Submission
No 171

INQUIRY INTO DENTAL SERVICES IN NSW

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Date Received:	14/06/2005

Theme:

Summary

File No: 02/6434
H05/5581

Ms Susan Want
Director
Standing Committee on Social Issues
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Ms Want

Please find attached the NSW Institute of Rural Clinical Services and Teaching's submission to the Inquiry into Dental Services in NSW by the Legislative Council's Standing Committee on Social Issues. In responding to the Inquiry's terms of reference the paper focuses on point 1(d) – access to public dental services, including issues relevant to people living in rural and regional areas of NSW.

The NSW Institute of Rural Clinical Services and Teaching was established in 2004 in response to a key recommendation from the NSW Rural Health Report (2002). A Ministerial appointed Executive Committee consisting of a range of rural clinicians, including medical practitioners, nurses, allied health professionals, and community members oversees the operations of the Institute. The Institute aims to:

- Promote excellence in practice by identifying and sharing good practice in rural health service delivery;
- Assist in development of networks between rural health staff and services within and between Area Health Services;
- Act as a source of information for rural and remote stakeholders on rural health workforce and services issues;
- Use its funds to create incentives for organisations to respond to perceived gaps in rural health services delivery; and
- Provide a voice for rural health services and the rural health workforce to highlight issues specific to rural and remote NSW.

If you would like further information about either the Institute or its submission, please do not hesitate to contact Dr Hugh Burke on 0419 971027.

Yours sincerely

Austin Curtin
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9 June 2005

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Submission to Legislative Council Inquiry into Dental Services

Rural and remote oral health

Oral health needs of rural and remote dwellers

Residents of rural and remote regions have poorer oral health than their urban counterparts, with greater tooth loss, higher rates of tooth extractions and less frequent visits for regular dental care (AIHW 1999, AIHW 2002). A higher percentage of rural older people have dentures compared with urban dwellers. A significantly greater percentage of people in rural areas (5.8%) attend public dental clinics compared to urban areas (3.9%).

Dental disease rates also differ between the locations. The average caries rate (measured as an index of decayed, missing or filled teeth) for rural 5 year olds is nearly one and a half times greater than the rate for their urban counterparts. There is very little information regarding comparative decay rates in adults.

Rural children under the age of 15 years are also more likely to be admitted to hospital for removal and restoration of teeth. Rural Indigenous people, both children and adults, have higher hospital admission rates for dental treatment, with the numbers steadily increasing.

Causes for the poorer oral health situation are many, and include a lack of available dental services rurally, long distances between centres, lack of appropriate dental education information, and lower socio-economic status in some regions. There is definitely a lack of equity in terms of oral health status and access to care, between bush and city dwellers.

Dental workforce

This is a highly critical issue in dental care: no programs or additional funds will be useful unless and until there is an available and appropriate rural dental workforce.

It has been well documented that there is a trend towards an overall dental workforce supply shortage in Australia (Spencer 2004; Australian Health Ministers' Conference 2004). The *National Oral Health Plan 2004-2013* states 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." An oral health workforce planning project (NSW Health 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, 26 dental therapists and 32 dental prosthetists, above the numbers in 2000. The authors do not explore issues specific to rural and remote regions. However, 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.

Oral health services in rural and remote NSW are largely provided by dentists and dental therapists (who are trained to provide dental care and education for the child population). Dental therapists in New South Wales can only be employed in the public dental sector and in Aboriginal Community Controlled Health Services. Dental hygienists and dental prosthetists provide limited public dental services, and currently are not widely employed in rural and remote areas.

Salaries are generally lower in the public dental sector and many claim the remuneration is inadequate. The Department has attempted to redress this, and to encourage dentists to work in rural public dental clinics, by introducing the Dental Officer Rural Incentive Scheme (DORIS) which offers a potential salary top up of $20000 per annum. The Department has also piloted the use of funds to encourage recent graduates to rural public dental clinics by further salary enhancement of $10000 per annum through the Graduate Rural Incentive Program (GRIP). This pilot should be expanded to become a permanent program.

DENTISTS

Currently there is a gap between urban and rural/remote supply of dentists. 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 Sydney with rural areas (89 dentists per 100,000).

