse embedded in their clinic, however in the past year they have struggled to recruit a dentist. This was funded through MBS billing, with no extra funding provided for these positions. One of these ACCHS relies on locums to bridge this gap and currently both these ACCHS refer to DHS at the local hospital. Although one of these ACCHS is satisfied with their equipment and infrastructure, the other expresses a need for a new chair. However funding for infrastructure, administration support and equipment maintenance for both theses ACCHS come from primary health care funding (similar to the other four regional ACCHS).

[51] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Am-I-eligible-for-PATS/PATS-Eligible-Medical-Specialist-Services.pdf

Remote WA

For the purposes of this paper, six services have been identified as remote with five serviced by the RFDS and the other having a model specific to their ACCHS.

Remote WA is generally serviced by the RFDS. They provide services, where insufficient services or no services exist, thereby covering areas that are not generally serviced by DHS. They exist to "*address market failure or fill the gaps*".[52]

The RFDS are limited by their funding model. Primarily they are funded by the Commonwealth Government to provide dental health services across the Kimberley and a small area of the Pilbara and Midwest (non-Aboriginal population generally). This is activity based (x number of procedures per day), however this model doesn't work for remote communities due to a lack of flexibility. RFDS also receives grant funding to provide 10 weeks of dental service provision in the Central Desert region. Consultations revealed that grant funding is more beneficial for regional and remote areas as it has more flexibility and adaptability to suit community needs. This provides more opportunity to provide preventative dental work, health promotion and to attend to children's dental needs.

RFDS provide the workforce and consumables, but utilise ACCHS infrastructure and equipment. ACCHS are responsible for arranging appointments and the maintenance and calibration of infrastructure and equipment, but are not funded to do this. Unfortunately, RFDS does not accommodate outreach needs as it is not included as part of the Commonwealth funding contract. RFDS has raised the need for outreach services with Commonwealth[53].

Currently workforce is very tight. RFDS explained that they currently hire ten casual dentists, yet it is still difficult to fill a six months roster and schedule. The FIFO model is costly and accommodation can be difficult to find.

The RFDS works in close partnership with ACCHS to arrange appointments, accommodate drop-in requests and prescribe antibiotics for infections. RFDS also populates MMEx and Communicare, but these programs are not dental focussed so there are still gaps in reporting (e.g. can't include teeth charts), however dentist will add notes to mitigate this.

The RFDS partnership with ACCHS helps to ensure a culturally secure service and build community trust in the dentist. It also assists with addressing community fear and 'shame'. Due to the limited time in community, there is little scope to provide extensive dental treatment such as root canals and dentures, and RFDS only provides clean and scale, and teeth extractions.

One of the remote ACCHS explained that the RFDS attends two weeks every two months (six visits per year), but that this service ceased through COVID-19 restrictions and lockdowns. This has led to an increased need for dental support in the region. This ACCHS provides the consumables, administration support, licensing and equipment without incurring extra funding for this support. As mentioned previously, RFDS mainly undertakes extractions and this ACCHS reports that this can deter people from attending dental appointments as they know they will likely lose a tooth.

[52] Information provided through consultation with RFDS.
[53] IBID.

This remote ACCHS used to have access to a DHS dentist that supported with outreach to communities twice a year (would bring all the equipment and consumables out to community with them), however that has also ceased as there is currently no dentist in that regional hospital. Occasionally, they bus people from the community to see a dentist, however the last time this was due to happen, the dental service was cancelled. Clients are often sent to a larger regional town hospital but this incurs a substantial cost as it is not covered by PATS and there is still a charge at the hospital.

There is little dental service provision for children. This ACCHS often works with the school to assist teachers in terms of dental health promotion and emphasising the importance of brushing teeth. Oral health issues are compounded by a lack of appropriate Environmental Health access in communities with the ACCHS explaining that people need working water to brush teeth and a safe and clean place to store their toothbrush. This ACCHS reports that there needs to be more funding and emphasis on dental health promotion.

