REPORT OF THE STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

THE PROVISION OF HEALTH SERVICES IN THE KIMBERLEY REGION OF WESTERN AUSTRALIA: DENTAL HEALTH

Presented by Hon Mark Nevill MLC

Report 33

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

Date first appointed:

December 21 1989

Terms of Reference:

1. There is hereby appointed a Standing Committee to be known as the *Estimates and Financial Operations Committee.*
2. The committee consists of 5 members.
3. The functions of the Committee are to consider and report on:
   (a) the estimates of expenditure laid before the Council each year; and
   (b) any matter relating to the financial administration of the State.
4. The Committee shall report on the estimates referred under clause 3 by or within one sitting day of the day on which the second reading of the *Appropriation (Consolidated Revenue Fund) Bill* is moved.
5. For the purposes of clause 3(a), the House may appoint not more than 6 members at any stage of its examination.
6. A reference in clause 3 to "estimates of expenditure" includes continuing appropriations, however expressed, that do not require annual appropriations.
7. The Committee may initiate investigations under clause 3(b) without prejudice to the right of the Council to refer any such matter.

Members as at the time of this inquiry:

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Hon Muriel Patterson MLC
Hon Ed Dermer MLC
Hon Simon O'Brien MLC
Hon Ljiljanna Ravlich MLC

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Government Response

This Report is subject to Standing Order 337:

> *After tabling, the Clerk shall send a copy of a report recommending action by, or seeking a response from, the Government to the responsible Minister. The Leader of the Government or the Minister (if a Member of the Council) shall report the Government's response within 4 months.*

The four-month period commences on the date of tabling.

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IN RELATION TO

THE PROVISION OF HEALTH SERVICES IN THE KIMBERLEY REGION OF WESTERN AUSTRALIA: DENTAL HEALTH

1 EXECUTIVE SUMMARY AND RECOMMENDATIONS

Executive Summary

1.1 In the Kimberley region of Western Australia, dental health is one of the biggest health problems. The Aboriginal people are experiencing what can be described as an epidemic of dental disease. The dental services are not adequate to meet the need of the Aboriginal people living in the Kimberley.

1.2 The problem of dental health of the Aboriginal people and the problems associated with the dental service provision in the Kimberley are not a new phenomenon and are well recognised.

1.3 The Standing Committee on Estimates and Financial Operations ("the Committee") is of the view that the State Government is currently failing in its commitment[1] to provide access to quality health care for all people living in remote areas of Western Australia by allowing dental health standards to continue to deteriorate in the Kimberley.

1.4 This report seeks to present some practical suggestions for action in order to improve the current poor status of dental health of the Aboriginal people in the Kimberley and thus improve their quality of life. It is the aim of the Committee that the implementation of the recommendations of this report will contribute to significantly reduce dental health problems and equip Aboriginal communities with the prerequisites to achieve and maintain good dental health.

[1] As made by Hon John Day MLA, Minister for Health in the report of the Health Department of Western Australia, *Remote Area Nurse Practitioner Project Report 2000*, April 2000.

Recommendations

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Recommendation 1: That a survey be undertaken of dental health in the Kimberley and that a plan and program be established to address dental health needs.

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Recommendation 2: That the State Government make a greater effort to put fluoride into the water supplies in the Aboriginal communities of the Kimberley to aid in the prevention of dental caries.

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Recommendation 3: That supplementary fluoride programs, in the absence of water fluoridation, be implemented in all schools in the Kimberley.

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Recommendation 4: That dental health education programs aimed at preventing dental disease be implemented immediately. The programs should include dental health instruction and daily brushing.

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Recommendation 10: That the Health Department of Western Australia establish 'dental centres' in key Aboriginal communities to house dental equipment to be used by visiting dental health staff.

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Recommendation 13: That the HDWA undertake a feasibility study into short-term vocational placements of final year dentistry students and first year dentists in the Kimberley.

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Recommendation 14: That the Health Department of Western Australia undertake a review of the role of dental auxiliaries (therapists and nurses) in providing dental health services in remote areas of Western Australia, similar to the Remote Area Nurse Practitioner Project.

REPORT OF THE STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

IN RELATION TO

THE PROVISION OF HEALTH SERVICES IN THE KIMBERLEY REGION OF WESTERN AUSTRALIA: DENTAL HEALTH

2 INTRODUCTION

2.1 The Standing Committee on Estimates and Financial Operations ("the Committee") was first appointed on December 21 1989. Under its terms of reference, the Committee is required, *inter alia*, to consider and report on any matter relating to the financial administration of the State.

2.2 In June 2000, the Committee resolved to inquire into the expenditure of public funds on the provision of health services in the Kimberley region of Western Australia. The following terms of reference were adopted for the inquiry:

> *"The Standing Committee on Estimates and Financial Operations shall conduct an inquiry and report to the Legislative Council on the allocation and expenditure of public financial resources on the provision of health services in the Kimberley region of Western Australia having regard to:*
>
> *1. The facilities and resources available to, and working conditions of, the State Government health service providers in the Kimberley region.*
>
> *2. The provision and effectiveness of public funding for health services in remote areas of the Kimberley region.*
>
> *3. The provision and effectiveness of public funding for community education and preventative health programs in the Kimberley region.*
>
> *4. The provision and effectiveness of public funding for specialist medical services in the Kimberley region.*
>
> *5. The provision and effectiveness of public funding for health services to Aboriginal communities in the Kimberley region.*

6. *Any other matters in relation to the provision of public funds for health services in the Kimberley region."*

2.3 The Committee advertised the above terms of reference in relevant newspapers, and called for public submissions. Public hearings were conducted in the major towns of the Kimberley during the week of August 21-25 2000 (see Appendix "A"). Further public hearings were conducted in Perth.

2.4 Due to the volume of evidence gathered, and the wide variety of issues raised during the inquiry, the Committee has chosen to prepare a number of separate reports, each based upon a specific issue that the Committee has identified as significant in relation to the provision of health services in the Kimberley. This report is the second of these separate reports arising from the inquiry, and shall deal with the issue of dental health of the Aboriginal people living in the Kimberley.

2.5 The Committee would like to thank all those persons and organisations that made submissions to the Committee and/or appeared as witnesses in hearings before the Committee (see Report 32 for a list of witnesses and submissions received). In particular, the Committee expresses its gratitude for the assistance given to the Committee by the staff of the Health Department of Western Australia ("HDWA").

2.6 The Committee would like to note, however, that a significant number of individuals approached by the Committee expressed reluctance to make any submission to the Committee due to a fear of intimidation and prejudice in their employment position.

2.7 Whether these fears are real or imagined, the Committee found during the course of the inquiry that there is an inordinately high degree of fear and mistrust both between and within the various government agencies, private organisations, and individuals working in the area of Aboriginal health in the Kimberley. Whilst the Committee makes no specific recommendation regarding this situation, readers of this report should note this very important aspect of the difficult environment in which health service providers operate on a day-to-day basis in the Kimberley region of Western Australia.

