

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

The Association For The Promotion Of Oral Health



**Supplementary Submission To
The Upper House Inquiry
Into Dental Services in NSW
By The Standing Committee on Social Issues
Legislative Council, NSW Parliament, 2005-2006**

**Analysis of the
Public Hearings and Submissions
February 28, 2006**

This document is an analysis of the public hearings and submissions made to the inquiry, with particular regard to issues APOH considers most important.

Please note that APOH considers the safety and efficacy of fluoridation to be well documented by the scientific literature. For this reason, although some submissions and witnesses spoke with regard to fluoridation, the current document makes little further mention of this issue.

Summary, Analysis and Recommendations

Testimony given at the public hearings supports the detailed analysis presented to the Committee by APOH in its submission (No. 65).

To facilitate analysis, this document distills the hearings and submissions into the main points which were consistently raised in the inquiry, and gathers diverse testimony supporting these points.

1. Community needs for dental services are unmet and increasing

Objective epidemiological data presented by expert witnesses as well as testimony by health workers and consumers provided ample evidence for rapidly growing and largely unmet community need.

A degrading dental workforce is apparent, together with a growing community disease load in an ageing population. Services are unevenly distributed so that rural areas are particularly disadvantaged.

Public services are exceptionally understaffed due to poor wages and conditions, relative to the private sector, while the public infrastructure is inadequate for needs.

2. Training infrastructure is inadequate and under-resourced

Despite increasing community need, there is a degraded and fragmented training infrastructure, with fewer students, academics and resources than in the past, so that the dental workforce can not be easily re-built.

Funding for the University of Sydney Faculty of Dentistry is particularly inadequate, and this is exacerbated by heavy internal taxation arrangements by the University, which captures about half of educational funding. This leaves the Faculty over budget each year by up to 20%. The present funding formula including accommodation of academics, is difficult to understand in light of the fact that all office and laboratory space for dental training and academia is provided to the Faculty by NSW Health and not the University.

Although dental students and their academic supervisors deliver significant direct service to public patients, they receive less support from NSW Health in comparison with their medical colleagues.

Poor infrastructure and heavy work-loads make it increasingly difficult to attract dental academics to NSW.

These problems have been exacerbated by the sale, by NSW Health, of the Dental Faculty Building at Sydney Dental Hospital thereby reducing academic infrastructure and limiting further growth in training.

3. There has been a lack of planning, financing and political will

There has been no real planning for dental workforce development. The acute shortages are already apparent in rural areas and in the NSW public dental service and this acute shortage is anticipated to spread to private practice in metropolitan areas in the near future.

Dental health policy is inconsistent across Area Health Services, reflecting a lack of past political and administrative interest in dental health.

There is a lack of uniformity in NSW with regard to water fluoridation, which requires State level legislation to ensure access by the entire community to this safe and effective health measure.

Similarly, dental insurance mechanisms are inadequate for community need.

The public dental service in NSW has the lowest funding per capita compared with other States and Territories in Australia.

4. Senior NSW Health officers responsible for dental services are uninformed with regard to dental health and are unwilling to improve services

The Chief Health Officer / Director, General Population Health (Dr D Robinson) and the CEO Hunter New England Area Health Service (Mr T Clout) represented NSW Health at the Inquiry. Both of these officers demonstrated a lack of awareness and knowledge regarding funding and dental service provision.

In particular, they were uninformed about: the low level of dental funding in NSW relative to the other states; the number of eligible persons on waiting lists; and the lengthy waiting times for public dental service.

A lack of understanding about the chronic nature of dental disease was revealed, especially in relation to the management of existing disease. The stance of the Department was to focus on the three strategies of oral health promotion, water fluoridation, and the Priority Oral Health Program but none of these involve increased levels of treatment of existing disease. It was not acknowledged that water fluoridation, though of very great importance, is not a panacea for all oral problems and that dental caries is not eliminated by fluoridation; caries is only substantially reduced. There will always be a need for the treatment of caries that is not prevented, in addition to the treatment of other oral diseases. A situation that fails to encompass the need for treatment and maintenance of existing and past disease would be regarded as untenable in any other health discipline. The oral health promotion activities referred to were not defined and no evidence was presented to indicate that they were effective, or under review. Finally, 90% of the NSW population already has access to fluoridated water, so that very little further improvement can be expected from fluoridation alone.

The incapacity of the public system to manage waiting lists was not recognized as important.

Of concern, the current model for service was suggested as the best possible by Mr Clout.

Dr Robinson suggested that preventive educational programs, telephone triage for acute pain and attempts to encourage individual councils to fluoridate was an adequate response to the growing community need.

APOH suggests that the absence of appropriate informed advice to government may account for the current poor levels of service and oral health in NSW.

5. Fluoridation was supported by informed and credible health professionals and academics

Disquiet was expressed by some individuals and anti-fluoridation organizations with regard to the safety, efficacy, environmental impact and ethical probity of fluoridation.

Nonetheless, expert testimony by health professionals and academics indicated that fluoridation of water supplies is a safe and effective means of reducing caries in the community.

6. Recommendations

- 1) Improve recruitment and retention of the dental workforce through an immediate 30% increase in salaries for clinical dental staff, together with introduction of appropriate awards.
- 2) Improve training and expand the public dental workforce through the introduction of a dental internship together with the establishment of registrar appointments and con-joint specialist university/hospital academic staff appointments
- 3) Improve the quality and efficacy of dental training by building additional dental educational facilities at Westmead Hospital to replace the former Dental Faculty building, sited adjacent to the Sydney Dental Hospital that was recently sold by NSW Health.
- 4) Improve accountability and efficacy of public dental services by increasing the authority of the Chief Dental Officer.

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To The

Supplementary Submission To The Upper House Inquiry Into Dental Services in NSW By The Standing Committee on Social Issues Legislative Council, NSW Parliament, 2005-2006

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Appendix:

List of Hearings and Witnesses

List of Hearings and Witnesses

Sydney, 29th June 2005

HANS FREDERICK ARTHUR ZOELLNER, Associate Professor and Chairman, Association for the Promotion of Oral Health

BARBARA ANN TAYLOR, Staff Specialist in Periodontics and Head of the Department of Periodontics, Sydney Dental Hospital

GEOFFREY HAROLD TOFLER, Professor of Preventive Cardiology and Senior Staff Specialist, Cardiology Department, Royal North Shore Hospital

ELI SCHWARZ, Dean, Faculty of Dentistry, University of Sydney

Sydney, 5th July 2005

DENISE MARGARET ROBINSON, Chief Health Officer and Deputy Director-General Population Health, New South Wales Department of Health

TERRANCE JAMES CLOUT, Chief Executive, Hunter New England Area Health, New Lambton, Newcastle

PETER ROBERT HILL, Principal Dental Officer, Oral Health Services Manager, Justice Health,

GARY MOORE, Director, Council of Social Service of NSW

SAMANTHA RUTH EDMUNDS, Senior Policy Officer (Health), Council of Social Service of NSW

FELICITY MARGARET BARR, Chair, Ministerial Advisory Committee on Ageing, New South Wales

ALEXIS TAYLOR, Caseworker, Uniting Care Burnside, Campbelltown,

KEO VORASARN, Intensive Family Support Worker, Uniting Care Burnside, Cabramatta,

JO ALLEY, Policy Officer, Uniting Care Burnside, North Parramatta

ANN MAREE DAVIES, Service User, Uniting Care Burnside, North Parramatta,

CHRISTOPHER STEPHEN WILSON, President, New South Wales Branch, Australian Dental Association

MATTHEW FISHER, Chief Executive Officer, New South Wales Branch, Australian Dental Association