Within these total dentist numbers, 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 1 per 100,000 people in the (previous) Far West Area Health Service, to 4 per 100,000 people 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. In 2005 three Area Health Services merged to form the Greater Western Area Health Service, an area two thirds the size of NSW. It is estimated that 57% of the total population, including both children and adults, is eligible for public dental care. This equates to about 169,000 people. Servicing this population are only five public dentists and 9 dental therapists creating a dental practitioner ratio per population ratio of about 1:12000, an overstretched capacity to supply services by any reckoning.

Spencer (2004) notes that the greatest numbers of dentists are in the middle age groups, and that by 2010 many of these will retire from the workforce, or decrease their workloads. With fewer dentists currently in the younger age groups, and lesser numbers of recent graduates, the overall effect will be a diminished dental workforce.

In the future Spencer predicts with concern that the previously mentioned looming general shortage in 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." A decreased dental workforce coupled with an increased demand for dental services from an ageing population that is keeping its teeth, has the potential to create many income opportunities for dentists in urban areas, thereby increasing the difficulties already experienced in recruiting and retaining dentists in rural/remote 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 open 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.

With regard to services provided by dental specialists such as orthodontic and oral surgery the NSW *Review Of Statewide And Specialty Oral Health Services 2002* found that rural residents suffered from a lack of access to specialist dental care. The report noted 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. However, at the same time the metropolitan setting appears to be moving towards increasing specialisation whereby there is a greater interest among recent graduates to move into specialty fields, and a reliance by urban general dental practitioners on specialist referral. This raises a concern that future dentists will not be equipped with the skills and confidence to provide the broad range of dental services currently being provided by rural dentists.

DENTAL THERAPISTS

Dental therapists are the backbone of child dental care through the existing School Dental Service, providing a range of dental services including oral health promotion to school-aged children. In recent years the oral health promotion activities have decreased, with a greater emphasis instead on dental screening and treatment.

There are regions in New South Wales that have had no regular School Dental Service programs for several years, and many of these have high dental disease rates, in some cases due to there being no fluoride in the water supplies. A health check program in Walgett (a non-fluoridated town) in the north west of the State found primary tooth caries in over 90% of the children. Given the alarming trend of increasing dental caries rates in young children (Spencer 2004), combined with no access to dental care and prevention, there is cause to be concerned at the state of oral health of future rural Australians.

The circumstances of this workforce raise some alarm bells with respect to the system's ability to replace these staff in future years. Within the new Greater Western Area Health Service over 70% of dental therapists are aged above 40 years, most of whom have lived and worked in their communities for many years, many on a part-time basis. Recent experience has demonstrated that replacing these workers when they leave has proved near impossible. These recruitment difficulties are unlikely to change in the future and will become more generalised as this ageing workforce reaches retirement age in the coming years.

Until 2004, dental therapists in New South Wales received their training at the Westmead School of Dental Therapy. This Diploma program has now been replaced by the three-year Bachelor of Oral Health at the Faculty of Dentistry at the University of Sydney, which will equip graduates with combined dental therapy, dental hygiene and oral health promotion skills. The final Diploma program students graduated in 2004. The new course commenced with 14 students in 2005 who will enter the workforce in early 2008. In addition the University of Newcastle delivers a Bachelor of Oral Health which provides students with combined dental hygiene and oral health promotion skills, but no dental therapy skills. Over 50 students commenced this course in 2005 and will commence work in early 2008.

While this move towards a Bachelor qualification for dental therapists is to be applauded, there appears to have been limited planning to date as to how this sudden explosion of dental hygienists/oral health promoters will be most effectively utilised, particularly in rural areas. There is great potential to employ such a practitioner in Indigenous communities (where the dental hygiene skills would be greatly useful in prevention programs and the management of periodontal diseases, the dental therapy skills for the management of child oral health, with oral health promotion to support individual and community-based prevention activities) and public rural dental programs.

The future of the School Dental Service for rural and remote communities will rely on an ongoing supply of dental therapists or Oral Health Therapists practising their dental therapy and oral health promotion skills in the bush. However the majority of these new skilled graduates will most likely prefer a city existence and be highly sought after, and better remunerated, in the private sector Furthermore it is probable that this degree will become a not infrequent pathway to the Bachelor of Dentistry program. As such, there is a grave danger that none or very few of these graduates will work in non-metropolitan regions, leading to increasing numbers of unfilled vacancies as the current dental therapists retire or leave the workforce.

