



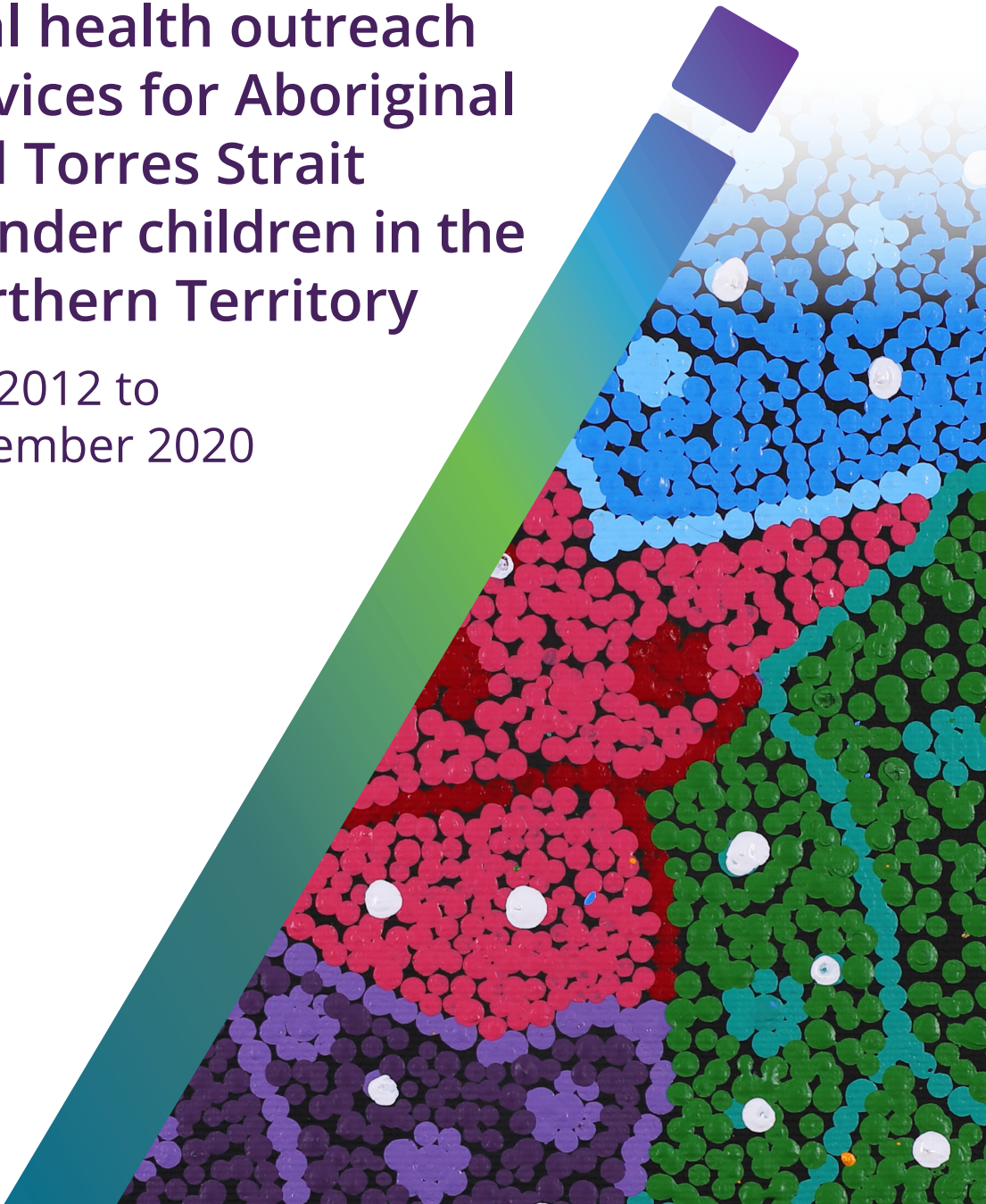
Australian Government

**Australian Institute of
Health and Welfare**

A.I.H.W.

Oral health outreach services for Aboriginal and Torres Strait Islander children in the Northern Territory

July 2012 to
December 2020



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December 2020



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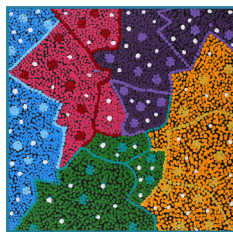
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Summary

Oral health is an important part of overall health and quality of life. Poor oral health can affect adults and children alike, causing pain, embarrassment, even social marginalisation. For children, the effects can be long-term, and carry through to adulthood.

Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to experience tooth decay. Several factors contribute to the poorer oral health of Indigenous children, including social disadvantage and lack of access to appropriate diet and dental services.

Since 2007, the Australian Government has helped fund oral health services for Indigenous children aged under 16 in the Northern Territory. The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP) complements the Northern Territory Government Child Oral Health Program by providing preventive (application of full-mouth fluoride varnish and fissure sealants) and clinical (tooth extractions, diagnostics, restorations and examinations) services.

This report presents data from the NTRAI OHP from July 2012 to December 2020.

How many Indigenous children received services in the NTRAI OHP?

In 2020, full-mouth fluoride varnish services, fissure sealant applications and clinical service visits were provided to Indigenous children in the Northern Territory under the NTRAI OHP. Of those children:

- 4,454 received 5,485 full-mouth fluoride varnish services, a decrease of 1,322 services from 2019
- 1,017 received fissure sealant applications to 4,187 teeth during 1,083 services, a decrease of 2,079 teeth from 2019
- 2,469 received clinical services during 3,036 visits (excluding 1,464 visits classified as urban)—such as dental assessments, fillings, extractions, or preventive services—a decrease of 1,744 visits from 2019.

In 2020:



4,454 children received fluoride varnish services



1,017 children received fissure sealant applications



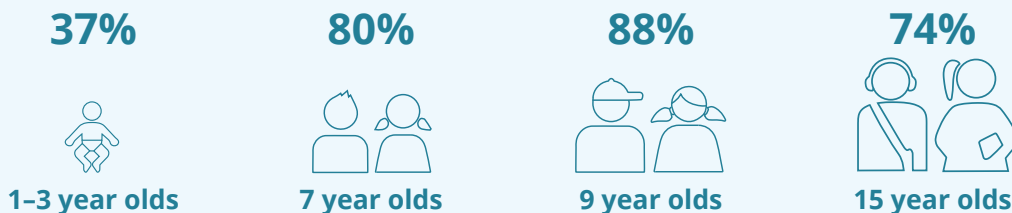
2,469 children received clinical service visits

Sources: tables S2.1, S2.3, S2.6.

How many Indigenous children experienced tooth decay in the NTRAI OHP?

Tooth decay varied by age, and in 2020, children aged 9 experienced the highest rate of tooth decay (88%). In comparison, children aged 1–3 experienced the lowest rates of tooth decay (37%).

Proportion of children in the NTRAI OHP who experienced tooth decay varied by age in 2020:



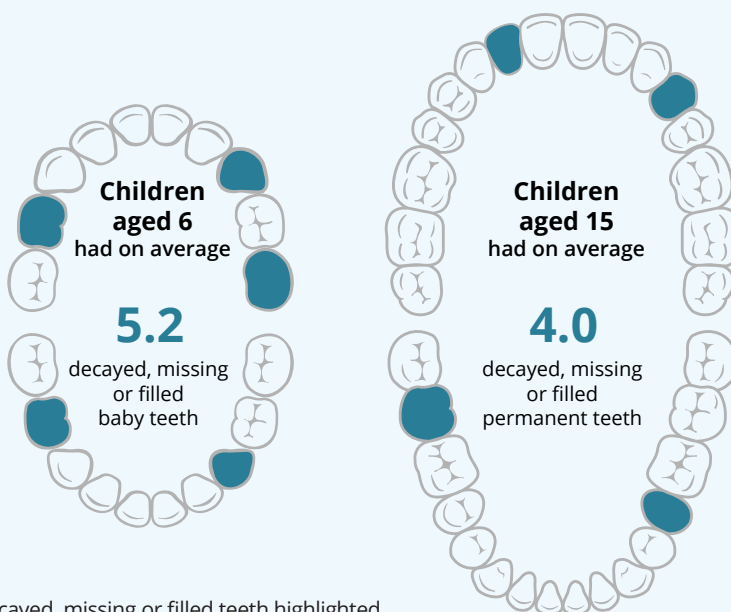
Source: Table S3.1.

How many decayed, missing or filled teeth did Indigenous children have?

A widely used indicator to measure oral health status is a count of the number of decayed, missing or filled teeth.

On average, in 2020, children in the NTRAI OHP aged 6 had the highest average number of decayed, missing or filled baby teeth (dmft), at 5.2 teeth, while children aged 15 had the highest average number of decayed, missing or filled permanent teeth (DMFT), at 4.0 teeth.

Among Indigenous children in the NTRAI OHP in 2020:



Source: Table S3.1.

Note: The number of decayed, missing or filled teeth highlighted has been rounded to the nearest whole number.

What was the impact of COVID-19?

Between 2019 and 2020 the number of full-mouth fluoride varnish services, fissure sealant applications and clinical service visits decreased. This was largely due to a fall in attendances between March and April 2020, coinciding with the introduction of restrictions imposed to control the spread of COVID-19. For example, the number of full-mouth fluoride varnish services for Indigenous children in March 2020 was 606—decreasing to 42 in April 2020, and then increasing to 309 services in May 2020.

Is the program meeting its benchmarks?