2.8 The dental health of Australia's indigenous people is generally worse than that of other Australians. Aboriginal people suffer greater levels of dental disease than the average non-Aboriginal Australian does. In the Kimberley, dental health is one of the biggest health problems. The Aboriginal people are experiencing what can be described as an epidemic of dental disease. The Aboriginal children in the Kimberley have over twice as much dental disease as other children in WA[1]. Poor dental health

[1] Based on statistics provided for 6-12year olds, letter from Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, October 5 2000.

throughout childhood can result in tooth loss in adult life. Many Aboriginal adults are missing some or all of their teeth by the time they are in their 30s.[2]

2.9 Poor dental health impacts adversely on a person's quality of life. The consequences may include pain, infection, impaired speech, interference with how and what one eats and embarrassment about one's appearance.[3]

2.10 This report seeks to present some practical suggestions for action in order to improve the current poor status of dental health of the Aboriginal people in the Kimberley and thus improve their quality of life. It is the aim of the Committee that the implementation of the recommendations of this report will contribute to a significant reduction in dental health problems in the Kimberley and equip Aboriginal communities with the prerequisites to achieve and maintain good dental health.

3 THE CURRENT SITUATION

3.1 The Aboriginal population in the Kimberley is approximately 15,500 and growing.[4] Of this population approximately one half to two thirds live close to the six towns[5] in the Kimberley with the remainder living in approximately 180 discrete Aboriginal communities ranging in size from small family groups to 700 people.[6]

Status of dental health of Aboriginal people in the Kimberley

3.2 The status of dental health of Aboriginal people in the Kimberley is extremely poor with a high prevalence of dental caries (tooth decay). This fact is well recognised although little scientific data exists on the extent of the oral health problem in the Aboriginal community in the Kimberley[7].

> *"… The dental health in the coastal communities is to the point where people are actually suffering health effects from severe periodontic disease, and there is a strong link between renal failure and rheumatic heart disease through periodontic disease. Children have unbelievable amounts of dental caries and it is recognised, but there*

2 Submission from the National Aboriginal Community Controlled Health Organisation to the Senate Standing Committee on Community Affairs Inquiry into Public Dental Services, 1998.

3 *Nutrition in Aboriginal and Torres Strait Islander Peoples – An Information Paper*, National Health and Medical Research Council, endorsed July 31 2000.

4 Atkinson D, Bridge C, Gray D, *Kimberley Regional Aboriginal Health Plan*, December 1999, p 6.

5 The six towns in the Kimberley are Broome, Derby, Fitzroy Crossing, Halls Creek, Wyndham and Kununurra.

6 Submission from the Kimberley Aboriginal Medical Service Council Inc., July 31 2000.

7 Submission from Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia, July 28 2000.

> *has never been a dental audit of dental health services and of dental health in the Kimberley …"*[8]

3.3 Generally speaking, the indigenous community is a high-risk population for oral diseases such as dental caries and periodontal (gum) disease. Most communities are in remote locations and dental services are limited. Poor oral hygiene combined with a western style diet high in refined carbohydrates has caused the high rate of both dental caries and periodontal disease amongst the indigenous population.

Statistical Data

3.4 There is a lack of statistical data on Aboriginal dental health in Western Australia generally and much less data available specifically on the Kimberley Aboriginal population.

> ***"Hon LJILJANNA RAVLICH**: Has a needs assessment been done on any other part of the dental health area in Aboriginal communities?*
>
> ***Mr Carrello**: Nothing specific.*
>
> ***Hon LJILJANNA RAVLICH**: You are aware of nothing else in the whole dental health area.*
>
> ***Mr Carrello**: David might be aware of it.*
>
> ***Mr Neesham**: We monitor children's health, but we do not see enough adults. The last bit of information on adult Aboriginal health would have been done in 1978, and the only previous work was probably done in 1960. A professor, who has since passed away, did it as part of his PhD thesis. One of our dentists did some studies on adults in the Broome-Derby area and it was unpublished. We have done some work on monitoring the status of children. Not much has been done on adults in any population. Only one national oral health survey has been done in Australia, and that was done in 1988. There is a terrible lack of data on the general population. Professor John Spencer from Adelaide has been doing a lot of work and gets a lot of valuable information by telephone survey and a few other methods. We have started collecting sample oral health data on people who*

[8] Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, p 10.

come into public clinics, but it is an area of significant deficiency nationally."[9]

3.5 More information is needed to improve oral health. The data available on the status of oral health of the population in the Kimberley is not adequate. This data is essential for program planning and evaluation.

"Good information systems must be in place to guide decisions in planning, funding allocations and evaluation of oral health outcomes and appropriate utilisation of funds."[10]

Recommendation 1: That a survey be undertaken of dental health in the Kimberley and that a plan and program be established to address dental health needs.

Dental Disease and medical conditions

3.6 The Committee is extremely concerned at reports that the oral health of Aboriginal people living in the Kimberley has deteriorated to such a degree that it is causing not only dental disease but also other illnesses.

"Sometimes dental problems with the teeth can lead to life-threatening conditions. When someone has a condition called rheumatic heart disease, infection enters the blood through the poor tooth and it can lodge on the damaged heart valves and cause blockages. So it does have a significance, I believe."[11]

3.7 The Committee notes that there is a growing field of research linking dental diseases to medical conditions, such as respiratory infections and cardiac conditions.

3.8 Studies have shown that having serious periodontal disease that involves loss of bone increases a person's risk of heart disease by up to two fold.[12] Also, people who have periodontal disease may be at greater risk of stroke due to an increased tendency to have blockages in the carotid arteries of the neck. This is because periodontal disease involves a large territory of bone and a lot of tissue is in contact with that bone. From this contact, bacteria and toxic, inflammatory, compounds can gain access to the blood

9 Mr Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 7.

10 Senate Standing Committee on Community Affairs Report into Public Dental Services, Parliament of Australia May 1998, Chapter 5, p 16.

11 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p 17.

