February 2025

Position Statement

QAIHC
Queensland Aboriginal and Islander Health Council

Oral health in Queensland

This statement outlines the Queensland Aboriginal and Islander Health Council (QAIHC)'s position on oral health for Aboriginal and Torres Strait Islander peoples.

The statement outlines the following considerations:

- **The context of oral health care for Aboriginal and Torres Strait Islander people**
- **Barriers to accessing oral health services**
- **Broader policy guidance**
- **Role of ACCHOs**
- **Recommendations.**

Summary

This Position Statement recommends dental checks, basic dental treatment, emergency dental treatment and oral hygiene/prevention as a core component of primary health care service provision within Aboriginal Community Controlled Health Organisations (ACCHOs) in Queensland.

QAIHC 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.

QAIHC supports the Statewide Oral Health Services Plan 2024-2032 (the Plan) but calls on the Queensland Government to prioritise oral health services for Aboriginal peoples and Torres Strait Islanders who are unable to access private dental services.

Context

Oral health for Aboriginal peoples and Torres Strait Islanders is a crisis issue in urgent need of strategic and comprehensive attention. Before colonisation, Aboriginal peoples had good oral health with minimal oral disease. Today, poor oral health is common for many Aboriginal and Torres Strait Islander people with multiple caries and untreated dental disease, and inability to receive preventive dental care. Broad contributing factors include:

- Poorer access than other Australians to oral health services due to lack of services or cost barriers;
- Preexisting chronic disease such as diabetes (which enhances predisposition to periodontal disease);
- Social factors such as food insecurity, and lower household incomes than other Australians.

Nationally, Aboriginal and Torres Strait Islander adults have greater levels of dental caries than non-Aboriginal and Torres Strait Islander Australians, with higher levels of untreated caries and missing teeth and lower numbers of filled teeth.[1] In children the number of both deciduous (first) and permanent (adult) teeth with caries experience (that is, teeth that have past and/or present caries) is about twice the number than in non-Aboriginal and Torres Strait Islander children. The proportion of untreated dental caries is also higher among Aboriginal and Torres Strait Islander children which often reflects a lack of access to dental services.[2]

Best practice standards recommend annual oral health review, including assessment of teeth, gums and oral mucosa.[3] However, data from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey showed that only 58% of Aboriginal and Torres Strait Islander children aged 0–14, and even fewer adults (36%) had seen a dentist in the last 12 months.[4]

1 AIHW 2007. Australia's dental generations. The National Survey of Adult Oral Health 2004–06.
2 Armfield JM, Jamieson L, Roberts-Thomson KF. AIHW 2007. Oral Health of Aboriginal and Torres Strait Islander Children. ISSN 1321-0254; ISBN-13 978 1 74024 618 7.
3 National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners. National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 3rd edn. East Melbourne, Vic: RACGP, 2018
4 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey [Internet]. Canberra: ABS; 2018-19 [cited 2024 October 3]. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release.

Contributing factors

Nutrition and food insecurity

Diet is one of the primary determinants of dental caries formation. The loss of traditional lands and hunter-gatherer lifestyle led to a rapid change to a poorer diet for generations of Aboriginal and Torres Strait Islander people.[5] Poor diet is linked to five of the seven leading risk factors contributing to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians – obesity, high blood cholesterol, alcohol, high blood pressure, and low fruit and vegetable intake.[6]

The nutrition burden among Aboriginal and Torres Strait Islander adults is underscored by both over-nutrition (over-consumption of unhealthy 'discretionary' foods) and under-nutrition (dietary deficiencies related to inadequate intake of healthy foods).[7] Few met dietary recommendations for healthy foods, with 39% aged over 15 years consuming the recommended daily amount of fruit and 4.2% of recommended daily amount of vegetables.[8] In addition, 41% of reported daily energy intake was derived from unhealthy 'discretionary' foods and drinks that are high in saturated fat, added sugar, salt and/or alcohol.[8]

A balanced diet from a variety of foods provides the range of nutrients needed for good oral health. Studies consistently demonstrate that a diet high in fruit and vegetables is associated with a reduced risk of oral health issues.[5] 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.

Food insecurity and issues of not having access to affordable, quality, healthy foods play a significant role to an individual's diet and nutrition, and consequently their oral health. Aboriginal and Torres Strait Islander people living in remote communities in particular face significant challenges with food security.[9] Due to the difficult trading environment, most remote community stores cannot purchase items at volumes that allow them to negotiate for better wholesale prices resulting in higher-than-average food and grocery prices compared to other parts of the country.[9] In addition, their supply chains for foods, particularly perishable foods like fruits and vegetables, are often severely affected by seasonal weather conditions and the cold chain cannot be guaranteed causing the food to spoil.[9]

