Standing Committee on Social Issues

Dental services

Tabled according to Standing Order 231

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Legislative Council. Standing Committee on Social Issues

Dental services in NSW : [report] / Legislative Council, Standing Committee on Social Issues. [Sydney, N.S.W.] : The Committee, 2006. – 228 p. ; 30 cm. (Report 37, March 2006)

"Tabled according to Standing Order 231".
"March 2006".
Chair: Jan Burnswoods.
ISBN 9781920788124

1. Dentistry—New South Wales.
I. Title
II. Burnswoods, Jan.
III. Series: New South Wales. Parliament. Legislative Council. Standing Committee on Social Issues. Report ; 37

362.1976 (DDC)

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Terms of Reference

1. That the Standing Committee on Social Issues inquire into and report on dental services in New South Wales, and in particular:

   (a) the quality of care received in dental services,

   (b) the demand for dental services including issues relating to waiting times for treatment in public services,

   (c) the funding and availability of dental services, including the impact of private health insurance,

   (d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,

   (e) the dental services workforce including issues relating to the training of dental clinicians and specialists,

   (f) preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and

   (g) any other relevant matter.

2. That the committee report by Friday 31 March 2006.

This inquiry was referred to the Committee by resolution of the Legislative Council (*7 April 2005, Minutes No.99, Item 8, p 1325)*

Committee Membership

Ms Jan Burnswoods MLC	Australian Labor Party	*Chair*
The Hon Robyn Parker MLC	Liberal Party	*Deputy Chair*
The Hon Dr Arthur Chesterfield-Evans MLC	Australian Democrats	
The Hon Kayee Griffin MLC	Australian Labor Party	
The Hon Charlie Lynn MLC	Liberal Party	
The Hon Ian West MLC	Australian Labor Party	

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Chair's Foreword

I am pleased to present the report of the Committee's Inquiry into dental services. The Committee makes strong recommendations aimed at addressing community and industry concerns about the availability and funding of public dental services and the quality of treatment received by eligible patients, the increasing need for public and private dental practitioners in the future and the need for a preventive dental focus.

The Inquiry process has illuminated the way in which decisions made over many years about different aspects of dental services have produced the current inequitable access to acceptable dental care between those who can afford to fund private dental treatment and those who rely upon public services. The Committee is greatly concerned that a large number of people are not able to access proper dental care.

To provide more comprehensive public dental services the Committee makes a range of recommendations, on the premise that sufficient funding to implement such recommendations must be made available. The Committee emphasises the need for both the Commonwealth and State Governments to provide additional funding for dental services, and examines Commonwealth incentives on private health insurance and the possible extension of Medicare.

The Committee has heard that access to public dental services is affected by unmanageable waiting lists, difficulties in accessing treatment, particularly in rural and remote areas, and a shortage of dental practitioners working in public dentistry. The quality of care that public dentistry staff can provide to patients is affected by time constraints due to the large number of patients requiring treatment and the resources available in public dental clinics. The Committee has made recommendations addressing each of these issues, with a view to ensuring that public dental services are sufficiently staffed and resourced to provide an adequate level of care.

The Committee learnt that the demand for both private and public dental practitioners is predicted to increase in the next ten years and has therefore made recommendations on issues pertaining to the dental workforce and the education and training of dental practitioners.

Dental disease is largely preventable and the Committee recognises that greater awareness of the importance of oral health needs to be generated through targeted education campaigns, similar to the 'Slip, Slop, Slap' campaign. The Committee also recommends that educative programs should be run through schools and early childhood health centres. The Committee received a large amount of evidence on the issue of fluoridation as a preventive measure, and sets out the arguments for and against fluoridating public water supplies.

On behalf of the Committee, I thank all of the participants for their time and expertise. I am grateful to my Committee colleagues for the work they have undertaken on this Inquiry. On their behalf I would like to acknowledge the Secretariat, particularly Ms Katherine Fleming and Ms Rebecca Main, for their assistance in the conduct of this Inquiry, and the production of this report. I commend this report to the Government.

Jan Burnswoods MLC
Chair

Executive Summary

Chapter 1 – Background to the inquiry

The Inquiry into dental services was referred to the Committee by resolution of the House on 7 April 2005. The motion to conduct the Inquiry was moved by the Hon Dr Chesterfield-Evans, in response to community concerns that the public dental service is not meeting current demand or providing adequate dental treatment for eligible patients, and that the cost of private dental care is increasing.

The Committee received 263 submissions to the Inquiry. The Committee also conducted eight days of hearings, at which it heard evidence from 64 witnesses, including NSW Health, the Australian Dental Association (NSW Branch), peak bodies representing various arms of the dental profession, oral health professionals and community groups. The Committee visited Port Macquarie and Broken Hill to gain an understanding of different aspects of public dental services and related issues, such as preventive treatment, in regional and rural areas of New South Wales.

Chapter 2 – Public and private dental services in NSW

This chapter provides an overview of the public and private dental services provided in New South Wales and the criteria for eligibility to receive public dental services. Many submissions expressed concern about the increasing cost of private dental treatment, which is described in the chapter, and which highlights the issue of affordability of dental services for lower income earners. The Chapter also provides information on the consequences of poor oral health and its detrimental effect on general health. Discussion of the predicted increase in demand for dental services in the future provides a context for later chapters concerning the need for an increased dental workforce.

Chapter 3 – Funding

The funding of public dental services in New South Wales was a key issue arising in this Inquiry, with a large number of submissions stating that funding is not sufficient to provide adequate public dental services. This chapter notes the ongoing debate between the Commonwealth and State Governments concerning their respective responsibilities to provide funding for public dental services, and explains the funding that is currently provided. The programs through which public dental services are administered are described, together with the problems that have arisen in implementing some of the programs and the corresponding effect on the provision of proper public dental services. The Committee makes recommendations concerning the need for increased funding of public dental services, the need for a more coordinated approach to oral health spending and the efficacy of some of the programs through which public dental services are administered.

In this Chapter the Committee also examines the impact of private health insurance on the provision of dental services, with particular reference to the Commonwealth Government's 30% rebate incentive on private health insurance, and the extension of Medicare to cover dental treatment. The majority of the Committee makes recommendations urging the Commonwealth Government to review the 30% rebate and redirect funding towards more affordable private and public dental services, and to extend Medicare to cover dental services provided to special needs groups and children up to the age of 16 years.

Chapter 4 – Dental workforce

This chapter examines dental workforce issues in New South Wales. The Committee notes that there is a current shortage of dentists and other dental practitioners working in public dentistry, particularly in rural and regional areas, which will be exacerbated by the increased demand for both public and private dental services in the future. The nature of the current dental workforce and its composition is described, as are the issues that deter dental practitioners from working in the public dental system, particularly lesser remuneration levels compared to private dentistry and a loss of dentistry skills. The Committee is committed to a well-resourced public dental service, staffed by salaried professionals and considered the suggestions made by many of the peak bodies representing dental practitioners that would promote employment in public dentistry. The Committee makes recommendations to strengthen the public dental workforce through increased remuneration levels, adjusting State awards and other incentives.

Chapter 5 – Education and training

This chapter considers the education and training of the dental workforce, following on from the workforce shortages described in Chapter 4. The Committee examines the current structure of dental courses, the cost of training students in dentistry, student fees and the number of graduating students. The Committee recommends that a greater number of HECS funded student places be provided in university courses to ensure that there are enough graduating dentists to meet future demand. To increase employment in the public dental workforce the Committee also recommends that internships for newly graduated dental practitioners be considered. The Committee also discusses the shortage of academics to teach in dental faculties.

Chapter 6 – Demand for and access to public dental services

A second key issue to arise out of the Inquiry was the great demand for public dental services. A large number of submissions commented on the length of time patients were required to wait in order to receive public dental treatment and the quality of the treatment received. This chapter details current demand and examines the quality of care received in dental services, noting the contrast in equipment and treatment in the public system to that in private dentistry. The Committee makes recommendations to reduce waiting lists for public dental treatment and to ensure that public dental clinics are adequately resourced and equipped.

Access to adequate public dental services emerged as a major issue, particularly for those patients living in rural and remote areas, and the Committee makes recommendations to increase those services and the adequacy of treatment provided. The oral health of special needs groups such as children, the elderly, indigenous Australians, migrants and refugees, disabled patients and other such groups is also addressed and the Committee recommends that services to these groups should be specifically addressed. The Committee also recommended in Chapter 3 that these groups should receive dental services by the extension of Medicare to cover their oral health.

Chapter 7 – Prevention

Oral disease is largely preventable, and this chapter examines the importance of preventive dental treatment, and how that treatment can be best provided. The lack of comprehensive monitoring of oral health in New South Wales was highlighted, as was the importance of such information in planning oral health strategies, and the Committee accordingly recommends that a survey unit be established within NSW Health.

The Committee notes the link previously discussed in Chapter 2 between oral and general health and the importance of an holistic approach to the two, and recommends that oral health promotion be integrated into mainstream health promotions in areas such as schools and early childhood health centres. The Committee also heard evidence that greater community knowledge about preventive treatment and the effect of diet on oral health is required and therefore recommends the dissemination of information through combined Federal and State Government targeted education programs, the use of oral health promotion teams, and nutrition education campaigns. The Committee also recommends that sufficient funding be allocated to prevention and oral health promotion strategies.

Chapter 8 – Fluoridation

The Committee received an overwhelming amount of evidence on the issue of fluoridation of public water supplies, with a significant amount of the material being scientific information outlining potential positive and negative effects of fluoridation. This chapter provides an outline of the arguments for and against fluoridation. The Committee recommends that any decisions as to fluoridating water supplies should be taken by NSW Health rather than local councils, and that the decision making process should be carried out in consultation with councils and communities.

Summary of Recommendations

Recommendation 10 **45**

That the New South Wales Government urge the Federal government to review the 30% rebate and to redirect funding towards more affordable private and public dental services.

Recommendation 11 **47**

That the NSW Government urge the Federal Government to extend Medicare to cover dental services to special needs groups and children up to the age of 16 years.

Recommendation 12 **71**

That:

- the award remuneration levels be reviewed for dental officers (dentists) and increased to a level to attract dentists to the public dental sector
- the State award for dental therapists and dental hygienists be reviewed and remuneration levels increased to include recognition of the Bachelor of Oral Health degree from both the University of Newcastle and the University of Sydney
- a State award for dental prosthetists be created
- the State award for dental specialists be reviewed and remuneration levels increased.

Recommendation 13 **73**

That NSW Health consult with the Australian Dental Council to address issues relating to overseas registered dentists and to promote the limited registration scheme.

Recommendation 14 **77**

That NSW Health consider additional incentives to encourage more oral health professionals to practise in rural areas.

Recommendation 15 **85**

That the NSW Government work with the University of Sydney and Commonwealth Government to increase the number of HECS places for the Bachelor of Dentistry course.

Recommendation 16 **86**

That the NSW Government with the universities and Commonwealth Government carry out a review of numbers and impact on the workforce of graduates from the Bachelor of Oral Health courses in NSW.

Recommendation 17 **87**

That NSW Health investigate the benefits of internships and specialist registrarships for graduating dentists, including the feasibility of achieving interstate mutual recognition.

Recommendation 18 **92**

That the NSW Government work in collaboration with the Commonwealth Government to address the issue of low remuneration for dental academics, and the corresponding need to increase funding.

Recommendation 19 **97**

That the Priority Oral Health Program be reviewed, with particular reference to waiting times, to ensure that patients in the public system receive adequate treatment within reasonable time frames.

Glossary

AIHW	Australian Institute of Health and Welfare
Dental assistants	Conduct established procedures associated with chair-side assistance to a dentist and practice administration
Dental caries	Holes in the teeth caused by tooth decay
Dental hygienists	Provide oral health education, prevention of dental diseases, and carry out treatment services as per a dentist's treatment plan
Dental prosthetists	Provide and fit dentures and mouthguards
Dental specialists	Specialising dentists for example oral surgeons and orthodontists
Dental technicians	Fabricate and repair dentures, inlays, outlays, bridges, crowns and mouthguards
Dental therapists	Treat children 0-17 years old, including prevention of dental diseases and control of dental caries, and only work in the public sector
Dentists	Also referred to as dental officers, who carry out general dentistry practices
dmft	Total number of decayed, missing and filled deciduous teeth
Edentulism	Loss of natural teeth
Endodontics	treatment and prevention of diseases of the pulp of teeth, eg root canal treatment
Gingivitis	Inflammation of gingivae (gums)
Maxillofacial	Relating to the jaw and middle third of the face
NACOH	National Advisory Committee on Oral Health
NHMRC	National Health and Medical Research Council
OECD	Organisation for Economic Cooperation and Development
Oral mucosa	The lining of the mouth
Periodontics	The branch of dentistry that is concerned with the tissues that support and attach the teeth and treatment and prevention of diseases affecting these tissues
Periodontitis	Disease of the gum and/or the surrounding bone, characterized by a receding of the gums, spaces opening between teeth, inflammation/infection, discomfort in the gums, and loosening of the teeth (also referred as periodontal disease)
Primary teeth	The first set of teeth that develops in mammals, also known as the deciduous or milk teeth
Root caries	Dental decay that occurs on the root portion of a tooth. (In younger persons, root surfaces are usually covered by gum [gingival] tissue)
Sealant	Sealing of pits, fissures or cracks in a tooth with bonded resin or adhesive cement to prevent development or progression of dental caries at the site
Secondary teeth	The permanent set of teeth that replace the primary teeth
WHO	World Health Organization

Chapter 1 Conduct of inquiry

Establishment and conduct of the Inquiry

1.1 The Inquiry into dental services in NSW was referred to the Committee by resolution of the House on 7 April 2005.[1] The motion to establish the Inquiry was moved by the Hon Dr Chesterfield-Evans, in response to community concerns regarding access to public dental services in general and particularly in regional and rural areas.[2]

1.2 The Committee widely advertised a call for submissions, including Sydney metropolitan, rural and regional newspapers. Specific stakeholders were also invited to make submissions, including industry organisations, relevant government agencies and non-government organisations, such as the NSW Council of Social Services (NCOSS).

1.3 In response to the call for submissions, the Committee received an overwhelming response of 263 submissions to the Inquiry. Submissions were provided by major stakeholders, including NSW Health, the Australian Dental Association and the Association for the Promotion of Oral Health. Submissions were also received from a number of individuals rasing their concerns about dental services in NSW. The full list of public submissions and authors appears at Appendix 1.

1.4 There have been eight days of hearings with a total of 65 witnesses representing 30 different organisations and groups, as well as individual witnesses. Appendix 2 contains a list of witnesses.

1.5 The Committee also conducted two site visits as part of this inquiry. The Committee visited Port Macquarie and Broken Hill to gain an understanding of dental services in regional and rural areas of New South Wales. See Appendix 3 for details of the site visits.

Report structure

1.6 Following the introduction, **Chapter 2** provides an overview of the public and private dental services in New South Wales and eligibility to receive public dental services. This chapter also provides information on the consequences of poor oral health and the predicted increase in demand for dental services in the future.

1.7 **Chapter 3** examines the commonwealth and state funding for dental services provided in NSW, as required by Term of Reference 1(c), and the impact of private health insurance on the funding of public dental services. This chapter also reviews the programs and policies directing the supply of public dental services.

1.8 In **Chapter 4**, the Committee addresses Term of Reference 1(e) relating to dental workforce issues in NSW, including the shortages in the workforce, initiatives to address the shortages, and workforce issues specific to rural and regional areas of NSW.

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1 Legislative Council, New South Wales, *Minutes of Proceedings No 99*, 7 April 2005, Item 8, p1325

2 Legislative Council, New South Wales, *Notices of Motion No 97*, 6 April 2005, Item 27, p4604

1.9 The related issue of the education and training of dental professionals is addressed in **Chapter 5**, as the Committee examines current education, fees for dental courses, the number of academics and funding for university training.

1.10 **Chapter 6** addresses Terms of Reference 1(a) and (b) with respect to quality of care received in dental services, and the demand and waiting times for public dental services. This chapter also focuses on access to dental services in NSW pursuant to Term of Reference 1(d), with particular reference to issues facing public dental patients living in rural and regional areas and patients who fall into groups with special needs.

1.11 In **Chapter 7** the Committee examines preventive dental treatments and initiatives (Term of Reference 1(f)), with particular reference to the importance of preventive treatment and the population health approach for oral health.

1.12 **Chapter 8** gives consideration to the issue of fluoridation in NSW and its impact on oral health. The Committee considers the arguments for and against fluoridation and the current state of fluoridation in NSW.

Chapter 2 Dental services in New South Wales

This chapter will provide the following introductory information:

- an overview of the public dental services available in New South Wales, including eligibility to access those services
- a comparison between the use of private and public dental services
- a description of the effects of poor dental health
- the predicted demand for dental services in the future.

Public dental services in New South Wales

2.1 Public dental services in New South Wales are administered through the various area health services, under the auspices of NSW Health. General services, such as examinations, fillings and dentures, are provided by the area health services through dental clinics based in schools, community health centres, hospitals, and sometimes through mobile clinics or rented private surgeries within each area. Specialist services, such as paediatric dentistry, oral and maxillofacial surgery, endodontics and periodontics are provided in two teaching hospitals located in Sydney: the Westmead Centre for Oral Health and the Sydney Dental Hospital. There are also approximately ten Aboriginal Medical Services providing dental services.

2.2 NSW Health advised that there are 630 public dental chairs[3] in New South Wales, of which 445 are in the metropolitan area health services, with 306 of those located at the two teaching hospitals, and 185 in rural area health services. There are approximately 173 public sector clinics in New South Wales, of which 85 are in rural area health services and 88 in the four metropolitan area health services. In addition, services are provided at 26 clinics in Justice Health facilities and one clinic at the New South Wales Children's Hospital.[4]

Eligibility for public services

2.3 Public dental services are provided to eligible people in each state of Australia, with the eligibility criteria varying from state to state.[5]

2.4 The eligibility of persons for public oral health care in New South Wales is set out in Circular 2000/29 from NSW Health,[6] which states that:

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3 For the purpose of this report 'dental chairs' refers to capacity to provide services and does not indicate an equivalent number of practising dentists

4 Submission 254, NSW Health, pp2-3

5 Dr Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, New South Wales Department of Health, Evidence, 5 July 2005, p2

6 NSW Health, '*Eligibility of persons for public oral health care*' Policy Directive PD2005_171, 27 January 2005

> All persons who are normally resident in New South Wales and hold one of the Centrelink concession cards listed below are eligible for free oral health care in NSW public oral health clinics (usually within their Area Health Service of residence). These concession cards include:
>
> - Health Care Cards
> - Pensioner Concession Cards
> - Commonwealth Seniors Health Cards.
>
> All dependants listed on Health Care Cards and Pensioner Concession Cards are also eligible for free oral health care in NSW public oral health clinics usually within their Area Health Service of residence.[7]

2.5 Eligibility also extends to preschool (0-5) as well as school aged children:

> All persons of preschool (0-5 yrs) age and those persons less than 18 years of age undertaking fulltime primary, secondary or tertiary studies at an educational institution (school, TAFE, University and other recognised tertiary institutions) or at home, or hold a concession card in their own right, are eligible for free public oral health care.[8]

2.6 In New South Wales, cardholders over the age of 19 and children aged up to 18 make up approximately 47% of the NSW population. As dependants are also eligible for public sector oral health services approximately 57% of the NSW population is eligible for such services,[9] compared to approximately 30% in Victoria and Queensland.[10] It is noted that the Commonwealth Government provides dental services for veterans through the Department of Veterans' Affairs, as further discussed in Chapter 3.

2.7 The table below shows a comparison of criteria from State to State with respect to eligibility to receive public health services. New South Wales, Queensland and the Northern Territory do not require their eligible patients to make a contribution towards their oral health care. Other jurisdictions do have a patient co-payment scheme:

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7 NSW Health, '*Eligibility of persons for public oral health care*' Policy Directive PD2005_171, 27 January 2005

8 NSW Health, '*Eligibility of persons for public oral health care*' Policy Directive PD2005_171, 27 January 2005

9 Submission 254, New South Wales Health, p5

10 Dr Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p2

Table 2.1 Eligibility criteria for public dental services, by State

State	Eligibility (holders of the following)
NSW	PCC*, HCC*, Commonwealth Seniors Card, & dependents of cardholders
TAS	PCC,HCC
SA	PCC, HCC
VIC	PCC, HCC
WA	HCC/PCC/ DVA*
NT	HCC, PCC, Sickness benefits recipients
QLD	HCC, PCC, Commonwealth Seniors Card and Qld seniors

* **PCC** = Pensioner Concession Card, **HCC** – Health Care Card, **DVA** – Department of Veterans' Affairs
Source Submission 254, New South Wales Health, p5

2.8 Holding of the relevant cards is based on criteria determined by Centrelink, is normally related to income benefits, and is controlled by the Federal Government.[11]

2.9 Mr Gary Moore, Director, NSW Council of Social Services (NCOSS), identified those people who fall into a gap in eligibility - the working poor and the elderly, such as retirees on limited incomes - who are not eligible for public dental services, but cannot afford private treatment or health insurance. The Committee notes that there are opposing views about extending or reducing the scope of eligibility for public dental services,[12] and the evidence of Dr Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, who advised that New South Wales has the most generous eligibility criteria for public dental care out of all the states and territories.[13] The Committee is aware that there are no current plans to review the eligibility criteria for public dental services in New South Wales.

Use of public and private dental services

2.10 Professor John Spencer, Director, Australian Research Centre for Population Oral Health, noted in research that while higher income Australians enjoy ready access to private dental care of the best quality, and a large segment of middle social position Australians have acceptable access to dental services and are able to purchase adequate basic dental care, there is a sizeable minority of middle and lower income Australians who are deprived of access to acceptable care, due to the overstrained public system and their inability to purchase adequate private dental services.[14]

11 Dr Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, New South Wales Department of Health, Evidence, 5 July 2005, p2

12 Mr Gary Moore, Director, Council of Social Services of New South Wales, Evidence, 5 July 2005, pp19-20; Ms Catherine Osbourne, Area Manager, Oral Health, North Coast Area Health Service, Evidence, 23 August 2005, p41; Submission 206, Greater Western Area Health Service, p5

13 Dr Margaret Robinson, Evidence, 5 July 2005, p2

14 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p1

2.11 The submissions to this Inquiry show that dental services in New South Wales are adequately available for the large proportion of the community who are able to fund their dental treatment, particularly in the city, suburban and coastal areas.[15] Practitioners in the private sector provide approximately 85% of dental services in New South Wales, with their fees being paid by individuals and with refunds from private health funds, where the individual has ancillary cover.[16] Approximately 85% of dental practitioners work in private practices.[17]

2.12 Due to the lengthy waiting times for access to public services many people who are eligible for such services nonetheless seek private treatment.[18] The table prepared by Professor Spencer and reproduced by the Australian Dental Association (NSW) (ADA (NSW)) below shows that while approximately 57% of the NSW population is entitled to receive public dental services, of the persons surveyed 82.3% reported that they had last used private dental services, 9.4% of persons visited a public dental clinic and 8.3% visited a school dental service.

Table 2.2 Age specific percentage of the New South Wales population eligible for use of public dental services and place of last dental visit among persons who had made a dental visit in the previous 12 months

	Eligibility		**Place of last visit**		
Age (years)	**Eligible %**	**Non-eligible %**	**Public dental clinic %**	**School Dental Service %**	**Private practice %**
5–11	23.4	76.6	9.0	45.1	45.9
12–17	19.7	80.3	19.9	17.3	62.8
18–24	16.6	83.4	13.3	-	86.7
25–34	13.2	86.8	7.0	-	93.0
35–44	7.9	92.1	6.1	-	93.9
45–54	10.1	89.9	4.9	-	95.1
55–64	24.7	75.3	6.5	-	93.5
65–74	49.0	51.0	10.4	-	89.6
75+	38.9	61.1	11.2	-	88.8
Total (weighted)	**19.1**	**80.9**	**9.4**	**8.3**	**82.3**

Source submission 226, ADA (NSW) Ltd, p27

2.13 For many the cost of private dentistry is a significant barrier, with private dental treatment costing an average of $295 per hour.[19] The Public Interest Advocacy Group noted that dental services are significantly more expensive than similar medical consultations with a general practitioner. Visits to a general practitioner are also subject to a Medicare rebate, which for many low-income earners will cover the entire consultation fee. A standard consultation with a dentist will generally be equivalent to at least half the weekly income of someone on a

15 Submission 76, Royal Australasian College of Dental Surgeons, p4

16 Dr Margaret Robinson, Evidence, 5 July 2005, p1

17 Submission 45, Australian Dental and Oral Health Therapists' Association Inc, p3

18 Submission 226, ADA (NSW) Ltd, p29

19 Submission 199, UnitingCare Burnside, p18

statutory income, and is not subject to a rebate.[20] Dr Francis Cunningham, General Manager, NSW Branch, Australian Health Insurance Association advised the Committee that:

> One of our concerns is with the significant rise and the upward trend in the increasing dentists' charges over the last 10 years. New South Wales has seen an increase in dentists' charges of 129% and utilisation increases of 50%. The rise in the dental segment of the health price index, which is greater than the consumer price index over the period September 1995 to June 2005, was 60%. [Insurance] funds alone do not determine price, as the underlying costs are set by dentists.[21]

2.14 The Committee received evidence that people on low incomes are rarely able to save enough money to see a private dentist[22] or, in the case of one 70-year-old patient who had been waiting for dentures for three years, must return to work or find alternative means of paying for private treatment.[23] The Combined Pensioners and Superannuants Association of New South Wales reiterates this point:

> The overwhelming majority of Australians who miss out on regular visits to the dentist don't go …because they cannot afford it….Private dental health services are extremely expensive and out of reach for low income earners.[24]

2.15 The Committee notes that while private dentistry services have increased, the benefit of a wider range of general and elective treatment goes to higher income earners who can afford to pay for private dentistry, many of whom also have private health insurance and receive the benefit of the 30% rebate (to be discussed in Chapter 3). Users of public dental services do not benefit from the wider range of treatment options available in private dentistry. The case study below demonstrates the range and cost of treatment received through a private dentist. The Committee notes that in the absence of private dental treatment, paid for by the patient, the only other treatment available would have been an extraction of the affected tooth.

Case study[25]

Example of range and cost of private dental treatment for patient presenting with a tooth abscess:

29.12.04	Emergency holiday dentist – radiograph and emergency drilling treatment	$80.00
29.01.05	Radiograph and removing old filling	$175.00
16.02.05	Root canal therapy	$227.50
09.03.05	Root canal therapy	$227.50
11.03.05	Post, temporary filling	$320.00
17.02.06	Cast, crown, etc	$1345.00
	Total	**$2375.00**

20 Submission 145, Public Interest Advocacy Group, p6

21 Dr Francis Cunningham, General Manager, New South Wales branch, Australian Health Insurance Association, Evidence, 16 February 2005, p85

22 Submission 145, Public Interest Advocacy Group, p6

23 Submission 26, Mr Kevin McLennan, p1

24 Submission 52, Combined Pensioners & Superannuants Association Inc, pp1-2

25 Confidential information received by the Committee

2.16 Users of public dental services tend to be in the lower socio-economic level of society. The Committee noted the evidence provided by Dr Robinson, NSW Health, in discussing eligibility for public dental services:

> There is a strong interrelationship between eligibility and socioeconomic status. There is a strong relationship between low socioeconomic status and dental disease. By definition, public dental patients are likely to experience more dental disease, and more advanced dental disease, than those who are in higher socioeconomic status groups. Services provided to the eligible population include a range of preventative general and some specialist care, but there is a gap between demand and the capacity to supply.[26]

2.17 The lack of equitable dental care between socio-economic levels in society has drawn comment in many of the submissions and contrasts with what the Public Interest Advocacy Group believes all members of society are entitled to:

> All people in New South Wales should have access to preventive, emergency and restorative dental care, irrespective of their financial circumstances. Access to dental care should be as required, and not subject to lengthy delays that result in worsening oral health, and decrease the likelihood of preventive care. The International Covenant on Economic Social and Cultural Rights, signed by Australia, recognises the right of all people to the highest attainable standard of health. This right includes the right to good oral health and nutrition.[27]

2.18 The submissions noted that those who are reliant upon the public system and who do not receive comprehensive care, particularly those in disadvantaged groups in the community, such as children from socio-economically disadvantaged families, recent unskilled immigrants, people with physical or intellectual disabilities or with mental health issues, and the elderly, who may be house-bound or institutionalised, tend to suffer poorer oral health and a greater instance of oral disease.[28] Research has found that in 2001-2002, public dental patients aged between 18 to 44 had, on average, more than four untreated decayed teeth compared with the 1.1 to 1.8 decayed teeth in similarly aged persons in the Australian population in 1987-1988.[29]

2.19 Professor Spencer uses edentulism (loss of natural teeth) in his research as an indicator of social gradient and dental health, as edentulism is more prevalent among those with poor dental health and access to treatment. He notes that edentulism shows a very marked social gradient, with a four-fold difference in total tooth loss between the lowest and highest household income categories, as shown in the table below:

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26 Dr Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p2

27 Submission 145, Public Interest Advocacy Group, p6

28 Submission 65, Association for the Promotion of Oral Health, p16

29 Submission 96, Sydney South West Area Health Service, p5

Table 2.3 Social inequality in tooth loss, adjusted for total tooth loss by the edentulous, Australia 2002

Household income	Edentulism %	Tooth loss among the dentate mean	Total tooth loss mean
<$12,000	25.6	9.07	14.9
$12-20,000	22.5	8.67	13.9
$20-30,000	9.4	6.19	8.6
$30-40,000	3.8	4.86	5.9
$40-50,000	2.4	3.80	4.5
$50-60,000	1.1	3.58	3.9
$60-70,000	3.1	4.20	5.1
$70-80,000	0.6	3.63	3.8
$80,000+	0.8	3.49	3.7
All	**7.8**	**5.08**	

*Source Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p16*

2.20 As the table indicates, people earning less than $20,000 - $30,000 per year are at significantly greater risk of suffering severe dental problems. The Committee notes that the evidence indicates that while dental services are readily available to a large proportion of society through self-funded treatment by private practitioners, there are many who are unable to afford such private treatment and are therefore reliant upon public dental services. The oral health of those who use the public system is starkly poorer and, as the public system is overstrained, users must continually advocate for their dental needs, often over years, which is difficult to maintain for people with other serious issues in their lives.[30]

Effect of poor dental health

2.21 Dental caries is Australia's most prevalent health problem, edentulism the third most prevalent and periodontal disease the fifth. Recent estimates suggest that 11 million people are suffering new decay each year. Caries is the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes.[31]

2.22 The Committee heard evidence that there has been little research done to determine the cost to society of poor dental health and its impact upon general health and wider health care costs. However, surveys conducted in the 1990s have indicated that Australians lost approximately 1.5 million days of work due to dental problems.[32]

30 Submission 145, Public Interest Advocacy Centre, pp7-8

31 Submission 199, UnitingCare Burnside, p7

32 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p4

2.23 As well as the economic impact of poor oral health, untreated oral conditions can have a significant effect on general health. The Committee notes the significant evidence that dental health and the health of the rest of the body are intrinsically linked, and should be regarded holistically:

> There is an undervaluing of oral health – it is not considered part of the main health system, it is not funded on an equivalent basis as other health issues are, it is rarely addressed in general health planning, the population does not see oral health as a major issue, there is a lack of understanding and education.[33]

2.24 In evidence Professor Spencer noted that oral health is linked to general health at multiple levels. He explained that in some cases oral disease can be a contributing cause of death:

> The last issue that I draw to your attention is the links between oral health and, in certain extreme cases, death. We generally talk about oral diseases as not being life-threatening but I think that ignores the evidence with regards to a limited number, but a real number, of situations where oral disease is the contributing cause of death—swelling associated with infections of the pulpa tissue and the tissues around the apex of a tooth and around the jaws and blockage to the airway; aspiration of oral debris, including tooth fragments from teeth that are breaking down with dental decay and aspiration pneumonia among the elderly; and there are at least some indications at present of septicaemias that actually have as their portal for entry into the body of the infection, the infected gum tissues. We need to at least acknowledge that oral health is linked to general health at multiple levels. That, of course, is what lies behind the frequent statement that oral health is an integral part of general health.[34]

2.25 Professor Geoffrey Tofler, Professor of Preventive Cardiology and Senior Staff Specialist of the Cardiology Department at the Royal North Shore Hospital, described the causative link between periodontal disease and cardiovascular risk and explained that improvements in periodontal care can reduce the risks for cardiovascular disease, heart attack and stroke.[35] Dr Barbara Taylor, Staff Specialist in Periodontics and Head of the Department of Periodontics at the Sydney Dental Hospital, also explained in evidence that periodontal disease is linked to diabetes, to micro- and macro-vascular disease, to diseases of the eyes, kidneys, outcomes such as strokes, heart attacks and hypertension, and is linked to pre-term and low birth weight babies:

> There is good evidence and a significant body of evidence in relation to diabetes. We already knew that diabetic people are more prone to periodontal disease but in recent years it has become apparent that inflammation itself can impact on diabetic disease. As you would know, diabetic people are more prone to microvascular and macrovascular disease—that is, disease affecting the small blood vessels and the big blood vessels. So that is things like diseases of the eyes, diseases of the kidneys, and macrovascular, is outcomes such as strokes, heart attacks and hypertension. That is one disease where we think periodontal disease is impacting on the population.

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33 Mr Gary Moore, Director NCOSS, Evidence, 5 July 2005, p19

34 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p3

35 Professor Geoffrey Tofler, Professor of Preventive Cardiology and Senior Staff Specialist, Cardiology Department, Royal North Shore Hospital, Evidence, 29 June 2005, p17

> The other area where there is a good deal of evidence…is pre-term delivery, early delivery, of underweight infants. There is good evidence to suggest that the mother's periodontal condition may favour the delivery of an early, underweight baby. So the corollary of that is that it would be wise to increase dental spending on pregnant women. You can improve the mother's health but you can improve the baby's health while it is still *in utero*.[36]

2.26 Dr Andrew Howe, Foetal Toxicology, University of Sydney, provided the Committee with his expert opinion on the link between gum disease in mothers and low birth weight babies and its comparison to smoking during pregnancy:

> There are projects now coming to the conclusion that having gum disease during pregnancy is the same as smoking during pregnancy: the effect on low birth weight is exactly the same … If you are born with a low birth weight you are behind the eight ball for the rest of your life. You have poor health outcomes, you have poor educational outcomes and you have poor job outcomes. So you will be put into a lower socio-economic group purely because either your mother smoked or had gum disease during pregnancy. There are pilot projects being done now that have taken groups of women with gum disease, instituted oral hygiene techniques and that has returned them almost to the control group as far as the birth weight of their children. So we can see that it would save the community a lot of money if we could institute these preventive programs. These are not high-skill preventive programs that dentists need to be involved in; these are ones that dental therapists can put in place. So they are not expensive programs. The dentists certainly need to diagnose and oversee them but they are not complex programs. Certainly education in the community as far as oral hygiene and gum disease would go a long way, as Professor Spencer would have pointed out, to preventing this disease.[37]

2.27 UnitingCare Burnside states in its submission that causative links have been found between dental health and general health relating to: oral bacteria and arthritis; periodontal disease and preterm birth and low birth weight; diseases that appear as oral complications in the mouth before appearing in other parts of the body, such as Parkinson's disease, AIDS, diabetes and oral cancer. Dental disease also shares common risk factors with other diseases – inappropriate diet, tobacco smoking, alcohol consumption and exposure to ultraviolet radiation are leading causes of tooth decay, gum disease and oral cancer.[38]

2.28 As well as the links between oral health and serious medical conditions discussed above, there are a range of other social impacts suffered by adults with poor dental health, as highlighted in research by Professor Spencer in the table below:

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36 Dr Barbara Taylor, Staff Specialist in Periodontics and Head of Department of Periodontics, Sydney Dental Hospital, Evidence, 29 June 2006, pp20-21

37 Dr Andrew Howe, Foetal Toxicology, Faculty of Medicine, University of Sydney, Member of the Regional Committee of the Royal Australasian College of Dental Surgeons, Evidence, 16 February 2006, pp24-25

38 Submission 199, UnitingCare Burnside, p8

Table 2.4 Prevalence of adults occasionally, fairly often or very often experiencing social impact in the last year because of problems with their teeth, mouth or dentures, Australia 2002

Social impacts	Percentage reporting the impact in the last year
Painful aching	25.5
Life less satisfying	18.2
Difficulty doing usual jobs	5.9
Sense of taste	8.9
Avoided foods	26.6
Uncomfortable to eat	31.2
Self-conscious or embarrassed	23.9
Pronunciation	6.6
Felt tense	12.9
Diet unsatisfactory	5.4
Interrupt meals	9.1
Difficult to relax	11.6
Irritable	9.0
Unable to function	2.0

Source Professor A John Spencer, "Narrowing the inequality gap in oral health and dental care in Australia", 2004, Australian Health Policy Institute, University of Sydney, p18

2.29 The evidence indicated that oral health problems have far-reaching consequences, including pain, infection, tooth loss, difficulties with chewing, swallowing and speech, disrupted sleep and productivity, and can affect self-esteem and social well-being.[39] The Healthy Cities Illawarra Aged Task Force carried out an oral health survey in 2004 to gather information on oral care in local aged care settings. The survey found that residents of aged care facilities had difficulty in accessing dental treatment and, as a result, suffered long term problems such as tooth decay, gum disease, ill fitting dentures and ulcers. Survey participants also commented on the impact that poor oral health has on their general health and quality of life, such as diminished ability to maintain a suitable dietary intake, gum disease, pain and social embarrassment.[40]

2.30 The Inquiry received numerous submissions from individuals further recounting experiences of all of the previously listed consequences of poor oral health, caused by lack of access to treatment, including suffering toothache and rotten teeth,[41] psychological pain caused by disfigured personal appearance, limited employment options and community engagement,[42] and weight loss and frailty caused by an inability to eat solid food (particularly in the cases of those waiting for denture services).[43] As one submission stated:

39 Submission 199, UnitingCare Burnside, p7

40 Submission 87, Healthy Cities Illawarra Inc, p4

41 Submission 56, NSW Ministerial Advisory Committee on Ageing, p2

42 Submission 52, Combined Pensioners & Superannuants Association Inc, p1

43 Submission 15, Ms Joy Mount, p2

…how can a person eat, smile with rotten teeth? How can they present for a job?[44]

2.31 A number of the submissions detailed the sometimes extreme action patients took when they were unable to access dental treatment, such as being driven by constant pain to pull out their own teeth with pliers,[45] or gluing broken dentures back together with superglue.[46] Other evidence was provided of patients with teeth that had deteriorated into blackened stumps, causing distress and social discomfort,[47] and patients who had become disillusioned with the public system and lost hope of ever receiving comprehensive treatment.[48]

2.32 With respect to children who suffer oral disease, research has shown a link to middle ear infection, and some reports show that children who are experiencing more dental disease show slightly delayed growth and development issues.[49] The Committee also notes the evidence that such children who do not receive adequate or timely dental care can suffer pain, fear and anxiety, infection, general health issues, future orthodontic needs, lowered self-esteem, and a negative concept of oral health that can be transferred to future generations.[50]

Conclusion

2.33 The Committee notes that the level of treatment that the public system is able to provide to users (to be further considered in Chapter 6) contrasts with the wide range of general and elective treatments provided to people who can afford to pay for services provided by private practitioners. The reduced treatment available in public dental services is affecting the health of public dental patients, who can suffer in a range of ways from social embarrassment up to serious medical conditions and, in extreme cases, the death of patients who do not receive adequate and timely treatment. The evidence demonstrates the importance of good oral health, with respect to both economic impacts, in terms of lost productivity, and general health impacts. The issue of holistic treatment of dental health will be further discussed in Chapter 7, and relevant Committee recommendations will be made at that time.

Increase in demand for dental services in the future

2.34 The evidence submitted to the Inquiry indicated that there will be an increased demand and greater need for dental services in the next twenty years. The table below sets out the contributing factors to the increased need for dental services in the future, including increasing population, per capita demand, the changing age profile of the population and decreasing edentulism.

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44 Submission 44, Ms Angela Drury, p1

45 Submission 16, Illawarra Dental Health Action Group, p2

46 Mr Thomas Kennedy, Councillor, Broken Hill City Council, Evidence, 30 August 2005, p4

47 Submission 16, Illawarra Dental Health Action Group, p2

48 Ms Ann Davies, Service User, Uniting Care Burnside, Evidence, 5 July 2005, p46

49 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p2

50 Submission 209, Ms Tanya Schinkewitsch, p3

Table 2.5 Contributors to Increased Demand for Dental Services

Contributors	Impact
Increasing population	As the total number of people in Australia increases, with all other things being equal, the total number of people demanding dental care will also increase.
Decreasing edentulism rates	Edentulous persons (those with no natural teeth remaining) demand dental care at a far lower rate than dentate persons (those who still have some teeth remaining). Historically, the percentage of the population that is edentulous has been declining, resulting in a greater percentage of those who are dentate. Therefore, a decline in edentulism equates to an increase in the dentate population resulting in an increase in total demand.
Age profile of the population	Not all age groups demand the same amount of dental care. If the population age distribution shifts in such a way that a greater proportion of people are in age groups that demand greater dental care, total demand will increase.
Increasing per capita demand	If per capita demand (the average number of dental visits per person) increases then total demand for visits must also increase. Historically, there is evidence that per capita demand for dental visits in Australia has been increasing over time.

Source submission 226, ADA (NSW) Ltd, p19

Increasing population

2.35 The Australian population is projected to increase from 19.1 million people in 2000, to 20.9 million in 2010 and 22.5 million in 2020, increases of 9.4% and 7.4% respectively. New South Wales is projected to remain the most populous state in Australia, and the trend for its population increase is proportional to that of Australia as a whole. In the period from 2000 to 2010 the dentate population (those who are most likely to use dental services) will increase at a greater rate (11.9%) than the population as a whole (9.4%).[51]

Decreasing edentulism rates

2.36 Over the past 20 years there has been a rapid decline in the occurrence of edentulism, leading to a rise in the number of teeth people retain and carry. This improvement to oral health has not, however, led to a corresponding reduction in the need for dental services, as the numbers of permanent teeth potentially at risk of oral disease will increase with the reduction in edentulism, and will double in the next twenty years in the age groups above 55 years.

Age profile of the population

2.37 Australia is projected to have a more middle aged and older population over the next 25 years. From 2000 to 2020 there is a projected marginal decline in the total number of persons aged 17 years or less and a marginal increase in the total number of persons aged 18-44 years. In the 45-64 years bracket there is expected to be at least a 28% increase, and for persons aged 65 years or more an increase of 25% to 2010 and a further 37% by 2020. By 2014 it is projected that there will be, for the first time in Australia, a greater number of people aged 65 years or more than people aged 5-17 years.[52]

51 Submission 226, ADA (NSW) Ltd, pp20-21

52 Submission 226, ADA (NSW) Ltd, pp20-21

> The baby-boomer generation will be moving into retirement with mouths full of teeth that are heavily restored and will require a lifetime of expensive maintenance.[53]

Increased per capita demand

2.38 In its submission ADA (NSW) refers to a study carried out by the Dental Statistics and Research Unit, Australian Research Centre for Population Oral Health, which found that the demand for dental visits in New South Wales increased by approximately 50% between 1979 and 1995 for both the dentate and edentulous groups, and in all age groups.[54]

2.39 The different sorts of treatments sought by patients have also increased, and will continue to increase, including the most common dental carie, low-level interventions such as diagnostic and preventive services, high-level interventions such as endodontic and crown and bridge services, and restorative services.[55]

2.40 The weighted number of dental visits per dentate person per year in Australia is projected to increase from 1.5 visits in 1995 to 1.86 visits in 2010, a 24% increase, as shown in the table below:

Table 2.6 Estimated Dental Visits per Dentate Person per year

	Year			
Age	**1995**	**2000**	**2005**	**2010**
0-4	0.20	0.20	0.20	0.20
5-11	1.85	2.07	2.29	2.52
12-17	2.17	2.39	2.56	2.82
18-24	1.34	1.38	1.42	1.46
25-34	1.11	1.12	1.13	1.14
35-44	1.41	1.55	1.69	1.83
45-54	1.52	1.73	1.93	2.14
55-64	1.54	1.74	1.93	2.13
65-74	1.49	1.74	1.98	2.23
75+	1.40	1.63	1.85	2.08
Total(weighted)	**1.50**	**1.62**	**1.74**	**1.86**

Source submission 226, ADA (NSW) Ltd, p24

53 Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, Evidence, 14 November 2005, p33

54 Submission 226, ADA (NSW) Ltd, p22

55 Submission 226, ADA (NSW) Ltd, pp22-23

2.41 ADA (NSW) noted in its submission that, using data collected between 1979 and 1995, the Dental Research and Statistics Unit projected the demand for dental visits in 2010 based upon:

- The estimated resident population of New South Wales (increasing from approximately 6.5 million in 2000 to 7.1 million in 2010)
- the estimated resident population who were or who are projected to be dentate and edentulous (taking into account trends in edentulism as more people in each age group retain a greater number of natural teeth)
- the per capita demand for dental visits for both dentate and edentulous persons based on a continuation of growth at the rate between 1979 and 1995 (extrapolated forward at either 0, 25, 50, 75 or 100% of the linear trend continuing across the period from 1996 to 2010).

2.42 ADA (NSW) noted that it is not certain that the trend of the recent past (increasing per capita demand) will continue into the future. While continuation of 100 per cent growth in per capita demand was certainly thought possible, the Dental Research and Statistics Unit used the rate of 50% growth across 1979 to 1995 to estimate its figures for 2010 which nevertheless produces a substantial increase in demand projected for the year 2010 of 23.2% for dental visits in New South Wales from 2000 to 2010:

Table 2.7 Projected requirement for dental visits, New South Wales 2000 and 2010

	Dental visits (1000s)					
	2000			**2010**		
Age	**Growth rate 1995+**			**Growth rate 1995+**		
(years)	**0%**	**50%**	**100%**	**0%**	**50%**	**100%**
0–4	86.0	86.0	86.0	81.5	81.5	81.5
5–11	1,174.6	1,240.6	1,306.6	1,130.9	1,321.6	1,512.2
12–17	1,151.4	1,207.7	1,264.0	1,179.4	1,352.4	1,525.4
18–24	808.5	826.1	843.7	849.1	904.4	959.7
25–34	1,068.3	1,075.8	1,083.3	1,070.7	1,092.9	1,115.1
35–44	1,388.1	1,456.1	1,524.1	1,438.8	1,649.7	1,860.7
45–54	1,232.7	1,323.0	1,413.3	1,464.3	1,784.7	2,105.2
55–64	810.7	864.1	917.5	1,225.4	1,463.9	1,702.4
65–74	548.5	591.9	635.3	723.2	892.6	1,061.9
75+	371.7	402.4	433.1	516.3	642.3	768.3
Total	8,640.6	9,073.8	9,507.0	9,679.5	11,185.9	12,692.4
% change 2000 to 2010				**12.0**	**23.2**	**33.5**

Source submission 226, ADA (NSW) Ltd, p26

Table 2.8 Requirement for dental visits, New South Wales 2000 and 2010 for persons eligible and non-eligible for public dental services (growth rate 1995+ 50%)

	Dental visits (1,000s)			
Age	**Eligible**		**Non-eligible**	
(years)	**2000**	**2010**	**2000**	**2010**
0–4	20,125	19,064	65,878	62,405
5–11	290,304	309,248	950,310	1,012,324
12–17	237,921	266,419	969,802	1,085,963
18–24	137,127	150,127	688,938	754,253
25–34	142,009	144,261	933,818	948,628
35–44	115,034	130,330	1,341,097	1,519,413
45–54	133,621	180,259	1,189,357	1,604,480
55–64	213,441	361,584	650,692	1,102,318
65–74	290,037	437,350	301,875	455,201
75+	156,543	249,854	245,881	392,444
Total	**1,736,161**	**2,248,495**	**7,337,649**	**8,937,430**
% change 2000 to 2010		**29.5**		**21.8**

Source submission 226, ADA (NSW) Ltd, p27

2.43 The table above shows an increase of 29.5 per cent in demand for dental visits by persons eligible to receive public dental services in 2010.

Other factors leading to increased demand for dental services

2.44 ADA (NSW) stated that a range of macro-economic factors, such as growth in gross domestic product and greater community affluence, and broad social factors, such as growing awareness about the importance of, and consumer expectations about, oral health will also affect the demand for dental services. The Association also noted that technological developments with dentistry continue to broaden the range of dental services available to the community, and advances in diagnostic testing, more frequent interventions for common dental conditions and the improved efficacy of materials and techniques used in dentistry will also have an effect.[56]

Conclusion

2.45 The Committee is deeply concerned that public dental patients in New South Wales do not receive the same level and range of treatment as users of private services, and that the increasing cost of private dentistry places it out of reach of many members of society. The Committee notes that demand for dental services is predicted to increase in the future, placing further demands on an already overstrained system. Federal, state and local governments have developed a number of new plans and programs to address current and future needs, with many of the plans still being in the early stages of implementation, as discussed in the following chapter.

56 Submission 226, ADA (NSW) Ltd, p21

2.46 In order to adequately meet current and future demands and to address the question of equitability in treatment between public and private dental treatment, it appears that changes must be made in all of the broad areas affecting dental services in New South Wales, beyond what has been discussed in this chapter, including access to public dental services, particularly in rural and remote areas, dental workforce and training, and the use of more effective preventive treatments. Each of these areas will be addressed in the following chapters, and specific recommendations will be made pertaining to the relevant issues in each area. The Committee notes that the key area in which the greatest changes must be made is with respect to funding, as examined in the following chapter.

Chapter 3 Funding and programs for public dental services

This chapter addresses Term of Reference 1(c), and examines the following:

- funding that is available to provide public dental services and the sources of that funding
- a comparison between the funding of public services in New South Wales and other States
- an outline of the major plans, programs and policies directing dental services in New South Wales
- the impact of private health insurance on the provision of public services
- the involvement of Medicare.

Level and source of funding

3.1 Spending on dental services in Australia is funded through a combination of direct and indirect state and federal government funding, private health insurance and contributions from individual patients.[57] The Australian Dental Association (NSW Branch) (ADA (NSW)) noted that:

> expenditure on oral health ranks seventh highest among the disease groups that account for the greatest level of health expenditure in Australia.[58]

3.2 As oral health and dental treatment is excluded from funding under Medicare, the majority of dental services in Australia are self-funded and provided by private practitioners, as compared to general health services, which are largely government funded. The figure below presents a comparison of the source of expenditure for health services and dental services in 2001-2002. The different areas of expenditure represented in the figure are defined as follows:

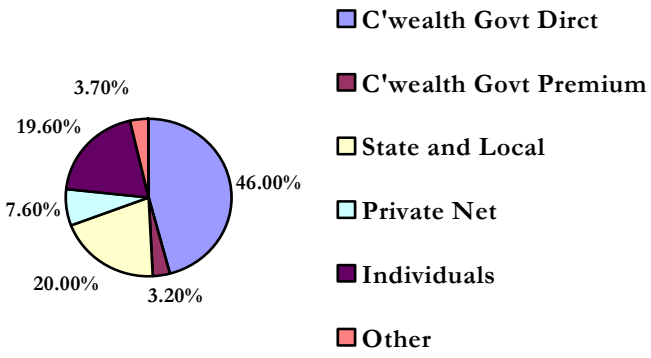
- Commonwealth Government direct: direct expenditure by the Commonwealth Government
- Commonwealth Government Premium: indirect expenditure through the 30% rebate on private health insurance
- State and Local: direct expenditure by state, territory and local governments
- Individuals: direct out of pocket expenses paid by individuals
- Private net: individual net contributions to health insurance.