12 Adler, Tina, 'Gum Disease: Not just a pain in the mouth', *Heartinfo*, June 5 1998. http://www.heartinfo.org/science/gum5698.htm

stream, where they may have an effect on the lining of blood vessels. It is believed that inflammation plays an important role in heart disease and stroke.[13]

Status of dental services

3.9 The Committee is of the view that the provision of dental services in the Kimberley is extremely inadequate.

> *"Dentistry in the Kimberley is very primitive and there are very few dentists. People do not get good service. That just about sums it up. There may be four dentists there. People who do not live in Derby, Broome or Kununurra have a very small chance of getting any sort of decent dental care."*[14]

> *"… when we finally set up the medical service on the Gibb River Road, the straw that broke the camel's back out there was, I think, a 14-year-old girl dying from an abscess - a toothache. That was the final straw of the so-called services that people were getting up on the Gibb River Road and that was the starting of us - the community got up in arms about it. They called us out there. They were sick of the so-called service they were receiving, but that is the sort of stuff that has been going on around here ..."*[15]

3.10 Dental services in the Kimberley are provided centrally by the HDWA, that is, through Perth Dental Hospital and Community Dental Services and not through specific funding allocation to the individual HDWA health services in the region.[16] There is no direct Commonwealth funding for dental service in the Kimberley.[17]

3.11 The HDWA Dental Health Services provides dental services to the Kimberley out of Kununurra, Broome, Derby and Fitzroy Crossing. At Derby and Fitzroy Crossing the services to the communities are provided solely by HDWA public dental officers. At Broome and Kununurra the services are provided to school children by school dental

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13 'Gum Disease may boost stroke risk', *Reuters Health*, April 21 1998. http://www.heartinfo.org/reutersnews/t0422-8f.htm

14 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia, Transcript of Evidence, September 11 2000, p 8.

15 Mr Arnold Hunter, Chairman, Kimberley Aboriginal Medical Service, Transcript of Evidence, August 21 2000, p 12.

16 Hon John Day MLA, Minister for Health, Questions, Legislative Assembly, *Hansard*, Tuesday, November 16 1999, pp 3180-1.

17 Submission from the National Aboriginal Community Controlled Health Organisation to the Senate Standing Committee on Community Affairs Inquiry into Public Dental Services, 1998.

therapists with support from the local private dentist. Adults are treated by the private dentist in Broome and Kununurra.[18]

3.12 The Committee was informed by Mr David Neesham, Director of the Perth Dental Hospital and Community Dental Services, that in the Aboriginal communities the service currently provided for children is adequate but for the adult population it is not adequate.[19]

3.13 The Committee notes the following comment in the recent Review of Health Services in the Kutjungka Region of Western Australia (the Kutjungka region includes the Balgo, Billiluna, Mulan and Yagga Yagga communities):

> *"Aboriginal people consistently raised concerns about the lack of dental services. Dentists prioritise the schoolchildren when they visit the region. Adults are required to travel to Halls Creek for dental treatment. Improved resourcing for dental treatment needs to be a major consideration for health service planning in the region."*[20]

3.14 The Committee is of the view that the State Government is currently failing in its commitment[21] to provide access to quality health care for all people living in remote areas of Western Australia by allowing dental health standards to continue to deteriorate in the Kimberley.

3.15 The HDWA dental services available in the Kimberley are limited.[22] There are only three dentists in the whole of the Kimberley region of Western Australia, servicing a population of approximately 30,000 people spread over 421,130 square kilometres.[23] There is a severe shortage of dental professionals, nurses, therapists and education officers and there is little use made of dental or health auxiliaries such as Aboriginal Health Workers.

3.16 The problems associated with dental service access in the Kimberley are well recognised. Oral health has been identified as one of the 10 key issues in the State Government's Norhealth 2020 planning program (which addresses the service and

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18 Letter from Hon John Day MLA, Minister for Health, August 30 2000.

19 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 2.

20 Centre for Remote Health & Menzies School of Health Research, *Review of Health Services in the Kutjungka Region of Western Australia – Final Report*, Alice Springs, October 1999, p 42.

21 As made by Hon John Day MLA, Minister for Health in the report of the Health Department of Western Australia, *Remote Area Nurse Practitioner Project Report 2000*, April 2000.

22 See the *Kimberley Regional Aboriginal Health Plan*, Appendix 2 for details of community visits by HDWA dental staff.

23 Submission from Kimberley Aboriginal Medical Services Council Inc., July 31 2000.

infrastructure needs in the North West of the State), and is also a key issue for Aboriginal health in the HDWA regional health planning program.[24]

3.17 Halls Creek has a visiting service from the public dentist in Fitzroy Crossing. The Fitzroy Crossing based service receives funding of $160 000 a year and services both Halls Creek and various communities in the region.[25]

3.18 HDWA mobile dental services in the Kimberley are provided to the town of Halls Creek and to 19 (out of the approximately 180) Aboriginal communities, approximately twice per year. These communities are: Mt Barnett; Gibb River; La Grange; Beagle Bay; One Arm Point; Lombadina; Looma; Christmas Creek; Noonkanbah; Yiyili; Gogo; Cherrabun; Balgo; Bililuna; Mulan; Oombulgurri; Kalumburu; Muludja; and Yakanarra.[26] Typical populations of communities are 50-100 people and visits last about one week. Most remote communities are only accessible to the visiting dental service vans (that is, by road) during the dry season (March to December).[27]

3.19 In Wyndham the dental service is provided by a visiting private practitioner from Kununurra, who participates in the Government's Country Dental Subsidy Scheme.[28] The scheme is for those persons living in country towns where dental care cannot be obtained from a Government clinic. Eligible persons can make application to receive a subsidy (from the HDWA)[29] towards the cost of general and emergency dental care from a participating private practitioner. People who receive a full or near full pension or allowance from Centrelink are eligible to use the scheme. The average waiting time for treatment through the scheme is approximately four to five months.[30]

3.20 School Dental Services are provided on a region wide basis and are coordinated through HDWA Dental Health Services in Perth. Expenditure on the School Dental Services provided in the Kimberley was $277,299 in 1998/1999.[31]

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24 Submission from Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia, July 28 2000.

25 Hon Peter Foss MLC, Questions Without Notice, Legislative Council, *Hansard*, May 24 2000, p 7136.

26 Letter from Jana Allan, Policy Officer, Minister for Health, November 16 2000.

27 Letter from Hon John Day MLA, Minister for Health, August 30 2000.

28 Submission from Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia, July 28 2000.

29 Health Department of Western Australia, *Annual Report 1997/1998*. http://www.health.wa.gov.au/publications/annualreport%5F9798/dentalhealth.htm

30 Hon John Day MLA, Minister for Health, Questions on Notice, Legislative Assembly, *Hansard*, Tuesday, May 2 2000, p 6298.

31 Submission from Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia, July 28 2000.

3.21 In the 2000/2001 financial year budget there has been an increase of $2.4 million in funding allocation for oral health in rural and remote areas across the State, specifically to address the oral health needs of the Aboriginal population.

3.22 The funding allocation for the provision of public oral health services in the North West for the 1999/2000 financial year was $852,000. The current funding allocation is for the maintenance and ongoing provision of current public oral health services in the North West[32], and is not designed to bring about any significant improvement in the service.

