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Submission for the Senate Inquiry into the Provision and Access of Dental Services in Australia

Recommendations

1. The Commonwealth Health Department to provide targeted funding to improve oral health in Aboriginal people commensurate with the scale of the need and the increased cost of service delivery in rural, remote and very remote areas.
2. Increase the Child Dental Benefits Schedule to 1.5 times the current rate in MM6 areas and double the rate in MM7 areas.
3. In alignment with Close the Gap principles and the National Oral Health Plan, transfer oral health services from the Northern Territory Government oral health service to ACCHSs where they have capacity to deliver these services.
4. Support ACCHS who are interested in providing dental services but do not currently have capacity so that over time, they can provide these services.
5. Ensure a robust communications plan between dental professionals in jurisdictional services and ACCHSs including by program deliverables focusing on communication between oral health services and primary health care.
6. Jurisdictional oral health services that receive any Commonwealth funding should be required to include the ACCHS sector in an effective governance mechanism oversighting public oral health service provision.
7. Ensure adequate water fluoridation for the outstanding communities with 600 or more people.
8. Revisit the cost-effectiveness of water fluoridation for communities of less than 600 people. For those communities with low water fluoride levels but where water fluoridation is not considered to be cost effective, increased funding should be provided so that fluoride varnish can be provided to all children less than five years of age at six monthly intervals.
9. Create incentives for oral health professionals to work and live in the NT including retention bonuses for oral health professionals in remote and very remote areas.
10. Increase training placements for dentists and other oral health professionals.
11. Invest in Aboriginal participation in the oral health workforce.
12. Implement cultural safety measures, such as training for non-Aboriginal oral health professionals and cultural support from Aboriginal Health Workers.
13. Implement a mentoring/education program for oral health professionals in remote NT to support their practice.
14. Expand eligibility for the Patient Assistance Travel Scheme to cover dental emergencies and dental reviews in high risk clients.
15. Introduce a national sugar tax along with healthy food subsidies for remote communities.
16. Integrate dental services into Medicare with a tiered system providing basic access to all and enhanced access to 1) people with a valid health care card, 2) all Aboriginal people, and 3) people with certain high risk health conditions. There should be clear guidelines outlining what dental treatment is linked to health gains and so can be included in the scheme.

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Introduction

AMSANT is the peak body for community controlled health services in the Northern Territory (NT). Our services are based from Darwin to the most remote areas of the NT. There are two main providers of comprehensive care in the NT- the government and the Aboriginal community controlled health services (ACCHS) sector. The ACCHS sector is the larger of the two main providers, and provides around two thirds of the total annual contacts in the NT Aboriginal primary health care sector.

This submission outlines reforms to dental health services in the NT, and also recommends broader changes that would reduce the current high unmet need for oral health services. AMSANT has advocated for many of the above recommendations previously.

Extent of oral health need in the NT

The picture of oral disease in NT Aboriginal communities is marked by remoteness, disproportionate rates of dental disease, and inadequately addressed issues such as chronic disease and social determinants of health.

26.3% of the NT population identify as Aboriginal (ABS 2023). Aboriginal people make up 38% of the population in remote areas, and 90% of the population in very remote areas (Gregory 2022). The Aboriginal population in the NT is younger than the overall population, with 46.8% of people aged under 25 years and 28.1% aged under 15 years. (ABS 2023).

Australian Institute for Health and Welfare (AIHW) data on dental disease are not specific for Aboriginal people living in the NT (AIHW 2023). However, the data noted that **decayed, missing or filled surfaces** (DMFS) in 5-14 year old Aboriginal and Torres Strait Islander children was most prevalent in outer regional and remote/very remote areas (which are the designations for all areas of the NT). Similarly, 2020-2021 national data show that the rate of **potentially preventable hospitalisations** due to dental conditions is higher for those living in outer regional, remote and very remote communities, and for Aboriginal and Torres Strait Islander people, compared to major cities and non-Indigenous people respectively (AIHW 2023). Rates of potentially preventable hospitalisations are particularly high for remote or Aboriginal and Torres Strait Islander children under 10 years of age (AIHW 2023). These population data reflect the results of studies conducted in Aboriginal patients in the NT, which show considerably higher prevalence and severity of dental and periodontal disease in Aboriginal people compared to non-Indigenous people (Kapellas 2021).