57 Submission 226, ADA (NSW) Ltd, p34

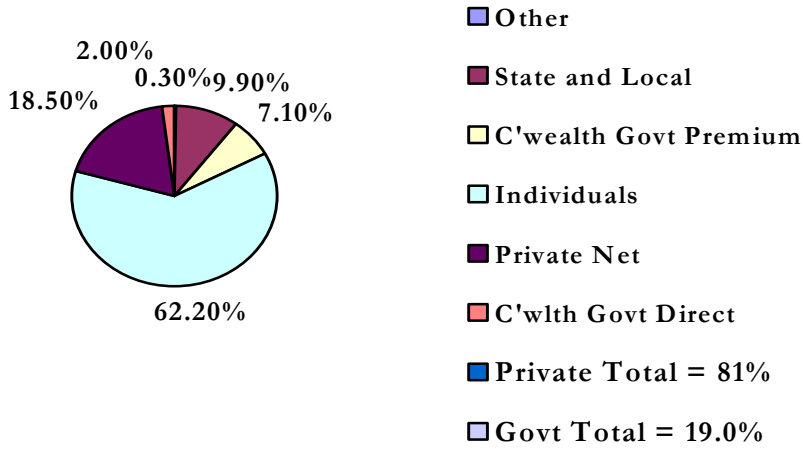
58 Submission 226, ADA (NSW) Ltd, p35

Figure 3.1 Source of expenditure on health and dental services, Australia 2001-02

Health services



Dental Services



Source: Professor A John Spencer, "Narrowing the inequality gap in oral health and dental care in Australia", 2004, Australian Health Policy Institute, University of Sydney, p33

3.3 Total expenditure on dental services in Australia in 2002-2003 was $4.37 billion, the equivalent of 6.06% of total health expenditure. This spending breaks down as shown below:

- Commonwealth Government (direct spending) $78 million
- Commonwealth Government (indirect spending) $298 million
- State, Territory and Local Governments $342 million
- Private health insurance funds $680 million
- Individual consumers $2,960 million.[59]

[59] Submission 226, ADA (NSW) Ltd, p35

3.4 ADA (NSW) noted that expenditure by individuals on dental services has risen from $984 million in 1992-1993 to $2.96 billion in 2002-2003, a rise of 300% in nominal dollars.[60]

Background

3.5 The funding of dental services has long been a point of contention between the Commonwealth and State and Territory governments. In 1946 the Australian Constitution was amended by referendum to add section 51 (xxiiiA), which specifically enshrines dental services as a Commonwealth power:

> 51. The Parliament shall, subject to this Constitution, have power to make laws for the peace, order and good government of the Commonwealth with respect to:-
>
> (xxiiiA) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

3.6 Section 51 is a concurrent power, which permits both the commonwealth and state and territory governments to legislate in that area. As a result there has been an on-going debate regarding the legal interpretation of, and the obligations and responsibilities of the commonwealth and state and territory governments under section 51 of the Constitution, particularly with respect to dental services.

3.7 Some submissions state that the Commonwealth Government is not acknowledging its responsibilities under the Constitution by not providing funding for public dental services.[61] The Senate Community Affairs Committee examined this issue in its inquiry into public dental services in 1998 and found that while the Commonwealth does not have a legal obligation pursuant to the Constitution to legislate for the provision of dental services, the Commonwealth should nevertheless use its power within the area to take a leadership role in developing strategies for the improvement of national oral health standards.[62]

3.8 The Senate Select Committee on Medicare, in its first inquiry in 2003, stated that:

> … the Committee does not accept the simple assertion that dental care is a matter of state and territory responsibility. Adequate access to dental care is too interrelated with other aspects of Commonwealth health care responsibility for any neat jurisdictional lines to be drawn. Furthermore, the social justice implications of the current problems are too great for the Commonwealth to ignore.[63]

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60 Submission 226, ADA (NSW) Ltd, p36

61 Submission 210, Combined Pensioners & Superannuants Association of NSW – Bathurst Branch, p1

62 Senate Community Affairs Committee, *Inquiry into public dental services*, May 1998, paragraph 4.18, accessed 9 February 2006 <http://www.aph.gov.au/SENATE/COMMITTEE/clac_ctte/completed_inquiries/1996-1999/dental/reports/c05.htm,>

63 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare*", 30 October 2003, p131

3.9 The Committee goes on to state that public dental care is a responsibility to be shared with state and territory governments and that the Commonwealth should take an active leadership role, which is clearly within its constitutional powers.[64]

3.10 Professor John Spencer, Director, Australian Research Centre for Population Oral Health, emphasised in his research the importance of a strong funding base in order to provide adequate public dental care, and argues that on-going debate about the responsibilities of the commonwealth and state and territory governments contributes to the continued deficiencies in funding:

> At present policy on public dental services is caught in a chilly standoff between the Commonwealth and the States … responses are more political rather than policy-shaping, short- rather than long-term, negative rather than creative. The policy environment has to be reshaped. A constructive dialogue between the Commonwealth and State governments needs to begin.[65]

3.11 ADA (NSW) stated in its submission that it:

> … does not intend to re-enter debate about who is responsible for funding public oral health care services in New South Wales, except to state that [it] believes that both State and Federal funding should be made available for the provision of public dental services and, furthermore, the Federal Government should play a leading role in developing and coordinating a national approach to oral health planning in this country.[66]

3.12 In its inquiry into public dental services, the Senate Select Committee noted that sections 81 and 96 of the Constitution also allow the Commonwealth to fund dental services. Section 81 provides an appropriations power, although this power is rarely used with respect to dental funding. Section 96, known as the 'States grant power', enables the Commonwealth to grant financial assistance to the States on such terms and conditions as it thinks fit. Under this power the Commonwealth provides substantial grants to the States for a wide range of purposes including, for example, funding for hospitals under the Medicare Agreements.[67] Professor Spencer noted that, with respect to oral health, this power has previously been used twice, for the development of a school dental service and for the Commonwealth Dental Health Program, which ran from 1996 to 1997.[68]

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64 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare*", 30 October 2003, p131

65 Spencer A, '*What options do we have for organising, providing and funding better public dental care?*,' 2001, Australian Health Policy Institute, University of Sydney, p50

66 Submission 226, ADA (NSW) Ltd, p38

67 Senate Community Affairs Committee, Inquiry into public dental services, May 1998, paragraphs 4.10, 4.11, accessed 9 February 2006, <http://www.aph.gov.au/SENATE/COMMITTEE/clac_ctte/completed_inquiries/1996-1999/dental/reports/c05.htm>

68 Professor John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence 16 February 2006, p7

3.13 State and territory governments have traditionally provided and funded public dental care.[69] ADA (NSW) believes that until the funding issue is resolved it is the responsibility of the New South Wales Government to ensure that there are sufficient funds to provide adequate public dental services.[70] Professor Spencer, however, noted that the Federal Government has become involved in other areas that have traditionally been regarded as state responsibilities, such as mental health and aged care.[71]

Commonwealth funding

3.14 The Commonwealth Government directly funds a small mix of dental services, for example via funding for specific populations through the Department of Veterans' Affairs and Department of Defence, and for in-hospital oral care services and outpatient radiological services through Medicare. ADA (NSW) argued that the total level of direct Commonwealth funding to New South Wales for oral health services is not thought to be large given that total spending in 2002-2003 was $78 million.[72] Professor Spencer noted in research that this spending comprises less than 3% of all spending on dental care.[73]

3.15 The Commonwealth Government also indirectly funds dental services via the Private Health Insurance Incentive Scheme, under which a government-funded, 30% rebate is offered on private health insurance. The NSW Council of Social Services (NCOSS) stated that 'many view the Commonwealth Government's denial of responsibility for, and their unwillingness to fund, dental care as being irreconcilable with the operation of their private health insurance rebate'.[74] ADA (NSW) argued that the rebate allows the Commonwealth Government to avoid its responsibility to implement a national oral health policy by claiming that it plays a significant role in the funding of oral health care, albeit indirectly.[75]

3.16 The issues of Medicare and private health insurance are more fully discussed from paragraphs 3.96.

State funding

3.17 The budget for dental funding in New South Wales has increased from $68.6 million in 1994-1995 to approximately $120 million in 2005-2006 as set out in the table below.

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69 Supplementary submission 226a, ADA (NSW) Ltd, p3

70 Submission 226, ADA (NSW) Ltd, p38

71 Professor John Spencer, Evidence 16 February 2006, p7

72 Submission 226, ADA (NSW) Ltd, p36

73 Professor A John Spencer, '*What options do we have for organising, providing and funding better public dental servic*es?' 2001, Health Policy Institute, University of Sydney, p25

74 Submission 200, NCOSS, p5

75 Submission 226, ADA (NSW) Ltd, p41

Table 3.1 Dental Funding - 1994/95 to 2004/05 (in Millions of Dollars)

Funding Source	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
General NSW funding	$68.6	$68.4	$70.6	$71.2	$73.2	$72.4	$72.5	$80.5	$97.5	$105.5	$113	$120
Commonwealth Dental Health Program	$20.7	$37.8	$18.6#	**Commonwealth Scheme Abolished**								
Total	$89.3	$106,2	$89.2	$71.2	$73.2	$72.4	$72.5	$80.5	$97.5	$105.5	$113	$120

Notes: # CDHP Scheme Abolished

Source submission 254, NSW Health, p19

3.18 ADA (NSW) believes that the amount of $120 million, comprising 1.1% of the total health budget allocated for the 2005/06 financial year ($10.9 billion), is insufficient and that a substantial increase in funding is required to provide adequate dental services.[76]

3.19 The Association argued that in the last decade the overall New South Wales health budget has increased from approximately $5 billion to $10.9 billion (more than 117%) while oral health spending has increased from $106.2 million in 1995-1996 (which included commonwealth funding) to $120 million (less than 13%) in 2005-2006, as shown in the table below.[77] The New South Wales contribution has increased by 75% in the same period.

Table 3.2 Oral health spending in New South Wales, 1994/95 – 2005/06

Financial Year	NSW Health Budget	NSW Oral Health Budget	Commonwealth Dental Health Program	Combined Oral Health Budgets
1994/1995	Unknown	$68.6	$20.7	$89.3
1995/1996	$5,012	$68.4	$37.8	$106.2
1996/1997	$5,139	$70.6	$18.6	$89.2
1997/1998	$5,591	$71.2	-	$71.2
1998/1999	$6,663	$73.2	-	$73.2
1999/2000	$7,421	$72.4	-	$72.4
2000/2001	$7,896	$72.5	-	$72.5
2001/2002	$8,302	$80.5	-	$80.5
2002/2003	$8,900	$97.5	-	$97.5
2003/2004	$9,267	$105.5	-	$105.5
2004/2005	$9,974	$113	-	$113
2005/2006	$10,900	$120	-	$120

Note: The Commonwealth Dental Health Program was initiated and funded by the Commonwealth Government and ran from January 1994 to December 1996 before being abolished.

Source supplementary submission 226a, ADA (NSW) Ltd, p21

76 Submission 226, ADA (NSW) Ltd, p36

77 Supplementary submission 226a, ADA (NSW) Ltd, p3

3.20 The Association stated that if oral health spending had increased at the same rate as overall health spending in that same period, the oral health budget in 2005-2006 would be approximately $230 million, almost double its current amount.[78]

Comparison of funding of public services in New South Wales and other states and territories

3.21 Many of the submissions noted that New South Wales has the lowest per capita spending on oral health care out of all of the states and territories, being less than half that in Queensland and the Northern Territory, as shown in the tables below. It is also noted that both Queensland and Victoria plan to substantially increase dental spending over the next four years.[79] The Committee notes the evidence that New South Wales spent 22% of the total amount of funds in Australia in 2001-2002 on public dental services, although its eligible population for public services is proportionally higher.[80]

Table 3.3 State and Territory dental expenditure, population and per capita dental expenditure 2004/2005

	2004/2005 dental expenditure ($)	**Population as at December 2004**	**Per capita dental expenditure ($)**
Northern Territory	$7,116,000	200,800	$35.43
Queensland	$127,900,000	3,919,500	$32.63
Tasmania	$15,025,000	484,000	$31.04
South Australia	$47,130,000	1,537,900	$30.65
Victoria	$117,700,000	5,002,300	$23.53
Western Australia	$44,500,000	1,998,400	$22.27
ACT	$7,154,800	324,300	$22.06
New South Wales	$109,700,000	6,760,000	$16.23
Australian Total	**$476,225,800**	**20,229,800**	**$23.54**

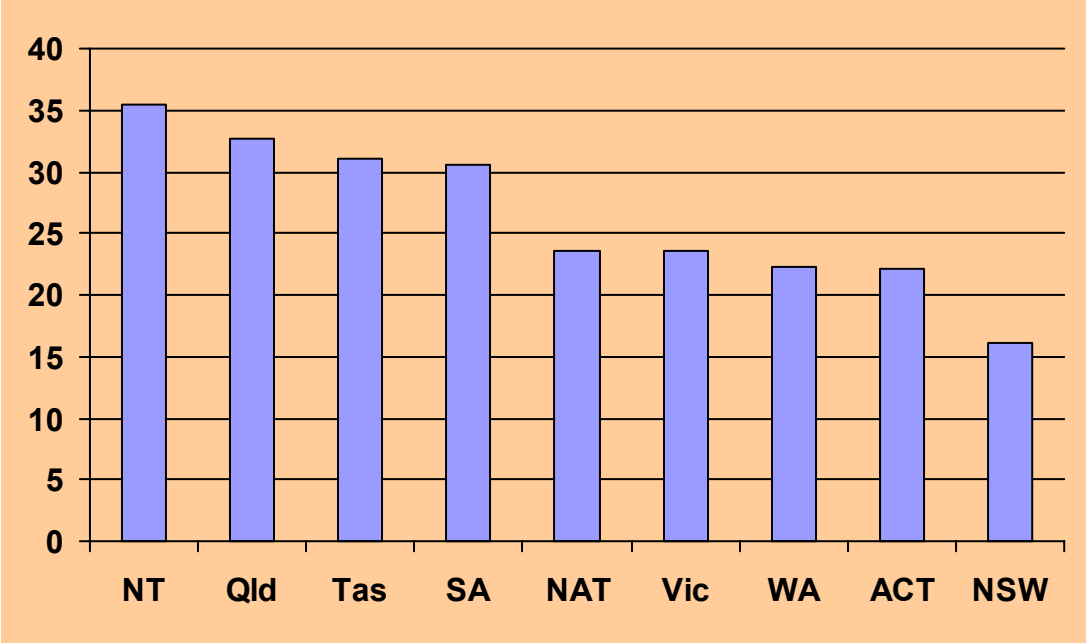
Source submission 226, ADA (NSW) Ltd, p37

78 Submission 226, ADA (NSW) Ltd, p36

79 Submission 65, Association for the Promotion of Oral Health, p23

80 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence 16 February 2006, Transcript p8

Figure 3.2 Per capita State and Territory dental expenditure 2004/2005



Source submission 226, ADA (NSW) Ltd, p37

3.22 Dr Denise Robertson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, argued that New South Wales has the most generous eligibility criteria for public care out of all of the states and territories, covering approximately 57% of the New South Wales population, as opposed to approximately 30% in Victoria and Queensland.[81]

3.23 The Greater Western Area Health Service estimated that it receives funding for public dental services that equates to approximately $37 per eligible person, which is insufficient to provide basic relief of pain services to eligible patients.[82]

3.24 The Committee accepts that New South Wales does have wider eligibility criteria than other states and territories (as previously discussed in chapter 2), but funding on a per capita basis remains the lowest in Australia.

Additional funding requirements

3.25 With respect to the additional funding that is required in New South Wales, Associate Professor Hans Zoellner, Chairman, Association for the Promotion of Oral Health noted in evidence that it is difficult to quantify how much additional funding is required to provide

81 Dr Denise Robertson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p2; and Evidence 16 February 2006, Transcript p39

82 Submission 206, Greater Western Area Health Service, p5

adequate public dental services in New South Wales, but believed 'you could easily and sensibly spend at least double in funding to really cater for all the issues we face…'.[83]

3.26 Many of the submissions called for the funding provided by the New South Wales government to at least match the per capita funding of Queensland. ADA (NSW) argued that, on this basis, the minimum annual budgetary allocation for public dental services should be at least $220.6 million, as opposed to the current spending of $120 million.[84]

3.27 The Committee is aware of the on-going dispute between the Commonwealth and State and Territory governments with respect to the sources of funding for public dental services. Nevertheless, the Committee firmly believes that public dental patients in New South Wales should not suffer as a result of this dispute and that additional funding is required in New South Wales to provide an adequate level of public oral health care.

Recommendation 1

That the funding of public dental services in New South Wales be reviewed and increased to improve public dental services and be comparable to other states.

3.28 Funding for public dental services in New South Wales is administered through the local area health services, and ADA (NSW) argued that this system results in a lack of transparency as to how funds are allocated, which has been a source of complaint for many years from those employed to provide public dental services. It quotes the NSW Minister of Health, the Hon John Hatzistergos, as stating that 'the relative allocation and expenditure against particular service grouping is at the discretion of local Area Health Services given different population and needs'.[85] The Association for the Promotion of Oral Health also notes that there is little or no consistency between area health services with regard to investment in dental infrastructure, with each area defining different priorities.[86]

3.29 Evidence received from area health services indicated that dental funding is not always used exclusively to provide dental services, as the Sydney South West Area Health Service noted:

> Oral health funding is not quarantined from other parts of Area Health Service funding, and is frequently called upon to contribute to cost cutting across Areas to meet budget constraints where other parts of the Area Health Service are experiencing fiscal problems.[87]

3.30 The Committee notes that while the various area health services have different funding priorities, a system entailing accountability and transparency is nevertheless necessary to ensure that the funding made available for the provision of public dental services is used

83 Associate Professor Hans Zoellner, Chairman, Association for the Promotion of Oral Health, Evidence 29 June 2005, p11

84 Submission 226, ADA (NSW) Ltd, p38

85 Supplementary submission 226a, ADA (NSW) Ltd, p20

86 Submission 65, Association for the Promotion of Oral Health, p24

87 Submission 118, Sydney South West Area Health Service, p6

appropriately to provide such services, and not to cover shortfalls in other areas of the area health services budget. The Committee also notes that more centralised coordination between area health services is required to monitor and regulate the oral health spending that occurs in each area health service.

Recommendation 2

That area health services spend their oral health budgets on providing oral health services, and that a transparent accounting system be developed to monitor oral health spending in area health services to ensure a coordinated approach to oral health spending.

Current plans, programs and policies directing dental services

3.31 There are currently a number of plans, programs and policies at federal, state and local government level, under which dental services operate in New South Wales. Most of these plans are still being, or have recently been developed, and are in the early stages of being implemented.

3.32 The submissions and evidence have identified the following bodies as being involved in the promotion of oral health:

- Association for the Promotion of Oral Health. The Association is a recently formed independent think-tank and advocacy group with membership representing major and minor stake-holders in oral health in NSW
- Australian Dental Association. The ADA membership comprises 90% of practising dentists in Australia, with branches in all states and territories, and aims to promote public health and dentistry
- Australian Health Policy Institute. The Institute is located at the University of Sydney and provides analysis of major health policy questions in Australia, including oral health
- Centre for Oral Health Strategy (NSW). The Centre is located in the Population Health Division of NSW Health and develops and coordinates oral health policy, and monitors population oral health prevention and service delivery programs in NSW
- Dental Research and Statistics Unit. The Unit is a collaborating unit of the Australian Institute of Health and Welfare and is housed at the Australian Research Centre for Population Oral Health. The Unit aims to improve oral health of Australians through the collection, reporting and analysis of information on oral health and access to dental care
- NSW Oral Health Promotion Network. The Network comprises representatives from all Area Health Services, the Centre for Oral Health Strategy, Sydney University Dental Faculty, community groups, industry partners and the New South Wales branch of the Australian Dental Association, and is responsible for monitoring and coordinating oral health promotion in NSW

- Westmead Centre for Oral Health. The Centre is one of two major public dental hospitals (together with the Sydney Dental Hospital) in NSW and also provides research and teaching in oral health.

3.33 While these are the main organisations that have made submissions to the Inquiry or have provided research that is relied upon in this report, many other bodies are also involved in consultations regarding the implementation of oral health plans in New South Wales.

Federal programs

The National Oral Health Plan 2004-2013

3.34 The National Oral Health Plan, entitled "*Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*" was published in July 2004. The National Advisory Committee on Oral Health, which was established by the Australian Health Ministers Conference, and comprises a broad representation of oral health experts and consumers, prepared the Plan. The Plan aims to:

> improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of oral disease. The Plan aims to help all Australians to retain as many of their teeth as possible throughout their lives, have good oral health as part of their general good health, and have access to affordable and quality oral health services.[88]

3.35 The four broad themes underpinning the Plan are:

- recognising that oral health is an integral part of general health
- using a population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease
- providing access to appropriate and affordable services – health promotion, prevention, early intervention and treatment – for all Australians
- education to achieve a sufficient and appropriately skilled workforce, and communities that effectively support and promote oral health.[89]

3.36 The key action areas that the Plan focuses on are:

- promoting oral health across the population
- children and adolescents
- older people
- low income earners and those who are socially disadvantaged
- people with special needs

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88 National Advisory Committee on Oral Health, "*Healthy mouths healthy lives: Australia's national oral health plan 2004-2013*", July 2004, pV

89 National Advisory Committee on Oral Health, "*Healthy mouths healthy lives: Australia's national oral health plan 2004-2013*", July 2004, pVI

- Aboriginal and Torres Strait Islanders
- work force development.[90]

3.37 The Plan's stated aims are to achieve improvements in the short term, over two years (2004 to 2006), change in the medium term over five years (2004 to 2009), and more fundamental change in the longer term over ten years (2004 to 2013). The Plan has the support of peak bodies, including the ADA, which states that the Plan 'has the potential to act as a key framework to guide the planning and delivery of oral health care in Australia … it is imperative that governments, the dental profession and the broader community work together to ensure that the oral health needs of the particular groups … are addressed'.[91] It is noted that the Plan does not include any funding from the Federal Government towards achieving its objectives.

3.38 The Plan is currently being implemented nationally. Professor Spencer, in discussing this implementation, noted that it acts as a backdrop to allow state and territory governments to draw up compatible oral health programs, and exerts a subtle influence for improving oral health, however there is currently a fragmented and uncoordinated response by the various state and territory governments. He also noted that the process could be strengthened and formalised by strong leadership at a national level from the Federal government, regardless of what funding arrangements are in place.[92]

3.39 The *National Oral Health Plan 2004-2013* has been initially implemented in New South Wales, through some of the programs to be described in the following paragraphs. Dr Clive Wright, Chief Dental Officer, NSW Health, stated that NSW Health has been working with members of the coordinating group of the national Plan to ensure that there are linkages between the New South Wales and Federal programs.[93] The Committee notes that it will be necessary for New South Wales to work in coordination with other state and territory governments, the Federal government and a broad range of stakeholders within New South Wales to achieve the plan's stated long-term objectives.

3.40 The Committee notes with approval the *National Oral Health Plan 2004-2013*, and NSW Health's intention to use the Plan for guidance in implementing its state programs. The Committee is concerned about the issues raised by Professor Spencer, including lack of co-ordination between states and territories, and suggests that NSW Health work in conjunction with its state and territory counterparts to ensure the Plan is implemented to its full extent.

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90 National Advisory Committee on Oral Health, "*Healthy mouths healthy lives: Australia's national oral health plan 2004-2013*", July 2004, p4

91 Australian Dental Association, National Dental Update, June 2005, p1

92 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence 16 February 2006, p12

93 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence 16 February 2006, p34

Recommendation 3

That NSW Health continues to work in coordination with other state and territory governments, the Federal government and a broad range of stakeholders within New South Wales to achieve the actions and objectives of the *National Oral Health Plan 2004-2013*.

Commonwealth Dental Health Program

3.41 The Commonwealth Dental Health Program ran from January 1994 to January 1997 and provided additional funding of approximately $100 million to state and territory governments to reduce waiting lists and provide greater access to public dental services. When the Program ceased, funding in New South Wales for public dental services decreased by $34 million, or 36% of the public dental budget.[94] As previously shown in table 3.16, the impact of the loss of federal funding through the program was substantial. NSW Health advised that in 1995-1996, with funding from the program and the New South Wales Government, services were provided to 444,000 adult patients; in 1997-1998, with the loss of the funds, the number of adults treated dropped to 172,000 – a 62.3% decrease.[95] The Combined Pensioners and Superannuants' Association noted that when the program finished in 1996 there were 380,000 Australia-wide patients waiting an average of six months for public dental care; by 2004 there were over 500,000 people waiting up to five years to receive treatment.[96]

3.42 Many of the submissions called for the reinstatement of the Commonwealth Dental Health Program, as does the New South Wales Government,[97] since its cessation resulted in reduced funding for public dental services and a consequent decrease in the public services available. The Senate Select Committee inquiry on Medicare noted that the Program was generally assessed as being successful in increasing access to, and quality of, dental care to the eligible population and reducing waiting times in public dental programs, and recommended the restoration of the Program, as it represented a targeted measure of limited cost that had proven to be successful in providing increased access to dental care to those most in need.[98] The Senate Community Affairs Committee inquiry into public dental services made similar observations as to the effectiveness of the Program, but recommended that a more permanent funding arrangement between the commonwealth and state and territory governments be put

94 Submission 226, ADA (NSW) Ltd, p40

95 Submission 254, NSW Health, p19

96 Submission 52, Combined Pensioners & Superannuants' Association Inc, p3

97 Dr Denise Robertson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p2; Hon J Hatzistergos MP, Minister for Health, 'Commonwealth called to act on oral health following new research', *Media Release*, 4 January 2006

98 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", pp129-131

into place.[99] NCOSS suggested that any such dental program should be funded at a minimum of $270 million per annum, with an ideal amount of $700 million per annum.[100]

3.43 The Committee notes the evidence and arguments in support of some form of Commonwealth funding for public dental services, and the impact that increased funding would have in improving the provision of such services. The Committee also notes that the Commonwealth has, in the past, participated in funding programs. The majority of the Committee therefore recommends that the New South Wales Government continue lobbying the Federal government to increase direct spending on oral health and public dental services.

Recommendation 4

That the NSW Government urge the Federal Government to increase direct spending on oral health and public dental services.

Other federally funded programs

3.44 The Federal Department of Veterans' Affairs provides dental services to patients holding a Repatriation Health Card. With the exception of some dental procedures that require prior approval, treatment is provided without requiring referrals.[101] NCOSS states that 'the Department of Veterans' Affairs is viewed as setting the standard in regards to their oral health program. It is designed to provide comprehensive care as well as being more financially rewarding to dentists'.[102] The scheme also provides additional services such as transport to clinics and allows for patient co-payments to be made in circumstances where a financial limit applies.[103] The scheme is, however, limited to a small and reducing section of the population.

Programs in New South Wales

New South Wales Oral Health Strategic Plan

3.45 Dr Clive Wright, NSW Health, stated that the implementation of oral health programs in New South Wales is linked to the *National Oral Health Plan 2004-2013* (as discussed in paragraphs 3.27 to 3.32) and that the Plan provides an important framework within which to identify and address issues relating to oral health services.[104]

99 Senate Community Affairs Committee, Inquiry into public dental services, May 1998, paragraph 5.5, accessed 9 February 2006, <http://www.aph.gov.au/SENATE/COMMITTEE/clac_ctte/completed_inquiries/1996-1999/dental/reports/c05.htm>

100 Submission 200, NCOSS, p8

101 Department of Veterans' Affairs, Fact sheet HSV17, March 2004, p1

102 Submission 200, Council of Social Services of New South Wales, p7

103 Department of Veterans' Affairs, Fact sheet HSV17, March 2004, p2

104 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence 16 February 2006, p34

3.46 NSW Health is currently developing an oral health strategic plan, which includes an oral health promotion framework for action up to 2010. The Plan is described as:

- setting priorities which include increasing fluoridation, oral health and primary health care
- increasing awareness in the population and community of the importance of oral health
- strengthening the coordination, training and information services for oral health promotion
- increasing partnerships with appropriate stakeholders
- including a component of improving access to services.[105]

3.47 In addition, NSW Health referred to the establishment of rural and regional oral health centres, developing specific programs for Aboriginal and Torres Strait Islander peoples and planning for future workforce needs to ensure supply meets increasing demand.[106]

3.48 The New South Wales Oral Health Promotion Network was established in August 2005, comprising representatives from all Area Health Services, the Centre for Oral Health Strategy, Sydney University Dental Faculty, community groups, industry partners and the New South Wales branch of the Australian Dental Association. The Network is responsible for monitoring and coordinating oral health promotion in accordance with the above framework.

3.49 ADA (NSW) reported that at the first Network meeting members were informed that no significant new funding would be made available for oral health promotion activities under the framework, which the Association believes raises serious questions as to whether the Network can implement its mandate, particularly as any fund allocations would be made at the expense of already overstretched clinical services.[107]

3.50 The Centre for Oral Health Strategy New South Wales was also created in late 2004, located in the Population Health Division of NSW Health. The Centre 'develops and coordinates oral health policy for the State, and monitors population oral health prevention and service delivery programs in NSW'.[108]

Aboriginal and Torres Strait Islander Oral Health Promotion Plan

3.51 Dr Wright, NSW Health, explained that this Plan is also not yet complete, although the principles set out in the Plan have been adopted and incorporated into other programs currently in place. Dr Wright stated that NSW Health is currently in the process of appointing an Aboriginal health project manager, who will be responsible for consulting with Aboriginal medical services and the community in the implementation of the Plan.[109]

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105 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence 16 February 2006, p34

106 Submission 254, NSW Health, pp6-7

107 Supplementary submission 226a, ADA (NSW) Ltd, p8

108 NSW Health, *Annual Report 04/05*, p16

109 Dr Clive Wright, Evidence 16 February 2006, p34

3.52 The Committee notes with concern the observations of the NSW oral health promotion network concerning the lack of funding to carry out oral health promotion activities and recommends that funding for such activities be provided.

Recommendation 5

That the oral health strategic plan, the associated framework for action, and the Aboriginal and Torres Strait Islander plan be implemented by NSW Health and the NSW Oral Health Promotion Network in consultation with relevant stakeholders, including the Commonwealth Government, and that sufficient funding to implement the objectives of the plan be made available.

Priority Oral Health Program

3.53 The Priority Oral Health Plan was introduced to ensure that public dental services in New South Wales are provided on the basis of need, ensuring that people with the greatest oral health need receive the earliest attention rather than treatment being given on a first come, first served basis.[110] Patients seeking dental treatment through the public system are categorised according to level of need using an information system for oral health. The difficulties encountered under this Program, particularly with respect to waiting times for treatment, will be discussed in paragraphs 6.4 to 6.17 of Chapter 6.

The Information System for Oral Health

3.54 The Information System for Oral Health was introduced in 2001. It is an integrated information system that is used by all public oral health clinics in New South Wales to collect data and to categorise the urgency of patients' needs for treatment under the Priority Oral Health Program. NSW Health reported that the system has already delivered improved data quality, collection and reporting mechanisms, and that future developments will include quality indicators and health outcomes reporting, and improved cost analysis and performance monitoring systems. The system operates under a single point of contact policy, whereby all patients contact a single call centre in order to request treatment. NSW Health also reports that the system has been recognised internationally and adopted for use in Queensland.[111]

3.55 Many submissions commented on the efficacy of the system. Dr John Powell, a practising dentist, stated that:

> as a tool this system has been effective in rationing treatment, however its success has been at the expense of those who simply wish to access diagnostic and preventive services.[112]

3.56 Dr John Webster of the South Eastern Sydney Illawarra Area Health Service believes that there are too many patients for the system to cope with, as shown by the growing waiting

110 Submission 254, NSW Health, p12

111 Submission 254, NSW Health, pp14-15

112 Submission 257, Dr John Powell, p2

lists,[113] and UnitingCare Burnside described patients' frustration in using the centralised booking call system, which requires lengthy waiting times on hold.[114] ADA (NSW) describes the system as being:

> a blunt tool to ration under-funded and understaffed public dental clinics.[115]

3.57 The Committee notes the discrepancies in views about the efficacy of the system, and that NSW Health is planning further developments to the system. The Committee recommends that NSW Health, in consultation with relevant stakeholders, review developments to the system to ensure its improved efficacy and usefulness to users.

Recommendation 6

That NSW Health, in consultation with relevant stakeholders and users, review developments to the Information System for Oral Health to ensure its improved efficacy and usefulness.

Child Oral Health Program

3.58 In 1999 the Child Oral Health Program, previously known as Save Our Kids Smiles, was reviewed and changes were recommended in the four primary areas of: oral health education; risk assessment; data management; and clinical treatment. Elements of the program were integrated into other community based oral health services, while the School Assessment Program, which is targeted at disadvantaged schools to identify children at high risk of oral disease, remains.[116] As a result of this review ADA (NSW) noted that there is now no school dental program in existence in New South Wales, although limited dental services are provided to children mainly by dental therapists in the public sector.[117]

3.59 The NSW Dental Therapists Association advised that the program is run at the discretion of the various Area Health Services in terms of the ages and grades of children targeted, for example, children in kindergarten and grades 3 and 6. Dental therapists provide the treatment to children, including fillings, extractions, preventive care and oral health promotion, and have been doing so for 30 years in New South Wales.[118] The children are given a dental risk assessment and from that are priority coded and given an appointment within 24 hours for emergency treatment or up to several months if just a general check-up is required. The Association reported that all schools in all areas are eligible to receive these assessments but in some areas the shortage of clinicians means that some schools will be excluded. Students from schools that are excluded can still receive treatment but it requires the advocacy of the parent or care-giver in calling the service via a call centre. The Association estimated that without the

113 Submission 53, Dr John Webster, p1

114 Submission 199, Uniting Care Burnside, p17

115 Supplementary submission 226a, ADA (NSW) Ltd, p15

116 Submission 254, NSW Health, p13

117 Supplementary submission 226a, ADA (NSW) Ltd, p13

118 Ms Kay Franks, President NSW Dental Therapists Association, Evidence 3 August 2005, p15

dental care provided in schools approximately 45% of children in certain areas would not receive any oral health care in their childhood.[119]

3.60 NSW Health states that all high school students, and all children who do not receive oral health assessments through their schools, may still access public oral health services through the Priority Oral Health Plan on a needs basis.[120] The Greater Western Area Health Service indicated that children receive comprehensive, timely and holistic services under the School Assessment Program, but with recruitment difficulties and changes to the workforce in terms of dental therapists (discussed in Chapter 4) the Service reported that waiting lists are starting to develop and that future treatment of children may not be as satisfactory.[121]

3.61 Several of the submissions also commented on the treatment of children through the school system. Ms Jennifer Lang, Oral Health Promotion Officer at the Wagga Wagga Community Health Dental Clinic, expressed concern about the lack of dental treatment and oral health promotions and information available to primary school children and high school students.[122] In its submission ADA (NSW) discusses the outcome of a child oral health-planning day convened by the Centre for Oral Health Strategy in April 2005. The report produced after the planning day noted that the current demand for emergency and routine services for children is not sustainable; that current methods of data collection for children in New South Wales are flawed, due to pre-selection for risk through the School Assessment Program and the Priority Oral Health Program, and that the School Assessment Program is unsuccessful in preventing caries; that access to oral health services for high priority groups is not equitable; that treatment and screening philosophies need to be re-evaluated; and that current funding is inadequate.[123]

3.62 In research Professor Spencer stated that expenditure on school dental services should be brought up to a benchmark set by those States with more consolidated programs that achieve higher levels of coverage, which will present a challenge in New South Wales.[124] Professor Spencer also stated that school dental services need to be revitalised and should include:

- specific oral health promotions focussing on preventive measures in maternal and child oral health, preschool oral health and school oral health
- expansion of the school dental service coverage, especially among lower socio-economic children who slip through the safety net
- a strong emphasis on clinical prevention based on risk identification and management

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119 Mrs Janet Wallace, Research Officer, NSW Dental Therapists Association, Evidence 3 August 2005, pp17, 22

120 Submission 254, NSW Health, p14

121 Ms Jennifer Floyd, Oral Health Network Manager, Greater Western Area Health Service, Evidence 31 August 2005, p19

122 Submission 85, Ms Jennifer Lang, Wagga Wagga Community Health Dental Clinic, p2

123 Supplementary submission 226a, ADA (NSW) Ltd, p14

124 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p54

- consideration of the fact that school dental services can shape oral health attitudes and behaviours for the future.[125]

3.63 The provision of public dental services is not clearly delineated under a comprehensive child oral health program and the evidence indicates that many children and high school students are not receiving adequate treatment or access to oral health promotion and education programs. The Committee discusses the issue of child dental services and Medicare in paragraph 3.102 of this Chapter, and will recommend that Medicare be extended to cover such services. In addition, the Committee also recommends that a child oral health program, targeted through schools, be implemented in New South Wales. The issue of child access to public dental services is further discussed in Chapter 6 of this report.

Recommendation 7

That a comprehensive child oral health program, targeted through schools, be implemented and adequately staffed and funded.

New South Wales Oral Health Fee for Service Scheme

3.64 This scheme was introduced on 1 July 2001, to assist public oral health clinics cope with increasing demand for services by engaging private dental practitioners to provide acute oral health treatment and denture services where no such services could be provided in the public clinics.[126]

3.65 The scheme is available to patients eligible for public dental care who have undergone an initial assessment at a public clinic and are determined to require acute care under the Information System for Oral Health. Patients are issued with a one-off voucher to obtain treatment from private dental practitioners, with a payment ceiling of $180 for an authorised course of acute care and $780 for dentures services. If the patient requires a continued course of treatment further vouchers must be issued.[127] There are approximately 1,100 private dentists registered in the scheme, and approximately 42,000 vouchers issued per year.[128]

3.66 A large number of submissions raised concerns that the fees paid to private practitioners via the vouchers are so low that they do not cover operating costs and that the range of treatment available via the vouchers is too narrow. The Association for the Promotion of Oral Health estimated that the cost of providing dental services using vouchers is approximately seven times that of delivering the same service within the public system and, as such, the voucher system is not as cost-effective as increasing funding for the direct provision of such dental care through the public system.[129]

125 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, pp51-52

126 Submission 226, ADA (NSW) Ltd, p43

127 Submission 200, NCOSS, p6

128 Submission 65, Association for the Promotion of Oral Health, p21

129 Submission 65, Association for the Promotion of Oral Health, p25

3.67 In evidence Mr Christopher Wilson, practising dentist and President ADA (NSW), reiterated that the voucher does not allow for a thorough examination of a patient's dental problem as the voucher's value will generally cover the cost of the extraction of a tooth, thus allowing for acute emergency treatment only. Dentists are unable to provide comprehensive treatment unless the patient can spend an additional $500-$600 to fix the problem, which is not possible for many patients. He also noted that many participating dentists perform pro bono work or waive additional fees, to the value of $30 million a year, in an effort to provide a more comprehensive service to patients being treated under this Scheme.[130]

3.68 Several submissions advised that participating dentists in the scheme are frustrated at being limited to providing acute treatment only, as covered by the value of the voucher, rather than the comprehensive treatment that would prevent the patient from suffering on-going problems.[131] The administrative requirements to participate in the scheme are also seen as being overly onerous.[132] A comparison is made with the fee schedule set under the Department of Veterans' Affairs dental scheme where vouchers are of a greater value, there are fewer restrictions on the work that can be done, and more comprehensive work can be done over a period of time as patients are able to easily return to on-going treatment.[133]

3.69 With respect to the provision of dentures under the scheme, the number of providers has declined in recent times, primarily due to the low fee schedule,[134] with members of the Association of Dental Prosthetists withdrawing their services from the scheme as it was no longer financially viable for them to continue. The Vice-President of the Association, Mr Graham Key, stated that dental prosthetists are being paid less than dentists for the same service under the system and that the members of the Association felt that they could not afford to continue working as a charity.[135] The denture rates offered under the Scheme are approximately 70% of the Department of Veterans' Affairs fee schedule for local dental officers and prosthetists.[136]

3.70 The NSW Health Circular concerning the Oral Health Fee for Service Scheme[137] states that the scheme's fee schedule is reviewed annually in consultation with ADA (NSW). The Association's submission pointed out that 'this has failed to occur in reality'.[138] Similarly Mr Key of the Association of Dental Prosthetists contested the claim that the fee schedule had been set in consultation with his Association.[139]

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130 Mr Christopher Wilson, President, ADA (NSW), Evidence, 5 July 2005, pp56-57

131 Mr Reginald Scott, President, Dental Technicians Association, Evidence, 3 August 2005, p27

132 Supplementary submission 226a, ADA (NSW) Ltd, p13

133 Mr Christopher Wilson, Evidence, 5 July 2005, p57

134 Submission 206, Greater Western Area Health Service, p6

135 Mr Graham Key, Vice President of the Association of Dental Prosthetists, Evidence, 3 August 2005, p40

136 Submission 206, Greater Western Area Health Service, p6

137 NSW Health, "*Oral Health Fee for Service Scheme (OHFFSS) - NSW*", Policy Directive PD2005_603, 5 July 2005, p1

138 Submission 226, ADA (NSW) Ltd, p43

139 Mr Graham Key, Evidence, 3 August 2005, p40

3.71 The Committee notes that many dental practitioners are willing to participate in a program such as the Oral Health Fee for Service Scheme, even to their own financial detriment, but that the low fee schedule, administrative requirements and lack of comprehensive care are disincentives to being involved.

3.72 NSW Health is currently reviewing the services provided through the Oral Health Fee for Service Scheme. The Committee notes the concerns raised over the fee schedule, and that a number of submissions support applying the Department of Veterans' Affairs fee schedule to the current scheme,[140] as that arrangement 'sets more realistic fees, provides patients with more comprehensive dental care and requires less administrative paperwork', and the fees increase with annual indexation.[141] The Committee recommends that the fee schedule also be reviewed, bearing in mind the Department of Veterans' Affairs arrangements.

Recommendation 8

That NSW Health review the fee schedule under the Oral Health Fee for Service Scheme, in consultation with the Australian Dental Association and other relevant stakeholders, with consideration to the dental fee schedule of the Department of Veterans' Affairs, and continue to review the schedule regularly.

3.73 The Royal Australasian College of Dental Surgeons suggested that if the Scheme is to remain in place, a patient co-payment scheme should be considered, whereby dentists are free to charge the client the extra fee above the 'scheduled fee', which would lessen the financial disincentive against involvement.[142] ADA (NSW) recognised that co-payments are likely to add financial burden to disadvantaged members of the community but believed that 'the benefits to be gained outweigh the detriment'.[143]

3.74 There is little information as to the budgetary implications of the use of co-payments and how it would impact on low-income users of public dental services, although NCOSS believed that a co-payment is beyond the means of the most disadvantaged.[144] The Committee therefore recommends that further research be conducted to determine the feasibility of co-payments, taking into account funding requirements, budgetary implications, the systems used in other States and impacts on low-income public dental services users.

140 Mr Gary Moore, Director, Council of Social Services of New South Wales, Evidence, 5 July 2005, p27

141 Supplementary submission 226a, ADA (NSW) Ltd, p13

142 Submission 76, Royal Australasian College of Dental Surgeons, p3

143 Submission 226, ADA (NSW) Ltd, p44

144 Mr Gary Moore, Director, NCOSS, Evidence, 5 July 2005, p28

Recommendation 9

That NSW Health conduct further research to determine the feasibility of co-payments for public dental services, taking into account funding requirements, budgetary implications, systems used in other States and impacts on low-income public dental services users.

Local area programs

3.75 Since 2003 the North Coast Area Health Service has been running the Teeth for Health program to prevent and control oral disease, which was developed in conjunction with NSW Health. The aim of the project is to 'draw attention to the poor oral health in the community, to inform the community that dental disease was largely preventable and to also encourage councils to consider fluoridation of water supplies as a means of helping to reduce the level of dental decay'.[145] The program is considered a success, as it resulted in three out of the four Councils that were not fluoridating in the Mid North Coast (Hastings, Kempsey and Coff's Harbour) referring the matter of fluoridation to the Director-General of NSW Health. The necessary directions were gazetted in 2004 and Councils had until November 2005 to comply.[146]

3.76 The Committee notes that the various area health services used differing strategic policies and programs. In providing evidence, Mr Terry Clout, Chief Executive, Hunter New England Area Health, NSW Health, explained that while there is commonality in terms of criteria and information systems, the various area health services differ in size, service capability and requirements, and must therefore put in place localised policies and procedures that best suit the needs of the region.[147]

3.77 NSW Health also runs outreach programs in rural and regional areas of New South Wales to provide specialist services that are commonly only available at the teaching hospitals in Sydney, such as paediatric, orthodontic and oral surgery programs, to more remote areas. There are currently programs operating out of areas such as Queanbeyan, Orange, Dubbo, Bathurst, Lithgow, Wagga Wagga, Lithgow, Coffs Harbour, Kempsey, Albury and the Hunter.[148]

Impact of private health insurance and the 30 per cent rebate

3.78 In 1997-98 the Commonwealth Government introduced the Private Health Insurance Incentives Scheme, initially targeted at low and middle-income earners and extended to all income categories in 1999. Under the scheme the Commonwealth Government pays a 30% rebate on all private health insurance, which means that, in practice, for every dollar spent on a private health insurance premium, the Commonwealth Government reimburses thirty cents.

145 Mr John Irving, North Coast Area Health Service, Evidence, 23 August 2005, p35

146 Submission 254, NSW Health, p10; fluoridation is discussed in chapters 7 and 8

147 Mr Terry Clout, Chief Executive, Hunter New England Area Health, NSW Health Evidence, 5 July 2005, p12

148 Submission 254, NSW Health, p4

The rebate is available to all Australians who are members of a private health fund or are paying the premium on behalf of someone else, and is available on all hospital, ancillary and combined cover.[149] In April 2005 the rebate was increased to 35% for those aged 65 to 69, and to 40% for those aged above 69.[150] In research Professor Spencer explained that the scheme was intended to 'reverse the steady decline in private health insurance and to relieve pressures on the public hospital system by moving more health care into the private sector'.[151]

3.79 Dr Frances Cunningham, General Manager, New South Wales, Australian Health Insurance Association, advised that as at September 2005, a total of 3.7 million people in New South Wales (52% of the population) had some form of private health insurance, with 3.2 million people also taking out ancillary cover, which includes cover for dental services. From September 1999 to September 2005 the percentage of privately insured people with dental cover rose from 73% to 79.5% in New South Wales and from 74% to 80.5% nationally.[152]

3.80 Professor Spencer noted in his studies, however, that only 14% of people who took up private health insurance between 1998 and 2002 had incomes of less than $20,000, while nearly 28% had incomes of $80,000 or more.[153] He also noted that between 17% and 20% of people eligible for public dental services have private health insurance:

> … for every one person who is eligible [for public dental services] who has private health insurance there are four people who are eligible for public dental care who do not have private dental insurance.[154]

3.81 ADA (NSW) stated that indirect expenditure by the Commonwealth Government on dental care, through the 30% rebate, was $298 million in 2002/03, and $357 million in 2004/05.[155] Dr Cunningham, NSW Branch, Australian Health Insurance Association, advised that approximately 50% of payouts for ancillary cover are paid with respect to dental services.[156]

Affordability of private health insurance

3.82 NCOSS argued that because most dental services are privately funded, an individual's ability to pay is a major factor if they require dental services.[157] Many of the submissions commented

149 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", 30 October 2003, p145

150 Dr Frances Cunningham, General Manager, New South Wales, Australian Health Insurance Association, Evidence 16 February 2006, p79

151 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p38

152 Dr Frances Cunningham, Evidence 16 February 2006, p78

153 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p39

154 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence 16 February 2006, Transcript p9

155 Submission 226, ADA(NSW) Ltd, p35

156 Dr Frances Cunningham, Evidence 16 February 2006, p81

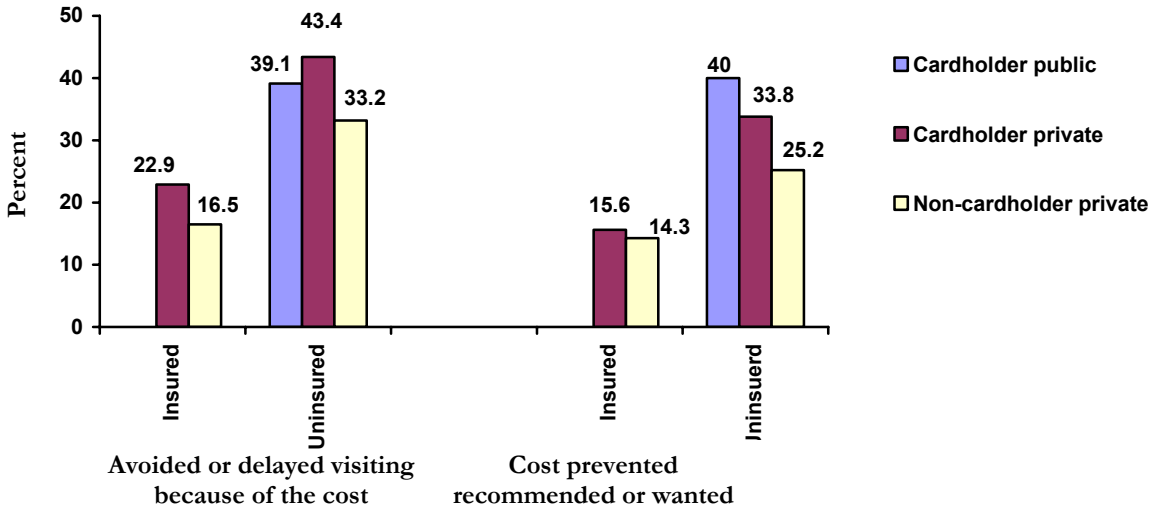
157 Submission 200, NCOSS, p6

on the expense of private dental services and private health hospital and ancillary premium in New South Wales is $1,521 for a single membership and $3,042 for a family membership, prior to the application of the rebate,[158] which is out of reach for many members of society. One submission stated:

> … anyone who is eligible for public dental services cannot possibly afford private health insurance. Most of these people are trying to survive on Centrelink money and can't afford health insurance of any kind unless they give up such things as food, paying for accommodation and energy bills etc …[159]

3.83 The Australian Institute of Health and Welfare, Dental Statistics and Research Unit, noted in a research report, that uninsured adults were approximately twice as likely to have avoided or delayed visiting a dentist because of the cost of treatment than those who were insured. Uninsured adults also reported that dental visits comprise a large financial burden and that cost of services had prevented them from having recommended or wanted treatment, as shown in the table below:

Figure 3.3 Dental care based on user's ability to afford treatment



Source Australian Institute of Health and Welfare Dental Statistics and Research Unit, July 2002, Research report No. 5, "Dental insurance and access to dental care", p5

3.84 The cost of private health insurance premiums is also increasing, making insurance less affordable for low-income earners. The cumulative premium increase in private health insurance between 2002 and 2005 is 29.84%. In addition, between December 1996 and December 2004, the average benefit paid per service for dental treatment has fallen from 58.18% of the cost of treatment to 48.89%.[160]

158 Dr Frances Cunningham, Evidence 16 February 2006, p81

159 Submission 23, Ms Helen Knight, p2

160 Australian Dental Association, "*Private health insurance and dental cover*", National dental update, April 2005, p1

The 30% rebate

3.85 The 30% rebate on private health insurance was presented as a means to encourage individuals to seek private treatment, thus relieving the strain on the public system, however many of the submissions argue that this has not occurred. The greatest criticisms of the 30% rebate, as noted by the Senate Select Committee during its inquiry into Medicare, are that public funds are used to subsidise private health insurance, that these funds are directed towards wealthier parts of society that can already afford private health insurance, and that such use of public funds is inequitable, inefficient and ineffective.[161] These arguments were also presented by a large number of submissions and in the evidence to the current Inquiry.