Reasons for the current situation

3.23 The major contributing factors to the poor dental health of Aboriginal people are:

3.23.1 *Lack of available dental services*: The existing dental services do not have the capacity to meet the dental needs of Aboriginal people. The shortage of dental services has meant that, for many people in the Kimberley, dental care comes down to treatment on a 'relief of pain' basis only, usually an extraction or temporary filling.[33]

3.23.2 *Barriers to dental care*: These include the physical inability to access care due to remoteness of the community, inaccessibility by road or lack of community transportation; lifestyle issues including a lack of preventive measures at the community and individual level as well as the difficulties encountered in providing a visiting service to transient populations; and general problems encountered in employing people to provide dental services in the Kimberley, that is:[34]

- difficulty in recruitment of staff;
- difficulty in retaining staff for more than a short period;
- difficulty in providing adequate housing for staff;
- difficulty providing attractive pay and benefits for staff in remote areas; and
- requirement to provide employment incentives such as provision of additional leave for staff.

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32 Minister for Health, Questions, Legislative Assembly, *Hansard*, Tuesday, 16 November 1999, p 3181.

33 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, p 9.

34 Submission from Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia, July 28 2000.

3.23.3 *Poor nutrition*: The high prevalence of poor nutrition among indigenous communities almost certainly gives rise to a significantly greater susceptibility to periodontal disease and to an increase in dental caries. [35]

3.23.4 *Low Income and Poor Diet:* Low incomes contribute to poor nutrition and diet and consequently poor dental health.

> *"The median incomes for the Kimberley Aboriginal people is well below $200 per week. Given the considerable expense of food and other essential items, especially in remote communities, these low incomes make living a healthy life extremely difficult."*[36]

The poor condition of Aboriginal oral health is largely attributed to a diet rich in sugar products. Sugars have long been known to contribute to dental caries.[37] Fermentable carbohydrates are carbohydrates like sugar and starch that bacteria can convert to acid; fermentable carbohydrates are cariogenic, that is they produce or promote the development of dental caries.

3.23.5 *Lack of education and awareness of good oral health:* Lack of education is a major factor contributing to poor dental health amongst the Aboriginal people of the Kimberley: *'Educational outcomes for Kimberley Aboriginal children continue to be the worst in the State and even functional literacy is a problem for young people in many areas'*.[38] The Committee believes that the lack of good oral hygiene is directly related to lack of education. The poor condition of Aboriginal dental health is largely attributed to a general lack of oral hygiene[39], such as not brushing teeth with fluoridated toothpaste after eating meals.

3.23.6 *Communities lacking access to fluoridated water supplies*: There is a lack of adequate fluoridation of the water supply to prevent caries. The dental benefits of fluoride have been well established.[40] Remote areas of the Kimberley generally do not have artificial water fluoridation.

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35 Martin-Iverson N, Phatourous A, Tennant M, 'A brief review of indigenous Australian health as it impacts on Oral Health', *Australian Dental Journal*, 1999, Vol 44, No 2, p 89.

36 Atkinson D, Bridge C, Gray D, *Kimberley Regional Aboriginal Health Plan, Executive Summary and Recommendations*, December 1999, pp 3-4.

37 *Nutrition in Aboriginal and Torres Strait Islander Peoples – An Information Paper*, National Health and Medical Research Council, endorsed July 31 2000, p 185.

38 Ibid.

39 Ibid, pp 184-185.

40 Martin-Iverson N, Phatourous A, Tennant M, 'A brief review of indigenous Australian health as it impacts on Oral Health', *Australian Dental Journal*, 1999, Vol 44, No 2, p 90.

The Minister for Health advised the Committee that since July 1 1998, the Aboriginal and Torres Strait Islander Commission ("ATSIC") had assumed responsibility for installation, maintenance and repairs, and testing of water plants in the Kimberley. ATSIC have contracted out this service to Ove Arup & Partners, an engineering and project management company.[41]

However, the Committee notes the following evidence of David Neesham:

> *"**The Chairman:** Can you supply the committee with any data on the fluoridation of community water supplies … ?*
>
> ***Mr Neesham:** We have only partial information. We responded to a parliamentary question on this area, which identified an oversight. The water authority normally routinely monitors this across the State. It contracted out this service, and the contractor has not been doing it. The small sample we had indicated that about half of the communities would have an ideal level of naturally occurring fluoride, and probably 25 per cent of the communities would be too low and 25 per cent would be too high. It would be a fairly simple project to get samples of all the water and have them tested, but that has not been done…"*[42]

The data on water fluoridation of community water supplies is limited. The HDWA is in possession of partial information only as to fluoride levels of the water supplies in the communities in the Kimberley.

The Committee was advised that in the Kimberley, fluoride concentrations in the range 0.55-0.80 mg/L would be optimal for caries prevention.[43]

41 Letter from Hon John Day MLA, Minister for Health, October 25 2000.

42 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 5.

43 Letter from Hon John Day MLA, Minister for Health, October 25 2000.

Fluoride concentration levels of a number of Aboriginal communities in the Kimberley Fitzroy Crossing area[44]

Date	Community	FLUORIDE (mg/L)
09/09/92	Bayulu	0.29
08/09/92	Djugereri	0.80
10/09/92	Junjuwa	0.37
06/12/91	Looma	0.13
09/09/92	Muludja TWS	<0.10
08/09/92	Ngalingkadji	1.27
08/09/92	Ngumpan	<0.10
08/09/92	Wangkatjunka	0.56
14/09/92	Yungngora	0.58

3.23.7 *Medical conditions:* There are general health problems that have direct relevance to the poor dental health status currently being experienced by Aboriginal people. Diabetes mellitus and rheumatic fever are two medical conditions which are prevalent among indigenous communities and which have a significant impact on oral health. The high rate of diabetes (which is related to obesity and a diet high in sugar and fat), in indigenous communities (mostly in the over 30 age group) significantly increases the risk of periodontal disease and dental caries.[45]

4 WHAT CAN BE DONE TO IMPROVE DENTAL HEALTH

4.1 The Committee is of the view that there are a number of measures that can be taken, in order to improve, maintain and enhance the dental health status of Aboriginal people in the Kimberley.

4.2 The two most important are:

1) preventative initiatives; and

2) improvement to the current dental health services provided by the State Government.

44 As provided by the Minister for Health, Ibid.
45 Ibid, p 90.

Prevention initiatives

4.3 It is well recognised that factors such as clean fluoridated water supplies, education and nutrition are important to ensure good dental health. Improvements in dental health in the western world over the last 50 years have demonstrated that dental problems are preventable. Successful prevention measures adopted by communities, individuals and oral health professionals can result in marked improvements in the dental health of the people living in the Kimberley.

4.4 It is important to note that dental health and good general health are closely related and therefore should not be looked at in isolation. The Committee believes that dental health should be incorporated as part of overall primary health care as well as in specific health education programs, such as diabetes education, health worker education, nutrition counselling and health promotion.