BERNARD RUPASINGHE, Policy Officer, New South Wales Branch, Australian Dental Association

Sydney, 3rd August 2005

KATHERINE SUZANNE VERN-BARNETT, Honorary Secretary, New South Wales Dental Assistants Association

BARBARA HAYES, Honorary Treasurer, New South Wales Dental Assistants Association

KAY FRANKS, President, New South Wales Dental Therapists Association, College of Dental Therapy, Westmead

JANET WALLACE, Research Officer, New South Wales Dental Therapists Association, College of Dental Therapy, Westmead

REGINALD FRANCIS SCOTT, OAM, President, Dental Technicians Association

GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales

JENINE ANNE BRADBURN, Secretary, Association of Dental Prosthetists Inc New South Wales

Port Macquarie, 23rd August 2005

LYNETTE CONSTANCE JAMES, Acting Secretary, Mid North Coast Fluoride Free Alliance

PATRICIA JOYCE WHEELDON, Secretary, Mid North Coast Fluoride Free Alliance

BARBARA JUNE GRANT-CURTIS, member of Citizens Against Fluoridation

LISA CHRISTINA INTEMANN, Councillor

Mr ROBERTS

Mrs McKAY: Hastings Safe Water Association

Ms TURNER: Chairperson of the Central Coast Pure Water Association

Mr SMITHERS: I am a councillor on Coffs Harbour City Council

Mr EVANS: Fluoridation is not Democratic

Ms HELSON: An alternative health person

BERNARD SMITH, General Manager, Port Macquarie-Hastings Council

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health Service

JOHN RUDD IRVING, Project Manager, North Coast Area Health Service

SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service

Broken Hill, 30th August 2005

VISKO PAUL SULICICH, Manager Infrastructure, Broken Hill City Council

RAYMOND JOHN HARVEY, Operational Services Officer, Broken Hill City Council

THOMAS ERIC KENNEDY, Councillor, Broken Hill City Council

Broken Hill, 31st August 2005

LYN MAYNE, Dental Officer, Royal Flying Doctor Service, Broken Hill

LINDA MARGARET CUTLER, Director, Clinical Operations, Greater Western Area Health Service, Dubbo

JENNIFER GAI FLOYD, Oral Health Network Manager, Greater Western Area Health Service, Dubbo

MASON KUMM, Oral Health Manager, Greater Western Area Health Service, Broken Hill

JASON PETER GOWIN, Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation, Broken Hill

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic, Broken Hill

GREG COCKS, Chief Executive Officer, Dental Centre, Broken Hill

BRIAN THOMAS JOSEPH DEVLIN, Dentist, Broken Hill

Sydney, 14th November 2005

TONY GENTILE, Chief Executive, Australian Beverages Council Ltd and Executive Director, Australasian Bottled Water Institute

DEBORAH JANE COCKRELL, Head of Discipline of Oral Health, University of Newcastle

JANE AMELIA TAYLOR, Senior Lecturer, Discipline of Oral Health, University of Newcastle, Ourimbah Campus

ROBIN WENDELL EVANS, Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney

Sydney, 16th February 2006

ANDREW JOHN SPENCER, Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons

ANDREW MACDONALD HOWE, University of Sydney, Foetal Toxicology, Faculty of Medicine, Member of the Regional Committee of the Royal Australasian College of Dental Surgeons



TERRANCE JAMES CLOUT, Chief Executive, Hunter New England Area Health Service

FREDRICK ALLAN CLIVE WRIGHT, Chief Dental Officer, NSW Health

DENISE MARGARET ROBINSON, Chief Health Officer, NSW Health

PETER MICHAEL DUCKMANTON, Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital

EWA JADWIGA BURY, Professional Vocational Committee of the Health Services Union, Dental Technician, Sydney Dental Hospital

DENNIS RAVLICH, Industrial Manager, Health Services Union

RUSSELL CLIFFORD LAIN, Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital

JOHN GIBBS, General Manager, Pacific Smiles Group

DAVID CHARLES WRIGHT, Director, Pacific Smiles Group

FRANCES CLARE CUNNINGHAM, General Manager, New South Wales, Australian Health Insurance Association

ANGUS CAMERON NORRIS, General Manager, Health and Benefits, MBF Australia

Appendix:

Grouping and Analysis of Submissions

Grouping And Analysis Of Submissions

Approach Used In Analysis Of Submissions

Not counting the current document, there were 258 submissions to the Inquiry. Each submission was classified as belonging to one of a number of discrete groups in order to facilitate analysis.

As detailed later in this document, a number of important major points emerge from testimony at the public hearings, and our analysis has focused upon these. Nonetheless, the written submissions provide valuable confirmatory and supportive data.

Since many of the submissions are similar to each other and so closely reflect the content of the hearings, this appendix details only what APOH felt to be the most interesting or remarkable points raised by individual submissions, with the content of most submissions only being mentioned in group-summary.

Groups Into Which Submissions Were Classified

For the purposes of analysis, APOH has grouped these in the following way:

Submissions From Public Dental Patients

(31 Submissions, Nos 7, 13, 15, 23, 26, 29, 44, 67, 68, 70, 80, 84, 90, 102, 110, 115, 116, 120, 121, 123, 125, 141, 144, 166, 197, 205, 217, 218, 219, 228, 233)

Submissions From Community Groups

(32 Submissions, Nos 16, 18, 25, 30, 35, 39, 40, 48, 52, 56, 59, 62, 66, 77, 87, 92, 98, 113, 133, 145, 161, 162, 168, 169, 196, 199, 200, 210, 216, 224, 229, 231)

Submissions From Concerned Citizens

(63 Submissions, Nos 6, 12, 22, 27, 28, 31, 51, 83, 86, 88, 93, 99, 101, 104, 105, 106, 112, 117, 119, 126, 130, 131, 134, 135, 136, 137, 138, 142, 143, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 163, 164, 165, 176, 177, 178, 179, 180, 181, 186, 187, 188, 189, 190, 191, 203, 204, 211, 213, 215, 234, 235)

Submissions From Dental And Para-Dental Professionals

(56 Submissions, Nos 33, 34, 36, 38, 41, 43, 46, 47, 50, 54, 55, 57, 58, 63, 64, 71, 72, 75, 82, 93, 94, 103, 111, 114, 127, 128, 129, 132, 139, 140, 159, 160, 167, 173, 182, 184, 185, 187, 192, 195, 201, 202, 207, 208, 209, 212, 214, 220, 222, 223, 230, 236, 237, 241, 255, 257)

Submissions From Educational Institutions

(8 Submissions, Nos 21, 42, 74, 76, 193, 194, 225, 240)

Submissions From Professional Organizations

(14 Submissions, Nos 45, 49, 61, 65, 78, 81, 109, 124, 198, 221, 226, 227, 238)

Submissions from Area Health and Other Service Deliverers

(14 Submissions, Numbers: 50, 53, 85, 96, 108, 118, 122, 170, 171, 183, 206, 246, 254, 257)

Submissions From Councils And Political Representatives

(9 Submissions, Nos 3, 3a, 32, 60, 60a, 79, 172, 251, 252)

Submissions Objecting to Fluoridation

(25, Submissions, Nos 2, 4, 5, 8, 9, 10, 11, 17, 19, 37, 89, 91, 97, 107, 146, 232, 242, 243, 244, 245, 248, 249, 250, 253, 256)

A number of submissions were made on a confidential basis, and cannot be accessed.

Submissions Were Consistent With Findings Of The Hearings And The Original APOH Submission To The Inquiry

Written submissions closely reflected the testimony of witnesses at the public hearings, and also confirmed the assertions made in the original APOH submission to the inquiry (No. 65).

