



Provision of and access to dental services in Australia

Queensland Aboriginal and Islander Health Council
submission

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Chief Executive Officer
Queensland Aboriginal
and Islander Health Council
PO Box 3205
South Brisbane, Qld 4101
P: (07) 3328 8500

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Provision of and access to dental services in Australia

QAIHC SUBMISSION TO THE SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS

About the Queensland Aboriginal and Islander Health Council (QAIHC)

QAIHC is the peak body representing the Aboriginal and Islander Community Controlled Health Organisation Sector in Queensland at both state and national level. Its membership comprises of Aboriginal Community Controlled Health Organisations (ACCHOs) located throughout Queensland. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation and is regarded as an expert in its field.

Today, QAIHC represents 33 community-controlled health services and 11 associate members who share a passion and commitment to addressing the unique health care needs of their communities through specialised, comprehensive, and culturally appropriate oral health care.

QAIHC wishes to highlight the importance of recognising that new policies, funding models and additional resources to the ACCHO Sector are needed to promote oral health amongst Aboriginal and Torres Strait Islander peoples. This includes building the capacity of ACCHOs to respond to barriers effecting provision of and access to dental services for Aboriginal and Torres Strait Islander peoples in Australia. The purpose of the recommendations directly aligns with Priority Reforms two and three of the National Agreement on Closing the Gap[1].

1. Opening statement

The oral health of the Aboriginal and Torres Strait Islander population in Australia is significantly poorer compared to that of non-indigenous Australians[2], leading to severe complications and disease contributing to the gap in health and placing financial pressure on individuals as well as the health system. With this submission, QAIHC wishes to address the main barriers to provision and access of dental services in Australia, particularly for Aboriginal and Torres Strait Islander peoples. Additionally, QAIHC urges governments to invest in ACCHOs and preventative oral health education and care within the Aboriginal and Torres Strait Islander population. The lack of access continues to be determined by multiple factors including institutional racism, lack of cultural awareness by some providers, poverty, geographical location, and education.

Despite efforts towards Closing the Gap in several social-economic areas, Aboriginal and Torres Strait Islander peoples remain the most disadvantaged and marginalised group in Australia when looking at oral health.

Poor health, including oral health, due to lack of access to safe healthcare, oral health literacy and oral health products in Aboriginal and Torres Strait Islander communities needs to be understood as both a cause and effect of social disadvantage. QAIHC stresses urgent policy action is required to ameliorate the high prevalence of Aboriginal and Torres Strait Islander people experiencing poor oral health.

This submission addresses the role that both governments and the ACCHO Sector can play to address, manage, and prevent oral health issues through increased access to adequate and culturally appropriate dental support, and further support The National Agreement on Closing the Gap[1]

2. Recommendations

Recommendation 1: That the Commonwealth Government and state government agencies collaborate with relevant oral health services, including those in ACCHOs to develop and implement data standards.

Recommendation 2: That the Commonwealth Government allocates funds to relevant organisations to investigate and develop software tools which are fully compatible with the current aggregation tools used in ACCHOs.

Recommendation 3: That the Commonwealth Government and state government agencies invest in co-designed preventative oral health programs for Aboriginal and Torres Strait Islander peoples to be facilitated by ACCHOs.

Recommendation 4: That the Federal Government in collaboration with the ACCHO Sector and other relevant education institutions develop education pipelines to assist more Aboriginal and Torres Strait Islander people to become oral health professionals.

Recommendation 5: That the Commonwealth Government and the state government agencies recognise oral health in core funding for ACCHOs to allow more ACCHOs to provide dental services.

Recommendation 6: That the Commonwealth Government co-design a new and more effective funding model that will allow more ACCHOs, particularly in rural and remote areas, to deliver dental services for community.

Recommendation 7: That the Commonwealth and state government agencies increase capital works and operational funding to expand ACCHO infrastructure to allow for dental services within services and to deliver outreach services to a growing Aboriginal and Torres Strait Islander population.