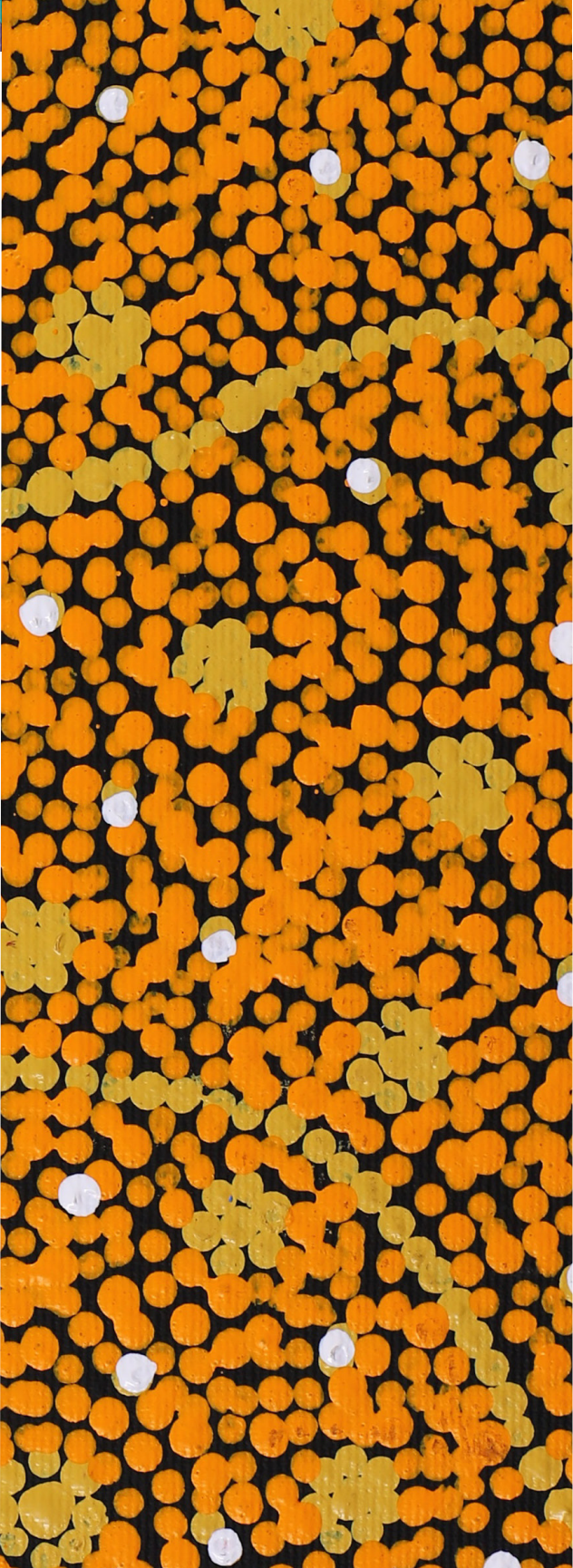
Outcomes for the NTRAI OHP are monitored through performance indicators and benchmarks. In 2020, COVID-19 restrictions are likely to have affected services delivered. However, the service delivery targets for all three service types were met or exceeded (Table S1).

Table S1: Progress against benchmarks, 2020

Service delivery targets	Outcomes
At least 3,800 clinical service visits per year	4,500 clinical service visits*
At least 5,485 fluoride varnish applications in 2020	5,485 fluoride varnish applications provided
Fissure sealant applications to at least 3,000 teeth in 2020	Fissure sealant applications to 4,187 teeth
Health outcome targets	
At least 50% of total service items are preventive services	66% of total service items were preventive in 2020

* In 2020, the benchmark outcome was 4,500 clinical service visits. Historically, clinical urban services have been excluded from reporting. For 2020 the specification for counting the number of clinical service visits includes 1,464 clinical urban services. Therefore 2020 benchmark data are not comparable with previous years.'





1

Introduction

Oral health plays a vital role in overall health, and can affect quality of life. Good oral health allows people to socialise and speak without pain, disease, discomfort or embarrassment. It can prevent children from being socially marginalised and embarrassed because of oral diseases and their consequences (NACDH 2012).

Oral health revolves around the health of the tissues in the mouth—bones, gums, muscles and teeth—with the most common oral diseases affecting the gums (periodontal disease) and teeth (tooth decay). Poor oral health has been linked to various chronic conditions including:

- cardiovascular disease
- oral cancers
- lung conditions
- diabetes
- stroke
- adverse pregnancy outcomes (DHSV 2011).

Poor oral health can affect adults and children alike, but in children, it can have long-term negative effects through to adulthood. As such, encouraging and maintaining good childhood oral health habits, and having access to oral health services, are important to prevent dental disease (NACDH 2012).

Data for Aboriginal and Torres Strait Islander children aged 5–14 show that, in 2011, dental caries accounted for 6.2% of the total non-fatal burden of disease for boys and 7.2% for girls (AIHW 2016).

Indigenous Australians are less likely to receive preventive dental care than non-Indigenous Australians, and are more likely to have untreated dental disease or to be hospitalised due to oral health (Jamieson et al. 2010; Kruger & Tennant 2015).

Oral health in the Northern Territory

At 30 June 2020, there were an estimated 23,000 Indigenous children aged under 16 in the Northern Territory—constituting 41% of its population aged under 16, the highest proportion of all Australian states and territories (ranging between 2% and 10% in the other jurisdictions) (AIHW analysis of ABS 2019, 2020).

Children in the Northern Territory have higher levels of tooth decay than in other states and territories and Indigenous children experience about 1.5 times as much tooth decay as non-Indigenous children (Ha et al. 2016).

Several factors contribute to the poorer oral health of Indigenous children, including:

- poverty and social disadvantage
- lack of availability and access to appropriate diet, resulting in the consumption of processed sugary foods and drinks

- lower use of fluoridated toothpaste
- lack of fluoridated water
- limited or no access to dental services, especially in rural and remote areas.

Australian Government oral health programs in the Northern Territory

The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP)—funded by the Australian Government, and implemented by the Northern Territory Department of Health—is designed to complement and support existing public dental services.

The program began in July 2015 and will be funded until June 2022. Funded activities aim to decrease the prevalence, incidence, severity and impact of oral health problems of Indigenous children in the Northern Territory (CFFR 2016). The program works with primary health-care providers to incorporate primary prevention into their services and deliver clinical oral health treatments to Indigenous children.

The NTRAI OHP supersedes the Stronger Futures in the Northern Territory (SFNT) (July 2012–June 2015) and the Child Health Check Initiative—Closing the Gap, or CHCI(CtG) (2007 to mid-2012) programs.

This report focuses on data collected from the SFNT and NTRAI programs, but also includes some information about changes in oral health over 2009–2020. For more information on the history of the program, see Appendix A.

About this report

This report is an update of the *Northern Territory Remote Aboriginal Investment: Oral Health Program July 2012 to December 2019* report. Supplementary tables are available at <http://www.aihw.gov.au/reports/indigenous-australians/oral-health-outreach-services>.

This report presents information on oral health services provided by the NTRAI OHP and the SFNT OHP to Indigenous children under the age of 16 in the Northern Territory. Not all dental services provided in the Northern Territory are captured within this report, as it includes only oral health services funded by the Australian Government through the NTRAI OHP. The data include more than 20,000 children under the age of 16 who came through the SFNT/NTRAI OHP between July 2012 and December 2020.

Services provided under the NTRAI OHP are available territory-wide to Indigenous children under the age of 16, but mainly focus on children living in remote areas, where they are most needed. Children and young people who receive services through the NTRAI OHP are not a random sample of the population, so the data might not be representative of the general population of Indigenous children in the Northern Territory.

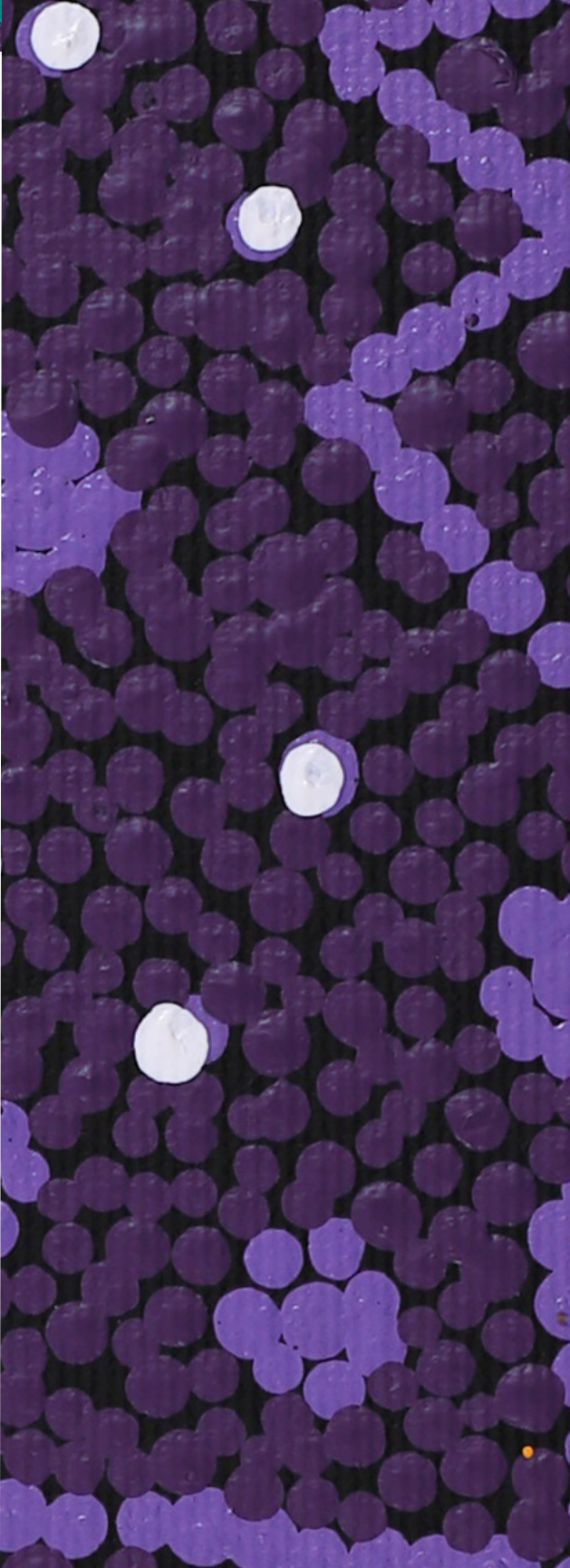
Parents or guardians of children must provide their consent for information to be shared with the Australian Institute of Health and Welfare (AIHW). As a result, some information in this report is representative of children for whom consent was obtained, rather than of all children in the program (see Chapter 2 for more information). In 2020, the consent rate was 64% for children who received full-mouth fluoride varnish services, 71% for children who received fissure sealant applications and 77% for those who received clinical service visits. Consent rates have fluctuated for each service type since the beginning of the collection in 2012 to 2020. Children can receive more than one service in a given period. The number of children can be counted accurately only for services where consent was given.

When a child's parent or guardian does not provide consent to share information, only a limited amount of aggregated information are available to the AIHW. Due to this limitation of the data, and as children can have multiple visits, the total number of service recipients presented in the report may overestimate the actual number of children who received services through the NTRAI OHP.

In 2020, of the 3,046 children and young people aged 0–15 with consent to share information, 1,704 children (56%) received NTRAI OHP services in *Very remote* areas, 870 (29%) in *Remote* areas, and 472 (15%) received those services in *Outer regional* areas.

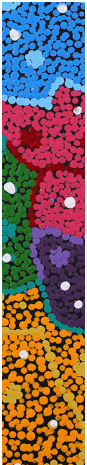
There have been changes to the Australian Government funded oral health programs since 2007, including the services provided and the data collected. These changes, in conjunction with the fluctuating consent rates and COVID-19 restrictions in 2020, may affect the numbers presented in this report relative to previous reports.

For 2020 the specification for counting the number of clinical service visits for benchmark outcomes includes clinical urban services. Therefore, 2020 benchmark data are not comparable with previous years. However, for consistency, counts and analysis of clinical service visits in this report differ from the benchmark outcome for clinical service visits; this is in keeping with methodology applied in previous reports and allow for comparisons over time.



2

Dental service delivery



Key findings

In 2020, in the NTRAI OHP:

- more than 4,400 children received full-mouth fluoride varnish services
- more than 1,000 children received fissure sealant applications
- children aged 12–15 had the highest average number of teeth with fissure sealants (4.9 teeth per child)
- nearly 2,500 children received clinical services, such as plaque removal, extractions, and restorative procedures—of whom about half (52%) were aged 6–11.

