

Indigenous oral health: A matter of rights



Madison Cachagee (Omushkego Mushkegowuk)^{a,*}, Brianna Poirier (Canadian)^a, Michael Larkin (Kokatha)^b,
Lisa Jamieson (New Zealander)^a

^aIndigenous Oral Health Unit, Australian Research Centre for Population Oral Health, Adelaide Dental School, The University of Adelaide, Adelaide, South Australia, Australia

^bAdelaide Medical School, The University of Adelaide, Adelaide, South Australia, Australia

Highlights

- Colonisation and systemic racism perpetuate stark oral health inequities for Indigenous peoples in Turtle Island, so-called Australia, and Aotearoa New Zealand, undermining their right to self-determination.
- Aboriginal community-controlled health services (ACCHSs) exemplify self-determination through culturally safe, community-led oral health initiatives.
- Exclusion of dental care from Medicare reflects systemic barriers and perpetuates a fragmented approach to healthcare.
- Indigenous-led health initiatives showcase transformative approaches to advancing culturally safe and equitable oral health solutions.
- Integrating oral health into ACCHSs frameworks and reforming workforce cultural safety are essential for achieving health equity and self-determination.

Despite consistently ranking among the top countries on the United Nations Development Programme's Human Development Index, Turtle Island (Canada and the United States), so-called Australia,¹ and Aotearoa New Zealand face a stark contrast in the health and social conditions of their Indigenous populations (Cooke et al. 2007). This is reflected in significantly lower Human Development Index scores for these communities, who

continue to face substantial disparities (King et al. 2009). Within Australia, and indeed elsewhere, colonisation, systemic racism and the ongoing exclusion from decision-making processes continue to pose significant barriers to achieving equitable health outcomes and care provision for Aboriginal and Torres Strait Islander peoples (Campbell et al. 2015). The ongoing failure of mainstream health services to provide culturally safe

*Corresponding author.

E-mail address: Madison.cachagee@adelaide.edu.au (M. Cachagee).

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¹The use of the term "so-called Australia" acknowledges the colonial imposition on Indigenous lands and the fact that sovereignty was never ceded. It reflects critical scholarship that challenges the legitimacy of the colonial state and recognises the enduring sovereignty and presence of Aboriginal and Torres Strait Islander peoples.





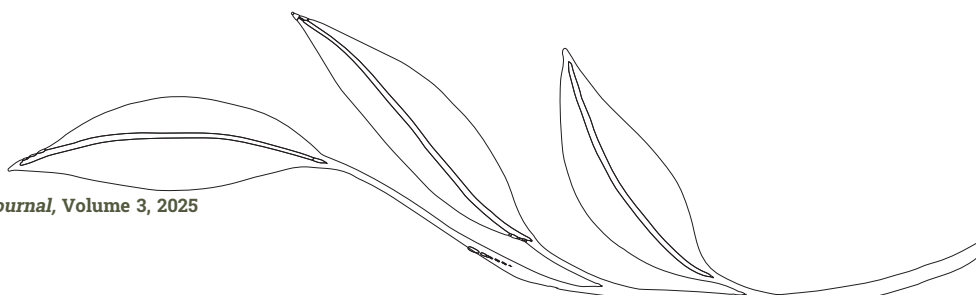
care reflects the design of Western biomedical models that have excluded Indigenous holistic perspectives of health and wellbeing (Gracey and King 2009; NIAA and AIHW 2024; AIHW 2011; Wispelwey et al. 2023).

In response, Aboriginal community-controlled health services (ACCHSs) and other Aboriginal community-controlled organisations champion self-determination, dismantling colonial structures and promoting culturally safe, community-led initiatives (NACCHO 2024; Poirier et al. 2022). The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) affirms Indigenous peoples' right to health equity and traditional practices (United Nations 2007), but systemic barriers, including the exclusion of dental care from Medicare, persist. This commentary explores the constraints placed on oral health self-determination and amplifies the voices of Aboriginal and Torres Strait Islander leaders who fiercely advocate for their communities' health and wellbeing. We call for urgent, widespread change to dismantle these constraints and honour the relentless resilience and leadership driving this critical movement forward.

Racism and self-determined oral health

Safe oral health access is crucial for overall wellbeing. Systemic racism in healthcare – reported by 42% of Aboriginal and Torres Strait Islander individuals (Freeman et al. 2016) – and other social services directly undermines self-determination by limiting access to education, culturally appropriate care and housing. Chronic stress from racism triggers physiological changes, increasing morbidity and mortality. Racism not only restricts the ability to make autonomous decisions about health but also perpetuates inequities that violate fundamental human rights (Hedges et al. 2021; Dudgeon et al. 2023).

