Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the

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

June 2023

Central Australian Aboriginal Congress Aboriginal Corporation
ABN 76 210 591 710 | ICN 7823
PO Box 1604, Alice Springs NT 0871
(08) 8951 4400 | www.caac.org.au

Aboriginal health in Aboriginal hands.

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Note

* In this document we use the term 'Aboriginal' as the most appropriate term in the Central Australian context to refer to Australia's First Peoples.

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Recommendation 2: Remove barriers to accessing urgent dental care for Aboriginal people living in remote communities through expansion of dental service eligibility under state and territory travel assistance schemes (in the NT, the Patient Assistance Travel Scheme).

Recommendation 3: Investment in bolstering publicly available dental services through both ACCHSs and government operated services.

Recommendation 4: Funding for oral health service provision allocated according to a needs assessment, and transferred from state and territory governments to ACCHSs for the provision of dental care for Aboriginal people.

Recommendation 5: Funding for the provision of remote area loading for services delivered in MM6 and MM7 locations under the Child Dental Benefits Schedule (CDBS).

Recommendation 6: Establish a government subsidy scheme based on fee-for-service models to increase access to dental services through either:

a) a universal Dental Benefits Scheme (similar to the Medicare Benefits Schedule)
or
b) reintroduce a scheme similar to the former Medicare Chronic Disease Dental Scheme, to ensure that priority groups, including all Aboriginal people, have timely access to services.

Recommendation 7: Funding for targeted and culturally responsive oral health promotion, and prevention strategies such as fluoride varnish, led by ACCHSs.

Recommendation 8: Develop a sugar tax and healthy food subsidy model designed to increase the consumption of healthy foods, and decrease consumption of high energy, nutrient-poor foods, with particular consideration for remote Aboriginal communities.

Recommendation 9: Strengthen water fluoridisation programs the NT, with a target for all remote communities to have access to safe, potable, appropriately fluoridated water.

Recommendation 10: Establish and require regular public data reporting on service provision to enable transparency and accountability on service delivery and service allocation. All data reporting should be available via region and include Aboriginality to allow equity in access to be measured.

Recommendation 11: Establish and resource regional collaborative dental health forums to drive greater coordination between service providers.

Recommendation 12: Address current dental workforce crisis in remote areas, including by providing tax relief for all practicing dental health workers working in MM7 regions where there is a significant Aboriginal population.

Recommendation 13: Fund traineeships, scholarships, and cadetships to enable Aboriginal people to enter, develop, and progress within the oral health service profession.

Central Australian Aboriginal Congress

1. Congress is a large Aboriginal Community Controlled Health Service (ACCHS) based in Mparntwe (Alice Springs). Established 50 years ago, Congress is one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care (PHC), and a strong advocate for the health of our people. Congress delivers services to more than 17,000 Aboriginal people living in Mparntwe and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu, Amoonguna, and Imanpa, as well as Yulara.

2. Our submission to the Select Committee into the Provision of and Access to Dental Services in Australia is based on our experience of delivering comprehensive primary health care including multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic, and political determinants of health and wellbeing.

3. Congress has provided dental services to the Central Australian Aboriginal community for almost fifty years. Our current dental services team consists of dentists and dental assistants who provide culturally responsive oral health care within Alice Springs, and collaborate with government dental health services to ensure dental services are delivered in the remote communities Congress serves.

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

4. Congress welcomes the Select Committee into the Provision of and Access to Dental Services in Australia and we commend the work they will undertake in inquiring into, and reporting on, the challenges in this sector. As an ACCHS, Congress has a long history of working with and for our community in the struggle for justice and equity for Aboriginal Australians. Congress therefore wishes to highlight the importance of specifically considering the provision of and access to dental services for Aboriginal people.

Why it is important to specifically consider Aboriginal Australians in this review

- Aboriginal people are disproportionally affected by oral health complications and are less likely to receive the dental care they need compared to non-Indigenous people
- Poor oral health increases the impact of chronic conditions and can lead to potentially preventable hospitalisation; specific efforts are required to 'close the gap' in oral health outcomes between Aboriginal and non-Aboriginal Australians.
- A collaborative approach between communities, state/territory governments, ACCHSs, and oral health services is needed to address the oral health disparities that impact Aboriginal Australians.
- The specific needs of Aboriginal people must be recognised by providers and funding bodies so that services are effective and accessible for Aboriginal people.
- There is a need for a high-quality, culturally competent dental services workforce, including an Aboriginal workforce, to meet the needs of the Aboriginal community.

The context of oral health in Aboriginal Australia

5. In traditional times, the diverse Aboriginal peoples of the Northern Territory had active lifestyles and a healthy diet low in sugar. While specific records on oral health are not available, it is highly likely that people generally had high levels of oral health.

6. However, contemporary Aboriginal Australians have been deeply affected by the processes of colonisation, including dispossession and impoverishment; the forcible removal of children and its intergenerational effects; the suppression of culture and language; and the experience of racism and discrimination. Aboriginal families continue to live with these effects of colonisation which challenge their capacity to live healthy lives, and provide care for and nurture their families. It is in this context that the high rates of adverse oral health conditions should be seen, with Aboriginal Australians more likely to have multiple caries (tooth decay), gum disease, and multi-tooth loss, compared to non-Indigenous people [1].

7. Any approach to addressing the high prevalence of oral health complications in Aboriginal communities must recognise the continued impact of colonisation and its effects, and be founded on the rights of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples [2], which states:

   > *Article 23: Indigenous peoples ... have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*

8. Despite the importance of oral health being held highly within Aboriginal communities [3], Aboriginal Australians are less likely to receive the dental care that they need, and have a higher likelihood of having untreated dental disease or having to be hospitalised due to oral health complications [4,5,6].

