



NACCHO

National Aboriginal Community Controlled Health Organisation

NACCHO Submission:

House Standing Committee on Health and Ageing Inquiry into Adult Dental Services in Australia

March 2013

NACCHO- National Authority Comprehensive Aboriginal Primary Health Care



NACCHO

National Aboriginal Community
Controlled Health Organisation
Aboriginal health in Aboriginal hands

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NACCHO Submission to the House Standing Committee on Health and Ageing – Inquiry into Adult Dental Services in Australia

March 2013

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Executive Summary

NACCHO thanks the House of Representatives Standing Committee on Health and Ageing, chaired by Ms Jill Hall MP, for the opportunity to make a submission into the Inquiry into Adult Dental Services in Australia and to inform the development of the National Partnership Agreement (NPA) for adult public dental services.

This submission is intended to provide a succinct comment to the House Standing Committee on Health and Ageing – inquiry into Adult Dental Services in Australia, providing detail on NACCHO's policy position on Oral Health. It argues for the inclusion of dental checks, basic dental treatment, emergency treatment and oral hygiene/prevention as part of the core primary health care services to be provided by all Aboriginal Community Controlled Health Services (ACCHSs) as the preferred provider.

NACCHO Position

NACCHO asserts that in order to improve the overall health and well-being of Aboriginal and Torres Strait Islander individuals, and thus the community, oral health must be improved and to achieve this all ACCHSs must be funded to provide oral primary health care services.

Since the announcement of the Dental Health Reform Package, also on 29 August 2012, we have been attempting to identify where Aboriginal and Torres Strait Islander people are prioritised in the new policy or in the transition arrangements. From reviewing papers released to date, the new reform package proposes to target disadvantage children and adults on the public waiting list through National Partnership Agreements to be negotiated with the States and Territories, but there is currently no information on specific measures to ensure access for Aboriginal and Torres Strait Islander people.¹

More worrying is the gap in time between the closure of the CDDS (8 September 2012 for new patients and 30 November 2012 for all treatments) and the proposed 2014 start date for the new reform package. Transition arrangements accessible for Aboriginal and Torres Strait Islander people as described to us, include continued access the existing Medicare Teen Dental Scheme and a component of the \$345 million yet to be finalised arrangement with the States and Territories to address adult waiting lists for 2012-2013. We wish to ensure that the transition arrangements have targets to meet the needs of Aboriginal and Torres Strait Islander people.

The *National Oral Health Plan: 2004-2013* clearly prioritises access to dental care for specific groups at risk, one of these being Aboriginal and Torres Strait Islander people. Some evidence of this prioritisation slowly taking traction was seen recently in the *Productivity Commission's 2012 Indigenous Expenditure Report*; where \$28.6 million was expended by all levels of government in 2010 - 2011 for dental services for Aboriginal and Torres Strait Islanders, which was a very welcome start.

NACCHO re-endorses the recommendations in Australia's National Oral Health Plan 2004-2013 endorsed by AHMAC in July 2004.

PRINCIPLES INFORMING the new National Partnership Agreement

The following principles should underpin process and outcome of the National Partnership Agreement on adult dental health services:

- Cultural respect;
- A holistic approach;
- Health sector responsibility;
- Community control of primary health care services;
- Working together;
- Localised decision-making;
- Promoting good health;
- Building the capacity of health services and communities; and
- Accountability for health outcomes.

RECOMMENDATIONS

NACCHO recommends that the NPA for adult public dental services:

1. Provide culturally appropriate oral health services to all Aboriginal and Torres Strait Islander people;
2. Increase the oral health workforce available to improve the oral health of Aboriginal and Torres Strait Islander people;
3. Increase oral health promotion activity with the aim of improving health outcomes for Aboriginal and Torres Strait Islander people;
4. Improve the collection, quality and dissemination of oral health information about Aboriginal and Torres Strait Islander people; and
5. Foster the integration of oral health within health systems and services, particularly with respect to primary health care and Aboriginal and Torres Strait Islander people.