Fluoridation

4.5 Fluoride reduces the incidence of dental caries and helps prevent cavities.[46] Fluoride prevents dental caries in two ways: through direct contact with teeth; and also when people drink it in the water supply during the tooth forming years and later. The ability of fluoride to inhibit and even reverse the initiation and progression of dental caries is well known.[47]

4.6 Fluoridation of the water supply, that is the controlled addition of a fluoride compound into a public water supply to achieve a concentration optimal for dental caries prevention is recognised as the most effective, socially equitable and safe method of prevention of dental caries.[48]

4.7 In Western Australia all major water supplies are fluoridated. Currently, in the Kimberley not all the water supplies are fluoridated.[49] As stated above, regular fluoride testing is not being carried out in any of the Kimberley Aboriginal communities at present.[50]

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46 Australian Dental Association, 'Fluoride and Your Dental Health', *Dental Health Information.* http://www.ada.org.au/brochures2/fluoride.htm

47 U.S. Department of Health and Human Services, *Oral Health in America: A report of the Surgeon General*, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, p 158.

48 Submission to the Senate Standing Committee on Community Affairs Inquiry into Dental Health from the Public Health Association (Oral Health Special Interest Group), January 23 1998.

49 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia, Transcript of Evidence, September 11 2000, p 8.

50 Letter from Hon John Day MLA, Minister for Health, October 25 2000.

4.8 The most common source of community water is bore water.[51] It is estimated that only half the Aboriginal communities in the Kimberley have an ideal level of naturally occurring fluoride. No fluoride is added to water in the remote Kimberley Aboriginal communities except those close to Derby and Kununurra, which use fluoridated town water supplies.[52]

4.9 The HDWA will not implement a water fluoridation program in communities of fewer than 3000 people, as it is not economically viable.[53] In the Kimberley the largest community population is approximately 750 people.

4.10 The Committee is of the view that fluoridation of the water supplies in the Kimberley should be continued where currently implemented and should be introduced at those Aboriginal communities without fluoridation. The Committee notes that this may not be practical in the short term.

4.11 There are however, other sources of fluoride available. For example, children whose home water supplies contain low amounts of fluoride can take dietary fluoride supplements to reduce dental caries. There are also forms of fluoride that can be applied directly to teeth, including toothpaste, mouth-rinses, and professionally applied fluoride treatments available in a dental clinic.

4.12 The Committee is of the view that the State Government should provide supplementary fluoride treatment for children in schools, especially as artificial fluoridation of water sources is often not practical. Other methods of fluoride delivery may well be more appropriate with some communities. Strategies such as fluoride mouth rinses in a school-based program, fluoride tablets or fluoridated milk are just some of the alternative methods of providing fluoride in communities.[54]

Recommendation 2: That the State Government make a greater effort to put fluoride into the water supplies in the Aboriginal communities of the Kimberley to aid in the prevention of dental caries.

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51 Environmental Health Needs Coordinating Committee, *Environmental Health Needs of Aboriginal Communities in Western Australia – The 1997 Survey and its Findings*, 1998, p 22.

52 Ibid.

53 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 5.

54 Martin-Iverson N, Phatourous A, Tennant M, 'A brief review of indigenous Australian health as it impacts on Oral Health', *Australian Dental Journal*, 1999, Vol 44, No 2, p 91.
See also for example, *Selected Section: Projects of Special Interest – Milk Fluoridation – Background*, Oral Health Country Profile Programme, WHO Division of Non-communicable Diseases, http://www.whocollab.od.mah.se/wpro/china/data/milkfluoridebackgr.html

Recommendation 3: That supplementary fluoride programs, in the absence of water fluoridation, be implemented in all schools in the Kimberley.

Education

4.13 Few will dispute the importance of the role of education to an individual's health and wellbeing. In fact, the effectiveness of modern health care has been shown to heavily hinge on the quality of health education. Dental health education, therefore, is a fundamental prerequisite of good oral health.

4.14 Dental health education programs must receive the highest priority. In order to achieve the most effective results for the people in the Kimberley, the dental education efforts should focus on teaching proper oral hygiene and on the maintenance of a balanced diet. (It is also essential to integrate oral health programs with current programs related to obesity and diabetes).

4.15 It is important to target Aboriginal children, as the caries rate among this group is so high. The dental caries level of Aboriginal children in the Kimberley is significantly higher than that for all WA children.[55] For example, the mean DMFT (decayed, missing due to caries, or filled teeth) figure, which is accepted worldwide as an indicator for oral health, for Aboriginal children in Western Australia between the ages of 11 and 13 is 1.7, compared to .79 for all other WA children aged 12.

4.16 A strategy which the Committee favours is school based programs supporting linkages with health care professionals and other dental partners in the community in order to reach children who are at higher risk of dental disease. The focus should be on the young people, under the age of 20 for the best long-term results.

4.17 Dental educational programs which instruct school children to care for their mouth and teeth, have been shown to be cost effective and to actually improve the oral health of the participants in the program.[56] Through dental education, students learn the importance of proper oral hygiene, tobacco use prevention, use of fluorides, and regular clinical visits for preventive dental care, as well as the importance of proper nutrition, playground safety as related to dental injuries, and what to expect during a visit to a dental office.

4.18 Another strategy that the Committee supports is to target parents and caregivers, to educate them on the ways to prevent and recognise oral disease in their children.

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55 Letter from Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, October 5 2000.

56 'Dental Health Education and Tobacco Use Prevention Program', http://www.health.state.ok.us/program/dental/dented.html

> *"The requirement to have good dental health requires nutritious diet, gum care, dental brushing, babies not fed bottles of Coke, all that. This still happens. At Beagle Bay, I was there two weeks ago, and I saw this kid with red cordial in a bottle, sucking away, and that child, you can guarantee, will have terrible dental health, and Coke, not only does it actually cause dental caries, it erodes the enamel on teeth as well ..."*[57]

4.19 In this regard, the Committee believes that necessary training should be provided to health-care providers, staff in state-supported programs and workers in pregnancy and parenting programs. Education programs should be developed for parents and caregivers to encourage appropriate use of nursing bottles and pacifiers, and to restrict the consumption of sugary foods and drinks.

Recommendation 4: That dental health education programs aimed at preventing dental disease be implemented immediately. The programs should include dental health instruction and daily brushing.

Recommendation 5: That the HDWA expand existing school and community based health education programs to incorporate dental health education programs.

Tooth Brushing Programs

4.20 Tooth brushing is one of the lifelong, preventive habits important to maintain dental health and prevent tooth decay and gum disease. It is important that children brush their teeth as tooth decay occurs faster in children than in adults.[58] Brushing removes plaque bacteria, which are responsible for tooth decay.

4.21 Studies have shown that compliance with a supervised brushing program results in a reduced caries increment amongst children.[59]

4.22 The Committee is of the view that school brushing programs should be introduced in each Aboriginal community to teach children how to brush their teeth correctly and help the children develop good, life long habits. Such a program would also ensure that the children are actually brushing their teeth.

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57 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, p 10.

58 'Child Dental Care – Brushing Teeth', *The Dental Zone,* http://www.saveyoursmile.com/parents/dzgettingkidstobrush.html

59 See for example, Jacquelyn F. Moorhead, Anthony J. Conti, Ronald G. Marks, Lewis P. Cancro, 'The Effect of Supervised Brushing on Caries Inhibition in School Age Children', *Journal of Clinical Dentistry*, 1991, 2: pp 97-102.