Diabetes

There is a well-established link between diabetes and advanced gum disease (periodontitis) with diabetes worsening both the severity and progression of periodontal diseases.[10] There are already disproportionately high levels of diabetes in Aboriginal and Torres Strait Islander people, with an estimated 13% of adults with diabetes or high sugar levels in 2018-19. This proportion increases in age from 0.8% in those aged 18-24 years old, to over one-third in those aged 55 and over (36%).[11]

Smoking

Smoking is the leading modifiable risk factor contributing to the burden of disease for Aboriginal and Torres Strait Islander people with this population 2.9 times more likely to be a current smoker compared to non-Indigenous Australians (after adjusting for differences in age structure).[12] An estimated 14% of periodontitis is attributed to smoking,[13] with more teeth and sites in the mouth affected in smokers compared to non-smokers.[14]

5 National Health and Medical Research Council. Nutrition in Aboriginal and Torres Strait Islander peoples: an information paper. Canberra: National Health and Medical Research Council, 2000.
6 Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. (Australian Burden of Disease Study series no. 6, Cat no. BOD 7) Canberra: Australian Institute of Health and Welfare, 2016
7 Lee A, Ride K. Review of nutrition among Aboriginal and Torres Strait Islander people. Australian Indigenous HealthBulletin. Feb 2018; 18(1).
8 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework. Tier 2: 2.19 – Dietary behaviour AIHW: Australian Government. Aug 2024.
9 The Parliament of the Commonwealth of Australia. Report on food pricing and food security in remote Indigenous communities. Nov 2020. Canberra.
10 Ghanem AS, Nagy AC. Oral health's role in diabetes risk: a cross-sectional study with sociodemographic and lifestyle insights. Front Endocrinol (Lausanne). 2024 Mar 7:15:1342783. Doi 10.3389/fendo.2024.1342783.eCollection 2024.
11 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework. Tier 1: 1.09 – Diabetes. AIHW: Australian Government. Aug 2024.
12 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework. Tier 2: 2.15 – Tobacco use. AIHW: Australian Government. Aug 2024.
13 Leite FRM, Nascimento GG, Scheutz F, and Lopez R. Effect of smoking on periodontitis: A systematic review and meta-regression. American Journal of Preventive Medicine, 2018; 54(6):831-41. Available from: https://www.ncbi.nlm.nih.gov/pubmed/29656920
14 Billings M, Parascandola M, Iafolla T, and Dye BA. Data visualization of the relationship between smoking and periodontal site-specific effects across the lifespan in the U.S. adult population. Journal of Periodontology, 2020. Available from: https://www.ncbi.nlm.nih.gov/pubmed/33251598

Poor oral hygiene and health literacy

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,[15] 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 and Torres Strait Islander communities.

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.[16]

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.[16]

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 toothbrushes, tooth paste and dental floss. These health promotion responses must take place within the holistic framework that ACCHOs offer so the broader social influences on oral health can also be addressed.

Water fluoridation

Fluoride occurs naturally in all Australian water supplies, but generally at levels that are too low to help prevent or reduce tooth decay.[17] Water suppliers in Australia can adjust the amount of fluoride to a level that can prevent tooth decay in a process called water fluoridation. Water fluoridation has long been recognised as a safe and cost-effective public health measure for preventing dental caries in the Australian population, particularly in rural and low-income areas.[18]

Water fluoridation is a population-wide investment. For every dollar that is spent on fluoridation in Australia, between $7 and $18 is saved due to avoided treatment costs, with one Victorian community reportedly saving around $1 billion over a 25-year-period through avoided costs from dental treatment and absenteeism for work and school.[19]

Queensland has the lowest water fluoridation coverage in the country, with a dramatic reduction in coverage after the 2012 Queensland Government decision to overturn mandatory water fluoridation for all communities with more than 1000 people.[18] Now, the decision on water fluoridation of town water supplies is a local government responsibility. While approximately 72% of Queenslanders receive fluoridated drinking water,[20] there are 50 local government areas that lack water fluoridation.[21] These areas are predominately in rural and remote regions of Queensland with high populations of Aboriginal and Torres Strait Islander people.

The lack of water fluoridation in Aboriginal and Torres Strait Islander communities acts to perpetuate and worsen existing oral health inequities. Adding fluoride to water is the most effective way of providing oral health benefits to the entire community.[3]

Consequences of oral health problems

Physical health

An obvious consequence of poor oral health is the loss of teeth due to gross dental caries, advanced periodontal disease, and trauma. Approximately a quarter of Aboriginal and Torres Strait Islander people aged 55 and over have complete tooth loss, with higher rates in those with more chronic health conditions, lower incomes and education attainment.[22] The loss of teeth can limit diet, particularly