Tertiary health services in the NT see high rates of Aboriginal children for dental emergencies. 2017-2019 data showed that Aboriginal and Torres Strait Islander children under 5 years were hospitalised for dental problems at 4.5 times the rate of non-Indigenous children in the NT (AIHW 2023a).

Aboriginal people in the NT also have significant rates of chronic disease and social determinants of poorer health that interplay with oral disease, which results in a higher need for both acute and regular preventative dental care. **Rheumatic heart disease** (for which prevalence is highest in the NT and among Aboriginal and Torres Strait Islander people (AIHW 2023b)) and its associated heart valve damage can predispose people with dental infection to endocarditis (RHD Australia 2020). The prevalence of **diabetes** in the NT is among the highest in the world – a study of 2018-2019 data found a prevalence of 40% in adult Aboriginal people in Central Australia (Hare et al, 2022). Chronic oral inflammation may interfere with glycaemic control and thus worsen outcomes in people with

diabetes (Mealey et al 2006, Negrato 2013). Also, poor glycaemic control is associated with severity of gingivitis and periodontitis (Mealey et al 2006, Negrato 2013); periodontitis is considered by some to be 'the sixth complication of diabetes mellitus' (Loe 1003, Mealey et al 2006). Thus regular dental care and oral health promotion is particularly important for people with diabetes. **Poor nutrition and high sugary drink consumption** (as outcomes of determinants like food and water insecurity, and housing without food preparation facilities) are both associated with oral disease (HealthInfoNet 2018, Algra 2021, Dimaisip-Nabuab et al 2018). The NT has one of the highest rates of consumption of sugar sweetened beverage (SSB) consumption in Australia (ABS 2018). Furthermore, dental disease can make it difficult to chew, which can exacerbate poor nutrition. The NT also has high rates of Aboriginal people with **chronic kidney disease** (four times the rate of non-Indigenous people in the NT (AIHW 2020), and there is evidence for interrelation between chronic kidney disease and oral disease (Baciu et al 2023). In addition, there are large numbers of Aboriginal people on dialysis and awaiting renal transplant, and dental clearance is part of the eligibility process for waitlisting (Scholes-Roberston et al 2022). **Smoking** is a risk factor for oral disease (Cancer Council 2019), and Indigenous Australian adults have the highest proportion of current smokers (54%) compared to other states and non-Indigenous Australian adults (AIHW 2020b).

Legislation and policies for dental services in the NT

Currently there are no jurisdiction-level policies in place for oral health in the NT. The NT government's Oral Health Services program (NT OHS) was implemented as part of the previous NT Oral Health Promotion Plan 2011-2015 (NT Department of Health 2011).

Water fluoridation is an important policy that has not been implemented consistently across the NT. Fluoride in drinking water in remote areas is associated with fewer dental caries (Jack et al 2016, Johnson et al 2014). Some areas of the NT have naturally occurring adequate fluoride levels in the water supply (Power and Water 2022). In the NT, communities with populations of 600 or more are eligible for water fluoridation if required (NT Health 2010). The position to support water fluoridation for communities of 600 or more people was based on a 2008 cost-effectiveness study by the NT Department of Health (Gray et al 2008).

However, not all eligible communities have had their source water fluoridated. The Public Health Association of Australia (PHAA 2020a) reported in a media release that 13 eligible communities with populations over 600 had not had their source water fluoridated. In total in 2022, 52 urban and remote communities without naturally fluoridated source water had not been fluoridated (Power and Water 2022).

Funding of dental services in the NT

Under the federal Child Dental Benefits Schedule, children aged 2 to 17 years who are eligible for Medicare and are receiving a relevant Australian government payment (e.g. Family Tax Benefit Part A) are eligible for up to $1052 of basic dental services every two years (Services Australia 2023).

