Aboriginal Health Council of Western Australia

The Select Committee into the Provision and Access of Dental Services in Australia

Dental Services in WA

24 May 2023

Introduction

The Aboriginal Health Council Western Australia (AHCWA) welcomes the opportunity to provide a submission to The Select Committee into the Provision and Access of Dental Services in Australia (the Select Committee).

AHCWA is the peak body for 23 Aboriginal Community Controlled Health Services (ACCHS) in Western Australia (WA). WA ACCHS are located across geographically diverse metropolitan, regional and remote locations. They deliver the most effective model of comprehensive primary health care for Aboriginal people[1] and are in a unique position to identify and respond to the local, cultural and health issues of Aboriginal people and their communities across WA. AHCWA exists to support and act on behalf of its 23 Member ACCHS, actively representing and responding to their individual and collective needs.

This submission responds to key areas of the Select Committee's Terms of Reference (particularly a, b, d, g and i) and includes feedback provided by AHCWA's Member Services and a number of other stakeholders. It highlights the barriers to dental service provision in Aboriginal communities and the detrimental impact that this can have on the physical health of Aboriginal people across the State.

There is a need for dental reform across the State and for both the State and Commonwealth Governments to invest in new and sustainable approaches to dental care for Aboriginal people, particularly those on low incomes and in regional and remote areas.

To address the great dental need in WA, AHCWA proposes the following recommendations:

Recommendation 1	That the Select Committee includes a recommendation to the WA and Commonwealth Governments to work with the ACCHS sector to address the dental health promotion needs of community, including sustainable training and funding.
Recommendation 2	That the Select Committee includes a recommendation for the WA and Commonwealth Governments to work with the ACCHS sector to examine new, sustainable, innovative and culturally secure ways to approach the dental workforce and dental service provision in the ACCHS sector. This is in line with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community-Controlled Sector).
Recommendation 3	That the Select Committee includes a recommendation to the WA and Commonwealth Governments to work with ACCHS to explore training

[1] Throughout this submission, AHCWA uses the term 'Aboriginal' to respectfully refer to all Aboriginal and Torres Strait Islander people across Australia.

	opportunities for Aboriginal Health Workers/Practitioners' and other health care professionals to apply fluoride varnish in lieu of a dentist/dental nurse.
Recommendation 4	That the Select Committee includes a recommendation to the WA and Commonwealth Governments to provide sustainable funding to the WA Metropolitan based ACCHS to continue to provide a comprehensive dental service to Aboriginal people across the Metropolitan area.
Recommendation 5	That the Select Committee includes a recommendation to the WA Government to expand PATS guidelines to include all urgent dental procedures, and procedures requiring general anaesthetic (for both children and adults).
Recommendation 6	That the Select Committee includes a recommendation to the WA Government to provide dental treatment free of charge to all Aboriginal people across WA and people on low incomes.
Recommendation 7	That the Select Committee includes a recommendation to the WA and Commonwealth Governments to sub contract dental funding directly to suitable WA ACCHS to provide culturally secure dental services, in line with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community-Controlled Sector).
Recommendation 8	That the Select Committee includes a recommendation to the Commonwealth Government to reform the Child Dental Benefit Schedule to increase the biennial cap; provide dental funding directly to the provider, rather than as a reimbursement and; expand the included dental treatment list.
Recommendation 9	That the Select Committee includes a recommendation to expand Medicare eligible items to include preventative and emergency dental treatment. This would enable Aboriginal people to have access to free dental treatment and allow ACCHS to fund dental services, including infrastructure and equipment maintenance and ancillary supports such as administration and transport which is currently a large out-of-pocket cost for many WA ACCHS.

Background

The health impacts of poor dental health are many and varied; as evidenced by the Australian Medical Association (AMA) recognising that oral health care is an important part of primary health care.[2] Poor oral health can impact many facets of a person's life with issues extending beyond immediate pain, infection and tooth loss and impaired functionality to impact:

- nutrition by affecting the ability to swallow and chew;
- confidence and life opportunities (negatively impacting a person's appearance, speech and self-esteem, leading to reduced involvement at school, work or other social settings);[3]
- social and emotional wellbeing and;
- chronic diseases such as cardiovascular disease (including rheumatic heart disease) and diabetes.

For people with diabetes, gum disease impacts 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.[4] Dental health examinations are also required as part of the kidney transplant evaluation

[2] https://www.ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal.
[3] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[4] IBID.

process, with ACCHS reporting that transplant approval has been denied to some patients due to poor oral health.