In addition, NACCHO asserts that:

- 1) Oral Health is a priority health issue for Aboriginal peoples.
- 2) Oral health is a core part of the holistic health that Aboriginal Community Controlled Health Services aim to provide.
- 3) Aboriginal Community Controlled Health Services should provide primary oral health care services including emergency and preventative oral health care and oral health promotion.
- 4) Australia's National Partnership Agreement to come into effect June 2014 should be fully funded and implemented, in particular in relation to measures for Aboriginal and Torres Strait Islander Peoples in particular.
- 5) The Patient-assisted Transport Scheme (PATS) must be extended to dental patients.
- 6) Dental services should be subsidised to all needy Aboriginal and Torres Strait Islander patients to reduce or eliminate cost as a barrier to accessing services..
- 7) Aboriginal and Torres Strait Islanders in correctional facilities should have access to culturally appropriate oral health programs.
- 8) All oral health workers must receive cultural awareness training either as part of their initial training or through on-going professional development. This will increase the level of culturally accessible oral health services.
- 9) There should be support for more Aboriginal and Torres Strait Islander individuals to be trained in all the oral health profession: dentists, dental hygienists, dental therapists, etc.
- 10) The Australian Dental Council (ADC) should include performance indicators for training schools for recruitment and retention of Aboriginal and Torres Strait Islander trainees and have a target of 2.4% of each profession being Aboriginal and/or Torres Strait Islander individuals.
- 11) Oral health should be included in the core training of all health workers including Aboriginal Health Workers.
- 12) Fluoridation of drinking water supplies is an effective strategy to reduce oral health problems.
- 13) Culturally appropriate Oral Health promotion materials need to be developed, tested for impact, and widely disseminated if effective.
- 14) Improved and regular collection of data on Aboriginal oral health status and use of services is needed to allow monitoring of the impact of interventions and assessment of achievement of oral health goals and targets.

NACCHO will:

- 15) Work with all Australian governments to develop oral health service provision at all its member health services.
- 16) Work with stakeholders to develop cultural awareness training for all oral health workers.
- 17) Campaign in support of fluoridation of city, town and community water supplies.

- 18) Improve the level of useful Aboriginal oral health data initially by influencing the capacity for the sector to collect national data collection in those Aboriginal Community Controlled Services with an existing oral health service - e.g. periodontal and dental caries status, oral hygiene knowledge and periodontal disease links with Diabetes etc.
- 19) Support research to collect information on the areas of individual oral health behaviours, knowledge and barriers in regards to oral health including the availability and affordability of oral hygiene items.

NACCHO calls upon the Federal Government, in collaboration with state and territory governments and NACCHO, to:

- 20) Fully fund and implement the 2014 National Partnership Agreement
- 21) Set and monitor goals and time specific targets in relation to meeting a range of oral health outcomes such as caries rates, periodontal disease rates and tooth extraction rates.
- 22) Formally recognise oral health as a key part of Aboriginal holistic health care to be provided by ACCHSs.
- 23) Allocate resources specifically for oral health services for Aboriginal peoples.
- 24) Increase oral health promotion activities in ACCHSs. This would require both increased financing for the development and testing of suitable materials, service provision and training of the AHW workforce.
- 25) Provide subsidised tooth brushes, tooth paste and floss to all remote communities in the first place and extend this as necessary to other communities where data collection indicates there is an access issue for these items.

NACCHO calls upon state and territory governments to:

- 26) Fluoridate all town, city and Aboriginal community water supplies that do not naturally contain a level of fluoride sufficient to prevent dental caries and immediately fluoridisation where this has ceased.

BACKGROUND

The issue of oral health for Aboriginal peoples is a crisis issue in urgent need of strategic and comprehensive attention. Before colonization Aboriginal peoples had good oral health with minimal oral disease, and although quality information on oral health for Aboriginal peoples is still limited it appears that Aboriginal peoples now have significant oral health problems and that their oral health status is poorer than non-Aboriginal people. There is good evidence linking poor oral health with poor overall health hence tackling oral health problems will improve overall health status.

Aboriginal and Torres Strait Islander people are more likely than non-Indigenous Australians to have lost all their teeth, have gum diseases and receive less caries treatment. Severe periodontal disease is more prevalent for Aboriginal and Torres Strait Islander people for all ages above 35 years. The early stages of poorer periodontal health are evident in Aboriginal and Torres Strait Islander people aged 18-24 years. ⁱⁱ

Levels of untreated decay were more than twice as high among Indigenous Australians (57.0%) compared with non-Indigenous Australians (25.1%).ⁱⁱⁱ