3.86 Professor Spencer argued in research that the 30% rebate is grossly inequitable, as a huge proportion of the private dental insurance rebate goes to those with middle and high incomes.[162] UnitingCare Burnside confirms, 'the majority of the tax rebate is received by higher income earners who would not normally access public dental clinics'.[163]

3.87 Professor Spencer also argued the scheme did not achieve its objective as it is an 'inefficient method of achieving any movement of health card holders into private dental care',[164] with research showing that only a small percentage of those who use public dental services (predominantly those with an annual income of less than $20,000 per year) have private health insurance, as demonstrated in the table below:

Table 3.4 Contributors, single and family, to private dental insurance, Australia 2002, by household income

	Contributors as a % of household income category		
Income	**Single**	**Family**	**Total**
<$12,000	11.8	8.1	19.9
$12-20,000	6.1	17.7	23.8
$20-30,000	8.9	17.5	26.4
$30-40,000	11.5	31.2	42.7
$40-50,000	14.0	36.2	50.2
$50-60,000	9.3	42.3	51.6
$60-70,000	9.3	50.2	59.5
$70-80,000	11.7	47.3	59.0
$80,000+	12.4	57.4	71.8

Source Professor A John Spencer, "Narrowing the inequality gap in oral health and dental care in Australia", 2004, Australian Health Policy Institute, University of Sydney, p 41

161 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", 30 October 2003, p146

162 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", Australian Health Policy Institute, University of Sydney, 2004, p44

163 Submission 199, Uniting Care Burnside, p18

164 Professor A John Spencer, "*What options do we have for organising, providing and funding better public dental care?*", 2001, Australian Health Policy Institute, University of Sydney, p39

3.88 Other criticisms of the 30% rebate include the subsidising of private health fund dental clinics by government funding through the rebate and the indirect effect it has on the dentistry workforce, in that dentists prefer to work for health funds rather than public clinics due to better salaries, working conditions and a wider range of treatment options. [165]

3.89 In contrast ADA (NSW) supported private health insurance and the 30% rebate on the basis that it makes ancillary cover for dental services more affordable, and noted that, since the rebate was introduced in 1999, the number of dental services provided through private health insurance has increased from 14.4 million in 1999 to 22.7 million in 2004. It argued that, on this basis, the removal of the 30% rebate might lead to a greater unmet demand for dental services. However, the Association does note that the 30% rebate costs the Government approximately $357 million a year for dental services, which is three times the cost of the former Commonwealth Dental Health Program.[166]

3.90 The Australian Health Insurance Association also expressed concern that if the rebate were removed it would impact on over 45% of the population, with respect to both dental and general medical health, and that the number of people with private health insurance would return to the low levels prior to the introduction of the rebate.[167]

3.91 In its submission Australian Health Management proposed that private health insurers should provide a basic, dental-only product to allow a greater number of people to have access to private dental services.[168] The Australian Health Insurance Association noted that at least one health insurer does provide a dental-only product, however, it must be taken up in conjunction with hospital cover.[169] Some submissions also called for private health insurers to provide rebates for dental services performed by dental therapists and hygienists, as treatment by therapists and hygienists is cheaper than by a dentist and therefore more affordable.[170]

3.92 NCOSS proposed that the Commonwealth Government be lobbied to remove the 30% private health insurance rebate and the funding used for the rebate be put towards directly funding public dental services.[171] The Royal Australasian College of Dental Surgeons also supported redirecting the funds used for the rebate to the direct supply of public dental services in New South Wales.[172] In evidence Professor Spencer proposed considering direct funding of public dental services along the lines of the family allowance payments or of the

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165 Submission 76, Royal Australasian College of Dental Surgeons, pp4,5

166 Submission 226, ADA (NSW) Ltd, p35

167 Mr Angus Norris, General Manager, Health and Benefits, MBF Australia, Evidence 16 February 2006, p79

168 Submission 108, Australian Health Management, Dental and Eyecare Practice, p8

169 Dr Frances Cunningham, General Manager, New South Wales, Australian Health Insurance Association, Evidence 16 February 2006, p83

170 Submission 74, Ms Leonie Short, p2; Submission 200, NCOSS, p8

171 Submission 200, Council of Social Services of New South Wales, p8

172 Dr Leonie Hutchinson, Chair, NSW Regional Committee, Royal Australasian College of Dental Surgeons, Evidence 16 February 2006, p22

provision of child-care fees, where there is a sliding scale as to the level of public subsidy that people in the community receive.[173]

3.93 The Australian Health Insurance Association argued that the Australian health system is a dual system of both public and private services, and that the current system with respect to private health insurance should remain in place, but that it could be expanded in some form to try to allow all people to have access to primary dental care.[174]

3.94 The Committee notes that a sizeable percentage of the population benefits from the 30% rebate on private health insurance, and the concerns expressed that removing the rebate would affect the affordability of such insurance and lead to a greater unmet demand for dental services. The Committee also notes the evidence that people who are eligible to receive public dental treatment generally cannot afford private health insurance and therefore do not receive the benefit of the rebate.

3.95 The Committee is cognisant of the fact that the private health insurance industry is regulated by the Federal Government and that this issue is, to a certain extent, beyond the purview of the Committee. Nevertheless the majority of the Committee believes that the 30% rebate on private health insurance is inequitable in itself, since the benefits flow overwhelmingly to those on higher incomes, and has also contributed to a shift in dental services, and hence the dental workforce, towards more expensive and discretionary procedures. The majority of the Committee therefore recommends that the New South Wales Government urge the Federal government to review the 30% rebate and to redirect funding towards more affordable private and public dental services. The Hon Robyn Parker MLC was not in agreement with the majority.

Recommendation 10

That the New South Wales Government urge the Federal government to review the 30% rebate and to redirect funding towards more affordable private and public dental services.

Medicare

3.96 Oral health is not funded under Medicare, although some patients receive rebates for certain treatments if they are suffering a chronic condition and have complex care needs that are being managed by their doctor under an Enhanced Primary Care Plan. Doctors can refer patients to receive up to three dental care services where the patient has a dental problem that is exacerbating the chronic condition for which the plan was formed. Common conditions that can be exacerbated by poor dental health include valvular heart disease, diabetes,

173 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence 16 February 2006, p11

174 Mr Angus Norris, Evidence 16 February 2006, p83

malignancies of the head and neck, and if patients are undergoing chemotherapy.[175] There are currently approximately only 7,500 people in New South Wales eligible to receive a rebate for dental treatment under Medicare, with approximately 1,200 patients receiving such rebate.[176]

3.97 A number of submissions support extending funding under Medicare to cover oral health services.[177] In evidence Associate Professor Hans Zoellner agreed that it would be sensible and rational to extend Medicare to cover some of the more common and basic dental procedures.[178] However, Mr Christopher Wilson, ADA (NSW), noted that past inquiries into funding dental services under Medicare have found that it would be an expensive undertaking and that taxpayers may not be prepared to fund it to the degree necessary. He stated that ADA is against funding oral health under Medicare and believes that it would be insupportable and create costly administrative procedures.[179]

3.98 In its first inquiry into Medicare, the Senate Select Committee examined the feasibility of extending Medicare to cover oral health services. The Select Committee heard evidence that the cost of the extension of public dental care to 100% of the population would be between $2.5 billion (with a 45% gap in the cost of treatment) to $4.5 billion (without the gap). The ADA argued to the Medicare inquiry that:

> Medicare is already under severe financial strain and the addition of a comprehensive universal dental scheme would simply lead to total collapse…[180]

3.99 The Senate Select Committee reported that extending Medicare to cover dental services was not desirable:

> … the Committee considers that for Commonwealth intervention to take the form of incorporating dental care into Medicare is undesirable, both by reason of the enormous budget implications of such a move, and because it would represent a virtual Commonwealth takeover of dentistry that does not fit easily with the shared responsibility with the states.[181]

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175 Submission 254, NSW Health, p18; Department of Health and Ageing, *Medicare items for dental care for people with chronic conditions and complex care needs*, DC FS January 2006, accessed 16 March 2006, <www.health.gov.au>

176 Telephone conversation between Dr Clive Wright, Chief Dental Officer, NSW Health and Principal Council Officer, 16 March 2006

177 Submission 200, Council of Social Services of New South Wales, p6

178 Associate Professor Hans Zoellner, Chairman, Association for the Promotion of Oral Health, Evidence 29 June 2005, p14

179 Mr Christopher Wilson, President, ADA (NSW), Evidence, 5 July 2005, p58

180 ADA, as quoted in Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", 30 October 2003, p129

181 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", 30 October 2003, p129

3.100 The Senate Select Committee found that the evidence it received pointed overwhelmingly to the reinstatement of the Commonwealth Dental Heath Program (as discussed in paragraphs 3.41 to 3.43), and recommended the reinstatement of that Program accordingly.[182]

3.101 The Committee notes that there is a limited extension of Medicare to cover dental services according to specific criteria. In Chapter 6 of the report the Committee examines the dental requirements of special needs groups, such as the elderly, particularly in aged care facilities, and the disabled. The Committee notes that the Federal Government has the primary responsibility to provide care for groups such as the elderly and the disabled, and suggests that further comprehensive care could be provided to these groups, in the form of dental rebates pursuant to Medicare, as has occurred for patients under Enhanced Primary Care Plans. As the unique medical and dental conditions and requirements of people in these groups can be specifically identified and defined, suitable criteria could be developed by which assistance could be provided through Medicare to groups of specialised patients who traditionally fall within the Commonwealth Government's purview, and who currently do not receive adequate oral health care.

3.102 The Committee also notes the recent incentives under Medicare for doctors who bulk bill children under the age of 16.[183] The Committee believes that these incentives indicate the importance of childhood health, and recalls the links and impacts between good oral health and general health as raised in Chapter 2. The majority of the Committee recommends that in order to provide comprehensive health treatment to all children, Medicare should be extended to cover child dental services for children up to the age of 16 years.

Recommendation 11

That the NSW Government urge the Federal Government to extend Medicare to cover dental services to special needs groups and children up to the age of 16 years.

Conclusion

3.103 The key issue arising out of this Inquiry is the need for greater funding to support public dental services. According to the submissions and evidence provided, the on-going debate between the federal and state and territory governments as to the source of funding is leading to a lack of sufficient funds and resources and, as a consequence, inadequate public dental services. The Committee notes that the Commonwealth and New South Wales governments have developed, or are currently developing, plans and programs in an attempt to provide adequate oral health options but that the implementation of these plans is constrained by funding and lack of resources. Without sufficient funding the oral health needs of people in New South Wales cannot be adequately addressed and the unacceptable state of many people's dental health will continue. The Committee firmly believes that more funding must be immediately made available to ensure that oral health care and promotion can be carried

182 Senate Select Committee on Medicare, First Inquiry, "*Medicare – health or welfare?*", 30 October 2003, pp129-131

183 Department of Health and Ageing, *Bulk billing incentives and more doctors and nurses – information about Medicare*, May 2004, p1, accessed 16 March 2006, <www.health.gov.au>

out. The Committee also believes that Medicare could be extended to ensure that special needs groups and children are able to maintain an acceptable level of oral health.

3.104 With respect to private health insurance, the Committee notes that the 30% rebate makes insurance more affordable for a sizeable percentage of the population and that its removal could lead to a greater unmet demand for dental services, but that low income earners and those entitled to receive public dental treatment do not benefit from the rebate. The majority of the Committee has therefore recommended that the Commonwealth Government be urged to review the 30% rebate.

Chapter 4 Dental workforce

Evidence presented to the Committee demonstrated a clear shortage in the dental workforce that was more apparent in the public sector and even more acute in the public dental workforce in rural areas of NSW. There were a number of initiatives put forward by witnesses and submissions to address the shortage. This chapter addresses Term of Reference 1(e), which requires the Committee to examine the dental services workforce. Education and training will be considered in the following chapter. This chapter specifically considers:

- the dental workforce and its numbers
- shortage in the dental workforce
- the rural and regional dental workforce
- initiatives to address the shortage in the dental workforce.

What is the dental workforce?

4.1 The dental workforce consists of:

- dentists, also referred to as dental officers, who carry out general dentistry practices
- dental specialists, for example oral surgeons and orthodontists
- dental prosthetists, who provide and fit dentures and mouthguards
- dental technicians, who fabricate and repair dentures, inlays, outlays, bridges, crowns and mouthguards
- dental therapists, who focus on the dental treatment of children 0-17 years old, including prevention of dental diseases and control of dental caries, and only work in the public sector
- dental hygienists, who deal with oral health education, prevention of dental diseases, and carry out treatment services as per a dentist's treatment plan
- dental assistants, who conduct established procedures associated with chair-side assistance to a dentist and practice administration.[184]

4.2 The *Dental Practice Act 2001* and the corresponding Dental Practice Regulation 2004 outline the practices for dentists and allied dental health workers. In accordance with the *Dental Practice Act 2001* dentists, dental specialists, dental therapists and dental hygienists must register with the Dental Board of NSW. There is also a separate Dental Technicians Registration Board for technicians and prosthetists.[185]

184 Submission 226, ADA (NSW) Ltd, pp11-15

185 Dr Matthew Fisher, CEO, ADA (NSW), Evidence, 5 June 2005, p54

Dental workforce numbers

4.3 The Committee was concerned to establish how many people are employed in the dental workforce in NSW, both in the private and public sector. NSW Health provided a picture of the dental workforce as at July 2005:[186]

Table 4.1 Public and private dental workforce numbers as at July 2005

	Number in public sector - July 2005	Number in private sector - July 2005[187]
Dentists	263.83 (FTE)	2688
Dental Specialists	33.31	269
Dental therapists	167.58	0
Dental hygienists	0.6	96
Dental prosthetists	10.8	412
Dental technicians	61.7	682

Source: Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, pp41-42

4.4 The Australian Dental Association (NSW Branch) (ADA (NSW)) indicated that in total there are 1459.15 full time equivalent employees in the NSW public dental workforce and provided the following additional information: [188]

Table 4.2 NSW Public dental workforce as at July 2005

	Number in public sector - July 2005
Dental Assistant	607 (FTE)
Dental Health Educators	4.65
Nurses – all types	26.18
Radiographers	6.18
Managers	51.8
Clerical	157.76
Miscellaneous	67.37

Source: Submission 226a, ADA(NSW), p5

186 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, pp41-42

187 Dr Wright advised that in relation to the private sector figures "We must apply some assumptions to make them comparable, in that the information from the register includes a proportion who might be practising interstate or overseas, or who might be practising part time. We have made an assumption that 75% of those who are registered are in practice in the State and that 84% of those practising in the work force are in the private sector."

188 Submission 226a, ADA (NSW) Ltd, p5

4.5 The following table provides the estimated dentist workforce from 2000 to 2003 and the split between private and public sector.

Table 4.3 Estimated dentist workforce 2001-2003

Year	Estimated dentist workforce in NSW	Working in public sector	Working in private sector	Academics and other
2000	2,935	13%	85%	2%
2002	3,006	12%	84%	4%
2003	3,116	11%	84%	5%

Source: Dentist Labour Force in NSW – 2003, NSW Health, p4

4.6 Below are figures for the dental workforce comparing numbers in NSW with other states. This information includes details on dentists, dental therapists, dental hygienists, dental prosthetists and specialists. Information for dental assistants and dental technicians was not included in this information sourced from the Australian Institute of Health and Welfare (AIHW). The practising rate in the tables below refer to the number of full time equivalent (37.5 hours/week) dentists, dental therapists, dental hygienists or prosthetists per 100,000 population.

4.7 The table below demonstrates that NSW is similar to other states in terms of the number of dentists and the practising rate, number of dentists per 100,000 population. However, the percentage of dentists working in the NSW public sector is the lowest for the states represented in the table below.

Table 4.4 Dentists in 2003

	NSW	VIC	QLD	SA	WA
Practising	**3,346**	**2,284**	**1,821**	**833**	**957**
Practising rate (FTE per 100,000 population)	**53.5**	**46.4**	**49.6**	**53.2**	**49.3**
Average age	44.4	44.4	44.3	45.6	44.8
Public – Total	**364** (11%)	**348** (15%)	**366** (20%)	**216** (26%)	**137** (14%)
Public – Dental hospital	155	82	136	48	27
Public – School dental service	-	18	46	22	28
Public – General dental service	119	160	99	80	48
Public – Defence forces	27	14	25	5	10
Public – Tertiary education	34	33	37	46	21
Public – Other	28	41	24	14	3
Private- Total	**2,828**	**1,919**	**1,406**	**601**	**817**
Private – Solo practice	1,193	597	504	210	313
Private – Solo with assistant	470	369	248	75	140
Private – Partnership	303	181	163	87	100
Private – Associateship	376	338	193	131	165
Private – Assistant	432	381	262	86	83
Private – Locum	34	38	35	5	14
Private – Industry	20	16	1	7	3
Other	**154**	**16**	**49**	**16**	**3**

Source: Additional response to questions taken on notice during evidence16 February 2006, Professor J Spencer, Australian Institute of Health & Welfare, Dental Statistics and Research Unit

4.8 In relation to dental therapists, the table below demonstrates that NSW is relatively low in terms of the practising rate. It is noted that in NSW there are 83 dental therapists in the school dental services, which is significantly lower than the 330 dental therapists working in the Queensland school dental service.

Table 4.5 Dental therapists in 2003

	NSW	VIC	QLD	SA	WA
Practising	**195**	**152**	**354**	**128**	**309**
Practising rate (FTE per 100,000 population)	**2.4**	**2.3**	**7.9**	**6.4**	**11.2**
Average age	39.4	38.4	40.2	40.2	41.3
Public - School dental service	83	119	330	120	173
Public – Community centre	88	15	5	1	4
Public – Dental hospital	8	-	1	-	4
Public – Teaching institution	13	4	9	6	8
Private	6	15	9	1	125

Source: Additional response to questions taken on notice during evidence16 February 2006, Professor J Spencer, Australian Institute of Health & Welfare, Dental Statistics and Research Unit

4.9 The table below for dental hygienists demonstrates that NSW is significantly lower in terms of the practising rate. The Committee recognises that there are only five dental hygienists working in the public sector in NSW.

Table 4.6 Dental hygienists in 2003

	NSW	VIC	QLD	SA	WA
Practising	**104**	**122**	**81**	**134**	**88**
Practising rate(FTE per 100,000 population)	**1.3**	**2.0**	**1.6**	**6.1**	**3.8**
Average age	38.3	36.0	35.8	39.7	30.4
Private – general practice	77	96	59	101	66
Private – orthodontic	9	15	7	10	15
Private – periodontic	5	8	3	8	1
Private – other	9	1	-	1	1
Public	5	1	10	7	7
Teaching and other	-	1	1	8	1

Source: Australian Institute of Health & Welfare, Dental Statistics and Research Unit, Dental hygienist labour force in Australia, 2003

4.10 The table below demonstrates that NSW is relatively high in terms of the full time equivalent practising rate for dental prosthetists. The Committee notes the average age of dental prosthetists which, while comparatively low in NSW, is higher than the average for other sectors of the dental workforce.

Table 4.7 Dental prosthetists in 2003

	NSW	VIC	QLD	SA	WA
Practising	**308**	**268**	**125**	**29**	**84**
Practising rate(FTE per 100,000 population)	**5.3**	**6.1**	**3.8**	**2.1**	**5.0**
Average age	48.5	47.9	52.0	52.3	44.9
Self-employed	257	241	106	26	57
Employee – private practice	10	9	2	-	71

Employee – commercial laboratory	12	4	2	-	10
Government clinic/laboratory	17	11	15	3	-
Public education institution	5	3	-	-	2
Other	5	-	-		-

Source: Australian Institute of Health & Welfare, Dental Statistics and Research Unit, Dental prosthetists labour force in Australia, 2003

4.11 The table below illustrates the number of dental specialists. The data is extracted from that on dentists, and does not indicate the number of dental specialists practising in the public and private sectors nor the practising rate.

Table 4.8 Dental specialists in 2003

	NSW	**VIC**	**QLD**	**SA**	**WA**
Practising	**316**	**296**	**187**	**105**	**107**

Source: Additional response to questions taken on notice during evidence16 February 2006, Professor J Spencer, Australian Institute of Health & Welfare, Dental Statistics and Research Unit

4.12 The figures in the tables for the dental workforce and comparisons between states lead the Committee to believe that dental workforce issues are significant for all states. This has also been recognised by NSW Health, who advised that workforce planning has been identified as an important national issue requiring strategic consideration:

> All States and Territories are facing similar difficulties in recruitment and retention of public sector staff. In NSW, a review of oral health workforce requirements between 2000 and 2010 was completed and there were also concurrent State reviews of dental education and training needs and statewide and specialist services.[189]

Shortage in the dental workforce

4.13 The Committee heard from many witnesses and submissions that there is a shortage in the dental workforce. This was also highlighted in the *National Oral Health Plan 2004–2013,* which suggests that the number of oral health practitioners (general and specialist dentists, dental therapists, dental hygienists, oral health therapists and dental prosthetists) across Australia falls short of the numbers required to meet current need:

> The ability of the dental workforce to meet demand for dental services in both the private and public dental sectors is also deteriorating. Australia was ranked 19th in terms of practising dentists per 100,000 population out of 29 OECD [Organisation for Economic Cooperation and Development] countries for which data was available.[190]

4.14 Of concern is the age of the majority of dentists currently practising. As noted in Table 4.7, the average age of dentists in NSW in 2003 was 44.4 (the same average as in 2000), which means that by 2010 and beyond many dentists will retire from the workforce, or decrease their workloads. This was also noted in a paper by the Australian Health Policy Institute. With

189 Submission 254, NSW Health, p16

190 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013*", July 2004, p39

fewer dentists currently in the younger age groups and lesser numbers of recent graduates, the overall effect will be a diminished dental workforce.[191] The paper predicts with concern that the looming general shortage of dentists will further exacerbate difficulties 'for population groups already without access to adequate dental care: rural and remote dwellers, Indigenous people, and urban adults eligible for public dental care'.[192]

4.15 ADA (NSW) advised that the national dentist labour force is projected to increase from 8,991 in 2000 to 10,583 by the year 2015, an increase of 17.7%. However, ADA (NSW) commented that:

> While projected growth, up to the year 2010, is expected to slightly out pace population growth, by 2013 the practising rate per 100,000 population starts to decline, indicating that projected growth in the labour force will not keep pace with population growth in the longer term. Around this time a large number of baby boomers will begin retiring from the workforce. This will have serious implications for future service delivery.[193]

Dental practitioner requirements

4.16 The Organisation for Economic Cooperation and Development (OECD) average for the number of dentists per 100,000 population is 56. In Australia the average is 43 dentists per 100,000 population.[194]

4.17 A significant issue with respect to the dental workforce is not just the number of dentists per 100,000 but their geographical distribution and public/private distribution. Levels in capital cities do approach the OECD average with 51.2 dentists per 100,000 but rural areas have a much lower average of 28.7 dentists per 100,000 population.[195] This is also highlighted in Table 4.7. The Association for the Promotion of Oral Health (APOH) commented that in Sydney there are sufficient dentists to supply demand in the private sector (58.4/100,000). However a marked difficulty is seen in some rural areas where there may be as few as 16 or 17 dentists per 100,000 population.[196]

4.18 The NSW Institute of Rural Clinical Services and Teaching commented that an oral health workforce planning project by NSW Health in 2002 found that, in order to supply the projected demand for dental services in the year 2010, New South Wales would require an additional:

- 391 dentists
- 13 dental hygienists

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191 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p2

192 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia",* 2004, Australian Health Policy Institute, University of Sydney, p55

193 Submission 226 ADA (NSW), pp30-31

194 Submission 65, Association for the Promotion of Oral Health, p31

195 Submission 65, Association for the Promotion of Oral Health, p31

196 Submission 65, Association for the Promotion of Oral Health, p31

- 26 dental therapists and
- 32 dental prosthetists, above the numbers in 2000.[197]

4.19 The Institute suggested that, even though the authors do not explore issues specific to rural and remote regions, 'given the projected shortfall in numbers of dental personnel, it will become increasingly difficult to sustain dental services in rural and remote regions given the increasing needs of urban areas.'[198]

4.20 APOH also commented that 'an additional 437 public and private sector dentists would be required to have 50 dentists for every 100,000 persons resident in the State.'[199]

4.21 The Committee acknowledges that between 391 and 437 new dentists will be required in both public and private practice to meet predicted demand levels in 2010.

Shortage in public sector dental workforce

4.22 The vacancies and shortages in the dental public service are of significant concern. This shortage is demonstrated in the table below, provided by APOH, showing vacancies in 2002.

Table 4.9 Clinical Staff Vacancies in NSW Public Dental Services in December 2002

Staff	No. positions available	Vacancies	% positions vacant
Specialist Dentists	32.7	5.5	16.8%
General Dentists	342.8	69.2	20.2%
Dental Therapists	162.4	16.7	10.3%
Dental Assistants	544.1	49.3	9.1%
Dental Technicians & Prosthetists	71.6	4.2	5.9%

Source: Submission 65, Association for the Promotion of Oral Health, p36

4.23 The Committee was advised that there are consistently about 60 vacant positions for general dentists in the public system, with few specialist practitioners attracted to the public service. Similar shortages are seen for paradental professionals, in particular it is currently almost impossible to attract dental hygienists to the public system.[200] Table 4.5 shows that between 11% and 13% of dentists are employed in the public dental sector.

Factors contributing to the public dental services shortages

4.24 The *National Oral Health Plan 2004-2013*, prepared by the National Advisory Committee on Oral Health, states that barriers to recruitment and retention in the public sector include:

197 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p1

198 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p1

199 Submission 65, Association for the Promotion of Oral Health, p31

200 Submission 65, Association for the Promotion of Oral Health, p36

- low remuneration
- salary differences between jurisdictions
- salary differences between the public and private sector
- job satisfaction
- career structure
- lack of recognition of excellence
- lack of continuing professional education opportunities
- stresses associated with workload pressures
- the high proportion of emergencies and limited range of treatments offered
- the nature of the patient base and
- long waiting lists.[201]

4.25 Many of these issues were also highlighted by the Health Services Union, representing oral health workers in the public sector, as the main issues affecting employment in the public dental clinics. Dr Russel Lain, Health Services Union, and Staff Specialist, Sydney Dental Hospital, advised the main issues affecting the workforce were:

- retention and recruitment
- lack of defined and flexible career paths
- time pressure due to the high throughput of patients
- lack of experienced clinical support
- deskilling.[202]

4.26 Dr Lain described the daily situation:

> … we face on a daily basis … approximately 85 patients seeking emergency treatment at Westmead hospital, 150 people telephoning through the call centre to get access to the Sydney Dental Hospital and the satellite clinics servicing our area health service, and about 50 to 100 walk-ins daily at the Sydney Dental Hospital. That presents a fairly significant time pressure due to the high throughput of patients. [203]

4.27 Deskilling is a major problem in the public dental workforce for all workers because of the relatively limited range of treatment options that are provided to patients. This means that the dentists employed in the public sector, as well as the support staff and technical staff, do not

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201 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013"*, July 2004, p42

202 Dr Russel Lain, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital, Evidence, 16 February 2006, pp53-54

203 Dr Russel Lain, Evidence, 16 February 2006, p53

gain the experience in the broad range of treatment modalities that are routine in the private sector.[204]

4.28 Dr Lain commented that time pressure and deskilling creates morale problems, which then can lead to recruitment and retention difficulties for the public dental workforce. [205]

4.29 ADA (NSW) supported the view that current rates of remuneration make it difficult to recruit and retain dental officers in the public sector. The following table provided by the ADA (NSW) illustrates the significant salary differences that exist between public dental officer positions in New South Wales and Queensland as at July 2004.

Table 4.10 Table: Comparison of public dental officer salaries in New South Wales and Queensland as at July 2004

GRADE	NSW	QLD
Dental Officer Grade 1		
Year 1	$ 48,797	$ 65,602
Year 2	$ 52,508	$ 67,282
Year 3	$ 56,223	$ 68,954
Year 4	$ 59,935	$ 72,166
Year 5	$ 63,646	$ 73,932
Year 6	$ 67,361	$ 75,703
Year 7	$ 71,071	$ 77,462
Dental Officer Grade 2		
Year 1	$ 73,857	$ 79,340
Year 2	$ 76,635	$ 81,219
Dental Officer Grade 3	$ 79,793	$ 83,835
		$ 86,648
Dental Officer Grade 4	$ 83,135	$ 89,458
		$ 91,766
Dental Officer Grade 5	$ 87,776	$ 95,823
		$ 99,580

Source: Submission 226, ADA NSW, pp47-48

4.30 ADA (NSW) commented that salary differences between the private and public sector are even more extreme. For example, it is not unusual for a third or fourth year graduate to earn a salary of $130,000 or more. When this level of remuneration is compared to the public sector it is not difficult to understand why current graduates find employment in the public sector so unappealing. With a starting salary of less than $50,000 it takes seven years for a public sector dentist to earn over $70,000. [206]

4.31 Another competitor for graduating dentists is the private health insurance dental clinics. ADA (NSW) suggested that although private health insurance clinics are still relatively small in

204 Dr Russel Lain, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital, Evidence, 16 February 2006, p54

205 Dr Russel Lain, Evidence, 16 February 2006, p54

206 Submission 226, ADA (NSW), p49

comparison to the rest of the private sector, they are conceivably the single biggest competitor with the public sector for graduate dentist positions:

> Many graduates who would once have considered a role within the public sector now find similar conditions offered by private health insurance clinics only with much more attractive benefits and greater levels of job satisfaction…
>
> For example, a job advertisement for the role of dentist in a clinic run by a private health insurance fund in 2004 advertised the following package for a graduate with a 'minimum of two years post graduate experience:
>
> **Salary:**
>
> From $90,000+ per annum, commensurate with experience
> Up to 12% superannuation
> Up to $500 Health Insurance Subsidy
> Rural Incentive Scheme (***Conditions Apply*)
>
> **Benefits:**
>
> Average 38 Hour work week, for full-time positions
> Negotiable rostered days off
> Great physical work environment
> Corporate Health Program – Total Health
> Superannuation benefits
> Work/life balance programs
> Employee Assistance Program
> Supportive leave provisions
> Continuing education and training[207]

4.32 The table below summarises the different salaries of second year post graduate dentists as provided by ADA (NSW):

Table 4.11 Remuneration for dentists with 2 years post graduation experience

NSW public sector	QLD public sector	Private health insurance clinic	Private practice
$56,223	$68,954	$90,000	Up to $130,000

4.33 The Committee recognises that low salary is the primary disincentive to dentists entering and remaining in the public sector. In addition to low remuneration compared to the private sector, there are other barriers including lack of career path, time pressures and deskilling, all resulting in low morale for oral health workers in the public sector. Initiatives to address these issues to some extent are considered later in this chapter.

The shortage in the regional and rural dental workforce

4.34 Of particular concern to the Committee is the impact of the shortage in the dental workforce on regional and rural areas. The NSW Institute of Rural Clinical Services and Teaching advised that figures from 2002 show that there are about twice as many dentists per 100,000 people in metropolitan compared with rural areas (48 dentists per 100,000 compared with 28 dentists). The ratio increases to over three times when one compares the eastern suburbs of

[207] Submission 226, ADA (NSW) Ltd, p49

Sydney (89 dentists per 100,000) with rural areas.[208] This is also demonstrated in the table below with the practising rate for dentists in 2000 dropping significantly outside capital cities.

Table 4.12 Practising rate (number per 100,000 population) of dentists in 2000 for capital city and rest of state[209]

	NSW	VIC	QLD	SA	WA
Practising rate – Capital city	58.4	N/a	52.3	64.6	55.6
Practising rate – Rest of state	31.2	N/a	36.7	28.1	29.0

4.35 Specifically for public dentists, the Institute advised that in 2004 there were 2.6 public dentists per 100,000 people in rural areas compared with 3.6 per 100,000 people in metropolitan areas. However, within rural areas the ratio of public dentists ranged from one per 100,000 people in the previous Far West Area Health Service to four per 100,000 in the previous Northern Rivers Area Health Service. The impact of this undersupply in dentists is heightened when one considers the geographical dispersion of the population in rural and remote NSW.[210]

4.36 The Institute commented that 'oral health services in rural and remote NSW are largely provided by dentists and dental therapists … Dental hygienists and dental prosthetists provide limited public dental services, and currently are not widely employed in rural and remote areas.'[211]

4.37 In terms of dental specialities such as orthodontic and oral surgery, the Institute pointed out that rural residents suffered from a lack of access to specialist dental care and as a result many general dental practitioners have taken on a wider range of "specialist" dental procedures such as minor oral surgery, periodontal surgery and orthodontic care.'[212]

4.38 The Committee heard from Professor Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, that shortfalls in the labour force 'are always felt first and will be felt the hardest by those areas that generally have difficulty in recruiting their slice of the dental work force anyway', such as rural dental services and public dental services.[213]

4.39 The Committee acknowledges that the shortage in the dental workforce in rural areas is more significant than in urban areas and that the rural public dental clinics are worse off in terms of recruitment and retention of staff. The Committee visited Broken Hill to hear from local dentists and the area health service about what the oral health situation is in Broken Hill and the Greater Western Area Health Service. The following case study provides a picture of the situation in Broken Hill at the time of the Committee's visit in August 2005.

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208 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p2

209 AIHW, Dental Labour Force 2000, pp60-61 – Victoria was not included in the data collection. Similar practising rate figures were not available from the AIHW 2003 data.

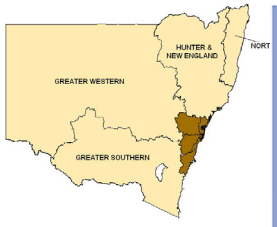
210 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p2

211 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p1

212 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p3

213 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p13

Case study: Public dental care in GWAHS



The Greater Western Area Health Service (GWAHS) gave the following information to the Committee during its visit to Broken Hill in August 2005.

GWAHS covers:
From the Victorian border in the south, Wentworth, Balranald, through to Queensland in the north, right from Tibooburra across to Collarenebri, and then it goes east to Bathurst, Mudgee and south along Cowra, Grenfell, Condobolin, Lake Cargelligo.

Population and space:
GWAHS is 58% of the geography of NSW, with a population of about 294,000 (similar to Newcastle's population). There are significant socioeconomic issues in the area, including 7.2% Indigenous population.

Public dental practitioners:
There are 68 full time staff positions for oral health services. Of those, 28 positions treat patients for example, dentists, dental therapists or dental prosthetists, and another 28 staff are dental assistants and 12 are administrative staff, including secretarial support and call centre staff.

The 10 dentist positions are distributed as follows:

- 2 in Bathurst
- 3 in Orange
- 2 in Dubbo
- 1 in Mudgee
- 1 in Broken Hill
- 0.5 position in Balranald
- 0.5 spread over the area health service in administration
- In Bourke there is private dentist who contributes half his time to treating public patients.

Vacancies:
Of the 28 treating positions there are 2 vacant positions that are for full-time dentists, one in Broken Hill and one in Orange.

There are dental therapist full-time vacancies in Condobolin, Orange, Bourke, a part-time position in Wentworth and a maternity relief position in Broken Hill. That represents 30% vacancy in the dental therapist workforce in the area.

Recruitment issues:
GWAHS commented that it has always been difficult to get dentists to work in rural areas and recently this has extended to dental therapists and dental prosthetists. Positions are widely advertised through newspapers, internet and dental recruitment agencies. Vacancies are also advertised in New Zealand and interstate.

Recruitment of prospective new graduates has recently provided a part-time dentist position in Bathurst and a full time dentist position in Dubbo. However, in relation to the vacancy at Broken Hill the decision was made to not recruit a new graduate as it is a solitary position in the area.

Services provided in 2004-2005:
GWAHS provided 78,837 occasions of service. Of those, about 37,000 were adults and 40,000 were children. There was 1,200 specialist services. Approximately 9,000 occasions were through the fee-for-service scheme (voucher issued for dental services carried out by a private dentist), which was predominantly for adults. GWAHS assessed approximately 20,000 children in schools. Approximately 13.5% of the services were for indigenous people.

Waiting lists:
There were 2,605 children on the waiting list, mainly waiting for preventive treatment (waiting times for children was not provided).

The adult waiting list is 5,704 adults. 1,417 of those are waiting for dentures the others are mostly waiting for treatment such as fillings and extractions. For adults who have pain, most would be seen within one week, or given a fee-for-service voucher.

Private dentists:
There are about 64 private dentists who work in the GWAHS boundaries. Of those, 36 participate in the oral health fee-for-service scheme (will treat public patients with vouchers) but only 14 of those 36 will do denture work as well.

Royal Flying Doctor Service (RFDS):
Since November 2004, the RFDS dentist has been working for the Greater Western Area Health Service four half days a month focussing on public patients in Broken Hill area. The RFDS dentist is also providing dental services to the local indigenous organisation – Maari Ma Aboriginal Corporation.

Funding:
The GWAHS is funded $37 per eligible person. Public dental care is primarily available for concession card holders and all 0-5 year olds and people under 18 years old in full time school/studies.

4.40 This case study of the GWAHS demonstrates an approximate practising rate of 3.4 public dentists per 100,000 population, if all dentist positions are filled. However, there were two vacant dentist positions, which reduces the rate to 2.7 public dentists per 100,000 population. This low number of public dentists in the GWAHS is exacerbated by distances in the region.

4.41 One means by which distances are addressed in the GWAHS is the Royal Flying Doctor Service (RFDS) dentist. The RFDS based in Broken Hill has one dentist, Dr Lynn Mayne, who covers an area of 640,000 square kilometres. Dr Mayne commented:

> I actually go to 15 clinics once you include stations such as Marrapina and Monolon. We stop off at stations and area people come into the station to be seen. I also cover Maari Ma Aboriginal Health Service … I also do the correctional services at Ivanhoe correctional health facility. At the moment I am also doing some work for the Greater Western Area Health Service, as it does not have a dentist. So I am doing all that. The Royal Flying Doctor Service clinics, I do approximately 150 and 160 odd clinics a year. I am seeing about 1,160 patients, clients or contacts.[214]

4.42 Dr Mayne advised the Committee that the level of services she provides is the same as a regular dental practice and only difficult oral surgical cases are referred. However, Dr Mayne stated that as there is no oral surgeon in the greater western area they are referred to other states, for example, Mildura in Victoria or Adelaide in South Australia.[215]

4.43 Dr Mayne advised that the number of dentists in the GWAHS, especially the Broken Hill area, was not satisfactory. Dr Mayne stated:

> We need another dentist or two, especially covering Maari Ma and some of the Greater Western Area Health Service at the moment as well. There is just not enough time. I am covering what I can cover to my satisfaction but I know that there is a list there all the time. I have been doing it for 7½ years. There is not a place I go to where there is not a list of people waiting.[216]

4.44 The Committee recognises the enormous effort contributed by the RFDS in servicing the oral health needs in the Broken Hill and Greater Western Area Health Service and believes that more needs to be done to encourage dental workers to work in rural and regional areas. Initiatives will be considered later in this chapter.

Conclusion

4.45 The Committee recognises the shortage in the dental workforce, especially in the public dental sector. The impact of the shortage on patients includes reduced access to dental services, increased waiting lists and times, reduction in access to preventive care and potential increase in pain and related ill effects as noted in Chapter 2. The effects of this shortage are not just on the patients but also on the workforce, with low morale, sense of deskilling and lack of career

214 Dr Lynn Mayne, Dentist, Royal Flying Doctor Service, Evidence, 31 August 2005, p1

215 Dr Lynn Mayne, Evidence, 31 August 2005, p1

216 Dr Lynn Mayne, Evidence, 31 August 2005, p2

path. These effects can then become barriers for recruitment and retention to the oral health public sector, particularly in rural and regional areas. Initiatives to address the shortages will now be considered.

Initiatives to address shortages in the dental workforce

4.46 The Committee is committed to a robust salaried public dental service and makes recommendations in this chapter to encourage the expansion of the public dental workforce. The previous sections have clearly demonstrated that there is a shortage in the dental workforce that is unlikely to improve in the future without changes to the current policies. There were a number of initiatives put forward by witnesses and submissions to address the shortage, some short-term and the majority longer-term solutions. The Committee notes that most of these initiatives will require funding commitments from both the State and Commonwealth Governments in order to be successful.[217]

4.47 This section specifically considers initiatives to address the shortage in the dental workforce by overcoming the barriers to recruitment and retention especially in the public sector, such as low remuneration and lack of career path, time pressures and deskilling. These initiatives include:

- increase of remuneration through award restructure
- better use of overseas trained dentists
- team approach
- promotion of rural dental practice.

4.48 Increasing the number of students training to enter the dental workforce will be discussed in the following chapter.

4.49 In evidence NSW Health advised that in terms of workforce issues they are currently involved in several initiatives to address recruitment and retention issues in the medium and long-term, including career pathways and remuneration. For example, Dr Robinson, NSW Health, advised the Committee:

> To attract dentists to the rural areas, we are looking at incentive packages, scholarships and clinical placements and a streamlined process for the entry of overseas trained dentists, aligned with the processes already in existence for overseas trained doctors. That is an interim measure in terms of addressing the work force issues.[218]

4.50 NSW Health commented that the NSW Centre for Oral Health Strategy is involved in the development of several approaches and initiatives that may be implemented to address recruitment and retention issues in the short, medium and long term. These include:

- developing career pathways in the public sector

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217 Submission 226a, ADA (NSW), p17

218 Dr Denise Robertson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p3

- reviewing state awards to ensure they cover the range of oral health professionals now employed in the public sector (eg dental prosthetists, Bachelor of Oral Health graduates)
- a coordinated approach to the recruitment of oral health staff
- a rural scholarship scheme and incentives for new graduates
- conversion courses for dental therapists to progress to the Bachelor of Oral Health
- review of the role of the dental assistant
- campaign to attract former clinicians back into practice (similar to "Reconnect" in nursing)
- clinical placements in rural area health services for final year dental students
- improved data collection on supply and demand.[219]

4.51 However, the Committee notes that, besides an Oral Health Workforce Group, which is also developing strategies, it is not clear what NSW Health has actually implemented in terms of these workforce planning initiatives.

4.52 In relation to these areas of development ADA (NSW) suggested that the likely success or implementation of these approaches will not happen without additional funding. In a supplementary submission, ADA (NSW) provided the following comments:

NSW Health Initiative	ADA NSW assessment of likely outcome
Developing career pathways in the public sector	Unlikely to occur in the absence of significant new funding for oral health services.
Reviewing State Awards covering oral health professionals	Meaningless in the absence of significant new funding for wage increases for public oral health staff.
A coordinated approach to the recruitment of oral health staff	We understand that progress to date on a number of initiatives has either not started or is very limited.
A rural scholarship scheme and incentives for new graduates	No rural scholarships currently in place. Incentives to encourage new graduates to practise in rural areas have had a disappointing response to date.
A conversion course for Dental Therapists to progress to the Batchelor of Oral Health	No arrangements currently in place, however if and when this occurs will be a result of initiatives of universities and not the Health Department.
Review of the role of dental assistants	This is not an activity being undertaken by the Department but is in fact being undertaken by the Community Services and Health Industry Skills Council
Campaign to attract former clinicians back into practice (similar to "Reconnect" in nursing)	There appears to be little if any progress made to date in relation to implementing this initiative.
Clinical placements in rural areas health services for final year dental students	The current program run by Sydney University and funded by ADA NSW is limited in both size and duration.

[219] Submission 254, NSW Health, p16

Improved data collection on supply and demand	No progress.

Source: Submission 226a ADA (NSW) Ltd

Remuneration

4.53 A number of submissions to the Inquiry have highlighted the need for increased remuneration through the restructure of the current State award scheme for public oral health practitioners. As a consequence of this, a clearer career path for oral health workers could be created. Below is a table depicting salaries under the existing State Award as at 1 July 2005.

Table 4.13 Starting and maximum salaries available under the State Award, as at 1 July 2005

	Dental Assistant	Dental Therapist	Dental Hygienist	Dental Technician	Dental Officer	Dental Specialist
Starting salary	$37,918	$39,536	$35,495	$41,542	$52,779	$88,913
Maximum salary	$45,739	$56,455	$38,544	$59,244	$94,938	$102,966

Source: Health Professional and Medical Salaries (State) Award, pp10-13

4.54 It should be noted that the Health Professional and Medical Salaries (State) Award, that covers oral health workers in the public sector, includes a 4% pay increase from 2004 to 2007. For example, the maximum pay rate for a dental officer will increase to $102,685 after 1 July 2007.

4.55 ADA (NSW) supported the introduction of a structured career pathway for public sector oral health professionals, however ADA (NSW) believed other factors are equally or more important:

> However, this support is heavily qualified by reiterating earlier statements about the acute need to overcome problems associated with remuneration, limited services and procedures available in public dental facilities and the pressures created by long waiting lists. Unless and until these problems are dealt with effectively, planning for and implementing career pathways will have little if any impact upon recruitment and retention because the only career pathway graduates will sensibly opt for will be straight into private practice, bypassing the public sector altogether.[220]

4.56 Associate Professor Cockrell, University of Newcastle, advised the Committee that the issues of awards and career progression are always on the agenda. Dr Cockrell commented that the first agenda item is awards and the lack of recognition of progression, and consequently the lack of a structured career pathway. 'It is not like medicine, where you do this job, then this job, and then you get to this position. You tend to fall into a career rather than have a career that is in any way guided for you.'[221]

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220 Submission 226, ADA (NSW) Ltd, p52

221 Associate Professor Deborah Cockrell, Head of Discipline Oral Health, University of Newcastle, Evidence, 14 November 2005, p18

4.57 As noted earlier in this chapter a barrier to attracting dentists to the public sector is the level of remuneration. Tables 4.10 and 4.11 demonstrate that remuneration for dentists in the NSW public dental sector is low in comparison to both private practice and even the Queensland public dental sector, with a maximum salary as at 1 July 2005 of $94,938.[222]

4.58 To combat this barrier to recruitment and retention in the public dental sector in NSW and hence potentially address the shortage of dentists in the public sector the Committee recommends that the award remuneration levels be reviewed for dental officers (dentists). The APOH recommended an increase of 30%.[223] The Committee is not in a position to determine how much the increase should be but strongly believes that the increase should be to a level that will attract dentists to the public dental sector. A comprehensive recommendation relating to awards is included following paragraph 4.85.

Dental therapists and dental hygienists

4.59 The new Bachelor of Oral Health (BOH) course at the University of Newcastle and the University of Sydney provides a career path opportunity for those already in the dental workforce and new entrants.[224]

4.60 Associate Professor Cockrell advised that for public sector workers undertaking the course a major concern is that the current State award does not recognise the level of skill that the graduates will have obtained. Therefore, they would return to the public sector as dental therapists at a lower salary than when they left as chair-side assistants. Associate Professor Cockrell provided an example:

> We have two students at the moment both of whom have worked on the coast as dental nurses, both of whom are highly motivated, both of whom would love to go back and work in those public clinics, but they probably will not because the salary is lower than the salary they were receiving when they left.[225]

4.61 Table 4.12, which provides the current salaries for dental therapists and hygienists, indicates that if a therapist or hygienist completes the BOH course they could re-enter the public sector on a lower wage than a dental assistant without a degree. This issue would need to be addressed before the first NSW trained BOH graduates become available in 2008.

4.62 The Association for the Promotion of Oral Health (APOH) advised that the public sector will be competing for BOH graduates against a private system paying in the order of $80,000 for hygienists' services. Unless salaries appropriate for a three-year university degree are offered, BOH graduates will not enter the public system. There appear to be no clear plans for the utilisation of these dental professionals. [226]

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222 Health Professional and Medical Salaries (State) Award, p10

223 Submission 65a, APOH, p4

224 Associate Professor Deborah Cockrell, Head of Discipline Oral Health, University of Newcastle, Evidence, 14 November 2005, p18

225 Associate Professor Deborah Cockrell, Evidence, 14 November 2005, p19

226 Submission 65, Association for the Promotion of Oral Health, p34

4.63 Professor Spencer advised the Committee that in South Australia about one quarter to one third of graduates from the Bachelor of Oral Health course enter dental therapy and the rest opt for dental hygiene. Professor Spencer notes the need to make dental therapy an enticing choice for graduates:

> … the school dental services in every State and Territory need to make working as a dental therapist a first-choice option for at least some of those people coming through the Bachelor of Oral Health programs.[227]

4.64 APOH advised that dental hygienists have a valuable role to play in delivering preventive services as well as in controlling periodontal disease and supporting special needs, aged care and orthodontics and should be better utilised in public dental health. However, there is a need to offer attractive remuneration packages to encourage hygienists to work in the public sector; as noted in Table 4.6 there are virtually no dental hygienists in the public dental sector and Table 4.12 indicates that dental hygienists get paid less than dental assistants in the public sector. APOH commented:

> For example, in Victoria hygienists are able to work independently in nursing homes. There are currently no dental hygienists providing clinical services in NSW Health. It is suggested that positions with sufficiently attractive conditions and remuneration be created. It is also noted that wages in the public sector are very low as compared with those available in private practice so that establishment of appropriate wage structures is important. [228]

4.65 The Committee believes that the State award for dental therapists and dental hygienists should recognise the level of skill the graduates in oral health have obtained. For this reason, and to encourage more dental hygienist to work in the public sector, the Committee recommends, as part of a comprehensive recommendation on State awards for oral health workers, that the State award for dental therapists and dental hygienists be reviewed to include recognition of the oral health degree from both the University of Newcastle and the University of Sydney (refer to Recommendation 12).

4.66 A further issue worth consideration in relation to dental therapists is their restriction to working in the public sector only. The Australian Dental and Oral Health Therapists Association (ADOTHA) advised in their submission that the dental therapy profession has been established in NSW for approximately 30 years, dedicated to providing primary dental care to the community, including clinical dentistry and oral health education and promotion.[229]

4.67 Dental therapists are currently restricted to the public sector as historically, training was funded by NSW Health. However, with the establishment of the Bachelor of Oral Health degrees ADOTHA suggests the restriction should be removed:

> As the education of dental therapists is no longer provided by the state there is no longer a viable argument that their employment be restricted to state government

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227 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p6

228 Submission 65, Association for the Promotion of Oral Health, p35

229 Submission 45, Australian Dental and Oral Health Therapists Association, pp4-5

> services. ADOTHA recommends that limits on employment be removed from the regulation of NSW dental therapists.[230]

4.68 In every other state the limitation imposed by employment restrictions on dental therapists has been recognised as both anti-competitive and detrimental to access to dental care for the public. NSW dental therapists are the only dental occupational group or health profession restricted to working within the public sector.[231]

4.69 Experience in other states has shown that broader employment of dental therapists has improved the relationships between dentists and dental therapists as their skills have become more widely understood and trusted. This has led to better team relationships, more collegial approaches to dental policy issues and continuing professional development, and more collaborative approaches across the dental workforce. [232]

4.70 There is a suggestion that dental therapists would migrate to the private sector due to increased pay rates, thus causing greater shortages in the public sector, which would have a dramatic impact on the public dental sector's services for children.[233]

4.71 ADOTHA commented in response that anecdotal evidence suggests that most dental therapists maintain a commitment to public sector work in combination with private sector work; this combination has been of benefit to the public sector because it has allowed dental therapists to broaden and develop their practice without the need for public sector organisations to restructure career hierarchies.[234]

4.72 ADA (NSW) cautioned against the extension of dental therapy to the private sector and advised that 'in the interests of public safety, it is clear that any regulatory body must carefully consider the competencies of each professional group before making any significant change.'[235]

4.73 The Committee notes that the dental therapist workforce is ageing as commented upon by the Wagga Wagga Community Health Dental Clinic:

> We are an aging group of ladies. We have 6 dental therapist with an average age of 40 years. The earliest graduated is 1975 the most recent is 1993. We are concerned that there will be no therapists ready to take our positions when we want to retire.[236]

4.74 The Committee shares the concern that graduates of the Bachelor of Oral Health course are not likely to replace those working in the public sector due to salary disparities between private and public systems. There is a danger that the school dental service will not be able to be staffed in the future. It is noted that with award restructuring this issue may be addressed.

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230 Submission 45, Australian Dental and Oral Health Therapists Association, pp4-5

231 Submission 45, Australian Dental and Oral Health Therapists Association, p5

232 Submission 45, Australian Dental and Oral Health Therapists Association, p6

233 Submission 45, Australian Dental and Oral Health Therapists Association, p5

234 Submission 45, Australian Dental and Oral Health Therapists Association, p6

235 Submission 226a, ADA (NSW) Ltd, pp 23-24

236 Submission 88, Wagga Wagga Community Health Dental Clinic, p2

4.75 ADOTHA also suggested the possibility of rasing the age limit for those who can be treated by dental therapists from the current 18 to 25 years of age. The Committee did not receive any further evidence on this issue so is unable to make a recommendation in this regard.

Dental prosthetists

4.76 In relation to dental prosthetists the Association for the Promotion of Oral Health (APOH) advised the Committee that there is no award for dental prosthetists and therefore, no formal guidelines on the employment, utilisation, pay rate or career structure for prosthetists in the public dental sector.

4.77 APOH suggested that it is necessary to create dedicated positions for prosthetists in the public dental workforce as it is accepted that dental prosthetists have the potential to significantly reduce waiting lists for dentures.[237]

4.78 APOH stated that there are currently 11 prosthetists working in the public sector: without an award, they are paid on an ad hoc basis by different public institutions. Incomes are significantly lower in the public sector as compared to private practice. Prosthetists greatly increase the clinical productivity of dental services by liberating dentists from direct patient contact in the preparation of straightforward dentures and also produce more dentures.[238]

4.79 The Committee believes that with a State award and consequently increased employment of dental prosthetists in the public sector there is a potential to address the denture waiting list for public patients in NSW. For this reason the Committee recommends, as part of a comprehensive recommendation on State awards for oral health practitioners, that a State award be created for dental prosthetists (see recommendation 12).