A worst case scenario could be a failure of the rural and remote School Dental Service. Unless incentives are created to entice graduates to practice dental therapy skills, particularly in rural and remote settings, the worst case scenario could be realised and there is a real danger that children will have very little dental care

Some have argued that this potential loss of workforce will not be a problem as dentists have the skills to provide all aspects of dental care including care to children. However, as previously documented, rural dentists, in the main, don't have the time to treat children because of the high adult dental disease rates, and there will be increasing difficulties of recruiting and retaining dentists in the bush in the first place.

OTHER DENTAL PRACTITIONERS

There has not been much emphasis in New South Wales, particularly the rural and remote areas, on dental team approaches to providing various levels of dental care. The use of dental prosthetists has relieved some denture waiting lists, and the use of dental hygienists can help in preventive dental care. Given this, consideration should be given to increasing these positions in the rural sector as an alternative to a dentist if it is believed that it will be unlikely to recruit dentists to the bush.

Also consideration should be given to creating new levels of allied dental practitioners with preventive dental and oral health promotion skills, such as oral health screening and the application of fluoride varnishes to susceptible teeth. Spencer (2004) has previously suggested that such practitioners could work in "non-traditional dental practice; for example, residential care facilities, remote Indigenous communities, hostels and detention centres." However if it is believed that it will be difficult to recruit the new Bachelor of Oral Health graduates to the bush then this new position may be the solution to maintaining the School Dental Service in rural NSW.

Service delivery

As previously noted, the decreasing numbers of dental personnel in rural and remote New South Wales is having a significant impact on access to dental care. Another compounding factor is the greater number of eligible concession card holders in some rural and remote regions: in the newly formed Greater Western, and North Coast, Area Health Services, 41% and 65% of the adult population is eligible for public dental care respectively.

The public dental system has attempted to relieve the pressure on its already stressed clinics by utilising private dentists to treat emergency patients with a voucher system, through the Oral Health Fee For Service Scheme (OHFFS). Pensioner dentures may also be similarly available from the private sector through the Pensioner Denture Scheme (PDS). Where private practitioners participate, these schemes have been effective in improving access to basic dental care. However in some towns such as Orange and Lithgow, there are no participating private dentists. While this may be symptomatic of the "divide" that is often drawn between the public and private system, as dentists become more scarce there needs to be greater cooperation between these sectors to provide dental care. However even with greater collaboration between the private and public sectors it is likely that there will simply not be enough dentists in rural and remote NSW and alternative models of care will need to be developed.

Lack of access to dental services results in a greater proportion of presentations for emergency care in rural/remote areas, and fewer visits for check ups and routine work (AIHW 2002). There have even been anecdotes regarding difficulty in accessing emergency care with stories about the use of battery acid to relieve dental pain, and "self-extraction" using farm and garage tools.

People may need to travel several hundred kilometres to a dentist. However if a dental emergency is diagnosed by a doctor, IPTAAS will not cover costs for general dental referrals such as tooth extraction. This is a grave situation as often there is facial swelling and infection associated with a problem tooth or teeth, and severe pain. One consequence is a potential overprescribing of antibiotics, which will relieve the symptoms but will not fix the actual dental problem.

Many rural medical practitioners are increasingly being called upon to treat dental emergencies due to the lack of dentists. Whilst legally they are able to provide dental care under the NSW Dental Act, most have had no training in appropriate diagnosis and management of dental pain and infections. General medical practitioners tend to prescribe analgesics and antibiotics to relieve a person's pain, however the only effective treatment is to address the actual dental problem. Some may attempt tooth extraction procedures, but this practice could be potentially dangerous without adequate knowledge and skills.

Given this situation we must investigate ways of supporting rural medical practitioners. One positive development has been the Rural Health Education Foundation's interest in the development of a dental emergency training package for doctors working in rural and remote locations.

When considering dental specialities the lack of access to specialist dental care has been well documented in the *Review Of Statewide And Specialty Oral Health Services*. People requiring specialist dental care find themselves travelling to larger centres such Sydney, or have no access at all, especially for orthodontic care. In response, the Department of Health has established Oral Health Centres of Excellence in Coffs Harbour, Queanbeyan and Dubbo, an initiative that should be applauded. They function in varying capacities and there is potential to develop further their ability to provide dental specialist care and training.

As mentioned in the section on Dental Workforce, there is a danger of the School Dental Service potentially collapsing in some regions unless greater consideration is given to the future recruitment and retention of appropriately skilled dental practitioners in rural and remote regions. Children, especially those in non-fluoridated towns, will have a very poor "dental start" to their lives, and there is a potential of their putting a greater burden on the health system in the future due to higher rates of dental disease.