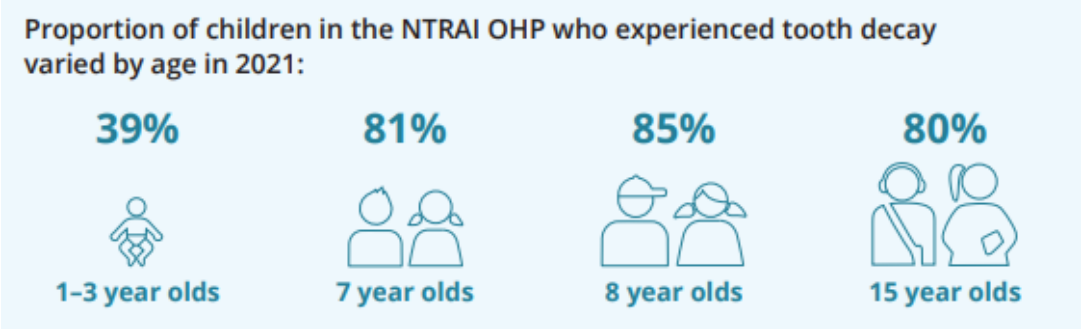
9. Factors that contribute to non-optimal oral health for Aboriginal people include poverty and social disadvantage, consumption of a high proportion of processed foods and sugar sweetened drinks [7], limited access to fluoridated water, lower use of fluoridated toothpaste, and limited (or no) access to oral health services [8,9].

10. Aboriginal people use income support at disproportionally higher rates than non-Indigenous people, and people living in remote communities need to spend more on food than other Australians. Prices for healthy, fresh foods, particularly fresh fruit, vegetables and dairy foods, are higher in remote areas for a number of reasons, including the cost of freight over long distances, and the high cost of storing perishable food. [10,11]. On average, a food basket (i.e. foods that meet the average energy and recommended nutrient needs of a family of six for a fortnight) is 41 per cent higher in remote NT communities than in Darwin [12]. As such, there are high rates of highly-processed, sugar rich food consumption which compromises oral health.

11. Knowledge, attitudes and behaviours can shape oral health. A study conducted with Northern NSW Aboriginal communities highlighted that 68% of service users believed that oral disease leading to extraction was normal, with only 53% reporting brushing morning and night [13].

12. For Aboriginal children aged 5-14 years nationally, tooth decay accounts for almost all (99.7%) the burden of oral health disorders, with 28% of this group having identified gum or teeth problems [14]. In 2021, the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) found that 85% of 8-year-old children seen by the program had tooth decay [15]. Additionally, children aged 7 years had an average of 5.1 decayed, missing or filled deciduous teeth, while youth aged 15 years had an average of 3.3 decayed, missing or filled permanent teeth. This represents approximately 1.5 times as much tooth decay for Aboriginal children, compared to non-Indigenous children in this region [16]. For children, the effects of impaired oral health can be caried into adulthood [15].

Figure 1: Excerpt from the 'Oral health outreach services for Aboriginal and Torres Strait Islander children in the Northern Territory July 2012 to December 2021' Report [15]



13. In the 2017-18 National Surveys of Adult Oral Health (NSAOH), 1 in 8 (13%) participating Aboriginal adults self-reported having fewer than 21 teeth, and 15% reported experiencing toothache 'very often' or 'often'. Despite this, only 51% reported visiting a dentist for a problem [17]. A study investigating the oral health outcomes of young Aboriginal adults in the Northern Territory found that this cohort had 10.8 times the prevalence of moderate to severe periodontal disease and 4.5 times the prevalence of gingivitis compared to their aged-matched counterparts nationally [18].

14. Impaired oral health has been linked to cardiovascular disease, stroke [19], oral cancer [20], adverse pregnancy outcomes [21], and lung conditions. It can also intensify chronic conditions such as diabetes and chronic kidney impairment, with oral inflammation impeding glycaemic management, and leading to further decline in kidney function [22]. It is known that 40% of Aboriginal adults living in remote Central Australian communities are living with diabetes [23], highlighting the significant population for which preventative and timely dental care services are required in this region. A recent study undertaken in Central Australia demonstrated that severe periodontitis was present in 54.3% of Aboriginal Australians with chronic kidney conditions, which is approximately 20 times that found in the wider NSAOH report [24].

15. Dental treatment prior to procedures associated with immunosuppression (such as organ transplant, cardiac valve surgery) is extremely important. Preoperative dental care is required to ensure that possible sources of infection that could lead to systemic infection are eliminated. Infection and inflammation caused by impaired oral health can have negative effects on outcomes (organ failure, bacterial endocarditis), and as such preoperative 'work up', requires complete dental assessment and indicated treatment to be completed prior to surgery [25]. Limited access to dental services in remote communities has been shown to be a frequent

cause of surgical delay for those with end stage renal failure (requiring transplant), or those with rheumatic heart disease (requiring cardiac valve surgery) [26].

16. Untreated caries can cause significant dental pain, impairing ability to effectively chew, which directly affects dietary choices, malnutrition risk and quality of life [24], and can further compound the impacts of chronic condition management.

17. Both Aboriginal children and adults have increased rates of hospitalisation due to oral health complications, compared to their non-Indigenous people. This contributes significantly to acute potentially preventable hospitalisations (PPH) which may have been avoided if timely and adequate primary care had been accessible. 'Dental conditions' are the single most common cause of PPH for both Aboriginal and non-Indigenous children aged 5-9 years old, with 1,328 PPH per 100,000 and 931 PPH per 100,000 in 2018 respectively [1].

18. The Aboriginal and Torres Strait Islander Health Performance Framework reported that an estimated 19% of Aboriginal Australians aged 2 years and over did not attend oral health services when they needed within the previous 12 months, and 23% of children under the age of 15 had never attended a dental service. [27].