Children

Aboriginal and Torres Strait Islander children in Australia are disadvantaged in terms of oral health. Information from the Child Dental Health Survey, the Aboriginal and Torres Strait Islander Children and Receipt of Hospital Dental Care Investigation and the Study of Aboriginal and Torres Strait Islander Child Oral Health in Remote Communities was analysed and published in 2007^{iv}. The data from NT (2002), SA (2003) and NSW (2000) shows that throughout the states and territories studied

- Aboriginal and Torres Strait Islander children (4-14 years old) had consistently higher levels of dental disease in the deciduous and permanent dentition than their non-Aboriginal and Torres Strait Islander counterparts;
- Aboriginal and Torres Strait Islander children most affected were those in socially disadvantaged groups and those living in rural/remote areas;
- Trends in Aboriginal and Torres Strait Islander child caries prevalence indicate that dental disease levels are rising, particularly in the deciduous dentition;
- Indigenous children aged <5 years had almost one-and-a-half times the rate of hospitalisation for dental care as other Australian children;
- The rate of Indigenous children receiving hospital dental care rose with increasing geographic remoteness;
- Less than 5% of remote Indigenous pre-school children reported brushing their teeth on a regular basis; and
- Many young remote Indigenous children experienced extensive destruction of their deciduous teeth.

Adults

There is even more limited formal information on adults.

An Australian Institute of Health and Welfare report ^v noted that edentulism (loss of all ones natural teeth) was found in 16.3% of Indigenous people compared to 10 % in non-Indigenous people in a study with a small number of indigenous participants.

This study also found that of those adults attending public funded dental treatment, a higher percentage of Indigenous patients had gum problems; they had a higher than average number of decayed teeth and a higher percentage of Indigenous patients had teeth extracted on visits.

In the 2004-05 National Health Survey and National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the Australian Bureau of Statistics collected information for the first time about the oral health of Indigenous people, in addition to the information on recent visits to health professionals. While more than three-quarters (78%) of all Indigenous people aged 15 years and over had lost fewer than five adult teeth in their lifetime, the proportion who had lost five or more teeth ranged from around 1% of people aged 15-24 years to 61% of those aged 55 years and over. Of people aged 55 years and over, almost half (47%) had lost 10 or more adult teeth. While older people in non-remote areas reported a higher level of tooth loss and greater use of dentures than those in remote areas, a higher proportion of people aged 55 years and over in remote areas (19%) than in non-remote areas (10%) said they required dentures but did not have them. ^{vi}

Data Issues

Clearly there is a lack of data on oral health issues both in terms of oral health status of adults and children and of services accessed by Aboriginal and Torres Strait Islander individuals. It is imperative that regular data collection of a standard set of information is established across all states and territories. Only in this way with concrete time limited targets are able to be set and monitored.

The Aboriginal and Torres Strait Islander Health Performance Framework include dental health (Tier 1 Health Status and Outcome 1.10 of Decayed, missing and filled teeth). However a larger set of indicators would assist in understanding the impact of interventions and the framework only monitors changes, it does not set time specific targets for these numbers.

Causes of oral health problems

Nutrition

Aboriginal and Torres Strait Islander people have a markedly different experience of oral health than other Australians. The loss of traditional lands and hunter-gatherer lifestyle led to generations of Aboriginal and Torres Strait Islander people having to depend largely on “rations” i.e. white flour and sugar, tea, rice and tinned or dried meat. The rapid change in diet led to new diseases – the lifestyle diseases such as diabetes, obesity, hypertension and renal disease becoming prevalent in Aboriginal and Torres Strait Islander communities. ^{vii}

Diet is one of the primary determinants of dental caries formation. In young children nursing caries (better called nursing bottle caries – tooth decay usually occurring in 1-2 year old children) are a significant issue. Nursing bottle caries usually present in a characteristic pattern with caries in the upper incisors, although in severe cases all of the teeth can be involved.

Nursing caries are caused by the prolonged exposure of a young child's teeth to sugar containing fluids (e.g. formula, other milks, juice or soft drink). The problem mainly arises when children are put to sleep or rest with a bottle, where the sugar containing fluid sits in the mouth and is in contact with the teeth for an extended period. This problem can also occur when dummies are coated with honey or glycerine.

The impact of nursing bottle caries is considerable, leading to possible poor nutrition, due to food restriction, a delay in the eruption of primary teeth and a possible increase in the prevalence in caries later in life ^{viii}.

The incidence of nursing bottle caries in Aboriginal children is unclear but anecdotal evidence from ACCHS indicates that it is a significant issue.