Recommendation 8: That the Commonwealth and state government agencies undertake clear actions to identify, acknowledge and address direct and institutional racism to increase accessibility and trust. This includes:

- Prioritise data development and reporting against progress toward Priority Reform three of the National Agreement on Closing the Gap, so that all governments can be held accountable for addressing racism in public services.
- Implement reforms to address institutional racism across all departments in all jurisdictions; to promote timely access by Aboriginal and Torres Strait Islander peoples. Prevent impacts of racism within public systems, by addressing transformational elements in clause 59 of the National Agreement on Closing the Gap.

Recommendation 9: That the Commonwealth and state government agencies implement policies to prioritise Aboriginal and Torres Strait Islander peoples on health care waitlists, including for dental care.

Recommendation 10: That the Commonwealth Government and state government agencies implement fixed dental charges like that of Allied Health to make services increasingly accessible.

Recommendation 11: That the Commonwealth and state government agencies undertake clear action to identify, acknowledge and address the social determinants of health through multi-strategic approaches.

Provision of and access to dental services in Australia

- To progress Closing the Gap programs that address health and social outcomes that are attributable to intergenerational trauma and racism, as delivered by ACCHOs.

Recommendation 12: That the Commonwealth and state government agencies consider the eligibility criteria for concession cards according to different forms of poverty; allowing more people living in disadvantage to access the public system.

Recommendation 13: That the Commonwealth and state government agencies fund, co-design, and implement programs that improve health literacy, including oral health literacy amongst Aboriginal and Torres Strait Islander peoples.

3. Data

ToR h: the adequacy of data collection, including access to dental care and oral health outcomes

Data on oral health is predominately private driven. The collection of data is primarily focussing on revenue rather than care provided and health outcomes, resulting in a severe lack of data, particularly regarding outcomes. At present there is no standard data collection regime regarding access and outcomes for private dental clinics to report. This lack of data, particularly from the private sector, makes it difficult to determine the oral health status of all Australians, including Aboriginal and Torres Strait Islander people, and their health outcomes. Additionally, data on who is accessing and how often is lacking.

Additionally, data collection of both dental care and outcomes in the public system and the ACCHO Sector is inadequate. At present, the data available is limited to the few medical services that offer oral health care as part of their practice, then further limited by the dental record software they use. These systems are often not compatible with the aggregation tool that is used by peak bodies or governments to collect data. These limitations make it cumbersome to export data leading to low or no collection, particularly in the Aboriginal and Torres Strait Islander space.

Additionally, the data sets and collections differ in detail. For example, regarding workforce, there are sources with significant differences in data and detail. This is because the Census is largely self-reported[3], while other datasets rely on services reporting for funding purposes (in the case of Online Services Reporting or registration renewals for National Health Workforce Dataset[4]).

4. Access to dental services

ToR B: the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;

ToR I: workforce and training matters relevant to the provision of dental service

In 2019, QAIHC consulted with Members on service provision. This information, along with a review of available literature, found that barriers to accessing oral health services for Aboriginal and Torres Strait Islander peoples living in Queensland include:

Provision of and access to dental services in Australia

Table 1: Main barriers to accessing oral health services:

Geographic location: People living in regional or remote Queensland have limited local services and transport options[5]. These barriers are often also faced by Aboriginal and Torres Strait Islander peoples living in urban areas.

ACCHOs financial capacity: Although a best practice model of care, oral health services are not integrated consistently into ACCHOs across the state. Inconsistent partnerships and inadequate government funding leaves ACCHOs' best practice oral health services financially vulnerable with no capacity to meet community demand.

Cultural safety of services: Cultural safety has been proven to be an essential element in interventions for Aboriginal and Torres Strait Islander peoples[6]. As there is limited representation of Aboriginal and Torres Strait Islander peoples in the oral health workforce, many mainstream clinical services are not culturally safe and do not effectively promote and deliver health promotion programs that improve health literacy.

Availability of public health services: Strict eligibility criteria and long waiting lists are associated with HHS oral health services where demand exceeds supply. There is no state-wide policy for prioritisation of Aboriginal and Torres Strait Islander peoples although evidenced to be of the highest need.

Poverty: *"More than two in five Aboriginal and Torres Strait Islander peoples over the age of 15 defer or avoid dental care due to cost"*[5] ACCHOs describe a high demand for affordable dental services, particularly by the 'working poor' who are not eligible for public services.