Submissions From Public Patients Reflect Inadequate Service Delivery In Public And Rural Settings

(Submissions 7, 13, 15, 23, 26, 29, 44, 67, 68, 70, 80, 84, 90, 102, 110, 115, 116, 120, 121, 123, 125, 141, 144, 166, 197, 205, 217, 218, 219, 228, 233)

Submissions by public patients make compelling reading and graphically illustrate the effects of dental under-funding together with failed renewal of the dental workforce.

Delays in treatment, long waiting lists, extended periods of time suffering with pain, and inadequate clinical resources are recounted time and again by public patients in desperate need.

These submissions reveal the individual human cost of a dysfunctional system, and make it clear that current service levels are inadequate.

Submissions From Community Groups Are Consistent With The Inadequate Service Delivery Documented Throughout The Inquiry

(Submissions 16, 18, 25, 30, 35, 39, 40, 48, 52, 56, 59, 62, 66, 77, 87, 92, 98, 113, 133, 145, 161, 162, 168, 169, 196, 199, 200, 210, 216, 224, 229, 231)

Submissions from Community Groups were consistent in expressing concern about the state of public dental services in NSW. Many deplored the state of public dental services, but also

recommend strategies for improvement consistent with that proposed by APOH as the following quotes and summary statements clearly illustrate:

Mrs Alice Scott, Chairperson for The Illawarra Dental Health Action Group (Submission No. 16) states: *"...who have resorted to pulling their own teeth out with pliers..."*, and goes on to say *"unless you have trauma, bleeding, swelling or pain you will not be seen by a dentist in the public system."*

Ms Lexie Smallwood, Council Business Manager of the National Rural Health Alliance ((Submission No. 25) bemoans the *"under supply of dentists"*.

Ms Felicity Barr, Chair NSW Ministerial Advisory Committee on Aging (Submission No. 56) , notes the impact on general medical services due to the parity of public dental services that seniors *"...only sought assistance (Sic from private dentists) when seniors gum and tooth problems had arisen that required medical attention..."*.

Mr Jim Simpson, Senior Advocate, The NSW Council for Intellectual Disability (Submission No. 66) notes that: *"that dental disease is the most common health problem faced by people with disabilities occurring in 86% of subjects..."* *"long waiting times ...waiting 3-6 months for an initial consultation, 6-9 months for treatment in the chair....and up to 18 months for general anaesthetics."*

"lack of career path to encourage dentists to specialise in working with people with disabilities."

Mrs Beth Eldridge, Coordinator Older Women's Network NSW (Submission No. 98), an agency funded by the Department of Aging, Disability and Homecare, states that: *"temporary measures are taken and that delays experienced before receiving appropriate and complete treatment may result in a greater crisis.."*

"...repeatedly compromised through months of delays awaiting treatment, there is an increased likelihood that they may have to seek additional medical services..."

Ms Ruth Das, Policy and Project Officer NSW Refugee Service (Submission No. 161), another NSW Government agency, who cater for "humanitarian migrants (refugees)": *"high level of dental disease among most refugee groups settling here...."* *"...95% of clients..."*

"c) refugees report an unsatisfactory rate of tooth extraction in contrast to repair/restoration..."

A further inditement on the state of public dental services is noted: *"Westmead Centre for Oral Health has established a pilot Refugee Dental Clinic....due to staff shortages the clinic has been in recession for a period of six months."* (Sic Note: as of June 2005 – and remains closed)

Pat Delaney of the Aboriginal Health & Medical Research Council (Submission No. 162) provides the following comments of concern: *"Council has witnessed the deterioration of dental care in the past 20 years"...."the recruitment and retention of dental personnel is increasingly difficult in all organisations..."*

But goes to offer some solutions: *"appropriate workforce models that use a dental team approach with appropriate funding to attract staff.."*

Mr Mal Peters, President NSW Farmers Association Council (Submission No. 162),

Quotes US Surgeon's Report: *"you cannot be healthy without healthy teeth."*, and in summary comments of the *"Maldistribution of dentists... and the concern of a "Ageing workforce (based upon a study of the graduating years of dentists listed on the Register)"*.

Ms Jane Woodruff, CEO Uniting Care Burnside (Submission No. 199) comments on her concerns about Burnside clinics interaction with the public dental services, noting "Quality a concern..." *"...the qualifications of oral health staff"*. Furthermore she reports:

- *"negative attitudes of staff"*
- *"experiences of poor treatment..."*
- *"lack of preventative focus...emphasis on extractions rather than filling teeth."*

Mr Gary Moore, Director, Council of Social Services, NSW (NCOSS)(Submission No. 220) *"an independent non-government organisation and is the peak body for the non-government services in NSW."* strongly endorses the recommendations providing the Inquiry by APOH.

Mrs Anne Warrant, Coordinator, Older Women's Network, Nowra (Submission No. 229), keenly identifies the problem: *"the shortage of trained dental clinicians and allied practitioners further increases the problem..."*

Difficulties Facing Dental Health In NSW Are Widely Appreciated Throughout The Community

(Submissions 6, 12, 22, 27 28, 31, 51, 83, 86, 88, 93, 99, 101, 104, 105, 106, 112, 117, 119, 126, 130, 131, 134, 135, 136, 137, 138, 142, 143, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 163, 164, 165, 176, 177, 178, 179, 180, 181, 186, 187, 188, 189, 190, 191, 203, 204, 211, 213, 215, 234, 235)

The difficulties expressed in submissions by public patients and community groups are widely understood throughout the community.

Submissions from concerned citizens reveal that although perhaps not personally in need of public dental services, many citizens are deeply concerned for the dental health of people in the wider community.

Importantly, the submissions reveal a similar understanding to that of APOH regarding the reasons for the current shortfall in workforce, as well as the degraded service delivery suffered by public and rural patients.

It is also clear from the submissions received, that the wider community has an expectation that the State Government take immediate and appropriate action to improve dental health in NSW.

Dental and Para-Dental Professionals Confirm The Impossibility Of Delivering Adequate Service In The Absence Of Adequate Resource And Workforce

(Submissions 33, 34, 36, 38, 41, 43, 46, 47, 50, 54, 55, 57, 58, 63, 64, 71, 72, 75, 82, 93, 94, 103, 111, 114, 127, 128, 129, 132, 139, 140, 159, 160, 167, 173, 182, 184, 185,

187, 192, 195, 201, 202, 207, 208, 209, 212, 214, 220, 222, 223, 230, 236, 237, 241, 255, 257)

Unsurprisingly, health professionals who are trained and dedicated to deliver service to the community are deeply frustrated by a lack of resource and workforce.

All of the difficulties facing dental professionals in NSW and detailed in the earlier APOH submission (No 65) are confirmed by these submissions including a need to: improve recruitment and retention of clinical staff; increase the public and rural dental workforces; and the need to achieve a sustainable configuration for dental health and education in NSW.

The difficulties expressed by public patients and community groups are confirmed by many of these submissions, while submissions by clinicians reflect the low morale that would be expected when working in seemingly impossible circumstances.

Importantly, many submissions recommend strategies consistent with those proposed by APOH to overcome these problems.

It is of interest that one submission reveals that the current model for Dental Services in NSW is used elsewhere in the training of post-graduate students as an example of "HOW NOT TO PROVIDE PAEDIATRIC DENTAL SERVICES" (Submission 223). Normally, this would be considered scandalous, but is unsurprising in light of the severely degraded and poorly led system in NSW.

