Submission No 185

INQUIRY INTO DENTAL SERVICES IN NSW

Organisation:

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Telephone:

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Theme:

Summary

15th June 2005-06-15

The Standing Committee On Social Issues
Legislative Council, NSW Parliament
Macquarie St, NSW 2000

RE: The Inquiry By The Standing Committee On Social Issues Into Dental Health

Dear Sir/Madame

As a Dental Therapist working in rural NSW I am very concerned with what I see as a crisis in Dental Health and by the failure by all governments, State and Federal, to adequately maintain dental services. both in terms of human resources and equipment. Dental Health has long been neglected not only by successive governments but also by the medical profession.

Whilst the most basic understanding of biology must inform the logic that healthy eating is the very basis of a healthy body and that healthy eating is not possible without healthy teeth and gums the medical community continue to isolate dentistry as though it is irrelevant.

This is a very flawed model of health as even mainstream thinking is beginning to realise as gingivitis is now being linked with Heart Disease.

Whilst services are suffering from neglect and dental health workers are struggling to work under circumstances which frustrate both clinician and patients, dental decay is rampant, not only in the lower socioeconomic demographic of our community but increasingly across all demographics.

A number of factors I see as causal to this current epidemic include-

- the epidemic of family breakdown- this affects dental health in various ways foremost being the rupture of routine. Toothbrushing is effective against decay only if it is regular and consistent. When children are swapping households routines are very difficult to maintain. 'Guilt-treating' is another cause of tooth decay after family breakups where both parents tend to give the children enormous amounts of treats in the form of junk food, especially lollies for younger children perhaps because they feel that they have let them down in other areas. Both parents and grandparents tend to do this. Single parents are often'time-poor' so meals are often not adequate- breakfast often not eaten at all, morning tea and lunch often bought from the school canteen, afternoon tea unsupervised snacks and dinner often pre-packaged meals.

- the prevalence of two parents working- the children of parents who are 'time-poor'are at high risk of dental decay for similar reasons as broken families. Diet is often determined by time rather than nutrition and in fact these children are sometimes at greater risk because there may be more disposable income to buy

unhealthy but expensive 'treat' foods and black cola drinks. Time-poor parents also find it very difficult to attend appointments with their children so tend not to seek check-ups or preventive sessions but only seek treatment when a toothache is disrupting their routine, and may send someone else (often a grandparent) with their child, thereby missing out on the oral health education that the health professional may give in the clinic.

- increased numbers of children attending private schools- often involving travelling time and/or boarding where children are making their own mostly poor decisions about snacking, again there is minimal supervision of the children's diet and toothbrushing.

- aggressive marketing of cariogenic food and drinks and increasing gullibility of the general public in regard to advertising. Parents and children that I see in the clinic are increasingly ignorant about what foods are consistent with a healthy diet and totally dumbfounded when I inform them of the sugar content of some foods. Without nutritional information parents and children cannot make informed choices and believe the products advertising almost by default.

- our increasing tendency as a community to eat every day as though it is Christmas Day. Aspirational parents are always looking for 'better' food for their children. The food retail market encourages this attitude just as any market and sugar and caffeine are easy ingredients to make a 'new' food attractive to children and parents.

- the epidemic of the black cola drink- probably the greatest single contributing factor to caries in the twelve to early twenties age group. Responsible for a decay pattern very difficult to restore due to the shape and location of the carious lesions.

At a time when the task of preventing or treating dental decay is possibly at its most challenging our governments are criminal in their neglect. Dental decay is a totally and cheaply preventable disease that is causing dreadful pain for many children and adults every day in NSW and lack of treatment for their dental disease is setting up a poor outcome for their general health.

At this time in our history we should be asking ourselves why we do not have adequate numbers of dental health professionals in both the public and private health models? Why are Public dental health workers paid so poorly? Dental Therapists receive little more than their assistants and years of operating in difficult conditions with poor support both professionally and financially have led to very poor morale amongst staff. Hence high sick leave and resignation rates . Why are there so few preventive dental health programs? Why do we need to import overseas Dentists? Why , when we are being told that we are wealthier than ever, that we are so affluent, cant we as a nation afford to train enough Dentists for our small population? And finally why is Dental Health not an integral part of Medicare?

I have been working for the NSW Dental Service for twenty six years and during that time I have witnessed a dramatic decline in the service at the same time as a dramatic increase in children's decay. Our staffing has decreased whilst the demographic we

provide our service has grown more than three times. Many staff are frustrated and stress leave is common amongst staff that are on the frontline delivering a service that is plainly inadequate to people in pain.

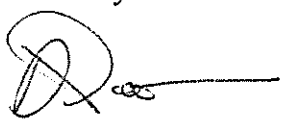
When I began working as Dental Therapist in rural NSW there were two full-time therapists responsible for two towns, Temora and Cootamundra, populations of approximately 6,000 and 8,000 at the time. We saw children from Kindergarten, aged approx. five to Year Six, aged approx. twelve. We saw over ninety percent of the school population. We were responsible for school lessons on Dental Health and nutrition throughout the area, 'Brush-Ins' with a fluoride toothpaste, in-clinic toothbrushing instruction, preventive fluoride treatments and clinical treatment of carious teeth. This was a thorough and comprehensive treatment program resulting in a clearly improvement in oral health over time.

The service has now one therapist, myself, operating only three days per week yet we now have many more children eligible to access the service- we see children from 0-18 years of age. There are effectively no prevention programs operating as the emphasis is on treating pain. There are no school lessons re Oral health and access to the service is limited.

The SAP, or screening that is carried out in the schools is problematic with poor vision making diagnosis difficult and parents unclear as to the exact nature of the service provided at the screening. Many parents are under the impression that a clinical dental examination is performed whereas what takes place is a brief assessment of their child's oral health under poor visual conditions with a wet field. Adequate caries diagnosis requires drying the tooth which is not possible at a 'SAP' screening and visual assessment of the teeth deteriorates further after morning tea and lunchtime as you can imagine.

NSW Dental Services need an enormous injection of funds, staff and creativity to be effective in a challenging health environment after many years of financial neglect. I congratulate APOH, A/Prof Hans Zoellner,and The Honourable Chesterfield Evans and his colleagues in the NSW Upper House for investigating Dental Health in NSW

Sincerely



Di Pearton
Dental Therapist