15 Kay E and Locker D. 1997. Effectiveness of oral health promotion: A review. Health Promotion Effectiveness reviews. No. 7 London Health Education Authority pp X1 – 11.
16 Armfeld JM, Chrisopoulos S, Peres KG, Roberts-Thomson KF & Spencer AJ 2016. Australian children's oral health behaviours. In: Do LG & Spencer AJ (eds). Oral health of Australian children: the National Child Oral Health Study 2012–14. Adelaide: University of Adelaide Press.
17 National Health and Medical Research Council (NHMRC). Information paper – Water fluoridation: dental and other human health outcomes, report prepared by the Clinical Trials Centre at University of Sydney, NHMRC; Canberra, 2017.
18 Senevirathna L, Ratnayake HE, Jayasinghe N, Gao J, Zhou X, Nanayakka S. Water fluoridation in Australia: a systematic review. Environ Res. 2023 Nov 15;237(Pt 1):116915.doi: 10.1016/j.envres.2023.116915.Epub 2023 Aug 18.
19 National Health and Medical Research Council (NHMRC). Water fluoridation and human health in Australia: Questions and answers, NHMRC; Canberra, 2017.
20 Queensland Health. Water fluoridation. Last updated 29 Nov 2021. Available from: https://www.health.qld.gov.au/public-health/industry-environment/environment-land-water/water/fluoridation
21 Health and Environment Committee. Health and Other Legislation Amendment Bill 2022: Public Briefing 16 December 2022 – Responses to Questions on Notice. 16 Dec 2022.
22 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework. Tier 1: 1.11 – Oral health. AIHW: Australian Government. Aug 2024.

hard-to-chew foods (e.g. fresh fruits, vegetables, meat and wholegrain foods) and contribute to poor nutrition.[7]

Poor oral health has also been linked to higher rates of chronic diseases, including diabetes,[23] as well as increasing the risk of infective endocarditis complicating rheumatic heart disease.[24] There is a correlation between people with severe rheumatic heart disease and poor oral health, so maintaining good oral health and hygiene is likely to have a greater positive impact on this group than other strategies like antibiotic prophylaxis during dental procedures.[24, 25]

Social and emotional wellbeing

Oral health is a major determinant of social and emotional wellbeing, and poor oral health can create a situation where the overall health of a person is compromised. Loss of teeth, significant decay and related halitosis can interfere with social interactions, reduce self-esteem and lead to psychological disorders like anxiety and depression.26 Poor oral health can accelerate social isolation, given the mouth is vital for both verbal and non-verbal communication.[27]

Barriers to accessing oral health services

An estimated 19% of Aboriginal and Torres Strait Islander people did not go to see a dentist when they needed to in the last 12 months.[22] There are numerous barriers to access oral health services, particularly for those in rural and remote areas.

Geographic barriers

There are reportedly 43% of Aboriginal and Torres Strait Islander people living in regional Australia, and 21% in very remote areas – locations with limited local dental health services and transport options.[28] Dental health services in these regions face further challenges with shortages of dental personnel, high staff turnover and an associated lack of cultural competency training within their dental workforce leading to treatment delays and increased emergency department presentations for symptom relief.[29]

Financial barriers

Free public dental services are delivered to eligible Queensland residents with concession cards (aged pension, Seniors card, Health Care card) and their dependants under the Queensland Oral Health Scheme.[30] These services include appointments for check-ups, preventative care, fillings, accidents and emergencies.[31] These include adults and children aged 4 years and older who have not completed year 10 at school, or are listed as a dependant, or eligible for the Child Dental Benefits Schedule (CDBS) funded by the Australian Government. Public dental services can be accessed through hospital and health services.[32]

The CDBS provides up to $1,052 in rebates (over 2 calendar years) for the provision of dental services to children. Services include basic dental care in either a public or private setting including dental examinations, x-rays, cleaning, fissure sealing, fillings, root canal treatments and extractions. Children must be aged 0 to 17 years with eligibility criteria such as a parent in receipt of a Centrelink payment. The CDBS services can only be claimed by registered dental practitioners.[33]

Despite these concessions and rebates, the majority of Aboriginal and Torres Strait Islander people pay for dental

23 Guo D, Shi Z, Luo Y, Ding R, He P. Association between oral health behavior and chronic diseases among middle-aged and older adults in Beijing, China. BMC Oral Health. 2023 Feb 14;23(1):97. doi:10/1186/s12903-023-02764-y.

24 Wilson W, Taubert KA, Gewitz M, et al. Prevention of infective endocarditis: guidelines from the American Heart Association: a guideline from the American Heart Association Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee, Council on Cardiovascular Disease in the Young, and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and the Quality of Care and Outcomes Research Interdisciplinary Working Group. Circulation 2007; 116(15): 1736-54 https://doi.org/10.1161/CIRCULATIONAHA.106.183095

25 RHDAustralia (ARF/RHD writing group). The 2020 Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (3.2 edition, March 2022); 2020.

26 Jamieson LM, Paradies YC, Gunthorpe W, Cairney SJ, Sayers SM. Oral health and social and emotional well-being in a birth cohort of Aboriginal Australian young adults. BMC Public Health. 2011 Aug 19;11:656. doi: 10.1186/1471-2458-11-656.