Submissions From Professional Organizations And Educational Institutions Support A Need For Expanded Service By Para-Dental Professionals

(Submissions 21, 42, 45, 49, 61, 65, 74, 78, 81, 109, 124, 193, 194, 198, 221, 225, 226, 227, 238, 240)

The value of developing a team-based model for treatment was raised by many professional organizations (Nos. 45, 74, 78, 94, 109, 124, 198, 225, 227, 236, 241) and dental educators and educational organizations (42, 74, 76, 198, 225, 236, 240), consistent with the proposals made by APOH (65).

There was also a universal recognition of the need for improved funding of both services and training, to permit appropriate deployment of the workforce as well as facilitate workforce development.

It should be noted that team based service delivery and education was proposed in many submission with a particular view to permitting management of what is clearly an uncontrolled epidemic of dental disease. Importantly, consistent with the model proposed by APOH, if properly implemented this approach would both reduce the cost and increase the quality of service.

Further recommendations universally expressed by professional organizations were consistent with those recommended by APOH including improved funding and expanded educational facilities.

Submissions from Area Health and Other Service Deliverers Confirm Difficulties And Suggest Introduction of Changes Consistent With APOH Recommendations

(Submissions 50, 53, 85, 96, 108, 118, 122, 170, 171, 183, 206, 246, 254, 257)

Organizations responsible for provision of services are universally frustrated by the difficulty of attracting and retaining clinical staff, as well as the limited resources available for delivery of service. Service is often reduced to emergency care (85, 96, 118, 206) while demand for service clearly exceeds capacity to treat, particularly in rural areas (50, 5, 96, 118, 122, 170, 206). The effects on this upon morale and recruitment appear self-evident.

Recommendations for internships, improved funding and mechanisms for improving recruitment to rural service are consistent with those proposed by APOH in its earlier submission (No 50, 65, 85, 96, 108, 118, 170, 183, 206).

A lack of funding resulting in inadequate opportunity to deliver preventive treatment, including maintenance of existing fillings, is noted across numerous area health services and other providers (No 85, 96, 118)

Some comments which appear particularly worth of note are as follows:

Dr Wakatama of the Royal Flying Doctor Service (122) indicates that : *"Some towns have high levels of indigenous people while on remote stations the population is non-indigenous. In both cases the need for dental work is high"* and

"In remote areas it should be recognised that the distinction between private and public dentistry is irrelevant. In reality most of the patients serviced are in no position to access private dental services either due to distance, or due to lack of finances"

Dr S Bhole, Clinical Director and Dr D Horvath Chief Executive Officer of the Sydney South West Area Health Service both indicate in submissions 96 and 118 that: *"If some, possibly unpalatable, decisions are not taken about 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."*, and *"Because there are insufficient resources to meet even the demand for emergency care, there is very little general care provided in public oral health clinics and, therefore, public patients find themselves in a cycle of deteriorating oral health and repeated extractions."*

The NSW Rural Health Priority Task Force (170) indicates that: *“Rural rates for dental conditions were almost twice as high in inner and outer regional, remote, and very remote areas in NSW compared with metropolitan areas”*

“Oral health was recognised as an area for action in The NSW Rural Health Report and the NSW Rural Health Plan announced the establishment of three rural Oral Health Centres to provide specialist dental care in regional centres”

St Vincents Hospital (183) notes particular difficulties with regard to the needs of the medically compromised, and the absence of adequate support for such patients in a rural setting. *“Many medically affected patients are affected to such an extent by their illness that they are unable to continue working, necessitating reliance on the a health care card which provides entitlement to access public dental services. For those in rural and remote locations, however, there is often inadequate provision of public health facilities within a reasonable distance if at all. In larger cities the public facilities are burdened with long waiting lists for planned treatment. Some facilities have 2-4 year waiting lists whilst others have closed their lists altogether, citing inadequate resources and provide only relief from pain and are unable to provide preventative dental care or a meaningful treatment plan for patients requiring more extensive management.”*

“On many occasions considerable dental treatment is required before a patient can proceed with organ transplantation, heart valve replacement therapy, or radiotherapy to the head and neck for cancer treatment. Often these patients are unable to access the appropriate treatment in the public sector or have it expedited to enable the planned umedical/surgical procedure to proceed as scheduled”

“Our experience over the last five years is that it is becoming extremely difficult for many rural and remote patients with health care card entitlements to access immediate dental care in the public sector”

In addition, the absurdity of Area Health Service Structures is reflected by what appears to be a loss of access to Sydney Dental Hospital for patients in some areas due to re-structuring of Area Health Service boundaries (183), and it is suggested that the State Wide function of Dental Hospitals should be more readily recognized and funded.

In this submission (183) it is also lamented that there has been a progressive reduction in dental student numbers from about 200 per year in the 1950s to much lower levels now, despite the increase in population.

Mr A Curtin of the NSW Institute of Rural Clinical Services and Teaching (171) makes reference to the clearly evident problems of recruitment in the public dental service, with particular emphasis upon the additional challenge of enticing clinical staff to rural areas. The impact of this is reflected in his comments: *“There are regions of NSW that have 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.”*

“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.”

The Greater Western Area Health Service (206) indicates that *“The demand for adult services exceeds the capacity of the service and appointments are allocated on a priority basis. The means that adult patients not in pain will generally wait at least two years for an appointment. Some patients may never be offered an appointment due to their low priority status under the NSW Priority Oral Health Program, and due to overall demand for services.”*

Consistent with this is that Dr John Powers of Hunter New England (50) recognizes that *“Health is regarded as fundamental in Australian society and health care a basic right, however this does not apply to oral health. Oral health is regarded as an optional extra, a private matter, with public care only provided as a tattered safety net for the most disadvantaged.”* as per Kaye Roberts-Thomson in a paper presented to the Conference of the Public Health Association in 2001, while there is a failure of the current triage protocol for management of chronic disease (50) .

In light of the insistence by some senior NSW Health officials that dental services are well funded (please see extracts from hearings in following appendices), it is interesting to note the comment by Dr Powers of Hunter New England (50) that: *“The current annual budget for Oral Health in NSW is approximately \$100 million, In real terms this is about the value of 10-15 houses in the Eastern Suburbs of Sydney and is patently inadequate.”*

The extraordinary impoverishment of dental services in NSW Health is well expressed by Dr J Webster, a Senior Dental Officer in South eastern Sydney Illawarra Area Health Service (53) who notes that: *“The public provision of dental services is in crisis and it will only get worse. More and more dentists will exit the system in frustration and this will just exacerbate the problem.”*

“... we have more patients in pain than we can treat now....Such people on these list are not there for treatment, as they will never get it. They are there so that we can have a record of how the system is failing.”

Appendix:

Page References To Points of Importance Discussed During Hearings

Page References To Points of Importance Discussed During Hearings

Reading This Part Of The Document

Points that APOH considers of greatest importance are listed below, together with page and paragraph references to the hearings which support the points made.

Please note that throughout this section of the document, the name of the relevant witness is given even if the paragraph number leads the reader to a question posed by a committee member.

Also please note that the relevant portions of the direct transcripts are provided in a further appendix.