Aboriginal and Torres Strait Islander health literacy: ACCHOs support health literacy; however, there is a need for dedicated, effective, focussed oral health literacy[7].

4.1. Geographical location and distribution of dentists

People living in regional and remote areas of Australia generally have poorer oral health than those living in major cities[8]. Oral health status generally declines as remoteness increases. People living in rural areas have access to fewer dental practitioners than their city counterparts, which, coupled with longer travel times and limited transport options to services, affects the oral health care that they can receive as well as health outcomes.

Research into the distribution of dentists in Australia from 2020 has revealed that all regions outside major cities have a population cohort with dentist to population ratios below the 65 dentists per 100,000 benchmark, conservatively estimated to be the minimum required for reasonable access to services[8, 9]. Additionally, within major cities there are fewer dentists per capita in the lower socio-economic districts[9]. The data shows an inequity in the distribution of dentists relative to the socio-economic profile and geographic location of the Australian population. This is particularly relevant when looking at oral health within Aboriginal and Torres Strait Islander peoples, as the largest percentage of First Nations residents reside in low socio-economic areas within major cities or in remote areas.

According to the Australian Institute of Health and Welfare, between 2013 – 2016, approximately 0.2% of the total dental workforce in Australia identified as Aboriginal and/or Torres Strait Islander[8]. The National Health Workforce Data set 2021 showed that there was a total of 16,574 registered dentists in Australia in 2021,

Provision of and access to dental services in Australia

of these 111 identified as Aboriginal and/or Torres Strait Islander (0.7%)[10]. In 2019 the number of dentists employed in Aboriginal Health Services across Australia was 360 (2.4%). However, the number of registered dentists living remote or very remote was 251 (1.6 %)[10]. This indicated that a large proportion of dentists practicing in remote areas are not residing in these areas hence they are likely to be fly-in-fly-out (FIFO).

The above data indicates that being Aboriginal and Torres Strait Islander and living in rural and remote areas are significant risk factors for presenting with poorer oral health compared to being non-Indigenous Australian and living in major cities. ACCHOs in Queensland highlight the importance of investing in preventative oral health programs, designed for community, to promote oral health from an early age. These programs should be facilitated by trusted community entities.

Additionally, regardless of where people live there is low access to an Indigenous identified dentist in Australia. This indicates issues regarding the education system and pipelines for this profession. This lack of dentists available for Aboriginal and Torres Strait Islander peoples significantly contributes to the gap in health.

People living in remote areas are often required to travel long distances to access services, particularly specialist services. Recent research has identified transport to, and cost of services continue to be amongst the main reasons Aboriginal and Torres Strait Islander peoples avoid accessing care[11]. Many rural and remote communities do not have ongoing and adequate transport options to assist people from remote communities to seek dental care and the transport available is often perceived as costly[11]. While government subsidies are available to pay for travel and accommodation costs incurred by Aboriginal and Torres Strait Islander people when travelling to access healthcare, people may be required to pay up front costs, and not all associated costs may be covered[12].

By combining cultural safety, comprehensive care model and bulk billing services provided by ACCHOs, Aboriginal and Torres Strait Islander peoples often prefer ACCHOs for relevant health care. However, due to a variety of barriers, many ACCHOs are unable to provide dental services in their clinics.

4.2. Dental services through ACCHOs

Due to the Model of Care in ACCHOs, they continue to be the most appropriate point of care for Aboriginal and Torres Strait Islander peoples. In January 2019, QAIHC conducted a Member Service Survey on Dental Services within the ACCHO Sector in Queensland. Fifteen Member services responded through a survey questioning practices, numbers, enablers and barriers to providing dental services. According to this survey, most ACCHOs provide a limited amount of oral health promotion to their clients. In most cases this service was provided when completing the Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715). Some ACCHOs participating in the survey were able to run successful dental services for adults and children. However, the majority of these were located relatively close to a major city. The practice models used for dental services within the ACCHOs varied depending on historical and current funding agreements, availability of equipment, availability of space and MBS Item 715 funding. ACCHOs' relationship with Queensland Health Dental Services, universities and private suppliers also influenced models. Consistent feedback from the survey was that the operation and funding of oral health services were a barrier, making it