In oral health, structural racism manifests through workforce disparities and contextual challenges (Hedges et al. 2021). Aboriginal and Torres Strait Islander representation in the Australian Health Practitioner Regulation Agency (Ahpra)-registered dental workforce is the second lowest among health professionals (0.4%) (Poirier et al. 2025). In 2020, 57 out of more than 18,000 dental practitioners – including dentists, dental therapists, dental hygienists and oral health therapists – were employed in ACCHSs. Recruiting and retaining dental practitioners remains a significant challenge for ACCHSs, even in urban areas. While some communities have the necessary clinical infrastructure, such as dental chairs, they often lack the staff to operate them, which forces many Aboriginal and Torres Strait Islander community members to seek dental care from undertrained general practitioners or emergency departments (NACCHO 2023). Although ACCHSs are a key provider of culturally safe care, public dental programs also serve Aboriginal and Torres Strait Islander communities – including in remote areas – but often face similar workforce shortages, recruitment difficulties and resource constraints (Select Committee 2023; Do et al. 2025). Cultural safety gaps further complicate access: minimal cultural competency training for dental staff leads to interpersonal racism, extending beyond clinicians to practice personnel (NACCHO 2023). These systemic challenges represent only the surface of the issues that Aboriginal and Torres Strait Islander communities face when accessing oral health care. An Aboriginal Elder emphasised a broader reluctance to seek health services, stemming from a history of experiencing racism within healthcare settings: 'Some of the older, our age. They don't like coming to this building (a health facility) simply because it was a no-go zone. It was known as white only building (during the days of the mission)' (Tynan et al. 2022). These stories are all





too common within Aboriginal and Torres Strait Islander communities, underscoring a harsh reality: the services they depend on consistently fail to address their needs.

Exclusion of dental care from Medicare – beyond financial barriers

The exclusion of dentistry from Medicare significantly restricts affordability and access of care. Despite Australians spending AUD \$11.1 billion annually on dental services (primarily out-of-pocket in the private sector), public funding remains insufficient, covering 13% of total costs for public dental programs (Sloan et al. 2024). An Aboriginal Health & Medical Research Council (AH&MRC) study in New South Wales revealed mixed reliance on both public and private services, largely due to the inaccessibility of public services resulting from barriers such as distance, long waiting times and high costs (Campbell et al. 2015). The exclusion of dentistry from Medicare represents more than a financial gap – it reflects a fragmented view of health that disconnects oral care from overall wellbeing.

Aboriginal community-controlled health services, which serve as trusted hubs of culturally safe and trauma-informed healthcare, struggle to provide dental services without adequate funding or trained staff. An estimated 40 unpaid staff contributed to dental service delivery in 2020–21, indicating resource reallocation from other critical areas (NACCHO 2023). This fragmentation perpetuates a siloed approach, overlooking the interconnectedness of physical, emotional and spiritual health (NACCHO 2024; NACCHO 2023; [Select Committee into the Provision of and Access to Dental Services in Australia 2023b](#)). True health equity requires integrating dental care into comprehensive and culturally safe systems led by ACCHSs.

Assertions of oral health self-determination

Through the leadership of ACCHSs, communities assert their autonomy in innovative ways, such as initiatives and associations like the Loddon Mallee Aboriginal Reference Group ([Dental Health Services Victoria 2023](#)) and the Indigenous Dental Association of Australia (IDAA 2024a). These initiatives stand as powerful examples of community leadership and assertions of self-determination.

In 2016, the Loddon Mallee Aboriginal Reference Group addressed gaps in mainstream models, such as high costs, inconsistent public dental services and the absence of targeted outreach for Aboriginal communities, by advocating for a regional fluoride varnish project. This led to a 2022 regulatory amendment allowing Aboriginal health practitioners (AHPs) in Victoria to administer fluoride varnish to children aged 3 to 17 years. This achievement positions ACCHSs as an important and culturally safe part of the dental health system by enhancing access to preventive care for Aboriginal and Torres Strait Islander communities ([Dental Health Services Victoria 2023](#)). Jaydene Burzacott, the first Victorian AHP to complete the training, noted that Aboriginal children trust AHPs, highlighting the importance of culturally safe care (Loughran 2023). This initiative reflects the commitment of ACCHSs to integrated and holistic models of care, and their power in overcoming structural barriers and demanding changes that improve community health.