Two main types of services are delivered through the NTRAI OHP—preventive and clinical (Box 2.1).

Box 2.1: Types of services

Visit: An attendance (including scheduled and walk-in) at a dental clinic on a specific date. A single visit can involve multiple types of services.

Preventive services

Preventive service: Includes the removal of plaque and calculus, oral hygiene instruction, application of fissure sealants, application of full-mouth fluoride varnish, and other preventive services.

Full-mouth fluoride varnish: The application of a clinically determined amount of fluoride varnish (a concentrated form of fluoride) to the surfaces of the teeth.

Fissure sealants: The application of a protective adhesive to grooves in the biting surfaces of teeth at the back of the mouth, usually as soon as adult molars erupt. The sealants prevent dental plaque and acid build-up, and can last for many years, but require regular check-ups to see if the sealant is intact.

Clinical services

Clinical service: Can include restorative services, endodontics, tooth extractions, diagnostic services or assessments, orthodontic services and periodontic services (treatment of gums).

Clinical service visit: A visit where at least 1 clinical service was delivered (excluding visits where only full-mouth fluoride varnish application and/or fissure sealants were delivered).

What services are provided?

The NTRAI OHP provides clinical and preventive oral health services to Indigenous children in the Northern Territory. Figure 2.1 contains a broad overview of the services and the number of clinical and preventive services provided.

Preventive services are part of routine care in all dental clinics, and are provided as part of an individual's dental treatment plan. Specific preventive services include the application of full-mouth fluoride varnish and fissure sealants. Other preventive services include the removal of plaque/calculus, dietary advice or oral health education.

General dental services that are provided in all NTRAI OHP settings include:

- examinations
- restorative fillings
- extractions
- emergency care
- preventive services.

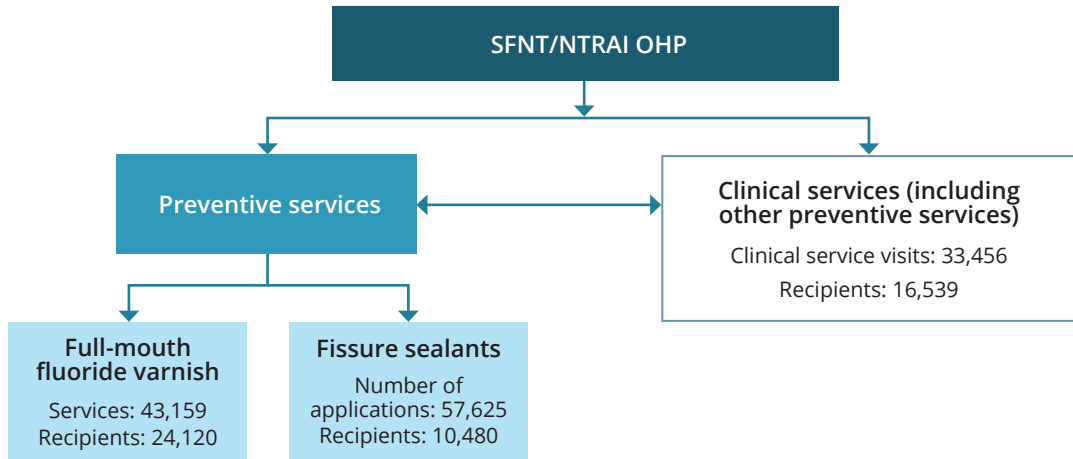
Consent rates

Parents or guardians of service recipients must provide their consent for information to be shared with the AIHW. The demographic information in this report, apart from the number of services and service recipients, represents only children whose parent or guardian provided consent to share their information. In 2020, the consent rate ranged from 64% to 77% depending on the service type.

When a child's parent or guardian does not provide consent to share information, only a limited amount of combined information is provided to the AIHW. Due to this limited information, in this report the number of non-consent service recipients for most years in the program is estimated to be equal to the number of non-consent visits. As children might have multiple visits, the total number of service recipients presented in Figure 2.1 might be an overestimate of the true number of children who had visits under the SFNT/NTRAI OHP. Children who had consent to share information and had multiple visits within the program, were included only once in the total number of service recipients between July 2012 and December 2020.

See Appendix A for more information.

Figure 2.1: Services provided under the SFNT/NTRAI OHP, July 2012 to December 2020



Notes

1. The 2-way arrows mean that a child can receive multiple types of services—for example, clinical services are preventive services, and services within the 2 categories.
2. A single clinical service visit can involve multiple types of services.
3. The number of fissure sealant applications is the number of teeth to which fissure sealants were applied.
4. The total number of service recipients includes children who did not have consent to share information with the AIHW. As such, for these children, the number of service recipients is estimated to be equal to the number of non-consent visits for most years of the program, and might be an overestimate of the true number of service recipients. Children with consent to share information, and who had multiple visits during the program were included only once in the total number of service recipients within each service type.

Sources: Tables S2.1, S2.3, S2.6.

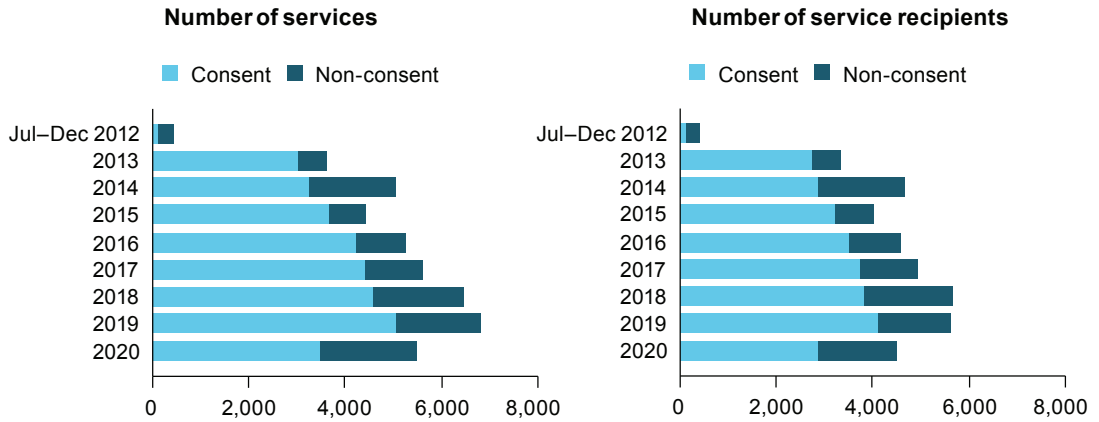
How many children had full-mouth fluoride varnish and fissure sealant services?

Full-mouth fluoride varnish

Full-mouth fluoride varnish has been shown to decrease the incidence of tooth decay by up to 25%–45% when professionally applied 2–4 times per year. It is considered to be a valuable public health intervention (Bonetti & Clarkson 2016; Marinho et al. 2013):

- In 2020, 4,454 children received 5,485 full-mouth fluoride varnish services (Figure 2.2).
- Between July 2012 and December 2020, 24,120 children received 43,159 full-mouth fluoride varnish services—this includes 13,392 children with consent to share information with the AIHW (2,845 children in 2020).
- The number of services and service recipients increased steadily between 2015 and 2019, but fell in 2020 due to restrictions to control the spread of COVID-19.

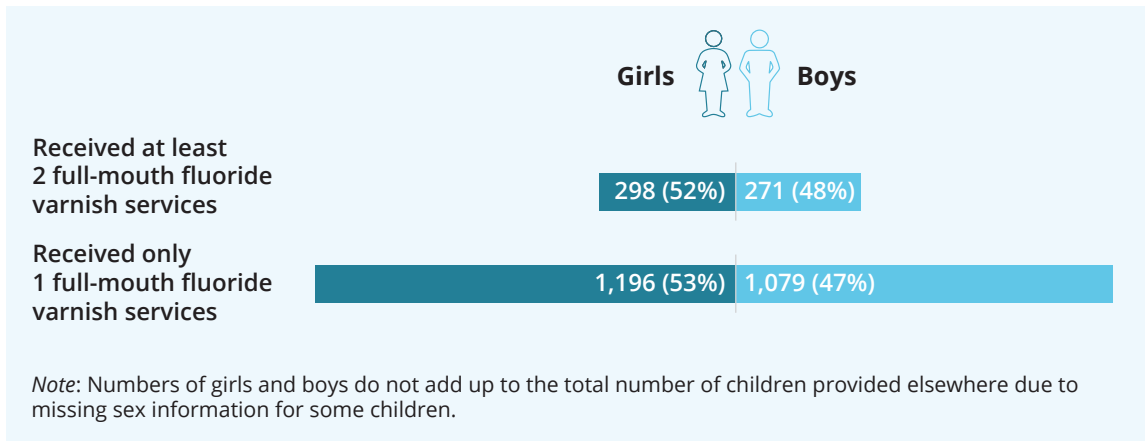
Figure 2.2: Full-mouth fluoride varnish services and service recipients, July 2012 to December 2020



Note: Consent refers to the services and service recipients where consent to share information with the AIHW was provided by the service recipient's parent or guardian. Where a parent or guardian does not provide consent to share information, only a limited amount of combined information is provided to the AIHW. Due to this limited information, in this report the number of non-consent service recipients for most years is estimated to be equal to the number of non-consent visits.

Source: Table S2.1.

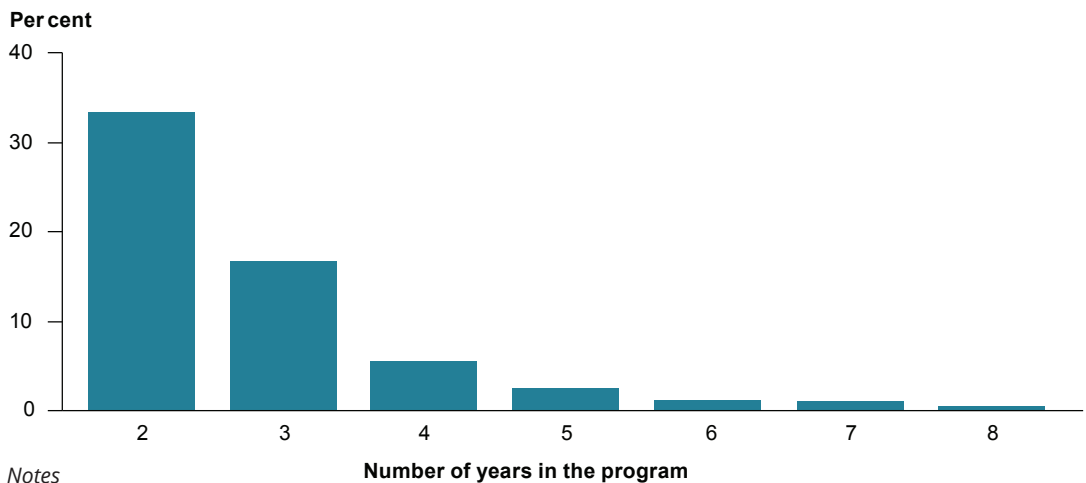
Consent rates to share information have fluctuated over the years. The consent rate for children receiving full-mouth varnish services was 64% (2,845 children) in 2020. In 2020, of those who received full-mouth fluoride varnish services, a slightly higher percentage were girls than boys.