27 Koyama S, Saito M, Cable N, Ikeda T, Tsuji T, Noguchi T et al. Examining the associations between oral health and social isolation: A cross-national comparative study between Japan and England. Soc Sci Med. 2021 May;277:113895. doi: 10.1016/j.socscimed.2021.113895. Epub 2021 Apr 18.

28 Australian Government. Healthy mouths healthy lives: Australia's National Oral Health Plan 2015-2024. Adelaide 2015.

29 Tynan A, Walker D, Tucker T, Fisher B, Fisher T. Managing oral health care and prevention: the experience of Aboriginal and Torres Strait Islanders living in a rural community in Queensland, Australia. Aust J Rural Health. 2022 Apr;30(2):228-237. doi: 10.1111/ajr.12853. Epub 2022 Feb 23.

30 Queensland Government. Public dental services. 2022 Mar 22. Updated 2024 Apr 8. Available from: https://www.qld.gov.au/health/services/oral-eye-ear/dental-services

31 Queensland Government. Queensland budget 2024-2025. 2024 Jun 11. Available from: https://budget.qld.gov.au/files/Budget_2024-25_Cost_of_Living_Action.pdf

32 Queensland Government. Public dental services. Op. cit. https://www.qld.gov.au/health/services/oral-eye-ear/dental-services

33 Department of Health and Aged Care. Guide to the Child Dental Benefits Schedule (CDBS). Version 12. 2024 Jan 1.

services through their own private health insurance.[22] There are no funded dental services for adults who are not concession card holders but are unable to afford private dental care such as the 'working poor'.Even if a dental service is provided with no fee, there are often indirect costs of attending these services including transport costs, the cost of taking time away from employment to attend for themselves or family members, and the costs of oral hygiene products to prevent oral disease.[30, 34]

The higher need and poorer access to public and private dental services experienced by Aboriginal and Torres Strait Islander people is not adequately recognised by State and Federal systems. There are also limited efforts to prioritise access to public dental care for Aboriginal and Torres Strait Islander people.

State and Federal funding for oral health also focuses on direct dental care, and disregards the importance of upstream approaches to oral health, including co-design of community-based education campaigns and promoting fluoridation of local reticulated water supplies.[35]

The lower access to dental care in Aboriginal and Torres Strait Islander children, especially younger children, warrants innovation and policy reform.[36] The CDBS, in particular, could be improved by expanding items to other early childhood health professionals and recognising the higher costs of delivering services in rural and remote areas through the introduction of a rural loading to the items or through another mechanism to incentivise rural services and ensure equitable expenditures.[37]

Studies have shown early oral health screening by non-dental professionals to be effective in the prevention of early childhood caries.[38] However, access to CDBS items are restricted to dental practitioners (dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists). The expansion of these items, particularly screening and preventative oral care services, to Aboriginal and Torres Strait Islander Health Practitioners, speech pathologists and other early childhood health professionals in the ACCHO sector would improve the reach of these services to more Aboriginal and Torres Strait Islander children.[37]

The ACCHO sector's role in improving Aboriginal and Torres Strait Islander oral health would be strengthened by the development of transparent, long-term funding solutions that respond to local community needs, with recognition of the higher costs of delivering services in rural and remote areas.

Cultural safety

Other systemic barriers to optimal oral health care include language and cultural barriers, lack of culturally appropriate services and personal and historical experiences of systemic and interpersonal racism. These factors play a large role in reducing access to dental services for Aboriginal and Torres Strait Islander people.[37]

Key policy documents, like the National Aboriginal and Torres Strait Islander Health Plan[39] and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework,[40] outline the clear benefits for Aboriginal and Torres Strait Islander people being cared for by Aboriginal and Torres Strait Islander health staff. However, there is very low representation of Aboriginal and Torres Strait Islander dental staff and there is a need to build up this workforce to assist in providing culturally safe and effective care.

Broader policy guidance

The National Agreement on Closing the Gap was signed in July 2020 by the Australian Government, all state and territory governments and the Coalition of Peaks.[41] The aim of the National Agreement is to overcome the inequality experienced by Aboriginal and Torres Strait Islander people

34 Tynan A, Walker D, Tucker T, Fisher B, Fisher T. Factors influencing the perceived importance of oral health within a rural Aboriginal and Torres Strait Islander community in Australia. BMC Pub Health. 2020 Apr 17; 20 (514). doi: 10.1186/s12889-020-08673-x.

35 Lalloo R, Kroon J. Impact of dental National Partnership Agreements on public dental service waiting lists in Queensland. Aust N Z J Public Health. 2017 Apr;41(2):199-203. doi: 10.1111/1753-6405.12575. Epub 2016 Sep 13.

36 Stormon N, Do L, Sexton C. Has the Child Dental Benefits Schedule improved access to dental care for Australian children? Health Soc Care Community. 2022 Nov;30(6):e4095-e4102.