As a child grows and other foods are introduced other oral health issues arise. The link between sugar consumption and dental caries has long been identified. In recent times frequency of carbohydrate intake and the number of meals and snacks per day have also been identified as important risk factors for the development of dental caries. ^{ix}

The grazing style of eating is potentially damaging to the teeth because of the increasing number of times teeth are exposed to acid produced from digestion of carbohydrates by plaque bacteria. Saliva flow increases every time we eat and acts to neutralise the acids, with constant snacking on carbohydrate containing food the saliva doesn't have enough time to do this i.e. PH levels don't return to normal. The excess acid starts the chain of events that lead to carie formation.

The form in which the carbohydrate is eaten is also important with sticky foods that stay on the teeth or sugar containing foods that are slowly eaten (e.g. lollypops), being highly cariogenic.

A balanced diet from a variety of foods will provide the range of nutrients important for good oral health. It has been a consistent finding across numerous studies that a diet high in fruit and vegetables is associated with a reduced risk of oral health. ^x

While the effects of sub optimum nutrition on oral health is hard to quantify, severe nutritional deficiencies, for example of Vitamin C, can have a significant impact on oral health, particularly periodontal disease.

As noted in the NHMRC 'Nutrition in Aboriginal and Torres Strait Islander peoples information paper'¹⁰ studies have shown that Aboriginal children living in remote communities do have diets high in energy and sugars, moderately high in fat and relatively low in complex carbohydrates. Some studies have also shown intakes low in some mineral (eg. calcium and iron) and vitamins (folic acid, Vitamin B2, betacarotene and Vitamin E)

Compared with national apparent consumption data, intake of sugar, white flour and sweetened carbonated beverages are higher in Aboriginal communities in the NT.

Information of the diets of rural and urban living Aboriginal people is poor.

Diabetes

There is widespread acceptance of the link between diabetes and periodontitis. We know that Diabetes increases your risk of periodontitis and that periodontal disease may have an effect on glycaemic control.¹⁰

When it is considered that Aboriginal people suffer from non insulin dependent diabetes at a rate at least 2-4 times higher than non –indigenous Australians^{xi} with the prevalence rates thought to be in the vicinity of 10-30% of the Aboriginal population, this is a very large issue to be addressed for the Aboriginal community.

Smoking

Smoking is a risk factor for periodontal disease, with smokers at four times the risk of periodontal disease compared with non-smokers.^{xii}

In 2004-05, half of the adult Indigenous population (50%) were current daily smokers (ABS 2006). In 2004-05, the rate of regular smoking among Indigenous men was around twice that of non-Indigenous men (51% compared with 24%) and the rate for Indigenous women was around two-and-a-half times that of non-Indigenous women (49% compared with 18%).^{xiii}

Injury

The area of injury in regard to the mouth and teeth is a significant one.

Sport, accidents and issues such as violence can lead to trauma requiring emergency oral services. A study of injury in five Cape York Communities in 1997^{xiv} found that there were high rates of injury in the communities studied, the leading type of injuries in the community were head injuries and while half of these were lacerations, it could be anticipated that the oral region was damaged in many cases.

Poor oral hygiene

Teeth cleaning is the removal of dental plaque and tartar from teeth in order to prevent cavities, gingivitis, and gum disease. Severe gum disease causes at least one-third of adult tooth loss.

At present there are a number of barriers to achieving good oral health promotion including lack of personal knowledge and skills of the individual, inadequate numbers of Aboriginal health workers and lack of support for training of Aboriginal Health Workers (AHW), lack of oral health professionals engaged in oral health promotion, cost and availability of appropriate oral hygiene items (eg. brushes, appropriate toothpaste, floss).

Fluoridated water supply

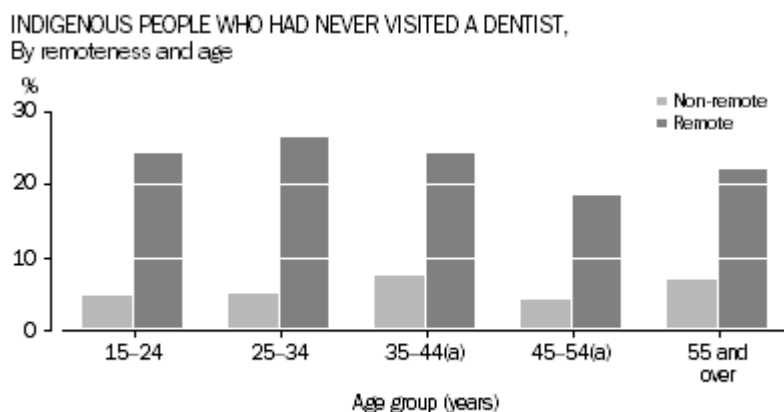
Fluoride has long been recognised as a key public health measure for preventing dental caries in the Australian population.