Oral health promotion

Dentistry unfortunately does not have a great past reputation for performance in oral health promotion activities. Support for water fluoridation is essential in terms of reducing dental caries (see below), however prevention of periodontal and other diseases in adults also needs to be considered. In a climate of decreasing access to dental services, emphasis needs to be placed on promotion and prevention activities, and improving access to care. NSW Health has recently drafted an oral health promotion strategy (NSW Health 2004) with a section specifically on rural and remote oral health needs. Some of the strategies include increasing fluoridation of public water supplies, the development of partnerships with other health organisations and agencies in adopting common risk factor approaches to prevention of dental diseases, and increasing the capacity of primary health care providers in the detection of early signs of oral health problems. These initiatives are to be encouraged.

Since 2000, there has been a series of primary health care programs run in small towns and communities in the far west of NSW - Well Persons Health Checks and Healthy Kids Checks. These are comprehensive screening, treatment, management and health promotion programs, which include oral health as an integral component. Whilst health and oral health data are collected, the emphasis is on providing appropriate ongoing treatment and advice. Oral health outcomes have included improved uptake of treatment in local dental services, the commencement of school-based tooth brushing programs in small towns with no fluoride in the water supply, and improved knowledge of oral health issues by health and allied health staff including Aboriginal Health Workers. These health check programs have highlighted oral health issues, and have created a framework for improving access to dental care and information.

Programs such as the school based toothbrushing spring from a strong base of community support and commitment, with no great funding. Recognition needs to be given to these initiatives, as they are driven by committed individuals and organisations, with opportunities for further expansion and development.

Fluoridation

The Centre for Oral Health Strategy has made available funds to support the fluoridation of public water supplies in rural towns and there have been several recent successes. This work is to be encouraged.

However water fluoridation is cost effective only for populations greater than 1000. Given that water fluoridation is proven to be effective in caries prevention, it becomes an equity issue when urban dwellers in New South Wales receive the benefits of water fluoridation, yet rural populations are missing out. Consideration must be given to improving oral health in smaller communities, with possibilities including school-based toothbrushing programs, fluoride rinsing programs, improved affordability and availability of oral hygiene items, coupled with targeted oral health education programs for families as well as community and health staff.

Indigenous oral health

Rural and remote regions have high proportions of Indigenous people, with particular oral health needs. While there is not a great amount of Indigenous-specific oral health data, it is known that Aboriginal and Torres Strait Islander children have twice the amount of dental caries with a greater proportion of untreated dental caries; adults have more missing teeth and greater levels of periodontal disease, with poor periodontal health showing in younger people (AHMC 2004). Higher levels of poorly managed Type 2 diabetes contribute to bad periodontal health, with the combination of these two factors contributing to the greater tooth loss in adults.

Past reports *(eg Aboriginal Oral Health Strategic Planning Project* (NSW Health 2002)) have identified several barriers to appropriate dental care for Indigenous people including: high cost of private services and lack of public dental services; lack of transport; and lack of access to appropriate oral health information and culturally appropriate services. Some approaches identified to improving these situations were to strengthen partnerships between the public and Aboriginal Community Controlled Health sectors, offer greater support for Aboriginal Health workers in oral health education, and develop targeted programs to those with greater needs especially children.

The situation has been exacerbated in recent times by the increasing difficulties in recruiting dentists to rural and remote Aboriginal Community Controlled Health Services, hence consideration of these health services must be included in all planning processes.

Dental education

Partly in response to the projected shortfall in dentist numbers, the Faculty of Dentistry has recently increased its intake from 50 to 82 students. While in absolute terms this may be impressive the real increase is probably much less once the analysis takes into account international and full fee paying students. The first year intake in 2005 of 82 students includes 45 HECS students, 12 international and 25 full fee-paying students. If we assume that these international and full fee paying students are unlikely to enter into a career as a public dentist, particularly in a rural and remote setting, the potential pool of rural recruits is only 45. Consideration must also be given to numbers of interstate students, for example in the current final year cohort there are several students from other States, who will most likely return to those States. With increasing pressure on Universities to raise funds through full fee paying and international students, there is some concern as to whether there will be any increase in the pool of future dentists interested in working in the bush.