Aboriginal people have dental disease at up to three times the rate of non-Aboriginal people across metro, regional and remote areas.[5] The majority of this burden of disease due to oral health issues is caused by dental caries (63 per cent), followed by periodontal (gum) disease (22 per cent) and severe tooth loss (15 per cent).[6] Dental caries are also the third leading cause of total disease burden for children aged 5-14 years, after asthma and mental health disorders.[7] 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 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).[8]

Poor oral health disproportionately impacts Aboriginal people, people from lower socioeconomic areas, and people living in regional /remote areas. As a result, these three cohorts have been identified as priority populations in both the WA State Oral Health Plan,[9] and the National Oral Health Plan.[10] Barriers to dental include cost of dental care, 'shame', lack of access to services and long waiting lists.

The importance of improving the oral health of Aboriginal people was recognised by the AMA in 2019, when they identified actions to improve Aboriginal oral health including increasing the fluoridation of Australia's water supplies; enhancing oral health promotion, growing the Aboriginal workforce and strengthening data collection.[11]

Terms of Reference:

a. The experience of children and adults in accessing and affording dental and related services;
b. The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas.

This section discusses Terms of Reference a and b, and provides a quick overview of current dental service provision in WA, particularly in regional areas. It then details the need for improved early childhood dental services and the welcome addition of the WA Early Childhood Dental Program. Finally, the regional summaries will explain the issues 15 ACCHS face by regions – metropolitan, regional, remote and very remote. These regional summaries will also include issues related to State and Commonwealth funding and impacts of COVID-19 on services.

Current public dental service provision in WA

Lack of accessibility to dental 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

[5] 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.
[6] IBID.
[7] 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.
[8] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[9] 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.
[10] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[11] 2019 AMA Report Card on Indigenous Health: No More Decay: addressing the oral health needs of Aboriginal and Torres Strait Islander Australians.

visiting services) and transport options.[12] Australia's National Oral Health Plan reports that 40 per cent of Aboriginal people over the age of 15 defer or avoid dental care due to cost, compared with 12.2 per cent who delayed or did not attend a GP.[13] Further, Aboriginal 15-year-olds have 50 per cent more tooth decay than non-Aboriginal people of the same age.[14]

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 the Royal Flying Doctor Service (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 ensuring Aboriginal people receive 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.[15] However, there is limited access to this in regional and remote areas.

DHS only supports people that have a current health care card or pension concession card. Treatment is subsidised by the WA Government up to a maximum of 75 per cent of the cost of the treatment, with the level of dental subsidy based upon a person's Centrelink income, which is assessed by DHS.[16] 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.

RFDS treats all clients regardless of income or access to concession cards. However, despite RFDS attending a number of 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 also struggles to find workforce and accommodation in regional areas. Their services ceased through COVID-19, so a number of locations did not have access to dental treatment for approximately two years resulting in 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.

Need for early childhood dental

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.[17] The Australian 2012–14 National Child Oral Health Study discovered that Aboriginal children in Australia aged 5 to 10 years had, on average, almost

[12] 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.
[13] Australia's National Oral Health Plan 2015-2024: COAG Health Council (2015).
[14] IBID.
[15] https://www.dental.wa.gov.au/About-us/Quick-Guide-to-Dental-Health-Services/
[16] IBID.
[17] 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).

three times the mean number of decayed, missing and filled tooth surfaces than non-Aboriginal children (3.4 vs 1.2).[18]

There is currently no State funded dental program in WA for children aged 0-4 years, and children in this age group have minimal access to appropriate community based dental care. As dental health is often not prioritised until it reaches crisis point, then resulting in emergency department and hospital admissions, the State Government has recognised the need for more investment into preventative dental, particularly for children until 5 years (when it is assumed they will be covered by the School Dental Service). These emergency department and hospital admissions are categorised as Potentially Preventable Hospitalisations (PPHs), and WA has the highest rate of early childhood PPHs of all Australian States and Territories.[19]

One ACCHS reports that many children require care at Perth Children's hospital, particularly if they have complex special needs and require general anaesthetic. This is a particular area of concern for the ACCHS who have explained that 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 identified the need for investment into health promotion and preventative measures with a lack of access to dental care provision for children. The clinic reported that school dental coverage is not sufficient, even in metropolitan areas explaining that many Aboriginal people 'fly under the radar'.