4.23 The Committee received evidence that the benefits of a brushing program, combined with a diet low in sugar, would be almost immediate and it would only take a couple of years to start to reverse the problem of dental disease amongst Aboriginal children.[60]

4.24 To be most effective, the brushing programs should involve fluoride toothpaste - *"Access to fluoride toothpaste is a very valuable preventative measure."*[61] It would also be necessary to involve teachers or a health worker in the community who would supervise the program and ensure that an education program is attached to the brushing program.

4.25 The Committee was advised that it would not be too expensive to implement such a program. Funding of such a program is estimated to be approximately $40,000 per year for the estimated 4000 children of school age in the Kimberley (this cost is based on the supply of 4 toothbrushes and the necessary toothpaste per child).[62]

Recommendation 6: That the State fund and implement a tooth brushing program in all schools in the Kimberley.

Nutrition

4.26 Traditionally, Aboriginal people in Australia experienced good dental health with no/minimal dental diseases because of a natural and nutritious diet low in fat and sugar (example: kangaroo, plants, berries). Aboriginal people now suffer greater levels of dental disease than average non-Aboriginal Australians, largely attributable to the new types of food that the Aboriginal people are now eating – a diet that is high in sugars (example: deep fried takeaways, soft-drink, lollies).[63] As stated above, food with high amounts of sugar is clearly linked to tooth decay.

4.27 In an effort to improve the nutritional health of the Aboriginal people (and flowing on from that the dental health of the Aboriginal people), nutrition and education programs are needed.

4.28 One such effort is to focus on the community stores. The Committee believes that measures are needed to ensure that the community stores improve the level of nutritious foods they provide, in order to get better value out of oral health programs.

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60 Mr Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 6.

61 Ibid, p 4.

62 Letter from Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, October 5 2000.

63 *Nutrition in Aboriginal and Torres Strait Islander Peoples – An Information Paper*, National Health and Medical Research Council, endorsed July 31 2000.

4.29 Studies have been undertaken which support the view that '… *retail store managers in remote Aboriginal communities wield considerable power over the food supply and that store managers can be important allies in efforts to improve dietary intake and nutritional status.'*[64] Community stores supply more than 95 percent[65] of the food eaten on remote Aboriginal communities.

4.30 The high cost of goods, especially of fresh fruit and vegetables in the Kimberley, is seen as a continuing obstacle to encouraging healthy eating habits in Aboriginal communities. Reasons for the high costs include: high transportation, storage and wastage costs.[66]

4.31 The Committee notes the policies and efforts already undertaken in this area by the HDWA[67] and other government organisations such as the Western Australian Department of Commerce and Trade.[68]

> *"Store based nutrition interventions have the potential to influence nutrition knowledge, food purchasing patterns and food intake. The interventions can influence consumers to actively choose nutritionally preferred products…*
>
> *Providing training and support to store managers, store committees and community councils will help the key decision makers to implement store-based nutrition interventions in Aboriginal communities."*[69]

4.32 The Committee believes that community stores can play an important role in educating people on good nutrition and diet, in order to influence stock selection and buying habits within communities. One effective way of doing this is through the use of posters and flyers. For example, healthy food approval stickers on items and "shelf-talkers" which clearly identify nutritious food can be used to encourage healthy eating practises.[70]

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64 Lee A.J, Bonson A.P.V. & Powers J.R., 'The effect of retail store managers on Aboriginal diet in remote communities', *Australian and New Zealand Journal of Public Health*, 1996, Vol 20, No 2.

65 Kimberley Public Health Unit, *Aboriginal Community Stores and Health – Background Information*, June 1999, p 7.

66 *Nutrition in Aboriginal and Torres Strait Islander Peoples – An Information Paper*, National Health and Medical Research Council, endorsed July 31 2000, p 56.

67 For example the Kimberley Public Health Unit Store Management Project.

68 Aboriginal Community Stores Schemes is a program delivered by the Office of Aboriginal Economic Development within the Commerce and Trade Department of Western Australia.

69 Kimberley Public Health Unit, *Store Management Project*, 1999, p 13.

70 Submission from David King, Proprietor, Rusty's Foodland Derby, undated.

4.33 The Committee sought submissions from storeowners in the Kimberley, on their views as to how stores operating in Aboriginal communities can help improve the health of the community.

4.34 The major points raised were:

- community stores should run on a not for profit basis, with the major aim of the store being to benefit the community rather than to make a profit;
- good management of the store is essential;
- As diabetes is a common problem in the Aboriginal communities, at least 35 percent of all goods stocked in the store must be directed at preventing diabetes; and
- supply, especially of fruit and vegetables, should be from a local source to ensure good quality and affordable prices.

> *"We believe our main impact has been in providing a good constant range of quality fruit and vegetables. Our sales of fruit and vegetables has increased in one month from $6000 to $9000 by improving the range and the quality.*
>
> *… The other biggest impact we have noticed is providing healthy ready to eat foods such as fresh sandwiches and stews. There appears to be a direct correlation between when fresh attractive sandwiches are provided, and the sales of items such as pies, bags of chips, etc, decreasing."*[71]

4.35 Initiatives suggested included:

- a central warehouse for supply of goods, such as NATS Store in Perth which supplies the Ngaanyatjarra Lands in the central desert;
- part of an individual's income to go directly to the store to be used as credit for food only;
- health promotions at stores to introduce people to healthy foods; and
- donating healthy food samples to schools

> *"Another suggestion may be for stores to donate a new type of fruit or health snack to the local school for children to sample each month, in*

[71] Letter, from Steve and Julie Dignan, Store Managers, Wirrimanu Community Store, September 18 2000.

> *the hope that it will introduce the children to a whole range of foods."*[72]

Recommendation 7: That State and local governments encourage community stores to adopt schemes to reduce costs and increase the range of nutritious foods stocked in order to help improve the dental and general health of the community.

Yakanarra Community – case example

4.36 The potential for success of preventative dental health programs is evident in the Yakanarra Community (an Aboriginal community located south of Fitzroy Crossing). The Committee understands, from its meeting with the HDWA dentist in Halls Creek/Fitzroy Crossing, Dr Maria Chan, on August 23 2000, that the people in Yakanarra enjoy better dental health than in other communities in the Fitzroy Valley and Halls Creek areas of the Kimberley.

4.37 As part of its "Community Health Strategy", the Yakanarra Community Store has stocked food and drinks which prevent diabetes, that is, food and drinks which are low in sugar, and which consequently improve dental health. The Community school funds a tooth-brushing program. The two initiatives combined have resulted in major improvements in the dental health of the children within the Yakanarra community.