Other funding includes the Commonwealth-funded program for remote dental services (see below). Currently there is **very limited funding to ACCHSs** to provide dental services, despite some ACCHSs having capacity to do so. By contrast, many interstate ACCHSs provide comprehensive dental services (for example, Aboriginal and Torres Strait Islander Community Health Services Brisbane).

There is a mismatch between the funding provided for dental care to the Territory and the proportion that reaches patients. Part of this is due to the **cost to fly in, accommodate and pay oral**

health professionals. Primary health care services are significantly more expensive to provide in very remote areas as are dental services (Zhao et al, 2018; Dyson et al, 2012), NACCHO has recommended increasing the Child Dental Benefits Schedule in remote and very remote areas to address this cost differential (NACCHO 2022).

Dental services in the NT

Dental services in the NT are provided by the NT government through the NT Oral Health Service (NTOHS), private providers based in towns and limited service provision in a few ACCHSs. Other ACCHSs are considering how best to provide oral health services. Importantly, there is **no shared governance of dental health data**, and so overall service uptake across the NT is not known.

NTOHS provides emergency and general dental services for children and adults in urban and remote community clinics, schools, and via dental trucks (around Central Australia). Oral health services to remote communities are partly funded through the Northern Territory Remote Area Investment (NTRAI) program. The NTRAI program is a National Partnership Agreement between the Commonwealth and NT governments under the Federal Financial Relations Act 2009. The program provides a wide range of services including oral health and ear/hearing health to Aboriginal communities in the NT. The oral health component is worth $5 million per year. The NTRAI scheme is currently under review with existing services being continued until June 2024, when there will be a transition process to services that are better aligned to the Close the Gap (CTG) principles, including transition to community control and reform of current government services.

The current oral health component of the NTRAI is delivered by the Northern Territory Government and provides dental outreach services for Aboriginal children under 16 years living in remote areas. It also delivers preventative treatment (full-mouth fluoride varnish and fissure sealant applications), as well as other clinical dental services (such as tooth extraction). Fluoride varnish treatment requires accredited training, and having trained staff available to provide six-monthly treatment is especially difficult given current workforce shortages. Further, the percentage uptake of fluoride varnish treatment in remote communities (and the number of children untreated) is not reported (AIHW 2022).

In the Top End, some ACCHSs have dental chairs within their clinics. In Central Australia, the major ACCHS (Congress) has a dental service – please refer to the separate submission by Congress for more detail on their commitment to continuing this vital service and the benefits to serviced communities. Remote communities rely on NTRAI dental vans to provide outreach services; smaller communities may only receive a visit every 3-6 months. Clearly, **dental emergencies** usually occur when there are no oral health professionals present. There is limited **eligibility for the Patient Assistance Travel Scheme (PATS),** which provides funding for transport and accommodation for rural and remote residents requiring health treatment) for oral health conditions. This needs to change so that if a primary healthcare professional believes that a patient requires emergency dental treatment, PATS is available.

Given the disparities between NT Aboriginal communities and the general population in dental disease and the contributing social determinants of health, **dental health promotion** should be considered a key feature of dental services in the NT. Current prevention activity through NTOHS includes a training course for remote primary health care workers to incorporate oral health screening and education into their practice, as well as fluoride varnish training (National Oral Health Promotion Clearinghouse 2015). However, this is largely a clinical screening and preventative

treatment rather than a health promotion program. Health promotion programs should ideally have community leadership and direction, and be multifaceted, including influencing sectors outside health and mobilising community leadership. There is considerable overlap between changes needed to reduce dental disease and important metabolic related diseases such as diabetes and kidney disease. ACCHSs should be funded to provide integrated and holistic health promotion strategies targeting dental disease specifically (e.g. promoting and reducing barriers to dental hygiene practices) as well as broader health promotion strategies that address risk factors for oral health and its comorbidities. Community leadership of such strategies is best achieved within the community controlled sector.