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 per cent 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.[20] One ACCHS explains that a child (5-6 years old) presented at the clinic with six adult teeth, but had two caries in these teeth, which demonstrates the need for early treatment. Untreated dental disease in early childhood results in ongoing daily dental pain, dental abscesses, the inability to eat or chew comfortably, embarrassment at discoloured or damaged teeth, anxiety, and functional limitation, including distraction from play and learning.[21]

Following the release of the WA Health's Sustainable Health Review 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"*[22], the Office of the Chief Dental Officer 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 of this Early Childhood Dental Program (ECDP) due to commence in 2024. There is a need to ensure the ECDP is culturally safe and rolled out effectively and sustainably in regional and remote areas.

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

[18] IBID.
[19] The Early Childhood Dental Program: Business Case Proposal by the Office of the Chief Dental Officer (2022).
[20] IBID.
[21] IBID.
[22] Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia.

rehabilitation, including root canals, crowns and dentures. This service is free of cost to all Aboriginal people aged 13 and above.

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 inexperienced dentists due to the high 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.[23] This is annual funding provided by the Commonwealth to the State and disseminated to four different services in WA. At the time of research for this submission, it was reported that funding was available until June 2023, but no further funding agreement had been confirmed which made it difficult to plan for the future. However, in May 2023, the federal budget detailed the "[extension of] public dental services, [outlining that] 360,000 adults on lower incomes will have continued access to public dental services, while work continues on long-overdue long-term reform worth $219.4 million".[24] Although funding is welcome, it is not clear how this will be implemented in practice, and given that this amount will be shared between states, it is likely insufficient to address the dire dental need in WA.

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

Due to the integration of the dental service into primary health care and the impact of poor oral health on a number of health problems, dental health is often included in this clinic as part of a larger health care plan. This enables the service to continue to provide a holistic model of care. For example, when someone wishes to attend for a dental health check, they are also provided with a full health check which provides an opportunity to screen for and address other health issues at an early stage.

This ACCHS has suitable infrastructure with a sterilisation space and links in with an external lab for dentures and crowns. However, infrastructure and equipment maintenance and the provision of a dental nurse are extra expenses that come from ACCHS core funding, and not covered by government funding.

The ACCHS reported that the dentist sees 15-20 people every day for acute care and that they are inundated with hospital requests requiring dental support before procedures and reports of complications due to poor oral health. 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. She was airlifted from community, brought to the clinic and treated immediately as there were concerns the infection could cause pregnancy complications. The ACCHS also explained that recently there has been a number of pregnant women with pre-eclampsia who have needed teeth removed, showing the need to prioritise dental care for pregnant women. It has been proven that poor dental health in pregnant women can lead to preeclampsia and preterm deliveries.[25]

Finally, the ACCHS reports that poor oral health impacts on overall mental health, confidence and employment prospects, leading to self-medication. They also added that dental access in prisons is another

[23] https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-12/Signed%20-%20Public%20Dental%20Services%20for%20Adults.pdf.
[24] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/budget-2023-24-building-a-stronger-medicare.
[25] 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.

key area of need. 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 larger regional centres across the State with access to a WA Country Health Service (WACHS) hospital that provides dental services in their regional town. DHS has Memorandums of Understanding (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 (although after advocacy from one ACCHS, DHS at this clinic will examine children with rheumatic heart disease). RFDS provides a supplementary service to two of the aforementioned four clinics based in the Kimberley region. However sometimes this does not go ahead if unable to find accommodation in the town for visiting dental staff. In these areas, many dental clinics were cancelled through COVID which has led to longer waiting lists.

DHS staff in the regional centres are located at the local WACHS hospital and provide both a dentist and dental nurse to the 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 provide transport. These administration and transport costs are also not funded.

DHS staff generally undertake check-ups, fillings and extractions, but do not provide crowns, root canals, dentures or cosmetic procedures such as braces. Often clients attend ACCHS 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 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 days where services are not available in the ACCHS. However, one ACCHS reports that many clients will not 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.

Sometimes, clients need to visit Perth for treatment (e.g. wisdom teeth extraction), however this is not covered by WA Health's Patient Assisted Travel Scheme (PATS), which provides financial assistance for eligible WA country residents to access medical services not available locally. 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.[26]

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.

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

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 the 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 medical services MBS billing revenue.

Finally, the remaining two ACCHS in regional centres had a dentist and dental nurse embedded in their clinic, however in the past year they have both struggled to recruit a dentist. Dental staff have been funded through medical 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. 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).

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.