The role of Aboriginal Community Controlled Health Services

Recommendation 1: ACCHSs are well placed to provide culturally responsive and accessible dental and related services for Aboriginal people, and should be recognised as preferred providers of government funded oral health services.

19. Aboriginal community-controlled health services (ACCHSs, sometimes referred to as Aboriginal Medical Services) are an extremely important delivery system for evidence-based, culturally appropriate services to address the health needs of Aboriginal communities. There are over 140 ACCHSs around Australia, delivering almost 3 million episodes of care annually through over 300 clinics, and employ over 6,000 staff whom, most of whom are Aboriginal and Torres Strait Islander Australians [28].

20. ACCHSs have a range of inter-linked structural advantages in delivering services and hence have improved outcomes compared to non-Indigenous services (government or private). These structural advantages include:

    a) *a holistic approach to service delivery*: including through addressing the social determinants of individual and family wellbeing, based on a lived understanding of the Aboriginal conception of health;

    b) *culturally responsive services*: Aboriginal community-controlled organisations are able to provide their care within a culturally responsive setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong relationships with the communities that they serve;

    c) *better access, based on community engagement and trust*: a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history. Aboriginal people consistently prefer to use Aboriginal organisations such as ACCHSs

over mainstream services giving them a strong advantage in addressing access issues;

d) *Aboriginal governance*: individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards;

e) *an Aboriginal workforce*: community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity strengthening in the Aboriginal community;

f) *high levels of accountability*: Aboriginal community-controlled services are highly accountable to their funders for the services they provide through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

21. Such advantages were recognised by a Senate Inquiry which recommended that [29]:

> *… future selection criteria and funding guidelines should give weighting to the contribution and effectiveness of Aboriginal and Torres Strait Islander organisations to provide to their community beyond the service they are directly contracted to provide.*

22. As comprehensive primary health care (PHC) providers, properly resourced ACCHSs are able to provide a wide range of services in the domains of public health, health promotion, and prevention to reduce the rates of oral health conditions, including:

    a) health promotion activities which include education on smoking cessation, healthy eating, and positive oral health behaviours;

    b) undertaking oral health screening, and providing preventative interventions (including application of fluoride varnish by trained Child and Family Health Nurses, Aboriginal Health Practitioners, and Remote Area Nurses);

    c) employing a multi-disciplinary team that can provide holistic, comprehensive, and culturally responsive service;

    d) advocacy for action on the social determinants of health that directly contribute to the significant disparities in oral health outcomes outlined above.

23. The key role of ACCHSs in PHC delivery was confirmed by one major study which concluded that up to fifty percent more health gain or benefit can be achieved if health programs are delivered for the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [30].

Addressing the Terms of Reference

a) the experience of children and adults in accessing and affording dental and related services

Recommendation 2: Remove barriers to accessing urgent dental care for Aboriginal people living in remote communities through expansion of dental service eligibility under state and territory travel assistance schemes (in the NT, the Patient Assistance Travel Scheme).

Key Points:

- People in Central Australia experience long wait times for dental services, and may need to travel long distances to receive timely dental care.
- Congress' Board, informed by the community, identified that access to dental services is an important priority. As such, this service has been delivered and core funded since 1980.
- Congress' dental service does not receive direct funding for service provision.

Barriers to Access

24. Within the Central Australia region, Aboriginal people face significant barriers in accessing oral health services, particularly in remote communities, with long waitlists for preventative and restorative treatment and services often in demand from those requiring emergency, problem-based care.

25. It is important to recognise the challenges of geography in this region. In the NT, only 19% of town-based residents who are eligible for public dental services reside within 5 km of a government dental clinic [31]. Beyond the major towns, remote communities in Central Australia are small and widely dispersed: many communities have only 200 or 300 people and have a network of even smaller outstations surrounding them. These communities can be over 500km from Mparntwe (Alice Springs) which acts as a hub for regional service provision. As such, people may need to travel long distances to seek necessary oral health care, incurring travel costs which many people may not be able to afford.

26. If a person is critically unwell due to a dental concern, they may require emergency aeromedical retrieval, with hospitalisation rates shown to significantly increase with increasing distance to dental services [31]. However, people requiring non-critical, yet urgent dental care services are often not eligible for support from the Patient Assistance Travel Scheme (PATS), which is a subsidy program in the NT that provides financial aid for expenses incurred when travelling a long distance to see an approved medical specialist [32].

27. Absolute deprivation (poverty) and relative deprivation (inequality) are both strongly correlated with poorer health outcomes and with increased rates of non-optimal oral health. Unfortunately, in remote areas across Australia both poverty and inequality are worsening for Aboriginal people, with Aboriginal incomes falling and the income gap to non-Indigenous people widening [33]. In Alice Springs, the weekly median personal income for Aboriginal people is only 40% of that of non-

Indigenous residents, and in remote locations in Central Australia, it is only 25% [34]. It is in this context that Aboriginal people in Central Australia overwhelmingly cannot afford to attend a private dentist, and therefore rely on access to public dental services.

28. It has been suggested that reasons for under-utilisation of dental services may be influenced by both physical access to oral health services, and the number and severity of competing health and social concerns within communities [3]. In the context of the many other health and social challenges faced by Aboriginal communities, the perceived low impact of dental conditions may affect the uptake of preventative services, and promotion and education strategies is required.

Development and current operations of Congress Dental Service

29. Congress has long identified that access and affordability of dental services does not meet the needs of the Central Australian community. As far back as 1977, Congress was providing the service of an Aboriginal Health Practitioner (AHP) to carry out regular oral health screening for children, and deliver education to parents on ways to check for oral health complications. In this same year, Congress lobbied for a dental service to be established as a part of the overall primary health care service but was unsuccessful at the time. Lobbying continued and in May 1980 Congress were successful in opening a dental clinic that would provide services free of charge. A dentist was employed as well as two trainee dental assistants who received on the job training from the dentist. In November 1997, Congress dental service received a Certificate of Accreditation for safe infection control standards from the Australian Medical Association. This important accreditation has continued to be maintained ever since.