Provision of and access to dental services in Australia

difficult to provide dental services for their communities. The majority of ACCHOs participating in the survey (83.33%) provided dental services free of charge to their Aboriginal and Torres Strait Islander clients with funding coming predominately from a combination of Medicare and self-funding. Only three ACCHOs mentioned that they were funded through Queensland Health/Department of Health. However, funding from the government is predominately activity based, hence why ACCHOs need to meet certain targets to receive the funding. This stream of funding does not take into consideration if the ACCHOs provide services above their funding target, nor does it cover the infrastructure and additional resources that are associated with providing dentistry services.

The majority of the ACCHOs providing dental services were only able to provide certain services such as general checkups, root canal treatment, extractions, children's dentistry, and X-rays. Whereas nonessential services such as mouth guards, whitening, veneers, splints etc. are less common. This highlights issues of equal access to elective health care services. Additionally, due to the funding scheme, ACCHOs in Queensland were not able to provide preventative oral health programs for the community. This is despite it being well known that a large percentage of Aboriginal and Torres Strait Islander peoples suffer poor oral health from an early age.

Many medical clinics, including ACCHOs in rural and remote areas struggle to get and maintain adequate workforce in their services, resulting in people in remote communities relying on FIFO services. Investment in a sustainable workforce to facilitate access is urgently needed to address the lack of provision and access to dental services, particularly in remote areas.

Most Aboriginal and Torres Strait Islander people are reliant on mainstream services, which are often associated with both high costs and a level of institutional racism leading to avoidance of care.

By investing in ACCHOs and preventative health programs co-designed, implemented and facilitated through ACCHOs, the incidence and prevalence of Aboriginal and Torres Strait Islander peoples experiencing poor oral health will decrease, resulting in a lower burden on the acute oral health care system. Additionally, investments in effective and accessible oral health care services will contribute to Closing the Gap. However, to allow for this, care must be structured and accessible. This can only be made possible through significant and sustained funding to community-controlled organisations.

4.3. Cultural safety of services – institutional racism

Restricted access to public services, including dental services is a consistent issue experienced by Aboriginal and Torres Strait Islander peoples. Studies indicate that barriers include: actions undertaken by Australian governments since colonisation; continued systemic and interpersonal discrimination and racism; mistrust in governments, workplaces and mainstream healthcare; and a decrease in self-confidence and self-esteem among Aboriginal and Torres Strait Islander peoples. This contributes both directly and indirectly to significantly limiting the access to and provision of health care services. This has resulted in a significant health burden amongst this population group[13]. Data reveals a significant underutilisation of dental services among Aboriginal and Torres Strait Islander peoples compared to non-Indigenous[14]. Additionally,

Provision of and access to dental services in Australia

intergenerational trauma has resulted in dental phobia, again contributing to poor oral health amongst the Aboriginal and Torres Strait Islander population.

ACCHOs are trusted health organisations that provide culturally safe, trauma informed health services tailored to Aboriginal and Torres Strait Islander peoples. Hence ACCHOs would be the best placed to provide oral health services.

Addressing all forms of racism in government and other mainstream organisations, and rebuilding trust with Aboriginal and Torres Strait Islander peoples may improve confidence and access to healthcare, including oral healthcare provision.

The need to identify and eliminate institutional racism within mainstream organisations both private and public is recognised under Priority Reform 3 of the National Agreement on Closing the Gap, *Transforming Government Organisations*[1]. However, QAIHC is concerned about the progress toward implementation of this priority reform, noting that the Annual Data Report released by the Productivity Commission in July 2022 states progress on priority reforms cannot yet be reported and developing measures to report on progress is currently in early stages[15, 16]. This is further reflected in the Closing the Gap Implementation Tracker, which provides no information on the progress toward achieving Priority Reform 3.

QAIHC acknowledges that the Commonwealth Government, to assist in Closing the Gap, has developed workforce strategies with the goal to increase the prevalence of Aboriginal and Torres Strait Islander people across all health disciplines to reflect the population[17].