RFDS provide services where insufficient services or no service exists, thereby covering areas that are not generally serviced by DHS. It exists to "*address market failure or fill the gaps*".[27] However, RFDS is limited by its funding model. Primarily it is funded by the Commonwealth 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 it is reported that this model does not work for remote Aboriginal 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. 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 provides the workforce and consumables but utilise ACCHS infrastructure and equipment. ACCHS are responsible for arranging appointments and the maintenance of infrastructure and equipment, but are not funded to do this. Unfortunately, RFDS does not accommodate community outreach needs within the Commonwealth funding contract, and are confined to particular locations. Currently workforce is very tight with RFDS staff explaining that they currently employ ten dentists on casual contracts, and still find it difficult to fill a six-month roster and schedule. The FIFO model is costly and staff 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. 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'. However, due to the limited time in community, there is little scope to provide extensive dental treatment such as root canals and dentures, and RFDS generally only provides clean and scale, and teeth extractions. Some ACCHS reports that the lack of alternative teeth replacement or ongoing treatment can deter people from attending dental appointments as they know they will likely lose a tooth.

[27] Information provided through consultation with RFDS.

One of the remote ACCHS explained that the RFDS attends six times 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. There is little dental service provision for children in this community and the ACCHS often works with the school to assist teachers in terms of dental health promotion and to emphasise the importance of brushing teeth. Despite this extra work by the ACCHS, oral health issues are compounded by a lack of appropriate Environmental Health access in communities, with a lack of access to working water and a safe and clean place to store toothbrushes. This ACCHS reports that there needs to be more funding and emphasis on dental health promotion.

Another ACCHS that receives RFDS dental services through grant funding reports that RFDS mainly provides fillings and basic extractions, 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 for equipment and maintenance, in addition to flights and accommodation for RFDS staff which can prove costly. The ACCHS is also responsible for booking appointments and administering COVID-19 Rapid Antigen Tests to clients before attending the dentist.

This ACCHS also explained that it was difficult to gain access to services in Perth, especially as many treatments are not covered by PATS, noting that only some surgeries at Perth Children's Hospital are covered. The ACCHS staff also explained that *"there is a two year waiting list at the Oral Health Centre* (tertiary training centre for dentistry, run by the University of WA) *in Nedlands for child dental care requiring a general anaesthetic. They have 10 children from [this area] on the wait-list".*[28] 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 well as there is no support for wisdom teeth removal or to go to 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 be variable – sometimes once per week or once per month. There was no dental service provision throughout 2020, or for 6 months in 2022. The turnout for dental appointments when the dentist is available is good, however DHS does not see school aged children. The ACCHS receptionist arranges and manages appointments utilising GP referrals and triage categories. At the time of AHCWA's consultation with ACCHS for this submission there were 650 people on the referral list waiting for dental appointments (patient population is 3000).

At this ACCHS, DHS provides basic dentistry (clean and scale, 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.

The ACCHS is responsible for equipment and maintenance which they are not funded for. They also provide the consumables for the visiting dentist and manage appointments.

Options are limited in this community 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 specialist

[28] Information provided by ACCHS participant.

treatment, 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"*[29] should be covered under PATS, this ACCHS explains that it appears to be approved or rejected at the discretion of the approval officer.

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.

The first ACCHS utilises a visiting dentist and dental nurse from South Australia. The dentist 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 upfront and is then reimbursed. The WA Health dental contract requires the surname of every client, and work undertaken, along with item numbers and DWAUs, so paperwork is quite onerous. It was explained that previously, dental was part of chronic disease management funding and the cap was several thousand dollars, which provided more flexibility. Reporting also does not include any information regarding community engagement and relationships, and the time taken to build these.

Due to the remote location, equipment maintenance is expensive and incurred by the ACCHS, although appointments are not needed at this particular service, which removes that administrative burden. The dentist provides dentures, cosmetic dentistry and extracts wisdom teeth, however 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). 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 noting that it is crucial *"to support people to get out of the cycle of presenting only when in pain"*.[30]

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 does 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 provided by the ACCHS which does not receive funding for this additional service. The ACCHS also provides the infrastructure and equipment, with RFDS supplying the dentist, dental nurse and consumables. If a client require emergency care they need to travel to a larger regional centre hospital or across the border to Alice Springs. There is very little service provision for children as there is no school dentist, but child health nurses and teachers will assist with brushing as needed. 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.

This ACCHS has an Aged Care facility that supports elderly people with a variety of co-morbidities and disabilities. This cohort is unable to travel to attend the RFDS clinic and the facility does not receive any

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

[30] Information provided by ACCHS participant.

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.