Dental services for Aboriginal people are undersupplied in the NT. The NT has the lowest full-time equivalent (FTE) of dentists of any jurisdiction (32.9 per 100,000 population in NT compared to 57.9 per 100,000 population nationally) (AIHW 2023). Aboriginal people are more likely to seek dental care in non-private settings (i.e. community clinics or ACCHSs), given that many people live in remote communities where there is no access to private services and also cost is likely to be a significant barrier for those reliant on Centrelink payments. About 20% of dentists in the NT work in the non-private sector, and in 2020, only 4 dentists were recorded as working at ACCHSs (AIHW 2023). There is also low FTE of dental therapists (3.0 per 100,000 population) and relatively high FTE of oral therapists (7.2 per 100,000 population) compared to other jurisdictions. However, the NT oral health workforce overall is very maldistributed, with few oral health professionals in remote and very remote regions.

The rate of **Aboriginal participation in the oral health workforce** is less than half that of non-Aboriginal people with even lower rate for dentists (AIHW 2020c). Cultural safety of services is enhanced by Aboriginal participation in the workforce. Participation rates in the oral health workforce should be at least at parity with population share (approximately 30%) across all levels of the workforce including leadership roles. This may be particularly important for oral health services given that people with histories of current, past, or intergenerational trauma may find it more difficult to attend oral health services. Unfortunately, intergenerational trauma is a common issue in Aboriginal communities. Increasing Aboriginal participation in the workforce and provision of oral health services within community controlled health services should make oral health services safer and easier to access for Aboriginal people who have experienced complex trauma.

As per the CTG principles, mainstream health services should be **culturally safe and responsive** to the needs of Aboriginal people. Mainstream services often have rigid appointment systems and policies about people who do not attend appointments that do not take into account complex life circumstances and histories of trauma. Development of more flexible, culturally safe and responsive models will require increased Aboriginal participation in the workforce, cultural safety training as well as support to implement a trauma informed approach (Gunter 2022).

Social determinants of health that affect provision of and access to dental care in the NT.

Many Aboriginal people face major **structural barriers** to accessing dental services in the NT. Geography is the clearest barrier for those living in remote communities, as they are usually reliant on outreach services with particularly infrequent visits to smaller communities. Financial and remoteness barriers result in less access to private providers, which is a large proportion of the dental workforce in the NT. Oral health promotion activities that encourage oral self-care

(toothbrushing and flossing) are impeded by social determinants such as inadequate housing infrastructure to support hygiene activities, consistent access and ownership of toothbrushes and toothpaste, and so on. Encouraging healthy diets (such as reducing sugary drinks) is also impeded by insecure and expensive supplies of healthy food and variable quality of drinking water.

Recommendations to improve dental services to Aboriginal people in the NT.

Below are recommendations to improve oral health services for Aboriginal people in the NT. Addressing causes of oral health inequity, including inadequate funding for remote services and providing equal access to preventative treatments, should be a priority given evidence of a higher burden of dental conditions as well as other chronic conditions that can be aggravated by poor oral health. Additionally, the Close the Gap Reform Priorities should guide the implementation of changes to service delivery.

Increase funding.

Funding needs to be increased to meet the oral health needs of Aboriginal people in urban and remote NT. The extent of inequity in oral disease between Aboriginal and non-Aboriginal people in the NT warrants urgent attention and targeted funding. The NTRAI Oral Health Program, which focuses on remote communities, is an example of this and this funding should continue either within the NTRAI program or within the Indigenous Health program; however, oral health of Aboriginal people in Darwin (and urban and regional areas nationally) should also be a focus of funding.

Workforce is a major area that requires additional resources. The current funding model does not account for the additional costs of flying dental professionals into the NT, the much higher costs of remote service delivery, accommodation and locum rates. Increased funding to meet health needs will also need to account for this existing shortfall.

Recommendation 1

The Commonwealth Health Department to provide targeted funding to improve oral health in Aboriginal people commensurate with the scale of the need and the increased cost of service delivery in rural, remote and very remote areas.