Dental specialists

4.80 The Committee heard that similar issues of remuneration impact on the recruitment and retention of dental specialists in the public dental sector. In particular, the time and costs involved in training to be a dental specialist are not reflected in the level of remuneration, as demonstrated in the table below:

237 Submission 65, Association for the Promotion of Oral Health, p35

238 Submission 65, Association for the Promotion of Oral Health, p35

Table 4.14 Training and costs for a specialist dentist

			Tuition Fees[239]		Income/Salary[240]	
	Degree/qualification	**Period (years)**	**HECS (total for course)**	**Non HECS (total for course)**	**Private**	**Hospital Public**
Primary degree	BMedSci BSc BA	3	$20,547	$54,000		
Dental degree	BDent BDS/BDSc	4 – 5	$32,047	$108,096		
General Practice[241]	Part 1 RACDS[242]	2	$2,000		$70,000-100,000+	$50,000
Specialist in training	MDSc DClinDent	3	$62,784			Registrar (0.6)[243] $35,083
Senior Registrar		1				$82,985
Total		**13**	**$117,378**	**$226,880**		
Post graduation salary/income					**$300,000 – 500,000+**	**$106,866**

Source: Submission 43, Dr Angus Cameron, Appendix 1

4.81 The Committee recognises the level of training and costs involved in becoming a dental specialist and acknowledges that the salary for a dental specialist in the public sector is significantly lower than the private sector. The Committee believes this is a barrier to the recruitment and retention of dental specialists in the public sector and recommends the review of the State award for dental specialists.

4.82 Dr Peter Duckmanton, Health Services Union, and Dental Specialist, Sydney Dental Hospital, stated that NSW Health has a plan to provide a career path for dentists in the public sector:

> I think you will find the Department of Health has got a plan in place where they have outlined three different streams, maybe four different streams, that people can move into: administration, clinical, research and teaching. This is a proposal they have put forward just recently, I believe.[244]

239 Quoted fees are for 2004-2005 and do not include CPI or other increases for future years.

240 Living expenses not included

241 Mandatory prior to commencement of specialty training (minimum only)

242 Primary Examinations Royal Australian College of Dental Surgeons completed within first 2 years

243 Junior Registrars are employed by Area Health Services at Westmead and Sydney Dental Hospital at 0.6 for 3 year MDSc degree program.

244 Dr Peter Duckmanton, Health Services Union, and Dental Specialist, Sydney Dental Hospital, Evidence, 16 February 2006, p58

4.83 However, NSW Health has not provided any specific details of this to the Committee.

4.84 It is clear that the public dental sector is in competition with the private sector and, in order to develop a comprehensive, salaried public dental workforce, it is necessary to encourage and attract more dentists, dental specialists, dental hygienists and dental prosthetists. The Committee believes that by restructuring the State awards for dental health practitioners and offering better remuneration and a more clearly identifiable career path, more dental health workers will be encouraged to join and remain in the public dental sector.

4.85 The Committee recommends a comprehensive re-evaluation of the State awards for dentists, dental prosthetists, dental hygienist and dental therapists as well as dental specialists.

4.86 The Committee recognises the cost to NSW Health of a substantial restructuring and increase in remuneration, but believes there is no alternative if the public sector is to provide adequate treatment and especially preventive care for patients.

Recommendation 12

That:

- the award remuneration levels be reviewed for dental officers (dentists) and increased to a level to attract dentists to the public dental sector
- the State award for dental therapists and dental hygienists be reviewed and remuneration levels increased to include recognition of the Bachelor of Oral Health degree from both the University of Newcastle and the University of Sydney
- a State award for dental prosthetists be created
- the State award for dental specialists be reviewed and remuneration levels increased.

Overseas trained dentists

4.87 Encouraging more overseas trained dentists to migrate to NSW was highlighted by witnesses and submissions as an immediate solution to address the shortage in the dentistry workforce, until more Australian trained dentists are available.

4.88 The Australian Institute of Health and Welfare in a report produced in 2003 suggested that as increased recruitment from Australian universities cannot contribute before 2007 at the earliest (predominantly 2008), some of the shortfall must be met by policies directed at the migration of overseas graduates and the review of current accepted qualifications.[245]

4.89 The Australian Dental Council is the body that certifies the qualifications of overseas trained dentists.[246] Currently, dentists who have graduated from the United Kingdom or New Zealand

245 The dental labour force in Australia: the position and policy directions, Spencer et al 2003, Australian Institute of Health and Welfare, p41

246 Dr Matthew Fisher, CEO, ADA (NSW), Evidence, 5 July 2005, p64

are immediately eligible for full registration in Australia. Dentists from other countries need to sit for examinations to be registered in Australia. [247]

4.90 The number of overseas trained dentists working in NSW is already significant. In terms of new membership of the ADA (NSW), there it is an equal split between overseas trained dentists through the Australian Dental Council and new graduates from the University of Sydney. Secondary to these is interstate membership applications, which are predominantly from South Australia.[248]

4.91 In NSW there is also a limited registration scheme under section 14 of the *Dental Practice Act 2001*. This allows overseas trained dentists, who at the time of application do not meet the requirements for full registration, to practise under limited registration. The NSW Dental Board specifies the conditions of limited registration for each applicant and the Minister for Health or a delegate must approve a suitable supervising dentist for each applicant. The scheme in NSW requires these dentists to practice in public sector oral health services in rural area health services. It is also expected that these dentists will pass the examinations of the Australian Dental Council within three years and therefore become fully registered dental practitioners.[249]

4.92 APOH advised that 'a number of such dentists are already employed by NSW Health, and expansion of this program is suggested.'[250] NSW Health confirmed there are five dentists currently working under limited registration in rural NSW.[251]

4.93 The NSW Institute of Rural Clinical Services and Teaching suggested it is necessary to be mindful not to create a two tiered system of only overseas trained dentists working in rural areas and Australian trained dentists working in metropolitan areas:

> While the use of overseas trained dentists has been often suggested as a possible solution to enhance rural/remote dental staffing, the counter view argued by Spencer and others is that such proposals "should be limited to the short term". They reason that these schemes rob young Australians of the opportunity to enter rewarding professions in the rural sector, lead to a two tier system where we will find Australian trained professionals in the city and overseas trained professionals in the bush and opens up a series of international equity issues. As such they argue that their use should be seen only as a temporary expedient and initiatives need to be put in place now that lead to future Australian trained dentists working in the rural sector.[252]

4.94 Issues with the current registration process for overseas trained dentists in NSW were highlighted by Dr Phillip Palmer, Director of Dentist Job Search, a company that recruits dentists on temporary visas from the United Kingdom and New Zealand to work in rural areas of Australia. Dr Palmer advised in his submission that he believes a two-pronged solution is necessary to address the shortage of dentists: increasing public funding for dental

247 Submission 254, NSW Health, p16

248 Dr Matthew Fisher, CEO, ADA (NSW), Evidence, 5 July 2005, p64

249 Submission 254, NSW Health, p16

250 Submission 65, Association for the Promotion of Oral Health, p38

251 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, p48

252 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p2

schools and varying the strict regulations that exist for some of the foreign dentists wanting to work in Australia, while maintaining high standards.[253]

4.95 Dr Palmer commented on the different eligibility criteria:

> … there are many dentists that have been registered and working in the UK for years, but who will fall into this second category of dentists needing to pass exams. I have personally spoken with a number of high-quality dentists from Sweden, Germany, and Holland with excellent English-speaking skills, and with degrees that enable them to work in the United Kingdom, who would consider positions in NSW, if the registration process was easier. The only problem is an anomaly in the acceptance of degrees.
>
> A dentist, who is qualified in Sweden, and then registers for practice in the UK, has no such ability to be immediately accepted into the workforce in Australia. In fact they would be treated the same as a dentist from Outer Mongolia as far as their acceptance here.[254]

4.96 Dr Palmer suggested that a relatively minor change in the registration guidelines to allow dentists who are registrable in, rather than graduated from, the United Kingdom to have immediate and automatic registration in NSW would result in a considerable difference to the dental workforce, and go a long way to alleviating the problem of shortage of providers.[255] The Committee notes the discrimination in the system in favour of only two countries, and suggests that a broader pool of overseas trained dentists should be examined. However, a decision to change the automatic registration criteria needs to be made by the Australian Dental Council, not NSW Health.

4.97 The Committee recognises that NSW Health has identified overseas trained dentists as a short-term solution to easing workforce shortages in rural areas. The Committee recommends that NSW Health consult with the Australian Dental Council to address issues relating to overseas registered dentists and to promote the limited registration scheme.

Recommendation 13

That NSW Health consult with the Australian Dental Council to address issues relating to overseas registered dentists and to promote the limited registration scheme.

Team approach

4.98 The team approach involves the better utilisation of allied dental health workers, such as dental assistants, therapists, hygienists and prosthetists, which in turn can free a dentist to focus on work that the allied dental health workers are not trained to carry out. The team

253 Submission 24, Dr Phillip Palmer, p1

254 Submission 24, Dr Phillip Palmer, pp1-2

255 Submission 24, Dr Phillip Palmer, p2

approach is a popular recommendation put forward in evidence and in a number of submissions, as well as being evidenced in the national oral health plan and in numerous research papers on oral health.[256]

4.99 The *National Oral Health Plan 2004-2013* advised that 'team models of care offer greater cost-effectiveness, together with an increased capacity to provide preventive care and oral health promotion, and to deliver services outside dental clinical settings'.[257]

4.100 The Plan also notes that 'greater integration of the range of oral health practitioner education has the potential to foster team dentistry, as well as retaining flexibility in education and training capacity to meet changing population needs'.[258]

4.101 The team approach is being promoted during oral health university study. The Faculty of Dentistry, University of Sydney advised that the team approach is a Faculty strength and effectively and efficiently utilises resources. Opportunities exist to extend this model with the integration of other oral health worker training and further education of allied health professionals such as medical practitioners, nurses, pharmacists, occupational therapists and physiotherapists.[259]

4.102 The Bachelor of Oral Health course at the University of Newcastle also supports the team approach. Associate Professor Cockrell commented:

> We also are encouraging them to work as oral health teams so that they take responsibility for how they work as a team and they work co-operatively, so that if someone cannot be there at eight o'clock someone else can be there at eight and they get to work as a team as students, thus mimicking what they are will be doing when they work in practice or clinics.[260]

4.103 Professor Spencer stated that other areas in health care are developing team approaches so it is reasonable to expect that oral health can go that way too. Professor Spencer commented:

> We can see the movement in the development of stronger teams in other areas of health care. It is commonsensical that a team approach with interesting combinations of skills and competencies is appropriate for dentistry as well. The main driver for how that team should be constructed is what sorts of services the individual members are best at providing, and what value we place on increasing certain types of services. So, if we want to increase the provision of preventive services to children in Australia, which is what we did in the early 1970s, then a school-based dental therapist would be an appropriate dental professional to introduce. If we want to increase the provision of certain services now, then we need to look at who has the skills and competencies

256 See Ms Kathy Vern-Barnett, Dental Assistants Association, and Ms Jenine Bradburn, Association of Dental Prosthetists NSW, Evidence, 3 August 2005.

257 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013"*, July 2004, p42

258 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013"*, July 2004, p40

259 Submission 240, Faculty of Dentistry, University of Sydney, p3

260 Associate Professor Deborah Cockrell, Head of Discipline Oral Health, University of Newcastle, Evidence, 14 November 2005, p21

> to be able to deliver that in an efficient way and ensure they have a presence in the dental team. [261]

4.104 The Committee supports the increased application of a team approach and recognises the benefits of freeing dentists' time by better utilising allied dental workers. This has the potential to allow public dentists to treat more than just emergency cases, which could reduce waiting lists and waiting times. It is hoped that such an approach would address the recruitment and retention barriers of time pressures on dentists and deskilling due to the lack of variety available when they are only able to deal with emergency dental care. The Committee believes this approach should be encouraged in the public dental sector. However, to create viable and effective teams there needs to be a full consort of allied dental health workers in the public sector.

Promoting rural dental practice

4.105 The shortage is more significant for rural public dental clinics than in urban public clinics. This was clearly demonstrated in the case study on the Greater Western Area Health Service (GWAHS) after paragraph 4.39. NSW Health highlighted a number of initiatives to promote rural dental practice including:

- final Year Student Placement Program
- dental Officer Rural Incentive Scheme (DORIS)
- limited registration for overseas trained dentists to work in rural areas.

Final Year Student Placement Program

4.106 NSW Health advised the Committee that the Final Year Student Placement Program in partnership with the Faculty of Dentistry, University of Sydney, area health services and ADA, is an initiative to promote rural dental practice.[262] As part of the curriculum for the Bachelor of Dentistry (started in 2001) offered by the University of Sydney, all final year students visit rural areas on a two-week rotation. Rural placements have occurred in Dubbo, Orange, Bathurst, Broken Hill, Tamworth, Albury, Griffith, Moruya and Newcastle.[263]

4.107 The University of Sydney advised that there is a broad agreement to extend the duration of this program and the potential to collaborate with partners including the Rural Medical Clinical Schools in Orange and Dubbo, Charles Sturt University and the GWAHS. The University also stated that to expand the program they will require additional teaching staff and infrastructure such as clinical facilities, accommodation for students and staff and information communication technology. The University advised that:

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261 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p13

262 Submission 254, NSW Health, p16

263 Submission 240, University of Sydney, p11

> To facilitate expansion of the rural initiative the Faculty applied for funding from the Department of Education, Science and Technology (DEST). The aims of this initiative are to extend the rural experience program for final year Faculty of Dentistry University of Sydney students; and to develop pathways to attract and admit students from rural backgrounds into the Faculty's undergraduate dental programs through collaboration with regional universities.[264]

4.108 While the Committee recognises that rural placements for final year students are a good way to encourage graduates to consider working in rural areas, this may not address the immediate and critical need for areas like the GWAHS. With consideration to the case study of GWAHS, students would need to be supervised and the program is limited when there is not a public dentist, such as in Broken Hill.

Dental Officer Rural Incentive Scheme (DORIS)

4.109 The Dental Officer Rural Incentive Scheme (DORIS) consists of a remuneration package of up to an additional $20,000 per year and limited rights to private practice within a public sector dental clinic.[265]

4.110 Dr Hill, NSW Health, advised that DORIS began in the mid 1990s.[266] There are currently 79 dentists practising under this scheme.[267] NSW Health provided the following table outlining the location of dentists partaking in the scheme:

Table 4.15 DORIS: Dentist numbers and locations

Area Health Service	Full time equivalent
Sydney South West	5.0
South Eastern Sydney/Illawarra	10.63
Sydney West	4.0
Northern Sydney/Central Coast	6.6
Hunter/New England	23.3
North Coast	11.8
Greater Southern	7.03
Greater Western	9.6
Justice Health	1.0
Total	**78.96**

Source: Answers to questions on notice taken during evidence 20 February 2006, NSW Health, Question 3

264 Submission 240, University of Sydney, p11

265 Submission 254, NSW Health, pp16-17

266 Dr Hill, NSW Health, Evidence, 5 July 2005, p16

267 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, p44

4.111 Dr Hill also commented that, unlike Queensland, where the incentive amount is scaled in relation to the remoteness of the area, in NSW a flat amount of $20,000 is paid regardless of remoteness. [268]

4.112 However, ADA (NSW) stated that 'despite the fact that a rural incentive scheme of up to $20,000 per annum applies for all dental officers employed outside the metropolitan area, this appears to have done little to encourage dentists to take up these positions.'[269] This is evidenced by the difficulties encountered by GWAHS in filling two vacant positions. ADA (NSW) commented in their supplementary submission that the DORIS is likely to be reviewed.[270] This was confirmed by NSW Health,[271] which stated that 'in the future, DORIS may also be available to dental specialists, therapists and technicians and to Bachelor of Oral Health graduates. The scheme may also link the size of the package to the remoteness of the communities served.'[272]

4.113 The Committee supports the review of DORIS but believes that more initiatives need to be considered to encourage dentists to rural areas.

Limited registration for overseas trained dentists to work in rural areas

4.114 As discussed previously, overseas trained dentists who are not eligible for full registration can apply for limited registration under section 14 of the *Dental Practices Act 2001*.[273] The Committee notes that the use of overseas trained dentists commissioned to work in rural areas as part of their limited registration has the potential to address the immediate shortage. However, currently there are only five dentists utilising this scheme. Therefore the Committee has recommended that limited registration be promoted to encourage more overseas trained dentists to work in the public sector in rural areas.

4.115 Overall the Committee believes that measures to promote rural dental practice need to be increased. The effectiveness of these initiatives seems limited in addressing the current and immediate shortage in rural areas. It is recommended that NSW Health consider additional incentives to encourage more oral health professionals to practise in rural areas.

Recommendation 14

That NSW Health consider additional incentives to encourage more oral health professionals to practise in rural areas.

268 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, p44

269 Submission 226, ADA (NSW) Ltd, pp47-48

270 Submission 226a, ADA (NSW) Ltd, p54

271 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 16 February 2006, p45

272 Submission 254, NSW Health, pp16-17

273 Submission 254, NSW Health, p16

Other solutions

4.116 NSW Health is developing a rural scholarship for a number of dentists who are presently undergoing training in their penultimate and ultimate year, with a view to working in the rural sector as an end result.[274]

4.117 Other solutions put forward in submissions included a collaborative program with Charles Sturt University (CSU) and the University of Sydney, and a team approach for dental practice, where allied dental staff such as therapists, prosthetists and hygienists are better utilised, as discussed earlier.

4.118 Professor Mark Burton, Faculty of Health Studies, CSU, advised there is an opportunity for the development of collaborative programs between the University of Sydney and CSU similar to what the CSU has done to increase the number of pharmacists in regional/rural areas. Professor Burton stated that:

> The current option being considered is a degree program that would see a regular cohort of rural sourced students being recruited by CSU, educated for an initial three year period, with appropriate curriculum, on one or more of its rural campuses and then articulating into the University of Sydney dental program. The latter would be bolstered by regular rural-based clinical experience programs within specific course streams.[275]

4.119 Professor Burton stated that additional discussions are being held in relation to connecting the University of Sydney's Bachelor of Oral Health degree program with CSU's indigenous health worker program offered from Dubbo:

> This would enhance the articulation pathways and entry of indigenous students into the areas of dentistry resulting in better dental care options for aboriginal communities. It also meets the strategy of broadening the potential professional outcomes for indigenous graduates to include oral technology as well as nursing and other health professions of relevance to key recruitment deficits.[276]

4.120 The Committee notes that such a collaborative program draws upon the suggestions in the *National Oral Health Plan 2004-2013* to encourage Australian graduates to take up positions in rural and remote areas for a specified period including:

- reimbursement of HECS
- more dedicated university places and scholarships for students from rural and remote backgrounds, and for Aboriginal and Torres Strait Islander students
- graduate incentive programs that offer a supported employment pathway into rural and remote areas.[277]

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274 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 16 February 2006, p45

275 Submission 42, Charles Sturt University, p3

276 Submission 42, Charles Sturt University, p3

277 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013"*, July 2004, p41

4.121 The Committee supports the collaboration between CSU and the University of Sydney and believes that this may encourage rural dental practice. However, it is a long-term solution, and a more immediate solution is also required to address the current need in rural areas.

4.122 The NSW Institute of Rural Clinical Services and Teaching suggested that the team approach and the better utilisation of allied dental health workers can also contribute to addressing dental demand in rural areas. The Institute commented that there has not been much emphasis in rural and remote areas on dental team approaches to providing various levels of dental care, and consideration should be given to increasing dental hygienist and prosthetist positions in the rural sector as an alternative to a dentist.[278]

4.123 The Committee acknowledges the benefits of the Institute's suggestion of better utilisation of allied dental workers through the team approach. However, the Committee notes that there may be similar difficulties in recruiting new Bachelor of Oral Health graduates to rural areas as there is in recruiting and retaining dentists. The team approach would be limited in areas such as the GWAHS, due to its overall staff vacancy levels. In general, a team approach would be limited unless there is increased recruitment of the full range of dental workers.

Conclusion

4.124 The AIHW reminds us that there is a need to recognise the link between dental workforce policy and oral health issues, for example, the level of care provided:

> The opportunity to link dental labour force policy to other issues in oral health and dental care should be explored ... Bringing vulnerable groups into programs that promote access to an acceptable minimum standard of dental care is a substantial challenge for dental policy. Cross-linkage to dental labour force policy, as outlined for sector and geographic distribution issues, is essential. It is necessary to consider the position of vulnerable groups in the overall context of dental labour force policy.[279]

4.125 This comment highlighted the need for a comprehensive oral health strategy that encompasses workforce issues and addresses the shortages.

4.126 The primary reason for lack of outcomes in relation to improvements for the oral health workforce is the non-commitment of new funding to oral health services. ADA (NSW) stated 'like previous workforce reports however, in 2002 and 2004, unless significant new funding is made available, implementation of these initiatives will be impossible.'[280]

4.127 The Committee also believes it is paramount that more funding is provided to implement a comprehensive range of workforce initiatives identified by NSW Health and the recommendations in this chapter, in order to immediately address the shortages in the dental health workforce.

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278 Submission 171, NSW Institute of Rural Clinical Services and Teaching, p4

279 The dental labour force in Australia: the position and policy directions, Spencer et al 2003, Australian Institute of Health and Welfare, pp43-45

280 Submission 226a, ADA (NSW) Ltd, 17

4.128 The Committee is mindful of Professor Spencer's comments on the need for a national approach or direction to workforce issues:

> No State is an island unto itself when it comes to issues of the labour force. It simply is not feasible for any State to think that it can somehow put a border or a boundary around this problem and produce more graduates out of its own universities and that will solve its problem as a State. Our dental work force has free and easy mobility to practise in any one of the eight States and Territories of Australia under reciprocal registration and mutual recognition issues. So no one State can solve this problem on its own. What we do need is a co-ordinated national strategy.[281]

4.129 In summary, it is necessary to break down and overcome the barriers in recruitment and retention to the public dental sector, such as low remuneration levels, lack of career path, time pressures and deskilling, to improve the level of service for patients. The Committee believes this can be done with increased funding and through implementing a comprehensive range of initiatives highlighted by NSW Health and the recommendations in this chapter, along with approaches and discussions on a national basis.

[281] Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p13

Chapter 5 Education and training

As discussed in the previous chapter, there is a shortage in all areas of the dental workforce. It has been identified that NSW needs between 391 and 437 more dentists and 39 more dental hygienists and therapists by 2010. An obvious way to address this shortage would be to increase the universities' output of dentists, dental specialists and other oral health workers. This chapter looks at the current education and training for dental professionals as well as fees for courses, the number of academics and funding issues. This chapter addresses Term of Reference 1(e) in relation to training of dental clinicians and specialists.

Training for dental professionals

5.1 The *National Oral Health Plan 2004-2013* stated that the dental education sector faces substantial challenges, including:

- the rate of graduates from Australian dental schools is approximately one-third lower than during the 1970s and at its lowest since the Second World War
- oral health courses are resource-intensive and further consideration of funding at the faculty level will need to be considered if schools are to sustain and increase the number of students
- recruitment and retention of teaching staff is severely undermined by salaries that compare very unfavourably to those in the private dental sector.[282]

5.2 The NSW Council of Social Services (NCOSS) commented in its submission that insufficient numbers of dental workers are graduating to replace those currently leaving the workforce:

> For example in the 1970's approximately 20 – 30 dental therapists would graduate compared to nine in 2004. For dentists there used to be 120 per year about 25 years ago and now there are only 80 (a quarter of which are international students who have to leave the country on completion of their course of studies).[283]

5.3 The following table provides information on oral health courses offered at Australian universities and indicates that there are numerous courses available across Australia. It should be noted that across the states the length of the course varies, and that some course are undergraduate entry while others are postgraduate entry:

[282] National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013"*, July 2004, p40

[283] Submission 200, NCOSS, pp13-14

Table 5.1 Oral health courses offered at Australian universities

State	University	Example of courses available
NSW	University of Sydney, Faculty of Dentistry	Bachelor of Dentistry Bachelor of Oral Health
	University of Newcastle	Bachelor of Oral Health
QLD	Griffith University, School of Dentistry and Oral Health	Bachelor of Oral Health (Dental Science, Oral Therapy and Dental Technology) Graduate Diploma in Dentistry
	University of Queensland, School of Dentistry	Bachelor of Dental Science Bachelor of Dental Studies Graduate Certificate in Clinical Dentistry Master of Dental Science Bachelor of Applied Health Science (Oral Health)
SA	University of Adelaide, Dental School	Bachelor of Dental Surgery Bachelor of Oral Health
VIC	University of Melbourne, School of Dental Science	Bachelor of Dental Science Bachelor of Oral Health Bachelor of Dental Studies Doctor of Clinical Dentistry Doctor of Dental Science
WA	University of Western Australia, School of Dentistry	Bachelor of Dental Science Bachelor of Science in Dentistry Master of Science in Dentistry Master of Dental Science

5.4 In terms of numbers of students graduating from dentistry courses, the Australian Institute of Health and Welfare provided the following information that demonstrates numbers have slightly decreased over the nine years from 1994 to 2003:

Table 5.2 Australian University dentistry course completions 1994 – 2003

University	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Sydney	41	45	49	38	31	61	52	54	58	61
Melbourne	46	44	53	49	42	44	46	45	45	48
Queensland	51	40	42	47	44	48	61	57	63	71
Adelaide	85	85	58	68	50	40	55	36	32	45
Western Australia	18	29	27	25	27	30	33	32	29	26
Total	**241**	**243**	**229**	**227**	**194**	**223**	**247**	**224**	**227**	**251**

Source: Australian Institute of Health and Welfare, Dental Labour Workforce 2003

5.5 There are also a number of TAFE institutions and other accredited training organisations that offer training for oral health, for example for dental assistants, hygienists and therapists.

5.6 Ongoing education is available to dentists through a number of organisations including the Australian Dental Association and the Royal Australasian College of Dental Surgeons, which are also involved in training dental specialists.

University of Sydney

5.7 The Faculty of Dentistry at the University of Sydney trains oral health therapists, dentists, specialists, and academics, and is a repository of oral health research and expertise.[284] The Faculty currently offers the Bachelor of Dentistry (BDent), which has recently replaced the Bachelor of Dental Surgery (BDS) degree. Students must already be graduates before they can apply for the BDent degree, which is a four-year course.[285]

5.8 Professor Eli Schwarz, Dean of the Faculty of Dentistry, University of Sydney, advised the Committee that there are 80 places in the BDent course, 45 higher education contribution scheme (HECS) places and 35 full fee paying places.[286]

5.9 The Faculty also offers a three year Bachelor of Oral Health (BOH), which was introduced in 2005, to train dental hygienists and dental therapists. This degree had 15 places in 2005 and 20 in the following years. The University advised:

> The BOH program is 100% Commonwealth funded to support its annual quota of 20, though it is unknown how long this will continue, or if the Faculty will be required to charge fees for domestic students in the future. This number of graduates is considered insufficient to maintain and enhance the dental therapy workforce into the future. The BOH program is currently not open to international students.[287]

5.10 The Faculty also offers a range of specialist training through postgraduate courses such as the Master of Dental Science (MDSc) program, with specialists graduating in Orthodontics, Paediatric Dentistry, Periodontics and Prosthodontics, Community Oral Health and Epidemiology and Oral Medicine and Oral Pathology. The Faculty commented that:

> Demand is high for the specialist training programs, although the intake quota for each is limited and competitive due to the resource intensive nature of the programs, and the limited number of specialist staff employed by both the teaching hospitals and the Faculty.[288]

Fees

5.11 There are 35 full fee paying places in the BDent course, which means students are liable to pay the tuition fee. The fees act as a disincentive for many who wish to take the BDent course and make it difficult for graduates to take up public dentists' positions on low pay when they may have high debts for tuition fees. Associate Professor Wendell Evans, University of Sydney, provided the following details on student fees for dentistry courses at the University of Sydney (for full fee paying students), which is also demonstrated in the table:

> The local student full fee amount for the BDent course in 2006 is $28,368 per year. These fees are indexed throughout the duration of the degree … there are also compulsory student union subscriptions, which range from $481 to $590. On top of

284 Submission 240, Faculty of Dentistry, University of Sydney, p3

285 Submission 240, Faculty of Dentistry, University of Sydney, p6

286 Prof Eli Schwarz, Faculty of Dentistry, University of Sydney, Evidence, 29 June 2005, p30

287 Submission 240, Faculty of Dentistry, University of Sydney, pp6-7

288 Submission 240, Faculty of Dentistry, University of Sydney, p7

> this, first semester BDent students will be required to purchase an equipment kit in order to carry out the requirements of the course. The combined cost of this kit and other course material incurred in the first semester is estimated to be about $3,000 and there will be subsequent costs throughout the course.[289]

Table 5.3 Example of fees for BDent course at the University of Sydney

	First year	Following years (x3)
Course fee	$28,368	$28,368
Subscriptions	$590	$481
Equipment	$3,000	
Total per year	**$31,958**	At least **$28,849/year** for a further 3 years
Overall total		**At least $118,505 for BDent[290]**

5.12 The fee for international students is $34,645 for 2006 with an additional amount of approximately $25,000 required for living costs.

5.13 Postgraduate course fees in dentistry at the University of Sydney range from $10,560 up to $21,120 for domestic students. Domestic PhD and MSc(Dent) students are covered under the Research Training Scheme, which is fee and HECS exempt, provided the student completes the degree within the minimum timeframe.[291]

5.14 Bachelor of Oral Health courses in NSW are Commonwealth funded, that is there are no full fee paying places although HECS applies.

Bachelor of Oral Health program at University of Newcastle

5.15 Associate Professor Deborah Cockrell, Head of Discipline of Oral Health, University of Newcastle, advised the Committee that the Bachelor of Oral Health (BOH) program was first offered at the beginning of 2005 at the University of Newcastle. The program was developed to fill a gap in oral health education in NSW. Associate Professor Cockrell stated:

> One of the aims was to offer a program in preventive oral health. The second aim was to provide extended rural and regional placements for dental students who were in their final year of studies at Adelaide and the third main agenda item was to introduce oral health education into a whole range of other health curricula within the faculty, so we now teach into every health course offered by the university.[292]

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289 Associate Professor Wendell Evans, Response to QON, from hearing on 14 November 2005, pp1-2

290 Not including subsequent costs and not accounting for indexation in fees.

291 Associate Professor Wendell Evans, Response to QON, from hearing on 14 November 2005, pp1-2

292 Associate Professor Deborah Cockrell, Head of Discipline Oral Health, University of Newcastle, Evidence, 14 November 2005, p14

5.16 The BOH is a three-year course with students graduating as a qualified dental therapist or dental hygienist or both, if a dual outcome degree is completed. The BOH focuses on community oral health, and oral health of the individual including target groups with poor dental outcomes such as the indigenous, children and rural residents. The course also involves visits and practice with these groups.[293]

5.17 There are 51 students enrolled in the BOH, with 48 of these being female. Associate Professor Cockrell advised the Committee that all of the students want to work in NSW once graduated, however the majority also want to work part-time. [294] Associate Professor Cockrell advised that next year 'we expect to take between 55 and 60 and we have HECS places available for all of our students.'[295]

Conclusion

5.18 It is interesting to note that the increased level of demand for dental care does not appear to have resulted in an increase in the intake into dentistry and oral health courses. The numbers graduating from the BDent course, even with the addition of overseas and interstate trained dentists, will not address the need of 391-437 dentists by 2010, and it is recommended that the number of places for this course be increased, in particular HECS places due to the high tuition fees for full fee paying places. It is noted that more funding would be required for such an increase as would more academics and infrastructure, which is considered later in this chapter.

Recommendation 15

That the NSW Government work with the University of Sydney and Commonwealth Government to increase the number of HECS places for the Bachelor of Dentistry course.

5.19 It is noted that with 80 graduates from the BOH courses in NSW by 2007-2008 there would potentially be enough graduates to reach the target of an additional 39 dental therapists and hygienists required by 2010. However, the Committee notes that, as mentioned by Associate Professor Cockrell, the majority of graduates would like to work part time. Further to this, consideration should be given to the fact that there may be an increase in demand for dental hygienists if, through award restructures, they are encouraged to move into the public sector. For these reasons the Committee recommends that the NSW Government, with the universities and Commonwealth Government, carry out a review of numbers and impact on the workforce of graduates from the Bachelor of Oral Health courses in NSW.

293 Associate Professor Deborah Cockrell, Head of Discipline Oral Health, University of Newcastle, Evidence, 14 November 2005, p17

294 Associate Professor Deborah Cockrell, Evidence, 14 November 2005, p17

295 Associate Professor Deborah Cockrell, Evidence, 14 November 2005, p17

Recommendation 16

That the NSW Government with the universities and Commonwealth Government carry out a review of numbers and impact on the workforce of graduates from the Bachelor of Oral Health courses in NSW.

Internship

5.20 A proposal raised during the Inquiry was an internship for dental graduates to ease the shortage in the public dental sector. The Association for the Promotion of Oral Health advised that there is no internship for dental graduates, who are able to gain full registration in NSW immediately upon graduation, in contrast to medical students. Because of this, the Dental Faculty of the University of Sydney has the responsibility to ensure a very high level of technical competence before graduation.[296]

5.21 NCOSS proposed in its submission to the Inquiry a 12-18 month internship in the public dental system for dentistry graduates. Ms Samantha Edmunds, Senior Policy Officer, NCOSS, commented:

> It is already on the drawing board to some extent. Our thoughts around it are that dentists leave the dental training system and are expected to be fully qualified and capable of going out and instantly providing dental treatment. Yet in the medical profession there is an internship period, when a person gets supported, supervision and guidance and develops their skills while practising under the supervision of someone with greater experience. It seems strange that there is that process for one health or medical profession but for another that can be dealing with some quite complicated and invasive treatments there is the expectation that they are able to just go out there and do it. So we see the internship as making better quality dentists.[297]

5.22 Mr Christopher Wilson, President, ADA (NSW), also supported the suggestion of an internship, which would help relieve the pressures that have been put on the university over the years about the amount of clinical time students receive.[298]

5.23 Mr Wilson did, however, comment that currently there is no structure to support an internship especially in the public dental sector where there is already strain on dentist numbers. Mr Wilson said:

> There would not be the supervision or the support that would be needed to benefit the first year graduate doing that sort of work. The range of procedures that could be done, as I think generally people have agreed, is very limited at the moment because of the pressure that the system is under. So if we can go down an internship route, it cannot happen until the structure to support it can be put in place, and that certainly will not happen overnight.[299]

296 Submission 65, Association for the Promotion of Oral Health, p11

297 Ms Samantha Edmunds, Senior Policy Office, NCOSS, Evidence, 5 July 2005, p29

298 Mr Christopher Wilson, President, ADA (NSW), Evidence, 5 July 2005, p62

299 Mr Christopher Wilson, Evidence, 5 July 2005, p62

5.24 When asked whether dental graduates should have a period of internship, Dr Robinson, NSW Health, advised that a voluntary internship could be an option but it would be very difficult to implement in a mandatory sense because it is not an expectation of the course, nor of the individuals at the present time.[300]

5.25 Dr Peter Hill, Principal Dental Officer, Oral Health Services Manager, Justice Health, NSW Health, suggested there should be further thought on the idea of implementing an internship in NSW, in relation to comparisons to other states in Australia:

> As far as that is concerned, in New South Wales the University of Sydney has a graduate entry dental program. The remainder of the States have an entry program straight from school so it is a bit different there. Certainly the feeling is that obviously if someone has already done a degree and then they have done a dental degree, that is seven years. I suppose, the other thing is that everything has to be done within the States because each State recognises the graduates from the other States. If you get one that falls out of line with an internship, it is just a matter of the person moving to the other State, getting registered there, and then coming back. That is an Australia-wide issue. It is certainly being looked at through the Australian Dental Council and the Australian Health Ministers as well.[301]

5.26 The Committee believes internships may be beneficial, for instance in having interns work in public dental clinics, but there are important practical issues, such as consistency in qualifications across Australia. Internships would not address the issue of shortages in rural areas in the short-term as supervision would generally not be available. However, the Committee believes it is worth investigating a program for graduating dental students similar to that undertaken by medical students, such as internships and specialist registrarships.

Recommendation 17

That NSW Health investigate the benefits of internships and specialist registrarships for graduating dentists, including the feasibility of achieving interstate mutual recognition.

Funding for university places

5.27 The Committee heard that dentistry is the second most expensive course to run in the university sector, falling just behind veterinary science. Dr Taylor, University of Newcastle, advised the Committee:

> If you have no existing teaching hospital against which to use the facilities that are there—which is the case in Newcastle and the Central Coast—first, you would have to build all those facilities, but you also need to have a very broadly trained range of specialist dentists to teach all the aspects of dentistry that you need to teach to a very

300 Dr Denise Robinson, Chief Health Officer and Deputy Director General, Population Health, NSW Health, Evidence, 5 July 2005, p14

301 Dr Peter Hill, Principal Dental Officer, Oral Health Services Manager, Justice Health, NSW Health, Evidence, 5 July 2005, p14

> high standard. Attracting people to work in the tertiary sector currently is not one of the easiest things we have found across Australia. To get high-quality dental academics is a struggle for many universities.[302]

5.28 The University of Sydney provided the Committee with details of funding for the Faculty of Dentistry. These are set out in the table below:[303]

Table 5.4 The total amount of funding the Faculty of Dentistry, University of Sydney receives[304]:

	Actual 12/2004	**Projected 12/2005**
Grants and HELP (including research grants)	3,011,474	3,900,183
Funded positions	517,128	601,124
Sub total	3,528,602	4,501,307
Student fees	1,883,562	2,256,716
Other income – donations, bequests, contract research	226,842	457,594
Total revenue	**5,639,006**	**7,215,617**

Source: Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

5.29 The University also provided a breakdown on where the funding comes from and it is noted that the majority comes from the Commonwealth Government, followed closely by full fee paying students. This is set out in the table below.

Table 5.5 The source of funding 2004-2005 for the Faculty of Dentistry at University of Sydney [305]

Source	**Value**
Operating grant from DEST based on student numbers (includes HECS)	$2,143,000
Student fees from full fee paying students	$1,883,562
Performance based income related to research output and post graduate students	$428,000
In-kind support from area health services	Not available (see next paragraph)

Source: Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

5.30 In relation to the in-kind support from the area health services, which is not direct funding but for example use of facilities free of charge, Professor Schwarz advised that by its nature

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302 Dr Jane Taylor, Senior Lecturer, Discipline of Oral Health, University of Newcastle, Evidence, 14 November 2005,p20

303 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

304 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

305 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

in-kind support cannot be easily converted to a dollar equivalent. However Professor Schwarz provided the following details on the level of support:

> The support provided by the Sydney South West Area Health Services and Sydney West Area Health Services comprise the entire clinical infrastructure for the Faculty of Dentistry at Sydney Dental Hospital and the Westmead Centre for Oral Health, including staff support, clinic support, patient support, conjoint academic and hospital staff positions, etc. Other Area Health Services in the state provide a variety of support functions for the Faculty's Practice Education Program, where final year students are placed in rural and regional clinics. The Faculty is not aware of any specific line item in the budgets of Area Health Services that indicate what this support amounts to.[306]

5.31 Professor Schwarz advised the Committee that the funding for HECS places in the Faculty of Dentistry at the University of Sydney has significantly decreased since 1999, with the HECS grant in 1999 producing 70% of their income compared to 33% of income in 2004. Therefore, 67% came from other sources including full fee paying students.[307]

5.32 With respect to HECS places for dentistry in 2005, the University of Sydney received $15,422 per dentistry equivalent full time student load (EFTSL) from the Commonwealth Government. However, the University estimates that the actual cost of teaching within the faculty in 2005 was $19,500 per annum per EFTSL.[308] The University advised:

> When the Faculty's and the University's costs [such as central student support, information technology and services and building infrastructure] are added together, there can be little doubt that the Commonwealth funding provided for HECS students in dentistry does not cover the full cost of their tuition. The quantum shortfall, however, is difficult to accurately quantify. [309]

5.33 In relation to how many places are available for students in the dentistry courses, Professor Schwarz stated that the number of places is constrained by the level of infrastructure for both the BOH and BDent courses. For example, both require access to clinical training using dental chairs and related equipment as well as academic staff numbers to offer teaching in a clinical environment.[310] Therefore, in order to increase student places an increase in infrastructure and academic staff would be required, which in turn means an increase in funding.

5.34 Conjoint appointments are one way of dealing with funding issues to cover an increase in staff numbers and potentially increase student places. Conjoint appointments mean that a professor or a lecturer could be employed by the university but the salary be paid by an outside source, for example NSW Health. Professor Schwarz explained that similar initiatives are in place with professional organisations and provided the following example:

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306 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

307 Prof Eli Schwarz, Evidence, 29 June 2004, p35

308 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

309 Correspondence, from Professor Eli Schwarz, Dean of Faculty of Dentistry, University of Sydney, dated 9 December 2005, to Chair.

310 Prof Eli Schwarz, Faculty of Dentistry, University of Sydney, Evidence, 29 June 2005, p30

> We also work with our other outside professional organisations, such as our position in orthodontics ... Those positions are funded by the Australian Society of Orthodontics, so that is another model that has been taken up by the faculty and that we are obviously very grateful for. There are a number of different ways that we can go about trying to further augment the funding that comes in direct allocations from the university.

5.35 It is clear that if more dentists are to be trained, more student places in the BDent course are necessary, which in turn means a need for more infrastructure and academic positions and, therefore, ultimately more funding. Academics will be considered in the next part of this chapter.

Dental academics

5.36 The Committee heard evidence highlighting the shortage of academic staff. NCOSS stated:

> The limited resources available to Australian universities, limited research opportunities and world shortage of dental academics is making it increasingly difficult to attract educational staff with the necessary specialist clinical and academic skills to deliver education and training programs. There are no full time academics for endodontics, crown and bridge work and periodontics.[311]

5.37 As noted in the previous chapter, one of the main reasons both for the shortage of specialists and the shortage of academics is the costs of pursuing these careers. Dr Angus Cameron, a specialist paediatric dentist in the Sydney West area, advised the Committee in his submission to the Inquiry that it is almost impossible economically for a dentist to pursue an academic career, which impacts on training of future dentists. Dr Cameron highlighted:

> In order to become an academic in a specialist discipline (eg Orthodontics, Paediatric Dentistry) a prospective student must complete 4 degrees and over 16 years of training:
>
> - Primary degree — 3 years (BA, BSc etc)
> - BDent — 4 years
> - General practice experience — 2 years (mandatory prior to commencement of graduate degrees)
> - MDSc — 3 – 4 years specialist training
> - PhD — 4+ years
>
> Following the completion of this pathway, they would be appointable at Senior Lecturer level with a salary of $84,000 (including clinical loading), while their newly qualified graduates would be earning a similar amount after 2 years of employment and 8 years less training. The fees involved in undertaking such training would be in

311 Submission 200, NCOSS, pp13-14

> the order of $100,000 (for Commonwealth funded positions) to $230,000 for local fee paying places. [312]

5.38 Dr Cameron advised that the cost of training for an academic may be prohibitive to taking up an academic career in a specialist dental field. For example, a Senior Lecturer may earn $86,079, however the training would have cost at least $117,378 (refer Table 4.79). A dental specialist who undertook the same training could earn between $300,000-$500,000 in the private sector.[313] This demonstrates the stark contrast between the level of remuneration for an academic and a dental specialist working in the private sector, even though both go through the same training and pay the same fees.

5.39 Dr Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons, pointed out that 'wages are not at all attractive to specialists going into the teaching field in the university. They are quite considerably lower than they would be for the equivalent medical specialist and much lower than private practice.'[314]

5.40 The Association for the Promotion of Oral Health (APOH) stated that there is an international shortage of dental academics and that this contributes to the difficulty in attracting academics to the dental faculty in NSW, as wages are comparatively low and support for research and conference travel lacking. Also, despite the central role of the University in the development of the workforce and improved clinical procedures, university funding for dentistry remains inadequate.[315]

5.41 APOH stressed that it is particularly difficult to attract specialist practitioners to either universities or the public system:

> The effect of this is that training in specialist areas for undergraduate students, postgraduate students and specialist trainees is severely compromised. This has progressed to the extent that there is now an acknowledged shortage of specialists in most areas of dentistry. This shortage is most keenly felt in the public system where wages and conditions are less attractive than in private practice while rural and regional areas have only extremely limited access to specialist services.[316]

5.42 APOH summarised that the shortage of specialists is due to the combined effects of:

- the absence of fully funded registrar positions
- the absence of sufficient consultant specialists in the public system providing training
- insufficient staffing and infrastructure in the Faculty of Dentistry
- significant fees charged by the University for specialist training in dentistry

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312 Submission 43, Dr Angus Cameron, p2-3

313 Submission 43, Dr Angus Cameron, p2-3

314 Dr Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons, Evidence, 16 February 2006, p22

315 Submission 65, Association for the Promotion of Oral Health, p41

316 Submission 65, Association for the Promotion of Oral Health, p38

- inadequate remuneration in the public system.[317]

5.43 To address these many issues the Royal Australasian College for Dental Surgeons supported a rotation system for specialist training to help avoid deskilling:

> Yes, the college supports … a system of specialist training, which is a similar model to the medical specialist training. You would have dentists who went in as registrars and could then rotate through the country dental clinics and then they could be mentors for the interns, newly graduated dentists who could also rotate through the country areas. This would be one way of addressing manpower issues within the public sector and the rural community.[318]

5.44 The Committee acknowledges that more academics are needed if an increase in student numbers is to happen and for this reason recommends that the NSW Government work in collaboration with the Commonwealth Government to address the issue of remuneration for dental academics and the corresponding need to increase funding.

Recommendation 18

That the NSW Government work in collaboration with the Commonwealth Government to address the issue of low remuneration for dental academics, and the corresponding need to increase funding.

Conclusion

5.45 The Committee recognises that more Commonwealth funding is required to increase the number of university places for oral health and, correspondingly, increase academic staff and infrastructure. It is acknowledged that this is a long-term solution to address the shortage in the dental workforce. A comprehensive range of initiatives is required to address the shortage in the dental workforce, including the recommendations in the previous chapter.

317 Submission 65, Association for the Promotion of Oral Health, p38

318 Dr Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons, Evidence, 16 February 2006, p29

Chapter 6 Demand for and access to public dental services

This chapter addresses Terms of Reference 1(a), (b) and (c) will provide information concerning:

- an assessment of the current demand for public dental services, including the issue of waiting times for treatment
- the quality of care received in private and public dentistry
- access to public dental services, with particular reference to rural and regional issues and special needs groups
- possible alternatives for providing increased access to public dental services.

Current demand for public dental services in New South Wales

6.1 A large proportion of the submissions and evidence indicate that the public dental system in New South Wales is under great strain, in terms of waiting times for access to treatment, the type and range of treatment that is provided, increased strain on other health services, and related issues, such as difficulties faced by those working in the public system. As one senior dental officer employed by an area health service stated:

> The public dental service in New South Wales is seriously overloaded. Waiting times are somewhere between excessive and infinite. Most patients will never receive comprehensive dental treatment at even a basic level. The main priority is relief of pain and the level of dental disease is so high that we cannot cope with it.[319]

Occasions of service

6.2 NSW Health reported that there has been a significant increase in the number of occasions of service provided to eligible users of public dental services. The term 'occasion of service' is used to measure levels of activity in public dental services, and is defined as the reported number of dental visits[320]. The table below sets out the occasions of service from 1999 to 2005 in NSW public dental facilities:

319 Submission 53, Dr John Webster, South Eastern Sydney Illawarra Area Health Service, p6

320 Submission 254, NSW Health, p12

Table 6.1 Trends in provision of services

Dental Program	Occasions of Service Per Year					
	1999/00	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**
Children	493,473	454,083	516,468	549,230	550,900	532,904
Adults	606,096	536,296	752,583	885,941	844,665	786,118
Specialists	50,914	57,235	80,128	86,612	76,509	73,029
Total	**1,150,483**	**1,047,614**	**1,349,179**	**1,521,783**	**1,472,074**	**1,392,051**

Source submission 254 NSW Health, p12; supplementary submission 226a, ADA (NSW) Ltd, p10

6.3 NSW Health asserts that there has been an increase of almost 30% in occasions of service in the past five years.[321] However, the Australian Dental Association (NSW Branch) (ADA (NSW)) contested this assertion by pointing to the fall of activity from 2002/03 to 2004/05. The Association believes that the term "occasion of service" is inaccurately defined as being the number of dental visits by patients; a call to the central call-centre, and an assessment of a condition, are both counted as occasions of service, even though the patient has not received any treatment. For this reason the Association contended that the measure is not useful and can be misleading.[322] The Committee notes that while it is a useful measure there has been a clear decline in service since 2002/2003, which was preceded by an increase between 1999/2000 and 2002/2003.

Waiting times under the Priority Oral Health Program

6.4 NSW Health introduced the Priority Oral Health Program in 2000 to ensure that public dental services in New South Wales are provided on the basis of need, ensuring that people with the greatest oral health need receive the earliest attention rather than treatment being given on a first come, first served basis.[323] Patients seeking dental treatment through the public system are categorised according to level of need using an information system for oral health. The table below sets out the recommended times under the Priority Oral Health Program in which patients should be able to access treatment:

Table 6.2 Priority Oral Health Program Code Summary Table

Priority Codes	Categories of Care	Recommended Access Time for Care
1 & 2	Emergency (trauma & serious medical condition)	<24 hours (Code 2 <3days)
3 a & b	Acute (pain)	<5 to <10 days
3 c	Loss of social function (dentures)	<3 months
4 – 6	Routine treatment	<12 months

Source submission 254, NSW Health, p13

321 Submission 254, NSW Health, p12

322 Supplementary submission 226a, ADA (NSW) Ltd, p10

323 Submission 254, NSW Health, p12

6.5 Dr Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, stated in evidence that for less urgent conditions it may take two to five days to access treatment, and for routine assessment and preventive care it may take several weeks to several months.[324] In contrast, ADA (NSW) stated that public dental facilities are so overwhelmed with meeting the demands of emergency patients (codes 1 and 2) and those suffering acute pain (codes 3a and 3b) that little, if any, other treatment is ever undertaken in public dental facilities.[325] It is suggested that some adult patients may never be offered an appointment due to their low priority status under the Priority Oral Health Program and the overall demand for services.[326]

6.6 Ms Catherine Osbourne, Area Manager, North Coast Area Health Service, provided information concerning eligible patients in the area waiting for treatment under the Plan. Ms Osbourne reported a waiting list of 2,542 adults and 620 children. With respect to the adults, there was no waiting list for emergency care (codes 1 and 2) and for acute care (code 3a) there was a waiting time of between five and eight days. With respect to the other codes the times varied, with some patients in code 6 (check-up and routine treatment) waiting for four and a half years.[327]

6.7 The waiting times with respect to children in the area are set out below:

Table 6.3 Child access to public dental services in North Coast Area Health Service

Priority Codes	Number of children	Waiting times
1 & 2 (emergency)	Nil	Nil
3 a & b (acute)	15	over 2 months
3 c	140	over 4 months
4 – 6 (routine)	667	up to 19 months

Source Ms Catherine Osbourne, Area Manager, North Coast Area Health Service, Evidence 23 August 2005, p30

Waiting lists

6.8 The issue of waiting lists under the Priority Oral Health Plan and the length of time it takes patients to receive treatment in the public system is the subject of a large number of submissions, as highlighted by the Greater Western Area Health Service:

> Given that dental conditions can be prevented, and treatment outcomes are better when treatment is provided early (a filling compared to an extraction), waiting times are a major issue for patients reliant on public dental services.[328]

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324 Dr Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, Evidence, 5 July 2005, p4

325 Supplementary submission 226a, ADA (NSW) Ltd, p12

326 Submission 206, Greater Western Area Health Service, p4

327 Ms Catherine Osbourne, Area Manager, North Coast Area Health Service, Evidence 23 August 2005, pp27-28

328 Submission 206, Greater Western Area Health Service, p4

6.9 The current demand for dental care far outstrips the public services available; UnitingCare Burnside quoted data from the Senate Community Affairs Reference Committee, which found that, of the approximately 500,000 people on waiting lists around Australia for public dental treatment, only 11% receive treatment each year.[329]

6.10 Within New South Wales evidence to the inquiry detailed waiting lists ranging from two to four and a half years at local clinics and hospitals,[330] and waits of three to ten years for other services such as dentures.[331]

6.11 The Sydney South West Area Health Service is the largest health service area in terms of population, covering close to 20% of the NSW population. The area has 570,000 adults and children eligible for public dental services in the region. Each month over 4,000 adults and 1,600 children seek care in the area. At the end of April 2005 there were 20,810 adults and 5,333 children waiting for general treatment in the Area, on waiting lists of two and a half years for children, and of over four and a half years for adults.[332]

6.12 Dr Angus Cameron, a specialist paediatric dentist, noted that there are currently over 650 children waiting for a general anaesthetic for dental treatment at the Westmead Hospital. The list is increasing at a rate of over 15% per annum, with many children less than three years of age waiting over 12 months for treatment, and there are similar waiting times in other area health services.[333] Generally the waiting time for children to access public dental services is less than for adults when they are in pain, however there are longer waiting lists for dental prevention check ups. The primary school dental checks provide some form of on-going care for children but these check-ups have been reduced in frequency, as discussed in Chapter 6.[334]

6.13 Dr John Webster from the South Eastern Sydney Illawarra Area Health Service believes that the current system could work now, if each patient only had one problem but, because the system has not been keeping up with demand since its inception, the number of problems that each patient has is increasing.[335]

6.14 Finally, in contrast to the demand for public dental services, ADA surveys indicate that the average private dental practitioner has approximately 90 minutes of unbooked time each week.[336]

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329 Submission 199, UnitingCare Burnside, p15

330 Submission 206, Greater Western Area Health Service, p4; submission 201, Dr Stephen Cox, p1; submission 216, Gunnedah Branch of the Combined Pensioners and Superannuants Association, p2; submission 6, Mr Elbary East, p1; submission 7, Mrs Shirley Davis, p3

331 Submission 26, Mr Kevin McLennan, p1; Mr Thomas Kennedy, Councillor, Broken Hill City Council, Evidence, 30 August 2005, p4

332 Submission 96, Sydney South West Area Health Service, p5

333 Submission 43, Dr Angus Cameron, p2

334 Submission 199, UnitingCare Burnside, p17

335 Submission 53, Dr John Webster, South East Sydney Illawarra Area Health Service, p3

336 Submission 76, Royal Australasian College of Dental Surgeons, p4

6.15 The Committee notes that while the Priority Oral Health Program was designed to provide equitable access to public services within realistic time frames, the evidence demonstrates that patients are not receiving adequate treatment within the time frames recommended. ADA (NSW) stated in its submission that the system does not help to overcome poor oral health in the community but in fact exacerbates existing problems due to lack of funding resulting in emergency care predominating over routine and preventive care.[337] As Dr Webster stated:

> we have far too many patients to spend much time on each one. We put patients on waiting lists from which they do not emerge.[338]

6.16 The Committee also notes that the evidence suggests that patients who are able to self-fund private dental treatment receive services that are among the best in the world. However, the overstrained and under-resourced public dental system is limited to providing emergency, acute treatment to patients, who are therefore being deprived of the preventive and comprehensive treatment necessary to reach a satisfactory level of oral health. This is contrary to the equitable distribution of care that the Public Interest Advocacy Group believes should be available:

> patients who access dental care through public funding – whether through a public dental clinic or a private practitioner with vouchers – should receive care that is equal to that received by private patients.[339]

6.17 The Committee recommends that the issues of waiting times and the type of treatment available to public dental patients be addressed in a review of the Priority Oral Health Program.