The ACCHS that receives RFDS through grant funding reports that RFDS mainly provides fillings and basic extractions (they won't do multiple extractions in a sitting), however they do attend the school to provide health promotion and education.

In this agreement, RFDS provides the dentist, dental nurse and consumables, but the ACCHS pays flights and accommodation, which can prove costly. The ACCHS has also recently purchased a new steriliser, x-ray machine, vacuum pump and compressor. These items and maintenance all come out of primary care funding. The chair recently required servicing which has to be completed by a biomedical engineer. This is another extra cost incurred by the service.

The ACCHS is also responsible for booking appointments and administering RATs to clients before attending the dentist. It was explained that the *"RFDS service comes at a great cost"*[54] both in terms of time and monetary costs.

This service also explained that it was difficult to gain access to services in Perth, especially as many treatments are not often covered by PATS, with only some surgeries at Perth Children's Hospital covered. The ACCHS staff explained that *"there is a two year waiting list at the Oral Health Centre in Nedlands for child dental care requiring a general anaesthetic. They have 10 children from [this area] on the wait-list".* This is a high proportion of children given that the total Aboriginal population in this community is approximately 270 people. They further explained that PATS is a major issue for adults as there is no support for wisdom teeth removal or a visit with a periodontist or orthodontist.

Another remote ACCHS has an agreement with DHS (hospital is located a few hours away) to travel to their service, however the frequency and duration of visits can vary – sometimes once per week or once per month. There was no dental service provision through 2020, or for 6 months in 2022.

The turnout for dental appointments is good, however DHS do not see school aged children. The ACCHS receptionist arranges and manages appointments utilising GP referrals and triage categories. At the time of the consultation, there were 650 people on the referral list waiting for dental appointments (patient population is 3000).

[54] Interview with ACCHS participant.

DHS provides basic dentistry (teeth scale and clean, extractions) with no root canals, no dentures (or alternative teeth replacements) and no access to orthodontics. The ACCHS reports that multiple extractions are often undertaken without consideration of eating ability or good nutrition.

Equipment in this ACCHS comes from primary health care funding. They recently purchased a new x-ray machine and a new chair at $35,000. They also provide the consumables for the visiting dentist, and cover the maintenance costs of equipment. This is handled by the clinic manager creating extra expense and adding to an already heavy workload.

Options are limited if someone requires general anaesthetic. There is no clear process for referrals and the regional hospital a few hours away has only seven dental theatre sessions for children per year. This theatre list covers the entire region encompassing four regional towns and prioritises a patient based on the amount of dental extraction (greater than 6 teeth); medical condition; whether family is on Centrelink benefit, and the urgency of dental needs after discussion with Perth Children's Hospital. There is no availability in the region for adults, and they have to go to Perth if requiring general anaesthetic, however PATS will not cover flights or accommodation. This ACCHS reported that a number of patients with oral cancer have their teeth removed leaving them unable to chew. As a result they need an orthodontist, but PATS won't cover travel or accommodation to go to Perth. Although dental services for adults that need hospital-based dental services and have a significant medical co-morbidity should be covered under PATS, this ACCHS explains that it appears to be approved or not approved at the discretion of the approval officer.

A number of ACCHS explained that the Army used to provide dental services in a couple of the regions but this has ceased. One of the ACCHS explained they contacted the Army due to the backlog of clients on the waiting list, but they explained they were not offering this service anymore. Another ACCHS explained this was also a recruitment drive to promote a career in defence and explained that a number of candidates are unable to make it through recruitment and training due to poor oral health.

ACCHS in remote areas also report that rheumatic heart disease patients are often overlooked, and it is very rare for a visiting dentist to ask if a client has RHD. It is particularly important to know if a person is on blood thinners as part of RHD treatment, because this needs to be paused if having dental treatment.