Recommendation 2

Increase the Child Dental Benefits Schedule to 1.5 times the current rate in MM6 areas and double the rate in MM7 areas.

Improve service capacity and delivery.

With the high rates of oral disease, in a population with high rates of preventable hospitalisations for dental disease, public dental services need to be expanded urgently. The challenges here include the difficulties in recruiting and retaining a stable oral health workforce (particularly outside Darwin), complexity of oral disease and interacting comorbidities, and providing culturally appropriate care.

A limited government review of the NTRAI Oral Health Program recommended that its future activities be co-designed with ACCHSs. This would largely limit reform to improving mainstream services given the service is provided by the NT government. However, transition of oral health services to community control is recommended in the National Oral Health Plan and by NACCHO

(COAG 2016). ACCHSs are best placed to provide a holistic health service that incorporates dental care, given their strong existing linkages with communities and holistic primary health care delivery model. Integrating dental and primary care would support a more comprehensive primary healthcare approach for Aboriginal communities, where preventative and clinical approaches can be integrated. Dental health promotion would be more effective and holistic if it was incorporated into broader health promotion programs instead of focusing just on a single disease. Incorporation of dental services into ACCHS would allow for better targeting of high-risk patients (such as patients with rheumatic heart disease) for urgent dental care. Integration would also improve clinical safety, program effectiveness, outreach to more marginalised or vulnerable members of the community and coordination. Integrating dental services into ACCHSs would also support greater Aboriginal employment and facilitate better use of Medicare to supplement and grow available funding. For many people, particularly those who have experienced significant trauma in their lives, visiting dentists can be confronting and difficult. ACCHSs are more likely to be able to provide culturally safe trauma informed dental services that are flexible and responsive to individual people's needs (Atkinson 2013). Finally, continuity of care and follow-up would be better provided through ACCHSs, for example when providing six-monthly fluoride varnish treatment for children.

Many remote ACCHSs in the Top End, and to a lesser extent in Central Australia, have the infrastructure and would have capacity to employ dental health professionals directly. Smaller services or services without the necessary infrastructure could use fly-in, fly-out services provided by a larger regional ACCHS, or they could use the current NTOHS program. For NTOHS dental services, a robust communications plan with ACCHSs to ensure continuity of care would improve program success and data capture. There should be reporting deliverables for Commonwealth-funded NT government services focusing on communication and integration. Some ACCHSs may choose not to provide oral health services and some Aboriginal people live in areas with state government primary health care services. Each jurisdiction should have a governance mechanism for public dental services that includes the ACCHS sector as a meaningful partner.

Maldistribution of the workforce (inadequate services to remote areas) should be addressed in line with developing and maintaining a sustainable and culturally safe workforce (see below).

Recommendation 3

In alignment with Close the Gap principles and the National Oral Health Plan, transfer oral health services from the Northern Territory Government oral health service to ACCHSs where they have capacity to deliver these services.

Recommendation 4

Support ACCHSs who are interested in providing dental services but do not currently have capacity so that over time, they can provide these services.

Recommendation 5

Ensure a robust communications plan between dental professionals in jurisdictional services and ACCHSs including by program deliverables focusing on communication between oral health services and primary health care.

Recommendation 6

Jurisdictional oral health services that receive any Commonwealth funding should be required to include the ACCHS sector in an effective governance mechanism oversighting public oral health service provision.

Provide equal access to fluoridated water.

Aboriginal people in the NT should have equitable access to effective public health interventions that reduce oral disease. Several remote NT communities that are eligible by size for water fluoridation (and where water fluoride levels are not naturally adequate) have not yet been fluoridated. This should be implemented promptly. For communities of fewer than 600 people, the evidence for cost-effectiveness should be re-visited and we recommend lowering the threshold for fluoridating community water supplies where feasible. Increased funding should be made available to small communities where fluoridation of water supplies is not considered cost effective so that fluoride varnish can be provided at scale to young children as this is a proven method for reducing dental caries. This treatment is being provided by visiting oral health services at present but it is unlikely that this treatment is being provided to all children < 5 on a six monthly basis particularly as smaller communities get very infrequent visits from oral health services.