Recommendation 19

That the Priority Oral Health Program be reviewed, with particular reference to waiting times, to ensure that patients in the public system receive adequate treatment within reasonable time frames.

Quality of care received in dental services

6.18 Issues affecting the quality of care received in dental services discussed in this section include:

- A comparison of care provided in private and public dental services
- Quality of public dentistry equipment
- Consequences of lack of treatment of oral disease
- Use of resources in general health services
- Increase in demand for dental services in the future.

337 Supplementary submission 226a, ADA (NSW) Ltd, p11

338 Submission 53, Dr John Webster, South Eastern Sydney Illawarra Area Health Service, p2

339 Submission 145, Public Interest Advocacy Group, p7

Private dental services

6.19 As previously noted, the majority of Australians seek self-funded, private dental treatment. Professor Spencer stated in his research that the quality of such care and its ability to improve the wellbeing of its recipients is widely accepted.[340] ADA (NSW) added that Australia's best oral health services are equal to the best in the world.[341] Patients using private dental care are easily able to access comprehensive services and are more likely to seek preventive treatment.

6.20 Private health insurance covers an extensive range of oral health services, and preventive dental services are increasingly being requested by members and reimbursed by health funds at a higher level than other dental services. It is also noted that a number of health insurers offer three consultations and visits per year for dental health checkups, while others pay for oral hygiene advice and other measures to encourage preventive treatment.[342]

Public dental services

6.21 NSW Health monitors the quality of care provided in public dental clinics using an evidence-based framework encompassing six quality of care indicators, namely, effectiveness; consumer participation; access; safety; efficiency and appropriateness. Directors and managers of oral health services, and senior dental clinicians, are responsible for monitoring and improving the quality of care provided in public dental clinics, according to methods set out in the table below:

Table 6.4 Quality of care initiatives

Initiatives	Dimensions of quality
The development of protocols for referring patients to specialist services	Appropriateness
A requirement for closer monitoring by the Areas of private practitioners involved in the Oral Health Fee For Service Scheme (OHFFSS) and the Pensioner Denture Scheme	Safety, access, efficiency
Regular feedback to the Centre about Area Health Services performance reflected in the number of Occasions of Service provided	Efficiency
Refinements to the Information System for Oral Health (ISOH) to generate data about service mix, treatment provided, workload and other factors that clinicians and managers can use to assess quality of care.	Effectiveness, access, safety, efficiency and appropriateness
Collaboration with Areas regarding the introduction of several of the Australian Council on Health Care Standards (ACHS) indicators of quality of care and the introduction of improvements where required.	Effectiveness, appropriateness

Source submission 254, NSW Health, p24

340 Professor A John Spencer, "*What options do we have for organising, providing and funding better public dental care*?", 2001, Australian Health Policy Institute, University of Sydney, p1

341 Submission 226, ADA (NSW), p2

342 Dr Francis Cunningham, General Manager, New South Wales, Australian Health Insurance Association, Evidence 16 February 2006, pp79-80; Mr Angus Norris, General Manager, Health and Benefits, MBF Australia, Evidence 16 February 2006, p81

6.22 NSW Health believed that quality could also be assessed by the satisfaction of patients who were able to access public dentistry services, and provided the table below demonstrating its findings in that respect. It is noted that the table does not include the views of patients who did not receive public dental treatment.

Table 6.5 Satisfaction with public dental services provided

Year	Number of Adults providing information	Estimated number of users of public dental services	Excellent %	Very Good %	Good %	Fair %	Poor %
2004	no figure provided	274,400	26.2	35.2	23.2	7.9	7.4
2003	13,088	213,900	31.5	32.7	21.2	7.7	6.9
2002	12,622	227,200	25.7	32.0	23.4	8.0	10.8

Source submission 254, NSW Health, p25

6.23 It is useful to view the quality of public dental care provided, first, with respect to the quality of the work done and, secondly, with respect to the breadth of services provided.

6.24 The Greater Western Area Health Service stated in its submission that the quality of clinical care provided in public dental clinics is generally of a high standard,[343] a view that is supported by many of the submissions.[344] As one staff member of a public dental clinic in Wagga Wagga stated:

> … the quality of the staff working in our clinic is top class. We are a very hard working group of people trying to do our best for our patients. Most of the time this is not appreciated, but we work on, knowing that we are doing a good job for the public health. The quality of care given to patients is also of an excellent standard. We would love to see everyone wanting dental treatment, and do all the work for them – but time, staffing and budget constraints prevent this happening.[345]

6.25 The Council of Social Services of NSW (NCOSS) believed, however, that while the public dental professionals are doing the best they can with limited resources, the current system dehumanises both the workers and patients.[346] Workers at the Wagga Wagga Community Health Dental Clinic reported being subjected to abuse by patients who had become impatient waiting for treatment.[347]

6.26 Dr Webster noted that the quality of care provided suffers most greatly with respect to the type and extent of work able to be provided to patients.[348] Many of the submissions commented on the fact that public dental services are not available unless patients present with acute symptoms, thereby denying preventive treatment and early intervention, and

343 Submission 206, Greater Western Area Health Service, p3

344 Submission 99, Ms Julie Osbourne, p1

345 Submission 85, Ms Jennifer Lang, Wagga Wagga Community Health Dental Clinic, p5

346 Submission 200, NCOSS, p4

347 Submission 85, Ms Jennifer Lang, Wagga Wagga Community Health Dental Clinic, p4

348 Submission 53, Dr John Webster, South Eastern Sydney Illawarra Area Health Service, p1

eventually requiring more extensive and invasive treatment. As stated by the Sydney South West Area Health Service:

> Oral Health Service clinics are overwhelmed with meeting the demand for high-priority care. Adult patients without pain but seeking care for known problems, and those seeking a check-up or preventive services, are placed on waiting lists, which continue to grow in length and in waiting time. Those patients who present with pain have their pain relieved and are then placed on a waiting list for general care. Few patients except those with the most devastated mouths, or those with severe medical problems, have been called from general care waiting lists for many years. [349]

6.27 The Royal Australasian College of Dental Surgeons noted in its submission that:

> The funding of dental services in NSW is inadequate to provide quality dental care to those members of the community eligible for publicly funded dental treatment. Consequently treatment is directed towards alleviating acute pain conditions in the most economical manner possible rather than instituting treatment modalities, which provide for optimal dental health.[350]

6.28 In evidence Mr Christopher Wilson, a practicing dentist and President, ADA (NSW), stated that:

> … there is certainly a very big demand for the emergency services. That means that a disproportionate amount of resources have to be devoted to that aspect of dental care in the public sector at the moment … The amount of resources that I in a private practice situation would devote to emergency care is only maybe a 10% proportion of my resources. I have no doubt that the public clinics I know of have to devote a lot more of their resources to that.[351]

6.29 Users of public dental services expressed dissatisfaction with the type of treatment they received, particularly with respect to the use of extractions where the tooth could have been saved if comprehensive treatment was available, and lack of general and preventive treatment.[352] Many submissions commented on the overuse of extractions as acute treatment, even though modern best practice recommends that teeth be retained where possible,[353]as the public services do not have the time and resources to provide courses of comprehensive treatment.[354]

6.30 The Sydney Dental Hospital, situated in the Sydney South West Area Health Service, performed 17,939 extractions in the year from April 2004 to April 2005, and endodontic treatment on only 727 teeth. It is noted that nearly half of emergency public oral health patients have extractions (46.2%) and, as there is little general care able to be provided in the public system, patients find themselves in a cycle of deteriorating oral health and repeated

349 Submission 96, South Sydney West Area Health Service, p5

350 Submission 76, Royal Australasian College of Dental Surgeons, p5

351 Mr Christopher Wilson, President, ADA (NSW), Evidence, 5 July 2005, p56

352 Submission 30, Morisset Senior Citizens & Pensioners Association, p1; submission 102, Mr David and Mrs Norma Parkes, p1

353 Submission 76, Royal Australasian College of Dental Surgeons, p2

354 Mr Christopher Wilson, Evidence, 5 July 2005, pp56-57

extractions.[355] Dr Sameer Bhole of the Sydney South West Area Service explained that in public dental patients the maintenance of teeth by endodontic treatment is limited first by the extensive state of breakdown of the teeth due to lack of routine treatment and secondly by the limited capacity to restore such teeth due to the duration and expense of endodontic treatment.[356]

6.31 The difficulties faced by those seeking comprehensive public dental treatment in an overstrained system are well illustrated in a case study presented by the Public Interest Advocacy Centre.

Case study

In August 1996 Rebecca had extensive problems with her teeth, including decay, and she was placed on the dental waiting list for a full or partial denture plate for her top teeth. Rebecca made regular enquiries but was never told how long she would have to wait for treatment. After eight years, in mid-2004, Rebecca was offered an appointment, and underwent assessment and x-ray. She was advised that, given the extent of decay in her teeth, they should be extracted and that a full denture plate was necessary. As Rebecca had difficulty attending the clinic due to its distance her files were transferred to a closer clinic to which she could walk. At the new clinic she was again assessed and x-rayed.

In November 2004 Rebecca had her teeth extracted in hospital and suffered an infection. She was told that she should attend the public dental clinic for further treatment, and received two vouchers (under the Oral Health Fee for Service Scheme) for treatment from a private dentist for a full denture plate for the top of her mouth and for a filling in one of her bottom teeth. The dental clinic advised the dentist as to which tooth required filling, and Rebecca believes that the dentist filled the wrong tooth, which remains painful and unfilled.

In December 2004 Rebecca was fitted for her dentures. She was only able to wear the denture for one to two hours a day due to the pain, and was unable to eat wearing it. In February 2005 some alterations were made to the denture but the problems persisted. The dentist was not able to see Rebecca for any further appointments as the value of the voucher had been used. To date, Rebecca does not have dentures that she can wear, and her general health is suffering due to her limited diet. She has been put into contact with a private dentist who is willing to complete the necessary dental work for free.[357]

6.32 Many of the submissions featured similar stories and difficulties resulting from a lack of comprehensive treatment over a reasonable period of time. Under the public system patients are also frequently treated by different dentists, making it difficult for the dentists to monitor and provide consistent treatment.

Conclusion

6.33 The Committee notes that patients of the public system are being deprived of preventive and comprehensive treatment that could alleviate dental conditions, and are suffering the consequent ill-effects of dental disease that could be avoided by adequate treatment. As previously stated, the Committee firmly believes that more comprehensive and preventive treatment needs to be provided by public dental services to address this issue. The issue of preventive treatment is discussed in the following chapter.

355 Submission 118, Sydney South West Area Health Service, p5

356 Submission 96, Dr Sameer Bhole, Sydney South West Area Health Service, p5

357 Submission 145, Public Interest Advocacy Centre, pp4, 5

Quality of public dentistry equipment

6.34 NSW Health described the facilities in its area health services as normally being 'first-class'.[358] However, many submissions provided evidence contrary to this assertion. Associate Professor Hans Zoellner, Chairman, Association for the Promotion of Oral Health, advised that there is little consistency as to the quality of equipment across area health services, with some Services better equipped than others, resulting in patients living in poorly equipped areas receiving lesser treatment.[359]

6.35 The Greater Western Area Health Service explained that many of the public dental clinics were designed over thirty years ago, and are today still using the original dental operating units and chairs. The Service's submission commented that:

> … there is a need for a significant capital investment to replace old equipment and to provide premises which meet functional requirements for service delivery and which meet the needs of patients including disabled access.[360]

6.36 The Royal Flying Doctor Service also commented on the quality of equipment available, and advised that equipment failures frequently cause suspension of service for considerable amounts of time due to the lack of technicians to undertake repairs. The Service cited the example of the White Cliffs Health Service Clinic, which despite a recent upgrade, has not been operational since October 2004 due to the lack of a dental chair and other related equipment, and noted that similar disruptions to service have occurred at two other remote clinics.[361]

6.37 The Health Services Union advised that many smaller dental clinics do not have a lot of the equipment necessary to provide anything besides emergency treatment, due to funding considerations.[362] The Association for the Promotion of Oral Health stated that there is currently little funding provision for ongoing maintenance and replacement of equipment in public dental services, resulting in public dental clinicians feeling constrained by insufficient equipment resources.[363]

Conclusion

6.38 The Committee notes that public dental clinics cannot provide adequate treatment without equipment of a certain quality, and that this issue is directly linked to matters of funding. The Committee recommends that the standard of equipment at public dental clinics, particularly in rural and remote areas, be reviewed to ensure that it is adequate to deliver a satisfactory level of treatment to patients.

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358 Dr Peter Hill, Principal Dental Officer, NSW Health, Evidence 5 July 2005, p16

359 Associate Professor Hans Zoellner, Chairman, Association for the Promotion of Oral Health, Westmead Centre for Oral Health, Evidence 29 June 2005, p8

360 Submission 206, Greater Western Area Health Service, p3

361 Submission 122, Royal Flying Doctor Service, p2

362 Dr Peter Duckmanton, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital, Evidence 16 February 2006, p55

363 Submission 65, Association for the Promotion of Oral Health, p24

Recommendation 20

That the standard of equipment at public dental clinics, particularly in rural and remote areas, be reviewed to ensure that it is adequate to deliver a satisfactory level of treatment to patients.

Access to public dental services

> Oral health is becoming increasingly polarised in Australia … Higher income Australians enjoy ready access to dental care of the best quality. A large segment of middle social position Australians have acceptable access to dental services and are able to purchase adequate dental care. However, a sizeable minority of middle and lower income Australians are deprived of access to acceptable dental care, either because of the inadequacies of the torn and tattered safety net of public dental services or their inability to purchase an adequate scope of private dental care.[364]

6.39 The Sydney South West Area Health Service reported that complaints from users of public oral health services centre on access; 69% of complaints the Service received in a six month period focussed on patients' inability to access care.[365] Access to public dental services has been extensively discussed in previous chapters, particularly with respect to funding, lack of an adequate dental workforce and waiting times. In addition to the large number of barriers already faced by public service users, the submissions reported two further factors affecting accessibility, the first being transport. Many submissions commented on the difficulties faced by users in negotiating public transport, particularly in rural areas, to access services that are often located in unfamiliar areas.[366]

6.40 Secondly, the accessibility of services also depends upon users' knowledge of the types of treatment available. UnitingCare Burnside reported one person as stating, 'low socio-economic families don't know how to access free dental services. Kids don't have experience of going to the dentist'. UnitingCare Burnside therefore suggested that education and the provision of information in this area is vital.[367]

Access in rural and regional NSW

6.41 Many of the submissions highlighted the issues faced by patients in rural and regional areas, particularly with respect to access to services. Access is most affected by the lack of both private and public dental practitioners in local facilities, as extensively discussed in Chapter 4, resulting in many patients having to travel in order to receive public dental care. NCOSS reported that at a recent consultation it was informed 'eventually it will not matter whether

364 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p1

365 Submission 96, Dr Sameer Bhole, Sydney South West Area Health Service, p9

366 Submission 199, UnitingCare Burnside, p19

367 Submission 199, UnitingCare Burnside, p20

you are rich or poor and living in a rural area as you will not be able to find someone to treat you regardless of the money you have'.[368]

6.42 Public dental services are provided to rural areas of New South Wales under the NSW Rural Health Plan. The NSW Rural Health Priority Task Force reported that in 2001 approximately 71% of the New South Wales population lived in metropolitan areas, 21% lived in inner regional areas and 8% in outer regional and remote areas, of which less than 1% lived in areas classified as remote or very remote. Indigenous people comprise almost one-third of the population of very remote areas. Income in rural areas tends to be lower, with a higher proportion of people relying on public dental services (5.8% in rural areas as opposed to 3.9% in urban areas).[369] One member of the NSW Farmers Association stated, 'as a result of the drought and poor commodity prices [the farming community] are not accessing dental professionals as they cannot afford to'.[370]

6.43 As a result of reduced access to services people in rural areas have poorer general levels of oral health. Compared with residents of urban areas, rural residents:

- have more tooth decay in children
- have more missing teeth (6.3 compared to 5.2 for urban residents)
- have a higher number of decayed teeth (4.1 compared to 3.0 for urban areas)
- are more likely to have no natural teeth (9.2% compared to 5.5% in urban areas)
- have more full dentures (20.9% compared to 16.4%)
- undergo more extractions (21.6% compared to 17% for major cities)
- have less frequent dental check-ups
- have fewer preventive dental treatments
- have less access to fluoridated water supplies.[371]

6.44 In describing the standard of oral health of patients in rural and remote areas, Dr Lyn Mayne of the Royal Flying Doctor Service commented:

> The indigenous population has very poor [oral] health and very poor general health as well. The non-indigenous population is in the same boat because of its remoteness. It is little things like fuel prices to drive eight hours to see a dentist. That has to come into the question. Because of the drought they cannot afford to leave the property to go to a dentist. A lot of them put up with a lot of pain and a lot of poor teeth and oral health because of that.[372]

368 Submission 200, NCOSS, p9

369 Submission 196, NSW Farmers Association, p5

370 Submission 196, NSW Farmers Association, p5

371 Submission 170, NSW Rural Health Priority Task Force, pp1-3

372 Dr Lyn Mayne, Dental Officer, Royal Flying Doctor Service, Evidence 31 August 2005, p3

Rural dental workforce

6.45 The problems faced with respect to the lack of dental practitioners were extensively discussed in Chapter 4. The Association for the Promotion of Oral Health reiterated that while Sydney has approximately 58 dentists per 100,000 residents, the Central West Area Health Service has 17.3 dentists per 100,000 population, and that some rural and remote areas have no dental services at all.[373] The Association also noted that there is an inequitable distribution of public health dentists across New South Wales. Patients from metropolitan areas have access to substantially more public health dentists on a population basis (11.05 per 100,000 residents) than those in rural areas (1.05 per 100,000 residents).[374]

6.46 As noted in the case study in chapter 4 (paragraph 4.39) on the Greater Western Area Health Service, the Service covers 58% of the geographical area of New South Wales, incorporating Broken Hill, Bathurst, Dubbo and Orange, with a population of people of approximately 300,000 scattered across that area. It reported a high rate of dental staff vacancies, particularly for dental therapist positions. The lack of workforce affects the waiting times for treatment, with an adult waiting list comprising 5,074 patients, (1,471 for dentures), and a child waiting list comprising 2,605 children.[375]

Case study

Dr Lyn Mayne of the Royal Flying Doctor Service is the sole dentist employed to cover an area of 640,000 square kilometres, servicing at least 1,160 patients and clients and providing 150 to 160 clinics per year. Her clinics include stations, the Maari Ma Aboriginal Health Service, the Ivanhoe correctional facility and some dentistry for the Greater Western Area Health Service, as it does not have a dentist.

For seven and a half years Dr Mayne has provided all of the dentistry for eligible patients in the area, with only serious oral surgical cases being referred, generally to either Mildura or Adelaide, as there is no oral surgeon in the area. Dr Mayne advised that demand for services exceeds her capacity to respond and that at least one or two additional dentists were required, particularly to cover the Maari Ma Aboriginal Health Service. She also advised that there is not one location or clinic she attends where there is not a list of people waiting.

There are no other staff members to assist Dr Mayne, although there is a student program in place between the Royal Flying Doctor Service and the University of Sydney, whereby dental students assist for between one and three weeks.

Dr Mayne reported that funding is inadequate, with many of the clinics not being fully equipped, even after being recently upgraded, resulting in her having to carry between 50 and 120 kilos of the Service's own equipment. Dr Mayne also advised that the budget for items such as dentures ($5,000) had not increased in seven and a half years, despite increasing need, allowing her to provide just seven sets of dentures per year to the patients in the entire area. The dentures are sent to Victoria to be made, as there is no local prosthetist to construct them.[376]

373 Submission 65, Association for the Promotion of Oral Health, p27

374 Submission 65, Association for the Promotion of Oral Health, p33

375 Ms Linda Cutler, Director, Clinical Operations, and Ms Jennifer Floyd, Oral Health Network Manager, Greater Western Area Health Service, Evidence 31 August 2005, pp19-21, 24

376 Dr Lyn Mayne, Dental Officer, Royal Flying Doctor Service, Evidence 31 August 2005, pp1-11

Services provided

6.47 The NSW Rural Health Priority Task Force reported that there are greater private than public dental services provided to country regions. The Task Force advised that in order to provide public specialist services, outreach programs connected to the dental hospitals in Sydney have been developed to build the capacity of public and private rural oral health services and improve access to training. Regional and rural oral health centres have also been developed to deliver more specialised oral health services and improve training and research opportunities such as paediatric, orthodontic and oral maxillofacial surgery.[377]

6.48 NSW Health provided the following list of outreach programs provided in rural and remote areas:

- Queanbeyan: paediatrics programs providing specialist consultation, limited treatment and referral services as well as local staff up-skilling
- Orange: paediatric clinics provided one day per month by Westmead Centre for Oral Health, expanded to include Telehealth; orthodontic services one day per month
- Dubbo: orthodontic services (privately contracted) for 6 hours per month; Orthodontic fee for service for complex cases
- Bathurst: two oral surgery sessions per month
- Lithgow: Westmead Centre for Oral Health paediatric program extended some services to Lithgow in October 2005, for a six month pilot to reduce waiting lists
- Wagga Wagga: oral surgery program
- outreach programs introduced in Coffs Harbour, Kempsey and Hunter
- Westmead Centre for Oral Health programs in Coffs Harbour (monthly paediatric and orthodontic services), Albury and Hunter (monthly paediatric services)
- two dental officers rotated to Lithgow for two days per week from January 2005
- an outreach endodontics pilot program commenced in January 2005 to the Illawarra.[378]

6.49 The Association for the Promotion of Oral Health reported that while there have been some attempts by specialist practitioners to rotate to some regional centres, there are insufficient specialists available to provide regular services across most of the State and only a few specialist disciplines are represented in current rotations.[379]

6.50 NSW Health advised that there are currently 11 mobile dental vans in use in rural areas, based at Menai, Warren, Wentworth, Trundle, Blayney, Kandos, Moulemein, Junee, Wagga Wagga, Dempsey and Lismore. A review of the vans in 2002 found: that where possible dental services should be relocated to fixed clinics; that the vans should be phased out if a suitable

377 Submission 170, NSW Rural Health Priority Task Force, p9

378 Submission 254, NSW Health, pp4,5

379 Submission 65, Association for the Promotion of Oral Health, p17

clinic is within a half-hour drive from the van location; and that the older and smaller vans should be phased out.[380] NSW Health also stated that while the vans provide access to different areas they do raise issues of infection control and occupational health and safety.[381] As a result of the review, the number of vans in use has decreased from 33 go 11, and van closures will continue over the next two years.[382]

6.51 Ms Susan Harris, Dental Therapist and Dental Manager, Durri Aboriginal Corporation Medical Service based in Kempsey, reported that the service had a mobile dental unit (known as the Molar Patroller) that was not in operation as the truck required upgrading. Ms Harris reported that the unit was an important component in the service providing treatment to rural and remote areas:

> … the mobile dental unit was acquired through a demonstration grant in 1996. It was a one-off grant that was only limited for 12 months. After that 12-month period we did not receive any funding to upgrade it, to continue maintenance and the running costs and we had lost the Commonwealth Dental Health Program, so the funding came out of our limited child budget. Just over the years we have not had the funding to maintain the mobile patroller. We have an expression of interest that we have submitted to the Department of Community Services proposing funding for an early intervention dental program, targeting families that reside in isolated and rural and remote areas. We are hoping to utilise the mobile patroller again and take the service to the community if we receive funding for it. I would think the same as area health, we are under-funded.[383]

6.52 The Royal Australasian College of Dental Surgeons referred to the now-defunct dental trains, set up with a surgery, and the use of mobile vans to go into rural areas and also supported the use of such units as an effective way of providing rural care, provided that infection control could be properly managed and funding was available.[384]

6.53 Rural service providers also co-operate through funding arrangements and agreements, and sharing equipment and premises, to provide the most comprehensive treatment possible to a wide range of patients. Such arrangements are in place, for example, between the Royal Flying Doctor Service, the Greater Western Area Health Service and Maari Ma Aboriginal Corporation.[385]

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380 Answers to questions on notice taken during evidence 16 February 2005, Dr Margaret Robinson, NSW Health, Question 4, p47

381 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, Evidence 16 February 2006, p46

382 Answers to questions on notice taken during evidence 16 February 2005, Dr Margaret Robinson, Question 4, p47

383 Ms Susan Harris, Dental Therapist & Dental Manager, Durri Aboriginal Corporation Medical Service, Evidence 23 August 2005, p49

384 Dr Andrew Howe, Foetal Toxicology, Faculty of Medicine, University of Sydney, Evidence 16 February 2006, pp32-33

385 Dr Lyn Mayne, Dental Officer, Royal Flying Doctor Service, Evidence 31 August 2005, p12

Travel to receive treatment

6.54 Many submissions commented on the need for people in rural areas to travel in order to receive treatment, with an average travelling distance estimated of at least 100 kilometres,[386] and submissions noted times of two to eight hours, often without public transport services.[387] The Health Services Union reported that in some rural areas there is no public transport and private bus services cost $30 for one adult and child, which means that families will only attend for emergency rather than on-going treatment.[388] UnitingCare Burnside reported:

> A major issue for those living outside rural town centres is that there is no public transport available. One respondent indicated that some people may need to drive for two hours. If they don't have their own car they have to rely on others for a lift, making it difficult to plan and attend dental appointments.[389]

6.55 Even in rural areas where public dental services are available, public dental patients face the added burden of often having to travel long distances to receive specialist services.[390] Patients in Broken Hill who require oral surgery are required to travel to Sydney, Adelaide or Mildura, however an orthodontist does visit the area once a month.[391] Dr Stephen Cox, of the Westmead Centre for Oral Health, noted that many patients are required to travel to the two dental hospitals in Sydney for specialist oral health services, as there is almost a complete lack of such services west of the Great Dividing Range.[392]

6.56 Dr Peter Duckmanton, representing the Health Services Union, advised that dentists in rural areas lack access to specialist help. Dr Duckmanton suggested that it would be useful to establish a system of video conferencing or electronic transfer of radiographs and other such information to allow rural practitioners to obtain a provisional diagnosis. It was noted that such systems exist for the transfer of information between rural and metropolitan hospitals but not for dentistry, and systems could be shared if medical and dentistry clinics were in a similar location. In the absence of such technology rural practitioners tend to rely on traditional referrals, resulting in a delay in the treatment of serious dental conditions.[393]

6.57 The National Rural Health Alliance noted that fluoridated water supplies are not available in most rural and remote communities, and recommended that, in the absence of providing fluoride in the water supplies, alternate strategies be investigated, such as subsidised

386 Submission 85, Ms Jennifer Lang, Wagga Wagga Community health Dental Clinic, p3

387 Submission 199, UnitingCare Burnside, p19; Dr Lyn Mayne, Royal Flying Doctor Service, Evidence 31 August, p3

388 Submission 61, Health Services Union, p6

389 Submission 199, UnitingCare Burnside, p19

390 Submission 25, National Rural Health Alliance, p2

391 Submission 122, Royal Flying Doctor Service, p3

392 Submission 201, Dr Stephen Cox, Westmead Centre for Oral Health, p2

393 Dr Peter Duckmanton, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital, Evidence 16 February 2006, p60

fluoridated toothpaste and fluoride supplements.[394] The question of fluoride is examined in Chapter 8 of the report.

Impact of lack of access to dental services on general health services resources

6.58 Lack of access to dental care places strains on other health services, particularly hospitals and medical services. In his submission Dr Peter Foltyn, a consultant dentist from St Vincent's Hospital Sydney, provided the case study of a patient who attended a public dental clinic in severe pain, but had been unable to access treatment. By the time the patient attended the emergency department at the hospital, he required an operation for a life-threatening respiratory obstruction caused by the swelling from a tooth-related abscess. The patient spent approximately ten days in hospital, and Dr Foltyn observed that had the patient had access to adequate oral health treatment when he first attended the public dental clinic, he would not have had to be hospitalised and consequently incurred expensive medical bills and expense to Medicare.[395]

6.59 Dr Foltyn also described how the wait for dental services affects medically compromised patients. On many occasions considerable dental treatment is required on patients reliant on the public system before they can proceed with different types of surgery, resulting in operative procedures being postponed or cancelled, and sometimes life-threatening delays and unnecessary and costly additional days in hospital. He noted that while such patients should receive expedited treatment within the public system, this often is not the case.[396]

6.60 The Association for the Promotion of Oral Health referred to a 2003 survey that revealed an increase in the number of hospitalisations for dental treatment for both children and adults between 1989 and 2003, of a 58% increase in children under five, 80% in children aged between five and 14, and of 55% in adults. During the same period dental conditions were the eighth most common reason for preventable hospitalisations. These hospitalisations arise from the severe neglect of teeth due to uneven access to regular dental care.[397]

6.61 It is further noted that when patients cannot access treatment through public services they sometimes turn to hospital emergency departments or general practitioners, who are not adequately trained or equipped to give appropriate dental treatment.[398]

6.62 Another difficulty caused by the lengthy waiting lists is additional pressure that is being placed on staff providing public dental services. One submission reported that demand had led to irate patients abusing staff at clinics, leading to staff suffering from stress and depression.[399]

6.63 The Committee notes that with poor oral health having so significant an effect on general health, there are economic and resource implications for other health care services, which treat

394 Submission 25, National Rural Health Alliance, p2

395 Submission 183, Dr Peter Foltyn, appendix 6

396 Submission 183, St Vincent's Hospital Sydney, pp7-8

397 Submission 65, Association for the Promotion of Oral Health, pp18-19

398 Submission 113, Rural Dental Action Group, p5

399 Submission 85, Wagga Wagga Community Health Dental Clinic, p4

conditions that might have otherwise been avoided or at least minimised if people had access to adequate oral health care and treatment.

Conclusion

6.64 The Committee is concerned that the public dental system in New South Wales is overstrained, and that public patients are having difficulty accessing dental services and are not receiving adequate treatment within the time frames recommended by the Priority Oral Health Program, leading to a section of society suffering poor dental health and its consequent effects.

6.65 The Committee notes that people living in rural areas, as well as having difficulty accessing public dental treatment due to a lack of dental practitioners, the provision of emergency treatment only and long waiting times, also face the added burden of distance. The Committee emphasises the importance of providing adequate and on-going treatment to people living in rural and remote areas and notes that the recommendations made in previous chapters with respect to funding and increasing the public dentistry workforce, particularly in rural areas, would contribute to increased access and treatment possibilities in rural NSW.

6.66 The Committee notes that many rural and remote communities do not have fixed facilities for providing dental services and recommends that the feasibility of using mobile dental units to provide greater opportunities for treatment to patients in such areas be investigated. Where facilities are in place, the Committee believes it is imperative that all clinics are fully equipped.

6.67 The Committee also notes that health infrastructure already exists in areas with hospitals and recommends that consideration be given to using these services to support dentists in providing timely treatment to patients.

6.68 The Committee notes that all of these recommendations will have concurrent funding implications.

Recommendation 21

That:

- rural and remote dental services be increased
- new dental clinics and facilities be located in areas accessible by public transport
- clinics and facilities in rural and remote areas be fully equipped
- the use of mobile dental units be investigated
- the use of existing medical infrastructure for the transfer of medical information be explored with respect to dental services.

Special needs groups

6.69 Many of the submissions noted that the public dental system does not provide comprehensive care for high-risk groups:

> Dental disease, particularly a high experience of dental caries, is prevalent in disadvantaged groups in our community, including children from socio-economically disadvantaged families, recent unskilled immigrants, people with physical or intellectual disabilities or with mental health issues, and the elderly who may be house-bound or institutionalised.[400]

Children

6.70 As discussed in chapter 3, New South Wales does not have a comprehensive program targeted directly at children, however dental therapists are employed to provide public dental services in schools.

Oral health

6.71 Professor Spencer reported in research that the oral health of Australian children improved dramatically from the mid-1960s to the mid-1990s, but since that time decay in both the deciduous and permanent teeth of Australian children has increased. Professor Spencer noted that this deterioration in oral health could be due to reduced exposure to fluoride from water supplies (through the use of other beverages and water purifiers) and a decrease in oral health promotion activities within school dental services.[401]

6.72 The NSW Commission for Children and Young People reported that most children in New South Wales have good oral health. Just under one half of children have a dental check-up each year as shown in the table below.

Table 6.6 Treatment received by New South Wales children aged 5-12, 2001

Type of treatment received	Percentage of children aged 5-12 receiving treatment
Check-up	48.9
Scale and clean	19.4
Fillings	17.2
Fluoride treatment	15.4
Removal of teeth	7.3
Orthodontics	5.6

Source submission 170, NSW Rural Health Priority Task Force, p5

400 Submission 65, Association for the Promotion of Oral Health, p17

401 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, pp4-7

6.73 Children in metropolitan areas received more frequent preventive and orthodontic treatments than those in rural areas. The rate of hospitalisations for children under the age of 10 for the treatment of oral disease has increased in recent years, with rates in rural and remote areas being almost three times as high as in metropolitan areas.[402] Dr Mayne, of the Royal Flying Doctor Service, confirmed that children in rural areas have poorer oral health, and reported that cases of extractions are higher in rural areas, and that the children she provides treatment to have been on a waiting list of up to one year, resulting in many of them needing specialist treatment involving travel to the nearest regional centre.[403]

Access to dental care

6.74 Children from lower socio-economic groups experience almost twice as many caries as children in higher socio-economic groups.[404] Professor Spencer noted in his research that children from affluent families have greater access to dental services than those from lower socio-economic groups, as shown in the table below.

Table 6.7 Access to dental care among Australian children in 2002

Performance indicator	Affluent	Health card holders
Perceived need for treatment	12.2	33.6
Experienced a toothache in last 12 months	3.9	8.4
Visited dentist 2+ years ago	1.7	7.6
Last visit was for a problem	18.5	30.2
Avoided or delayed because of cost	5.2	11.8
Waited more than 6+ months for appointment	-	-
Cost prevented recommended treatment	4.5	3.8
Received extraction in last 12 months	18.8	33.6
Received filling in last 12 months	4.3	8.9

*Source Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p30*

6.75 As previously noted, all children up to the age of 18 are eligible for public dental services and dental therapists are employed to provide general treatment in schools. However, with the difficulties faced by the dental therapist profession (as set out in Chapter 4) and the increasing vacancy rates, adequate and on-going general treatment within the schools program is

402 Submission 199, UnitingCare Burnside, p14

403 Dr Lyn Mayne, Dental Officer, Royal Flying Doctor Service, Evidence 31 August 2005, pp8-9

404 Submission 199, UnitingCare Burnside, p14

becoming less frequent, with larger waiting lists for children starting to emerge.[405] As one witness commented:

> I guess the concern now is for the future. We are starting to see the waiting list develop now and we are starting to see areas where we are finding it difficult to provide services. We may reach a point where we cannot provide a holistic dental care for your children.[406]

6.76 Children from disadvantaged population groups, such as Aboriginal and Torres Strait Islanders, those with disabilities and specific diseases, those living in rural areas and the children of refugees or migrants have more limited access to dental services and often lack the support and education programs necessary to develop skills in oral self care. The Aboriginal Health and Medical Research Council reported that during a recent oral health check in one small town in the far west of New South Wales, 90% of the mostly Aboriginal children had dental caries and for most it was their first dental visit.[407]

6.77 The NSW Commission for Children and Young People emphasised the importance of ensuring good oral health in children because:

- poor oral health in childhood predicts poor oral health in older age
- it provides the skills needed for oral self care in the future
- oral health problems can affect the quality of children's lives
- untreated oral disease in primary teeth can affect secondary teeth and lead to more complex problems
- oral disease is preventable.[408]

Proposals

6.78 Associate Professor Deborah Cockrell noted that just 20 minutes in the entire primary school health education program is devoted to oral health, and suggested that alliances should be formed between oral health practitioners and schools, to ensure children receive access to adequate information and education and to improve oral health outcomes.[409]

6.79 The NSW Farmers' Association suggested that providing all rural and remote children with free dental attention should be a priority, in order to help break the cycle of poor rural/remote oral health, and recommended the use of mobile dentist trucks and greater oral health education in schools.[410]

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405 Submission 199, UnitingCare Burnside, p17

406 Ms Jennifer Floyd, Oral Health Network Manager, Greater Western Area Health Service, Evidence 31 August 2005, p31

407 Submission 162, Aboriginal Health and Medical Research Council, p2

408 Submission 224, NSW Commission for Children and Young People, p4

409 Associate Professor Deborah Cockrell, Head of Discipline of Oral Health, University of Newcastle, Evidence 14 November 2005, p24

410 Submission 196, NSW Farmers' Association, p8

6.80 The NSW Commission for Children and Young People suggested a number of areas of priority for further action in the future:

- sustaining and enhancing universal preventive dental treatment, such as fluoridation of water, and education and awareness campaigns on maintaining oral health and making lifestyle choices (such as good nutrition and not smoking) to support oral health
- promotion of oral health and education on dental self care in childhood, which involves the dissemination of information to children through parents, teachers, child care providers general practitioners and other allied health workers
- access to dental visiting for children and young people, by ensuring that all children, and particularly those from disadvantaged groups receive treatment through school dental services
- action with respect to children and young people with special needs by targeted interventions to support these children and their families
- appropriate services for children and young people, by encouraging children to be involved in consultations with dentists and in the planning of health services, and improving communication between children and dental practitioners.[411]

Conclusion

6.81 The Committee notes that access to dental treatment and education about oral health are the primary concerns expressed in the submissions. The review of the dental therapist profession will assist in increasing access to services through school-targeted programs, and the Committee will examine education programs for both adults and children in Chapter 7. The Committee also reiterates its recommendations in Chapter 3 of the report, that a school-targeted child oral health program be implemented in New South Wales, and that Medicare should be extended to cover dental services provided to children up to 16 years of age.

Elderly patients

6.82 Many of the submissions stated that access to dental services is one of the greatest issues faced by elderly patients, after financial barriers. The NSW Ministerial Advisory Committee on Ageing confirmed that elderly patients reported that distance and lack of transport often prevented them from seeking treatment.[412] The Advisory Committee also advised that in areas where public transport is not readily accessible community transport does provide some additional service, however it is at a cost that many elderly patients cannot afford.[413]

6.83 A further issue reported by NCOSS is that many elderly people in the public dental system do not receive timely treatment and are often given antibiotics to deal with oral infections, raising concerns about the interaction between the antibiotics and medication they may already be on

411 Submission 224, NSW Commission for Children and Young People, pp4-8

412 Submission 56, NSW Ministerial Advisory Committee on Ageing, pp2-3

413 Mrs Felicity Barr, Chief, NSW Ministerial Advisory Committee on Ageing, Evidence 5 July 2005, p37

for other conditions. NCOSS advised that anecdotal information indicated that elderly people with oral health problems often became even more unwell and required treatment for four or five problems rather than just for the initial oral infection.[414]

6.84 The Ministerial Advisory Committee on Ageing also commented on the lack of information available to elderly patients, particularly with respect to the effects of different medication on oral health conditions, such as dry-mouth syndrome, and recommended that there be greater co-operation between the medical profession, dental profession and pharmacists so that the relationship between medication and oral health is fully explained and understood.[415]

Aged care facilities

6.85 Older people living in residential care facilities are among some of the most vulnerable members of the community. High levels of oral disease are compounded in residential care settings because of rapid tooth loss, gum diseases, decreased use of full dentures, complex medical problems, reduced physical dexterity and impaired sensory functions. Many of these issues are also compounded by dementia and extreme frailty.[416]

6.86 The Healthy Cities Illawarra Aged Task Force carried out an oral health survey in 2004 to gather more information on oral care in local aged care settings. The three main areas of concern identified by residential care facilities were:

- inadequate preventive oral care, such as regular checkups and monitoring, early identification of dental problems and initial dental assessment prior to admission to a residential facility
- poor service levels and access to treatments, such as delays in obtaining basic treatment and difficulties faced in attending external appointments and in accessing rooms that are often not wheelchair accessible
- the significant impact of oral health on general health and quality of life, such as diminished ability to maintain a suitable diet, gum disease and pain.[417]

Patients with dementia

6.87 Elderly patients with dementia are at particular risk, with the NSW Ministerial Advisory Committee on Aging reporting that one in four people over the age of 85 is affected by the condition, and that their dental health deteriorates at a greater rate over a one-year period than those without dementia.[418] This group of patients has higher levels of dental disease as maintaining general and dental care is more difficult; a common problem associated with dementia is the loss of the swallowing mechanism, and food remains in the mouth for periods

414 Submission 200, NCOSS, p4

415 Mrs Felicity Barr, Chief, Ministerial Advisory Committee on Ageing, NSW, Evidence 5 July 2005, p33

416 Submission 87, Healthy Cities Illawarra Inc, p2

417 Submission 87, Healthy Cities Illawarra Inc, p2

418 Mrs Felicity Barr, Evidence 5 July 2005, p35

of time, resulting in increased oral disease.[419] The Advisory Committee reported that such patients are also less able to accurately report pain and discomfort caused by ill-fitting dentures or oral disease and can become distressed when approaches are made to provide them with oral hygiene care.[420] There is only a small proportion of the dental work force that is capable of dealing with dental care in demented patients.[421]

Proposals

6.88 COTA National Seniors Partnership called for an oral health plan specifically to address the needs of older Australians, both in the community and aged care facilities, and to ensure that special needs residents in such facilities have access to public dental services.[422]

6.89 With respect to patients in residential care facilities the Healthy Cities Illawarra Aged Task Force recommended:

- training for staff in residential care facilities in oral health
- having staff members (such as dental nurses) who are specifically trained to carry out dental screens, monitor the provision of oral care and organise dental treatments
- funding for oral health assessments on admission to aged care facilities
- funding and support to allow dentists to carry out regular dental check-ups and professional cleaning
- incentives for facilities to provide basic treatment facilities and the carrying out of oral health training
- reimbursement incentives for private dentists to service facilities
- support for adjunctive and preventive aids such as mouth props, saliva substitutes, and fluoride.[423]

6.90 The Ministerial Advisory Committee on Ageing supported a public education program, to disseminate general information on oral health to all sections of the community.[424]

6.91 The Advisory Committee also recommended training for staff undertaking home care visits to the elderly under the Home and Community Care program, to augment their personal care activities with dental care. The Committee acknowledged that the invasion of the mouth by

419 Submission 56, NSW Ministerial Advisory Committee on Ageing, pp2-3; Mrs Felicity Barr, Chief, NSW Ministerial Advisory Committee on Ageing, Evidence 5 July 2005, p35

420 Submission 87, Health Cities Illawarra Inc, pp3-4

421 Mrs Felicity Barr, Evidence 5 July 2005, p35

422 COTA National Seniors Partnership, p2

423 Submission 87, Health Cities Illawarra Inc, p6

424 Mrs Felicity Barr, Evidence 5 July 2005, p33

somebody could be threatening and humiliating and that specific training would be necessary for carers.[425]

Conclusion

6.92 The Committee notes that the Australian population is aging and issues relevant to elderly patients will become increasingly important. The Committee recalls its recommendation made in Chapter 3, that Medicare should be extended to cover dental care for special needs groups, including the elderly. The Committee also recommends that the issues listed below be considered with respect to elderly patients in the light of the new oral health plan to be implemented in New South Wales.

Recommendation 22

That, in addition to recommendation 11 concerning the extension of Medicare to cover dental care for special needs groups, the following issues be considered with respect to elderly patients in the light of the new oral health plan to be implemented in New South Wales:

- access to dental services, including transport possibilities and difficulties faced by frail patients in wheelchairs
- education about oral health, including the dissemination of information through doctors, dentists and pharmacists about medication and its effect on oral health
- the greater provision of oral health services in aged care facilities
- the training of dentists, staff and carers in the oral health needs of elderly and frail patients and patients suffering dementia.

Aboriginal and Torres Strait Islanders

6.93 Professor Spencer noted in research that indigenous Australians once enjoyed good oral health, through diet and traditional teeth-cleaning methods, however they are now susceptible to systemic disease and poor oral health.[426]

6.94 Oral health care is provided to Aboriginal people in New South Wales by dental programs principally managed by Aboriginal community controlled health organisations, resulting in varying levels of service across the State. Some areas have dental services, others have funding to employ a dentist but have difficulty with recruitment, and some areas have developed a service agreement with local dental personnel. Some of the areas offer free dental care and others charge a co-payment contribution; decisions concerning eligibility for dental care and

425 Mrs Felicity Barr, Chief, Ministerial Advisory Committee on Ageing, NSW, Evidence 5 July 2005, p36

426 Professor A John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia*", 2004, Australian Health Policy Institute, University of Sydney, p9

the charging of co-payments are made by the management boards of the health organisations.[427]

6.95 Aboriginal and Torres Strait Islander communities are at significant risk, experiencing dental decay at twice the rate of non-indigenous populations, 16% loss of all natural teeth compared to 10% of non-indigenous people[428] and worse periodontal health, in many cases exacerbated by a higher incidence of type 2 diabetes.[429] The Royal Flying Doctor Service noted that dental care has not historically been a part of this population's experience, and that their oral health is affected by diet, lack of access to fluoridated water supplies and lack of preventive knowledge and treatment.[430]

6.96 It is noted that hospitalisation rates for Aboriginal people for the removal or restoration of teeth are substantially higher in rural than urban areas, and increased substantially from 1993 to 1999, as shown below.

Table 6.8 Hospitalisation rates for oral health for urban and rural Aboriginals 1993-1999

	Number per 100,000 residents 1993	**Number per 100,000 residents 1999**
Urban Aboriginals	44.8	103.8
Rural Aboriginals	106.2	271.5

Source submission 65, Association for the Promotion of Oral Health, p27

6.97 The difficulties faced by rural public dental patients, such as waiting lists, access only to emergency treatment and lack of preventive treatment, are shared by the Aboriginal communities,[431] and are exacerbated by the remoteness of many of these communities.

6.98 The Maari Ma Aboriginal Health Corporation advised that there is very little access to public dental care for the people within its purview, with some emergency and restorative treatment available through the Royal Flying Doctor Service and clinics in Broken Hill, but virtually no denture services or oral health education and promotion.[432] As previously noted, approximately 90% of largely Aboriginal children in one remote town had dental decay and many had not previously visited a dentist.

6.99 The NSW Rural Health Priority Task Force identified other factors affecting public dental services, including the requirement of several forms of identification, which many Aboriginal people do not have; the difficulties faced in obtaining consent for treatment from a child's parent/guardian in extended Aboriginal families; other health priorities besides oral health;

427 Submission 170, NSW Rural Health Priority Task Force, pp6-7

428 Submission 170, NSW Rural Health Priority Task Force, p3

429 Submission 162, Aboriginal Health and Medical Research Council, p2

430 Submission 122, Royal Flying Doctor Service, p3

431 Submission 46, Mr Glen Hughes, Dharah Gibinj Aboriginal Medical Service, p1

432 Submission 247, Maari Ma Aboriginal Health Corporation, p2

and difficult access for low-income earners who may not yet have health cards.[433] Fear of dentists was also cited as a further barrier.[434]

6.100 In discussing the oral health treatment provided by the Durri Aboriginal Corporation Medical Service, Ms Harris stated:

> The poor state of dental health is much more prevalent in the adult Aboriginal population because funding for the provision of a comprehensive adult dental program has been fragmented and inadequate and lacked continuity. Our vision for our dental clinic is to improve the dental health status of Aboriginal people in culturally supportive ways to reduce overall health benefits.[435]

6.101 The Aboriginal Health and Medical Research Council noted that Aboriginal people feel more comfortable seeking health care in an Aboriginal community-focussed environment, which can be achieved by Aboriginal input into dental programs and treatment planning, and the training of Aboriginal dental workers. The Council advised that an Australian Indigenous Dental Association has recently been formed, with four members, and stated that 'indigenous participation in dental training is low and support needs to be provided to encourage Aboriginal students to consider a dental career'.[436]

6.102 The Maari Ma Aboriginal Health Corporation suggested developing a travelling dental kit of instruments and materials to enable dental practitioners to travel and provide service more easily.[437] The Corporation also suggested a school based education program, comprising elements such as a teeth-brushing program.[438]

6.103 The submissions highlighted the importance of providing culturally appropriate and accessible oral health services for Aboriginal and Torres Strait Islander people. The Aboriginal Health and Medical Research Council also highlighted the importance of oral health promotion and preventive education, the incorporation of oral health into other health and community programs, access to fluoridated water supplies and the development of culturally appropriate educational materials.[439]

6.104 The Committee notes the poor oral health of indigenous people and the added difficulties faced in accessing dental treatment due to the remoteness of many communities. The Committee recommends that the new oral health plan for New South Wales consider the need to provide culturally appropriate and accessible oral health services for indigenous people, comprising education for children and adults, the provision of a wider range of services beyond emergency treatment, and the means of providing preventive treatment and education.

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433 Submission 170, NSW Rural Health Priority Task Force, p7

434 Ms Susan Harris, Dental Therapist and Dental Manager, Durri Aboriginal Corporation Medical Service, Evidence 23 August 2005, p48

435 Ms Susan Harris, Evidence 23 August 2005, p45

436 Submission 162, Aboriginal Health and Medical Research Council, p5

437 Submission 247, Maari Ma Aboriginal Health Corporation, p3

438 Mr Jason Gowin, Co-ordinator, Annual Health Checks, Maari Ma Aboriginal Corporation, Evidence 31 August 2005, p47

439 Submission 162, Aboriginal Health and Medical Research Council. pp5-6

Recommendation 23

That the new oral health plan for New South Wales consider the need to provide culturally appropriate and accessible oral health services for indigenous people, comprising education for children and adults, the provision of a wider range of services beyond emergency treatment, and the means of providing preventive treatment and education.