One remote ACCHS receives visits from both RFDS and DHS (attending one day per week). DHS also provides outreach services three times per year. Acute and emergency dental is seen at the local hospital, but it is often difficult to get to Perth for emergency dental treatment. Despite having a number of services attending the ACCHS, there are still major gaps in dental care among clients due to high burden of disease in community.

Another ACCHS also receives visits from both RFDS and DHS (four times per year), which is also supplemented by a philanthropic organisation called the Kimberley Dental Team. The Kimberley Dental Team travels across smaller communities in the Kimberley. They utilise four wheel drive vehicles with dental chairs, sterilisers, instruments, anaesthetic and compressor.

Very remote WA

For the purposes of this paper two ACCHS have been identified as very remote ACCHS. Both of these ACCHS have very different models of care in relation to dental services.

The first ACCHS utilises a visiting dentist and dental nurse from South Australia. The dentist has been attending this community since 2000 and visits three to four times per year for three weeks at a time. This funding comes from WA Health through the Federation Funding Agreement, previously the National Partnership Agreement. This funding is only for adult dentistry, however there is no school dental service in this community leading to a major gap in child dental service provision.

The funding model is predicated on an activity based model with each activity allocated Dental Weighted Activity Unit Value (DWAU), with the State Government paying a certain amount per DWAU. The dentist undertakes the work and is then reimbursed. The WA Health dental contract requires surname of every client, and work undertaken, along with item numbers and DWAUs, so paperwork is quite onerous. Reporting does not include information regarding community engagement and relationships, and the time taken to build these. Previously, dental used to be part of chronic disease management funding and the cap was several thousand dollars.

This ACCHS has a dental room, including chair and equipment. The steriliser is the most difficult equipment to maintain; 18 months ago their steriliser stopped working and it was difficult, time consuming and expensive to get a technician to come out to fix it and latest models are expensive. They also need to be calibrated every year and accredited to a particular standard.

Appointments are not needed at this particular service, which removes that administrative burden, and the dentist links in with Communicare. The dentist provides dentures, cosmetic dentistry with composite resin and extracts wisdom teeth, however he does not provide crowns and root canals have only had minimum success (they require multiple visits and follow up appointments which are hard to ensure). Wisdom tooth presentation is quite common and mostly addressed in the chair with local anaesthetic. Referrals were described as difficult as PATS does not provide transport assistance.

This ACCHS also emphasised the need for health promotion and early diagnosis and intervention. It is crucial to support people to get out of the cycle of presenting only when in pain. However, this community has been struggling to recruit nurses, which makes it difficult to provide chronic disease support and health promotion.

The second remote ACCHS has 11 community clinics spread across a wide geographical area. The ACCHS has a MOU with RFDS to provide up to four visits per year to the largest community in their region. As RFDS do not provide outreach to smaller communities, the ACCHS provides transport from smaller communities (up to 270km away) to the dentist, alternating communities on each visit. The buses and drivers are funded directly by the ACCHS which does not receive funding for this additional service.

This ACCHS has an Aged Care facility that supports elderly people with a variety of co-morbidities and disabilities. Although this cohort is unable to travel to attend the RFDS clinic, the facility does not receive any dental support, leaving a massive gap for this age group and exacerbates many chronic conditions. This ACCHS would like to expand outreach services into the smaller communities and the Aged Care facility.

The ACCHS provides the infrastructure and equipment, with RFDS providing dentist, dental nurse and consumables. Due to difficulties accessing services, often clients are treated with antibiotics and pain relief if in acute pain. If they require emergency care they may go to larger regional centre hospital or to Alice Springs.

One community serviced by this ACCHS has a completely different model of care. It is located 800 kms away from the largest community serviced by RFDS, and 700 kms from Alice Springs. Due to this isolation the community had very little access to dental, and emergency dental was attended to in Alice Springs. However, about two years ago, they began receiving comprehensive dental care from RFDS Central Operations (which ordinarily covers South Australia and Northern Territory). RFDS Central Operations provides all the equipment and workforce.