30. Today, the vision of Congress' dental team is to provide a culturally appropriate and timely oral health care service for Aboriginal people in Central Australia, including a focus on education and primary prevention, and maintaining partnerships to ensure dental services continue to be delivered in Congress remote clinics. However, this service **does not receive direct funding**.

31. In the 2021/22 year, the Congress dental services team consisted of 1.2 FTE dentists and 3.0 FTE dental assistants who delivered a 5-day per week service and saw an average of 8.8 clients per day. There is currently a 0.8 FTE dentist vacancy that Congress is still recruiting to, which has proven to be very difficult. Due to high service demands in Mparntwe, Congress dental service has had limited capacity to deliver oral health education, primary prevention activities, or services to remote communities.

32. At Congress, the clinic operates from 8:45am – 5pm. Each day there are seven booked appointments (five in the morning session, two in the afternoon session), with up to three walk-in (emergency) appointments. Unfortunately, if there are more than three people requesting emergency appointments, they are triaged and some people may need to be turned away. Currently, there is a six-week wait for a booked appointment.

33. Congress recognises the importance of providing flexible, walk-in appointments regularly given that our clients are more likely to present for problem-based oral health care rather than for general care. Over the past 10 years, walk in

appointments have represented 48% of all service contacts. The ability to provide this urgent and emergent care contributes to reducing the incidence of PPH.

34. Since March 2020, Congress has been in a successful partnership (MoU) with the Royal Flying Doctor Service (RFDS) who have provided oral health services to the remote community of Mutitjulu, committing to three 2-week long visits per annum. Oral Health Services NT (OHS-NT), operated by the Department of Health, provide services to other Congress operated remote clinics with two scheduled visits to each community per annum.

35. In 2022, Congress commenced a collaboration with Alice Springs Family Dental (ASFD), a private dental provider in town, who release one of their employed dentists to provide services at Congress one day per week. This dentist provides services at the Congress based dental clinic.

Public Dental Services

36. Remote communities in Central Australia not serviced by Congress receive either one or two visits per annum by the visiting OHS-NT program.

37. NT Department of Health operate free public dental services for eligible Territorians. A current Concession Card is required to access this service. However, some Aboriginal community members do not have the card on hand at the time of service request.

38. Anecdotally, there is currently a 9-12 month wait for some public oral health services, however, information about NT public dental waitlist times are not made publicly available [35, 36].

b) the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas

Recommendation 3: Investment in bolstering publicly available dental services through both ACCHSs and government operated services.

Key Points:

- The NT is adversely impacted by the oral health workforce maldistribution across Australia
- Given the impact of poverty and the social determinants of health in the NT, all the pressure is currently on public dental services which are unable to meet the needs of community

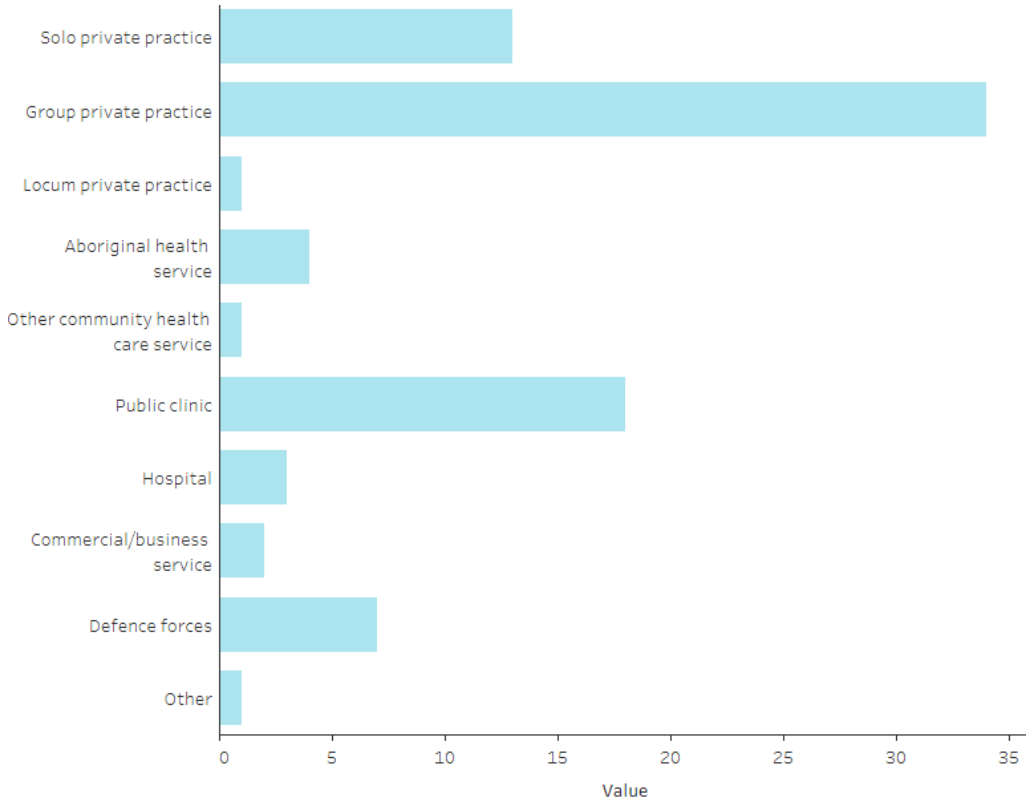
The dental health workforce in the Northern Territory

39. Despite the excellent efforts of the experienced and well-respected dental service teams in Central Australia, who work as optimally as possible to meet the oral

health needs of community in this region, significant demand remains unmet. There is a collegiate atmosphere between services providers in this region with positive, though informal, referral pathways that aim to optimise overall service effectiveness and efficiency.