Another example of oral health self-determination is the work of the Indigenous Dental Association of Australia (IDAA), a not-for-profit professional association dedicated to supporting and nurturing the Aboriginal and Torres Strait Islander dental workforce. The IDAA advocates for increased representation and





culturally responsive dental education. Its members combine professional expertise with lived experience, enabling authentic advocacy and reinforcing the importance of community-led leadership in oral health (IDAA 2024a; IDAA 2024b).

Moving forward

While there are areas of Australia's dental health system that are being transformed by assertions of Aboriginal and Torres Strait Islander self-determination, there is still a need for reform that supports integrated dental care within ACCHSs. Changes to the health system are urgently needed; nationally, there are calls to integrate dentistry within ACCHSs, such as NACCHO's Core Services and Outcomes Framework (NACCHO 2021). As Aunty Pat Turner has emphasised, frameworks like the Core Services and Outcomes Framework provide powerful tools to assess and address the critical gaps in the health system, as determined by Aboriginal and Torres Strait Islander peoples (NACCHO 2021). By centring community leadership and prioritising community needs, these frameworks can drive reforms that are both inclusive and transformative. The path forward demands structural changes within ACCHSs, backed by national-level reforms; to achieve this, concrete action is essential. Aboriginal and Torres Strait Islander communities possess an undeniable right to equitable healthcare and the autonomy to design and control their own health systems and outcomes – rights recognised by UNDRIP (United Nations 2007).

Recommendations for reform:

1. Integrate Aboriginal health workers and practitioners into the dental workforce.

Aboriginal health workers and practitioners are crucial for improving oral health but remain underutilised due to inconsistent engagement,

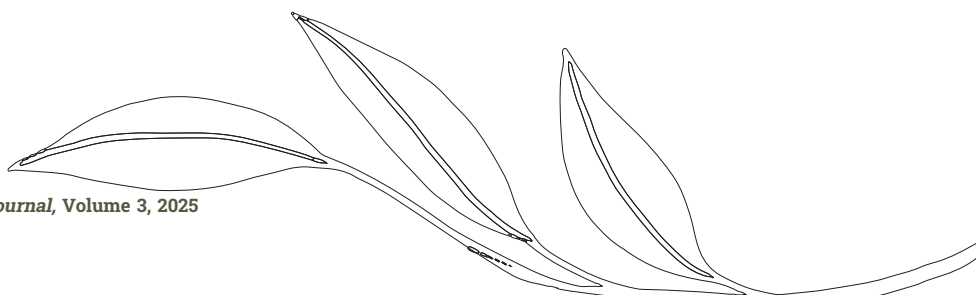
limited access to training and the perception of oral health as a specialised field. Recognising their contributions and providing consistent training will strengthen community-centred care (Poirier et al. 2023; Villarosa et al. 2018; Poirier et al. 2022).

2. Re-educate the existing dental workforce to advance anti-racism and cultural safety practices.

While a national cultural safety curriculum (Satur 2021) has been developed for tertiary education and is integrated into dental school programs through accreditation standards, there are significant gaps within the current workforce. Targeted funding and a commitment to (un)learning and (re)learning are crucial to drive meaningful structural change, fostering a more culturally safe and equitable oral health system (Poirier et al. 2025; Forsyth et al. 2019; Senior 2016).

3. Strengthen relationships and foster meaningful engagement between dental practitioners and ACCHSs.

ACCHSs must be repositioned as central pillars of the oral health system, rather than treated as isolated entities. Targeted funding is needed to support community outreach opportunities for dental practitioners within ACCHSs, enabling them to better understand the realities of Indigenous oral health and contribute to community-led and integrated care. This investment would create the infrastructure and dedicated time required to build respectful, sustained partnerships that support integrated referral pathways, ensuring seamless continuity of care and a shared understanding of each patient's journey. Embedding placements within ACCHSs as part of dental training for all practitioners would further strengthen these relationships. Collaborative and culturally safe approaches are key to addressing systemic inequities and enhancing health outcomes for Aboriginal and Torres Strait Islander communities





(Poirier et al. 2022; Shrivastava et al. 2020; Mangoyana et al. 2023).