Both RFDS services paused through COVID-19,. RFDS WA provided no services to this ACCHS for the duration of 2022 and recommenced in 2023, however the RFDS Central Operations recommenced their service at the start of 2022 when borders opened.

There is very little service provision for children as there is no school dentist. This has been identified as an area of need. It was reported that dental is part of WACHS deliverables (particularly for children with rheumatic heart disease), but it is impossible to report against it when there is no service available.

In February 2023, RFDS has agreed to come to the region to deliver an education package, and will work with the school nurse and child health nurses to deliver this. This will provide dental health promotion and focus on early intervention.

Finally, in one community there is a MOU with a private dentist to provide dental services.

Advocacy Options

Based on the feedback received from Member Services, AHCWA proposes the following options to potentially address dental health challenges and as possible avenues for advocacy. Please note these are not mutually exclusive and CEOs may decide that a number of these options should be undertaken concurrently.

1. Workforce options

Examining new and innovative ways to approach the dental workforce in the ACCHS sector is key. Looking at alternative workforce models to ensure sustainability of dental care throughout the state is crucial. Currently, dental care is fragmented and supplied by a number of different service providers, with little communication and coordination between them. ACCHS are responsible for arranging appointments, administration, licenses, and equipment provision and maintenance without receiving any extra funding. It is clear that the level of dental support and services provided by the ACCHS sector does not align with funding received and the ACCHS culturally safe model of care. To ensure autonomy, self-determination, continuity of care and culturally safe care, alternative workforce models are explored below.

However, it must be noted that there is a large dental workforce shortage currently in WA with DHS struggling to recruit, particularly in regional/remote areas. At a recent meeting, DHS stated that they have only filled 47 per cent of their workforce in regional/remote areas.

a. Embedding dentist and dental nurse in ACCHS clinic

Benefits

- Embedded in clinic so greater continuity of care across the ACCHS.
- Can link in more with other clinical staff.

- Will utilise Communicare/MMEx which enables consistent data and record keeping across all areas of the clinic.
- More autonomy for ACCHS, and aligns with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community Controlled Sector).
- Research shows that embedded services have had the most success at improving oral health: "*Where oral health services have been embedded within [ACCHS], it has proven to have greater community uptake, they have overcome access barriers, increased utilisation and had a direct impact on the level of periodontal disease and dental carries which risk chronic disease Embedding oral health services supports the early detection of preventable chronic disease, therefore improving access to early treatment. Good oral health will mean that individuals keep their natural teeth for longer*"[55].

Challenges and risks

- It is difficult to recruit workforce across the dental sector, both mainstream and ACCHS.
- Salary cost could be high as competing with private practice for dentists.
- There is a need to source sustainable funding and staffing.
- Sourcing funding to cover all costs (staffing, equipment and infrastructure maintenance, licenses).
- Dental is currently not Medicare billable.

b. Sharing dentist and dental nurse across a region (Kimberley, Pilbara, Midwest and Goldfields) with a possibility to provide outreach services at a regular interval

Benefits

- Shared cost across the ACCHS located in the region.
- Shared workforce.
- Could be easier to recruit as could be recruiting from a wider pool of staff in a number of towns across a region.
- Staff would utilise Communicare/MMEx which enables consistent data and record keeping across all areas of the clinic.
- Located in the region.
- Can link in more with other clinical staff.

Challenges and risks

- It is difficult to recruit workforce and it may be difficult to recruit a dentist and dental nurse that wants to travel.
- Cost of travel across region can be costly.
- Roster needs to ensure equitable access across the region.
- Still an outreach service – not embedded in a particular clinic.
- May need an extra role for administration (travel, managing roster etc).
- Sourcing funding to cover all costs (staffing, equipment and infrastructure maintenance, licenses). Dental is currently not Medicare billable.