One community serviced by this ACCHS has a unique 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 coves South Australia and Northern Territory). RFDS Central Operations provides all the equipment and workforce.

Terms of Reference:

g. Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services;

i. Workforce and training matters relevant to the provision of dental services.

The following section details potential pathways to improve oral health outcomes, which includes potential workforce and training options to address the need across the State:

Pathways to improve oral health outcomes

Based on feedback received from the ACCHS sector, AHCWA has proposed a number of potential options to improve dental health services and outcomes. Please note that these are specific to the WA ACCHS sector but could be transferable to dental service provision broadly (particularly in regional/ remote areas). These are not mutually exclusive and can be undertaken concurrently.

1. **Funding for dental health promotion**

Recommendations from the State Oral Health Plan identified the need to develop integrated models of care that incorporate oral health education, prevention and screening with other primary care services.[31] 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 supports an emphasis on increased dental health promotion explaining 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".*[32]

Focussing on dental health promotion would shift the focus from acute care to preventative care, possibly preventing caries and gum disease later in life. It empowers community, families and children by providing oral health education, and ACCHS could partner and link in with schools to ensure a whole-of-community approach. Health promotion roles could also provide possible employment to local community, whilst ensuring culturally secure and locally relevant information.

Recommendation 1: That the Select Committee includes a recommendation to the WA and Commonwealth Governments to work with the ACCHS sector to address the dental health promotion needs of community, including sustainable training and funding.

[31] 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.

[32] 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.

2. Workforce issues

Looking at alternative workforce models to ensure sustainability of dental care throughout the State is crucial. It is particularly important to examine new and innovative ways to approach the dental workforce in the ACCHS sector to address the great need across the State. Currently dental care is fragmented and supplied by a number of different service providers, with little communication and coordination. ACCHS are responsible for arranging appointments, administration tasks, licenses, transport to appointments and equipment provision and maintenance without receiving any extra funding. Due to the ad hoc nature of visiting services one ACCHS explained that it *"can often feel like service is thrown at us as it is not organised by ourselves".*[33] Also, as explained in the regional summaries, there are still significant dental service provision gaps, such as lack of outreach into more remote communities. To ensure self-determination, continuity of care and culturally safe care, alternative workforce models that provide ACCHS with more autonomy need to be explored.

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[34].

Recommendation 2: That the Select Committee includes a recommendation for the WA and Commonwealth Governments to work with the ACCHS sector to examine new, sustainable, innovative and culturally secure ways to approach the dental workforce and dental service provision in the ACCHS sector. This is in line with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community-Controlled Sector).

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

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.[35] Further, 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".*[36]

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 procedure that can reduce the progression of dental disease.[37] 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.[38]

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

[33] Information provided by ACCHS participant.
[34] Information provided through consultation with DHS.
[35] 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.
[36] KBC Australia and Rural Health West. *Increasing Dental and Oral health training in rural and remote Australia: Feasibility* study (Abridged Interim Report) 2022.
[37] 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.
[38] IBID.

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.[39]

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. Further funding for the program was not continued once election committing funding ceased.[40] However those trained were able to continue to apply fluoride varnish. There is potential to recommence training in this space.

This training would help to focus on prevention rather than acute care, thereby possibly preventing caries and gum disease later in life. It would also build AHW/P skills and competencies, and could address some of the workforce issues as service providers may not have to employ dentists/ dental nurses.

Recommendation 3: That the Select Committee includes a recommendation to the WA and Commonwealth Governments to work with ACCHS to explore training opportunities for AHW/P's and other health care professionals to apply fluoride varnish in lieu of a dentist/dental nurse.

4. 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. It is clear that this ACCHS would have greater capacity to manage the high demand for its services if it was supported by a more sustainable funding model. As detailed previously in this submission, having dental embedded in this clinic ensures a multidisciplinary, locally based preventative care model for oral health care and treatment. It also ensures greater continuity of care across the ACCHS, and ensures consistent data and record keeping across all areas of the clinic.

Recommendation 4: That the Select Committee includes a recommendation to the WA and Commonwealth Governments to provide sustainable funding to the WA Metropolitan based ACCHS to continue to provide a comprehensive dental service to Aboriginal people across the Metropolitan area.

5. PATS advocacy to expand parameters to include dental

Under current WA Health 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.[41] 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.[42] The WA Government needs to expand PATS guidelines to include all urgent dental procedures, and those requiring general anaesthetic (for both children and adults). This will help to ensure equitable access to dental care for clients located in regional and remote areas.