It is time to shift from a monetary-driven, largely private model to one that centres community wellbeing. Legislative changes and appropriate funding are urgently needed to mandate equitable provision of dental care, guided by groups such as IDAA and ACCHSs. These changes would ensure that oral health is recognised as a fundamental right – not a privilege – and should be integrated into comprehensive healthcare.

Author contributions

M. Cachagee: Conceptualisation, investigation, resources, writing – original draft, writing – review and editing; B. Poirier: Conceptualisation, investigation, resources, writing – review and editing, writing – original draft preparation; M. Larkin: Writing – review and editing, supervision; L. Jamieson: Writing – review and editing, supervision.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Positionality statement

In recognition of the deeply relational nature of Indigenous research, we intentionally position ourselves within this work, acknowledging our responsibilities, connections and the relationships that shape and inform our approach (Russell-Mundine

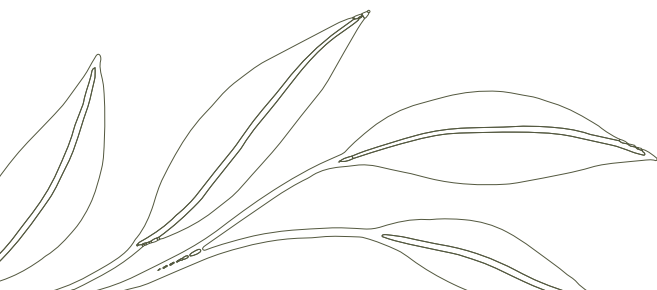
2012; Yunkaporta 2019; Wilson and Wilson 2008). We are guided by a proud and culturally connected Mushkegowuk woman (MC), who leads with the strength of her identity as a daughter, sister, aunty and researcher (Samms Hurley and Jackson 2020). Our team includes both Indigenous (ML, MC) and non-Indigenous members (BP, LJ) from various regions: northern Turtle Island (colonially known as Canada), so-called Australia,¹ and Aotearoa New Zealand. Our team brings together diverse perspectives to confront racial inequities, advance decolonisation and prioritise Indigenous health. We approach this work with deep humility and gratitude, sharing the immense honour of collaborating with Indigenous communities. Our partnerships, spanning numerous projects, are grounded in a collective dedication to supporting the self-determination and wellbeing of Indigenous peoples. We are committed to continuous learning and growth throughout this ongoing journey.

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Author biographies

Madison Cachagee is a master's student, Indigenous Oral Health Unit, University of Adelaide, Australia.





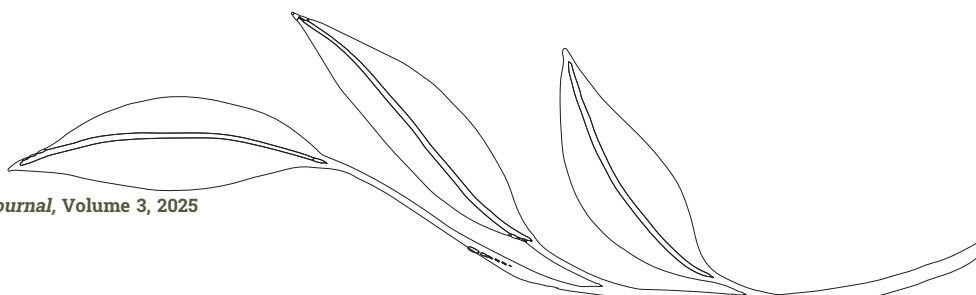
Brianna Poirier is a post-doctoral research fellow, Indigenous Oral Health Unit, University of Adelaide, Australia.

Michael Larkin is a senior lecturer - Indigenous Health, Adelaide Medical School, University of Adelaide, Australia.

Lisa Jamieson is an NHMRC Associate Professor, Australian Research Centre for Population Oral Health, University of Adelaide, Australia.

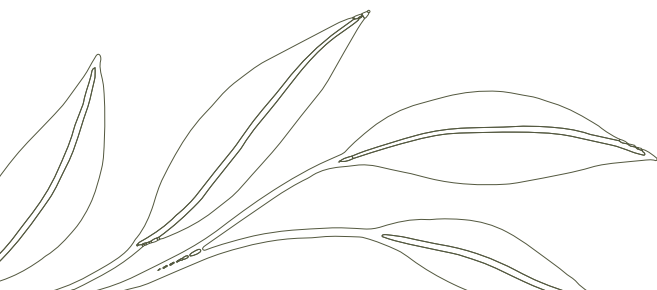
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