As most dentist services are performed by non-Indigenous Australians, cultural capacity training needs to be developed and mandatory for all staff. Under Priority Reform 3 in the National Agreement of Closing the Gap clause 59 states, *“The Government Parties commit to implement the following transformation elements within government mainstream institutions and agencies”*[1]. This includes embedding and practicing meaningful cultural safety, which recognise Aboriginal and Torres Strait Islander people’s strength in their identity as a critical protective factor[1]. To allow for this, ongoing cultural awareness training courses for all boards and staff should be introduced. The training should be developed and delivered in partnership with Aboriginal and Torres Strait Islander organisations, communities, and people.

The importance of cultural training to reduce racism in the mainstream system as well as having an appropriate representation of identified staff across disciplines, including dental services, is recognised in many strategies including the National Agreement, Making Tracks Together, and Unleashing the Potential, the National Health Reform, the System Strengthening Plan, the 10-year Plan and the National Aboriginal and Torres Strait Islander Health Workforce Plan 2021-2031[18].

4.4. Availability of public health services

Some people can receive free public oral health services through Hospital and Health Services (HHS). The eligibility criteria for adults for free public oral services includes being eligible for Medicare and receiving benefits from a concession card. For children to be eligible for free public oral health services they must be a resident, be eligible for Medicare and meet at least one of the following criteria: be aged four years or older; have not completed Year 10; be eligible for the Medicare Child Dental Benefits Schedule; be referred by

Provision of and access to dental services in Australia

community child health nurse; hold, or be listed as a dependent on, a valid Centrelink concession card; or be in out of home care. If eligible, long waiting lists are still associated with HHS oral health services where demand exceeds supply[19].

A data analysis of Queensland from June 2022 (most recent available) confirms 75% of people on average have been waiting within the acceptable timeframe, however only 41% of people have been treated within the acceptable timeframe for their assigned priority[19]. Please see below table for filtered data.

Table 2: Shows the average percentage of people who have been waiting and seen within the acceptable timeframes as per their category.

Category	Waitlist within an acceptable wait timeframe	Seen in an acceptable timeframe.
Clinical Assessment	54%	26%
General	97%	70%
Priority 1	47%	19%
Priority 2	66%	21%
Priority 3	87%	59%
General Anaesthetic Category 1	36%	8%
General Anaesthetic Category 2	40%	13%
General Anaesthetic Category 3	76%	44%

It is important to highlight that the acceptable timeframes are wide considering the number of people eligible for public dental support. However, when data is filtered it becomes evident that people needing dental support exceed HHS's capacity, leading to people waiting for oral health support and treatment for more than 4 years depending on their issues/needs[19].

Although there is no available data showing waiting times between race, research suggests Aboriginal and Torres Strait Islander peoples in general wait longer for treatment compared to non-Indigenous Australians. At present, there is no state-wide policy for prioritisation of Aboriginal and Torres Strait Islander peoples, although evidenced to be of the highest need.

4.5. Poverty

ToR A: the experience of children and adults in accessing and affording dental and related services;

ToR B: the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;

ToR D: the provision of dental services under Medicare, including the Child Dental Benefits Schedule;

On all standard indicators of poverty and disadvantage, Aboriginal and Torres Strait Islander peoples continue to be the most deprived population group in Australia. Approximately one in three Aboriginal and Torres Strait Islander households have income poverty, significantly affecting their ability to access health care[20]. The prevalence of Aboriginal and Torres Strait Islander peoples living in poverty is significantly higher in remote

Provision of and access to dental services in Australia

and very remote areas. Today it is estimated that 54% of Aboriginal and Torres Strait Islander peoples living in remote and very remote areas live in poverty[21].

Limited access to finance and transport is often cited in the literature as the main barrier to engaging in health care services, including dental healthcare. Limited finances, amongst a large percentage of Aboriginal and Torres Strait Islander peoples, have resulted in patterns of dental service use to address pain rather than preventative health practices[22].