[55] IBID.

c. Regional FIFO model, with a dentist based in Perth; works for ACCHS but travels to regions regularly

Benefits

- Shared cost across the ACCHS located in the region.
- Shared workforce.
- Could be easier to recruit as dentist remains based in Perth.
- Will utilise Communicare/MMEx which enables consistent data and record keeping across all areas of the clinic.
- Can link in more with other clinical staff.

Challenges and risks

- It is currently difficult to recruit workforce – may be difficult to get a dentist and dental nurse that wants to travel from Perth.
- Roster needs to ensure equitable access across the region, may be difficult to manage as it is a visiting service.
- Still a visiting service so not embedded in a clinic.
- May need an extra role for administration (travel, managing roster etc).
- Cost of travel from Perth could be expensive.
- Sourcing funding to cover all costs (staffing, equipment and infrastructure maintenance, licenses). Dental is currently not Medicare billable.

d. Placements for final year dental students

Benefits

- Little to no cost to clinic for workforce.
- Could be a solution to lack of workforce availability.
- Could utilise Communicare/MMEx which would enable consistent data and record keeping across all areas of the clinic.

Challenges and risks

- Supervision needed for students which requires a qualified dentist. DHS not currently providing supervision due to lack of capacity.
- Still a visiting service so not embedded in a clinic.
- Need to ensure placements have a sufficient timeframe. Short placements have a number of limitations including frequent student onboarding impacts service delivery and the development of students' clinical skills is not optimised when they cannot complete a long cycle of care, hence limiting the value of these placements to the health services and students. Rural Health West details that regional and remote placements need to be greater than 8 weeks to provide a full cycle of care and develop clinical and professional skills.[56]
- Bachelor of Oral Health programs are offered by nine universities throughout Australia with seven offering rural placements in the final year. Of the nine universities offering a dental degree program,

[56] KBC Australia and Rural Health West. *Increasing Dental and Oral health training in rural and remote Australia: Feasibility* study (Abridged Interim Report) 2022.

all have final year rural placements available, but these are not a course requirement for three universities. If it is not a course requirement, students may be less likely to go regional/remote.[57]

e. Partnering or developing MOU with DHS to job share dental workforce

Benefits

- Little to no cost to clinic for workforce.
- Could be a solution to lack of workforce availability.
- Could utilise Communicare/MMEx which would enable consistent data and record keeping across all areas of the clinic.
- May ensure a better referral into hospital system for urgent care, due to established relationships with the health system.
- Already have MOUs with DHS in particular regions (DHS dentist and dental nurse attend ACCHS one day a week in a number of clinics).
- Continuity of care across the two systems.
- Relationship building that would also likely ensure better care in the hospital system.

Challenges and risks

- Workforce is likely still an issue as DHS are struggling to recruit.
- DHS may not agree as understaffed.

2. Health promotion funding for dental promotion

Recommendations from the *State Oral Health Plan* have identified the need to develop integrated models of care that incorporate oral health education, prevention and screening with other primary care services and develop integrated models of care that incorporate oral health education, prevention and screening with other primary care services.[58]

ACCHS also identified dental health promotion as an important funding area. Linking in with schools and engaging children at a young age was understood to have greater health outcomes later in life.

Research has also identified that "*increased oral health education was strongly recommended by the majority of participants who considered education as a cornerstone to achieving optimal health outcomes"* and that "*the role of the dentist in increasing awareness around dental health and the prevention of disease was seen as valuable rather than the prevailing focus on symptomatic management of carious lesions".*[59]

Benefits

- Helps to focus on prevention rather than acute care, thereby possibly preventing caries and gum disease later in life.