There Is Increasing Community Need For Dental Services

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,

Page 1, last Paragraph:

Page 4, Paragraph 1:

Page 4, Paragraph 5:

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 2, Paragraph 2

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing 5th July, Page 33, 1st Paragraph

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): Hearing 3rd August, Page 17, Paragraph 2:

Ms FRANKS (President NSW Dental Therapists Assoc): Hearing 3rd August, Page 17, Paragraph 5:

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st Page 9, Paragraph 17:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service: Hearing August 31st , Page 1, Paragraph 12

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Pages 29 to 30, Last Paragraph:

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 1, Paragraph 4:
Page 1, Paragraph 10:

There Is Insufficient Dental Workforce To Deliver Dental Services

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,

Page 1, last Paragraph

Page 4, Paragraph 5:

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 5:

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing July 5th,
Page 63, Paragraph 13:

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): Hearing July 5th, Page 63,
Second Last Paragraph 13:

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing
August 23rd
Page 26, Paragraph 9:
Page 27, Paragraph 8:
Page 31, Paragraph 8:

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 3, Paragraph 7:

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st,
Page 19, Paragraph 8:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st,
Page 20, Paragraph 8 :

Mr GOWIN: Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation, Hearing August 31st,
Page 38, Last Paragraph:

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic: Hearing August 31st ,
Page 49, Paragraph 8:
Page 50, Paragraph 12:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th
Page 29 to 30, Last Paragraph:

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian
Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006,
Page 14, Paragraph 4:

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee
of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006
Page 21, Second Last Paragraph:

Dentists Are Un-Evenly Distributed, So That Rural Areas Have Very Few Dentists Available

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005
Page 6, Paragraph 6:

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing 29th June,
Page 38, Paragraph 4:

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 5

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th,
Page 32, Paragraph 7:

Page 37 Paragraph 3:

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing July 5th,
Page 41 Last Paragraph:

Ms GRANT-CURTIS: Hearing August 23rd ,
Page 6, Paragraph 6:

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing
August 23rd ,
Page 26, Paragraph 9:

Mr SULICICH, Manager Infrastructure, Broken Hill City Council: Hearing August 30th
Page 1, Paragraph 11

THOMAS ERIC KENNEDY, Councillor, Broken Hill City Council,: Hearing August 30th
Page 3 Paragraph 9,

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 1, Paragraph 11:
Page 2, Paragraph 3:
Page 3, Paragraph 7:
Page 17, Paragraph 8:

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st ,
Page 19, Paragraph 8:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st ,
Page 20, Paragraph 4:

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic: Hearing August 31st ,
Page 49, Paragraph 8:

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee
of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006,
Page 28, Paragraph 1:

Public Dental Services Are Particularly Under-Staffed Relative To Community Need

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th ,
Page 2, Paragraph 2

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th ,
Page 32, Paragraph 7:

Ms DAVIES (Public Dental Patient): Hearing July 5th ,
Page 45, Paragraph 6:

Ms Vern-Barnett (Hon Secretary, NSW Dental Assistants Assoc): Hearing 3rd August,
Page 8, Paragraph 7:

Ms GRANT-CURTIS: Hearing August 23rd ,
Page 6, Paragraph 6:

Ms OSBORNE, Area Manager, Oral Health, North Coast Area Health,: Hearing August 23rd , Page 33,
Paragraph 7:

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 1, Paragraph 11
Page 4, Paragraph 6:
Page 9, Paragraph 17

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st ,
Page 19, Paragraph 9:

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee
of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006,
Page 28, Paragraph 1:

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services
Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 57, Paragraph 14:

Dental Clinicians Cannot Be Attracted To The Public Service Because Of Poor Wages And Conditions

A/Prof ZOELLNER (Chairman of APOH) Hearing 29th June 2005,
Page 3, Paragraph 7:

Professor SCHWARZ: Hearing 29th June,
Page 34, 3rd Last Paragraph:

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing 5th of July,
Page 55, Paragraph 9:

Ms FRANKS (President NSW Dental Therapists Assoc): Hearing, August 3rd ,
Page 22, Paragraph 9:

Mr GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales,
Hearing August 3rd ,
Page 46, Paragraph 16:
Page 47, Paragraph 9:

Ms GRANT-CURTIS: Hearing August 23rd ,
Page 6, Paragraph 6:

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing
August 23rd ,
Page 26, Paragraph 11:
Page 42, Paragraph 8:
Page 44, Paragraph 3:

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal
Corporation Medical Service, Hearing August 23rd ,
Page 46, Paragraph 3:
Page 49, Paragraph 11:

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 1, Paragraph 11:
Page 4, Paragraph 2:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st ,
Page 20, Paragraph 5:

Mr KUMM: Oral Health Manager, Greater Western Area Health Service: Hearing August 31st ,

Page 26, Paragraph 17

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006,
Page 22, Paragraph 5:
Page 28, Paragraph 7:

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 53, Paragraph 14:
Page 57, Paragraph 6:

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 54, Paragraph 5
Page 57, Paragraph 8:
Page 64, Paragraph 6:

Public Dental Infrastructure Is Inadequate For Needs

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service: Hearing August 31st,
Page 33, Last Paragraph:

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006,
Page 28, Paragraph 9:

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 55, Paragraph 9:
Page 57, Paragraph 3:

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 64, Paragraph 7:

Aboriginal Dental Health And Services Are Poor

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd ,
Page 44, Paragraph 8:
Page 49, Paragraph 10:
Page 49, Paragraph 10:

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 3, Paragraph 7

Mr GOWIN: Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation: Hearing August 31st,
Page 43, Paragraph 16:
Page 44, Paragraph 6:

There Is A Degraded Dental Training Infrastructure, So That The Dental Workforce Can Not Be Easily Re-Built

A/Prof ZOELLNER (Chairman of APOH) Hearing 29th June 2005,

Page 2, Paragraph 6:

Page 8, First Paragraph

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing June 29th,

Page 32, Paragraph 4:

Page 33 Last Paragraph:

Page 35, Second last Paragraph:

Mr GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales,
Hearing August 3rd,

Page 44, Paragraph 16:

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing
August 23rd,

Page 42, Paragraph 9:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st,

Page 28, Paragraph 6:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th,

Page 39, Paragraph 5:

Page 40, Last Paragraph:

In The University Of Sydney, About Half The Funding For Dental Education Is Captured Centrally And Not Directly Available To Teach Dental Undergraduate Or Post-Graduate Students

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing June 29th,

Page 29, 4th Last Paragraph:

Page 35, Paragraph 2:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th,

Page 40, Paragraph 11:

Page 41, Paragraph 5:

The University Of Sydney Provides No Office, Clinical Or Pre-Clinical Facilities For Dentistry, With The Dept. Of Health Effectively Providing All Dental Training Infrastructure At Its Hospitals

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing 29th June,

Page 38, Paragraph 10:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th,

Page 40, Paragraph 11:

Page 41, Paragraph 5:

Dental Students Make Significant Contribution To Oral Health Service But Are Not Supported To The Same Extent As Medical Students

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st ,
Page 19, Paragraph 1:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th ,
Page 40, Paragraph 15:
Page 41, Paragraph 2:

The Faculty Of Dentistry At Sydney University Is Up To 25% Over Budget Expenditure Per Year

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing 29th June
Page 33, First Paragraph
Page 33, Paragraph 7:

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the
Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th
February, 2006, Page 7, Paragraph 6:

It Is Not Possible To Attract Enough Dentists And Dental Academics From Overseas Or Inter-State

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 8, Last Paragraph

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing June 29th,
Page 32, Paragraph 6:

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th ,
Page 39, Paragraph 5:
Page 40, Last Paragraph:

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services
Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 61, Last Paragraph:

Far Fewer Dentists Are Being Trained In NSW Than In The Past, And Many International Students Will Likely Leave After Training

A/ Prof EVANS: A/ Prof, Head of Discipline, Community Oral Health and Epidemiology, University of
Sydney: Hearing November 14th ,
Page 38, Paragraph 10:
Page 39, Paragraph 10:

Dental Workforce Shortages Are Not Just A Problem For The Poor, But Already Impact The Middle-Classes

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 6, Paragraph 14
Page 7 Paragraph 1

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing 5th July,
Page 37, Paragraph 10:

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): Hearing 3rd August,

Page 7, Paragraph 13:

Mr GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales,
Hearing August 3rd,
Page 36, Paragraph 15:

There Has Been No Real Planning For Dental Workforce In Australia With A Shortage Of 1,500 By 2010

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 5, Paragraph 10:

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing June 29th,
Page 30, Paragraph 5:
Page 34, Paragraph 1
Page 34, Paragraph 3

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29,
Page 31, Paragraph 9:

Ms FRANKS (President NSW Dental Therapists Assoc): Hearing August 3rd,
Page 19, Paragraph 12:
Page 20, Paragraph 2:

Mr GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales,
Hearing August 3rd,
Page 44, Paragraph 1:

There Has Been A Lack Of Political Will And Leadership

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 5, Paragraph 6

CHAIR: Hearing August 23rd,
Page 44, Paragraph 14:

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian
Research Centre for Population Oral Health, University of Adelaide): Hearing 16th
February, 2006, Page 1, Paragraph 7
Page 12, Paragraph 4:

The Public System In NSW Is Inconsistent Across Area Health Services And Is Also Physically Degraded

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 8, First Paragraph:
Page 15, Paragraph 7

Dr HILL (Principal Dental Officer, Ex Acting Chief Dental Officer, Justice Health), Hearing, July 5th,
Page 9, Paragraph 6:

Dental Insurance Mechanisms Are Inadequate And Do Not Recognize The Importance Of Dental Health

A/Prof ZOELLNER (Chairman of APOH), Hearing 29th June,
Page 11, Paragraph 2,

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 5:
Page 21, Paragraph 11

Ms EDMUNDS (Sen. Policy Officer NCOSS): Hearing July 5th,
Page 20, Paragraph 10:

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July,
Page 41, Paragraph 9:
Page 42, Paragraph 3:

Dental Services In NSW Are Inadequately Funded And Are Lower Than In Any Other State Or Territory

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005,
Page 5, Paragraph 3:

Mr MOORE (Director NCOSS): Hearing July 5th, Page 19, Paragraph 4:

TERRANCE JAMES CLOUT, Chief Executive, Hunter New England Area Health, Hearing 5th of July,
Page 5, Paragraph 5

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July
Page 42, Paragraph 3:

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing July 5th,
Page 59, Paragraph 11:

Dr FISHER (CEO, NSW Aust. Dental Assoc.): Hearing July 5th,
Page 59, Second last paragraph
Page 63, Paragraph 6:
Page 60, Paragraph 5:

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): Hearing July 5th,
Page 60, Paragraph 2

The Hon. IAN WEST: Hearing July 5th,
Page 63, Paragraph 6:

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health,: Hearing
August 23rd,
Page 30, Paragraph 9:

SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical
Service, Hearing August 23rd,
Page 44, Paragraph 9:

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st,
Page 2, Paragraph 7:
Page 2, Paragraph 7:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service: Hearing August 31st,

Page 34, Paragraph 5:

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006,

Page 1, Paragraph 9:

Page 8, Paragraph 6:

Page 8, Paragraph 7:

Page 8, Last Paragraph

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,

Page 65, Paragraph 3:

The Oral Health Fee For Service System Is Not Cost Effective

Ms OSBORNE, Area Manager, Oral Health, North Coast Area Health: Hearing August 23rd

Page 34, Paragraph 3:

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st,
Page 20, Paragraph 6:

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006,
Page 26, Paragraph 4

Introduction of Co-Payments May Not Improve Things

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st, Page 15, Paragraph 13:

Senior NSW Health Officials Demonstrate A Lack Of Awareness Of The Low Levels Of Public Dental Funding In NSW

TERRANCE JAMES CLOUT, Chief Executive, Hunter New England Area Health, Hearing 5th of July,
Page 5: Paragraph 5

Hearing 16th February, 2006, Page 34, Paragraph 6:

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,

Page 6, Second last paragraph

Page 8, 3rd Last Paragraph:

Hearing 16th February, 2006, Page 36, Paragraph 4:

Hearing 16th February, 2006, Page 40, Paragraph 2:

Mr CLOUT (CEO Hunter New England Area Health): Hearing July 5th,

Page 8, Last Paragraph

There Is A Failure Of The Responsible Senior NSW Health Officials To Recognize The Need For Increased Levels Of Service Provision And Educational Infrastructure In The Public System

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,

Page 1 Paragraph 5:

Page 1, Paragraph 7

Hearing 16th February, 2006, Page 38, Paragraph 7:

COMMENT FROM APOH: There was no mention in the testimony of Dr Robinson, or Mr Clout of a need for increased delivery of dental services, only of improved prevention.

Although prevention is clearly important, it fails to recognize and manage the high current levels of disease.

Dr Robinson indicated that 90% of dental disease is preventable, and that for this reason the impression is given that the main responsibility lies in prevention. However, APOH indicates that the same could be said of both diabetes and cardiovascular disease, for which about 90% are preventable through improved diet and exercise, while nobody would accept inadequate expenditure in managing established disease. Dental disease should be considered in the same way.

The Opinion of Dr Robinson and Mr Clout Contrasts Strongly With The Opinion Of Others Concerned With Oral Health As Well As The Experience of Patients In The Public System

Mr MOORE (Director NCOS): Hearing July 5th,
Page 19, Paragraph 4:

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th,
Page 32, Paragraph 7:
Page 33, Paragraph 3:

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing, July 5th,
Page 42, Paragraph 1:

Ms DAVIES (Public Dental Patient): Hearing 5th July,
Page 43, Paragraph 1

COMMENT FROM APOH: Despite the rhetoric by Dept. of Health Officials regarding implementation of preventive strategies, there is no evidence of a preventive approach used for patients already seen.

This reflects failed understanding by Dept. of Health Officials that dental disease is chronic, and once established, requires life-long treatment. Patients with existing caries, fillings and periodontal disease, require regular maintenance treatment so that effective prevention requires high levels of treatment delivery

Further discussion of a lack of a proper involvement of dental treatment as a preventive strategy is illustrated in the transcripts listed below

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing 5th July,
Page 57, Second Last Paragraph

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): Hearing August 3rd,
Page 8, Paragraph 10

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): Hearing August 3rd,
Page 16, Paragraph 8:

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006,
Page 64, Paragraph 10:

Senior Health Officials Also Seem Confused In Reference To The Advice That They Have Sought:

JENINE ANNE BRADBURN, Secretary, Association of Dental Prosthetists Inc NSW, : Hearing August 3rd,
Page 40, Paragraph 9:

This confusion by senior health administrators is not limited to NSW, but is seen throughout the State and Federal Systems, with No Clear Commitment to improved services expressed in the National Oral Health Plan

Mr GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales,
Hearing August 3rd,
Page 48, Paragraph 5:

Three Strategies For Oral Health Are Outlined By NSW Health, But None Of These Involve Increased Levels Of Treatment Of Existing Disease

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 2, Paragraph 5:

Here Dr Robinson indicates that there are 3 separate NSW Health Strategies:

Strategy 1: Oral Health Promotion Projects

Strategy 2: Fluoridation

Strategy 3: Priority Oral Health Program (Telephone triage protocol)

COMMENT FROM APOH: The "priority oral health program" is a triage protocol, largely delivered by non-clinically trained staff over the telephone. It does not deliver increased levels of care and has caused significant concern amongst both clinicians and patients regarding the appropriateness of having non-clinical staff make diagnosis by questionnaire over the telephone.

It might also be noted that "triage" is a battle-field strategy for assigning treatment priorities, and generally inappropriate for the peace-time management of chronic diseases such as caries and periodontitis. Triage includes a category of "beyond help", in which no treatment is offered.