[39] Information from the Office of the Chief Dental Officer and WA Country Health Service.
[40] IBID.
[41] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022---Summary-sheets.pdf#page=2.
[42] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf.

Recommendation 5: That the Select Committee includes a recommendation to the WA Government to expand PATS guidelines to include all urgent dental procedures, and procedures requiring general anaesthetic (for both children and adults).

6. Ensure free dental care is available to all Aboriginal people, by changing DHS criteria

Currently DHS only provides subsidised public dental care if a person has a health care or pensioner concession card,[43] however dental care should be available free of charge to all Aboriginal people across the State and people on low incomes. South Australia provides free priority and emergency dental care to Aboriginal adults that have a current Centrelink card[44].

Recommendation 6: That the Select Committee includes a recommendation to the WA Government to provide dental treatment free of charge to all Aboriginal people across WA and people on low incomes.

7. Sub-contract dental funding directly to ACCHS.

There is potential to sub contract dental funding directly to ACCHS, rather than DHS and visiting services. 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 Queensland ACCHS including agreements between The Institute for Urban Indigenous Health and its members with Metro North, Metro South and West Moreton Hospital and Health Services;[45] and Goolburri Aboriginal Health Advancement Company Limited and Darling Downs Hospital and Health Services.[46]

South Australia provides a block grant through the South Australian Dental Service to fund ACCHS in the APY Lands,[47] and South Australian Dental Service also provides funding to other ACCHS to provide dental services, including a service in Yulata.[48]

Recommendation 7: That the Select Committee includes a recommendation to the WA and Commonwealth Governments to sub contract dental funding directly to willing WA ACCHS to provide culturally secure dental services, in line with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community-Controlled Sector).

Terms of Reference:
d. The provision of dental services under Medicare, including the Child Dental Benefits Schedule.

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. 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,

[43] https://www.dental.wa.gov.au/
[44] https://www.dental.sa.gov.au/professionals/programs/aohp#adults.
[45] https://www.qaihc.com.au/media/37576/0069-qaihc-oral-health-care-in-queensland_v10_f.pdf.
[46] IBID.
[47] https://www.nganampahealth.com.au/nganampa-health-dental.
[48] https://www.dental.sa.gov.au/assets/downloads/Documents/Programs/AOHP/Participating-Private-Dental-Clinics-Aboriginal-Schemes.pdf.

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 does not cover orthodontic dental work; cosmetic dental work or any dental services in a hospital.[49] As such, it is insufficient to address the needs to many Aboriginal children across WA.

It is underutilised by Aboriginal people and ACCHS, as it is an activity based fee-for-service model, which assumes pre-existing capacity in an area to deliver child dental through bulk billing and families then receiving reimbursement. In relation to complex clients, ACCHS are often reliant on Medicare medical billing revenue 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).

Recommendation 8: That the Select Committee includes a recommendation to the Commonwealth Government to reform the Child Dental Benefit Schedule to increase the biennial cap; provide dental funding directly to the provider, rather than as a reimbursement to the client and; expand the included dental treatment list.

Medicare

Both child and adult dental should be covered under Medicare. The lack of affordable and accessible dental care for all Australians, and particularly Aboriginal 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. 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[50]. Possibly there is potential for a similar program to ensure Aboriginal people have access to free dental care.

Recommendation 9: That the Select Committee includes a recommendation to expand Medicare eligible items to include preventative and emergency dental treatment. This would enable Aboriginal people to have access to free dental treatment and allow ACCHS to fund dental services, including infrastructure and equipment maintenance and ancillary supports such as administration and transport which is currently a large out-of-pocket cost for many WA ACCHS.

Conclusion

The ACCHS sector has raised issues with dental care provision in WA on a number of occasions. Services throughout the State are fragmented, and often reliant on visiting services. Despite oral health impacting a range of health issues, State and Commonwealth investment into public dental remains inconsistent and not fit for purpose.

There is a great need for dental reform across the State and for both State and Commonwealth Governments to invest in new and sustainable approaches to dental care for Aboriginal people, particularly those on low incomes and in regional and remote areas. Building the capacity of willing ACCHS to provide dental care is in line with Priority Reform 2 of the National Agreement on Closing the Gap (Building the Community-Controlled Sector). Where this is not possible, there should be resourcing and funding for partners to work with the ACCHS sector to ensure continuity of care and culturally secure services.

[49] https://www.servicesaustralia.gov.au/whats-covered-child-dental-benefits-schedule?context=22426.

[50] 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.