In its 2007 public statement on the issue NHMRC recommendation was that fluoridation of drinking water remains the most effective and socially equitable means of achieving community-wide exposure to the caries prevention effects of fluoride. It is recommended that water be fluoridated in the target range of 0.6 to 1.1 mg/L, depending on climate, to balance reduction of dental caries and occurrence of dental fluorosis.^{xv}

Many Aboriginal peoples don't have access to an artificially fluoridated water supplies and must rely on the natural fluoride levels in their water supply, which can vary greatly and usually in Australia is not sufficient to reduce the rate of caries.

Access to oral health services

The 2004-05 NATSIHS reported that of Indigenous people aged 15 years and over, 11% had never visited a dentist or other health professional about their teeth. This proportion was 24% for Indigenous people in remote areas compared with 6% in non-remote areas (see table below).⁶



(a) Non-remote data has a relative standard error of 25% to 50% and should be used with caution

Indigenous Australians were around half as likely as non-Indigenous Australians to have seen a dentist during the two weeks before the survey.⁶

Access to oral health services appears to vary greatly across Australia from minimal to non-existent. While larger rural communities are serviced minimally by private oral health professionals the cost is largely prohibitive for most Aboriginal people. Reports from the ACCHS sector have also noted that these private services are often inappropriate for Aboriginal clients, lacking cultural awareness and often the skills to deal with the complex oral and general health issues.

The abolition of the Commonwealth Dental Health program in 1996 has made a largely inadequate public dental system worse, according the ACCHS sector. Despite the loss of the program, and because oral health has always been considered a core part of comprehensive primary health care, many ACCHSs have maintained the provision of dental services.

In order to address these issues for their communities many ACCHS have been creative in trying to access some form of service for their community. Short term solutions have included transporting people to large centres where the ACCHS have a dental service, purchasing time from a private practitioner (even though their service is not funded to do this) or by applying for project money to pilot models of service.

While useful stopgaps, none of these solutions are sustainable or by any means adequate.

The issue of dental services for children is also a concerning one. Dental Therapists are qualified to treat basic dental issues in children less than 18 years, depending on local state /territory dental legislation. In some areas school dental programs are well established and children, mainly at the Primary level, receive free dental services. In other areas, ACCHS

employ Dental Therapists to service children. Like the general oral health services, not all communities have this basic level of service with many Aboriginal children not having access to any form of primary oral care.

The lack of dentists willing to work in rural and remote areas and in publicly funded positions in urban areas is an enormous barrier to improving the oral health care of Aboriginal peoples.

Consequences of oral health problems

Physical health

Briefly poor oral health can cause both physical and social and emotional wellbeing including problems.

One of the obvious consequences of poor oral health is the loss of teeth (edentulism). Tooth loss can be due to gross dental caries, advanced periodontal disease, and trauma. In some people with uncontrolled diabetes, all teeth could be lost before they reach the age of 40.

Loss of some or all of the teeth, pain associated with infection or poor fitting dentures can all lead to significant limiting of the diet.

The 'Nutrition in Aboriginal and Torres Strait Islander peoples Information Paper'¹⁰ reviewed the literature on this area and concluded that the loss of natural teeth significantly reduces the ability to chew foods, lowers chewing performance and results in avoidance of hard-to-chew foods (eg. fresh fruits, vegetables, meat and wholegrain foods).

While the impact of poor oral health on nutrition is quite clear, there is a less clear literature developing on the potential links between chronic oral infection with the development of conditions such as cardiovascular disease, pre-term, low birth weight babies; cardiovascular disease; and rheumatoid arthritis.^{xvi}

The literature in this area is of varying quality and more studies are needed to clarify the exact mechanisms and the influence of variables such as age, sex, socioeconomic status and ethnic/racial background.

Another concern is the risk of bacterial endocarditis in a person with a history of rheumatic fever or valvular heart disease. Bacterial endocarditis arises predominately from streptococci and staphylococci which may originate from oral infections.