Recommendation 7

Ensure adequate water fluoridation for the outstanding communities with 600 or more people.

Recommendation 8

Revisit the cost-effectiveness of water fluoridation for communities of less than 600 people. For those communities with low water fluoride levels but where water fluoridation is not considered to be cost effective, increased funding should be provided so that fluoride varnish can be provided to all children less than five years of age at six monthly intervals.

Build sustainability of oral health services

Oral health service provision for Aboriginal people in the NT need to be sustainable with substantial growth to meet demand. The reassessment of the NTRAI OHP (oral health plan) should consider a long term health service plan for remote Aboriginal people.

For both urban and remote Aboriginal people, a sustainability plan for oral health services should consider the World Health Organization building blocks for healthcare services (Stockton 2021, Duane 2022). This might include the following:

- **Development and maintenance of an adequate workforce**. Building and retaining the workforce is currently one of the most significant challenges for oral health services in the NT. The workforce planning strategy should focus on 1) oral health professional ratios based on population need rather than population size; 2) recruitment and retention; and 3) cultural safety.

  There need to be more incentives for oral health professionals to work and live in remote and very remote areas, particularly for oral health professionals working in the public sector. General practitioners are provided with generous incentives that reward length of service in

remote and very remote regions. This should also be introduced for oral health professionals.

Although there is likely to be an ongoing need for locum staff for some time, the aim should be to recruit professionals who wish to stay in the NT long term. The skills of local oral health therapists and dental therapists could be maximized to provide much of the treatment in Aboriginal communities, and to provide a more continuous service that would be supported by visiting dentists. New oral health professionals would require training in the cultural needs and oral health issues of Aboriginal people in the NT. Fluoride varnish training should continue to be provided for oral health professionals working in the NT. Finally, local training capacity should be increased.

A sustainable workforce plan should also include training of a local Aboriginal oral health workforce, in line with the National Oral Health Plan (COAG 2016). This would improve remote workforce capacity and cultural safety and workforce sustainability. Additionally, Aboriginal Health Workers should be trained or upskilled as 'cultural translators' for visiting oral health professionals, and to reinforce oral hygiene messages to patients.

Finally, elements of interprofessional practice, such as training for medical and allied health professionals to recognise dental health emergencies, would also increase sustainability.

- **A fit-for-purpose digital health system**. ACCHSs that want to provide oral health services should be funded for a suitable Clinical Information System. Telehealth and teleconference technology for mentoring and education will be useful in supporting visiting oral health professionals (particularly in remote NT) to work at the top of their scope.

- **Access to treatments**. The long transport times in remote NT mean that the majority of Aboriginal people will rely on outreach services. However, many dental emergencies will occur when there are no oral health professionals in the community. Support is required for patients with dental emergencies to travel into major centres. This would require the eligibility criteria for the Patient Assistance Travel Scheme to be revised to include dental emergencies.

- **Local service involvement in governance**. Involvement of ACCHSs and AMSANT in oral health service governance (regardless of whether dental services are delivered through them) would facilitate development and implementation of oral health services that better align with the needs of Aboriginal people. Inclusion of the ACCHS sector in governance would also maximise intersectoral collaboration.

- **Delivery of evidence based community-oriented preventative and restorative services**. Aboriginal people are twice as likely to present with acute dental conditions and are less likely to present for preventative treatments compared to non Aboriginal people (Kruger et al, 2010). Increased funding, transfer of oral health services to ACCHSs and greater community engagement in oral health service delivery should assist in reorientating services towards prevention and early intervention.

Recommendation 9

Create incentives for oral health professionals to work and live in the NT including retention bonuses for oral health professionals in remote and very remote areas.

Recommendation 10

Increase training placements for dentists and other oral health professionals.