40. The NT is adversely impacted by a significant disparity in the distribution of the dental health workforce in Australia. In 2022, 164 out of a total of 25,584 practicing dental practitioners in Australia listed their main employment site to be within the NT. This represents 0.64% of the workforce. The number of FTE dentists in the NT was 32.9 per 100,000 population, compared to 57.9 per 100,000 population nationally. [1].

Figure 2. Number of dentists by main employment setting, NT, 2020 [1]



Adequacy and availability of Congress dental services

41. Dental services at Congress remain an important focus of primary health care for the Aboriginal community in Central Australia. The only exception to a continuous dental service at Congress has been when recruitment of dental professionals has proven difficult. However, the risk to interruption of dental service accessibility is mitigated by a strategy to provide vouchers to external private dental service providers if/when Congress' service have been interrupted by factors out of the service's control.

42. At Congress, the dental team is equipped to provide preventative (application of full-mouth fluoride varnish and fissure sealants, removal of plaque/calculus, oral health education) and clinical (emergency care, tooth extractions, diagnostics, restorations and examinations) services. Crowns, bridges and dentures are available through Congress however, require multiple appointments and out of

pocket costs (up to $500 per denture set) as impressions are sent to a local private dental laboratory.

43. Children who present to Congress with complex oral health conditions need to be referred to public dental services as the service is better equipped to provide complex care, primarily due their ability to access and resource the administration of general anaesthesia.

Adequacy and availability of public dental services

44. In 2022, NT Health employed 17.66 FTE dentists [37]. Despite this, it is evident that dental health services are critically under-resourced comparative to need, and need to be increased. As outlined in paragraph 38, information on the NT's public dental waitlist times is not available; however, it is reported that remote, children's, and identified priority group dental services are not waitlisted. Urban areas also utilise a recall list after completion of waitlisted treatment, with recall frequency based on clinical need. Clients may access urgent care on an as needs basis. In urban areas, where waitlists are utilised for general care requests, in the case that a person on the waitlist does not respond after 'multiple' contact attempts they are removed from the waiting list (though may be reinstated to their original date of listing if they present for care at a later stage), resulting in loss to follow-up a being a significant risk for our community members.

45. Oral health services that provide both regular preventative and restorative treatment services are needed. In 2012, 85% of services provided by the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) were listed as being preventative service items, however, this has since dropped to 66% in 2021 [9].

46. Mobile dental trucks are used to reach many remote communities in Central Australia and Barkly Region. OHS-NT teams comprising a dentist or a dental/oral health therapist and dental assistant travel to remote communities in Central Australia and Barkly regions for 1–3 weeks at a time.

47. Evaluation of the NTRAI OHP program by NIAA outlined that a key program performance indicator was:

> *75% of all communities across Northern Territory (excluding the major centres: Darwin, Katherine, Nhulunbuy and Alice Springs) receive a dental service within each calendar year as demonstrated through the schedule for delivery of services provided to the Commonwealth by 1 March each year. This will detail the communities anticipated to be visited in the current and previous calendar years. [38].*

This KPI is inadequate as it accepts that 25% of communities in the NT will not receive a visit from an oral health team within the year, and does not provide information on actual service delivery. Accountability of service provision cannot be maintained given that frequency of trips (one or more scheduled visits), the duration of each visit, number of contacts, and the communities who did/did not receive a service are not publicly reported.

48. Long standing and known barriers to remote service provision include high costs, distance, weather extremes, clinic space, and accommodation availability in remote locations. Government funding for service provision must account for these known facts, and be sufficient to ensure equity in access to essential healthcare services.

49. With (significantly) increased capacity, the Congress dental team would be able to provide outreach services in the Congress owned dental truck. This truck has a clinic equipped with necessary equipment to perform preventative and basic restorative services.

Adequacy of oral health promotion and preventative interventions

50. Actions for effective health promotion are multifaceted and may involve activities including health education, skills development, social marketing, community action, and advocacy at the local and system-wide levels.

51. It is recognised that promoting good oral health must include the provision of health promotion and illness prevention strategies as a fundamental part of comprehensive primary health care and as a core component of all oral health services for Aboriginal communities. Existing funded oral health promotion programs in the NT include activities and resources targeted for *Early Childhood* and *School Aged Children* cohorts, and the Healthy Smiles Training Program, all of which are delivered by NT Health.

52. Full-mouth fluoride varnish has been shown to decrease the incidence of tooth decay by up to 25%–45% when professionally applied 2–4 times per year. It is therefore considered to be a valuable public health intervention [39,40]. Given that dental services to remote communities are provided on 1-3 occasions per annum, it is highly unlikely that eligible community members will receive this preventative care from these services at the clinically indicated frequency. To mitigate this, health professionals in the NT, such as Aboriginal Health Practitioners, Child Health Nurses, and Remote Area Nurses, are able to undertake training (such as the Healthy Smiles Training Program) that enables them to provide this treatment in line with the competency requirements of HLTOHC011 – Applying Fluoride Varnish and the Central Australia Rural Practitioners Association (CARPA) Standard Treatment Manual [41]. This innovative approach facilitates increased access to this preventative intervention for those living in remote communities.

c) the interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services

Recommendation 4: Funding for oral health service provision allocated according to a needs assessment, and transferred from state and territory governments to ACCHSs for the provision of dental care for Aboriginal people.