37 NACCHO. Provision of and access to dental services in Australia: submission to select committee. 2023 Jun. Canberra.

38 Heilbrunn-Lang AY, Carpenter LM, de Silva AM, Meyenn LK, Lang G, Ridge A. Family-centred oral health promotion through Victorian child-health services: a pilot. Health Promot Int. 2020 Apr 1;35(2):279-289. doi: 10.1093/heapro/daz025.

39 Department of Health and Aged Care. National Aboriginal and Torres Strait Islander Health Plan 2021-2031. 2021 Dec 15. Updated 2022 Jun 27.

40 Department of Health and Aged Care. National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031. 2022 Mar 7; Updated 2022 July 7.

41 Australia, Australian Capital Territory, Australian Local Government Association, New South Wales, Northern Territory, Queensland, South Australia, Tasmania, Victoria, Western Australia,Coalition of Aboriginal and Torres Strait Islander Organisations. 2020, National Agreement on Closing the Gap [Department of the Prime Minister and Cabinet], [Barton, Australian Capital Territory] viewed 3 October 2024 http://nla.gov.au/nla.obj-2825246596

so that their life expectancy is equal to all Australians, through the implementation of the four Priority Reforms:

- **Priority Reform 1** – Formal partnership and shared decision making
- **Priority Reform 2** – Building the community-controlled sector
- **Priority Reform 3** – Transforming government organisations
- **Priority Reform 4** – Shared access to data and information at a regional level.

In Queensland, the draft Statewide Oral Health Services Plan 2024-2032 identifies that oral health services are delivered as a hybrid model of public and private services. "Public oral health services are funded by the Queensland Government and the Commonwealth Government, with a focus on providing care to an eligible population. The eligible cohort consists of priority populations, many of whom face geographical and financial barriers which prevent equitable access to oral health services. Universal access to oral health care is not available in Australia and hence the goal of the public oral health system is to meet the health needs of eligible and priority populations."[42]

Aboriginal and Torres Strait Islander peoples have been identified as a priority population as part of this statewide plan, particularly those in rural and remote areas. Direction 1 of this plan is 'Holistic and patient-centric oral health care will be delivered, informed by individual health, cultural and socioeconomic needs of priority populations.' One of the actions to achieve this is to 'establish formal partnerships with relevant stakeholders to develop integrated models of care that incorporate oral health education, prevention and screening with other primary care services.' Improving the resourcing of, and access to, ACCHO dental services and preventative care activities would meet this action.

Role of ACCHOs

Nationally, there are approximately 70,000 ACCHO dental-service client contacts provided by around 140 paid dentists and dental support staff, of whom around 60 were Aboriginal and/or Torres Strait Islander. There were also around 40 unpaid staff who also provided dental services.[36]

In January 2019, QAIHC conduced a Member Service Survey on Dental Services within the ACCHO Sector in Queensland with 15 responses from member services. The majority of respondents (83%) 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. Due to this funding scheme, however, ACCHOs were only able to provide certain services (e.g. general checkups, root canal treatment, extractions, children's dentistry and x-rays) with limited funds for preventative oral health programs in the community.

Three services received funds through the Queensland Health/Department of Health however, these funds were predominantly activity-based with certain targets needing to be met to receive the funding. Funding did not take into consideration if the ACCHOs provided services above their funding target, nor did it cover the infrastructure and additional resources that were associated with providing dentistry services.

Oral health has always been considered a core part of comprehensive primary health care, so many ACCHOs have maintained the provision of dental services. However, inconsistent partnership and inadequate government funding places ACCHOs in a financially vulnerable position with limited or no capacity to meet community demand. In responding to community need, many ACCHOs have implemented short-term solutions including self-funding oral health services, purchasing time from private providers, applying for grant funds to pilot models of service, and transporting patients to larger services with dental services. While useful, none of these solutions are adequate or sustainable to meet the needs of a community.

Oral health is vital for the prevention of chronic disease, and ACCHOs can lead the way to ensure equitable access to oral health services. Collaboration and funding is needed to embed oral health services in ACCHOs around the state. Embedding oral health services will provide a return on investment through the early detection of chronic disease, reducing rates of preventable hospitalisations, and reducing the impacts of systemic and interpersonal racism. Please see the Appendix: *Oral Health Case Studies* for examples of oral health services delivered by ACCHOs in Queensland

42 Queensland Health. Draft Statewide Oral Health Services Plan 2024-32. Accessed 3 Oct 2024.

Recommendations

QAIHC recommends:

1. Any interventions to address oral health be implemented in accordance with the National Agreement on Closing the Gap and its four Priority Reform Areas.
2. Integrating oral health services within broader health systems and services, particularly as part of primary health care service provision to Aboriginal and Torres Strait Islander people.
3. Statewide prioritisation of Aboriginal and Torres Strait Islander people for public dental services.
4. Co-design of oral health services with QAIHC and ACCHOs and needs-based funding for ACCHOs to deliver oral health services to Aboriginal and Torres Strait Islander communities.
5. That Hospital and Health Services (HHSs) and/or the Queensland Department of Health negotiate service delivery agreements with ACCHOs in their region to:
    - Prioritise and support Aboriginal and Torres Strait Islander public health dental patients (see Appendix: North Coast Aboriginal Corporation for Community Health (NCACCH) case study demonstrating an effective partnership between the ATSICCHO and Sunshine Coast HHS); and/or
    - Sub-contract Government funding allocations direct to the ACCHO so that these services can offer free dental care to Aboriginal and Torres Strait Islander persons. Existing examples of such agreements include (see Appendix): the Institute for Urban Indigenous Health and the Queensland Department of Health for dental services provision in the IUIH Network catchment.
6. That Queensland Health work with ACCHOs that deliver dental services to develop optimal care pathways for when referral to a specialist dental service or maxillofacial specialist consultation is required.
7. Queensland government to promote the fluoridation of water supplies of towns, cities and Aboriginal communities with more than 1000 people that do not naturally contain a level of fluoride sufficient to prevent dental caries.[8]
8. ACCHOs are resourced to co-design and deliver training to support Aboriginal and Torres Strait Islander Health Practitioners to deliver preventative dental services.
9. Aboriginal and Torres Strait Islander Health Practitioners have access to the Child Dental Benefits Scheme (CDBS) items for fluoride applications and other preventative measures.
10. Increased remote loading for CDBS items to address the higher costs of remote service provision.
11. Development of culturally appropriate oral health promotion material that can be locally tailored and used by ACCHOs to respond to the particular needs within Aboriginal and Torres Strait Islander communities.

1. IUIH

QAIHC
Queensland Aboriginal and Islander Health Council

The Institute for Urban Indigenous Health (IUIH) promotes an integrated model of care which facilitates the delivery of culturally safe oral health services, in conjunction with primary health care services to Aboriginal and Torres Strait Islander families.

IUIH institute for urban indigenous health

History

Prior to 2014, only three South East Queensland ACCHOs offered dental services - ATSICHS Brisbane at its Woolloongabba and Logan clinics, Kalwun Health Service in Miami, and at Kambu's Ipswich clinic (through a part-time arrangement with Queensland Health for Queensland Health Eligible Patients [QHEPs]). In 2014, IUIH opened a dental service in Deception Bay. These ACCHOs provide high quality dental services integrated with comprehensive and culturally responsive primary care, and growth in patient numbers resulted in a need for further planning of dental services across the region.

Services

IUIH is a regional ACCHO that leads planning and development of integrated health and wellbeing services for the Aboriginal and Torres Strait Islander population of South East Queensland (SEQ). IUIH's Member ACCHOs are: ATSICHS Brisbane, Kalwun Health Service (Kalwun), and Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba). IUIH also operates Moreton ATSICHS and the Goodna Clinic.

Yulu-Burri-Ba and Moreton ATSICHS dental services are provided through a service delivery partnership with IUIH. ATSICHS Brisbane and Kalwun continue to manage and operate their respective dental services with support from IUIH.

Services include:

- routine dental checkups and screening with an established recall service
- oral hygiene including scale and cleans
- emergency dental treatment
- fillings and extractions
- dentures, mouth guards and splints
- specialist referrals
- oral health promotional activities including at community events.

Specialty services including oral and maxillofacial surgery, paediatric specialist services and treatments requiring a general anesthetic, are referred to Queensland Health. IUIH continues to build referral pathways with Queensland Health and the private sector.

Opportunities for growth

In 2013, a 'Dental Voucher' scheme was introduced by Queensland Health across Hospital and Health Services (HHSs) in South East Queensland (Metro North, Metro South and West Moreton HHSs). This scheme allowed for registered non-government dental clinics, including ACCHOs, to be recompensed for dental services provided to QHEPs. This scheme presented an opportunity for SEQ ACCHOs, but it also identified some challenges.

The dental voucher system commenced by focusing on QHEPs (Aboriginal and Torres Strait Islander and non-Indigenous) who had been on Queensland Health dental waitlist for greater than 12 months. This did not recognise the high number of Aboriginal and Torres Strait Islander QHEPs who were not on a QH waitlist but who wanted to access dental services under this scheme.

In 2017, in response to this and other challenges, IUIH negotiated with Queensland Health, to 'cash out' dental vouchers across the SEQ region.

This negotiation considered:

- The high number of Aboriginal and Torres Strait Islander patients who meet QH eligibility criteria and who were regular patients of ACCHOs across the region
- The identified community dental need (dental burden of disease)
- The need for improving current and future dental clinic infrastructure
- The impact that the high demand has on staffing numbers and subsequent service delivery capacity.

This 'cashing out' approach enabled a more streamlined dental revenue model, with funding for eligible clients including adult concession card holders and children who were eligible for the Child Dental Benefits Scheme (CDBS). However, there was still no funded dental services for adults who were not concession card holders and unable to afford private dental care i.e. the working poor.