The current Bachelor of Dentistry program at the Faculty of Dentistry, University of Sydney, has mandatory 2-week rural placements for final year students of the four year graduate degree program. We are aware that the Faculty has plans to introduce longer placements with a view to piloting the scheme in 2006 or 2007. Students have no introduction to rural issues prior to this, unless they choose to do their third year elective placement in a rural setting which very few students do. The Faculty should be supported to further develop its rural program, and introduce greater exposure to rural and remote issues earlier in the course, as well as coordinating these placements more closely with other health disciplines.

The new Bachelor of Oral Health programs will produce dental personnel with varying skills. Support must be given for these programs to expose their students to rural and remote issues through their course, and to encourage their graduates to work outside the major cities. Further as mentioned consideration will need to be given to developing rural job descriptions if the unlikelihood of attracting the mainstream positions to the bush eventuates. These positions will need to be set up so that they integrate into an overall dental career pathway.

If a greater push for rural placements eventuates, there could be a likely scenario where approximately 150 students per year would be seeking a rural placement: 80 dental students, 20 Bachelor of Oral Health students (Sydney), and 50 Bachelor of Oral Health students (Newcastle). As well, there is a partnership between the Universities of Newcastle and Adelaide, which is working currently to provide a small number of Adelaide final year dental students 10-week experiences based in the Hunter/New England region. It will become critical that there be some central rural point of coordination and support for this potential volume of students. Furthermore much work will be required in developing the dental educational infrastructure within rural NSW required to support this potential increase in trainee numbers.

Finally, there are currently no rural and remote education scholarships in NSW, unlike those for medical students. This needs to be addressed.

Recommendations

Considering the preceding discussions, below are some recommendations to improve dental care in rural and remote regions.

1. Support the development of a Centre for Rural and Remote Oral Health that would enable a strong focus on rural and remote oral health issues and solutions and ensure a strong connect between the training and services sectors with respect to future initiatives. Ideally this Centre would be based in a rural location and its structure should include formal linkages with the University of Sydney's Faculty of Dentistry and other NSW rural universities. Effective examples of similar centres include the Western Australian Centre for Rural and Remote Oral Health in Perth and the NSW Centre for Rural and Remote Mental Health, based in Orange, that has formal linkages with the University of Newcastle.

Functions of this centre might include the coordination of recruitment and retention activities for all sectors including private, public and Aboriginal health services; guidance and support for rural dental education, including the development and maintenance of rural clinical placements; coordination of professional development and continuing education programs, particularly in the skills areas necessary for rural and remote general dental practice; and identification of linkages with other rural health and community programs.

2. Review the future workforce requirements of rural and remote NSW and the need to develop location specific job designs, salary packages and career pathways that enable the local delivery of largely self-sufficient services. Full use must be made of the whole dental team including oral health therapists, dental therapists, hygienists and prosthetists, for a more cost effective approach to provision of preventive dental care. Consideration must also be given to expansion of duties of non-dental personnel such as Aboriginal Health Workers, to include oral health promotion and preventive duties.

3. Develop creative service models that result in greater linkages between private and public sectors. Examples might include limited rights of private practice in public dental clinics, more effective use of the whole dental team and the creation of linkages between urban dental practices and rural towns where dentists from the urban practices visit their "partner" towns on a regular basis.

4. Review and improve salaries and conditions for all rural dental staff in the public and community sector.

5. Review the School Dental Service in rural and remote regions, with consideration of long term sustainability of dental therapy staffing, and the delivery of appropriate clinical and preventive activities.

6. Establish appropriate salary and career structures for Oral Health Therapists, with particular consideration of the School Dental Service, that encourage them to work rurally.

7. Support the development of appropriate oral health promotion and preventive activities in rural and remote regions, involving dental and other health and community personnel, and particularly considering the needs of Indigenous people, those in non-fluoridated communities, and children. Programs such as the Well Persons Health Checks which integrate oral health with general health should particularly be encouraged.

8. Expand the range of specialist services provided in regional centres.

9. Continue to encourage non-fluoridated communities to get fluoride in the water supply.

10. Expand the rural component of dental undergraduate programs, with supported rural placements within the public, private and non-government sectors.

11. Introduce opportunities for rural education scholarships along the lines of the medical profession.

12. Develop appropriate dental emergency training packages for rural and remote medical GPs.

13. Review IPTAAS restrictions regarding referral for necessary emergency dental care.

14. Provide culturally appropriate and accessible oral health services for Aboriginal and Torres Strait Islander people.

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