Dental disease is typically chronic (caries and periodontitis), so that proper management involves control of existing disease together with maintaining fillings / periodontal conditions already treated and preventing new disease from occurring. Triage is an inappropriate approach for the control of chronic disease.

Examples of where this triage approach is demonstrably inappropriate is provided by the testimony of Ms DAVIES (Public Dental Patient) in the Hearing on July 5th, Page 43 through to 44 (relevant portions marked elsewhere in this analysis), and is also underscored by the further comments below:

Ms TAYLOR (Caseworker, Uniting Care Burnside): Hearing July 5th,
Page 44, Paragraph 2:

Ms DAVIES (Public Dental Patient): Hearing July 5th,
Page 36, Paragraph 4

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st,
Page 11, Paragraph 1:

Current Identified Priority Areas For NSW Public Dental Health Ignore The Bulk Of Disease In The Majority Of NSW Citizens

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 3, Paragraph 9:

COMMENT FROM APOH: Caries increases by four-fold with onset of adolescence, and the largest increases in disease have been in young and middle-aged adults. None of these groups is identified as requiring priority.

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st ,
Page 2, Paragraph 4:.

Waiting Lists For Dental Services In NSW Are Very Long

A/Prof ZOELLNER (Chairman of APOH): (continued discussion) Hearing June 29th
Page 15, Paragraph 3:

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 5:

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): CHAIR: Hearing 5th July,
Page 33, Paragraph 3:

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd ,
Page 44, Paragraph 9:

THOMAS ERIC KENNEDY, Councillor, Broken Hill City Council,: Hearing August 30th, Page 4 Paragraph 5,

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st ,
Page 8, Paragraph 16:

Comment From APOH: Since this hearing, there has been public revelation that the dental waiting list in NSW has risen from 160,000 in 2004, to 215,000 in 2005.

Senior NSW Health Officials Demonstrate A Lack Of Awareness Of The Waiting Times For Routine Dental Treatment As Well As For Emergency Dental Care

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health):
Hearing July 5th, Page 3, Paragraph 3:

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 4, Paragraph 1:

COMMENT FROM APOH: The short waiting times inferred by Dr Robinson contrast strongly with the experience of others

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July,
Page 41, Paragraphs 8 and 9:

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 4:

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th,
Page 32, Paragraph 7:

Ms TAYLOR (Caseworker, Uniting Care Burnside): Hearing July 5th,

Page 44, Paragraph 2:

Ms VORASARN (Family Support Worker, Uniting Care Burnside): Hearing 5th of July,
Page 46, Paragraph 6:

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st , Page 8,

The Chief Dental Officer Is: Based In A Single Area Health Service, Isolated From Main NSW Health Offices, And Subordinate To Less Informed NSW Health Officials

FREDRICK ALLAN CLIVE WRIGHT, Chief Dental Officer, NSW Health, North Sydney, Darcy and
Institute Streets, Westmead: Hearing 16th February, 2006,
Page 34, Paragraph 6:

Senior NSW Health Officials Perceive No Pressing Need For Change

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 9, Paragraph 5:
& Hearing 16th February, 2006, Page 39, Second Last Paragraph:

Here (Transcript 5th July) Dr Robinson indicates that it makes no sense to "your ambulance down the
bottom of the cliff when people are just falling over it", and suggests that instead "barricades up at the top"
have to be established.

**COMMENT FROM APOH: 90% of NSW is already fluoridated, so that increased fluoridation is
unlikely to have a great effect on global caries experience**

Dr Robinson also suggests a range of preventive educational initiatives, some of which take advantage of
multidisciplinary teams

**COMMENT FROM APOH: These preventive initiatives are laudable and currently unresourced, but
although having the potential for long term benefit, fail to manage the current and growing disease
load of a largely dentate and ageing populat
ion.**

**It is important to appreciate that once a tooth is filled, it must be regularly re-filled to maintain the
filling.**

**There is no mention of increased services to address treatment needs and the model outlined by Dr
Robinson foreshadows no real change.**

Mr CLOUT (CEO Hunter New England Area Health), Hearing July 5th,
Page 9, Paragraph 5:

Here Mr Clout indicates that NSW Health looks both Nationally and Internationally for example to follow,
and that a mix of service models including the Oral Health For Service Scheme has been developed that
other States are following. The Information System for Oral Health Program is also cited as a success
because it has been purchased by Queensland Health.

**COMMENT FROM APOH: The Oral Health Fee for Service Program is recognized as patchy and
estimated as 4 times more expensive than service within the public system.**

**Similarly, the ISOH System is simply a data-bank recording treatment delivered in the public
system. It does not provide increased services**

Mr Clout was asked what he would like in an ideal world, and he reported that "I think the model is the right model. In an ideal world I would like to see it continued for a long period."

COMMENT FROM APOH: Mr Clout believes that despite the wide-spread concern, in an ideal world, he would like to see things continue as they are for a long period.

This Contrasts Strongly With The Opinion Of Others Concerned With Oral Health As Well As The Experience of Patients In The Public System

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 19, Paragraph 4:

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW):
Hearing, July 5th, Page 32, Paragraph 7:

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing July 5th,
Page 47, Paragraph 2:

Ms DAVIES (Public Dental Patient): Hearing July 5th,
Page 49, Paragraph 13:

A Formal Submission From NSW Health Was Not Made In Time For The Commencement Of The Dental Inquiry

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 1, Paragraph 4:
Page 6, Paragraph 2

Numerous Reasons Are Offered For Past And Future Inaction In Implementation Of Improved Dental Services

1) Suggestion It Is Impossible To Proceed Without National Coordination

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th,
Page 3, Paragraph 8:
Dr Robinson indicates a need for National Coordination to progress oral health

COMMENT FROM APOH: There seems little or no evidence of effort to coordinate activities across State jurisdictions to address workforce. It is implied that little can be done without waiting for other States to act in concert.

2) Shuffling of Responsibilities Between State And Commonwealth:

Ms EDMUNDS (Sen. Policy Officer NCOSS): Hearing 5th July
Page 20, Paragraph 3

COMMENT FROM APOH: There is a long standing tendency for State and Commonwealth Governments to discard responsibilities on the basis that it is the role of the respectively opposite partner of government. This is further reflected in the discussions below:

Mr MOORE (Director NCOSS): Hearing July 5th,
Page 22, Last Paragraph

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th,
Page 38, 4th last Paragraph:

Ms EDMUNDS (Sen. Policy Officer NCOS):
Hearing July 5th, Page 21, Paragraph 6:

COMMENT FROM APOH: Withdrawal of the Commonwealth Dental Program is often cited as the cause of NSW difficulties, while APOH considers this an abrogation of State responsibility

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing July 5th,
Page 58, Paragraph 9:

Mr Wilson suggests that introduction of medicare funding for dental health would be difficult because much dental disease is preventable, it would be too expensive and also too administratively difficult

COMMENT FROM APOH: It is important to recognize that the ADA has traditionally stood against inclusion of dentistry in Medibank/Medicare, likely in the same way that the Medical profession also opposed this initiative at the time Medibank was introduced.

The three reasons indicated by Mr Wilson above should be viewed in context of the following points:

a) The fact that dental disease is largely preventable does not explain exclusion from medicare. If the same criteria were applied to heart disease and diabetes, for example, neither of these two mostly preventable diseases would be included in medicare.

b) Medicare expenses for dental treatment could be readily contained if limited (at least in the first instance) to caries control, preventive treatment and relief of pain including extraction and root canal therapy. In addition, there would be savings in medicare by patients going directly to dentists for treatment instead of inappropriately obtaining antibiotics and pain-killers from medical practitioners for dental infections.

c) Administration of dental medicare would be no more difficult than for medicine and could be stream-lined if need be.