53. Since 2007, the Australian Government has funded integrated oral health services for Aboriginal children in remote communities in the NT, initially through the Stronger Futures in the Northern Territory and Child Health Check Initiative – Closing the Gap programs, and now through the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP). The program is designed to complement and support existing public dental services and has funding secured until June 2024. This oral health program is delivered to remote communities in

Central Australia by the NT government's OHS-NT program, with NTRAI OHP service provision reported on an annual basis [15].

54. The Commonwealth have entered a 10-year strategic partnership with RFDS, who provide oral health services for Mutitjulu (NT), Kintore (NT) and Kirriwikurra (WA). As described in paragraph 34, Congress has an active MoU with RFDS, who work with Congress' Mutitjulu clinic.

55. Referral pathways exist between Congress and OHS-NT, however, no formal agreements for service provision are provided to support increased dental service capacity at Congress.

56. We look to examples of successful and sustainable dental service provision through ACCHSs interstate. In Queensland, the Institute for Urban Indigenous Health (IUIH) Network are funded by Queensland Health to provide culturally responsive dental services to over 10,500 Aboriginal clients through 21 active dental chairs (including 2 dental vans), thereby relieving pressure on the mainstream public dental service. Additionally, Nganampa Health Council are funded by the South Australian Department of Health to provide dental services to remote Aboriginal communities in the APY Lands in northern SA [42].

d) the provision of dental services under Medicare, including the Child Dental Benefits Schedule (CDBS)

Recommendation 5: Funding for the provision of remote area loading for services delivered in MM6 and MM7 locations under the Child Dental Benefits Schedule (CDBS).

Recommendation 6: Establish a government subsidy scheme based on fee-for-service models to increase access to dental services through either:

a) a universal Dental Benefits Scheme (similar to the Medicare Benefits Schedule) *or*
b) reintroduce a scheme similar to the former Medicare Chronic Disease Dental Scheme, to ensure that priority groups, including all Aboriginal people, have timely access to services

57. As previously outlined, Congress offers a dental service for children and adults, with both booked and walk in (emergency) appointments. As a result, this service sees numerous clients who are not eligible for Medicare reimbursement. As such, Congress is unable to claim for these consultations, despite addressing the oral health service needs of our community members. Of the oral health services provided through Congress in 2018-2022, only 1.6% of consults met eligibility to submit a claim under the Child Dental Benefits Schedule (CDBS). This corresponded to a return of $133 per claimable consult and does not support financial sustainability of this valued service.

58. Despite providing preventative and restorative oral health services for children, many children present to Congress with complex oral health complications, which require treatment under a form of sedation. Congress does not have these facilities,

meaning that these clients are referred to the public dental service with its consequent long wait times.

59. As outlined in paragraph 48, funding allocation must account for the high costs associated with service provision for remote communities. The existing CDBS does not provide adequate reimbursement to cover costs such as transport, accommodation or travel allowance, and is therefore unable to be solely relied upon to provide a service that is financially sustainable in this setting. The provision of remote area loading under the existing CDBS would strengthen the ability of providers to deliver adequate services for remote communities.

60. When in operation, the Medicare Chronic Disease Dental Scheme (Medicare clinical items 85011-87777) was effective in recognising the significance of optimising the oral health of those living with a chronic condition, and was the first scheme to pay Medicare benefits towards private dental treatment [43]. Under the scheme, clients with a chronic condition who were being managed by their GP could access up to $4250 worth of dental treatment under Medicare, if their dental condition was impacting on their illness. This scheme benefited over 780,000 people nationally, until its closure on 30 November, 2012. [44]. In the absence of a universal dental benefits scheme, a scheme similar to this, with clearly defined eligibility and entry guidelines for identified priority groups (including all Aboriginal people), should be reintroduced to enable primary health care services, such as ACCHS, to provide holistic and comprehensive care in a sustainable manner to those at highest need of dental care.

61. Medicare is Australia's universal health care system, however it fails to recognise the extensive and systemic impact of poor oral health. The expansion of the current Child Dental Benefits Schedule, to include the provision of Medicare subsidised dental health services for adults will provide a universal scheme that treats oral health in the same way as any other medical condition in Australia.

e) the social and economic impact of improved dental healthcare

62. For Aboriginal people, health encompasses not just individual physical wellbeing, but is inclusive of the social, emotional and cultural wellbeing of the whole community. Oral health impacts everyday activities such as eating, smiling, speaking and socialising. As such, there may be unintended social and psychosocial consequences of impaired access to oral health care.

63. Speaking and socialising can become difficult, uncomfortable and embarrassing for some with severe oral health complications. This can influence personal appearance and self-esteem and have subsequent impact on mental health, quality of life, and/or ability to participate in school or the workplace [45]. As such, absenteeism from the education/the workforce or time lost because of illness attributable to oral health complications could be reduced with improved dental healthcare.

64. There is increasing literature to support the positive economic impact of shifting oral health services to be predominantly prevention, rather than treatment focused [46,47]. We look to Dental Health Services Victoria (DHSV) who have recently developed a co-designed Value Based Health Care (VBHC) Framework for public dental services delivery which aims to improve health outcomes and reduce costs

throughout care. The VBHC model was shown to emphasise prevention interventions and achieved 36% higher utilisation of preventative services, and 44% lower non-attendance rates than the traditional model of service provision. [48].

f) the impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services

65. ACCHSs played a leading role in the response to the COVID-19 pandemic and since March 2020, Congress has been a key source of COVID-19 related information for clients and community members in the Central Australia region. Rates of infection amongst Aboriginal and Torres Strait Islander people have been significantly lower than for the general population, thanks in part to swift action by the ACCHS sector which was able to implement evidence-informed public health measures based on detailed social and cultural knowledge of local Aboriginal communities [49].