The proportion of service recipients receiving an annual fluoride varnish service decreased the longer children stayed in the program (Figure 2.3). Among children who received their first service in 2013 (8 years in the program), only 0.5% (8 children) had an annual fluoride varnish service in 2020.

However, it was difficult to follow up children accurately because in each year from 2015 about 20%–35% of parents or guardians of children who received fluoride varnish services did not give consent to share their information with the AIHW.

Figure 2.3: Proportion of service recipients over the period 2013 to 2020 who received an annual fluoride varnish service, by number of years in the SFNT/NTRAI OHP



Notes

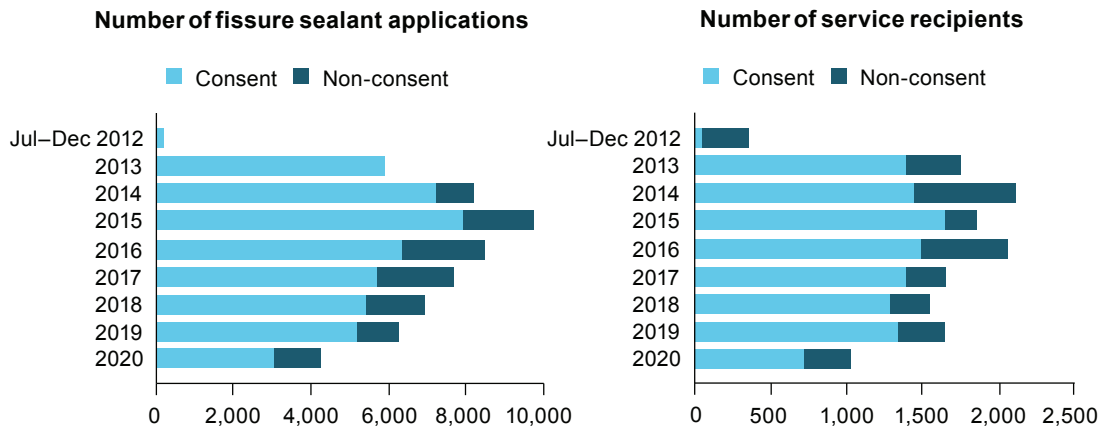
1. Only includes service recipients aged 15 or under who were still eligible for services through the NTRAI OHP in 2020.
2. Excludes service recipients whose parent or guardian did not consent to share information.

Source: Table S2.11.

Fissure sealants

- In 2020, 1,017 children had fissure sealants applied to 4,187 teeth (Figure 2.4).
- The number of children in the program who received fissure sealant applications fluctuated over time. Between 2019 and 2020, the number of both fissure sealant applications and service recipients decreased.
- Between July 2012 and December 2020, 10,500 children received fissure sealant applications to 57,625 teeth. This includes 7,328 children for whom consent to share information with the AIHW was provided.
- Consent rates to share information have fluctuated since the start of the program. The rate of consent for service recipients was 71% in 2020.

Figure 2.4: Fissure sealant application and service recipients, July 2012 to December 2020



Notes

1. Fissure sealant applications refers to the number of teeth that fissure sealants were applied to.
2. Non-consent data for the number of teeth that fissure sealants were applied to only available from July 2014.

Source: Table S2.3.

A fissure sealant can be applied to numerous teeth during 1 visit. In 2020, among the 1,017 children and young people who had fissure sealants applied, 722 (71%) had information recorded on the number of teeth to which fissure sealants were applied. These service recipients had fissure sealants applied to an average of 4.1 teeth.

Among the 403 children who received a fissure sealant service in 2020 and had their dmft/DMFT score recorded, 328 had existing caries. Children with existing caries had, on average, fissure sealants applied to fewer teeth compared with children with no existing caries (3.8 and 5.3 teeth, respectively).

Children who had fissure sealant applications, by caries status, 2020



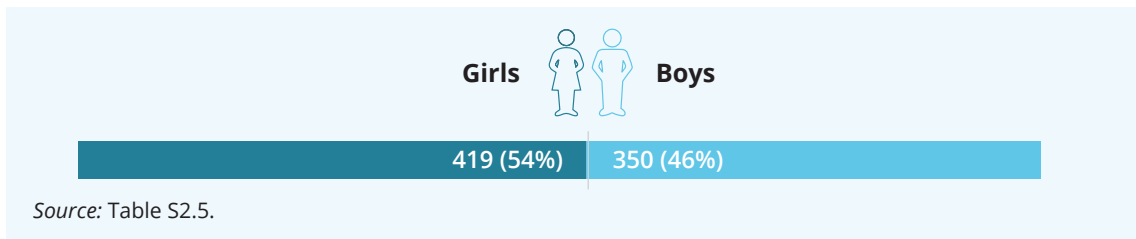
Children **with no existing caries** had an average of **5.3 teeth** with fissure sealants



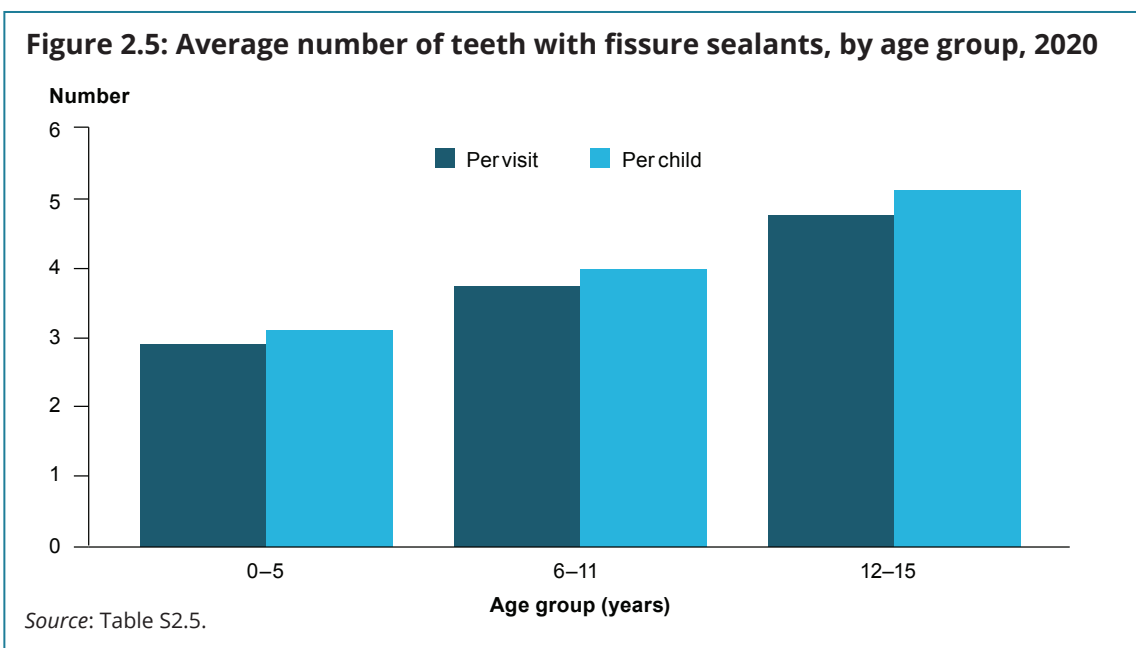
Children **who had existing caries** had an average of **3.8 teeth** with fissure sealants

Source: Table S2.4.

Girls had more visits than boys for fissure sealant applications in 2020.



Children aged 6–11 made up the largest proportion (61%) of those who received fissure sealants through the NTRAI OHP in 2020. However, children aged 12–15 had the highest average number of fissure sealants per child (5.1) (Figure 2.5). The lower averages for younger children are expected because fissure sealants should be applied to permanent teeth.



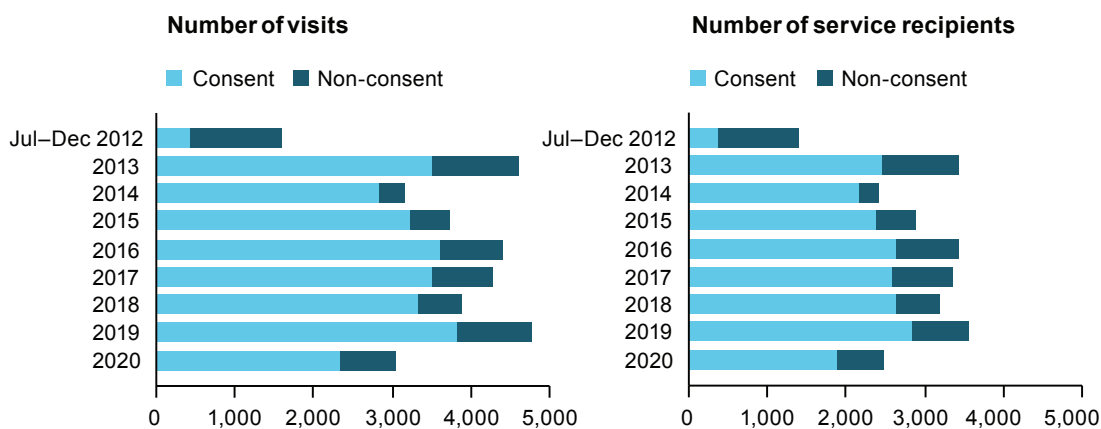
How many children had clinical service visits?

Clinical service visits can include restorative services, endodontics, tooth extractions, diagnostic services or assessments, orthodontic services and periodontic services (treatment of gums). The analysis of clinical service visits in this chapter differs from the benchmark outcome; this is in keeping with methodology applied in previous reports and allow for comparisons over time.

- In 2020, 2,469 children received 3,036 clinical service visits (excluding 1,464 visits classified as urban) (Figure 2.6).

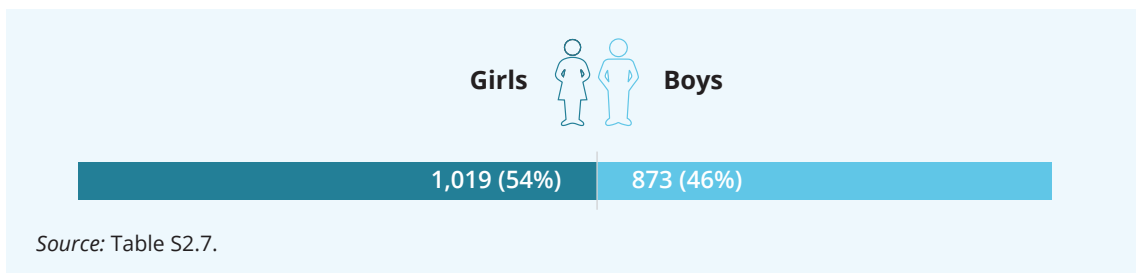
- Between July 2012 and December 2020, 16,539 children received 33,456 clinical service visits. This includes 10,245 children with consent to share information with the AIHW.
- The numbers of visits and service recipients have fluctuated over the years, but were higher in 2019 than in 2020.
- Consent rates have fluctuated over time, ranging between 72% of service recipients in 2013 and 91% in 2014. The consent rate in 2020 was 77%.