Medicare offers rebates for both children and adults to access dental care in certain scenarios. To be eligible, children must be between two and 17 years old, be eligible for Medicare and they or a parent must receive an eligible Centrelink payment, such as the Family Tax Benefit A. The benefits are capped at \$1,052 per child every two calendar years, which may not be adequate for someone with complex needs[23]. This is inadequate for children experiencing poor oral health due to the high cost of oral health services. Adults can also be covered if they fulfil certain eligibility criteria related to holding a concession card. However, out-of-pocket costs are often still required[2], which many Aboriginal and Torres Strait Islander people are unable to afford/prioritise. The eligibility criteria for concession cards are stringent as they are often based on income[24]. Household income should not be the only indicator of poverty as this makes most employed people ineligible for a concession card and therefore unable to access the public system for dental care. Most people, including Aboriginal and Torres Strait Islander peoples, are reliant on the private market for dental services which are often perceived as unaffordable.

When visiting oral health services, clients pay per service provided rather than per hour. This means that dental services are an unknown cost, leading people with limited income to avoid services.

Private health insurance providers often cover parts of dental care. Among people in non-remote areas, 20% of Indigenous adults had private health insurance in 2012–13, compared with 57% of all Australian adults. The most common reason that Indigenous Australians did not have private health insurance was that they could not afford it (72%)[2].

4.6. Aboriginal and Torres Strait Islander health literacy:

Specific data on the health literacy of Aboriginal and Torres Strait Islander peoples is scarce, with no national data. A known social health literacy gradient exists, linking low health literacy and poor health outcomes in many Australian minority populations [25, 26]. Nationwide, low health literacy was reported amongst 59% of Australian adults[26]. Network models have captured the dynamic relationships between oral health literacy and psychosocial, sociodemographic and oral health-related factors[27]. A study from 2020 found that for participants with low oral health literacy, self-rated oral health appears as a mediator in the pathway between oral health-related quality of life, oral health literacy, perceived stress, and oral health-related self-efficacy[27]. Although there is no national data on the oral health literacy levels of Indigenous Australians, several factors put this population at higher risk of presenting poor oral health literacy[27, 28]. In addition to cultural and linguistic particularities, the socio-economic disadvantage that Aboriginal and Torres Strait Islander peoples face in areas such as education, income and employment are relevant indicators of low levels of oral health literacy[28].

Provision of and access to dental services in Australia

ACCHOs would be the best point of education for Aboriginal and Torres Strait Islander communities to improve health literacy, including oral health literacy. Although ACCHOs do support health literacy, there is a need for dedicated, effective, focused oral health literacy which requires additional funding and resources.

Improving health literacy among Aboriginal and Torres Strait Islander Australians is an important way to support self-determination and autonomy in both individuals and communities, by enhancing knowledge we are improving health outcomes contributing to Closing the Gap.

5. Closing the gap.

ToR E: the social and economic impact of improved dental healthcare

Poor oral health is proven to have a significant impact on individual health. Outcomes include chronic pain, infection, difficulty eating and poor nutrition, mental health and wellbeing issues, and sleep disruptions. It can create additional complications in chronic health conditions such as diabetes and kidney disease[29, 30]. Research suggests people suffering from poor oral health have a higher risk of developing certain health complications[31]. The diseases linked to poor oral health are of high prevalence in Aboriginal and Torres Strait Islander populations. Additionally, poor dental health can in turn limit success in employment outcomes[32]. Studies have found that poor oral health is significantly impacting quality of life, contributing to stress, financial challenges and at times affecting physical health, further widening the gap.

People living in remote and very remote areas are more likely to smoke and drink at risky levels. Additionally, they have reduced access to fluoridated drinking water and face increased costs for healthy food choices and oral hygiene products. These risk factors contribute to this population's overall poorer oral health[8].

Addressing access to appropriate and culturally safe dental services and resources for Aboriginal and Torres Strait Islander peoples has the potential to improve both social and economic determinants and thereby help in Closing the Gap. To do so, new policies addressing inequity in oral health and access to health services must be addressed. This includes more investment into oral health services for Aboriginals and Torres Strait Islanders to address poor provision and access to preventative services, general check-ups, treatment services and electives. To ensure people are treated holistically, investments into ACCHOs to facilitate clinical and preventative oral health services is essential.

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Provision of and access to dental services in Australia

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