66. Oral health service delivery to remote communities was severely impacted between March and April 2020, when bio-security areas were established to prevent the spread of COVID-19. Restrictions to remote community visits continued until 2021, limiting service delivery to these areas and lending to further unfavourable dental visiting patterns for these community members. 'Town' based oral health services continued during this time, and were provided in line with COVID-19 infection control standards.

67. With cost-of-living and economic barriers in mind, many Aboriginal people are employed in low-income jobs or dependent on concession supports which are not increasingly in line with inflation and subsequent cost-of-living increases. As outlined in paragraph 27, this has an impact on people's everyday lives, leaving them with less resources, and making it less likely that they will be able to access healthcare that incurs any out-of-pocket costs.

g) pathways to improve oral health outcomes in Australia, including a path to universal access to dental services

Recommendation 7: Funding for targeted and culturally responsive oral health promotion, and prevention strategies such as fluoride varnish, led by ACCHSs.

Recommendation 8: Develop a sugar tax and healthy food subsidy model designed to increase the consumption of healthy foods, and decrease consumption of high energy, nutrient-poor foods, with particular consideration for remote Aboriginal communities.

Recommendation 9: Strengthen water fluoridisation programs the NT, with a target for all remote communities to have access to safe, potable, appropriately fluoridated water.

68. Holistic approaches are required to improve oral health outcomes in Australia. The Ottawa Charter for Health Promotion sets out five key areas for action to support

healthy behaviours: building healthy public policy, creating settings and environments that are supportive of good health, supporting community action, educating and informing the community, and reorienting health services towards these approaches [50]. Health promotion measures may also be considered to include fiscal and regulatory measures that aim to change behaviour and it has been emphasised that where significant reductions in the prevalence of oral health complications have been found, population-based measures, and strategies to address the social determinants of health have played a greater role than oral health services alone [51].

69. Adequate and appropriate oral health promotion strategies, such as those described in paragraphs 50-52 are essential for increasing community awareness of the importance of optimal oral health and subsequently improving the oral health outcomes of community. Given ACCHS's inherent links with community, they are well placed to provide oral health education and promotion services, however, this requires designated funding. ACCHS's are also well placed to provide preventative interventions, such as the application of fluoride varnish to the teeth of children from the age of eighteen months. This is embedded into the 'Healthy Under 5 Kids' program Well Child Check which are routinely performed by Congress' Child Health Nursing team. Expansion of the existing Healthy Smiles Training Program (including a 'train the trainer' approach), will ensure that more staff, particularly those working in remote communities, are able to provide this effective intervention. ACCHSs also provide a platform for reorienting the health system towards a more integrated, culturally safe response to Aboriginal health needs, through a combination of direct advocacy and the development, implementation and evaluation of evidence- based approaches to what are often seen as intractable health challenges.

70. Oral health is dramatically impacted by sugar consumption. In the NT, prices for healthy, fresh foods, particularly fresh fruit, vegetables and dairy foods can be over 40 per cent higher in remote communities than in urban areas [52]. In contrast, energy-dense, nutrient-poor foods are relatively inexpensive, leading to their higher consumption, increasing risk to oral health [53]. A tax on sugar has been shown to be effective in reducing consumption and is projected to lead to the biggest health gains, particularly for people on the lowest incomes [54]. Taxes work best in combination with subsidies that increase the affordability of healthy foods such as fruit and vegetables [55]. The impact on additional food costs for consumers can be offset by hypothecating the tax to subsidise fresh fruit and vegetables in rural and remote areas.

71. Congress has advocated for the provision of safe and potable drinking water for all Territorians, including those living in remote communities on Aboriginal land, and reiterate this here, given that oral health is impacted by water access and quality. Although some communities have naturally fluoridated water, in many areas in Australia, fluoride is added to the water supply to aid in reducing tooth decay. In 2017, Queensland and the Northern Territory had the lowest rates of adequate water fluoridisation in the country, with only 76% and 78% of the respective populations having access to fluoridated drinking water, compared to over 90% of people in other states and territories [56]. The WHO have listed inadequate or excess fluoride in drinkable water as a major public health concern and advise that the optimal concentration of fluoride in drinking water is 0.5-1.0mg/L, and should not exceed 1.5mg/L due to the risk of fluorosis [57].

72. The Northern Territory Government's 2010 Position Statement on the Use of Fluorides in the NT affirmed that water fluoridisation should be extended to all people living in communities with a fixed population of 600 or more residents [58]. However, today 13 remote communities with a population of over 600 residents continue to not have access to fluoridated water. NT Power and Water's Drinking Water Quality Report 2022 [59] provides a summary of water quality results for fluoride in each community, highlighting that a number of major towns, including Alice Springs and Katherine, do not have access to water that is fluoridated to the minimum levels recommended by the WHO (average fluoride concentration in Alice Springs = 0.49mg/L, Katherine = 0.46mg/L). Additionally, there are a number of communities with fluoridation levels that have naturally exceeded 1.5mg/L (Tennant Creek recorded a maximum 1.7mg/L). Appropriately fluoridating water is seen as a population-wide investment, with every dollar spent on fluoridation, expected to save between $7 and $18 in avoided treatment costs [60], and urgent action is needed to ensure that all Territorians have access to appropriately fluoridated water.

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

Recommendation 10: Establish and require regular public data reporting on service provision to enable transparency and accountability of service delivery and service allocation. All data reporting should be available by region and include Aboriginality to allow equity in access to be measured.

Recommendation 11: Establish and resource regional collaborative dental health forums to drive greater coordination between service providers.

73. As previously outlined, data collection, and more importantly data reporting, on the accessibility of oral health services in the NT is not publicly available. Oral health data collection is siloed in the NT and current reporting does not provide feedback on the communities or proportion of eligible people receiving service. Given that many oral health complications are preventable with timely access to dental care, time to treatment is an important indicator of service effectiveness. Waiting times alone do not provide an adequate guide of service availability, however, understanding and reporting service demand is essential for service planning and accountability. Data should be collected in a way that not only enables comparability between jurisdictions, but also provides information about service utilisation of high-risk groups, and drives service improvements.