Figure 2.6: Clinical service visits and service recipients, July 2012 to December 2020



Source: Table S2.6.

Overall, in 2020, girls made up a higher proportion of children receiving clinical service visits than boys.



Source: Table S2.7.

In 2020, the majority of children who received a clinical service visit were aged 6–11 (52%), followed by those aged 0–5 (27%) and 12–15 (21%) (Table S2.7).

Services provided

In 2020, almost all children who received a clinical service visit in the NTRAI OHP received diagnostic (assessment) services and preventive services other than full-mouth fluoride varnish and fissure sealants. Preventive services include dental prophylaxis (for example, removal of plaque and calculus), as well as dietary advice, oral hygiene instruction and mouthguards.

Types of clinical services provided through the NTRAI OHP in 2020:



Notes

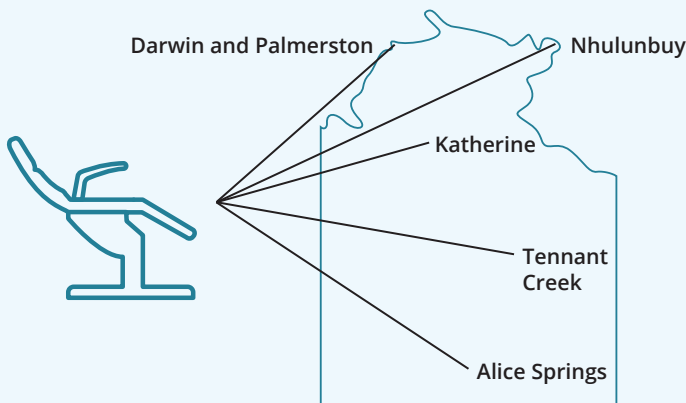
1. Only children who had a clinical service visit and provided consent to share information were included.
2. The percentages equate to over 100% as children can receive multiple types of services in 1 visit.


Source: Table S2.8.

How were services delivered?

The NTRAI OHP services are provided across the Northern Territory, in multi-chair community clinics as well as single-chair clinics in urban and regional primary schools. To improve access to oral health services in remote areas, single-chair clinics are also found in remote community health centres or delivered through mobile dental trucks.

Multi-chair community clinics where NTRAI OHP services are delivered





Dental services provided under general anaesthetic are carried out by Oral Health Services Northern Territory staff in the Northern Territory. Dental services are provided to children under general anaesthetic for the treatment of dental disease and include dental extractions, fillings and metal crowns. Full-mouth fluoride varnish may be provided during the course of the procedure, but is not reported as a preventive service in this instance. Since 2015, data related to services provided under general anaesthetic have not been provided to the AIHW, so the services are not included in this report.

Mobile dental trucks are used to reach many remote communities in Central Australia. Outreach dental service teams comprising a dentist or a dental/oral health therapist and dental assistant travel to remote communities in Central Australia for 1–3 weeks at a time. Some teams also travel to remote single-chair clinics.

Remote community health centres are primarily used for service delivery in the Top End—the northern region of the Northern Territory—where dental teams use a single-chair clinic to provide dental services for 1–3 weeks at a time.

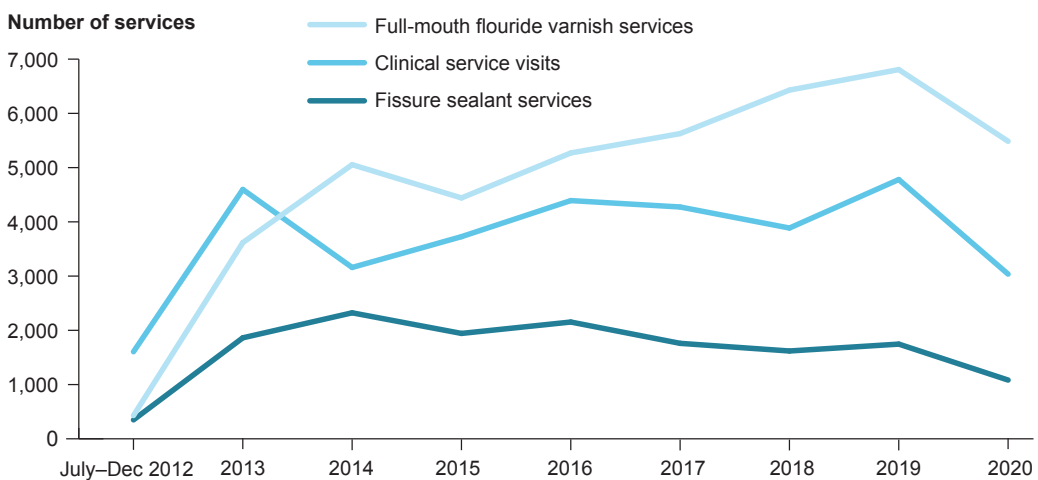
Distance, transport, unpredictable weather, cost and accommodation availability are all factors that challenge service delivery in remote areas of the Northern Territory. However, the NTRAI OHP complements and supports services in remote areas that are funded by the Northern Territory Government, enabling more visits and more equitable access to oral health services.

Impact of COVID-19

Early 2020 saw the emergence of a pandemic caused by the novel coronavirus disease COVID-19. Restrictions imposed by the Australian and state and territory governments restricted people’s movement and activities to limit the spread of the disease, and many people changed their behaviour to protect themselves and others from the risk of exposure.

Between July 2012 and 2019, the number of full-mouth fluoride varnish services and clinical services visits generally increased. In that same period, the number of services for fissure sealant applications were relatively steady. However, between 2019 and 2020, the number of services decreased for all 3 service types (Figure 2.7). In 2020 services decreased by 1,322 for full-mouth fluoride applications, 1,744 for clinical service visits, and 663 services for fissure sealant applications. The analysis of clinical service visits in this chapter differs from the benchmark outcome; this is in keeping with methodology applied in previous reports and allow for comparisons over time.

Figure 2.7: Number of full-mouth fluoride varnish services, clinical service visits and fissure sealant application services, July 2012 to December 2020



In 2020 there was a noticeable drop between March and April in the number of full-mouth fluoride varnish (Figure 2.8) and clinical service visits (Figure 2.10), and between February and April for fissure sealant application services (Figure 2.9). For all 3 service types, numbers of services increased in May. For example, the number of full-mouth fluoride varnish services/visits for Indigenous children in March 2020 was 606—decreasing to 42 in April 2020, and increasing to 309 services in May 2020.

The numbers of full-mouth fluoride varnish services and clinical service visits increased from July, with the second half of the year following a similar pattern to 2019. The number of services for fissure sealant applications increased in July before falling in August, peaking in November and from then showing a similar pattern to 2019.

The fall in all services around March and April 2020 coincides with when measures to reduce the risk of community transmission of COVID-19, including limiting public gatherings and reducing non-essential travel, were put in place across Australia (Health 2020). Pre-pandemic data from 2019 show a small drop in April, likely associated with Easter, public holidays and school holidays, but not to the same extent as that seen in 2020. While data for 2019 show considerable decreases in all service types from May to July, this pattern is not evident in 2020 (Figure 2.11).

Figure 2.8: Number of full-mouth fluoride varnish services among Indigenous children and young people, January 2019 to December 2020 (monthly)

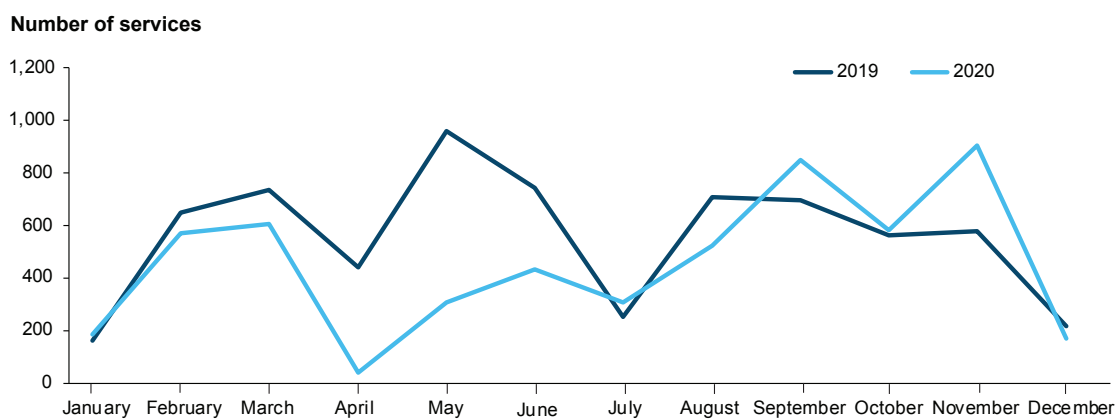


Figure 2.9: Number of services for fissure sealant applications among Indigenous children and young people, January 2019 to December 2020 (monthly)

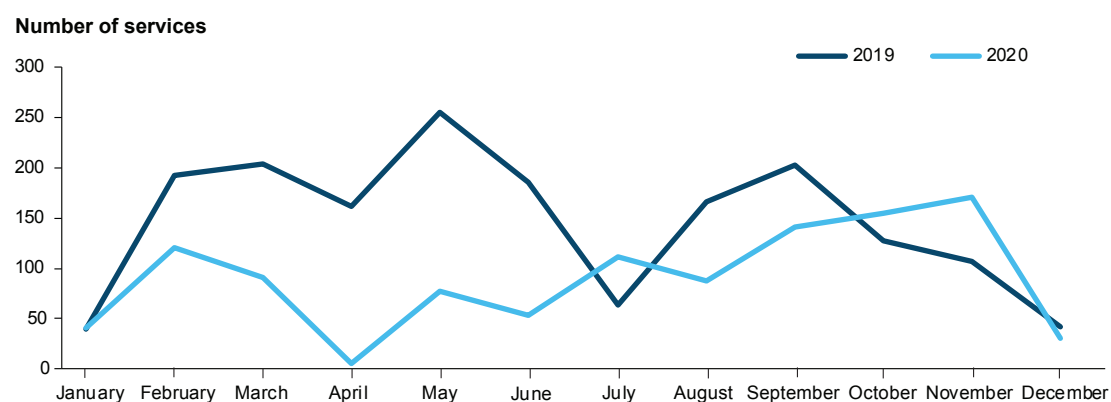


Figure 2.10: Number of clinical service visits among Indigenous children and young people, January 2019 to December 2020 (monthly)