> *"… the children's good dental health is the result of a communal approach to the issue. Firstly, a major factor contributing to the good health of our children's teeth is the "No Sugar" policy of our Community-owned store. The store sells only sugar-free cool drinks and fruit juice. It sells no ice-cream or chocolate and only a couple of sweet lines; it only sells sugar free gum. It sells a wide range of fresh fruit and vegetables.*[73]

4.38 The Committee commends the approach of the Yakanarra community.

4.39 The Yakanarra Community School is an Independent Aboriginal Community School, governed by an Aboriginal School Council. The School obtains its funding from various Commonwealth Education Programs and State Education grants.[74]

4.40 The Yakanarra Community School funds and implements a school-wide daily teeth cleaning program. The school provides tooth brushes and toothpaste for all the children in the school. The school allows 10 minutes after the daily lunch break for

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72 Ibid.

73 Letter from Laurel Sutcliffe, Principal, Yakanarra Community School, November 13 2000.

74 Ibid.

teeth cleaning. The primary students are closely supervised and taught to brush their teeth correctly and are instructed on what are the causes of tooth decay.[75]

4.41 The cost of the program to the Yakanarra Community School is $960 per year. This figure is based on providing 40 children toothpaste and tooth brushes (six to eight per year) each.[76]

4.42 The preventative measures outlined above if implemented across the Kimberley, will result in less need to perform emergency dental treatment in the future, better oral health for Aboriginal people and ultimately a greatly reduced financial burden on the State.

Recommendation 8: That the Health Department of Western Australia and the Ministry of Education review the tooth brushing program and store policy at Yakanarra Community to see how they can be effectively promoted and implemented throughout the Kimberley.

Improvement to the current dental health services

Dental service provision

4.43 All members of the Australian public should have access to timely and cost efficient oral health care and dental services. In the Kimberley they do not have this.

4.44 Improving the standard of health services and access to health services would make a valuable contribution to improving the dental health and the general health of the Aboriginal people in the Kimberley, particularly if the improvements raised the services to a level comparable with those of other Australians. The challenge remains as to how to improve services and access with the limited funding available.

Equipment

4.45 An immediate improvement to the current dental services would be achievable through the provision of better dental equipment - currently, some of the equipment being used in dental practices in the Kimberley is old and unreliable. In Halls Creek for example, the equipment is sub-standard. The compressor is not reliable and the chair is outdated. The Committee sees no reason why the Kimberley should not have modern dental equipment. The proposed new hospital to be built in Halls Creek should include a new dental facility.

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75 Ibid.

76 Facsimile from Laurel Sutcliffe, Principal, Yakanarra Community School, November 14 2000.

Recommendation 9: That an up-to-date dental facility be established in the new Halls Creek District Hospital.

Access

> *"Access to care is the first essential capacity to increase peoples opportunity for treatment."*[77]

4.46 Access to dental services must be improved. The Committee was advised that the best way to improve access to dental care by remote communities is to provide more frequent visits by dentists of shorter duration. *'Rather than visit for one or two weeks a year, visit three days a week every month or every six weeks'*.[78]

4.47 In order to assist in providing more frequent visits by dentists, a useful aid would be the permanent establishment of dental equipment at certain communities. Services could be provided in a number of large and strategically located communities and people from outlying areas could travel to these places for treatment.

> *"Chances for fly in fly out access could be improved through judicious use of capital equipment into some of the key communities."*[79]

4.48 In evidence to the Committee, Mr David Neesham stated that the cost of setting up the centres would be much less expensive than setting up a full dental surgery. The equipment required would be a chair that can be dismantled and kept within the community, a small compressor and a small dental unit.[80] An advantage would be that these could be secured in a lockable cabinet in a health centre and other health professionals could use the area when not in use by dentists. Another advantage would be time saved. Currently, the dentist has to transport equipment that is heavy and cumbersome and much time is taken moving and setting it up. The result would be more time available for the dentist to see more patients. This approach would also allow more frequent visits to communities greatly in need of regular dental visits, like Balgo, Gibb River and Kalumburu.

> *"You need infrastructure that is set up there, ready to go, … but we do not have that infrastructure set-up at all in the Kimberley. We do in town. We have a dental van that sits at Broome Primary or Cable*

77 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 3.
78 Ibid, p 3.
79 Ibid, p 2.
80 Ibid, p 3.

beach. If you go to a remote community there is not access to that sort of service."[81]

4.49 The Committee notes that the HDWA has plans to site a dentist at Halls Creek in addition to the one dentist presently at Fitzroy Crossing to allow better access to the communities and to provide a permanent dental service in the area.[82] The Committee supports this initiative to provide better access to dental services in the Fitzroy Valley and Halls Creek area.

4.50 Access to dental care for school aged children can be increased through dental programs that are school based or school linked (as mentioned above). These programs, which may be mobile or physically based at schools, remove financial and other barriers in the existing health-care delivery system. They take advantage of the fact that children in school settings are an easily accessible and captive audience.

Recommendation 10: That the Health Department of Western Australia establish 'dental centres' in key Aboriginal communities to house dental equipment to be used by visiting dental health staff.

Recruitment of dental staff

4.51 There are difficulties in recruiting dental staff, as with other health staff, to work in remote areas such as the Kimberley. An extremely high turnover of dental staff is currently being experienced within the Kimberley. For example, over the last five years, three dentists have held the itinerant dental officer position based in Derby and five dentists have held the public dental officer position based at Fitzroy Crossing.[83]

4.52 State Government budget restraints have inhibited the recruitment of dentists and nursing staff from the metropolitan area to the Kimberley[84] and incentives used by the HDWA to attract and retain dental staff to the Kimberley appear to be ineffectual.

4.53 Major effort is needed to provide workable solutions to narrow the gap in the provision of dental services to the people living in the Kimberley due to a lack of dental staff.

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81 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, pp 10-11.

82 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 2.

83 Letter from Hon John Day MLA, Minister for Health, October 25 2000.

84 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 2.

4.54 Noting the difficulty in recruiting dental staff, the Committee is of the view that qualified experienced dentists, from Perth for example, could be encouraged and funded to do short term locums of approximately two weeks duration in the Kimberley. The establishment of dental centres, as recommended above, will provide the necessary infrastructure to support the visiting dentists and the dentists can be flown in and out of the communities. The Committee believes that such a scheme will improve access to regular dental services in the Kimberley.

Recommendation 11: That the Health Department of Western Australia examine the feasibility of establishing a dedicated short-term locum employment position in the Kimberley for dentists.

4.55 The Committee believes that through the development of dental health training programs for the non-dental health personnel in rural and remote communities, some change could be effected.