74. While the NTRAI OHP publishes an annual report on service provision, however this only captures oral health services funded through this program. Additionally, there are limitations to the data collected by this program as parents or guardians of children who are participating in the program (receiving services) must provide their consent for information to be shared with the Australian Institute of Health and Welfare (who compile the report) [38]. The consent rate in 2021 was 59% for those receiving preventative services, and 78% for those who received clinical services. This means that the number of children counted as receiving a service

can only be accurate performed where consent was given. As such, data reporting may result in the total number of actual service recipients being overestimated (e.g. same child is counted twice).

75. An evaluation of the effectiveness, efficiency, and appropriateness of the NTRAI OHP by the National Indigenous Australian Agency in 2022 highlighted that annual reporting did not provide information that identifies whether the oral health of Aboriginal children is improving. The report also highlighted that the program was limited by a lack of strong connection with ACCHSs. Recommendations for future program planning and reporting included that, in addition to providing information on number of services provided, measures that enable service effectiveness and cultural competency to be determined should be a key focus of all oral health service evaluation and drive continual improvements. Recommendations also included strengthening program governance, collaborative coordination, and streamlined monitoring and evaluation, alongside Aboriginal representatives. We call for all recommendations outlined in the NIAA evaluation to be implemented in full. [38].

76. ACCHSs are experienced in data collection and reporting regimes and are accountable to the funding bodies that enable service provision. Therefore, ACCHSs play a critical role in continuous quality improvement and responsible innovation, enabling the implementation and evaluation of new services and programs and building an evidence base of what works.

77. Currently, Congress' dental team records client information within the Communicare electronic medical record. It has been recognised that the capability of Communicare to appropriately capture detailed and meaningful dental health information is limited. Appropriate dental practice management software is therefore being procured, however, this generates further unfunded expenses associated with dental service provision through ACCHSs.

78. Public dental services are often delivered separately to other health services, and as a result are not reported on in routine health service provision forums. Whilst there are informal collaborative relationships between oral health services providers in the region, there are no formal mechanisms that enable collaborative efforts towards a needs-based assessment, service planning, quality improvement, reporting, and advocacy. Appropriate funding and resources are necessary to facilitate and steer these forums, which have the potential to optimise broader service effectiveness.

i) workforce and training matters relevant to the provision of dental services

Recommendation 12: Address current dental workforce crisis in remote areas, including by providing tax relief for all practicing dental health workers working in MM7 regions where there is a significant Aboriginal population.

Recommendation 13: Fund traineeships, scholarships, and cadetships to enable Aboriginal people to enter, develop, and progress within the oral health service profession.

79. A primary health care workforce is critical for the continued success of the ACCHS sector to meet the health needs of the Aboriginal peoples of Australia. Today, especially in remote and very remote areas, the availability of staff to fill key roles in the primary health care multidisciplinary team is a key limiting factor in meeting the healthcare, including oral healthcare, needs of community. Maintaining a workforce in remote areas is challenging, and attracting and retaining suitable permanent oral health team members is no different [61]. Failure to address this current workforce crisis will undermine further attempts to 'close the gap' in health outcomes for Aboriginal people. Workforce shortages, staff turnover and high service demand contribute to impaired relationships and partnerships with the community [3]. Strategies to address workforce shortages may include:

    a) Providing tax relief (e.g. full or significant partial tax exemptions or credits) for all essential workers in MM6 and MM7 areas, with a gradient based on remoteness throughout Central Australia (including the oral health workforce)

    b) Implementing a Commonwealth funded retention payment system for remote essential workers after 12 months of service

    c) Establishing a national scheme of scholarships and cadetships directed especially through ACCHSs to support the training of the Aboriginal oral health workforce, including dentists, dental assistants, oral health therapists etc.

    d) Indexing core funding for ACCHSs to take account of inflation and allow more competitive salaries to be offered

    e) Increasing the Medicare bulk billing incentive in rural and remote areas

Please refer to attachment 1. Health Workforce Letter for further recommendations for ways to address health workforce shortages in remote locations.

80. An Aboriginal oral health workforce is essential to providing culturally responsive services. Congress has supported the employment of Aboriginal Dental Assistants and facilitated on-the-job, vocational, and higher education training for these staff members. Dedicated funding for Aboriginal people to enter, develop, and progress within the oral health profession, through scholarships, traineeships and cadetships, will lend in strengthening workforce capacity in remote and regional areas. Longer term efforts to address education levels, poverty, inequality, poor housing and intergenerational trauma has the potential to unlock Aboriginal participation and contribution in the oral health, and wider, workforce.

81. New AHPRA and Dental Board of Australia accreditation standards, to be implemented for dental programs over the next five years, mandate the inclusion of Aboriginal and Torres Strait Islander cultural safety curriculum [62]. Resources and further training to support the existing oral health workforce to undertake cultural safety training and self-reflective practice to address assumptions, bias, and racism, are required to enhance accessibility of dental services for Aboriginal people.

82. There is a need to address the disparity of conditions that are able to be provided to privately employed dentists, who may be offered commissioned based rates, compared to government or ACCHS employed dentists who are limited to salary rates. Strategies to address this may include incentives similar to the Medicare Practice Incentive Payment (PIP) Rural support stream, provide to GPs who work

in remote practices.

83. As previously outlined, expansion of existing training programs for remote health practitioners in applying fluoride varnish will greatly improve the provision of this preventative service. This program may have more reach if Dental Assistants become approved to become trained in the application of fluoride varnish.

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