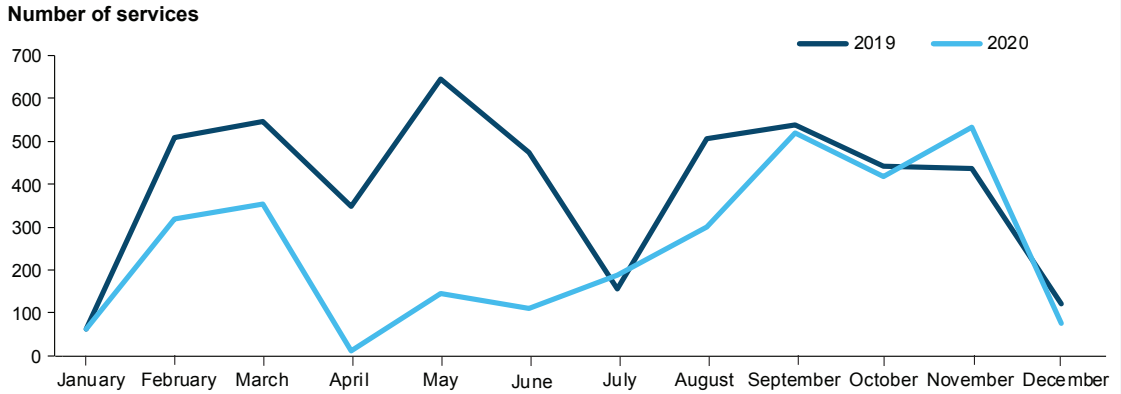
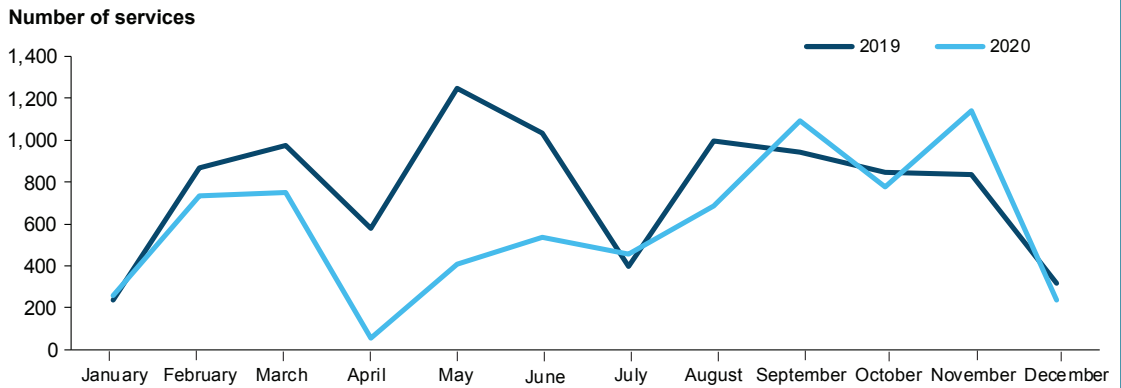


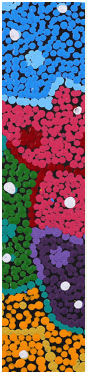
Figure 2.11: Total services (number of full-mouth fluoride varnish services, clinical service visits, fissure sealant application services), January 2019 to December 2020 (monthly)





3

Oral health status



Key findings

In 2020, among Indigenous children in the NTRAI OHP:

- those aged 9 were the most likely to have tooth decay experience (88%)
- those aged 5 had the highest average number of decayed, missing and filled teeth
- generally, the proportion of those who experienced tooth decay fell over time.

How many children had decayed, missing and filled teeth?

Tooth decay is the most prevalent oral disease among children and adults. Therefore, a widely used indicator to measure oral health status is a count of the number of decayed, missing or filled teeth. The decayed, missing or filled teeth (dmft or DMFT) score is a measure of the number of such teeth a child has (Box 3.1).

Box 3.1: The dmft and DMFT score

The dmft or DMFT score counts the number of teeth that are decayed, missing or filled. Lower case dmft refers to deciduous or baby teeth, while upper case DMFT refers to permanent or adult teeth.

For example, a dmft score of 5 means that a child has 5 decayed, missing or filled deciduous teeth.

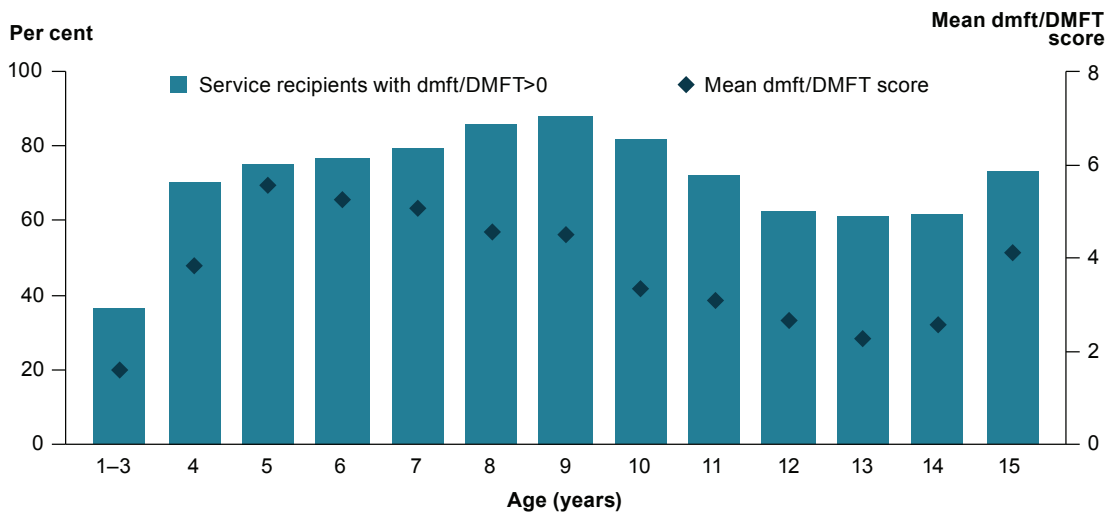
When children have a dmft/DMFT score that is greater than 0, this is known as having caries or tooth decay experience.

The proportion of children with tooth decay experience (a dmft/DMFT score greater than 0) varied with age (Figure 3.1). Children aged 7–10 had the highest percentages of tooth decay experience in 2020, with:

- 88% of those aged 9 experiencing tooth decay
- 86% of those aged 8 experiencing tooth decay
- 82% of those aged 10 experiencing tooth decay
- 80% of those aged 7 experiencing tooth decay.

The highest mean dmft/DMFT scores were among children aged 5 (5.6) and 6 (5.3).

Figure 3.1: Children with tooth decay experience, by age, 2020



Source: Table S3.1.

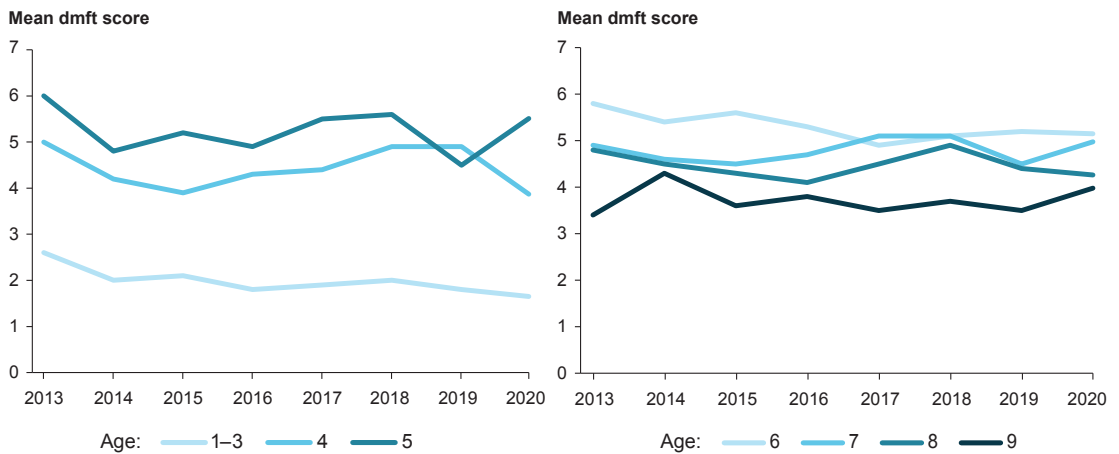
In general, mean dmft scores were higher than mean DMFT scores, meaning that more decayed, missing and filled teeth were found among children’s baby teeth. The dmft scores for children aged 5–11 were higher than the DMFT scores, but for children aged 12–15 DMFT scores were higher than dmft scores. In 2020:

- children aged 5 had the highest average dmft score (5.6)
- children aged 15 had the highest average DMFT score (4.0).

The proportion of children who had experienced decay differed with age and over time (figures 3.2 and 3.3). Between 2013 and 2020, the mean dmft or mean DMFT also varied by age. Children aged 1–3 and young people aged 12 experienced the largest decreases in dmft and DMFT scores, respectively. Compared to 2013, in 2020 the average number of decayed, missing or filled teeth decreased by:

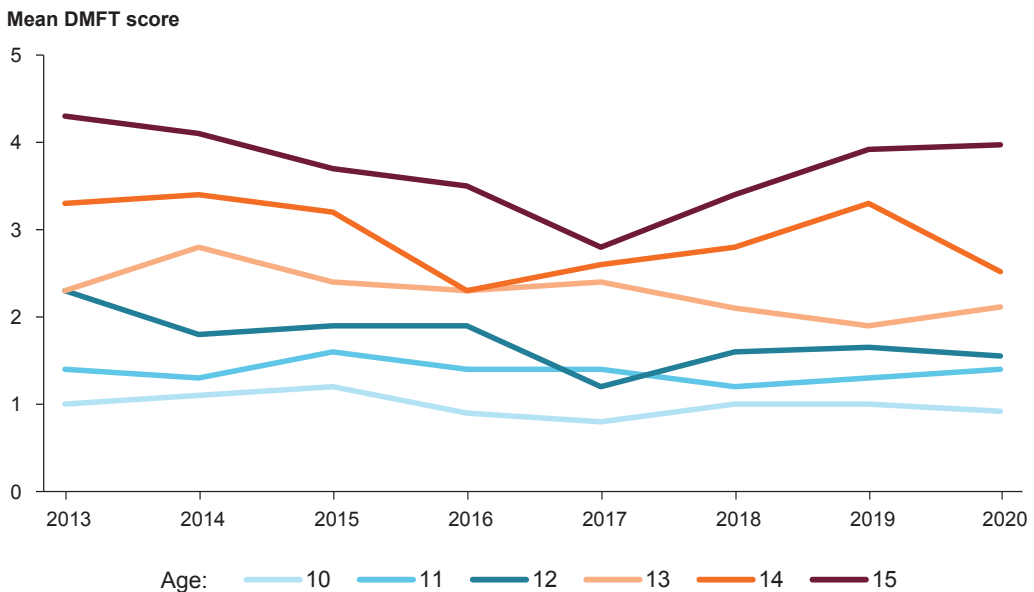
- 38% among children aged 1–3 (dmft)
- 30% among children aged 12 (DMFT).