As there are very high rates of rheumatic fever in Aboriginal communities this is a very serious issue. While the risk of possible bacterial endocarditis from dental procedures is often highlighted, everyday oral health practices can also be dangerous.

Social and emotional wellbeing

Poor oral health can be a major determinant of social and emotional wellbeing. With the mouth so important to verbal and non-verbal communication, any illness in this region has the potential for significant impact.

Poor oral health can make social interactions very difficult and potentially embarrassing. Missing or prominent teeth, significant decay or periodontal disease and related halitosis, can all lead to a reduction in self esteem and have been related psychological disorders such as anxiety and depression.

The pain associated with chronic oral disease can upset sleeping patterns and can have a significant effect on quality of life. ACCHSs have also suggested a link to substance misuse resulting from the chronic pain associated with some oral disorders.

With lowered self-esteem, poor communication skills, in a society with new social norms of retained and healthy teeth, poor oral health can lead to a loss of job offers and career progression due to appearance.

Solutions

Clearly the solutions must address the causes of the problem.

Improve Nutrition

Access to nutritious affordable food and, once the food is available, encouragement and support to change to a better diet will be one important key to improving oral health in the medium to long term.

Improve Diabetes self management

Quality self management of diabetes will improve oral health.

Reduce Smoking

Reduction in smoking will improve oral health.

Reduce impact of Injuries

Preventative strategies such as compulsory mouthguards for contact sports need to be introduced to Aboriginal communities. Development of high quality dental first aid would also decrease the impact of injuries on oral health.

Improve Oral Hygiene

Oral health promotion activities have the potential to prevent many oral health problems. While simplistic educational approaches on their own have been shown to have limited benefit,^{xvii} comprehensive oral health promotion initiatives, based on the Ottawa Charter and guided by the principles of community control and self-determination are important for all Aboriginal communities.

Learning and using good oral hygiene practices early in life is an essential part of attaining and maintaining good oral health. Early introduction of regular brushing and flossing is vital for all children and it must be maintained as a regular habit throughout life with reinforcement later in life (particularly for those at high risk for oral problems such as pregnant women or on diagnosis of diabetes).

Brushing with a fluoride containing toothpaste provides a topical fluoride application and the combination of brushing and flossing has the purpose of removing dental plaque, which contains the bacteria responsible for the development of caries and periodontal disease.

Responses to this issue must include increased numbers of Aboriginal Health Workers, better access to oral health promotion training for Aboriginal Health Workers, undergraduate training in primary care and Aboriginal health for oral health professionals and subsidies for tooth brushes, tooth paste and dental floss. These health promotion responses must take place within the holistic framework that ACCHS offer so the broader social influences on oral health can be also be addressed.

The development and testing of interventions to promote improved oral hygiene will be necessary to ensure they are effective before being rolled out across all Aboriginal and Torres Strait islander communities.

Fluoridate drinking water supplies

All drinking water should be fluoridated to meet the NHMRC guidelines. Health providers should advocate fluorination of water in areas of need where communities have a well monitored reticulated water supply.¹⁸

Improve Oral Health Service provision

There are a large number of reasons for the poor use of oral health services by Aboriginal and Torres Strait Islander peoples. A wide variety of strategies will be needed to improve access and utilisation. These strategies can be divided into 4 main areas:

- increasing the workforce trained in Aboriginal and Torres Strait Islander cultural awareness,
- increase the willingness of oral health workers to work in ACCHSs,
- increase the total workforce available, and
- reduce the cost of services to Aboriginal and Torres Strait Islander clients.

Increasing workforce cultural awareness

At present there is little public health or Aboriginal health curriculum in undergraduate dental training and a general lack of exposure to Aboriginal clients and their specific and often complex oral health issues. This can lead to a fear of working with Aboriginal communities and an unwillingness or ignorance regarding the need to change their approach to practise to better meet the need of Aboriginal clients they do see.

This can be overcome with the requirement for inclusion of Aboriginal and Torres Strait Islander issues in all curricular (see the Curriculum Framework being used by the Medical Deans of Australia and New Zealand to ensure medical schools deal well with this same issue) and the introduction of cultural awareness training as part of continuing professional development requirements,

Increasing willingness of oral health workers to work in ACCHSs

There are concerns among dental health professionals that positions in Aboriginal communities are not seen as part of the usual career ladder and there is a strong perception of poor conditions for workers in the sector. All of the training institutions have a strong private practice focus, as does the professional body, the Australian Dental Association (ADA).