In 2023, supported by Hospital and Health Service of the SEQ First Nations Health Equity partnership, QH Connected Community Pathways (CCP) funding was secured to expand the delivery of dental services across IUIH Network clinics. This funding enabled regional service expansion, including extended general dental care, after-hours services and dental lab capacity across the existing IUIH Network dental clinics. Of particular focus for this expansion has been patients who are not eligible for Queensland Health services but are on low incomes (the working poor).

In 2024 this CCP funding was incorporated into the pre-existing QH funding contract. The combination of funding within one contract from QH enables the delivery of oral health services and increased access to all Aboriginal and Torres Strait Islander people accessing ACCHSs in SEQ. This includes existing clients who were not previously eligible under previous QH & CDBS funding.

The Queensland Health funding agreement, combined with ACCHO contributions, has seen over 50 full-time, part-time and/or casual dental professionals employed across 10 dental clinic sites including:

- Three Senior Dentists/Clinical Supervisors
- 28 Dentists (FT/PT/Casual)
- Five Oral Health Therapists (including OHTs with extended scope of practice)
- A Dental Prosthetist and Dental Technician (employed at ATSICHS Brisbane, with a clinical referral pathway across the IUIH network providing timely access for patients requiring denture services)
- 33 Dental Nurses/Assistants and Dental Receptionists, including three staff who have commenced a full-time dental assistant traineeship at the ATSICHS Brisbane clinics.

Funding model

The IUIH—Queensland Health dental funding agreement is based on a fee for service arrangement whereby activity and outcome measures are agreed.

Dental activity data is collected by Member ACCHOs and submitted to QH through IUIH . Failure to reach identified targets may result in reduced funding received from QH.

Benefits to community

For PATIENTS:

Accessible and culturally safe dental services: for Aboriginal and Torres Strait Islander families that contributes towards improvements in their overall health and wellbeing as well as contributing towards Closing the Gap on health disadvantage.

Changing patients' attitudes towards dental procedures: through positive dental experiences, encouraging regular dental check-ups and good oral health hygiene.

For ACCHOs:

Coordinated care: Oral health services delivered seamlessly in conjunction with primary health care services within ACCHOs ensuring Aboriginal and Torres Strait Islander families receive the best available and coordinated care.

Continual Quality Improvement (CQI): Commitment to CQI through the establishment of a Dental Clinical Governance Framework focusing on best practice in Aboriginal and Torres Strait Islander dental care across the region.

Employment opportunities: with a range of dental professionals employed across the ACCHOs including opportunities for young Aboriginal and Torres Strait Islander people through dental specific traineeships (e.g. dental assistants).

A regional focus: IUIH work with IUIH member services to identify and manage dental infrastructure and service needs.

Shared procurement opportunities: through a regional focus on operational costs and creating opportunities for costs savings through bulk purchasing on behalf of the ACCHO network.

Service delivery partnership: between QH and IUIH.

Challenges

Facility establishment costs: capital works cost for new dental services that are required to meet the growing population.

Attraction & Retention of workforce: in a competitive market to ensure that service delivery continues at full capacity.

Projected population growth: Based on the 2021 census, the SEQ region has the largest and one of the fastest growing Indigenous populations in Australia, with an estimated population in 2024 of around 124,000 Aboriginal and Torres Strait Islander persons and projected to grow to over 150,000 by 2031.[1] Being able to meet the associated growth in demand for dental services without a parallel rate of growth in funding is an ongoing challenge.

Impact

As at June 2024, dental services are provided from 10 clinics within the IUIH network, an increase in site capacity of150per cent since 2014. This increase in dental service capacity has resulted in over 10,000 dental appointments completed in a 12 month period including:

- 3,989 QHEP patients
- 4,978 adult non-QHEPs; and
- 2,238 CDBS eligible children.

ACCHO dental services increase access: for prosthesis, as of June 2024 there is current infrastructure planning to provide two additional dental labs across SEQ (MATSICHS Caboolture and IUIH Goodna clinics). These labs will increase access for clients requiring dentures, mouth guards and splints. This will also alleviate pressure and reduce waitlists for the only existing community controlled lab in operation that services SEQ (ATSICHS Brisbane Woolloongabba).

1 Australian Bureau of Statistics (2011-to-2031), Estimates and Projections, Aboriginal and Torres Strait Islander Australians, ABS Website, accessed 11 November 2024.

2. NCACH

NCACCH
North Coast Aboriginal Corporation for Community Health

"High quality and accessible primary health care"

History

North Coast Aboriginal Corporation for Community Health (NCACCH) is a not for profit, community-controlled health corporation and is funded by the Australian Government's Department of Health (DoH), Country to Coast (PHN) and the Queensland Government Department of Health.

NCACCH is an innovative leader in Aboriginal and Torres Strait Islander healthcare, providing a range of services and programs through its hybrid Brokerage and Aboriginal Medical Service (AMS) model for health service delivery. NCACCH maintains contracts with over 600 primary and allied health professionals across the region.