Figure 3.2: Mean dmft score among children aged 1–9, by age, 2013 to 2020



Sources: tables S3.1, S3.2, S3.3, S3.4, S3.5 and S3.6.

Figure 3.3: Mean DMFT score among children aged 10–15, by age, 2013 to 2020



Sources: tables S3.1, S3.2, S3.3, S3.4, S3.5 and S3.6.

Oral health status of total population of children

The National Child Oral Health Study provides a descriptive 'snapshot' of oral health in the total child population in Australia. Data are collected nationally from children aged 5–14 using interviews and standardised dental examinations. This study was last conducted in 2012–14.

Nationally, among the survey respondents, in 2012–14:

- 5.5% identified as Indigenous (38.7% in the Northern Territory)
- 2.5% were living in *Remote and very remote* areas (44% in the Northern Territory)
- 60.6% of Indigenous children aged 5–10 had experienced decay in their deciduous or baby teeth (compared with 40.5% of non-Indigenous children)
- 36% of Indigenous children aged 6–14 had experienced decay in their permanent teeth (compared to 22.7% for non-Indigenous children) (Ha et al. 2016).

Previous annual reports have compared the NTRAI OHP outcomes for Indigenous children with the results for total child population based on a comparison with the 2012–14 study. However, as the reference periods are diverging, this comparative analysis has not been updated for this report because the results may be misleading. Similar analysis may be updated as more recent survey data become available.

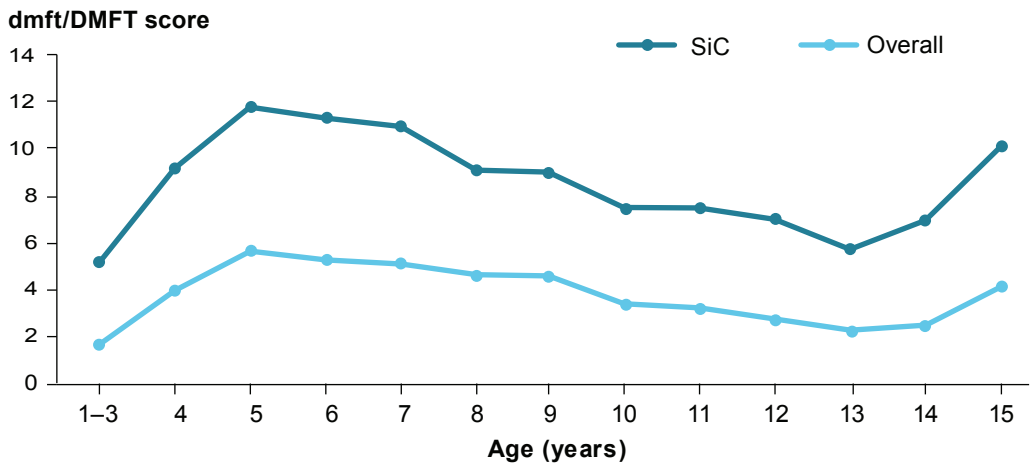
Significant Caries Index

The Significant Caries Index (SiC) is used to identify children who have the most tooth decay experience in a group. In the NTRAI OHP, the SiC value is the average number of dmft/DMFT among children with the highest 30% of dmft/DMFT scores of all children in the program.

Figure 3.4 shows the difference between the mean dmft/DMFT scores among children with SiC values and all children in the NTRAI OHP.

In 2020, children in the NTRAI OHP with the highest 30% of dmft/DMFT scores (SiC values) had scores that were 2–3 times as high as children in the NTRAI OHP overall.

Figure 3.4: SiC and mean total dmft/DMFT scores of children in the NTRAI OHP, by age, 2020



Note: The SiC value is the mean dmft/DMFT score among children in the NTRAI OHP who have the highest 30% of dmft/DMFT scores (the most tooth decay experience).

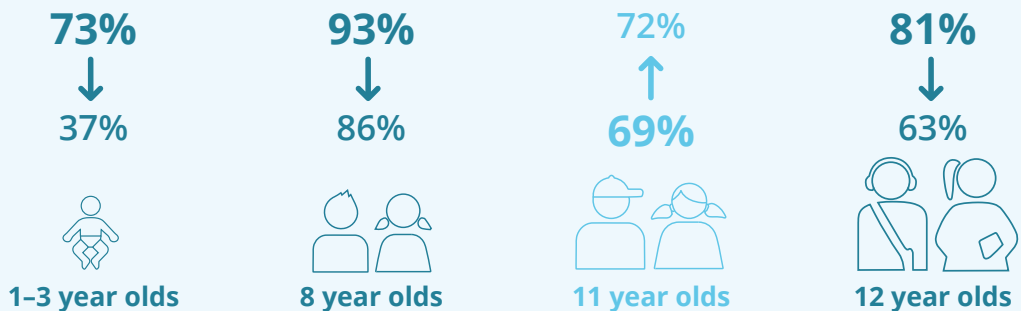
Source: Table S3.1.

How has tooth decay experience changed over time?


Although this report focuses on services provided between July 2012 and December 2020, information from 2009 to June 2012 (from the CHCI(CtG) program) are included in this section to provide some insight into longer-term trends.

From March 2009 to December 2020, the proportion of children with tooth decay experience fell for most ages, though it rose from 69% to 72% for children aged 11.

Tooth decay experience from March 2009 to December 2020



Source: Table S3.9.

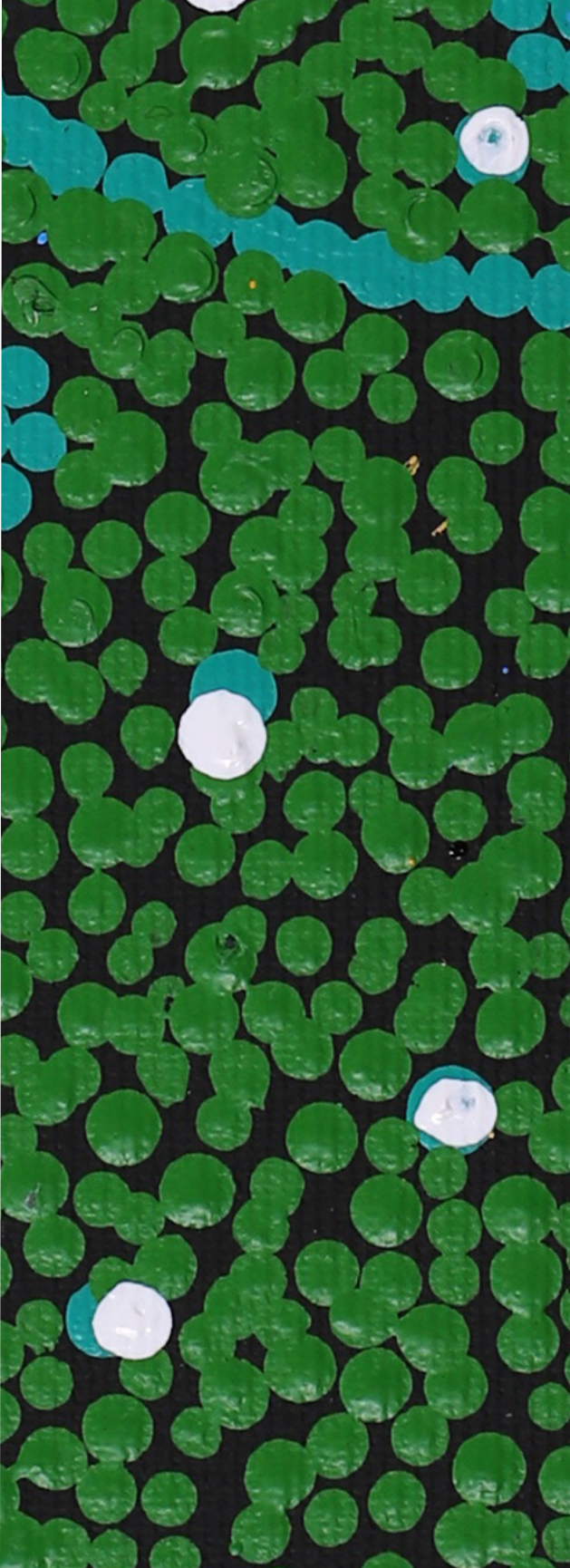


Changes over time could be either associated with changes in the sample of children who were in the program at different times, or due to actual changes in tooth decay experience among children in the program. A number of reasons could explain changes over time:

- Preventive interventions (for example, full-mouth fluoride varnish) introduced at the population level through the SFNT/NTRAI OHP could decrease tooth decay.
- The CHCI(CtG) cohort is relatively small, and the smaller sample size could cause variability in the findings.
- Children aged 6–10 have fewer teeth because their permanent teeth are still developing after they have lost their baby teeth. This could be a reason for this age group having the smallest increase in dmft/DMFT over time.

Results are based on data made available to the AIHW periodically, and are not representative of the whole population.





4

Progress against benchmarks

Progress against benchmarks

The NTRAI OHP has performance indicators and benchmarks to monitor the program's outcomes. The targets are set jointly by the Australian and Northern Territory departments of health, through the Northern Territory Health Implementation Plan (CFFR 2016).

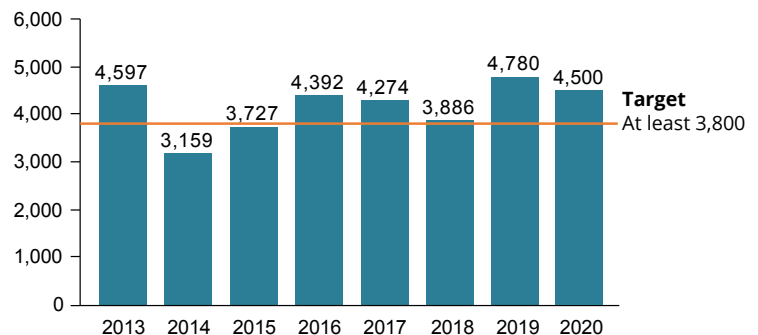
Service delivery targets

In 2020, COVID-19 restrictions may have affected the number of services delivered under the NTRAI OHP. However, the service delivery targets for all service types were met or exceeded

The annual targets for fluoride varnish applications and fissure sealant applications were originally set out in the Northern Territory Health Implementation Plan of the NTRAI National Partnership and may change based on agreement between the Australian and Northern Territory governments.