4.56 An effort that is receiving much support, is the greater recruitment and training of Aboriginal people. Aboriginal health workers should be supported to acquire dental knowledge, at the very least in oral health promotion and even to the extent of being able to perform some basic dental procedures. The Aboriginal health workers remain in the communities while dentists come and go. In the Kimberley, where the Aboriginal communities are dependent on government dental services, Aboriginal health workers trained in dental health, could provide community education and support.[85]

> *"Health services need to recognise the importance of the employment of local Aboriginal people to long term improvements in Aboriginal health and to the provision of appropriate services."*[86]

4.57 The Committee notes that amongst the recommendations of the Kimberley Regional Aboriginal Health Plan, were that:

a) greater use be made of Aboriginal health workers in promoting dental health and performing preliminary assessment of dental problems; and

b) increased training in dental health for Aboriginal health workers be provided, and that this training be developed in conjunction with tertiary institutions training dental health staff.[87]

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85 Submission from the National Aboriginal Community Controlled Health Organisation to the Senate Standing Committee on Community Affairs Inquiry into Public Dental Services, 1998.

86 Atkinson D, Bridge C, Gray D, *Kimberley Regional Aboriginal Health Plan Executive Summary and Recommendations*, December 1999, p 11.

87 Ibid, p 30.

4.58 The Committee was informed that HDWA is spending $800,000 of recurrent funds this financial year[88] to establish a collaborative unit between HDWA and the University of Western Australia to provide a focus for rural and remote oral health services, which will be know as the Centre for Rural and Remote Oral Health ("the CRROH"). The objectives of the CRROH are:

- advocacy and research;
- practitioner support;
- Aboriginal oral health programs; and
- facilitation of new rural oral health programs.

4.59 An important function of the CRROH will be to offer dental students the opportunity to undertake rural work experience placements. The specific tasks to be undertaken by the CRROH in the first two years of its establishment include the development and implementation of an oral health training program for Aboriginal Health Workers and community health workers throughout the State, and the development and implementation of oral hygiene programs for Aboriginal populations in rural and remote locations, including the Kimberley region.

4.60 The Committee supports the initiative to provide further training to Aboriginal health workers in basic dental health.

Recommendation 12: That each of the larger communities in the Kimberley have access to an Aboriginal Health Worker, trained to provide dental health education.

4.61 The Committee also supports the initiative of the CRROH to investigate the possibility of introducing innovative dental health programs in the Kimberley that make use of undergraduate and first year dentists.

4.62 The Committee notes that the use of undergraduate professionals to supplement shortages in professional services to the public is now a common strategy. For instance, the University of Western Australia has recently introduced an unrepresented criminal appellant's scheme, which makes use of the skills of final year law students.[89]

4.63 The Commonwealth Parliament Senate Standing Committee on Community Affairs report into Public Dental Services outlined a vocational training program whereby all newly qualified dentists would be required to complete, under supervision, a period of vocational training in placements determined for them. The graduates would treat

88 Mr Corey Carrello, Purchasing Manager, Health Department of Western Australia, Transcript of Evidence, September 11 2000, p 4.

89 *The Unpresented Criminal Appellants Scheme*, http://www.law.ecel.uwa.edu.au/law/UCAS/UCASbackgroundpaper.html

public patients and could be assigned to work in public dental services or private practices, in rural or remote locations. In addition to the beneficial practical experience for dentists, the scheme was seen as an opportunity to counteract the shortfall of dentists servicing rural and remote areas by placing dentists in such areas for at least six months and, hopefully, encouraging more of them to locate there permanently. The report also noted that post graduation vocational training programs operate throughout Europe and provide enormous benefits to both the new graduates and the health system in general.[90]

Recommendation 13: That the HDWA undertake a feasibility study into short-term vocational placements of final year dentistry students and first year dentists in the Kimberley.

Dental auxiliaries

4.64 Dental auxiliaries can play an important role in providing preventive services (which have the added benefit of not involving the same level of costs as a dentist's services).

> *"You do not necessarily need a dentist. In the main you need a well-trained health worker, who is good public health stock, to do dental health…*
>
> *… You need the doctor to treat the serious illness, but having the doctor come in and provide Aboriginal health worker work, or public health or nursing is really a waste of that person's expertise and they do not have any expertise in the other areas, and so what we are doing is providing the most expensive to provide the worst service in public health and it would be the same with the dentist. Bring the dentist in, he provides the most expensive, and it is the end stage, not the beginning stage. So it is really not working effectively."*[91]

4.65 The Committee considers that dental therapists can do a lot of work presently undertaken by dentists in the Kimberley, such as in community schools where the children experience a high amount of dental caries.

> *"You need infrastructure that is set up there, ready to go, and you need frequent visits by dental therapists because catching stuff early is really what it is all about. So if you have got frequent dental therapy visits, and occasional dental visits, most of the school vans*

90 Senate Standing Committee on Community Affairs Report into Public Dental Services, Parliament of Australia May 1998.

91 Ms Isabelle Ellis, Transcript of Evidence, p 11.

are manned by dental therapists. They provide a very good service…"[92]

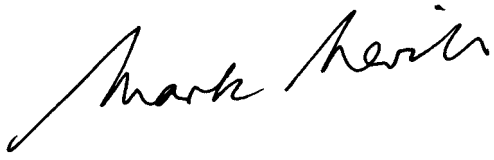
4.66 Dental therapists are specially trained health care professionals who are able to provide high quality dental care. The clinical services which can be provided by dental therapists include: examination and treatment planning; administration of local dental analgesia; filling teeth (deciduous and permanent); extraction of deciduous teeth (baby teeth); scaling teeth to remove calculus (tartar); cleaning teeth; applying fluoride to teeth; referring a child to a dentist for further specialist treatment.[93]

4.67 Currently, in the model of dentistry provided by the HDWA Dental Health Service in the Kimberley, dental therapists do not service remote area communities[94] and are restricted to only servicing children.

4.68 The Committee notes the initiative of the HDWA in developing an operational framework for the proposed introduction of remote area nurse practitioners in remote areas of Western Australia. The initiative's aim is to formally extend the role that nurses fill in remote areas and to provide residents of the remote areas greater access to local health care services.[95]

4.69 The Committee is of the view that there should be an increased use of dental auxiliaries in the Kimberley, that is nurses, therapists and hygienists in order to make more effective use of their services.

Recommendation 14: That the Health Department of Western Australia undertake a review of the role of dental auxiliaries (therapists and nurses) in providing dental health services in remote areas of Western Australia, similar to the Remote Area Nurse Practitioner Project.



Hon Mark Nevill MLC
Chairman

Date: November 23 2000

92 Ibid, p 10.
93 *Dental Act 1939*.
94 Mr David Neesham, Director, Perth Dental Hospital & Community Dental Services, Transcript of Evidence, September 11 2000, p 10.
95 Health Department of Western Australia, *Remote Area Nurse Practitioner Project Report 2000*, April 2000.

APPENDIX A: TRAVEL ITINERARY

Monday, August 21 2000
Broome (public hearings)

Tuesday, August 22 2000
Derby (public hearings)

Wednesday, August 23 2000
Halls Creek

Thursday, August 24 2000
Fitzroy Crossing

Friday, August 25 2000
Kununurra (public hearings)