Migrants and refugees

6.105 UnitingCare Burnside advised that overseas born people who speak a language other than English at home reported:

- a higher usage of emergency dental care
- visiting the dentist with a problem rather than for a regular check-up and lower rates of preventive services
- a higher rate of advanced periodontal attachment destruction
- more extractions
- more experience of toothache
- lower levels of dental insurance
- greater difficulty in paying a $100 dental bill.[440]

6.106 NCOSS noted that the ability of migrants to access dental care is limited by the availability of dental services in terms of affordability, accessibility and language barriers.[441]

6.107 The NSW Refugee Service advised that some 4,000 refugees who enter Australia on humanitarian grounds settle in New South Wales every year. This group has a high level of dental disease due to lack of fluoridated water in their country of origin, poor dental hygiene, limited access to preventive and curative dental health care in the past, dietary and nutritional issues and, in some cases, the effects of torture and/or other physical trauma. These refugees are permanent residents but most have difficulty finding work initially and are dependent upon Centrelink benefits and public health services.[442]

6.108 In addition to the previously discussed barriers to obtaining public dental treatment, these immigrants face difficulties such as insufficient staff awareness of refugee health issues, poor usage of qualified health care interpreters and fear, particularly when the refugee has experienced torture.

6.109 The Refugee Service noted that there have been measures to improve refugees' access to public dental services, including the pilot Refugee Dental Clinic at the Westmead Centre for Oral Health, elevating the coding level of need for treatment of refugees in the Priority Oral

440 Submission 199, Uniting Care Burnside, p11

441 Submission 200, NCOSS, p11

442 Submission 161, NSW Refugee Service, p1

Health Program and the development of strategies to increase access to service and education. The Service recommended that further action should be taken including: identifying refugees as a priority target group; the training of staff in refugee health needs; the presence of interpreters, particularly in emergency cases; targeted education programs; the introduction of routine oral health screening for newly arrived refugees and using bicultural workers for liaison between the different health services.[443]

Disabled patients

6.110 The Council for Intellectual Disability stated that most people with intellectual disability are dependent upon public dental services, often suffer from undiagnosed or poorly managed health problems, that dental disease is up to seven times more frequent than in the general population, and that it is often very difficult for them to obtain appropriate treatment. The Council set out the factors contributing to that difficulty, including:

- communication issues, particularly for those patients with limited verbal communication
- shortage of skills amongst dentists in working with people with intellectual disability
- lack of time that can be spent with patients with intellectual disability
- the poverty of patients and the inadequate supply of free and subsidised dental services
- inadequate awareness of dental care issues amongst disability support workers and other carers.[444]

6.111 The Council suggested isolating a specific budget in each Area Health Service to address 'special needs' dentistry to ensure that people falling within this category receive timely and informed services. The Council also proposed that dentists should receive appropriate training in treating patients with disability, that special needs dentistry be recognised as a speciality within dentistry with an acknowledgement of the high level of training and skills required to perform such work, as has occurred in Victoria, and that there be ongoing education programs in oral health for people with intellectual disabilities, their families and disability support workers. The Council noted the successful use in the Illawarra area of a network of specialist clinical nurses to liaise between health services and disability services.[445]

Other high-risk groups

6.112 Based on the submissions the Inquiry received, other high-risk groups were identified as including patients with complex medical conditions such as cancer, HIV positive people, the homeless, people with a substance dependency, child abuse victims and prisoners and ex-prisoners. It is noted that many of these special needs patients often cannot be treated in small public dental clinics due to their extensive and severe oral health problems, which often have

443 Submission 161, NSW Refugee Service, p4

444 Submission 66, NSW Council for Intellectual Disability, p2

445 Submission 66, NSW Council for Intellectual Disability, p4

to be treated under general anaesthetic. Such treatment is constrained by lengthy waiting lists during which time their oral health further deteriorates.

Patients with other chronic and complex conditions

6.113 The Cancer Institute of New South Wales explained that many cancer patients require dental care as an integral part of their treatment and ongoing care regimes, for example, patients undergoing radiotherapy treatment of head and neck cancers should have the teeth in the direct field of radiotherapy removed and be placed on a preventive program to minimise dry mouth symptoms. The Institute noted that unless the patient holds a Commonwealth Health Care Card they are not eligible for any assessment or dental therapy which is necessary for the treatment of their main existing condition, resulting in costly dental work.[446]

6.114 NCOSS reported that patients with Hepatitis C also suffer poor oral health. Sufferers are prone to tooth decay and dry mouth symptoms, cirrhosis of the liver can result in prolonged bleeding after dental procedures, and patients are often subject to discrimination in accessing dental services due to fear among dental workers of the risk of infection.[447]

HIV positive people

6.115 Over 60% of Australians with HIV/AIDS reside in New South Wales, of whom approximately half (4,000-5,000) are eligible for public dental services. The AIDS Council of New South Wales reported that approximately 90 per cent of people with HIV will develop at least one oral condition associated with the disease. As these oral conditions are often the first sign of HIV infection it is important for patients to access timely treatment, which can lead to the early diagnosis of the infection. The oral disease suffered by those with HIV can be severe and result in the need for extensive treatment. Many HIV positive people report that they are less rather than more likely to seek treatment as their oral health deteriorates, given the health and treatment challenges they perceive.[448]

6.116 New South Wales allocates approximately $260,000 per annum to assist in providing public dental treatment to HIV positive patients, however, the AIDS Council of New South Wales reported that there is no evidence to suggest that access to dental services has improved, with HIV positive patients being mainstreamed within dental services, resulting in a loss of expertise in treatment and increased waiting times. The Council suggested that relatively minor adjustments in funding and service delivery could make a substantial difference to HIV positive patients, and proposed that special further provision be made for such patients in terms of priority in treatment and funding. The Council also noted that there is a heightened trepidation about the risks of treating HIV positive patients among oral health practitioners and that there needs to be continuing education in this area.[449]

446 Submission 169, Cancer Institute of New South Wales, p3-4

447 Submission 200, NCOSS, p21

448 Submission 168, AIDS Council of NSW, p6

449 Submission 168, AIDS Council of NSW, pp6,7

Homeless people

6.117 NCOSS reported that 80% of homeless people have some form of oral disease, of whom 62% have severe periodontal disease. People who are homeless often have multiple health issues, and are likely to have very poor oral health and to require extensive dental work.[450]

6.118 The Public Interest Advocacy Centre reported that those who are homeless are likely to change their accommodation and contact details many times, increasing the likelihood that they cannot be contacted when they become eligible for dental assistance, and that many are facing other serious issues in their lives, which makes it difficult for them to advocate for their oral health needs through the public system. The Centre stated that public dental services must be made more accessible for such groups, and that public dentistry patients are entitled to receive the same level of care and treatment as private patients.[451] NCOSS proposed that such patients should receive priority access to basic general care in public dental clinics based on a referral from a service provider.[452]

People with a substance dependency

6.119 NCOSS reported the findings of a study that people with a substance dependency are more likely to experience oral health issues, have difficulty accessing treatment, especially if there is a cost involved, and may not consider oral health to be of particularly great importance.[453] Uniting Care Burnside noted that substance abuse is associated with a low expendable income, chaotic life and poor nutrition, resulting in poor oral health.[454]

6.120 Uniting Care Burnside suggested that these special needs groups could be targeted by NSW Health in a similar way as other services, such as Centrelink and the Department of Housing, by employing outreach workers who consult with people through the auspices of Uniting Care Burnside and other such organisations. A dental worker could identify and prioritise dental problems and advocate timely treatment within the public dental system, as well as provide educative information.[455]

Child abuse victims

6.121 NCOSS stated that improved access to public dental health services would be valuable in detecting child abuse, as less than a third of actual abuse cases are reported each year, and 75% of physical abuse involves injury to the head and neck. NCOSS reported that the oral cavity is a central focus for physical abuse in children because of its significance in communication and nutrition and is also often a frequent site for sexual abuse.[456]

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450 Submission 200, NCOSS, p13

451 Submission 145, Public Interest Advocacy Centre, p7

452 Submission 200, NCOSS, p13

453 Submission 200, NCOSS, p12

454 Submission 199, Burnside, p13

455 Ms Alexis Taylor, Caseworker, Uniting Care Burnside, Evidence 5 July 2005, p50

456 Submission 200, NCOSS, p10

Prisoners and ex-prisoners

6.122 Prisoners receive dental services within correctional facilities, however NCOSS reported that in a 2001 survey 45% of respondents whose last visit was to a prison dentist had a tooth extracted compared to 35% who visited a community dentist. The survey also advised that 87% of female and 70% of male prison inmates reported they required an examination or filling.[457] The Rural Dental Action Group noted that the difficulty of providing dental treatment for prison inmates is ongoing, and commented that the time when a person is incarcerated provides an opportunity to provide appropriate dental treatment and education.[458]

Conclusion

6.123 The Committee notes the common requirements among special needs groups including the perceived need for priority in treatment, specialised programs taking into account the unique circumstances of each group, training for dental workers in the specific needs of the different groups, and the dissemination of information to the various groups concerning the services that are available to them. The Committee recalls its recommendation in Chapter 3 concerning extending Medicare to cover the dental care of special needs groups, and also suggests that the issues facing these and other special needs groups that may not have been specifically referred to in the submissions or evidence be considered in the new oral health plan for New South Wales.

Recommendation 24

That the new oral health strategic plan for New South Wales consider the issues related to special needs groups, including priority in treatment, appropriate training for dental practitioners and the need for ongoing education programs and the dissemination of information.

Other methods of providing service

6.124 The Committee heard a proposal from the Pacific Smiles Group concerning a public-private partnership means of providing public dental services to a pre-determined group through private practitioners, modelled on a system in use in the United Kingdom. Under the partnership it is proposed that the New South Wales Government could contract a private company to finance, design, construct, operate and maintain large public/private dental clinics in areas of need or in central areas with good transport links, in return for income via a long-term contract. Dentists at the clinic would accept public patients during designated time periods each day and provide services tailored for such patients, including restorative and preventive treatment and oral health education. Outside of the public patient treatment hours dentists at the clinic would be permitted to treat private patients. Payment from the government for public services could be made on a fee-for-service regime or an agreed model. It was suggested that such a system would lead to greater access to public dental services and preventive treatment and education; a highly motivated dental workforce with fewer

457 Submission 200, NCOSS, p20

458 Submission 113, Rural Dental Action Group, p6

difficulties recruiting dentists to perform public dentistry work; and a reduced requirement on the government for initial capital investment and for recurrent capital works and maintenance.[459]

6.125 The Committee also heard from the Barrier Dental Clinic in Broken Hill, a not-for-profit organisation which charges a membership of $2 a week and provides subsidised dental services to members and their dependents, at a rate of approximately 30% less than average private practitioner fees. The greatest problem faced by the clinic is in the recruitment of dentists to work in a rural area, which affects waiting times to receive treatment.[460]

6.126 The Committee notes with interest the alternative means of providing public or subsidised services to patients, and recommends that the feasibility of such arrangements be further investigated.

Recommendation 25

That NSW Health consider the feasibility of alternative means of providing public or subsidised dental services including public-private partnerships.

Conclusion

6.127 The Committee is deeply concerned that the public dental system in New South Wales is under severe strain, with the demand for access to adequate dental treatment by eligible patients outweighing current capacity and resources. Waiting lists of up to four and a half years for general treatment and up to ten years for other services such as dentures, combined with inadequate equipment and under-resourced clinics mean that many people are missing out on basic dental care, which, in turn, is affecting their general health and wellbeing. Where dental services are being provided for emergency and acute cases, modern best practices are often not being followed and patients suffer from an overuse of extractions and lack of preventive treatment. The demand for dental services is predicted to increase in the future, placing further demands on an already overstrained system.

6.128 Access to public dental services is affected by a number of factors, including: funding; the lack of sufficient numbers of dental practitioners within the public system; waiting times; distances that must be travelled to attend dental clinics; and the unique circumstances of special needs groups. The Committee notes that reduced access to services corresponds with poor oral health, and strongly believes that users of public dental services should be able to easily access comprehensive and on-going treatment, and has made recommendations to that end. The Committee is aware that the recommendations made in this chapter are related to the overall issue of funding.

6.129 The issues of education and preventive treatment were frequently raised during this chapter, and the Committee examines those areas further in the following chapter.

459 Submission 81, Pacific Smiles Group, pp20, 24-26

460 Mr Lawrence Nettle, Manager, Barrier Dental Clinic, Evidence 31 August 2005, pp50-52

Chapter 7 Prevention

The Committee heard that oral diseases are in large part preventable conditions. Almost 90% of tooth loss is due to dental caries and to periodontal disease, which are preventable and treatable, and hence much of that tooth loss is avoidable. The Committee also heard that oral health is an integral part of general health, and oral health status can be regarded in general terms as a risk factor for general health.[461] This chapter addresses Term of Reference 1(f), which requests that the Committee examine preventive dental treatments and initiatives.

This chapter examines preventive dental treatments and initiatives and the optimum method of delivering such services. In particular this chapter will consider:

- the importance of prevention
- the population health approach for oral health
- preventive treatments and initiatives.

Importance of prevention

7.1 The prevention of oral health disease, including dental caries, edentulism and periodontal disease, is important for a number of reasons including the effect of oral health on general health and well being, and the fact that prevention can reduce costs and demand on the public system in the long term.

7.2 Ms Samantha Edmunds, Senior Policy Officer, NSW Council of Social Services (NCOSS), stated 'if you can get in those prevention strategies early on, it is that long-term approach. It is sort of like if you do it now, you are saving that long-term demand on the public health system.'[462]

7.3 Professor John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, also commented on the cost effectiveness of treating dental disease:

> First, there is an outcome in the cost of treating dental disease per se and the direct impact of that disease on people's lives. In that area we have somewhat more information about the cost-effectiveness and cost-benefit of different dental preventive approaches. We have rather less evidence about the extended potential series of links: poor oral health contributes to poor general health and by improving oral health one would improve general health and reduce wider health care costs. We are only scratching the surface of documenting those sorts of issues. I have read reports on the area of medically necessary dental treatment that have tried to come up with cost-enefit equations of the treatment of people's oral health prior to going into heart valve replacement surgery and the subsequent outcomes of that surgery.

461 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p1

462 Ms Samantha Edmunds, Senior Policy Officer, NCOSS, Evidence, 5 July 2005, p24

> Treating the dental disease prior to that surgery was a very cost-effective approach in improving the outcomes and reducing the need for subsequent surgery and sometimes for the replacement of heart valves at a second round attempt at surgery later on.[463]

Links between oral health and general health

7.4 As noted in Chapter 2, poor oral health affects the general health and well being of a person. The Committee acknowledged in Chapter 2 that the evidence demonstrated the importance of good oral health, with respect to economic and general health impacts. With poor oral health having so significant an effect on general health there are also further economic and resource implications for other health cares services, which treat conditions that might have otherwise been avoided or at least minimised if people had access to adequate oral health care and preventive treatment.

7.5 The Committee was advised that periodontal or gum diseases are now being investigated as potential risk factors for the development of systemic disease, such as cardiovascular and pulmonary disease, instead of just localised infections. The causes of the two major dental diseases (caries and periodontal disease) are inadequate diet, stress, poor hygiene, smoking, alcohol/substance misuse and injury. These risk factors are common to a number of chronic diseases and health impacts.[464] Links with general health conditions were identified by witnesses and include diabetes, pre-term delivery and low birth weight as well as in extreme cases death.[465]

7.6 This link was described by a number of witnesses and highlighted in submissions including that of the Australian Dental Association NSW (ADA (NSW)), which commented:

> A number of health conditions and diseases are associated with oral symptoms and disease. In particular, periodontal disease (disease of the gums) may contribute to cardiovascular disease, pre-term birth and low birth weight, while diabetes directly affects the periodontium (the tissues of the gum that support the teeth). Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV infection, infective endocarditis, otitis media, and nutritional deficiencies in children and older adults.[466]

7.7 The Committee recognises that there are links between general health and well being and a person's oral health and, for this reason, the Committee believes that oral health, including preventive initiatives, should be considered along with general health planning and funding by both the Commonwealth and NSW Governments.

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463 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p3

464 Submission 254, NSW Health, p22

465 Professor A John Spencer, Evidence, 16 February 2006, p2

466 Submission 226, ADA (NSW) Ltd, p56

Prevention in the private dental health clinic

7.8 The level of preventive care in private dental health practices is considered to be considerably higher than that offered in the public sector. As Professor Spencer noted in research:

> Public dental care has lower rates of provision of preventive services (31% less) and higher technology restorative services, endodontics (25% less) and crown and bridge services (100% less) than private dental care. … These differences reflect the predominance of emergency or problem visiting for public dental care and the subsequent lack of opportunity for more comprehensive and preventive dental care.[467]

7.9 A contributing factor to the higher provision of preventive care in private practices is the employment of dental hygienists, who primarily carry out preventive care. As noted in Chapter 4, in 2000, of the 58 dental hygienists in NSW, all were employed in either the private sector or teaching. There were none working in the public sector. The Dental Hygienists' Association of Australia commented that 'dental hygienists in NSW are employed in private practice, either in a general dental practice setting or work for a specialist (periodontist, prosthodontist or orthodontist).'[468]

Prevention in the public dental health clinic

7.10 As noted in Chapter 2, many of the submissions and much of the evidence noted that the care received in public dental clinics is primarily acute, emergency or episodic care and not preventive care. This issue was highlighted by public patients, staff in public dental clinics and NSW Health.

7.11 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, clearly stated to the Committee that the care provided in public dental clinics is mostly acute care and not preventative care. Further to this, Dr Robinson advised that 'for people who are wishing to access the service in terms of routine assessment and preventive care, the waiting time could be considerably longer [than those waiting to be treated for acute care]…. it may be several weeks, or it may be several months.'[469]

7.12 This was supported by Ms Jo Alley, UnitingCare Burnside, who suggested that Burnside has received comments 'about the lack of preventive focus on existing services':

> There were quite a few people who commented about the trend in public dental services to pull out teeth, to rip out teeth, rather than trying to fix them by putting in fillings or doing major work to retain teeth. They were the sorts of issues that came up in our consultations.[470]

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467 Professor A J Spencer, *What options do we have for organising, providing and funding better public dental care?*, 2001, Australian Health Policy Institute, University of Sydney, p34

468 Submission 238, Dental Hygienists' Association of Australia, p1

469 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p4

470 Ms Jo Alley, UnitingCare Burnside, Evidence, 5 July 20005, p42

7.13 The Rural Dental Action Group stated in their submission that 'in the rural public dental clinics there is currently very limited preventive treatments and initiatives, particularly to adults as staffing levels are pressed to cope with emergency cases'.[471] This group further comments that:

> As a large percentage of the population only seeks dental treatment in an emergency creative measures need to be developed to educate the public about the importance of teeth brushing, flossing and dental checks … a large amount of prevention lies in the education of each individual in the care and maintenance of their own teeth. Education is often given opportunistically only when people seek care for a dental problem.[472]

7.14 The submission from the Sydney South West Area Health Services highlighted that the 'excessive demand for urgent clinical service has meant that limited resources have been devoted to population health initiatives, preventive dental treatments and oral health promotion.'[473]

7.15 Ms Catherine Osborne, Area Manager, Oral Health, North Coast Area Health Service, provided the Committee with the main reason public dental health services are unable to provide preventive care resources, stating 'we on the North Coast are not in a position to provide preventative care for adults at the moment … we have not got the resources to do it.'[474]

7.16 Another reason given for the public dental health focus on emergency care was that public patients usually visit clinics for episodic or emergency care and are not interested in waiting for preventive or ongoing care, as Ms Osborne advised:

> It can be that we find a lot of our clients access us just for episodic care. They are not really interested in having a general course of care. Some clients just want that and if they are asked if they want to wait and have preventative treatments they do not. So it is a mixture, it is not as black and white as it may seem.[475]

7.17 The Committee acknowledges that the care provided in public dental clinics is primarily acute, emergency or episodic care rather than preventive and that this is likely to be due to the high demand on the system and a lack of resources to cope with the demand. This is in contrast to the level of care provided in private dental practice. The Committee believes that public dental services need to include preventive care in order to reduce the acute demand on the public services and, most importantly, prevent the ill-effects of dental disease on general health. How to increase the preventive care in public dental clinics will now be considered.

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471 Submission 113, Rural Dental Action Group, p9

472 Submission 113, Rural Dental Action Group, p9

473 Submission 118, Sydney South West Area Health Service, p2

474 Ms Catherine Osborne, Area Manager, Oral Health, North Coast Area Health Service, Evidence, 23 August 2005, pp26-27

475 Ms Catherine Osborne, Evidence, 23 August 2005, pp26-27

Population health approach

7.18 The population health approach was recommended in the *National Oral Health Plan 2004-2013* as the most appropriate and effective approach for improving oral health and aims to systematically:

- promote health and prevent and intervene early in the pathway to disease through strategies that involve individuals, communities and whole societies
- build individual and community capacity and provide enabling cultures and environments
- provide a comprehensive range of high quality, integrated health care services
- reduce disparities in health status through equitable allocation of health resources and access to health services.[476]

7.19 In terms of oral health, a population health approach means that, because many of the factors which contribute to oral diseases cannot be managed solely through the provision of personal dental care services, they can be better addressed through a range of population-based and targeted public health interventions. [477]

7.20 Dr Robinson, NSW Health, advised the Committee:

> I am convinced of the need to introduce a population oral health approach in New South Wales that better addresses the risk factors by population-based and targeted health interventions. This would be an approach that currently utilises both the dentists and dental and other health professionals from both the public and private sectors to promote good oral health and to reduce oral disease. To address the oral health of the whole population makes sense in fulfilling the obligations of our area health services where they are obligated to promote, protect and maintain the health of the community as defined under the *Health Services Act 1997*.
>
> The various research reports commissioned by New South Wales Health, the Australian Institute of Health and Welfare and the dental statistics research unit at the University of Adelaide also support a population health approach.[478]

7.21 NSW Health has adopted the population health approach. The Centre for Oral Health Strategy was created in late 2004 and was strategically placed within the Population Health Division where strong links exist between health protection, health promotion, and Aboriginal health. The division has a strong focus on prevention via a population health approach.[479]

7.22 ADA (NSW) supported this approach and suggested that only a population health approach can offer a way to manage the growing demand that is occurring for dental services, utilising

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476 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013*", July 2004, p3

477 Submission 254, NSW Health, p23

478 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p1

479 Submission 254, NSW Health, p23

both public and private resources as effectively as possible, and working across sectors and communities to maximise oral health gains and promote oral health across the community. [480]

7.23 NCOSS also recommended a population health approach, as the determinants of health status at the individual and population level include a range of psychological and environmental factors including income, employment, poverty, education and access to community resources as well as demographic factors such as gender and ethnicity.[481]

7.24 The Committee believes that, as highlighted by the *National Oral Health Plan 2004-2013* and NSW Health, a population health approach is the best way to deliver oral health services including preventive initiatives and treatments.

Preventive initiatives

7.25 NSW Health suggested to the Committee that there are four pillars of prevention in oral health promotion, consistent with a population health approach. These are:

- education and awareness programs
- application of appropriate behaviour types of programs, such as oral hygiene instruction
- contact with provider programs, which are access issues related to constant reinforcement
- water fluoridation.[482]

7.26 A number of initiatives were brought to the Committee's attention through evidence and submissions, which coincide with NSW Health's view of the four pillars of prevention in oral health promotion. This is not an exhaustive list of preventive initiatives, however they should be considered as part of a whole approach to preventive care for oral health in NSW. The Committee focuses on having these initiatives operating in the public sector due to the current lack of preventive care available in that arena. However, these initiatives may also positively impact on people accessing private dental care as well.

7.27 The preventive initiatives that will be considered include:

- fluoridation, which is considered briefly here and in detail in the following chapter
- oral health promotion, such as education and awareness programs
- oral health promotion teams, including oral hygiene instruction
- collaboration of health workers
- nutrition programs.

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480 Submission 226, ADA (NSW) Ltd, p58

481 Submission 200, NCOSS, p16

482 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, p48

7.28 The Committee recognises that prevention is especially important for children, who need to learn how to maintain good oral health at an early age. The issue of specific child dental programs and access to dental services are discussed in Chapters 3 and 6 respectively.

Community survey

7.29 In order for preventive initiatives to be both appropriate and successful, Associate Professor Zoellner, from the Association for the Promotion of Oral Health (APOH), suggested the need for monitoring and surveillance of the community in terms of oral health:

> What we mean by surveillance is to monitor the disease process in the community, use that information to plan how we are going to fix that and then to monitor how effective that is so that we have a constant feedback into the health system to control how many dentists we produce, how we use them, how we distribute our resources and how effectively those resources are addressing the community needs. So we see surveillance not as an academic tool but as a very practical tool to make sure that the money that we spend is spent wisely and has a real effect. [483]

7.30 Professor Zoellner suggests that NSW Health needs a surveillance unit to undertake this work, consisting of about 10 or 12 full-time staff including dental and paradental professionals who will collect data in the field using mobile dental units. Also on the team would be an oral health epidemiologist, a statistician and a computer programmer, using a modified NSW Health Information System for Oral Health.[484]

7.31 With respect to the cost of such surveillance, Professor Zoellner commented that the real expense is in not having surveillance. He commented, 'I think that surveillance—of course it costs something, but not that much compared with non-surveillance. Ignorance is going to be much more expensive than finding out what the real needs are.'[485]

7.32 NSW Health acknowledged that there is a lack of comprehensive data, particularly for adults in relation to oral health status. The lack of comparable data on disease prevalence and trends in communities restricts the development of cost-effective strategies to improve oral health and eliminate health disparities. Only one National Oral Health Survey has been conducted in Australia, in 1987-1988.[486]

7.33 However, through the Centre for Oral Health Strategy and area health services, NSW Health is currently participating in the 2005 National Adult Survey of Oral Health (NSAOH). NSW Health provided the following information on the NSAOH:

> This survey was officially launched on the 16th of June [2005] at the Sydney Dental Hospital by Dr Greg Stewart, Director of Population Health, Planning and Evaluation, Sydney South West Area Health Service. Six examination teams who had undergone training and calibration by the Australian Research Centre for Population Oral Health started examining survey participants directly after the launch.

483 Associate Professor Zoellner, APOH, Evidence, 29 June 2005, pp12-14

484 Associate Professor Zoellner, Evidence, 29 June 2005, pp12-14

485 Associate Professor Zoellner, Evidence, 29 June 2005, pp12-14

486 Submission 254, NSW Health, p10

> Approximately 2,000 individuals 15 years of age and older have been randomly selected from households throughout NSW to participate in the NSAOH. The focus of the Survey will be measuring levels of tooth loss, dental decay, gum disease and oral mucosal lesions.

7.34 NSW Health suggested that data collected from this current survey will be valuable in informing statewide policy and planning of dental services for adults in NSW and will facilitate the strategic move towards a population oral health approach in NSW.[487]

7.35 The Committee notes that surveillance and monitoring of oral health would be useful in developing and implementing preventive strategies as well as in identifying risk factors with links between general health and oral health. The Committee notes the participation of NSW Health in the NSAOH. While this is extremely important in providing relevant information for policy and planning the Committee is unclear if it will provide an ongoing monitoring and evaluation of preventive initiatives. The Committee recommends that NSW Health consider the proposal of a survey unit and its role within the Centre for Oral Health Strategy.

Recommendation 26

That NSW Health consider establishing a survey unit and its role within the Centre for Oral Health Strategy.

Fluoride

7.36 Fluoride occurs naturally in most public water supplies although the level varies. Fluoridation programs adjust the fluoride concentration to an optimum level (around 1 mg/litre) for the prevention of dental caries and the management of potential health and environmental risks.[488]

7.37 Fluoridation was introduced in the Sydney metropolitan area in 1968.[489] NSW Health advised that although approximately 90% of residents of New South Wales now have access to fluoridated water, this is unevenly distributed with 100% of the population of Sydney having access to fluoridated water, falling to 59% of the population outside Sydney.[490] NSW Health stated that water fluoridation has proven to be the most cost effective dental public health measure since its introduction in Australia in the 1960s.[491]

7.38 The *National Oral Health Plan 2004–2013* also supports extending fluoridation of public water supplies to communities across Australia with populations of 1000 or more. The Plan states:

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487 Submission 254, NSW Health, p10

488 Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, Evidence, 14 November 2005, p36

489 *Water Fluoridation in Australia Today*, University of Adelaide, 1997, p1

490 Submission 254 NSW Health, p9

491 Submission 254 NSW Health, p9

> Fluoridation of public water supplies is the single most effective public health measure for reducing dental caries across the population, with its most pronounced effects among those who are disadvantaged and most at risk (Acheson 1998, DHS 2000a). Fluoridation needs to be extended across Australia, particularly within rural areas. The population needed for cost-effective provision of fluoridation depends on the level of dental decay in the community. Recent analysis conducted in New Zealand suggests, on conservative assumptions, that a population of 1,000 is near the practical lower bound (Wright et al 2001).[492]

7.39 Fluoridation of public drinking water addresses the aims of the population health approach as referred to in paragraph 7.25, by intervening early and reducing dental caries as well as reducing disparities in health status, as all groups in fluoridated communities have access to the public drinking water.

7.40 Professor Spencer stated that he remains convinced that water fluoridation is the starting point for preventive policies for oral health:

> We have had a history of being involved in research on the effectiveness of fluoridation in Australia. I certainly have a history of being engaged in advocacy in relation to water fluoridation. Most recently we held a workshop in Adelaide under the banner of the National Advisory Committee on Oral Health. The workshop was strongly of the view that water fluoridation should continue in Australia, because it is effective, efficient, socially equitable and safe. It is a population strategy to prevent caries. We are also of the view that water fluoridation should be extended with support from all levels of government to as many people living in non-fluoridated areas of Australia as is possible.
>
> We remain firmly convinced that water fluoridation is the population-level cornerstone of our prevention of dental caries in children, adolescents and young adults … We remain convinced that this is the key starting point in sensible preventive policies for oral health.[493]

7.41 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, advised that NSW Health has focussed not just on fluoridation but also on other preventive initiatives and recognises that there needs to be more than just fluoridation, as a whole package of prevention strategies is the most effective method to ensure the whole community has access to prevention.[494]

7.42 There are a number of arguments for and against the use of fluoride in public drinking water which will be considered in the next chapter. The Committee recognises that fluoridation is a preventive program and acknowledges that it needs to be part of a total package on prevention of oral disease.

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492 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013*", July 2004, p16

493 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p16

494 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, Evidence, 5 July 2005, p11

Oral health promotion

7.43 The Committee heard that the use of oral health promotion strategies is one aspect of a preventive focus on oral health and 'they are designed to prevent and/or reduce the incidence of oral diseases before they reach a stage that requires more intensive, invasive and costly procedures.'[495] This echoes the first aim of the population health approach outlined in paragraph 7.25, to promote health and prevent and intervene early in the pathway to disease through strategies that involve individuals, communities and whole societies.

7.44 However, NCOSS stated that even though international research shows that health promotion activities are very effective in addressing health needs, the NSW Government continues to focus funding into acute services. While there is a need to continue with acute care there must also be appropriate funding focussed on prevention and early intervention. NCOSS commented that 'many would argue that an increased focus on health promotion and early intervention activities would reduce costs in the long term.'[496]

7.45 Oral health promotion initiatives can have a significant impact on the population, as indicated by Associate Professor Cockrell, University of Newcastle, who stated that:

> When you talk to people about the risks and you explain it in very simple language, whether it be on a group or individual basis, you may not change everybody's behaviour—I am not naive enough to think that you would—but you will affect the behaviour of a certain proportion of the population. At the moment, those people are not getting the simple messages to which they are entitled to allow them to make that decision as to whether they want to change their behaviour. [497]

7.46 The Committee recognises that oral health promotion requires more funding. As Dr Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons suggested, public awareness campaigns are necessary to address preventable dental disease:

> After 25 years of practice, I am still astounded by how many people come to see me and do not realise that their dental disease can be prevented. They think it is something that is inevitable—that they will inevitably lose their teeth. As I said, the college really believes that a major preventive program like the anti-smoking program, the Slip, Slop, Slap or the Life Be In It campaign needs to have a lot more government funding … if we do not address the preventive aspect we will be constantly chasing our tails with this issue. The preventive is the basis of the whole thing, and it really is so simple.[498]

7.47 It was noted by Associate Professor Cockrell that oral health promotion relies on staffing and reaching out to communities, 'and there are lots of analogies in general health where we adopted a preventative approach to that particular health problem. For example had we

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495 Submission 200, NCOSS, p16

496 Submission 200, NCOSS, p16

497 Associate Professor Cockrell, University of Newcastle, Evidence, 14 November 2005, p27

498 Dr Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons, Evidence, 16 February 2006, p25

continued to graduate more and more plastic surgeons in relation to melanoma instead of the health promotion aspect, it is an interesting thought.'[499]

7.48 As noted in Chapter 3, the NSW Oral Health Promotion Network was established in August 2005 and is responsible for monitoring and coordinating oral health promotion in accordance with a framework. Dr Clive Wright, Chief Dental Officer, NSW Health, advised the Committee that:

> The strategic oral health promotion framework was developed over a period of time, and it looks at health promotion up until 2010. It has been incorporated into the New South Wales oral health strategic plan itself. The overall strategic plan is not completed yet; it is with the department. So I am trying to dissect out the oral health promotion component for you. It sets priorities which include increasing fluoridation, increasing oral health and primary health care; increasing awareness in the population and community of the importance of oral health; strengthening the co-ordination, training and information services for oral health promotion; increasing partnerships with appropriate stakeholders; and a component of improving access to services.[500]

7.49 The Committee notes that at the first Network meeting members were informed that no significant new funding would be made available for oral health promotion activities under the framework, which raises serious questions as to whether the Network can implement its mandate, particularly as any fund allocations would be made at the expense of already overstretched clinical services.[501]

7.50 NCOSS recommended that funding to assist the NSW Oral Health Branch to implement the NSW Oral Health Promotion Framework for Action Plan 2010 would enable broad strategies to be implemented in relation to oral health.[502] The Committee has made a similar recommendation in Chapter 3.

Local oral health promotion

7.51 An example of a local oral health promotion was the "Teeth for Health" program in the Mid North Coast region, chosen by NSW Health as the site for testing a population health approach. The approach used for the fluoridation campaign in the Teeth for Health Project involved a "grass roots" approach using basic principles of health promotion.[503]

7.52 The preventive program Teeth for Health is further explained by Mr John Irving, Project Manager, North Coast Area Health Service, who pointed out it was more than just fluoridation of the public drinking water:

> The aim of the project was to draw attention to the poor oral health in the community … Another thing was to inform the community that dental disease was largely preventable and to also encourage councils to consider fluoridation of water supplies as a means of helping to reduce the level of dental decay. That is very much based on

499 Associate Professor Cockrell, University of Newcastle, Evidence, 14 November 2005, p27

500 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, p34

501 Supplementary submission 226a, ADA (NSW) Ltd, p8

502 Submission 200, NCOSS, p18

503 Submission 254, NSW Health, p10

> the recommendation about the effectiveness, safety and equitable nature of water fluoridation.
>
> [Of] Hastings, Coffs Harbour, Bellingen and Kempsey, so far all but Bellingen have received directions to fluoridate and, as the General Manager from Hastings said earlier, it happened on 6 August last year. The other impact about the Teeth for Health program is that fluoridation was only ever one part of it, but it has become the dominant fight for obvious reasons. Prevention really is the focus of the program and, apart from water fluoridation, you have diet, oral hygiene and what goes on at the dentist, such as fissure sealants and so forth to encourage the community to adopt a better diet, to reduce sugar intake, to indulge in better oral hygiene and, wherever possible, use dental applications such as fluoride or other types of sealants to reduce the likelihood of tooth decay.
>
> In doing what we have been doing over the past two years, which is how long the program has been running, we have been able to develop partnerships with other health organisations, other health professionals, bodies such as local councils, that can undertake further prevention activities based around things such as diet and oral hygiene.[504]

7.53 The Sydney South West Area Health Service advised that the oral health services branch in that area is actively involved in oral health promotion and education activities, however the Service commented that these are conducted in isolation from other health promotion activities:

> Regular oral health education is carried out to Early Childhood Health Nurses, Mothers groups, disability carers and community groups. The annual Dental Awareness Month activities are promoted and heavily supported by the Sydney Dental Hospital. However, these activities in SSWAHS and in other areas tend to be conducted in isolation from mainstream health promotion units which have greater expertise.[505]

7.54 The Committee notes that oral heal promotion programs are not consistent across area health services, due to their differing size, population needs and service capability. However, the Committee believes that it is important to integrate oral health promotion into mainstream health promotion, such as Early Childhood Health Centres, the Blue Book and primary school education programs.

Recommendation 27

That oral health promotion be integrated into mainstream health promotion, such as Early Childhood Health Centres, the Blue Book and primary school education programs.

504 Mr John Irving, North Coast Area Health Service, Evidence, 23 August 2005, pp35-36

505 Submission 118, Sydney South West Area Health Service, p8

Targeted oral health promotion

7.55 The Committee acknowledged in Chapter 6 that special needs groups including children, the elderly, Aboriginal and Torres Strait islanders, migrants and refugees and the disabled require specialised programs taking into account the unique circumstances of each group.

7.56 NCOSS emphasised that the provision of oral health promotion needs to be tailored to target groups and be culturally appropriate.[506] Targeted oral health promotion would clearly address the second and fourth aims of the population health approach as outlined in paragraph 7.25, namely, to build individual and community capacity and reduce disparities in health status through equitable allocation of health resources and access to health services.

7.57 Targeted oral health promotion was supported by Dr Taylor who described barriers to prevention:

> We need to look at the population that we are treating. In the public health service we are treating people who are poor or marginalised and who may not necessarily know their rights, with poor access and ability to access health services. You cannot go to the dentist if you do not know where the dentist is or if you cannot read the signs to get there. We also have to consider the population that we are dealing with.[507]

7.58 Ms Jo Alley, UnitingCare Burnside, also stressed the need for culturally appropriate prevention strategies and provided examples:

> In south-west Sydney the area health service nutritionists have been involved in conducting a multilingual bottle feeding multi-strategic health promotion intervention. That is the sort of thing that could be picked up on. There are types of pilot projects that are around, particularly working with people from culturally and linguistically diverse—different ethnic—groups that could be funded more extensively. But these programs usually operate on very limited budgets … NSW Health could put in a little extra money and make it more statewide, utilising the resources that it has developed and using the print media and ethnic radio. [508]

7.59 The Sydney South West Area Health Service noted that 'special programs to target high-risk groups have been successful in the past, although some programs, for example targeting humanitarian program migrants, have not been able to continue due to resources restrictions.'[509]

Plans for an oral health promotion campaign

7.60 NSW Health commented that there is, in fact, a plan for an oral health promotion campaign:

> I think there are a lot of people working towards having that done but it is very, very difficult to get all the ducks in line—if I may use that term—that you need to put that together and then get all the parties co-ordinated to do it. But I have been encouraged

506 Submission 200, NCOSS, p18

507 Dr Barbara Taylor, Head of the Department of Periodontics, Sydney Dental Hospital, Evidence, 29 June 2006, p22

508 Ms Jo Alley, Policy Officer, UnitingCare Burnside, Evidence, 5 July 2005, p47

509 Submission 118, Sydney South West Area Health Service, p8

> by the fact that there has been a Commonwealth and State commitment to this, through the Health Ministers' program, and it is on the agenda.[510]

7.61 However, Dr Wright, NSW Health, advised that there is a need to be cautious with public sector promotion campaigns, and to ensure the programs are evidence based and will deliver outcomes. Dr Wright provided the following example:

> For example, going into schools and providing health information on a classroom basis or even awareness programs that build up the expectation that you, together with clinical contact, will change a health outcome and that there are barriers to you being able to make that clinical contact. So I think we have to look very carefully in terms of those specifics of health education and health promotion programs that they do have an evidence base, they are sustainable in the linkages and perceptions that we create in the public image. If we cannot deliver in terms of the access components those programs themselves do not work.[511]

7.62 The Committee believes that an oral health promotion campaign, like the "Slip Slop Slap" and "Life Be In It" campaigns, would be beneficial to improving oral health. The Committee recognises that campaigns need to be targeted and culturally appropriate as well as part of whole oral health strategies. The Committee acknowledges that NSW Health is developing an oral health promotion framework, however it is noted that it is still in development and that there may be issues of funding as referred to in Chapter 3. The Committee believes that an oral health promotion campaign may require national and state coordination and additional funding to be truly effective, but that additional funds would be recouped in the long term by the reduction in costs of providing dental treatment.

Recommendation 28

That a targeted oral health promotion campaign, like the "Life Be In It" and "Slip Slop Slap" campaigns, be part of the Oral Health Promotion Framework, and that the NSW Government continue to work with the Federal Government to ensure funding and coordination of a national oral health campaign.

Oral health promotion teams

7.63 The Association for the Promotion of Oral Health estimates that substantial gains could be made in oral health if each area health service employed an oral health promotion team of two to four people. This is currently not the case, with only a patchy commitment by different area health services to oral health promotion activities.[512]

7.64 Oral health promotion teams have the ability to deliver on the aims of the population health approach, as set out in paragraph 7.25, including the first aim to promote, prevent and intervene early as well as the third aim to provide a comprehensive range of high quality

510 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, Evidence, 16 February 2006, p49

511 Dr Clive Wright, Chief Dental Officer, NSW Health, Evidence, 16 February 2006, pp49-50

512 Submission 65, Association for the Promotion of Oral Health, p47

integrated health care services. For example, an oral health promotion team could provide a more extensive range of services than just acute treatment, which is currently the focus in public dental clinics.

7.65 During his discussions with the Committee, Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, advised the Committee that intensive prevention is the way forward for oral health and suggested the better use of allied dental health workers, which was also discussed in Chapter 4.

7.66 Associate Professor Evans suggested that the Bachelor of Oral Health students, including dental therapists and hygienists, should be deployed to focus on prevention rather than treatment:

> The people we are training will have both dental hygienist and dental therapy skills, so they will be able to do the work of hygienists and dental therapists. The focus should be that they are deployed to focus on prevention rather than treatment. We now have the technology to prevent most disease, but dentistry has become institutionalised to sell replacement parts and to focus on the treatment of disease rather than on its prevention, and that is a major difficulty that has to be overcome.[513]

7.67 Associate Professor Evans highlighted the fact that more prevention in oral health means an increased need for more allied dental health workers, such as dental therapists and hygienists:

> The way we see it is that these new dental teams, with the therapists and the hygienists, will take care of the less complex things that need to be done and will focus on prevention. Dentists will be busy doing the more difficult things. That is why we need to have hygienists and therapists to do basic dentistry, and to focus on the delivery of the intensive prevention—which, as it goes, people take over themselves.[514]

7.68 Professor Spencer suggested caution in providing additional allied dental practitioners to the team as it may lead to an increase in demand on the system. For example, when an allied dental professional is added to the dental team, they do not just substitute for some of the services that the dentist previously provided. They also create a complementary area of new work, expanding both the provision of services and the demand for services.

7.69 Professor Spencer further commented that there is limited research into the outcomes from adding allied dental professionals:

> I would have to say the research in this sort of area is grossly underdone. We have looked at, for instance, dental hygienists and their involvement in the provision of services in private dental practices. Certainly, from some of the evidence that we had, a dental hygienist is a substitute for a dentist in the provision of the services which they are allowed to provide, which are mainly what we would call the more preventative services and the lower level interventions for periodontal disease or gum disease. They will substitute for a dentist in the provision of a great many of those services within the dental practice and 30% of their role might be that substitution.

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513 Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, Evidence, 14 November 2005, p42

514 Associate Professor Wendell Evans, Evidence, 14 November 2005, p42

> But the remaining part of their role seems to be the provision of services that were not previously provided by that dental practice to the patients that sought care from it. So there is an increase in the rate of provision of preventative services and periodontal services, which simply were not provided previously. We think that is about 70 %.
>
> … we have to look at these things very carefully because they are not necessarily the solution to our labour force issues. It might be the solution to reshaping the mix of dental care. It might draw the mix of dental care in the direction of preventative services and periodontal services, but it is not necessarily as great a contributor to the issue of the differential and supply and demand for services.[515]

7.70 With respect to research, Associate Professor Evans is currently conducting a study to examine intensive prevention work and its cost efficiency: He stated that:

> I was one of three people to get NHMRC [National Health and Medical Research Council] grants in dentistry throughout Australia. It is a randomised control trial of dentist practices in New South Wales metropolitan, rural and remote areas. Dentists in pairs will be randomised to provide either standard care or the intensive preventive care that we are doing. The person who is doing that will do a complete economic evaluation of both parties. So this will provide the first evidence to determine whether or not it is cost effective to deliver preventive care.
>
> ... We hope to have results in three years. We expect it will be a lifetime's work and we will forecast forward and try to add data to the models as we go. It is entirely clear that if people want to have no dental decay from today onwards, we are more or less able to deliver that and also to stop gum disease, which is a little more difficult. But, for all practical purposes, there is no longer a need to have people's mouths full of decayed teeth.[516]

7.71 Chapter 4 considered workforce issues for oral health and recommended that allied dental health workers, such as dental hygienists and dental therapists, should be better utilised through a team approach to oral health care. The idea of an oral health promotion team could build on that recommendation.

7.72 The Committee heeds Professor Spencer's advice in terms of more allied dental health professionals creating increased demand. The Committee is interested in the results of Associate Professor Evans' studies and suggests that any preliminary results would be useful for NSW Health to consider. The Committee noted in Chapter 4 that more allied dental health workers are needed and it is clear that if there is to be a more preventive focus from NSW Health then the recommendations in that chapter, especially Recommendation 12, become even more pertinent to the improvement of oral health in NSW.

7.73 The Committee notes that the area health services differ in size, service capability and use localised policies and procedures that best suit the needs of the region,[517] hence an oral health

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515 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, pp14-15

516 Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, Evidence, 14 November 2005, p42

517 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, Evidence, 5 July 2005, p12

promotion team may not be suitable for all area health services. The Committee also notes that additional resources would be required. However, an oral health promotion team is worth consideration by NSW Health because of the potential for increasing prevention strategies in the public dental clinics.

Recommendation 29

That NSW Health consider the use of oral health promotion teams in area health services across NSW.

Collaborative health approach

7.74 A collaborative health approach to oral health is where health workers, dental and other, as well as service providers work together in prevention strategies for oral disease. This is demonstrative of the third aim of the population health approach, to provide a comprehensive range of high quality, integrated health care services. The Committee received evidence on a number of examples where collaborative work is already being undertaken.

7.75 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, NSW Health, suggested one possible approach being the training of all health professionals in the interrelationships between dental disease and general health:

> I think a couple of the programs that are now being run by the University of Sydney and the University of Newcastle are recognising the need for there to be a much more general education for all health professionals in respect of the interrelationship between dental disease or oral health and general health, and that is gradually, but probably too slowly from my point of view, being incorporated into those programs.[518]

7.76 A further example of collaboration between services is the area health services working with Families First programs, as indicated by Mr Clout:

> At an area health service level … there is an initiative we are looking at for oral health clinicians to work very much more closely with the Families First clinicians who are a range of clinicians, including doctors, nurses and allied health staff who actually go out and work with at-risk families. There is a very high correlation between at-risk families, socioeconomic disadvantage and multiple diseases, including oral health. We should look at programs with our dental clinicians and the general health clinicians in providing that education health promotion and information to people at the preventive and promotion end of dental care, and also identification of families that need to then be referred particularly and specifically to the services.[519]

518 Mr Terry Clout, Chief Executive, Hunter New England Area Health Service, NSW Health, Evidence, 5 July 2005, p5

519 Mr Terry Clout, Evidence, 5 July 2005, p5

7.77 NCOSS supported the idea of collaboration between all health workers to provide prevention:

> I think we have always argued for a multidisciplinary approach to health, whatever that may be and whatever that team may consist of, to meet that group of people's needs. That would probably be another effective way of getting into some of those really disadvantaged groups that you need to get into. It would be a way of skilling other people in some of the basic oral health treatments. As we said before, it is about linking into programs that are in existence so it is not costing more money to set up new programs—you are actually linking into something that is funded, active and happening and you can see whether it is being effective. It is part of that team approach that needs to happen, and which is happening in other aspects of health. It just means linking oral health into that approach.[520]

7.78 The Sydney South West Area Health Service provided examples of health workers working collaboratively with Early Childhood Health Nurses in their area,[521] but it is not clear whether other area health services are participating in similar collaborative work.

7.79 The Committee recognises the importance of all health workers working collaboratively to identify, treat and help prevent oral health disease, and urges NSW Health to consider extending the existing collaborations and creating new ones.

Nutrition programs

7.80 Good nutrition is an important factor in good oral health, and poor nutrition is a risk factor in oral disease. Nutrition programs address the first aim of the population health approach as outlined in paragraph 7.25.

7.81 Good oral health is not just about good oral health practices and access to treatment, it is also about what people are eating that can cause decay. NCOSS said that this is of particular concern among people with transient lifestyles and for some people living in rural and remote communities where access to fresh fruit and vegetables can be difficult.

> There is also a trend of decreasing ownership of fridges for those that are on a very low socio-economic level. People from a low socio-economic background may only have enough disposable income to live one day at a time and so purchase junk food rather than trying to plan meals and purchase food 5-6 days ahead, which requires substantial initial pay out. There is also a misconception amongst many disadvantaged groups that fast food such as McDonalds is cheaper that purchasing and preparing food from the supermarket. Therefore any discussion about prevention strategies must also include the consideration of nutrition. [522]

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520 Ms Edmunds, Senior Policy Officer, NCOSS, Evidence, 5 July 2005, p28

521 Submission 118, Sydney South West Area Health Service, p8

522 Submission 200, NCOSS, p18

7.82 The consumption of soft drinks and sugary foods significantly impacts on oral health, as highlighted by Associate Professor Cockrell:

> The black cola drinks are supposed to be the worst because of the concentration of phosphoric acid, especially if you have a twist of lime in it because you have got a bit of citric acid in it as well. All of the soft drinks have the same effect in terms of erosion of enamel, and sugar consumption. You know all you have got to do is walk into a well-known supermarket at the weekend and look at the amount of snack sugary food that goes into a trolley. So if you actually take away the responsibility—and the sugary things impact the diabetes, the obesity and all of those other health issues too.[523]

7.83 Associate Professor Cockrell demonstrated her strong view on the impact of soft drinks on oral health by suggesting a health warning be attached to soft drinks in order to warn consumers. [524]

7.84 Associate Professor Evans also commented that soft drinks have had a significant impact on oral health of children:

> At a conference I attended in Adelaide it was reported that there is data to show that in the last 10 years the exposure to fluoride has decreased in the order of 15% amongst children. They are saying that it may be due to the increased consumption of not just bottled water per se but the consumption of soft drinks. When I was a child my fluid intake came from milk until I was aged 10. Having soft drink and fizzy drink was a special treat. Now it seems that it is just what people drink.[525]

7.85 In research Professor Spencer commented that 'dental decay is a diet related disease and therefore health promotion programs directed at childhood obesity can also incorporate a focus on the reduction of dietary hits of extrinsic sugars and highly acidic drinks.'[526]

7.86 Witnesses highlighted for the Committee the links between oral disease and nutrition, where bad nutrition can lead to tooth decay and tooth decay can lead to bad nutrition. Professor Spencer commented that that there are 'links between tooth loss and nutrition and this is a particular issue among our older adults as their tooth loss contributes to changes in diet and their nutritional intake, which contributes to loss of weight and a general deterioration in their health.'[527]

7.87 The Committee also heard that any nutrition programs would need to be culturally sensitive. The Pacific Smiles Group suggested in its submission that nutrition programs need to be mindful of a culturally diverse society, since 'some cultures see the oral health care message as

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523 Associate Professor Cockrell, University of Newcastle, Evidence, 14 November 2005, p27

524 Associate Professor Cockrell, Evidence, 14 November 2005, p27

525 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p34

526 Professor A. John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia"*, 2004 Australian Health Policy Institute, University of Sydney, p50

527 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p2

prescriptive and a perceived "victim blaming" exercise. Recommendations to change diets have also been seen as insulting to cultural practice in some groups.'[528]

7.88 The Committee notes the importance of good nutrition for good oral health and general health. The Committee is aware that in programs such as the Teeth for Health program nutrition messages are incorporated, however it is suggested that more could be done to promote the benefits of good nutrition and oral health, at schools for example, through the oral health promotion and general health promotion activities of NSW Health.

