Dental Health Services Victoria: Submission to the Senate Select Committee on Regional and Remote Indigenous Communities

The Terms of Reference for the Senate Select Committee states that *'the Committee will inquire into, and report on:*

c) the health, welfare, education and security of children in regional and remote Indigenous communities'.

It is assumed that as a consequence of this process there will be further policy development aimed at addressing the identified issues. Therefore the focus of this submission is to emphasise the importance of integrating oral health with other health and welfare strategies targeting the health and welfare of indigenous children and their families.

A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. (1) Poor oral health causes pain and suffering and affects the quality of life and wellbeing of those affected. (2)

Oral diseases affecting the teeth and gums are among the most common health concerns experienced with almost all Australians affected at some time in their lives. Dental decay (caries) is the second most costly diet-related disease in Australia, and in 2006-07 dental care accounted for 5.8 percent ($5.7 billion) (AIHW) of total health expenditure.

Some groups within the population experience a disproportionate level of oral disease due to the presence of various factors which unfortunately, are more prevalent in some indigenous communities.

a) **Oral disease is more prevalent among indigenous communities. It is also more prevalent among people living in regional and remote communities.**
Aboriginal and Torres Strait Islander peoples and people living in rural and remote communities have all been identified as being at greater risk of oral disease (refer references).

b) **The interactions of a range of influences determine oral health.**
The determinants of oral health encompass the interactions of a broad range of influences. These include nutrition, lifestyle, social connectedness, risk behaviours, personal health practices and coping strategies, hygiene, socio-economic status, education, cultural beliefs, attitudes and health knowledge as well as access to oral health services and interventions. (2, 5-6) Social isolation and exclusion, cultural difference and discrimination can also contribute to poor health outcomes and increased rates of oral disease.

c) **The people who have the worst oral health are the most disadvantaged.**
Oral disease is most strongly associated with socio-economic status (5) as system wide barriers, such as the cost of services and lack of education and awareness, generally preclude those with the greatest need from services (8).

d) **Oral health and general health are inextricably linked.**
Oral health is integrally linked to general health and shares common risk factors such as lifestyle behaviours with a range of chronic conditions such as diabetes, cancer and cardiovascular disease. (3, 7-9) However the nature of this connection and interaction with other health conditions is not yet well understood and recent trends showing an increase in the incidence of chronic lifestyle-related disease, such as those related to obesity, are predicted to continue. People with the greatest risk of poor oral health are the same groups bearing a disproportionate level of morbidity associated with obesity, alcohol and tobacco

DHSV believes that the development of health interventions for indigenous communities would be enhanced by:

1) Accepting the underlying tenets of population health such as that developed by Health Canada and which necessitates a particular focus on addressing the determinants of poor health outcomes

2) A greater emphasis on community engagement and empowerment to address health problems
3) Support for the establishment of a 'Lead Agency' approach to mentor and support capacity building in indigenous health services and programs
4) To develop appropriate monitoring of health outcomes and targets for improvement. This also needs to be supported by investment in mechanisms to facilitate sharing and dissemination of the latest evidence and best practice across the health sector.
5) The development of a whole of government approach to address the non-medical determinants of health in these communities.
6) An integrated approach that capitalizes upon progress made by existing initiatives. Extensive partnerships will need to be formed, resourced and supported in order to achieve the improvements required. It is also imperative that investment in this field is well informed and strategic within the context of the broader health sector.
7) Incorporate a greater emphasis on indigenous and regional and remote communities in the national preventative health strategy that is currently under development (refer *Australia: The healthiest country by 2020).*
8) Investing in programs that provide the tools and information to build health literacy of individuals and communities to enable informed decision regarding their health.
9) Incorporating the recommendations and findings from a variety of publicly funded studies and strategies developed to address oral health and the health of indigenous communities. (See the references cited below).

DHSV is committed to supporting and contributing to a national indigenous health agenda and would welcome the opportunity to further participate in the development of strategies aimed at improving the oral health of indigenous people.

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