[57] IBID.
[58] WA Department of Health. State Oral Health Plan 2016–2020. Perth: Office of the Chief Dental Officer, Clinical Services and Research, Department of Health, 2016.
[59] Poirier B, Tang S, Haag DG, Sethi S, Hedges J, Jamieson L. Oral health promotion and programming provided by Aboriginal Community Controlled Health Organisations in South Australia. Health Promot J Austral. 2022;33(S1):255–61.

- ACCHS could partner and link in with schools to ensure a whole-of-community approach.
- Empowers community, families and children by providing them with oral health education.
- Providing possible employment to local community.

Challenges and risks

- Finding sustainable funding could be an issue.
- It may be difficult to recruit suitable workforce.

3. Mobile Clinic (e.g. dental bus or truck)

Some services expressed the need for a mobile clinic to provide outreach dental services to communities, and the Australian Dental Association details that "mobile dental services should be available where fixed location clinics are not viable or suitable".[60] Mobile services have been trialled at a couple of services previously, and the RFDS currently works with Karara Mining Limited to provide residents in the Midwest with free dental services via purpose built mobile dental van.[61]

Benefits

- Flexibility to provide outreach services.
- Provides access to underserved communities.
- Less money spent on transport to appointments.
- Could utilise Communicare/MMEx which would enable consistent data and record keeping across all areas of the clinic.

Challenges and risks

- Recruitment of suitable workforce will still be an issue.
- Need to ensure bus/truck is fit for purpose and can get to remote communities.
- Equipment requires maintenance, and may need to be connected to electricity.
- It will likely only suitable for less complex procedures.

4. Enabling Aboriginal Health Workers and Practitioners to apply fluoride varnish

Further recommendations from the *State Oral Health Plan* recommend increasing the representation and engagement of Aboriginal people in the oral health workforce and working nationally to review oral health funding models to support flexible oral health service delivery for Aboriginal people.[62]

A Rural Health West report found that *"increasing access to health services and improving provision of culturally safe health care to Aboriginal and Torres Strait Islander peoples is best achieved when that care is provided by an Aboriginal and Torres Strait Islander health professional".*[63]

[60] https://www.ada.org.au/Dental-Professionals/Policies/National-Oral-Health/2-7-4-Mobile-Dental-Services/ADAPolicies_2-7-4_MobileDentalServices.aspx.
[61] https://www.flyingdoctor.org.au/wa/what-we-do/dental-services/
[62] WA Department of Health. State Oral Health Plan 2016–2020. Perth: Office of the Chief Dental Officer, Clinical Services and Research, Department of Health, 2016.

[63] KBC Australia and Rural Health West. *Increasing Dental and Oral health training in rural and remote Australia: Feasibility* study (Abridged Interim Report) 2022.

Enabling Aboriginal Health Workers and Practitioners (AHW/Ps) to provide fluoride varnish programs would potentially help to reduce dental disease for Aboriginal clients. The AMA accepts fluoride varnish application to be a safe treatment that can reduce the progression of dental disease.[64] The use of fluoride varnish programs is also a major component of the *National Oral Health Plan* as it increases accessibility of fluoride to children who might otherwise not have regular access to fluoride toothpaste, fluoridated water, or dental care.[65]

In 2013, the WA Minister for Health announced an election commitment of $6 million over four years to employ and train Aboriginal Health workers to provide basic assessment, primary care and prevention in ear, eye and oral health to children in remote communities in the Kimberley, Pilbara, Midwest and Goldfields regions in partnership with ACCHS. This was extended over time to the whole of WA.[66]

To allow fluoride varnish to be applied by non-dental health professionals, an exemption to the Medicines and Poisons Act 2014 was required from the Chief Executive Officer of the WA Department of Health. This is still current. The exemption specifies that AHW/Ps, registered nurses, clinical nurses and clinical nurse specialists – remote area health care, who have been assessed as having completed the mandatory training and are employed by a Health Service Provider or an Aboriginal medical service can possess and use fluoride varnish. The mandatory training must be conducted by a registered dental practitioner within a Registered Training Organisation (RTO) and comprise the HLTSS00073 Oral Health Care Skillset.