Recommendation 30

That nutrition education be included in NSW Health oral health and general health promotion initiatives.

Conclusion

7.89 The Association for the Promotion of Oral Health argued that to make sustainable gains in oral health, consumers and communities must be involved in making choices and participating in decisions about oral health, and that 'this requires education to achieve an appropriately skilled workforce and communities that are empowered to support and promote oral health.'[529]

7.90 The Committee found it difficult to identify precisely the current oral health promotion and other preventive strategies and programs being run in the area health services. The Committee recognises that oral health promotion is not standard across NSW, with different preventive initiatives working in different area health services, and in some cases not being available through public dental clinics.

7.91 The Committee notes that the NSW Oral Health Promotion Framework is being developed, which should offer clearer standards under which area health services can operate. However, the Committee understands that the framework is still in development and it is likely, as suggested by a number of witnesses, that the main issue is a lack of funding and resources, a common theme throughout the Inquiry.

7.92 The Sydney South West Area Health Service commented that it has insufficient resources available to provide the level of service that the community desires, to develop population health initiatives, and to provide training and education for the future workforce:

> If some, possibly unpalatable decisions are not taken about the priorities and objectives of the public oral health sector, then the current system will continue on a crisis and patchwork basis, with the result being a deskilled, poorly trained and thus inappropriate workforce providing poor clinical service with few population health initiatives.[530]

528 Submission 81, Pacific Smiles Group, p10

529 Submission 65, Association for the Promotion of Oral Health, p47

530 Submission 118, Sydney South West Area Health Service, p2

7.93 The Committee acknowledges that the optimum delivery of preventive initiatives is through a population health approach, which includes initiatives such as, but not limited to, fluoridation, oral health promotion through education campaigns, oral health promotion teams, a collaborative approach of health workers and nutrition programs. The Committee recommends that funding be specifically allocation to prevention and oral health promotion strategies.

Recommendation 31

That additional funding be specifically allocated to prevention and oral health promotion strategies.

Chapter 8 Fluoridation

The Committee received an overwhelming amount of evidence, much of it containing detailed information, on the issue of fluoridation of public water supplies. A significant amount of the material was scientific information outlining the potential positive and negative effects of fluoridation. The Committee appreciates individuals' concerns on the issue but is not in a position to make a judgement in relation to scientific information as it is outside the Committee's expertise. This chapter addresses Term of Reference 1(f) in relation to fluoridation.

This chapter is primarily based on information the Committee received in submissions and evidence and will look at:

- fluoride and fluoridation
- support for fluoride
- main arguments against fluoride
- bottled water and fluoride.

Fluoride and fluoridation

8.1 Fluoride occurs naturally in most public water supplies although the level varies. Fluoridation programs adjust the fluoride concentration to an optimum level (around 1 mg/litre) for the prevention of dental caries and the management of potential health and environmental risks.[531] Fluoride is odourless and tasteless so there is no perceptible change to the water. The fluoridation occurs at water treatment works.[532]

8.2 According to the Australian Dental Association, fluoride was first introduced into a public water supply in Australia in 1953 in Beaconsfield, near Launceston, Tasmania.[533] Fluoridation was introduced in the Sydney metropolitan area in 1968.[534] Fluoridation is not mandatory across New South Wales. NSW Health advised that although approximately 90% of residents of New South Wales have access to fluoridated water, this is unevenly distributed with 100% of the population of Sydney having access to fluoridated water, with the figure falling to 59% of the population outside Sydney.[535]

8.3 The NSW Health submission suggested that water fluoridation has proven to be the most cost effective dental public health measure since its introduction in Australian in the 1960s. NSW Health advised that:

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531 Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, Evidence, 14 November 2005, p36

532 http://www.ada.org.au/_FAQFl.asp

533 *Fluoride: Nature thought of it first*, Australian Dental Association, 2003, p1

534 *Water Fluoridation in Australia Today*, University of Adelaide, 1997, p1

535 Submission 254, NSW Health, p9

> Annual costs of water fluoridation per capita vary considerably with the size of the community. Estimates range from $0.21 per person for a population of 2,700,000 (Sydney 1996) to $3.76 for a population of 5,200. Moreover, for each dollar invested in fluoridation, over $80 in treatment costs are prevented, amounting to an 80:1 benefit to cost ratio. Few disease prevention efforts and even fewer government-sponsored programs achieve that level of return on investment.[536]

Fluoridation legislation

8.4 Legislation providing for water fluoridation in New South Wales is described as permissive or enabling legislation. Under the *Fluoridation of Public Water Supplies Act 1957* (the Act) NSW local councils have responsibility for deciding whether or not to fluoridate the public water supply, with the approval of NSW Health. The Local Government Association of NSW and the Shires Association of NSW advised:

> Just over 100 of the 152 councils in NSW are responsible for water supply. On the basis of information supplied by NSW Health, in May 2003 57 NSW councils responsible for water supplies did not fluoridate (8 had high naturally occurring levels that made it unnecessary), 23 fluoridated some parts of their area and not others and the remainder fluoridated all parts of their area. Whilst there have been amalgamations since then, it remains clear the majority of councils who do not fluoridate all of the water supply in their localities represents a significant proportion of rural and regional councils.[537]

8.5 The Fluoridation of Public Water Supplies Regulation 2002 deals with the procedures for keeping records of the addition of fluoride, analysing the water for fluoride content, and qualifications of the operators, as well as precautions to be taken by water supply authorities to protect the operators. The Regulation stipulates that the fluoridation of a public water supply must be in accordance with the Fluoridation Code.[538] The Code includes technical materials that have not been specified in the Act or in the Regulation.

Referral of the decision on fluoridation

8.6 Under the Act councils can also refer the decision whether or not to fluoridate the public water supply to the Director-General of NSW Health, who makes the decision on the advice of the Fluoridation of Public Water Supplies Advisory Committee established by the Act.[539]

8.7 In August 2004, NSW Health increased its funding for fluoridation from 50% to 100% of capital costs incurred by council. Letters were sent to all un-fluoridated councils informing them of this change. The Brewarrina Shire Council accepted the offer and at least another 10 councils are expressing interest in fluoridation and have requested assistance from NSW Health with information, programs and community consultation. Dr Denise Robinson, Chief

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536 Submission 254, NSW Health, p9 – endnotes 6&7

537 Submission no. 172 Local Government Association of NSW and Shires Association of NSW

538 Code of Practice for the fluoridation of public water supplies, August 2002, NSW Health

539 The committee also has the power to initiate and refer to the Minister proposals concerning the addition of fluoride to public water supplies.

Health Officer and Deputy Director-General Population Health, NSW Health, told the Committee that 'the only cost to the councils now relates to the ongoing maintenance of their program. Depending on the size of the community that can work out from, say, 35¢ to 40¢ per head per year to somewhere between $2 and $3, depending on the size of the water supply and the community. But it is a relatively low cost with huge benefits to the population.'[540]

8.8 The NSW Health Teeth For Health project, outlined in the previous chapter, has resulted in the implementation of oral health promotion strategies, particularly water fluoridation in the Mid North Coast of New South Wales since 2002. NSW Health advised that the local data gathered during these campaigns demonstrated that un-fluoridated communities in rural New South Wales had a significantly higher number of caries compared to neighbouring fluoridated areas, despite the use of fluoride toothpaste.[541]

8.9 NSW Health advised the Committee that, as a result of the initiative taken by the Mid North Coast Area Health Service and the Centre for Oral Health Strategy, councils at Coffs Harbour, Hastings, Kempsey and Moree referred the decision on the fluoridation of their water supplies to the Director-General of Health. The Director-General of NSW Health, having sought the advice of the Fluoridation of Public Water Supplies Advisory Committee, directed these councils to commence fluoridation by November 2005.[542]

8.10 The Committee understands that these councils are currently in varying stages of undertaking fluoridation, including construction of infrastructure.

Support for fluoridation

8.11 The Committee heard evidence in support of fluoridation from academics and the dental profession as well as NSW Health. Fluoridation of public water supplies is also endorsed by the World Health Organisation (WHO) and, in Australia, the National Health and Medical Research Council (NHMRC). The main reasons put forward for support of fluoridation include:

- fluoride reduces dental caries in children and adults
- fluoride can be distributed through public water supplies so can be accessed by all households in fluoridated areas, regardless of socio-economic level
- fluoride is cost effective as a preventive program by reducing the need for government spending on treatment of dental disease.

8.12 WHO states that 'there is clear evidence that long-term exposure to an optimal level of fluoride results in diminishing levels of caries in both child and adult populations.' [543]

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540 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p11

541 Dr Denise Robinson, Evidence, 5 July 2005, p2

542 Dr Denise Robinson, Evidence, 5 July 2005, p2

543 http://www.who.int/oral_health/action/risks/en/index1.html

8.13 NHMRC states that 'water fluoridation at optimal levels, varying from 0.6 ppm in sub-tropical regions to 1.1 ppm in temperate climates, continues to provide significant benefits in the prevention of dental caries for both deciduous and permanent teeth. The evidence for a protective effect on dental health is strongest in childhood but can also be demonstrated in adults.' [544]

National Advisory Committee on Oral Health: Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004–2013

8.14 The *National Oral Health Plan 2004–2013* supports extending fluoridation of public water supplies to communities across Australia with populations of 1000 or more. The Plan states:

> Fluoridation of public water supplies is the single most effective public health measure for reducing dental caries across the population, with its most pronounced effects among those who are disadvantaged and most at risk (Acheson 1998, DHS 2000a). Fluoridation needs to be extended across Australia, particularly within rural areas. The population needed for cost-effective provision of fluoridation depends on the level of dental decay in the community. Recent analysis conducted in New Zealand suggests, on conservative assumptions, that a population of 1,000 is near the practical lower bound (Wright et al 2001).[545]

NSW Health

8.15 NSW Health advised the Committee that in line with the recommendation of the *National Oral Health Plan 2004-2013*, NSW Health is committed to the introduction of fluoride in all communities with a population of over 1,000 where fluoridation of the water supply is possible, and other fluoridation strategies in smaller communities.[546]

8.16 As stated earlier, NSW Health noted that fluoridation has the potential to avoid the spending of millions of dollars on dental disease. The estimated benefits/cost ratio for fluoridation is 80:1. For every dollar spent there is $80 in benefit in reduction in oral health care needs.[547]

Australian Dental Association

8.17 Representatives of the Australian Dental Association (NSW Branch) (ADA (NSW)) advised that the Association supported fluoridation of water in NSW and that:

- the ADA has supported the fluoride initiative since 1956
- the majority of research that it has assessed is fully supportive of water fluoridation

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544 *Review of Water Fluoridation and Fluoride Intake from Discretionary Fluoride Supplements*, NHMRC, 1999, pii

545 National Advisory Committee on Oral Health, "*Healthy mouths, healthy lives: Australia's National Oral Health Plan 2004-2013*", July 2004, p16

546 Dr Denise Robinson, Chief Health Officer and Deputy Director-General Population Health, NSW Health, Evidence, 5 July 2005, p3

547 Dr Denise Robinson, Evidence, 5 July 2005, p3

- it supports making fluoridation mandatory for local government areas.[548]

NCOSS

8.18 NSW Council of Social Services (NCOSS) supported the fluoridation of public water in NSW; based on the evidence available from numerous research studies and as a public health measure that addresses socio-economic disadvantage, it supports the introduction of fluoridation in currently un-fluoridated water supplies in NSW. NCOSS recommended that legislation be passed mandating water fluoridation. NCOSS also recommended that water fluoridation should be fully supported with Government funding start up costs and councils bearing responsibility for running costs.[549]

Allied dental professions

8.19 The four allied dental professions (NSW Dental Assistants' Association, NSW Dental Therapists Association Inc, the Dental Technicians' Association and the Association of Dental Prosthetics Inc) represented at the hearing held on 3 August 2005 supported the fluoridation of public water supplies.[550]

Australian Health Policy Institute, University of Sydney

8.20 Professor Spencer suggested in research that water fluoridation is a safe, effective and socially equitable public health measure for the prevention of dental decay across all age groups and the extension of water fluoridation can diminish inequalities in oral health in Australia. Professor Spencer advised:

> Some 30 % of Australians do not have access to water fluoridation. Those without access to fluoridated water, with the exception of Brisbane, are biased toward lower social position households (Spencer et al, 1998). They include some of Australia's most vulnerable groups for poorer oral health: Indigenous people and rural dwellers. All treated potable water supplies should be fluoridated. A Commonwealth, State and Territory governments' cost sharing agreement on capital and recurrent costs of water fluoridation should be reached so as to stimulate the implementation of water fluoridation.[551]

8.21 This paper also comments on fluoridation being cost effective:

> No other single measure can be taken that would achieve the cost-effectiveness of water fluoridation. It provides improved child, adolescent and young adult oral health that is a platform for all other oral health promotion and ongoing maintenance of oral

548 In 2003 the ADA published a paper that highlights the development and benefits of fluoridation of public water entitled *Fluoridation: Nature thought of it first.*

549 Submission 200, NCOSS, pp17-18

550 Evidence, 3 August 2005.

551 Professor A. John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia"*, 2004, Australian Health Policy Institute, University of Sydney, pp49-50

> health (Wright et al 1999; 2001; Sanderson and Wilson, 1994). Its extension into areas with a bias toward lower socio-economic households and its increased benefit for those most at risk would contribute to reducing inequalities in oral health.[552]

8.22 In his evidence to the Committee, Professor Spencer stated that he remains 'firmly convinced that water fluoridation is the population-level cornerstone of our prevention of dental caries in children, adolescents and young adults.'[553]

Main anti-fluoride arguments

8.23 A number of submissions to the Inquiry do not support the fluoridation of public water supplies in New South Wales. The main argument against fluoridation of public water supplies is that the ingestion of fluoride is not as safe as NSW Health and research suggests. Health concerns put to the Committee in the submissions and evidence include the following:

- fluoride is unsafe in high doses as reported by the World Health Organisation and the Australian National Health and Medical Research Council
- fluoride can cause dental fluorosis (mottling of enamel) which can lead to increased tooth decay
- fluoride can cause skeletal fluorosis, increased bone density, structural damage to bones and calcification of joints and ligaments
- fluoride accumulates on the bone and causes tumours on bones and joints
- silicofluoride is used in fluoride schemes:
  - silicofluoride has not been tested as safe for human consumption
  - is linked to behavioural disorders in children and increased rates of social violence and crime
  - the industrial grade product contains arsenic and lead
- statistics show that populations with access to fluoridated water either have increased tooth decay as opposed to non-fluoridated populations, or there is little difference.

8.24 Other arguments raised in the submissions and evidence against the introduction of fluoride include:

- some people are hyper-sensitive and therefore the daily intake of fluoride by individuals from all sources should be measured before new fluoride schemes are introduced
- only 1% of water is actually consumed so the cost of installation of fluoridation schemes (approximately $1million/water supply) would be better spent on direct dental services

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552 Professor A. John Spencer, "*Narrowing the inequality gap in oral health and dental care in Australia"*, 2004, Australian Health Policy Institute, University of Sydney, pp49-50

553 Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide, Evidence, 16 February 2006, p16

- there has been a lack of government response to concerns raised
- human rights and medical ethics become an issue if state actions take precedence over individual wishes
- fluoride research does not meet the Cochrane standards[554] and a recent review of fluoride literature by the University of York suggests more research is required
- fluoride in the water may have an impact on flora and fauna.

Port Macquarie public forum

8.25 The Committee travelled to Port Macquarie on 23 August 2005 to hear from the local community about the issue of fluoridating the public drinking water in the Hastings Council area. Fluoridation was a contentious issue in the area as the local council had referred the decision to fluoridate to NSW Health, which on the advice of the Fluoridation of Public Water Supplies Advisory Committee directed Hastings Council to fluoridate the public drinking water.

8.26 The Committee heard from Mr Bernard Smith, General Manager of Hastings Council, who provided background on the issue of fluoridation and the council:

> Back in 1999 the Mid North Coast Area Health Service approached council with information regarding how council has dealt with fluoridation in previous years. You may have heard this morning that there was a referendum back in the early 1990s about it. In January 2001 we received correspondence from the area health service advocating the benefits of fluoridated water, and inviting me to a meeting with other mid North Coast mayors to discuss it. In March 2001 council engaged Hunter Water to provide some general information about fluoridation both from a technical and community point of view. Then in December 2003 we received an invitation, in effect, from the area health service advising of what was entitled a Decay Crisis Summit, which was to be held in the second quarter of 2004. Council subsequently attended that, which was a teleconference, along with other mid North Coast councils chaired by Dr Norman Swan.
>
> At that time the issue re-emerged as a public issue and generated a significant amount of public discussion and debate. Obviously, it was firmly back on the public agenda. We had council elections in April 2004. We then found ourselves in the position of having two notices of motion at a council meeting on 31 May. I am sure the panel is aware, but there are two ways in which fluoridation can be introduced to the water supply. One through the council making the decision itself to fluoridate or, alternatively, it can refer the matter to the State Government-appointed body. Ultimately we had two notices of motion at a council meeting, one saying that we should not fluoridate and that we should conduct a public poll. The other one put forward a motion that it be referred to the expert panel that is set up under the Fluoridation of Public Water Supplies Act. Subsequently council resolved to refer the matter to that panel.[555]

554 The Cochrane standards is a rating system given to the quality of evidence used in studies.

555 Mr Bernard Smith, General Manager, Hastings Council, Evidence, 23 August 2005, p21

8.27 Mr Smith advised that as a result there was a gazettal on 16 August 2004 directing Council to introduce fluoride to its water supply. Mr Smith stated that Council is finalising detailed design and that 'we expect the facility to cost in the order of $1.2 million. It will cost around $75,000 a year to operate.' They expect to have the facility operational in May or June 2006. [556]

8.28 In relation to costs, Mr Smith commented that:

> In terms of the capital cost of $1.2 million, like any of these projects that has increased in recent times. In our recently adopted budget we have $1 million provided to be offset by funding from the State Government of $1 million. Obviously, we will go back and have a talk to them about the additional funds. With regard to the recurrent cost, the mid North Coast offered $20,000 per year for the first two years. Obviously, that is insufficient and we have gone back and asked them for more money please. But the recurrent cost will be possibly $75,000 per year. [557]

8.29 Mr Smith advised that the Council heard evidence from both sides of the fluoride debate and felt that the Council was being asked to make a decision on a very technical and scientific matter, which is why it made the decision to refer the matter to NSW Health.[558] He stated:

> Particularly given it was such a technical issue and they were in receipt of a lot of scientific information, which most people would not be able to interpret, and also given that, ultimately, it felt that the issue at large was more the domain of State Government than local government, they were a couple of important elements in their determining that the State Government was the most appropriate body to determine what should occur. [559]

8.30 The Committee heard from a number of local groups and organisations that are opposed to fluoridation of the public drinking water on the Mid North Coast. Ms Lyn James, Acting Secretary, Mid North Coast Fluoride Free Alliance, said she believes fluoride is not the answer for dental problems as 'we have to look at the problems of sugar—sugary foods, drinks and things that are detrimental to the actual teeth—and not put a bandaid on them by putting fluoride in the water.'[560]

8.31 Ms James advised the Committee of her grandson who she claims suffers from dental fluorosis:

> As a grandmother I am here representing my grandson, who has dental fluorosis. My grandson not only suffers pain and discomfort from his teeth because they crumble and break … As you know, if you smile the first thing people see is your teeth. It could affect your job prospects. It could affect your personality and so on. [561]

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556 Mr Bernard Smith, Evidence, 23 August 2005, p21

557 Mr Bernard Smith, Evidence, 23 August 2005, p21

558 Mr Bernard Smith, Evidence, 23 August 2005, p22

559 Mr Bernard Smith, Evidence, 23 August 2005, p22

560 Ms Lyn James Acting Secretary, Mid North Coast Fluoride Free Alliance, Evidence, 23 August 2005, p1

561 Ms Lyn James Acting Secretary, Mid North Coast Fluoride Free Alliance, Evidence, 23 August 2005, p2

8.32 Mrs Patricia Wheeldon, Secretary, Mid North Coast Fluoride Free Alliance, advised the Committee that there is a need to test individual ingestion of fluoride before fluoridating the water:

> The population has not been tested for individual ingestion of fluoride. WHO states that this is essential prior to introducing fluoride to water supplies. The NHMRC also state that. Why no testing? I have asked and have been given assurance by NSW Health—after four months and the intervention of the NSW Ombudsman to gain a reply to my four questions—that no testing is being undertaken as to ingestion rates regarding fluoride, and no testing into fluoride-induced arthritic symptoms. Despite requests from NSW Health, no testing into the Aboriginal population has been presented.[562]

8.33 Mrs Wheeldon also commented that the Australian Research Council for Population Oral Health, Child Dental Health Survey 2000, shows better permanent teeth in unfluoridated Hastings/Macleay than in 37-year fluoridated Sydney. Mrs Wheeldon suggested:

> Save Our Kids Smiles 2004 shows better permanent teeth again in unfluoridated Hastings/Macleay than in fluoridated Nambucca. I have a bundle of affidavits signed by professionals opposed to fluoridation. They are concerned with the health implications. There has been no public consultations. Public meetings we have had have been arranged by concerned residents and health department officials refuse to attend. Only one-sided information received via the media.[563]

8.34 Mrs Barbara Grant-Curtis, member of Citizens Against Fluoridation, commented that 1% of the population may be sensitive to fluoride:

> I am dead set against fluoridation. I speak because of the acknowledgment by even the health authorities and the pro-fluoridationists that at least 1% of the population is sensitive or allergic to fluoride. We are having more and more people who have chemical sensitivity problems, multiple chemical sensitivity, and I am one of them. We have a lot of people who have children that are full of the problems of attention deficit disorder—my family has that as well.[564]

8.35 Mrs Grant-Curtis further commented that there has been a lack of consultation on the issue:

> We called forums at which the public health department, dentists and everybody else refused to speak. So as far as we are concerned there is no democracy in this, there is no consultation and there is no warning of possible side effects or adverse effects to general health. There is compulsory mass medication and it is not even based on an assessment of a person's state of health or his or her consumption or use of water. If you can say this is science, well, holy cow, I do not want to know about it.[565]

8.36 Councillor Lisa Intemann, Hastings Council, advised the Committee that 'it is my understanding from the evidence that fluoridation does not actually assist in the reduction or

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562 Mrs Patricia Wheeldon, Secretary, Mid North Coast Fluoride Free Alliance, Evidence, 23 August 2005, p2

563 Mrs Patricia Wheeldon, Evidence, 23 August 2005, p2

564 Mrs Barbara Grant-Curtis, member of Citizens Against Fluoridation, Evidence, 23 August 2005, p5

565 Ms Barbara Grant-Curtis, member of Citizens Against Fluoridation, Evidence, 23 August 2005, p5

the prevention of tooth decay and furthermore that the excess consumption of fluoride in various forms can be detrimental to human health."[566]

8.37 Cr Intemann also commented on Hastings Council's decision to refer the fluoridation matter to NSW Health:

> My second concern is the manner in which it is being brought to us. Page 6, I think it is, of the code for the Fluoridation of Public Water Supplies Act 1957 says that the water supply authority is expected to have undertaken community consultation prior to referring the matter to New South Wales Health. We have letters from offices of the Department of Health indicating that they specifically delayed the introduction of the discussion locally until after council elections last year so that we could not engage in community debate. I am not privy to all of the discussions with the mayor, et cetera. Nevertheless, it certainly was indicated to me that we, as the council, were not given an option.[567]

8.38 Cr Intemann suggested that other countries have stopped fluoridation:

> I would like to encourage you to consult particularly with other countries that have made the decision not to fluoridate recently. In 2005 it was Scotland. In 2004 it was South Africa. In 2003 it was Basel in Switzerland. That city kept fluoridating for 40 years after the rest of Switzerland stopped. In 2003 they stopped fluoridating on two grounds. Firstly, the lack of evidence for any effectiveness on tooth decay and, secondly, evidence of adverse risks to health.[568]

8.39 Cr Intemann also commented on the issue of receiving an 'unregulated dose of fluoride':

> There is an amount of fluoride in modern consumption which is one thing and we, as a population, need to be dealing with what are the effects, I don't know. But if we are adding it to the water as well, I believe, two things follow: first, people have got an unregulated dose because we do not know who is drinking the water, how much, et cetera and, second, it confounds your whole research, adding something extra there. If fluoride really is not very good for our health then we are adding something which is confounding the situation. But you are confounding the research situation as well because it is being added through the water so we have no idea how much people are consuming. And so it effects both your health situation and the research situation because we do not know what is in there and how much people are consuming.[569]

8.40 Mrs Therese Mackay, Hastings Safe Water Association, stated that the Association is against fluoridation based on scientific grounds:

> I represent the Hastings Safe Water Association, which has been around since 1989. Our group is totally opposed to the use of fluoride. There is no place for fluoride inside the human body. We have researched scientific literature and understand that there is no proof, double blind scientifically acceptable studies—certainly not done in Australia, but there is not one in the world … —that fluoride prevents dental decay. It

566 Councillor Lisa Intemann, Hastings Council, Evidence, 23 August 2005, p11

567 Councillor Lisa Intemann, Evidence, 23 August 2005, p11

568 Councillor Lisa Intemann, Evidence, 23 August 2005, p11

569 Councillor Lisa Intemann, Evidence, 23 August 2005, p12

> is not a nutrient. It is not only not essential to life it is incredibly harmful and has no place in dentistry or in our water.[570]

8.41 Ms Sylvia Turner, Central Coast Our Water Association, suggested that '38 years of fluoridation in Sydney and 40 years of fluoridation in Tasmania have not overcome or assisted to overcome this problem [dental decay]. There needs to be a better answer.' [571]

8.42 Mr Gavin Smithers from Coffs Harbour stated that local government has been virtually forced to fluoridate water supplies at an ongoing cost to the council:

> Dental care is not a local government responsibility. If local government were to be contributing funds to medical care there may be a number of other issues that are of high priority; I do not know. Despite the calls for the review of the efficiency, effectiveness and safety of fluoridation, the State refuses to fund this issue.
>
> I recommend that the State pick up the bill for the ongoing cost of fluoridation because, if nothing else, it may prompt an overdue funding review. So fluoridation is not an elegant solution to the dental problem.[572]

8.43 Mr Smithers also commented on the University of York review of literature on fluoridation:

> However, the York review has repeatedly commented on the low to moderate quality of data that safety conclusions are based upon. No matter what is said locally the York review is still the only global review of fluoridation that has taken into account almost every paper available. If the comments show that it does not matter what we at a local level are saying. [573]

8.44 Mr Wayne Evans, Fluoridation Is Not Democratic (FIND), commented:

> I am addressing fluoridation verses democratic rights and human rights in Coffs Harbour. In 1991 just over 70 per cent of the Coffs Harbour residents voted against the fluoridation of their public water supply. In June 2004, without adequate community consultation and with no reason to suggest that the community had changed its opinion about fluoridation, it was decided by five Coffs Harbour city councillors to hand the decision of fluoridation over to the New South Wales Director-General of Health—the same director-general who had never refused an application to fluoridate the public water supply referred under section 6A of the Fluoridation of Public Water Supplies Act 1957.[574]

8.45 The Committee noted the comments made by participants in the public forum and wrote to NSW Health in relation to a number of technical issues that were raised. In particular, the Committee requested information on:

- the University of York review of literature on fluoridation

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570 Mrs Theresa McKay, Hasting Safe Water Association, Evidence, 23 August 2005, p15

571 Ms Turner, Central Coast Our Water Association, Evidence, 23 August 2005, p17

572 Mr Smithers, Evidence, 23 August 2005, p18

573 Mr Smithers, Evidence, 23 August 2005, p18

574 Mr Evans, FIND, Evidence, 23 August 2005, p19

- Cochrane standards for evidence
- tests for the total dose of fluoride ingested
- the therapeutic index of fluoride and dental and skeletal fluorosis
- benefits from fluoridation for adults and children
- topical fluoride versus systemic fluoride
- other countries deciding not to fluoridate for public health reasons
- toxicity of compounds used in fluoridating water.

8.46 The response from NSW Health is available on the Committee's website (www.parliament.nsw.gov.au/socialissues). The Committee does not have the expertise to make a judgement on whether fluoridation has negative impacts, as suggested by the participants in the public forum.

8.47 The Committee is concerned about the role local government is required to play in making a decision whether or not to fluoridate water. As was clearly stated by Hastings Council, the Council was asked to make a technical decision on the issue of fluoridation. The Association for the Promotion of Oral Health (APOH) suggested that legislative change should be enacted, removing the responsibility for fluoridation from local councils, and mandating this as a NSW Health responsibility.[575] This was also recommended by ADA (NSW) and NCOSS.

8.48 The Committee recognises that some community members in the Mid North Coast felt there was a lack of consultation on the decision to fluoridate and strongly suggests that if NSW Health takes on decisions to fluoridate there should be community consultation and public awareness programs. It is also suggested that NSW Health continue to cover costs for capital works for local government areas that are going to fluoridate and that the ongoing-costs are met by the council.[576]

8.49 The Committee recommends that legislation be amended to make it NSW Health's decision to fluoridate and not the local council responsibility.

Recommendation 32

That the legislation be amended to make decisions to fluoridate public drinking water the responsibility of NSW Health not local councils, with provisions for consultation with councils and communities.

575 Submission 65, Association for the Promotion of Oral Health, p46

576 Water rates paid to Sydney Water and Hunter Water authorities cover recurrent costs of fluoridation in metropolitan NSW.

Associate Professor Wendell Evans' comments on anti-fluoride arguments

8.50 The Committee invited Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, to give evidence as he is considered to be an expert in fluoridation and oral health. Associate Professor Evans shared his expertise with the Committee in relation to the various fluoridation arguments.

8.51 Associate Professor Evans provided a number of statistics and results of studies that indicated the effect of fluoride on the population. For example, in 1979, of people aged 65 to 74, approximately 60% of them had no teeth; now, due entirely to water fluoridation and the use of fluoridated toothpaste, people with no teeth in that age group constitute about 40%, and by 2020 it will be down to 10%.[577]

Hawkesbury and Blue Mountains study

8.52 Associate Professor Evans highlighted a study for the Committee to show the impact of fluoridation, that compared school aged children in the Hawkesbury, fluoridated in 1969, and the Blue Mountains, fluoridated in 1993. The study demonstrated the positive impact of fluoride on children's teeth through the measurement of dmft (decayed, missing and filled teeth) index, which measures the load of dental disease people carry.[578]

8.53 Associate Professor Evans advised that this is the most recent study examining the effect of water fluoridation in Australia. The tables below demonstrate that after the introduction of fluoride to the public drinking water in the Blue Mountains the dmft index for children decreased. [579]

Table 8.1 The benefit of water fluoridation in the Blue Mountains: dmft data for children aged 6 – 8 years

	Blue Mountains			**Hawkesbury**			
	Mean			Mean			
	N	**dmft**	sd	N	**dfmt**	sd	p
Baseline[580] 1992	473	**1.91***	2.79	469	**1.12**	2.00	0.0001
Follow up[581] 2003	427	**0.83****	1.70	466	**0.85**	1.67	0.9712

*71% more than for Hawkesbury (fluoridated 1969)
**57% less than at baseline

8.54 Associate Professor Evans said of the results in this table:

> These were representative, random samples of children in both areas. So, this was the situation in the Blue Mountains in 1993, which is on the top line, and in the Hawkesbury area. The value there of 1.91 mean dmft means that the primary teeth—that children aged six to eight had, on average, nearly two decayed, missing and filled

577 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p29

578 Associate Professor Wendell Evans, Evidence, 14 November 2005, p31

579 Associate Professor Wendell Evans, Evidence, 14 November 2005, p31

580 Patterson et al, 1993

581 Evans et al, 2003

> teeth, compared with children in the fluoridated Hawkesbury, which was 1.12. The little "3" above the 1.91 indicates that there was 71% more decay in the Blue Mountains, compared with Hawkesbury, which was fluoridated in 1969.
>
> The survey that we did in 2003 is on the next line down and you can see that in both areas to the mean number of decayed, missing and filled teeth is 0.83 and 0.85. So, it is almost equivalent in both areas and now children in the Blue Mountains have the same level of oral health as children who continue to have the benefits in Hawkesbury. The note there at the bottom indicates that this is 57% less decay than when they started out 10 years previously. These are the dramatic results you get with water fluoridation and it is shown by looking at the dmft index, not just looking at the percentage of children who have decay. That is for the primary teeth. [582]

Table 8.2 The benefit of water fluoridation in the Blue Mountains: dmft data for children aged 9 – 11 years

	Blue Mountains			**Hawkesbury**			
	Mean			Mean			
	N	**dmft**	sd	n	**dfmt**	sd	p
Baseline[583] 1992	435	**0.74***	1.22	418	**0.49**	1.04	0.0005
Follow up[584] 2003	351	**0.27****	0.72	448	**0.31**	0.81	0.6015

*51% more than for Hawkesbury (fluoridated 1969)
**65% less than at baseline

8.55 Associate Professor Evans commented on the results in this table that, since the introduction of fluoride in the Blue Mountains, children aged 9-11 years have 65% less tooth decay than before fluoridation took place in the area. Associate Professor Evans explained in detail:

> If we look at the data now for the permanent teeth of children you can see that in the Blue Mountains before fluoridation the average 9- to 11-year-old had 0.74 verses 0.49. That was 51 per cent more decay that the children were carrying, compared with those in Hawkesbury. Now, 10 years later, the average child has one-third of a tooth that is decayed, that is, 65 per cent less than they started off at. This is showing the truly dramatic results that are there for all to see captured by using the dfmt index. Of course, now we know—it does not show here—that approximately 80 per cent of the children have no decay at all at age 12.[585]

Research

8.56 With respect to the University of York review of literature on fluoridation referred to in anti-fluoride arguments, Associate Professor Evans provided clarification to the Committee:

> It has been most unfortunate that the York report has made it appear that water fluoridation is not effective and that the evidence is very weak. We would argue that they are using the wrong index and that the reduction in dental caries is highly dramatic. Equally dramatic is the improvement in oral health. The evidence is entirely robust, and completely overwhelming and dramatic. It is so obvious, and the costs related to a reduction in dental services to children is so clear.

582 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p31

583 Patterson et al, 1993

584 Evans et al, 2003

585 Associate Professor Wendell Evans, Evidence, 14 November 2005, p31

> This is the first time it has been analysed in that way. It has become clear that it may be appropriate to use that method for other diseases but certainly not for dental caries. I think it was inappropriate to apply that methodology to demonstrate or to affirm the quality of the evidence, which they have said is poor.[586]

8.57 Associate Professor Cockrell, University of Newcastle, provided further advice on fluoride research and the University of York review:

> ... I think with many of these papers … the review has come back as saying that all the literature that is put up against fluoride is flawed basically. There is as much for it as there is against, and the design of the studies has not got the scientific validity or reliability that allows you to make the conclusions that you make.
>
> There has been one systematic review done by the group at the University of York and its conclusions were basically that overall the research is not of a high quality whether it ends up being pro-fluoride or anti-fluoride. From what it could distil from looking at all of the papers that it reviewed, probably the predominant adverse outcome was fluorosis of the teeth but for other adverse medical effects it could find no evidence to support the fact.[587]

8.58 The lack of studies into fluoridation was highlighted by Associate Professor Evans and he explained the difficulties involved in conducting such studies:

> To do what they say, to do the Blue Mountains study, we would have to organise to take the children to a place—where they did not know whether they came from the Hawkesbury or not—and somehow prevent them from telling the people who are examining them where they come from. It is an enormous problem actually going to schools to get their co-operation to do it. This has been done in the United Kingdom, where they have bussed children to a third location and told them not to wear their school uniforms and not to tell anybody what they had done. That has been done and, clearly, the results are just the same.[588]

Therapeutic level

8.59 The therapeutic level, or the level of fluoride that yields the most benefit with least detriment, is an important issue raised in anti-fluoride arguments and Associate Professor Evans advised the Committee that too much fluoride can lead to dental fluorosis and in extreme cases skeletal fluorosis:

> The point is that as you increase the fluoride level in the water from zero upwards, once you get to one part per million or approximately that amount the beneficial effect in reducing decay does not increase any further. If you have double or triple the amount of fluoride you do not get any further benefit against tooth decay … At one part per million you get the maximum protection against caries. But as you increase the level of fluoride in the water above one part per million that is when you get dental fluorosis. [589]

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586 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p33

587 Associate Professor Cockrell, University of Newcastle, Evidence, 14 November 2005, pp25-26

588 Associate Professor Wendell Evans, Evidence, 14 November 2005, p33

589 Associate Professor Wendell Evans, Evidence, 14 November 2005, p35

8.60 The therapeutic level for fluoride in the water is about one part per million. This is increased in a colder climate. For example, in Canada there would be 1.2 parts per million of fluoride in the water and in Hong Kong it is 0.5, because people in tropical areas drink much more water.[590]

8.61 Associate Professor Evans remarked that dental fluorosis in Australia is unlikely to be a result of fluoride in the water:

> There is nowhere in Australia that water levels contain that much fluoride naturally occurring. The only other way people would get that amount of fluoride would be if, as a child, they were swallowing toothpaste, which has quite a high concentration. A tube of toothpaste is fluoridated at 1,000 parts per million, and we do hear that children eat toothpaste. I have been to conferences where people say that they spread out the fluoride gel in the deep-freeze and give it to their children as confectionery. That is the sort of thing that happens. [591]

8.62 The variation in naturally occurring fluoride in New South Wales water is about 0.1 to 0.2 parts per million, depending on the geology of the area. Associate Professor Evans explained 'if your water comes from a deep well it will have more fluoride but if it is just rainwater and lake water the level will be really negligible.'[592]

8.63 Associate Professor Evans argued that as there is no possibility of the fluoride level in the natural water in NSW being at a dangerous level there really is no need for fluoride intake to be measured. He commented that if there were a high level of fluoride in the natural water supply then it would be evidenced by numerous cases of fluorosis.[593]

8.64 With respect to skeletal fluorosis Associate Professor Evans advised that it is uncommon in Australia and mainly observed in remote parts of China, India and Africa:

> To get skeletal fluorosis—it is observed in remote parts of China, India and Africa where the fluoride concentration naturally occurring in the water is more than eight parts per million and people have been exposed to that level over a lifetime. It just does not occur in industrial societies where fluoride in the water is at one part per million. If you go to Sydney hospitals you will see no cases of skeletal fluorosis. It just does not exist.[594]

8.65 Associate Professor Evans responded to another anti-fluoridist argument that research has not been done on the sources used to fluoridate water, such as sodium fluoride, sodium fluoride silicon and sodium tetra fluoride which could be potentially toxic:

> No. All this research has been done in great detail in the United States. The Centers of Disease Control at Atlanta do all this research. It is not done in Australia because there is no point in doing it.[595]

590 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p36

591 Associate Professor Wendell Evans, Evidence, 14 November 2005, p36

592 Associate Professor Wendell Evans, Evidence, 14 November 2005, p36

593 Associate Professor Wendell Evans, Evidence, 14 November 2005, p36

594 Associate Professor Wendell Evans, Evidence, 14 November 2005, p35

595 Associate Professor Wendell Evans, Evidence, 14 November 2005, p37

8.66 As outlined in the previous chapter, NSW Health is currently participating in the 2005 National Adult Survey of Oral Health (NASOH). NSW Health states that this survey will also look at fluoride effects:

> Dental decay rates between adults who have lived in fluoridated and non-fluoridated areas and prevalence of fluorosis measured in this survey will inform the Department of the benefits and/or risks of water fluoridation and the use of other discretionary forms of fluoride.[596]

8.67 The Committee recognises that fluoridation does benefit oral health and that the therapeutic level of one part per million is important to maintain to protect against dental fluorosis. The Committee notes that there appears to be difficulties with research into fluoridation as noted in the University of York review and by Associate Professor Evans. NASOH is a good opportunity to look at the effects in fluoride and the Committee recommends that NSW Health publish the results of the survey when available.

Recommendation 33

That NSW Health publish the results of the National Adult Survey of Oral Health when available.

Bottled water

8.68 During the Committee's visit to Broken Hill, the Committee heard that as a result of purification issues with the public water, most people in the town were consuming bottled water instead of tap water. Councillor Thomas Kennedy, Broken Hill City Council, commented that:

> About two years ago the water became so bad and so smelly that people stopped drinking it and started buying bottled water … What has happened in the last two years or so, I would say that around 80 to 90% of people in the town no longer drink tap water; they drink only bottled water. That means there is no fluoride in that water.[597]

8.69 The Committee was interested to hear about the issue of fluoridation and bottled water. In particular, the Committee wanted to know if a general increase in consumption of bottled water may have an impact on oral health, assuming bottled water does not contain fluoride.

8.70 The Committee heard from Mr Tony Gentile, Chief Executive, Australian Beverages Council Ltd and Executive Director, Australasian Bottled Water Institute who advised that about 670 million litres of bottled water is sold a year, with this amount increasing approximately 10% per year.[598]

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596 Submission 254, NSW Health, pp10-11

597 Councillor Thomas Kennedy, Broken Hill City Council, Evidence, 30 August 2005, p8

598 Mr Tony Gentile, Chief Executive, Australian Beverages Council Ltd and Executive Director, Australasian Bottled Water Institute, Evidence, 14 November 2005, p3

8.71 Mr Gentile was anxious to point out to the Committee that bottled water does not compete with tap water:

> You have got to appreciate that bottled water does not compete with tap water, especially water packaged for retail. Bottled water packaged for retail is primarily a commercial beverage and it competes with all other commercial beverages. The amount of it consumed in lieu of tap water would be absolutely negligible. A little bit less so on the 15-litre cooler side where that is more, I assume, replacement for some tap water. [599]

8.72 The Committee was concerned that children drinking tap water may have better oral health than those drinking bottled water. Mr Gentile suggested that 'the greatest consumption of water by children is in the home and the greatest consumption of water in the home use tap water. Very, very few homes—less than 5 % of households—would have a cooler within the home.' [600]

8.73 Mr Gentile stated that no fluoride is added to bottled water as 'you are not allowed to call anything "natural spring water" or "natural mineral water". If you add anything to the water it stops being water, it stops being a food under the GST terminology and becomes GST payable.'[601]

8.74 Further to this, Mr Gentile suggested that 'people do not buy soft drinks because they are fluoridated, or they do not buy fruit juices. They buy them because they are thirsty, because they want a beverage with their meal, something refreshing. That is the role of the refreshment beverage industry.'[602]

8.75 When asked whether fluoride should be added to bottled water Mr Gentile commented:

> Compulsorily? Absolutely not! … Because some people do not want it … The people who do not want to consume fluoride at the moment, from Sydney tap water, have a choice. They can either distil their water at home and get rid of it through a filter, or they can buy bottled water … We are opposed to compulsory addition of anything to our beverages, because we do not believe that our beverages should be used as medicine. They are refreshment beverages.[603]

8.76 Associate Professor Cockrell, University of Newcastle, commented on the issue of bottled water pointing to a 1989 Colorado study into the effects of bottled water on children's teeth. Associate Professor Cockrell explained:

> In 1989 a study was done in Colorado that looked at the intake of bottled water in children. In a paediatric dental practise in 1989,which is a while ago now, it was 10%, so one would assume that it has gone up … 10% of children drank bottled water.[604]

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599 Mr Tony Gentile, Chief Executive, Australian Beverages Council Ltd and Executive Director, Australasian Bottled Water Institute, Evidence, 14 November 2005, p3

600 Mr Tony Gentile, Evidence, 14 November 2005, p6

601 Mr Tony Gentile, Evidence, 14 November 2005, pp4-5

602 Mr Tony Gentile, Evidence, 14 November 2005, p7

603 Mr Tony Gentile, Evidence, 14 November 2005, pp8-9

604 Associate Professor Cockrell, University of Newcastle, Evidence, 14 November 2005, p25

8.77 Associate Professor Cockrell said that 'it was interesting that the paper also showed that it analysed the fluoride content of bottled water and it ranged from 0.04 to 1.4 parts per million.'[605]

8.78 Associate Professor Evans also commented on the issue of bottled water and fluoride, pointing out that fluoride is in Sydney water and if they are using this water then the bottled water will contain fluoride:

> Where does the water come from? If it comes from Sydney, it contains fluoride at one part per million. So, they are not taking fluoride out of the water. Where are they getting the water from? Fluoride is a natural element and the thirteenth most abundant in the earth's crust. It is in rocks and soil at 800 parts per million, so all water contains fluoride. If it is rainwater, then it contains less fluoride. With most reticulated water systems that rely on lakes and rivers there is little fluoride—that is why it has to be adjusted upwards—but if it is well water often it has quite high levels of fluoride. If they are using mineral water it will have naturally occurring fluoride. [606]

8.79 Associate Professor Evans suggests the bottled water producers are unlikely to be filtering out fluoride in the water supply:

> As far as I know it is still there. Some of the filters do remove fluoride but they have to be changed. They soon become clogged and are not effective. I think that some of them are not very effective at all.[607]

8.80 The Committee notes these comments. From this evidence it appears that the increased consumption of bottled water has not impacted on oral health. Indeed, if bottled water successfully competes with packaged fruit juice and soft drinks its impact on oral health may be positive.

Conclusion

8.81 The Committee acknowledges that fluoride is only part of the answer in preventing oral disease and recognises that, as asserted by many witnesses, prevention needs to encompass a whole package of strategies such as those examined in the previous chapter. As Associate Professor Zoellner commented, in terms of prevention we need more than just fluoridation:

> I think that people have developed a false sense of security: there is all this fluoride in the water and the kids are fine. It is certainly true that compared with previous generations—two or three generations ago—we have much better teeth. But there is a false sense of security there. Of course, if patients are denied treatment early their problems simply get worse.[608]

8.82 The Committee acknowledges that water fluoridation has impacted positively on the decayed, missing and filled teeth (dmft) index in children as demonstrated by the Hawkesbury and Blue

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605 Associate Professor Cockrell, Evidence, 14 November 2005, p25

606 Associate Professor Wendell Evans, University of Sydney, Evidence, 14 November 2005, p32-33

607 Associate Professor Wendell Evans, Evidence, 14 November 2005, p32-33

608 Associate Professor Zoellner, APOH, Evidence, 29 June 2005, p4

Mountains study and that fluoride has a role to play in improving oral health. In relation to the effects of fluoridation on general health, it is assumed that the low dosage of 1 part per million in water is unlikely to cause dental or skeletal fluorosis, but more research may be necessary in this regard.

8.83 The Committee notes the concerns of people against fluoridation, such as the participants in the Port Macquarie public forum. As previously stated, the Committee is not in a position to evaluate the scientific arguments put forward by anti-fluoridists. However, the Committee recognises that water fluoridation has impacted positively on oral health and believes fluoridation should continue. The Committee is also interested in the outcomes of the National Adult Survey of Oral Health in relation to fluoride and other oral health outcomes.