Exposure to working in ACCHSs during training would reduce some of these fears and explicit encouragement from the ADA to include placements in ACCHSs as a positive in professional development would encourage individuals to take up posts.

Proper funding of ACCHSs to provide comprehensive oral health services to all their clients would allow competitive remuneration including packages that would encourage take up of posts in rural and remote areas.

Increase the total workforce available

Dental therapists are key oral health practitioner group with a major role in caring for the oral health of children. Dental therapists provide basic dental services like fillings and extractions and are predominately employed in public positions and primarily in school dental programs. Dental Therapists in most States are limited by State Dental Acts to only provide services to children and young people up to 18 years who are at school.

The potential for expanding the role of the Dental Therapists beyond children and young people could potentially increase availability of oral health services provided through ACCHSs. However, the Australian Dental Association do not support any changes to the age ranges in which Dental Therapists can treat.

Aboriginal Dental Assistants play a key role in achieving a quality oral health services for the Aboriginal population. The importance of these positions is undermined however by the low award wages they are offered. In Victoria qualified Dental Assistants earn less than Aboriginal Health Workers, even after their specialist training. Better remuneration would increase this part of the workforce.

AHWs are also the key health service providers in ACCHSs with many AHWs playing a significant role in oral health issues, particularly for those services without an oral health service. In some jurisdictions trained AHW are allowed to provide basic oral health services (e.g. extraction), while others conduct oral health promotion or provide dental assistance as part of their services commitment to holistic health care. Oral health promotion should be included in all AHW training and more specialised training for extraction etc could also be used to increase the oral health service providers available in ACCHSs.

Reduce cost of services to Aboriginal and Torres Strait Islander peoples

Many Aboriginal people with partial or total edentulism are not able to obtain dentures. There are many reasons for this, including lack of available services, long waiting lists in public dental programs, **high costs of privately made dentures**. As a result people are doing their best to function with few/no teeth, and therefore suffering associated health problems. The cost of providing dentures through publicly funded programs is also high, and can place a great strain on services' budgets.

Even if a service is available free of charge often the transport costs are prohibitive for Aboriginal and Torres Strait Islander clients.

To ensure that Aboriginal and Torres Strait individuals access all oral health services they need financial barriers need to be removed.

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Case Study: Comprehensive Urban Oral Adult Health Model of Service – Melbourne Victoria

Author: Dr Alex Thomas

Date: 18/3/13

Oral health of an Aboriginal Australian is determined from the very day of conception in regard to the maternal nutrition and health.

Access for the Aboriginal Australian to the health services plays an important part in the maintenance of health for the expectant mother. The first tooth is formed at the 6th week of the intrauterine life. And life cycle of the teeth continues throughout the pregnancy child birth until the age of 16 for the teeth to be completed in the mouth.

Access to health care, lack of proper health education, housing, poverty, social and financial deterrents added with chronic diseases like diabetes, asthma, alcohol and substance abuse will affect the growth of the baby in the intrauterine life which in turn affects the proper development of the tooth.

The vicious cycle of poverty social, financial, racial factors plays an important part in the nutrition of the child. Mother's knowledge about the proper oral health care, provision of proper nutrition, access to oral hygiene products will begin the journey into the world of dental decay, gum disease, pain, and missed school days.

As the child grows up smoking, alcohol, substance abuse, poor nutrition lack of oral hygiene aggravates the existing poor oral health added with many chronic physical and mental ailments.

By the age of 40 most of the Aboriginal Australians would have lost some teeth in their mouth. This would have led to pain, agony, discomfort, swelling and loss of income

In this journey of poor health and wellbeing the chances of the life style diseases is more commonly prevalent in the Aboriginal community

When compared to mainstream Australians in suburban and rural Victoria. Aboriginal Australians do not access the community health centres due to socio economic and racial reasons, "They stare at me" "I don't like going to the community health centres, some people don't even want to smile because I am black" This is the common thing I hear as a general dental practitioner

Hospitals are considered to be a place of last resort for the Aboriginal people. Even in case of emergencies people do not want to attend the centres due to the lack of transport modalities, many of the Aboriginal Australians do not drive.

