RHeaNA
Refugee Health Network of Australia

Select Committee into the Provision of and Access to Dental Services in Australia
PO Box 6100
Parliament House
Canberra ACT 2600

Submission on behalf of the Refugee Health Network of Australia (RHeaNA)

About RHeaNA

The Refugee Health Network of Australia (RHeaNA) is a network of health professionals with expertise in refugee health representing every State and Territory. The purpose of the network is to improve the delivery of health care to refugees and those from refugee-like backgrounds living in Australia.

Rationale for this submission

Several studies have shown poorer oral health for many newly arrived adults and children from refugee backgrounds compared to the general population. Oral health may be affected by a number of pre-arrival issues including lack of fluoridated water, malnutrition, damage caused to teeth and gums by torture or trauma, and, poor access to dental care and oral health education. Common oral health problems among people from refugee-like backgrounds include dental caries, missing teeth and periodontal disease; less common issues include orofacial trauma or oral cancers.

Post-arrival issues for refugee settlers include low oral health literacy, the competing priorities of settlement, suboptimal understanding of dental service access, and the easy availability of low-cost sugar-rich food.

Input on Term of Reference

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

Refugees migrating here on permanent visas, and most temporary protection visa holders, are eligible for Medicare and Health Care Cards, so are eligible for public dental care.

Recently arrived refugees are unable to afford private dental care, at least initially, so are largely dependent on public dental services. The long waiting lists for public services, particularly for adults, mean that this population with a high burden of oral disease is delayed in accessing necessary care.

Paradoxically, some persons from refugee origin countries such as Syria have had sophisticated oral healthcare in the past. They are perplexed by the lack of access to treatments such as bridges and crowns in the public system.

Timely access to dentures is another unmet need for some adults in this target group. They often arrive with poorly constructed, missing or damaged dentures. They may have none at all despite the need - one example being the tribal removal of the lower incisors seen in some southern Sudanese. As individuals age, the consequences of lack of past preventive measures

and limited dental care in their country of origin may lead to tooth removals and a need for dentures as a matter of urgency to maintain fundamental nutrition.

Suboptimal referral processes are also significant barriers to assessment and care.

Suggestions:

- All persons from refugee-like backgrounds should have access to an oral health assessment after arrival, in line with best-practice national guidelines [ASID Refugee Guidelines].
- Access includes appropriateness and acceptability of service delivery – dental schools need to train students in how to work with refugees, including use of professional interpreters.
- Ensure use of professional interpreters in dental assessments; family and friends should not be used [NSQHS Standards].
- Ensure public access to high-risk groups including children <6 years, asylum seekers and those with complex dental needs.
- Primary Health Networks (PHNs) can help ensure GPs in their local region are familiar with referral processes to local public dental services.
- Newly arrived refugees should not be subject to mandatory waiting times that exist for migrants in some jurisdictions before being able to access public denture services.

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

Although the scale of public services in rural and regional areas is less, local arrangements sometimes mean that access for certain priority groups such as refugees is addressed in a reasonable manner. However in certain states (e.g. WA, NT and Qld), there remain significant dental access barriers in regional and rural areas, impacting on screening, health promotion, anaesthetic capability, specialist orthodontics and broader dental intervention.

An example of good practice is philanthropic initiatives such as the Kimberley Dental Team which have a focus on providing equitable outreach to Indigenous populations within WA.

Suggestions:

- Given the focus on resettling refugees in rural and regional areas, outreach oral health teams could be developed for rural and regional areas with significant populations of people from refugee-like backgrounds.

- Increased primary care nurse training in oral health could improve care in all settings.

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

Asylum seekers living in the community on bridging visas do not receive Health Care Cards, so have extremely limited options for oral health care. While restrictions on Medicare Cards for asylum seekers have reduced in recent years, this has not improved access to dental care. Presentations tend to be acute and needing more urgent care. Most states and territories have policies that allow one-off treatment for acute dental issues in asylum seekers; however, such policies are not always known by frontline staff who may turn asylum seekers away.

Suggestions:

- Commonwealth, state and territory governments negotiate on how to provide adequate dental care to asylum seekers living in the community.
- Jurisdictions ensure public services are well informed about any provision to provide care for non-eligible persons.
- Such policies should include more than just relief of pain.

d. ***the provision of dental services under Medicare, including the Child Dental Benefits Schedule*.**

The Child Dental Benefits Schedule has been very beneficial in promoting access and care for children and adolescents, including those from refugee backgrounds.

Suggestions:

- Means testing of the *Child Dental Benefits Schedule* should be maintained.
- Funding and systems should support family-based care wherever possible that integrates prevention, treatment and oral health literacy for the whole family [PHAA].
- Integrated models of dental health care provision with broader refugee health care delivery and health promotion is supported by consumer research in children and parents [Nicol et al 2014].
- Provide access to free interpreters via the national Translating and Interpreting Service (TIS) for private dentists in line with other health professionals (e.g. doctors, pharmacists and some allied health staff) to enhance care under the Child Dental Benefits Schedule, and more generally.

e. ***the social and economic impact of improved dental healthcare****.*

Poor oral health is a significant public health issue and can cause long-term morbidity. Improving dental healthcare for newly arrived refugees will help them to settle successfully, by improving their quality of life and self-esteem, and their ability to eat properly, learn English, and attend job interviews. Early childhood caries is a significant preventable public health issue, with early intervention cost effective whilst reducing health care burden and complications. Adults and elders with poor dental health often struggle to eat nourishing food and to obtain work.

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

Dental services have been significantly disrupted by COVID-19 measures (hospital and community settings); this has impacted on waitlists and unmet dental/oral health needs in patients; this impact is accentuated in those with high needs such as refugees.

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

Suggestions:

- Facilitated access to oral health care for newly arrived refugees will help reduce deterioration in already poor oral health status, and allow for treatment of unmet needs. This can be through a combination of triage processes that fast-track this target

group, and vouchers for subsidised private care for both children and adults, especially older persons.
- Work with current public and community health processes (e.g. community and child health nurses) in promoting oral health checks and education at all points of contact in early childhood and school entry.

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

Suggestions:

- Recording of visa status for those arriving in the past 12 months to two years would enable a better understanding of the oral health status, and level of care needs, for humanitarian entrants and others from refugee-like backgrounds.

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

Suggestions:

- All dental service staff should be trained in trauma-informed care; for those working in areas where refugees settle, this training should give specific attention to the refugee experience.
- Expand training in primary oral health to nurses working in primary care.
- Education on interpreter use should be incorporated into all professional dental training (including hygienists and therapists).
- Specific scholarships for dental assistants should be extended to persons from newly arrived refugee populations, with individuals from those communities encouraged to train as such.
- Resettled refugees with an oral health qualification from overseas should be more readily able to attain recognition of their qualifications in Australia and to acquire local supervised experience.
- Dentists need to have employment conditions that attract them to working, and remaining in, the public dental system, including in rural and regional areas.
- Tertiary dental needs for refugee and other children should be facilitated by having access to paediatric general anaesthesia lists, with both metropolitan and regional/rural hospitals having this capability.

Thank you for the opportunity to submit to this Select Committee.