Appendix 1 Submissions

No	Author
1	Confidential
2	Mr David Wilson
3	Mr Bob Behl - General Manager, Hay Shire Council 3a – supplementary submission
4	Mr and Mrs Peter and Alison Kennedy
5	Mr Francis Hand
6	Mr Elbary East
7	Mrs Shirley Davis
8	Ms Sylvia Turner - Co-Convenor, Central Coast Pure Water Association
9	Mr Henri Virtanen
10	Ms Erika Lovriha
11	Ms Fiona Crosskill
12	Mrs Aileen Roberson
13	Ms Teresa Bealey
14	Confidential
15	Ms Joy Mount
16	Ms Alice Scott - Chairperson, The Illawarra Dental Health Action Group
17	Ms Lyn James, Mid North Coast Fluoride Free Alliance
18	Ms Margaret Smith - President, Molong Branch Combined Pensioners and Superannuants Association Inc
19	Mrs Patricia Wheeldon 19a – supplementary submission 19b – supplementary submission
20	Ms Karen Woodham
21	Assoc Prof Chris Daly - Co-ordinator, MDSc (Periodontics) Program University of Sydney, Faculty of Dentistry
22	Mr Colin Ball
23	Ms Helen Knight
24	Dr Phillip Palmer, Prime Practice Pty Ltd
25	Ms Lexia Smallwood - Council Business Manager, National Rural Health Alliance
26	Mr Kevin McLennan
27	Ms K H Goodridge
28	Ms Alana Cotter

No	Author
29	Name Suppressed
30	Mr Bob Jay - Morisset Senior Citizens & Pensioners Association
31	Mr Paul Vernon-Roberts
32	Councillor Ron Page - Mayor, City of Broken Hill
33	Mr Martin Feeg
34	Ms Janice Lau
35	Mrs Robyn B C Smith - Southern Highlands Older Womens Network
36	Dr Ian McNeill
37	Ms Faye Richardson
38	Dr Gordon Moller, Shellharbour Village Dental Surgery
39	Mr Spencer Kain, Gymea Sub Branch of the Australian Manufacturing Workers Union Retired Members
40	Ms Lucy Cheetham, COTA National Seniors Partnership
41	Mrs Brianne Bartos
42	Dr Mark Burton, Charles Sturt University
43	Dr Angus Cameron
44	Ms Angela Drury
45	Ms Robyn Furniss, Australian Dental and Oral Health Therapists' Association Inc
46	Dr Glen Hughes, Dharah Gibinj Aboriginal Medical Service
47	Mr and Mrs Kevin and Alison Kennedy
48	Mr Suresh Manickam
49	Mr Ross Nettle, Barrier Dental Clinic
50	Confidential
51	Mr Ray Rauscher
52	Mr Morrie Mifsud - State President, Combined Pensioners & Superannuants Association Inc
53	Dr John Webster, South Eastern Sydney Illawarra Area Health Service (SESIAHS)
54	Ms Jessica Altimira
55	Ms Janet Wallace
56	Ms Felicity Barr – Chair, NSW Ministerial Advisory Committee on Ageing
57	Ms Kay Franks
58	Mr Thomas Hasson
59	Ms Betty Brady - President, Griffith Branch Combined Pensioners & Superannuants Association Inc

No	Author
60	Mr Adrian Piccoli MP, Member for Murrumbidgee
	60a – supplementary submission
61	Mr Michael Williamson - General Secretary, Health Services Union
	61a – supplementary submission
62	Mr John Newell – President, Manning Valley Branch Combined Pensioners & Superannuants Association Inc
63	Mr Paul Dever – President, Sydney University Dentistry Undergraduates Association
64	Ms Yuko Mary Tazawa
65	A/Prof H Zoellner – Chairman, Association for the Promotion of Oral Health
	65a – supplementary submission
	65b – (supersedes supplementary submission 65a, which was provided to the Committee in draft form)
66	Mr Jim Simpson - Senior Advocate, The NSW Council for Intellectual Disability
67	Mrs Louise Kindred
68	V Thornton
69	Confidential
70	Mr John Broad
71	Dr Rail Taliana - Head of Department c/ Westmead Centre for Oral Health
72	Ms Margaret Reid
73	Confidential
74	Ms Leonie Short - Senior Lecturer, Oral Health Therapy Griffith University
75	Ms Leone Hutchinson
76	Ms Leone Hutchinson - Chair, NSW Regional Committee Royal Australasian College of Dental Surgeons
77	Ms Theo Hettershide - Committee Member, Parramatta Branch Grey Power
78	Ms Kay Franks – President, NSW Dental Therapists Association Inc
79	Cr Lisa Intemann - Member, Hastings Council
80	Ms Barbara Malcolm
81	Dr Alex Abrahams - Managing Director, Pacific Smiles Group
82	Ms Bertha Power
83	Ms Olive Johnston
84	Mr Allan Tisdell
85	Ms Jennifer Lang - Oral Health Promotion Officer, Wagga Wagga Community Health Dental Clinic
86	Ms Michelle Gravolin

No	Author
87	Ms Kathy Tavener-Smith - Community Programs Officer, Healthy Cities Illawarra Inc
88	Ms Emma Jay
89	Mr John Bryant
90	Mr Vyvyan Stott
91	Mr David Jones
92	Mr William Hall – Chairperson, Retired Associates of the PSA
93	Ms Venkatesh Bhardwaj
94	Ms Martina Shephard
95	Mr Bruce Halliday and Norm Dunlevy
96	Dr Sameer Bhole Liverpool Hospital Sydney South West Area Health Service
97	Ms Ailsa Boyden – Spokesperson, Australian Fluoridation Information Network 97a – supplementary submission
98	Ms Beth Eldridge – Coordinator, Older Women's Network New South Wales Inc
99	Ms Julie Osborne
100	Confidential
101	Dr Catherine Errey
102	Mr and Mrs David and Norma Parkes
103	Manish Arora
104	Ms Catherine Emmanuel
105	Ms Louise Kenny
106	Mr Derek Tracey, Aesthetic Prosthetics Pty Ltd
107	Ms Barbara Grant-Curtis, Citizens Against Flouridation
108	Ms Christine Thomas – General Manager, Dental and Eyecare Practice
109	Mr Reginald Scott OAM, Dental Technicians Association
110	Ms Alexandra Clark
111	Mr Peter Fatouris
112	Ms Lisa Kihlstrom
113	Mrs M E Bollinger, Rural Dental Action Group
114	Dr J Kenny
115	Mrs Mary Kirk
116	Mr Robert Paul
117	Ms C Kenny
118	Dr Diana Horvath – Chief Executive, Sydney South West Area Health Service

No	Author
119	Ms Emily Hams
120	Ms Barbara Newrick
121	Mrs Joan Byrne
122	Dr Anne Wakatama - Chief Medical Officer, Royal Flying Doctor Service
123	Ms Margaret Bailey
124	Mr Martin Dunn – President, Association of Dental Prosthetists Inc
125	Mrs Lorraine Barnes
126	Ms Y Winott
127	Ms Monique Romei
128	Dr Jennifer Lim
129	Mr N Duckmanton
130	Ms Sivabalan Vasudavan
131	Ms Rosanne Vartuli
132	Mr William Dawes - Adjunct Associate Professor and Dental Surgeon, University of Sydney
133	Mr Bob Lester - Community Development Coordinator, Families in Partnership Co-operative Ltd
134	Mrs Inge Zoellner
135	Mr Reinhold Zoellner
136	Ms Paula Ewings
137	Ms Barbara Polients
138	Ms Susie Pickmere
139	Dr Emily Kyaw, Senior Dental Surgeon
140	Ms L Galleghan
141	Ms J A Hodgson
142	Ms Deborah Malone
143	Ms Robyn Paxton
144	Mrs Jeanette Blue
145	Mr Robin Banks - Chief Executive Officer, Public Interest Advocacy Centre
146	Mr Phillip Robertson, Carmoora Clinic
147	Ms Margaret Langman
148	Ms Tracey Cairns
149	Dr Paula Bacchia
150	Ms Sandra Post
151	Ms Kerriene Moss

No	Author
152	Mr J Longbottom
153	Mrs Helen Zoellner
154	Ms Marley Wilks
155	Mrs Sheila Treanor, Registered Nurse Camden Hospital
156	Ms Sharyn Docherty
157	Mrs D Lambeth
158	Ms Susan Rosevear
159	Ms Ilana Fisher
160	Ms Anne Pritchard - Community Dental Health Programmes Officer, Albury Community Health Centre
161	Ms Ruth Das - Policy and Project Officer, NSW Refugee Service
162	Ms Sophie Erzay, Aboriginal Health and Medical Research Council
163	Ms Alison Sharpe - Registered Nurse, Camden Hospital
164	Ms Skye Deutschbein
165	Professor N A Jacques
166	Ms Shirley Campton
167	Ms Barbara Taylor - Staff Specialist & Head, Department of Periodontics Sydney Dental Hospital
168	Mr Stephen Gallagher - Treatment Advocate & Policy Adviser, AIDS Council of New South Wales Inc
169	Mr Matthew Mikus-Wellings - Project Officer, Cancer Institute of New South Wales
170	Dr W Hunter – Co Chair, NSW Rural Health Priority Taskforce
171	Mr Austin Curtin – Chairperson, Executive Committee, NSW Institute of Rural Clinical Services and Teaching
172	Mr Noel Baum - Strategy Manager, Community Team, Local Government Association of NSW and Shires Association of NSW
173	Prof Hans Zoellner
174	Ms Margaret Vautin
175	Dr Jason Chua Dental Surgeon Griffith Base Hospital
176	Ms Christine O'Connell
177	Ms Michele Woolfe
178	Ms Judith Ford - Dental Assistant, Griffith Base Hospital
179	Ms Debra Vearing - Senior Dental Therapist, Griffith Base Hospital
180	Ms Sharnie Moore
181	Ms Kim Taylor, Dental Assistant
182	Mr Malcolm Bourne

No	Author
183	Dr Peter Foltyn, Dental Department St Vincent's Hospital Sydney
184	Mr John Gibbins
185	Ms Diane Pearton
186	Ms Joanne McLennan
187	Ms Amy Barter
188	Ms Dee-Anne Gorham
189	Mr Ben Alain Ruiz
190	Ms Kristy Chambers
191	Ms Christy Wheatley
192	Dr Anthony Martin
193	Professor Neil Hunter – Director, Institute of Dental Research
194	Mr Wendell Evans Associate Professor The University of Sydney
195	Dr Eduardo Alcaino, Eduardo A Alcaino & Associates
196	Mr Mal Peters – President, NSW Farmers Association
197	Mr Marcello Aliberti
198	Ms Pieta Laut - Executive Director, Public Health Association of Australia
199	Ms Jane Woodruff - Chief Executive Officer, Uniting Care Burnside
200	Mr Gary Moore – Director, Council of Social Service of New South Wales
201	Dr Stephen Cox, Westmead Centre for Oral Health
202	Dr Klaus Stelter - Executive Director, St George Division of General Practice Inc
203	Ms Nada Abdo
204	Mrs A Jarvis
205	Mrs Mignon Ellem
206	Dr Claire Blizard - Chief Executive, Greater Western Area Health Service
207	Ms Susan Clark, Westmead Centre for Oral Health
208	Ms Elizabeth Baldwin
209	Ms Tanya Schinkewitsch
210	Ms Margaret Mauro - Vice President, Combined Pensioners & Superannuants Assoc of NSW - Bathurst Branch
211	Dr Roy Byun, Institute of Dental Research
212	Ms Wendy Currie – Lecturer, Bachelor of Oral Health Program
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214	Ms Lejla Zizovski
215	Ms Jenny Pickup

No	Author
216	Mr C Wise - Senior Vice President, Gunnedah Branch of the Combined Pensioners & Superannuants Assoc
217	Mrs Corazon Gelbkron
218	Ms Laurel Prince
219	Ms Vanessa Causer
220	Dr Anastasia Georgiou
221	Dr Mark Schifter - President Oral Medicine Society of Australia & New Zealand
222	Dr Mark Schifter
223	Mr Peter Dennison
224	Ms Gillian Calvert Commissioner NSW Commission for Children & Young People
225	Assoc Prof Deborah Cockrell, University of Newcastle
226	Dr Matthew Fisher - Chief Executive Officer, Australian Dental Association (NSW Branch) Ltd 226a – supplementary submission
227	Ms Kathy Vern-Barnett - Hon Secretary, NSW Dental Assistants' Association
228	Ms Margaret Louise
229	Ms Anne Warren - Co-ordinator, Older Womens Network, Nowra
230	Ms Jill Potter
231	Mr R E Lynch - Vice President, NSW Division Association of Independent Retirees Ltd
232	Mr John Webber – Chairman, Safe Water Association of NSW (SWAN)
233	Mr Joe Parr
234	Ms Jo Laney
235	Mr Pirkko Boyd
236	Ms Melanie Murphy
237	Mr Matthew Cohen
238	Ms Miriam Thomas - President, NSW Branch Inc The Dental Hygienists' Association of Australia
239	Ms Therese Mackay – President, Hastings Safe Water Association
240	Professor Eli Schwarz - Dean, Faculty of Dentistry The University of Sydney
241	Ms Heather Christine Hawes, University of Newcastle Oral Health Students Society
242	Mr Lewis Clyde James
243	Mr Wayne Evans, FIND (Fluoridation is not Democratic)
244	Mr Gavin Smithers

No	Author
245	Mr Peter Clarke
246	Dr Greg Cocks, The Dental Centre
247	Mr Jason Gowin - Co-ordinator, Health Checks Maari Ma Health Aboriginal Corporation
248	Mr Bryan Morrow
249	Mr & Mrs Phil & Anne Laughton
250	Ms Jean Helson
251	Cr Jillian Cranny 251a – supplementary submission
252	Cr Kerry Child
253	Mr Anton Ingarfield
254	Ms Robyn Kruk – Director, General NSW Health
255	Dr Nigel Curtis – Consultant, Oral and Maxillofacial Surgeon
256	Mr Rod Macpherson
257	Dr John Powers
258	Mr Tony Gentile - Executive Director, Australasian Bottled Water Institute Inc
259	Mr Thomas Kennedy
260	Mrs Jennifer McCarthy
261	Dr John Ryan – Chairman, Professionals Against Water Fluoridation (PAWF)
262	Mrs Merilyn Haines
263	Dr Frances Cunningham - General Manager, NSW Branch Australian Heath Insurance Association

Appendix 2 Witnesses

Date	Name	Position and Organisation
29 June 2005		
Jubilee Room, Parliament House	Professor Hans Zoellner	Chairman, Association for the Promotion of Oral Health
	Dr Barbara Taylor	Staff Specialist & Head, Department of Periodontics, Sydney Dental Hospital
	Professor Geoffrey Tofler	Professor of Preventive Cardiology, Royal North Shore Hospital
	Professor Eli Schwarz	Dean, Faculty of Dentistry, University of Sydney
5 July 2005		
Waratah Room, Parliament House	Ms Sam Edmunds	Senior Policy Officer, Council of Social Service of NSW
	Mr Gary Moore	Director, Council of Social Service of NSW
	Ms Felicity Barr	Chair, NSW Ministerial Advisory Committee on Ageing
	Ms Jo Alley	Policy Officer, UnitingCare Burnside
	Ms Ann Davies	Service User
	Ms Alexis Taylor	Caseworker, UnitingCare Burnside
	Ms Keo Vorasarn	Intensive Family Support Worker, UnitingCare Burnside
	Mr Christopher Wilson	President, Australian Dental Association
	Mr Bernard Rupasinghe	Policy Officer, Australian Dental Association
	Mr Matthew Fisher	CEO, Australian Dental Association
	Dr Denise Robinson	Chief Health Officer & Deputy Director General, Population Health, NSW Health
	Mr Terry Clout	Chief Executive, Hunter New England Area Health Service, NSW Health
	Dr Peter Hill	Principal Dental Officer & Oral Health Services Manager, Justice Health, NSW Health
3 August 2005		
Room 814/815, Parliament House	Ms Kathy Vern-Barnett	Hon Secretary, NSW Dental Assistants' Association
	Ms Barbara Hayes	Treasurer, NSW Dental Assistants'

Date	Name	Position and Organisation
		Association
	Ms Kay Franks	President, NSW Dental Therapists Association Inc
	Ms Janet Wallace	Research Officer, NSW Dental Therapists Association Inc
	Mr Reginald Scott OAM	President, Dental Technicians Association
	Ms Janine Bradburn	Secretary, Association of Dental Prosthetists Inc
	Mr Graham Key	Vice President, Association of Dental Prosthetists Inc
23 August 2005		
Port Macquarie	Ms Lyn James	Mid North Coast Fluoride Free Alliance
	Ms Barbara Grant-Curtis	Citizens Against Fluoridation
	Cr Lisa Intemann	
	Ms Therese Mackay	Hastings Safe Water Association
	Mr Bernard Smith	General Manager, Hastings Council
	Mr Mark Pilgrim	Business Manager, Hastings Council
	Ms Catherine Osborne	Area Manager Oral Health, Mid North Coast
	Mr John Irving	Project Manager, Teeth for Life
	Ms Sue Harris	Manager, Dental Services, Durri Aboriginal Medical Service
Forum participants	Mr Paul Vernon-Roberts	
	Ms Sylvia Turner	
	Ms Patricia Wheeldon	
	Mr Gavin Smithers	
	Mr Wayne Evans	
	Ms Jean Helson	
30-31 August 2005		
Broken Hill	Cr Thomas Kennedy	Broken Hill City Council
	Mr Visko Sulicich	Manager, Infrastructure, Broken Hill City Council
	Dr Lyn Mayne	Dental Officer, Royal Flying Doctor Service
	Mr Mason Come	Oral Health Manager, Greater Western Area Health Service
	Ms Jenny Floyd	Manager, Western Rural Oral Health Network, GWAHS
	Ms Linda Cutler	Director, Clinical Operations, GWAHS

Date	Name	Position and Organisation
	Mr Jason Gowin	Coordinator, Health Checks, Maari Ma Health Aboriginal Corporation
	Mr Ross Nettle	Barrier Dental Clinic
	Dr Greg Cocks	The Dental Centre
	Mr Brian Devlin	Go Dental
14 November 2005		
Waratah Room, Parliament House	Mr Tony Gentile	Executive Director, Australasian Bottle Water Institute Inc
	Assoc Professor Deborah Cockrell	Head of Discipline of Oral Health, University of Newcastle
	Dr Jane Taylor	Senior Lecturer in Oral Health, University of Newcastle
	Assoc Professor Wendell Evans	Head of Discipline, Community Oral Health and Epidemiology, University of Sydney
16 February 2006		
Jubilee Room, Parliament House	Professor A John Spencer	Professor of Social and Preventive Dentistry & Director of the Australian Research Centre for Population Oral Health, University of Adelaide
	Ms Leone Hutchinson	Chair, NSW Regional Committee, Royal Australasian College of Dental Surgeons
	Dr Andrew Howe	Member, Royal Australasian College of Dental Surgeons
	Dr Denise Robinson	Chief Health Officer & Deputy Director General, Population Health, NSW Health
	Dr Clive Wright	Chief Dental Officer, NSW Health
	Mr Terry Clout	Chief Executive, Hunter New England Are Health Service, NSW Health
	Dr Peter Duckmanton	Member, Dental Professional Vocational Committee, Health Services Union
	Dr Russell Lain	Member, Dental Professional Vocational Committee, Health Services Union
	Ms Ewa Bury	Member, Dental Professional Vocational Committee, Health Services Union
	Mr Dennis Ravlich	Industrial Manager, Health Services Union
	Mr John Gibbs	General Manager, Pacific Smiles

Date	Name	Position and Organisation
	Dr David Wright	Director, Pacific Smiles
	Dr Frances Cunningham	General Manager – NSW, Australian Health Insurance Assoc
	Mr Angus Norris	General Manager Health and Benefits Management, MBF

Appendix 3 Site Visits

Date	Location
23 August 2005	Port Macquarie The Committee travelled to Port Macquarie and conducted a public hearing at the Port Panthers Leagues Club (see Appendix 2). During the hearing the Committee heard from local groups and individuals. The Committee also invited individuals to participate in a public forum. This opportunity allowed people to present their concerns relating to the fluoridation of the local water supply. This hearing was held to also take evidence from the Hastings Council in relation to the Committee's inquiry into the funeral industry.
30 August 2005	Broken Hill The Committee travelled to Broken Hill and conducted a public hearing at the Broken Hill City Council Chambers (see Appendix 2). During the hearing the Committee heard from representatives including the Greater Western Area Health Service, Royal Flying Doctor Service, local dentists and the Maari Ma health Aboriginal Corporation. These hearings were held to also take evidence from a local funeral director (including a tour of his funeral home) and the local council in relation to the Committee's inquiry into the funeral industry.

Appendix 4 Minutes

Meeting 56, 8 April 2005, Room 814/815, 9.35am

1. Members present

Jan Burnswoods MLC (Chair)
The Hon Robyn Parker MLC (Deputy Chair)
The Hon Kayee Griffin MLC
The Hon Ian West MLC
The Hon Dr Arthur Chesterfield-Evans MLC

2. Minutes

Resolved, on the motion of Mr West, that the minutes of meeting number 54 and 55 be adopted.

3. Correspondence

…

4. Inquiry into the disturbances at Macquarie Fields

…

5. New Inquiries – Funeral Industry and Dental Services in New South Wales

The Committee considered the new inquiries into the Funeral Industry and Dental Services.

Resolved, on the motion of Dr Chesterfield-Evans, that the closing date for submissions be six weeks after the date of advertisement and a joint advertisement for the two inquiries be placed in the Sydney Morning Herald, the Illawarra Mercury and the Newcastle Herald, along with advertisements in the Wagga Wagga Daily Advertiser; Albury Wodonga Border Mail; Coffs Harbour Advocate; Lismore Northern Star; Tamworth Northern Daily Leader; Dubbo Daily Liberal; Orange Central Western daily; Grafton Examiner; Broken Hill Truth; Tweed Daily News; Griffith Area News; Bathurst Western Advocate; the Goulburn Post; and the CPSA "The Voice" and that a letter from the Chair to relevant and interested individuals, agencies and the community be sent as soon as possible.

6. Hearing – Inquiry into Teacher Recruitment and Training

…

7. Adjournment

The Committee adjourned at 5.05pm.

Victoria Pymm
Senior Council Officer

Meeting 58, 14 June 2005, 9:30am, Jubilee room

1. Members present

Ms Jan Burnswoods (Chair)
Hon Robyn Parker (Deputy Chair)
Hon Dr Chesterfield-Evans
Hon Kayee Griffin
Hon Charlie Lynn
Hon Ian West

2. Public Hearing – Inquiry into Recruitment and Training of Teachers
…

3. Minutes of meetings nos 56 and 57
Resolved on the motion of Ms Griffin: That the draft minutes of meetings nos 56 and 57 be adopted.

4. Correspondence
Item 3 – Letter dated 31 May 2005 from Jon Blackwell, Chief Executive Officer, WorkCover advising that WorkCover's comments on the Dental inquiry will be incorporated in the NSW Health whole of government submission

5. Hearing - Inquiry into Teacher Recruitment and Training
…

6. Inquiry into the Funeral Industry
…

7. Inquiry into the Dental Services in New South Wales
The Chair tabled a list of submissions received (nos 1 to 144)

The committee discussed dates for the first hearing and future directions for the inquiry.

8. Public Hearing – Inquiry into the Funeral Industry
…

9. Adjournment
The committee adjourned at 4.35 pm.

Susan Want
Acting Director

Meeting 59, 29 June 2005, 1:30 pm, Jubilee Room

1. Members present
Ms Burnswoods, Chair
Ms Parker, Deputy-Chair
Dr Chesterfield-Evans
Ms Griffin
Mr Lynn
Mr West

2. Correspondence Out
…

3. Inquiry into Dental Services in New South Wales
Resolved on the motion of Ms Griffin: That

(a) the committee accept submission nos 1 to 200, and

(b) under Standing Order 223(1), the submissions be made public with the exception of submission nos 1, 14, 69, 73, 100, and certain information in submissions 29 and 183.

4. Public Hearing – Inquiry into Dental Services in New South Wales
The public and the media were admitted.

Hans Zoellner, Chairman, Association for the Promotion of Oral Health, affirmed and examined.

Questioning concluded, the witness withdrew.

The public and the media withdrew.

5. Inquiry into public disturbances at Macquarie Fields
…

6. Minutes of Meeting no. 58
Resolved on the motion of Mr Lynn: that the draft minutes of meeting no.58 be adopted.

7. Sub-Committee
…

8. Future hearings and witnesses
…

9. Public hearing – Inquiry into Dental Services in New South Wales.
The public and the media were admitted.

Ms Barbara Taylor, Staff Specialist & Head, Department of Peridontics, Sydney Dental Hospital, and

Professor Geoffrey Tofler, Professor of Preventive Cardiology, Royal North Shore Hospital, sworn and examined.

Questioning concluded, the witnesses withdrew.

Professor Eli Schwarz, Dean, Faculty of Dentistry, University of Sydney, affirmed and examined.

Questioning concluded, the witness withdrew.

The public and the media withdrew.

10. Adjournment
The committee adjourned at 5.10pm until Tuesday 5 July 2005 at 9.30 am.

Susan Want
Acting Director

Meeting 60, 5 July 2005, 9.30am, Waratah Room

1. Members present
Ms Burnswoods (Chair)
Ms Parker (Deputy-Chair)
Ms Griffin (until 3.30pm)
Mr West

2. Apologies
Dr Chesterfield-Evans
Mr Lynn

3. Public Hearing – Dental Services in New South Wales
The public and the media were admitted.

Denise Margaret Robinson, Chief Health Officer and Deputy Director-General Population Health, New South Wales Department of Health, affirmed and examined, and

Terrance James Clout, Chief Executive, Hunter New England Area Health, and

Peter Robert Hill, Principal Dental Officer, Oral Health Services Manager, Justice Health, sworn and examined.

Questing concluded, the witnesses withdrew.

Gary Moore, Director, Council of Social Service of NSW, and

Samantha Ruth Edmunds, Senior Policy Officer (Health), Council of Social Service of NSW, affirmed and examined.

Questioning concluded, the witnesses withdrew.

Felicity Margaret Barr, Chair, Ministerial Advisory Committee on Ageing, New South Wales, affirmed and examined.

Questioning concluded, the witness withdrew.

The public and the media withdrew.

4. Minutes
Resolved on the motion of Ms Parker: that the draft minutes of meeting no. 59 be adopted.

5. Inquiry into Dental Services in New South Wales
Resolved on the motion of Mr West: That

(a) the committee accept submission nos 201 to 223 and 226, and

(b) under standing order 223(1) the submissions be made public.

6. Future witnesses and hearings
…

7. Public Hearing – Dental Services in New South Wales
The public and the media were admitted.

Alexis Taylor, Caseworker, UnitingCare Burnside,

Keo Vorasarn**,** Intensive Family Support Worker, UnitingCare Burnside,

Jo Alley, Policy Officer, UnitingCare Burnside, and

Ann Maree Davies, Service User, UnitingCare Burnside, affirmed and examined.

Questioning concluded, the witnesses withdrew.

Christopher Stephen Wilson, President, New South Wales Branch, Australian Dental Association, and

Matthew Fisher, Chief Executive Officer, New South Wales Branch, Australian Dental Association, sworn and examined, and

Bernard Rupasinghe**,** Policy Officer, New South Wales Branch, Australian Dental Association, affirmed and examined.

Questioning concluded, the witnesses withdrew.

The public and the media withdrew.

8. Adjournment

The committee adjourned at 4.40 pm *sine die*.

Susan Want
Acting Director

Meeting 61, 3 August 2005, 2.00pm, Room 814-815, Parliament House

1. Members present

Ms Burnswoods (Chair)
Dr Chesterfield-Evans
Ms Griffin
Mr Lynn

2. Apologies

Ms Parker
Mr West

3. Minutes

Resolved on the motion of Mr Lynn: that the draft minutes of meeting no.60 be adopted.

4. Inquiry into Dental Services in New South Wales

(a) Resolved on the motion of Ms Griffin: That
  (i) the committee accept submission nos 224, 225 and 227 to 237, and
  (ii) the submissions be made public.

(b) The Chair tabled answers to questions taken on notice by Professor Tofler at the hearing held 29 June 2005.

Resolved on the motion of Ms Griffin: That the answer be made public.

5. Inquiry into the Funeral Industry in New South Wales

…

6. Inquiry into the Recruitment and Training of Teachers

…

7. Correspondence

(a) *Received*

The Chair tabled the following correspondence:

(i) …

(ii) …

(iii) Letter from Mr & Mrs T Simon dated 13 July 2005 regarding dental services in New South Wales.

(b) *Sent*

(i) Letter to Mr Peter Black MP, Member for Murray-Darling, dated 26 July 2005 informing him of the committee visit to Broken Hill on 30 and 31 August 2005.

(ii) Letter to Mr Robert Oakeshott MP, Member for Port Macquarie, dated 26 July 2005, informing him of the committee visit to Port Macquarie on 23 August 2005.

(iii) Letter to Mr & Mrs T Simon dated 26 July 2005 regarding dental services and informing Mr & Mrs Simon that the committee is unable to investigate individual matters.

8. Public Hearing – Dental Services in New South Wales

Katherine Suzanne Vern-Barnett, Hon Secretary, NSW Dental Assistants Association, and

Barbara Hayes, Treasurer, NSW Dental Assistants Association, sworn and examined.

Questioning concluded, the witnesses withdrew.

Kay Franks, President NSW Dental Therapists Association, College of Dental Therapy, Westmead, and

Janet Wallace, Research Officer, NSW Dental Therapists Association, College of Dental Therapy, Westmead, sworn and examined.

Questioning concluded, the witnesses withdrew.

Reginald Francis Scott OAM, President, Dental Technicians Association, sworn and examined.

Questioning concluded, the witness withdrew.

Graham Key, Vice President, Association of Dental Prosthetists Inc New South Wales, and

Jenine Anne Bradburn, Secretary, Association of Dental Prosthetists Inc New South Wales, sworn and examined.

Mr Key tendered a document giving answers to draft questions provided by the committee prior to the hearing.

Questioning concluded, the witnesses withdrew.

9. The committee adjourned until 8 August 2005 at 9.30 am.

Susan Want
Acting Director

Minutes No 62, 9.30am, Monday 8 August 2005, Jubilee Room

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy-Chair)
Dr Chesterfield-Evans
Ms Griffin
Mr West

2. Apologies

Mr Lynn

3. Public hearing – Inquiry into the Funeral Industry

…

4. Deliberative meeting

Confirmation of Minutes

Resolved on the motion of Dr Chesterfield-Evans: that the draft minutes of meeting no.61 be adopted.

Inquiry into Dental Services in New South Wales

Submission received:
Resolved on the motion of Ms Griffin: That

(i) the committee accept submission no 238, and
(ii) the submission be made public.

Tabled documents:
Resolved on the motion of Ms Griffin: That

(i) the committee accept the document tendered by Mr Graham Key, Vice-President, Association of Dental Prosthetists Inc New South Wales, during the hearing held on 3 August 2005, and
(ii) the document be made public.

Inquiry into the Funeral Industry

…

Inquiry into the Recruitment and Training of Teachers

…

5. Public hearing - Inquiry into the Funeral Industry

…

6. Adjournment

The committee adjourned at 4.36 pm until 10.00am Tuesday 23 August 2005 (public hearing, Port Macquarie)

Susan Want
Acting Director

Minutes No 63, 10.00am, Tuesday 23 August 2005, Renaissance Room, Panthers, Port Macquarie

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Ms Griffin
Mr West

2. Apologies

Mr Lynn

3. Inquiry into dental services in New South Wales

Submissions

Resolved on the motion of Ms Parker, that:

(a) the committee accept submissions no 239, 240, 241 and 242 and

(b) the submissions be made public

Response to question on notice

Resolved on the motion of Dr Chesterfield-Evans, that the answer to a question taken on notice by Prof Eli Schwartz, Dean, Faculty of Dentistry, be made public.

4. Inquiry into public disturbances at Macquarie Fields

…

5. Public hearing – inquiry into dental services in NSW and inquiry into the funeral industry

Public hearing

The public and media were admitted.

Ms Lyn James, Acting Secretary and Ms Patricia Wheeldon, Secretary, Mid North Coast Fluoride Free Alliance were sworn and examined.

Evidence concluded and the witnesses withdrew.

Ms Barbara Grant-Curtis, Member, Citizens against Fluoridation, was sworn and examined.

Evidence concluded and the witnesses withdrew.

Cr Lisa Intemann, Councillor, Hastings Council, was sworn and examined.

Evidence concluded and the witnesses withdrew.

Public forum

The Committee facilitated a public forum with members of the local community, to hear the community views water fluoridation, at which the following people spoke:

Mr Paul Vernon-Roberts
Mrs Therese Mackay, Hastings Safe Water Association
Ms Sylvia Turner, Central Coast Pure Water Association
Mr Gavin Smithers
Mr Wayne Evans, Fluoridation Is Not Democratic (FIND)
Ms Jean Helson, Citizens Against Fluoridation

Public hearing
Mr Bernard Smith, General Manager and Mr Mark Pilgrim, Business Manager, Hastings Council, were sworn and examined.

Questions concluded, the witnesses withdrew.

Ms Catherine Osborne, Area Manager, Oral Health, Mid North Coast and Mr John Irving, Project Manager, Teeth for Health, North Coast Area Health Service, were sworn and examined.

Questions concluded, the witnesses withdrew.

Ms Sue Harris, Manager Dental Services, Durri Aboriginal Medical Service, was sworn and examined.

Questions concluded, the witness withdrew.

Tendered documents
Resolved, on the motion of Ms Griffin, that the documents tendered by witnesses at the hearing and forum be accepted.

6. Adjournment
The Committee adjourned at 4.02pm until 2.00pm on Tuesday 31 August 2005 (Broken Hill public hearing and site visit)

Rachel Simpson
Director

Minutes No 65, 9.30am, Wednesday 31 August 2005 Broken Hill Council Chambers, Broken Hill NSW

1. Members present
Ms Burnswoods (Chair)
Dr Chesterfield-Evans
Ms Griffin
Mr West

2. Apologies
Mr Lynn
Ms Parker

3. Public hearing – Inquiry into Dental Services in NSW
The public and the media were admitted.

Dr Lyn Mayne, Dentist, Royal Flying Doctors Service, was sworn and examined.

Questioning concluded, the witness withdrew.

Ms Linda Cutler, Director, Clinical Operations, Ms Jenny Floyd, Manager, Western Rural Oral Health Network and Mr Mason Come, Oral Health Manager, Greater Western Areas Health Service, were sworn and examined.

Resolved, on the motion of Ms Griffin, that the document tendered by Ms Cutler be accepted.

Questioning concluded, the witnesses withdrew.

Mr Jason Gowin, Co-ordinator, Health Checks, Maari Ma Aboriginal Health Corporation, was sworn and examined.

Resolved, on the motion of Mr West, that the document tendered by Mr Gowin be accepted.

Questioning concluded, the witness withdrew.

Mr Ross Nettle, Manager, Barrier Dental Clinic, Broken Hill, was sworn and examined.

Resolved, on the motion of Dr Chesterfield-Evans, that the document tendered by Mr Nettle be accepted.

Questioning concluded, the witness withdrew.

Dr Greg Cocks, Dentist, The Dental Centre, Broken Hill, was sworn and examined.

Resolved, on the motion of Mr West, that the document tendered by Dr Cocks be accepted.

Questioning concluded, the witness withdrew.

Dr Brian Devlin, Dentist, Go Dental, Broken Hill, was sworn and examined.

Questioning concluded, the witness withdrew.

4. Deliberative meeting

Confirmation of minutes

Resolved, on the motion of Ms Griffin, that minutes Nos. 62 and 63 be confirmed.

Inquiry into public disturbances in Macquarie Fields

…

Transcripts of evidence – Broken Hill

…

Inquiry into the funeral industry

…

5. Adjournment

The committee adjourned at 3.15pm until 9.30am Monday 5 September 2005 (public hearing, Parliament House).

Rachel Simpson
Director

Minutes No 66, 9.30am, Monday 5 September 2005, Jubilee room

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Mr Lynn
Ms Griffin
Mr West

2. Public hearing – Inquiry into the Funeral Industry

…

3. Deliberative meeting

Confirmation of minutes

Resolved on the motion of Ms Parker that an addition be made to Minutes no 63, item 6, *Tabled Documents*: 'Resolved, on the motion of Ms Griffin, that the documents tendered by witnesses at the hearing and forum be accepted'.

Resolved, on the motion of Dr Chesterfield-Evans, that Minutes No 64 and 65 be confirmed.

Correspondence

…

Sent

Letter dated 26 July 2005 from Chair to Mr Robert Oakeshott MP, Member for Port Macquarie, advising Mr Oakeshott that the Committee is travelling to Port Macquarie in August for the dental services and funeral industry inquiries.

Letter dated 26 July 2005 from Chair to Mr Peter Black MP, Member for Murray-Darling, advising Mr Black that the Committee is travelling to Broken Hill in August for the dental services and funeral industry inquiries.

…

Inquiry into the funeral industry

…

Inquiry into dental services

Resolved, on the motion of Mr Lynn to make submission 50 partially confidential and to accept and make public submissions 243 – 247.

Resolved, on the motion of Mr West, that documents tabled by witnesses at Port Macquarie on 23 August 2005 be made public, with the exception of photographic material tabled by Ms James at Port Macquarie on 23 August 2005 not be made public.

Resolved, on the motion of Dr Chesterfield-Evans, that the Committee seek a response from NSW Health to issues raised by anti-fluoridationists at the Committee's hearing on 23 September 2005.

Resolved, on the motion of Dr Chesterfield-Evans, that the Committee seek evidence from major providers of bottled water or the association that represents them, regarding fluoridation of bottled drinking water.

Inquiry into teacher recruitment and training

…

4. Adjournment

The committee adjourned at 5.30pm until 9.00am Monday 19 September 2005 (public hearing, Parliament House).

Rachel Simpson
Director

Minutes No 67, 9.30am, Monday 19 September 2005, Jubilee room

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Mr Lynn
Ms Griffin
Mr West

2. Apologies

Dr Chesterfield-Evans

3. Public hearing – Inquiry into the Funeral Industry

…

4. Deliberative meeting

Tabled documents

…

Confirmation of minutes

Resolved on the motion of Mr West that minutes no.66 be confirmed.

Correspondence

Resolved, on the motion of Ms Parker, that the following correspondence be noted:

Received

- …
- Ms Barbara Grant-Curtis, 5 September 2005, letter to Director advising of corrections to transcript and providing clarification and further comment on issues raised during her evidence at the Port Macquarie hearing for the dental services inquiry.

Resolved, on the motion of Ms Parker to publish with the transcript from the hearing on 23 August 2005, clarifications to transcripts from:
a) Ms Grant-Curtis
b) Ms Harris

- Ms Sue Harris, Durri AMS, undated, providing corrections to transcript and clarification of figures provided during her evidence at the Port Macquarie hearing for the dental services inquiry.
- …

5. Inquiry into public disturbances at Macquarie Fields

…

6. Inquiry into the funeral industry

…

7. Inquiry into dental services

Resolved, on the motion of Mr West to accept and make public submissions 248 – 250.

Consideration of a resolution to write to Prof Eli Schwarz to request further information in relation to his response to questions taken on notice (*considered by the committee on 23 August 2005*) was deferred until the next meeting.

8. Adjournment
The committee adjourned at 11.45am, *sine die.*

Rachel Simpson
Director

Minutes No 68, 1.10pm, Wednesday 19 October 2005, Room 1153

1. Members present
Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Mr Lynn
Ms Griffin
Mr West

2. Apologies
Dr Chesterfield-Evans

3. Correspondence
…

4. Inquiry into dental services
Resolved, on the motion of Mr West, to accept and make public submission 254 from NSW Health.

5. Inquiry into teacher recruitment and training – consideration of Chair's draft report
…

6. Next meeting
Monday 14 November 2005, 2-5pm, Room 1153

Victoria Pymm
Senior Council Officer

Minutes No 69 2.00pm, Monday 14 November 2005 Waratah Room

1. Members present
Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Mr Lynn
Ms Griffin
Mr West

2. Deliberative meeting

Confirmation of minutes
Resolved, on the motions of Mr West and Ms Griffin, that minutes nos 67 and 68 be confirmed.

Correspondence
…

Dental inquiry

Received:

1. The Hon John Hatzistergos MLC, 3 November 2005, letter to Chair providing additional information on technical issues with fluoridation as requested.
2. Mr Andrew Stoner MP, Member for Oxley, 26 October 2005, letter to Chair regarding Committee's examination of issue of fluoridation of public water in north coast council areas.
3. Mr Paul Francis, President, Kempsey & District Ratepayers and Residents Association, 23 October 2005, letter to Chair expressing concern at decision to fluoridate public water in the Kempsey area.
4. Dr John Powers, 12 October 2005, email to Secretariat providing revised version of submission number 50 for Dental Services Inquiry (previous submission retracted at Dr Powers' request).
5. Ms Patricia Wheeldon, 6 October 2005, letter to Chair attaching copy of correspondence sent to NSW Ombudsman by Kempsey and District Ratepayers and Residents Association in relation to fluoridation of drinking water.
6. Ms Robyn Kruk, Director General, NSW Health, 28 September 2005, letter to Chair advising that response to correspondence requesting additional information in relation to fluoridation is being considered.
7. Ms Catherine Osborne, Area Manager, Oral Health, North Coast Area Health Service, 23 September 2005, letter to Director providing corrections to transcript of evidence and answers to questions taken on notice on 23 August 2005 for the dental inquiry.
8. Mr Jason Gowin, Coordinator, Health Checks, Maari Ma Health, undated letter received 21 September 2005, providing answers to questions taken on notice on 31 August 2005 for the dental inquiry.

Sent

1. Letter dated 9 November 2005, from Chair to Professor Eli Schwarz, requesting further details regarding funding for the Faculty of Dentistry.
2. Letter dated 8 November 2005, from Chair to Mr Andrew Stoner, MP, Member for Oxley, in response to letter dated 26 October 2005, regarding fluoridation and the dental inquiry.
3. Letter dated 16 September 2005, from Chair to the Hon John Hatzistergos MLC, requesting NSW Health's response to issues relating to fluoridation raised at Port Macquarie hearing in relation to the dental inquiry.

Funeral inquiry

…

Macquarie Fields

…

3. Inquiry into recruitment and training of teachers

…

4. Inquiry into dental services

Resolved, on the motion of Mr West, to accept and make public submissions 251 – 253 and 255-256.

Consideration of a resolution to replace submission 50 with a new version (at the request of the author) was deferred until the next meeting.

The Committee noted that hearings will be held in the week commencing 12 December 2005.

5. Inquiry into the funeral industry

…

6. Public hearing – Inquiry into dental services in NSW

The public and the media were admitted.

Mr Tony Gentile, Executive Director of the Australasian Bottled Water Institute Inc was sworn and examined.

Questioning concluded, the witness withdrew.

Associate Professor Deborah Cockrell, Head of Discipline of Oral Health, University of Sydney was affirmed and examined, along with Dr Jane Taylor, Senior Lecturer in Oral Health, University of Newcastle.

Questioning concluded, the witnesses withdrew.

Associate Professor Wendell Evans, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney, was affirmed and examined.

Questioning concluded, the witness withdrew.

The public and the media withdrew.

8. Adjournment

The committee adjourned at 6.15 pm until Monday 5 December 2005, 9am, Room 1153 (funeral industry report deliberative).

Katherine Fleming
Principal Council Officer

Minutes No 71, 9.30am, Monday 5 December 2005, Jubilee Room

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Mr Lynn
Ms Griffin
Mr West

2. Public hearing – inquiry into public disturbances at Macquarie Fields

…

Deliberative meeting

3. Publication of transcript

…

4. Confirmation of minutes

Resolved on the motion of Mr West that minutes nos 69 and 70 be confirmed.

5. Correspondence

The Committee noted the following correspondence:

Funeral industry inquiry

…

Dental inquiry

Sent:

- Letter dated 16 November 2005, from Director to Mr Tony Gentile concerning questions taken on notice from the oral hearing held on 14 November 2005.
- Letter dated 16 November 2005, from Director to Professor Wendell Evans, concerning questions taken on notice from the oral hearing held on 14 November 2005.

Macquarie Fields

…

6. Inquiry into dental services

Resolved on the motion of Dr Chesterfield-Evans to accept and make public documents tendered by Mr Gentile, Associate Professor Cockrell and Associate Professor Evans at the hearing held on 14 November 2005.

Resolved on the motion of Dr Chesterfield-Evans that submission 50 be confidential, and to accept and make public submission 257.

7. Inquiry into public disturbances at Macquarie Fields

…

8. Inquiry into the funeral industry

…

9. Adjournment

The committee adjourned at 4.00pm until 9.30am Monday 12 December 2005, Jubilee Room, Parliament House.

Rebecca Main
Senior Council Officer

Minutes No 74, 9.30am, Thursday 16 February 2006 Jubilee Room

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Mr Lynn (until 11.00am)
Ms Griffin
Mr West

2. Public hearing – inquiry into dental services in NSW

Professor A John Spencer, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide was affirmed and examined.

Questioning concluded, the witness withdrew.

Ms Leone Hutchinson, Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons was sworn and examined.

Dr Andrew Howe, University of Sydney, Foetal Toxicology, Faculty of Medicine, Member of the Regional Committee of the Royal Australasian College of Dental Surgeons, was affirmed and examined.

Resolved, on the motion of Ms Parker, that the documents tendered by Ms Hutchinson be accepted.

Questioning concluded, the witnesses withdrew.

Dr Denise Robinson, Chief Health Officer, NSW Health, was affirmed and examined.

Dr Clive Wright, Chief Dental Officer, NSW Health, and Mr Terry Clout, Chief Executive, Hunter New England Area Health Service were sworn and examined.

Resolved, on the motion of Mr West, that the documents tendered by Dr Wright be accepted.

Questioning concluded, the witnesses withdrew.

Dr Peter Duckmanton, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital, Ms Ewa Bury, representing Professional Vocational Committee of the Health Services Union, Dental Technician, Sydney Dental Hospital and Mr Dennis Ravlich, Industrial Manager, Health Services Union were affirmed and examined.

Dr Russel Lain, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital, was sworn and examined.

Questioning concluded, the witnesses withdrew.

Mr John Gibbs, General Manager, Pacific Smiles Group, and Dr David Wright, Director, Pacific Smiles Group were affirmed and examined.

Resolved, on the motion of Ms Griffin, that the document tendered by Mr Gibbs be accepted.

Questioning concluded, the witnesses withdrew.

Dr Frances Cunningham, General Manager, New South Wales, Australian Health Insurance Association, was affirmed and examined.
Mr Angus Norris, General Manager, Health and Benefits, MBF Australia, was sworn and examined.

Resolved, on the motion of Ms Griffin, that the document tendered by Dr Cunningham be accepted.

Questioning concluded, the witnesses withdrew.

Deliberative meeting

3. Inquiry into dental services

Resolved, on the motion of Ms Griffin, that the documents tendered during the public hearing be accepted and made public.

Resolved on the motion of Mr West to accept and make public submissions 19a, 19b, 65a, 226a and 258-262.

Dr Chesterfield-Evans moved:
That the question taken on notice by NSW Health regarding the non-payment of the dental materials bill be defined to include:

- That there be a specific answer regarding the allegation at the Dental hospital, and
- That we request the mean, median and standard deviation of the time between when dental bills are received and when they are paid and
- That this answer be in terms of both the number of bills and the total quantum of dollars in expenses.

The Committee divided:

Ayes: Ms Parker, Dr Chesterfield-Evans
Noes: Ms Burnswoods, Ms Griffin, Mr West

Question resolved in the negative.

Dr Chesterfield-Evans moved:
That the Committee make further efforts to find out:

- Whether the dental faculty infrastructure has been sold, and if so, what, when and at what price?
- What percentage of Commonwealth monies received for dental students is taken as charges by the University and whether this percentage differs from the percentage taken by other faculties which have a greater percentage of their facilities on campus?

Debate ensued.

The Committee divided:

Ayes: Ms Parker, Dr Chesterfield-Evans
Noes: Ms Burnswoods, Ms Griffin, Mr West

Question resolved in the negative.

4. Confirmation of minutes

Resolved, on the motion of Ms Griffin, that minutes nos 71, 72 and 73 be confirmed.

5. Correspondence

The Committee noted the following correspondence:
Public disturbances at Macquarie Fields
…

Dental services inquiry
Received

1. Letter from Mr Marcello Aliberti, 31 January 2006, to the Committee, regarding use of elderly for training dental students.
2. Letter from Mrs Patricia Wheeldon, 27 January 2006, to Chair, regarding fluoridation.
3. Letter from Prof Eli Schwarz, University of Sydney, 9 December 2005, to Chair, regarding Chair's letter dated 9 November 2005 requesting further information to questions on notice.
4. Letter from Assoc Prof Wendell Evans, University of Sydney, 5 December 2005, to Director, response to questions on notice from hearing on 14 November 2005.

Sent

1. Letter to the Hon Julie Bishop MP, Federal Minister for Education, Science and Training, from Chair, 7 February 2006, requesting information on funding for oral health and dentistry university courses.
2. Letter to the Hon Tony Abbott MP, Minister for Health and Ageing, from Chair, 7 February 2006, requesting information on Commonwealth funding and programs for oral health.

Funeral industry inquiry

…

6. Inquiry into the funeral industry

…

7. Inquiry into public disturbances at Macquarie Fields

…

8. Government response to report on Inebriates Act 1912

…

9. Adjournment

The committee adjourned at 5.20pm until 9.30am 24 March 2006, Room 1153.

Rachel Simpson
Director

Minutes No 75, 9.30am, Friday 24 March 2006, Room 1153

1. Members present

Ms Burnswoods (Chair)
Ms Parker (Deputy Chair)
Dr Chesterfield-Evans
Mr Lynn
Ms Griffin
Mr West

2. Confirmation of minutes

Resolved, on the motion of Mr West, that Minutes No 74 be confirmed

3. Correspondence

The Committee noted the following correspondence:

Dental services

Received

Letter from Dr Francis Cunningham, Australian Health Insurance Association Ltd, 2 March 2006, to Director, response to question on notice from hearing on 16 February 2006.

Letter from Dr Denise Robinson, NSW Health, 10 March 2006, to Director, response to questions on notice from hearing on 16 February 2006.

Submission

Submission No 263, Dr Francis Cunningham, Australian Health Insurance Association

Resolved, on the motion of Mr West, that submission No 263 be published.

Answers to questions taken on notice
Resolved on the motion of Dr Chesterfield-Evans, to publish the following answers to questions taken on notice:

1. at the hearing on 16 February 2006 from the Australian Health Insurance Association and NSW Health
2. at the hearing on 14 November 2005 from Associate Professor Wendell Evans

Resolved, on the motion of Ms Griffin, to publish answer to request for additional information from Professor Eli Schwarz, dated 9 December 2005.

Funeral industry inquiry
Received
…

Sent
…

4. Chair's draft report
The Chair tabled the draft Report and a number of amendments, which having been circulated, was taken as being read. The Committee proceeded to consider the draft Report in detail.

Chapter One read.

Resolved, on the motion of Mr West: that Chapter One be adopted by the Committee.

Chapter Two read.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 2.2 be amended by inserting a definition of 'dental chair' in either the paragraph of footnote.

Resolved, on the motion of Dr Chesterfield-Evans: that the case study in paragraph 2.15 be amended by inserting the words 'for patient presenting with a tooth abscess' in the title of the case study.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 2.21 be amended by inserting the word 'disease' after the word 'periodontal' in the first sentence.

Resolved, on the motion of Dr Chesterfield-Evans: that Chapter 2, as amended, be adopted by the Committee.

Chapter Three read.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 3.2 be amended by inserting an explanation of the following terms used in Figure 3.1:

- Commonwealth Government direct
- Commonwealth Government premium
- State and Local
- Individuals
- Private net

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 3.4 be amended by inserting 'a rise of 300% in nominal dollars' at the end of the paragraph.

Resolved, on the motion of Ms Parker: that paragraph 3.43 be amended by inserting 'majority of' before the word 'committee' in the final sentence.

Ms Parker moved: that Recommendation 4 be deleted.

Question put and negatived.

Dr Chesterfield-Evans moved: that Recommendation 4 be amended by adding 'and reinstate the Commonwealth Dental Health Program'.

Question put and negatived.

Resolved, on the motion of Mr West: that Recommendation 5 be amended by inserting 'including the Commonwealth Government' after 'relevant stakeholders'.

Resolved, on the motion of Ms Parker: that Recommendation 7 be amended by inserting 'staffed and' after 'adequately'.

Resolved, on the motion of Dr Chesterfield-Evans: that the title of figure 3.2 be amended by deleting the words 'affordability of' and adding the words 'based on user's ability to afford treatment' after the words 'dental care', and that figure 3.2 be amended by inserting 'percent' on the Y-axis of the graph.

Resolved, on the motion of Ms Parker: that paragraph 3.95 be amended by inserting 'majority of' before 'the Committee' in the second and third sentences, and that a new sentence be added at the end of the paragraph to read: 'The Hon Robyn Parker MLC was not in agreement with the majority'.

Ms Parker moved: that Recommendation 10 be deleted.

Question put and negatived.

Dr Chesterfield-Evans moved: that Recommendation 10 be amended by deleting 'more affordable private and'.

Question put and negatived.

Resolved, on the motion of Ms Parker: that paragraph 3.102 be amended by inserting 'majority of' before 'the Committee' in the third sentence.

Ms Parker moved: that Recommendation 11 be deleted.

Question put and negatived.
Resolved, on the motion of Ms Parker: that paragraph 3.104 be amended by inserting 'majority of' before 'the Committee' in the final sentence.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.6 be amended by inserting a new sentence at the end of the paragraph to read 'The practising rate in the tables below refer to the number of full time equivalent (37.5 hours/week) dentists, dental therapists, dental hygienists or prosthetists per 100,000 population'.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.8 be amended by deleting the final sentence and inserting instead 'It is noted that in NSW there are 83 dental therapists in the school dental service, which is significantly lower than the 330 dental therapists working in the Queensland school dental service'.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.14 be amended by including a reference to the average age of dentists in 2000.

Resolved, on the motion of Dr Chesterfield-Evans: that footnote 209 be amended to indicate that practicing rates for dentists for 2003 for capital cities and rest of the state are not available.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.46 be amended by inserting at the beginning of the paragraph 'The Committee is committed to a robust salaried public dental service and makes recommendations in this chapter to encourage the expansion of the public dental workforce'.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.73 be deleted and replaced with the following paragraph:

> The Committee notes that the dental therapist workforce is ageing as commented upon by the Wagga Wagga Community Health Dental Clinic:
>
> > We are an aging group of ladies. We have 6 dental therapists with an average age of 40 years. The earliest graduated is 1975 the most recent is 1993. We are concerned that there will be no therapists ready to take our positions when we want to retire.

Resolved, on the motion of Dr Chesterfield-Evans: that a new paragraph 4.74 be inserted to read:

> The Committee shares the concern that graduates of the Bachelor of Oral Health course are not likely to replace those working in the public sector due to salary disparities between private and public systems. There is a danger that the school dental service will not be able to be staffed in the future. It is noted that with award restructuring this issue may be addressed.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 4.84 be amended by inserting 'in order to develop a comprehensive, salaried public dental workforce' after 'and' and before 'it is necessary'.

Resolved, on the motion of Dr Chesterfield-Evans: that table 5.2 be amended to include years 1994 to 2003, and that paragraph 5.4 be amended to reflect the changed date range.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 5.26 be amended by deleting 'it is worth investigation by NSW Health' and inserting 'it is worth investigating a program for graduating dental students similar to that undertaken by medical students, such as internships and specialist registrarships'.

Resolved, on the motion of Dr Chesterfield-Evans: that Recommendation 17 be amended by inserting 'and specialist registrarships' after 'internships'.

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 6.22 be amended by inserting 'It is noted that the table does not include the views of patients who did not receive public dental treatment' at the end of the paragraph.

Resolved, on the motion of Mr West: that the heading of Table 6.5 be amended by adding the word 'provided' at the end of the heading.

Resolved, on the motion of Ms Griffin: that Recommendation 20 be deleted and replaced with the following:

> 'That the standard of equipment at public dental clinics, particularly in rural and remote areas, be reviewed to ensure that it is adequate to deliver a satisfactory level of treatment to patients'

Resolved, on the motion of Dr Chesterfield-Evans: that paragraph 8.46 be amended by inserting a footnote to read: 'Water rates paid to Sydney Water and Hunter Water authorities cover recurrent costs of fluoridation in metropolitan NSW.'

Resolved, on the motion of Dr Chesterfield-Evans: that Chapters 3 to 8, as amended, be adopted by the Committee.

Resolved, on the motion of Mr Lynn: that the report, with amendments, be adopted by the Committee, signed by the Chair, and presented to the House.

Resolved, on the motion of Dr Chesterfield-Evans: that the Committee secretariat be authorised to make any typographical or grammatical changes to the report prior to tabling of the report.

Resolved, on the motion of Ms Griffin: that pursuant to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under the authority of Standing Order 223, the Committee publish all non-confidential tabled documents, correspondence, answers to questions taken on notice, minutes, submissions and transcripts.

Resolved, on the motion of Mr West: that dissenting statements be submitted to the secretariat no later than 9.00am Tuesday 28 March 2006.

Resolved, on the motion of Mr Lynn: that the draft Chair's Foreword be circulated to Committee members under Standing Order 229.

The Chair indicated that she would hold a media conference following tabling of the Report at 1.00pm on Friday 31 March 2006 and that Committee Members were invited to attend.

5. Inquiry into public disturbances at Macquarie Fields

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6. Adjournment

The Committee adjourned at 2.00pm *sine die*.