With the purpose of providing a holistic and comprehensive primary health care service, NCACCH seeks to improve health and social outcomes to our community through:

- Provision of access to a full regional network of health care professionals.
- Encouraging choice for individual Indigenous community members. And through exercising this choice, building cultural sensitivity and inclusiveness across the community while simultaneously promoting market competition between health care service providers as they seek to attract Indigenous clients; and
- Utilising its Aboriginal Medical Service and partnerships with primary healthcare and other specialised services, as a proactive strategy in delivering community wide "Closing the Gap" health status improvement initiatives

Services

NCACCH has developed and implemented a unique Brokerage Model for providing Aboriginal and Torres Strait Islander community members of the Sunshine Coast and Gympie regions with choice and access to a wide range of health care providers.

This model provides most of the benefits of private health insurance without the 'upfront' and 'gap' payments and delivers equitable and efficient access to existing health care services. The Brokerage Model was developed to ensure that each NCACCH client would be assured of having individual choice to determine their own definition of cultural appropriateness of the services they choose to attend.

NCACCH organises oral health professionals to facilitate education and training to community, staff and Aboriginal and Torres Strait Islander Health Workers to increase knowledge about the benefits of preventative health checks.

Client eligibility

NCACCH clients are eligible for the dental referral scheme where the need is in excess of the Child Dental Benefits Scheme (CDBS) value or where they are not eligible for Adult Public Dental Health services (Concession Card Holder). NCACCH have a partnership with the Sunshine Coast Hospital and Health Service (SCHHS) and provide the dental referral scheme for individuals who would otherwise fall through public health gaps. In addition, NCACCH have 25 listed private eligible dental clinic providers across the region.

Funding model

Working in complimentary care, NCACCHs brokerage dental service and its long-term formal relationship with Sunshine Coast Hospital and Health Service (SCHHS). Benefits include:

- Long-term established formal partnership with SCHHS
- SCHHS prioritises eligible public health clients and has an Aboriginal and Torres Strait Islander Oral Health Service clinics

A majority of the SCHHS Aboriginal and Torres Strait Islander Health workforce (including other identified SCHHS employees) refer clients to NCACCH to refer either to the SCHHS or through the NCACCH Dental Referral Scheme

Dental Referral Scheme

Additionally, based on need, each financial year, NCACCH identify an allocation amount, for oral health services in 2023–2024 NCACCH received 1159 referrals (equating to approx. $261,000 in total spend). Individual client allocation is $300. This enables NCACCH to allocate dental funds to:

- Pre-prep and grade 10 upward (others are expected to use the CDBS).
- Eligible clients (A NCACCH client is an Aboriginal and Torres Strait Islander person who has lived in the area for at least three months). Non-Aboriginal and Torres Strait Islander people who are the biological parent of a child under 18 are also eligible (supporting family unit).

How to access the NCACCH Dental Referral Pathway

An eligible client needs to seek referral from a volunteer community referrer (e.g. Centrelink/Hospital and Health Service/Aboriginal and Torres Strait Islander Health Worker or Liaison Officer). NCACCH receives a referral form if approved, the client receives a text message and/or phone call from NCACCH requesting they contact their preferred dental practice, from the list of eligible providers, and make an appointment. NCACCH send the allocated budget to that provider for the client to use in the current financial year.

Benefits to community

Positive partnership: Excellent public dental system partnerships.

Waiting times: For public dental scheme eligible recipients, prioritisation for appointments.

Culturally safe dental services: For NCACCH Dental Referral Scheme participants, access to limited but free, culturally safe, dental services (depending on extent of work required).

Diversity of locations: Services close to home.

Health promotion activities embedded in services: Oral health worker talks to community staff and health workers to increase knowledge about preventative checks. NCACCH organise workshops to educate referrers on how to disseminate good oral hygiene information to clients.

Challenges

Limited service: Only basic dental services are covered under the Dental Referral Scheme (up to a value of $300 per client per financial year).

Demand for Service: Increasing population resulting in increase demand for service with nil funding increase.

Transport: No transport offered.

Funding: Does not roll over. Some clients have to time costly treatment so the appointments are split across two financial years.

Geographical gaps in service delivery: e.g. Difficulty to recruit practices to ensure equal geographical coverage.

Impact

DENTAL REFERRAL SCHEME:

- In 2023/24 NCACCH received 1159 referrals
- No formal complaints received from clients about cultural safety of dental services or clinical service provided.
- Community education is undertaken on an ongoing basis to raise awareness of good oral hygiene practices. Partnership with Sunshine Coast Hospital and Health Service

Community Feedback

Each year NCACCH runs a community survey in which dental and oral health repeatedly has been raised by community as a high priority, which helps to inform NCACCH's Board when deciding whether to reinvest in the Dental Referral Scheme.

NCACCH has not received any negative feedback about the quality or availability of dental services provided. Anecdotal feedback received from community regarding costs increasing resulting in decrease services able to be accessed.