Employing Aboriginal people in community Health centres can improve the access of the Aboriginal patients. This has proven an effective method in Royal Dental Hospital of Melbourne where the number of Aboriginal people accessing the Royal Dental hospital dramatically improved after an Aboriginal Community Development Officer was employed. An Aboriginal Liaison Officer position was also initiated.

The clinician's experience in culturally appropriate treatment is one of the main factors of access of the Aboriginal Australians to the dental clinic ACCHOS are different in this set up because they are run by the community for the community.

ACCHOS are the place the community members meet to see their family, have a cuppa and discuss the problems they face in day today life.

Culturally appropriate treatment can only be given by some who has in depth knowledge about Australian and Aboriginal history, compassion ability to treat someone above and beyond the social racial and financial criteria. Understanding the pain of genocide, stolen generation, mental agony of inability, feeling loneliness, history of past and present drug abuse can reflect in the oral hygiene and health. Oral health and hygiene becomes not a priority in this case.

Life style diseases take a toll in the oral health of the Aboriginal people.

Neither the state nor federal government can run away from the responsibility of fixing the problems they have created.

In Victoria VAHS is the hub for the ACCHOS which is situated in the city. Aboriginal people from far and wide in the state utilize the VAHS in Fitzroy.

The mobile dental van servicing the rural population was decommissioned 9years ago which had left three quarters of the Aboriginal Victorian's oral health in turmoil. That had brought forward the transportation of the patients from the country Victoria into the VAHS creating bulk blocked bookings. This had created confusion and increased waiting list among the regular patients of VAHS.

Plenty Valley Model

A paper was presented in Dental Health Services of Victoria by Dr Alex V Thomas, Marten Post and Glenys Vickery about the access for the Aboriginal people.

Plenty Valley Community Centre is medium sized community Health centre in the outer northern suburbs of Melbourne servicing a diverse population. City of Whittlesea which is a part of the Plenty Valley Community Health (PVCH) Centre has fourth largest Aboriginal population in Melbourne. The number of Aboriginal clients attending the plenty valley community centre was about fifty for the year's 2003-2008.

PVCH management wanted to service more to the Aboriginal clients as a first step they appointed an Aboriginal Liaison Officer (ALO). The ALO then sought out Aboriginal mothers with supported parenting program; another initiative was to ask the preschool children to be brought to PVCH for one off dental check-up days and yarning sessions. This became a big success

An Aboriginal person was selected to the Board of Management to get the attention of the local Aboriginal community. After all these it took one more year to get the real programs in place.

Meetings with VAHS were underway to confirm that PVCH was not in competition with VAHS but just complimentary to the services provided. A dentist with 17 year of experience in culturally appropriate treatment agreed to work on Saturdays to start the Saturday dental program.

Saturday dental program became a big hit a one shop stop for the patients to bring children for breakfast sit down have a yarn to the nurse make appointment with other allied health. Transport was provided for the patients who could not find their way to the dental clinic. An Aboriginal liaison officer was around throughout the morning session to assist the clients with the provision of breakfast and other necessities .In the first year we saw 110 patients just half a day.

Private Practise.

An elderly lady was sent by the doctor to my private practise under the Medicare Chronic diseases scheme. She had many medical conditions and was on intravenous Bisphosphonates to prevent the spread of bone cancer. She wore an existing full upper denture, no lower denture and some lower teeth.

The doctor did not have any idea of an Aboriginal Health service even though he had been practising for years in northern suburbs. I had explained to the elderly lady who was originally from W.A that I am an experienced dentist in Aboriginal health, by giving her respect and calling her aunty made her relax and accept and understand the treatment plan more clearly. I informed about the difficulties in having the extractions in an office based setting and the benefits of getting the treatment in Hospital based settings. I discussed with her about referring her to Royal Dental Hospital Melbourne.

Her oncologist was contacted and clearance was received prior to the reference to the Royal Dental Hospital Melbourne .In Royal dental Hospital the waiting list would be about 3 months. She was in a hurry to go back to WA for family reasons and the new dentures had to be finished before then.

Aboriginal liaison was contacted at the RDHM informed her about the situation. She personally came collected the referral letter. Arrangements were made for the patients to see the specialist in RDHM a taxi voucher was made available, blood test were done in the consultation she did not go into a waiting list. All the remaining teeth were extracted and the dentures constructed before she left back to WA.

This was made possible only because I had the 20 years of experience in Culturally appropriate treatment.