Recommendation 11

Invest in Aboriginal participation in the oral health workforce.

Recommendation 12

Implement cultural safety measures, such as training for non-Aboriginal oral health professionals and cultural support from Aboriginal Health Workers.

Recommendation 13

Implement a mentoring/education program for oral health professionals in remote NT to support their practice.

Recommendation 14

Expand eligibility for the Patient Assistance Travel Scheme to cover dental emergencies and dental reviews in high risk clients.

Introduce a sugar tax and food subsidies.

Although taxation and food subsidies are not within the remit of this Inquiry, it is clear that the oral disease burden in the NT is linked to upstream factors including high levels of sugary drink consumption. Addressing the high rates of oral disease (and other interacting chronic diseases) must include reduction of these contributing factors otherwise the demand for oral health services will continue to outstrip the capacity to meet that demand.

There are examples internationally of the effectiveness of sugar taxation on reducing consumption of sugar sweetened beverages (Grattan Institute 2016, Schwendicke 2016, Briggs 2017, Jevdjevic 2019) and modelled evidence for the effectiveness of a sugar tax in reducing oral disease burden in Australia (Sowa 2019). Sugar taxation is currently a topic of debate in Australia and has the support of the Australian Medical Association (AMA 2023), the Australian Dental Association (ADA 2019) and the Public Health Association of Australia (PHAA 2020b). In addition to disincentivising sugar consumption through taxation, healthy foods would need to be subsidised in remote areas given the high and growing gap between remote and urban food prices (56% price differential between the cost of food to feed a family of four for a week between Darwin and remote communities in the NT (NT Department of Health 2022). There is significant evidence supporting healthy food subsidies and taxation as an effective measure to improve population health outcomes more broadly (Niebylski et al, 2015, Blakeley et al 2020). Given the escalating and unsustainable rates of chronic disease in Aboriginal people in the NT, more radical action is needed otherwise we are at risk of the life expectancy gap widening rather than closing.

Recommendation 15

Introduce a national sugar tax along with healthy food subsidies for remote communities.

Integrate dental services into Medicare.

Universal and equitable access to dental care for Aboriginal people in the NT would be much improved through integration of dental services into Medicare. The previous Commonwealth program integrating dental services into Medicare was the Chronic Disease Dental Scheme (CDDS), which introduced new Medicare billing items for dental care, but was not always equitable as disadvantaged people without chronic disease were ineligible. This would have been particularly inequitable in the NT Aboriginal communities as Aboriginal people have a higher risk of chronic disease than the general population. Other criticisms of the CDDS were of unclear eligibility criteria, insufficient consultation during planning with health providers, insufficient promotion to patients, and cost blowout (Weerakoon 2014). There were also concerns about excessive spending on less necessary but very expensive care in the field of prosthodontics such as crowns and bridges with a less clear link to health gain from this more expensive care (Harris M et al, 2012). The NT had the lowest per capita spending on this scheme and provided more basic care, whilst NSW had the highest per capita expenditure and a high proportion of very expensive care demonstrating that the scheme reinforced geographic inequity rather than reducing it (Lam et al 2012). These lessons should be incorporated into any new universal dental care system: in particular, it should be accessible by all disadvantaged people. This could be through a tiered system of basic access for all for a limited range of essential and emergency dental care, and enhanced access for 1) people with health care cards, 2) all Aboriginal people, and 3) people with health conditions where dental care is particularly important. However, there also needs to be greater investment in public provision (including by ACCHSs) of remote dental care as even if Medicare benefits were substantially increased for remote regions, Medicare could only provide a portion of the funding required – block funding would also be needed. More expensive dental care with less clear evidence of health gain should be excluded in order to support expanded access and cost effectiveness.

Recommendation 16

Integrate dental services into Medicare with a tiered system providing basic access to all and enhanced access to 1) people with a valid health care card, 2) all Aboriginal people, and 3) people with certain high risk health conditions. There should be clear guidelines as to what dental treatment is linked to health gains and so can be included in the scheme.

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