Indicator:
Clinical service visits provided

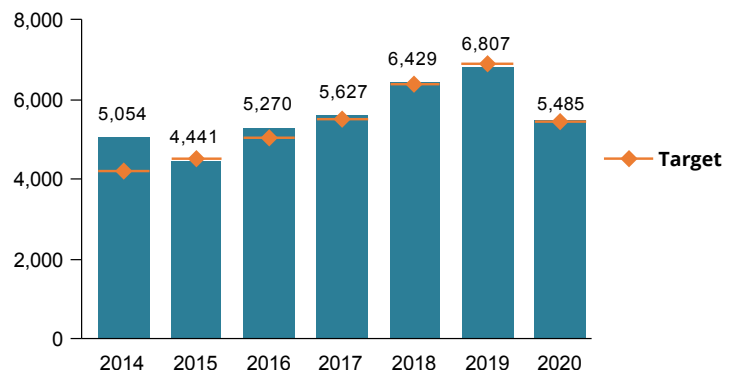
Target: 3,800 occasions of **clinical service** per year



Note: Historically, clinical urban services have been excluded from reporting. For 2020, the specification for counting the number of clinical service visits includes 1,464 clinical urban services. This was agreed with the Commonwealth Department of Health.

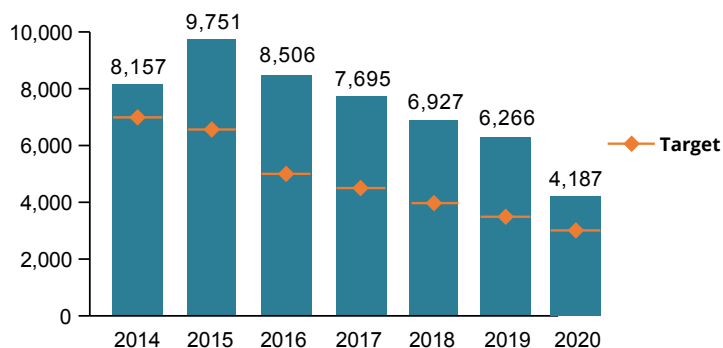
Indicator:
Fluoride varnish applications

Target: 5,485 **fluoride varnish applications** in 2020



Indicator:
Fissure sealant applications

Target: Fissure sealant applications to 3,000 teeth in 2020



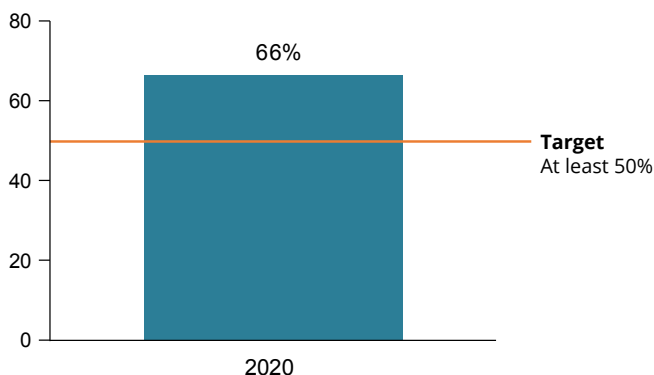
Note: The declining number of fissure sealants is due to the one-time only application of fissure sealants per tooth as well as to clinicians determining the most appropriate clinical treatment.

Health outcome targets

In 2020, the health outcome target for prioritisation of preventive services was exceeded.

Indicator:
Prioritisation of preventive services

Target: At least 50% of total service items are preventive services



Note: The data for preventive services target include fissure sealants, full-mouth fluoride varnish and preventive services (for example, removal of plaque/calculus) that were provided during clinical visits. Only data where consent was obtained to share information were used.

Appendix A: About the Northern Territory Remote Aboriginal Investment Oral Health Program data collection

Data collection, management and reporting

The Department of Health commissioned the Australian Institute of Health and Welfare (AIHW) to collect, manage and report on oral health services data provided through the Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP).

The data are extracted from an electronic information system in which dental professionals record clinical information, before the data are sent electronically to the AIHW.

Children who receive oral health services under the NTRAI OHP are not a random sample of Indigenous children in the Northern Territory. Further, not all dental services provided in the Northern Territory are captured in the NTRAI dental data collection, because it includes only oral health services funded by the Australian Government through the NTRAI OHP. Services provided through other funding sources (for example, the Northern Territory Government or private sector) are not included in this report. As a result, findings in this report are not representative of all Indigenous children in the Northern Territory.

The data the AIHW receives rely on parents or guardians of service recipients providing their consent to share individual information. Detailed information on dental services are sent to the AIHW only when consent is given. In cases where that consent is not given, the AIHW receives only a limited amount of combined information.

Due to this limited information, the number of non-consent service recipients presented in this report for most years is estimated to be equal to the number of non-consent services. As a result, apart from the total number of services and service recipients, other information in this report is representative of children for whom consent was obtained, rather than of all service recipients.



History of the program

Services provided by the NTRAI OHP were originally a part of the Child Health Check Initiative (CHCI), a response to the poor oral health found among Indigenous children in the Northern Territory National Emergency Response prescribed areas in mid-2007.

The program later continued under the Closing the Gap (CtG) initiative in the Northern Territory National Partnership Agreement from mid-2009 to mid-2012. These 2 programs, from 2007 to mid-2012, are collectively referred to as the CHCI(CtG). Improvements were seen in the oral health of children who received services through CHCI(CtG) oral health programs, which shows their importance.

As a result of these improvements in oral health, the Australian Government continued to fund, and also expanded, the program under the Stronger Futures in the Northern Territory Oral Health Program (SFNT OHP) from July 2012 to June 2015. This program has been continued through the NTRAI OHP since July 2015 and will be funded until 2022.

Appendix B: Data quality statement

SFNT/NTRAI OHP dental data collection summary

- This data collection includes more than 20,000 Indigenous children and adolescents aged 0–15 who received oral health services under the SFNT OHP and, later, the NTRAI OHP.
- Data collected as part of the SFNT/NTRAI OHP are a by-product of a clinical process. Dental professionals who provide clinical services document the results on standard data collection forms or in a computer-based data collection system.
- In the first 6 months of the SFNT/NTRAI OHP (July to December 2012), the consent rate to share data with the AIHW was low (27% for clinical service visit recipients, 26% for full-mouth fluoride varnish recipients, and 22% for fissure sealant recipients), so data collected in this period are not representative of all SFNT dental services and service recipients. Consent rates have fluctuated since the initial period for all services in the collection. In 2020 consent rates for service recipients were 77% for clinical service recipients, 64% for full-mouth fluoride varnish recipients and 71% for fissure sealant recipients.

A full data quality statement for the SFNT/NTRAI OHP dental data collection can be found online at <https://meteor.aihw.gov.au/content/index.phtml/itemId/750723>.

Acknowledgments

Ms Pooja Chowdhary, Ms Ruth Penm and Ms Isabella Stephens of the AIHW's Indigenous Group prepared this report. The authors thank Dr Fadwa Al-Yaman and Ms Elizabeth Hynes of the AIHW for their guidance and comments.

The Department of Health provided funds to support data collection and report production, and members of the Indigenous Health Division are thanked for their comments on this report.

The authors also acknowledge the assistance, cooperation and feedback of the Northern Territory Department of Health. Special thanks go to the many clinicians and administrators who supported this data collection while also providing clinical services in remote locations across the Northern Territory.

As well, the authors wish to thank the families of the children who consented to share their information with the AIHW for this report.

Abbreviations

AIHW	Australian Institute of Health and Welfare
CHCI(CtG)	Child Health Check Initiative/Closing the Gap program
dmft	decayed, missing or filled deciduous (baby) teeth
DMFT	decayed, missing or filled permanent (adult) teeth
NTRAI	Northern Territory Remote Aboriginal Investment
OHP	Oral Health Program
SFNT	Stronger Futures in the Northern Territory
SiC	Significant Caries Index

Glossary

deciduous (baby) teeth: Primary teeth that develop during the embryonic stage of human development and erupt (that is, become visible in the mouth) during infancy. They are usually lost and replaced by permanent teeth, but in the absence of permanent replacements, can remain functional for many years.

dental caries: A biofilm-mediated disease that can lead to cavities (small holes) in the tooth structure which compromise both the structure and the health of the tooth, and commonly known as tooth decay.

diagnostic services: Services that include:

- examinations (consultations; written reports; referrals; and initial, periodic and emergency oral examinations)
- radiographical examination and interpretation (intraoral radiographs and skull radiographs)
- other diagnostic services (including bacteriological examinations, antibiotic sensitivity tests, biopsies and models).

dmft: Decayed, missing or filled **deciduous (or baby) teeth**.

DMFT: Decayed, missing or filled **permanent (or adult) teeth**.

dmft/DMFT: The score for **deciduous (baby) teeth** and **permanent teeth** combined (that is, dmft + DMFT).

endodontics: Pulp or nerve treatments (pulp capping, pulpotomy, extirpation or debridement of root canal).

extraction: Removal of permanent or deciduous tooth or tooth fragment.

fissure sealants: Protective adhesive applied to grooves in the biting surfaces of teeth at the back of the mouth, usually as soon as adult molars erupt. The sealants prevent dental plaque and acid build-up, and can last for many years; however, regular check-ups are required to see if the sealant is intact.

full-mouth fluoride varnish: A clinically determined amount of fluoride varnish (a concentrated form of fluoride) applied to the surfaces of teeth.

Indigenous: A person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which they live.

permanent teeth: Adult or secondary teeth that start to erupt at about 6 years of age. By about age 21, a person usually has 32 permanent teeth.



preventive services: Services including:

- dental prophylaxis (removal of plaque, removal of calculus, recontouring of existing restorations)
- topical fluoride (application of fluoride solution or gel, instruction on self-application)
- other preventive services (including dietary advice, oral hygiene instruction, fissure sealing and provision of mouthguards).


restorative services: Removal of diseased tooth structures and replacement with amalgams, glass ionomer, silicate and composite resins (filling of 1, 2, 3 or more surfaces).

Significant Caries Index (SiC): Mean **dmft/DMFT** score among children who have the highest 30% of dmft/DMFT scores.

tooth decay experience: A dmft/DMFT score greater than 0.

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Related publications

The following AIHW publications might be of interest:

- AIHW 2021. Oral health outreach services for Aboriginal and Torres Strait Islander children in the Northern Territory July 2012 to December 2019. Cat. no. IHW 235. Canberra: AIHW.
- AIHW 2019. Northern Territory Remote Aboriginal Investment: Oral Health Program July 2012 to December 2018. Cat. no. IHW 224. Canberra: AIHW.
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- AIHW 2014. Stronger Futures in the Northern Territory: Oral Health Program July 2012 to December 2013. Cat. no. IHW 144. Canberra: AIHW.
- AIHW 2012. Northern Territory Emergency Response Child Health Check Initiative—follow-up services for oral and ear health: final report, 2007–2012. Cat. no. DEN 223. Canberra: AIHW.
- AIHW 2011. Dental health of Indigenous children in the Northern Territory: findings from the Closing the Gap Program. Cat. no. IHW 41. Canberra: AIHW.

These reports can be downloaded from www.aihw.gov.au/publications. The website also includes information on ordering printed copies.



This report presents information on oral health outreach services provided to Aboriginal and Torres Strait Islander children and young people aged under 16 in the Northern Territory. There were some improvements over time in the proportion of Indigenous children in the NTRAI OHP with tooth decay.



Stronger evidence,
better decisions,
improved health and welfare