Further funding for the program was not continued once election committing funding ceased.[67] However those trained were able to continue to apply fluoride varnish. There is potential to undertake advocacy in this space to recommence training.

Benefits

- Helps to focus on prevention rather than acute care, thereby possibly preventing caries and gum disease later in life.
- Building up AHW/P skills and competencies.
- Could address workforce issues as service providers won't have to employ dentists/ dental nurses.

Challenges and risks

- Training needs to be built into RTO, this may not be training RTOs want to put on scope.
- Staff may need to take time out of work to undertake training.

5. Sustainable funding for the metropolitan area

The metropolitan based ACCHS struggles to provide sustainable dental health services, as the short-term nature of funding contracts (up to 12 months) creates challenges for recruitment and long-term service planning. This service reports that people travel from across WA to access its dental service, as it is one of the only comprehensive, culturally appropriate dental services in WA. It is clear that this ACCHS would

[64] Australian Medical Association (2019) AMA Report Card on Indigenous Health: No More Decay: Addressing the Oral Health Needs of Aboriginal and Torres Strait Islander Australians. https://www.ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal.
[65] IBID.
[66] Information from the Office of the Chief Dental Officer.
[67] IBID.

have greater capacity to manage the high demand for its services if it was supported by a more sustainable funding model.

Benefits

- Embedded in clinic so there is greater continuity of care across the ACCHS.
- Sustainable funding would enable the metropolitan based ACCHS to offer longer term contracts and would likely make it easier to recruit staff.
- Dentist would utilise Communicare which would enable consistent data and record keeping across all areas of the clinic.

Challenges and risks

- It may still be difficult to recruit workforce due to dental staff shortages across the state.

6. Promoting regional and remote dentistry through student placements

The WA Centre for Rural Health at the University of WA is located in the Midwest, Gascoyne and Pilbara regions of WA. The aim of this centre is to improve rural, remote and Aboriginal health through education, student placement support and facilitating allied health, nursing and pharmacy placements. There is an opportunity for advocacy to the WA Centre for Rural Health to include regional and remote dental placements.

7. Advocacy to State and Commonwealth Governments

Given that there is currently a Senate Inquiry underway into dental service provision in Australia through the *Select Committee into the Provision and Access of Dental Services in Australia*, there may be appetite with the Commonwealth Government to address dental services gaps and barriers. There may also be opportunity to work alongside the Australian Greens in relation to their dental reform agenda to place more pressure on the State and Commonwealth Governments.

a. PATS advocacy to expand parameters to include dental services

- Under current PATS guidelines, only adults with a 'significant medical co-morbidity' requiring 'hospital-based dental services', or 'special needs and requir[ing] general anaesthetic' are covered. These parameters are too restrictive, as individuals who do not have significant co-morbidities or special needs, but require urgent care, do not have access to a PATS subsidy.[68] For example, patients with tooth abscesses (which can progress into life-threatening scenarios), and those requiring wisdom teeth extractions (under general anaesthetic), are not covered under current PATS arrangements.[69] There is opportunity to advocate to the State Government to expand PATS guidelines to include all urgent dental procedures, and those requiring general anaesthetic (for both children and adults).

b. Advocacy with RFDS in relation to their funding model

[68] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022---Summary-sheets.pdf#page=2

[69] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf

- RFDS is funded by both the Commonwealth and State Governments. State funding is grant based which has more flexibility to undertake preventative care, however Commonwealth funding is activity based, which provides less flexibility and is not as suitable for regional and remote dentistry. There is a possible opportunity for joint advocacy with RFDS to change Commonwealth funding model.

c. Advocate for criteria change with DHS tonsure free dental care is available to all Aboriginal people

- Currently DHS only provides subsidised public dental care if a person has a health care or pensioner concession card.[70] Opportunity to advocate to State Government to change DHS eligibility criteria to include all Aboriginal people.

d. Advocate for dental care to be included under Medicare

- The provision of affordable and accessible dental care for all Australians is a major gap in the Australian public health system. Seeing a dentist often results in significant out-of-pocket costs, even for those who can afford private health insurance. This makes dental care unaffordable for most people on low incomes, and many go without the treatment they need.
- The Australian Council of Social Service recommended increasing funding for public dental services to meet the needs of eligible populations estimating a budget impact of $500 million (-$750 million in 2024-25).[71]
- Until late 2012, the Medicare Chronic Disease Dental Scheme funded private dental care for adults with a chronic disease, including Aboriginal people. This ceased due to a dental reform package that funded the CDBS and other dental funding reforms.[72] Possibly there is potential to advocate for a similar program to ensure Aboriginal people have access to free dental care.

e. Sub-contract dental funding directly to ACCHS

There is an opportunity to advocate to sub-contract dental funding directly to ACCHS. There is precedence for this model already in WA (as detailed above with funding to a metropolitan and very remote ACCHS), Queensland and South Australia. Existing frameworks include agreements to sub-contract Federation Funding Agreement (previously the National Partnership Agreement) funding to ACCHS including agreements between:

- a) The Institute for Urban Indigenous Health and its members with Metro North, Metro South and West Moreton Hospital and Health Services (equivalent of Health Service Providers in Queensland), and
- b) Goolburri Aboriginal Health Advancement Company Limited and Darling Downs Hospital and Health Services.
- South Australia provides a block grant through the South Australian Dental service to fund ACCHS in the APY Lands, and an ACCHS in Coober Pedy and Adelaide.

[70] https://www.dental.wa.gov.au/

[71] Australian Council of Social Service 2023: Budget Priorities Statement 2023-24 Submission to the Treasurer

[72] https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1213a/13bd022; Campbell, M.A., Hunt, J., Walker, D. and Williams, R. (2015), The oral health care experiences of NSW Aboriginal Community Controlled Health Services. Australian and New Zealand Journal of Public Health, 39: 21-25.

There is also a service in Brisbane that has a funding agreement with Queensland Health. This funds eight dental chairs and an extensive team of health professionals including dentists, oral health therapists, dental assistants, dental technicians and dental prosthetists.

There is also opportunity to advocate directly to State and Commonwealth Government to fund dental in the ACCHS sector bypassing RFDS and DHS.

It is also worth noting that food insecurity and a lack of access to cheap nutritious foods in regional and remote areas is an issue that impacts on oral health which needs to be addressed by the State and Commonwealth Governments in conjunction with a number of other solutions. In a study carried out in regional WA, the impact of diet and lifestyle on oral health was a common theme. The reliance on store bought foods was mentioned in ACCHS consultations on numerous occasions, with the decision to make healthy food choices or purchase oral hygiene materials influenced by the easy access to sugar, high cost of living and food insecurity in regional and remote communities.[73]

To discuss:

- What are the next steps from here?
- What would CEOs like AHCWA to do?
    - Where would CEOs like us to focus our efforts?
    - Letters and advocacy to ministers (including Minister Sanderson)?
    - Present scoping paper to government, along with case studies?
    - Options paper to be turned into position paper as a basis for a meeting with State/Commonwealth stakeholders?
    - Utilise Commonwealth/State Partnership forum?
    - Advocacy to Office of the Chief Dental Officer?
    - Work with the Australian Greens on their dental reform agenda?
- AHCWA is providing a submission to the Senate Inquiry, but are there other proactive written submissions the CEOs would like us to explore?
- How do CEOs want AHCWA to progress this over 6-12 months?

[73] Patel, J, Durey, A, Naoum, S, Kruger, E, Slack-Smith, L (2022) Oral health education and prevention strategies among remote Aboriginal communities: a qualitative study. Australian Dental Journal (67:83-93).