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th
February, 2006, Page 7, Paragraph 1:

Committee Members Expressed Surprise And Or Shock At The Testimony Offered By Witnesses

CHAIR:

Hearing 5th July, Page 15, Paragraph 2:

Hearing 5th July, Page 42, Paragraph 5:

Hearing August 31st, Page 4, Paragraph 7:

The Hon Ian West: Hearing June 29th,
Page 9, Paragraph 7

The Hon Robyn Parker:

Hearing June 29th, Page 9, Last Paragraph:

Hearing July 5th, Page 43, Second last Paragraph

Hearing July 5th, Page 59, Paragraph 11:

The Hon. Dr ARTHUR CHESTERFIELD-EVANS:

Hearing August 23rd, Page 30, Paragraph 18:

Hearing August 23rd, Page 43, Paragraph 5:

Appendix:

Transcripts of Hearings Documenting Important Points

There Is Increasing Community Need For Dental Services

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005, Page 1, last Paragraph: *"There is in fact a significant increase in demand in the community for dental services and yet a significant reduction in the capacity to manage this"*

A/Prof ZOELLNER (Chairman of APOH) Hearing 29th June 2005, Page 4, Paragraph 1: *"There has been a threefold increase in the number of carious, untreated teeth, amongst public patients between 18 and 24 years of age in a six-year period and a twofold increase in other age groups over the same time.*

In the 20-year period before that there was about a twofold increase. So there seems to be an acceleration in this.

In large part it is simply because fluoride has been wonderfully successful: teeth are being retained.

But also the complexity of the work that is required has increased. As I mentioned earlier, patients are living into old age with their own teeth, so there is more work to do.

But not only that, a patient coming to the dentist now may be aged, frail, taking a whole cocktail of medications. So that patient is surgically compromised.

A patient who has a dicky heart and a clapped-out kidney is quite delicate to treat. It takes some care to manage such patients safely. So the complexity of the work has increased."

Chesterfield Evans, Hearing 29th June 2005, Page 4, Paragraph 2: *"There has been a 58% increase in the hospitalization of children under five for dental care and an 80 % rise in hospitalizations for children five to fourteen. Why is that?"*

A/Prof ZOELLNER (Chairman of APOH) In Response, Page 4, Paragraph 5: *"it probably reflects the fact that they are simply not getting treatment at an earlier stage. There is no proper control for these patients. So, of course, if your capacity to treat has gone down you cannot help these patients before they accumulate so much disease and have such severe problems that they require hospitalisation."*

CHESTERFIELD-EVANS, Page 4, Paragraph 6: *"So the reason that there is more hospitalisation is that there is less treatment available earlier?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 2, Paragraph 2 *"..... requirements for dental visits will increase by 25 per cent nationally to 2010 but the increase amongst those eligible for public care is predicted to increase by 33 per cent.*

CHAIR: Hearing 5th July, Page 32, 2nd Last Paragraph: *You mentioned in your submission that you have talked to people in Narrandera, Tamworth, Moree, et cetera. Would most of the people that you talked with be eligible for public dental services in New South Wales? Are you talking mostly about people who have a seniors card or a health card?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *They certainly have a seniors card, yes. I understand from the chief dental officers presentation to the Committee that from the New South Wales old persons health survey in 1999 the majority of respondents, 71.1 per cent, held a card that made them*

eligible for publicly funded oral health care services. So, yes, in New South Wales the bulk of older people are eligible because of the high rate of pension entitlement.

COMMENT FROM APOH: The ageing population greatly increases the number of people eligible for public dental care

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): Hearing 3rd August, Page 17, Paragraph 2: *That is right. We have areas throughout New South Wales that have a very low decay rate. For instance, the North Shore would have a fairly low decay rate. We have other areas in rural New South Wales and in south-western Sydney where the decay rate is extremely high.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *In the children?*

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): *Yes, and in adults too.*

Ms FRANKS (President NSW Dental Therapists Assoc): *And increasing.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *And increasing in children?*

Ms FRANKS (President NSW Dental Therapists Assoc): *Yes, the 0 to 5 year age group, their decay rate is increasing.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *And it is not being picked up in the propaganda we are getting?*

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): *No. At least 45 or probably more percentage of children in certain areas only see dental therapists in their entire dental life. They do not see a private dentist and that is because of their low socioeconomic situation. The families simply do not have the finances to access a private dentist.*

CHAIR: *What was that percentage?*

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): *I think it is around 46 per cent.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Hearing August 31st, Page 9, Paragraph 17: Is the situation getting worse?*

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, *In what way?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are more people losing more teeth and fewer people having dentures or doing without them?*

Dr MAYNE: *I would like to be a bit self-serving and say that I hope not. I hope that, after seven years, I have made a difference.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It depends on demand. We often get people who are doing a terrific job. When we talk to them we establish they are doing a terrific job in the situation that they are in. When we ask, "What do you want?" they say, "Three of me", or, "Three times as much as I have. I*

am going backwards because I prioritise." A lady in Port Macquarie who said she was doing a great job talked about priorities, how they were going, and the waiting times amongst those who were high priority. Her last remark was, "I need two or three times as much money as I have." Obviously, that means she is going backwards, although she did not put it that way.

Dr MAYNE: I think there are a couple of things. I think the local town dentists have certainly sent us backwards with the public in Broken Hill. Those people just do not have anything now. As far as the communities I am serving are concerned, I hope we are moving forward, albeit very slowly. What I would like to achieve out there is to get onto the kids—education and preventive work. We want to move forward with the new lot that are coming through. We do not want to end up with the same thing. I think without more money, more time and more services that is very hard to do. Over the time I have been here I can see that just the fact I have got people to a point where their mouths are restored and they are coming back for their check ups, I think we are moving forward.

CHAIR: Hearing August 31st , Page1, Paragraph 11: How would you describe the state of dental health of the people seeking public services? We have heard quite a lot of evidence, for instance, about waiting lists and need and so on, all meaning that perhaps too much of the service is emergency or extractions and there is never the time or the money or perhaps the human resources to provide the preventive work, so it is always playing catch up. Would that be a fair description of most of your area or is that a bit harsh?

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service I think that is fair for adults. The demand for relief of pain is such that that is mostly what we provide for adults. So, we all know that teeth with holes in them get worse before they ache and it is when the tooth aches that we are helping the patient. So, it is fair to say that their dental conditions are getting worse. They may only wait one week once they come to us and say they are in pain but what has happened to that tooth in the previous 12 months or two years when it was not in pain? The adults who access our service, as Linda said earlier—eligible patients have health care cards or a pension card but obviously some people with a card are poorer than some others. We know our communities are socio-economically disadvantaged and we know that is a risk factor for oral health and for general health. They live in rural areas. They often have not had fluoridated water, now or when growing up. They often have not been able to access regular dental care due to cost, and sometimes the distance, which is an additional cost, and most would require extensive dental treatment if we provided all of the treatment that they needed.

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 29 to 30, Last Paragraph: What I wanted to say as my opening statement is to just refer to some oral health trends that identify why this issue is before the Legislative Council; it is because dentistry is in a rather unusual state and what we have to cope with. During the next 20 years there will be two important things happen: firstly, there will be a dramatic decline in endentulism—that means people with no teeth will continue. in 1979,..... if you take people aged 65 to 74, you will see that approximately 60 per cent of them had no teeth in 1979. Due entirely to water fluoridation and the use of fluoridated toothpaste we can see now that the people with no teeth in that age group is about 40 per cent. By 2020 that would be down to 10 per cent.

So the impact of that is that the number of teeth that are not being extracted now, and because they are still in people's mouths of my generation, is going to rise dramatically.in the age group of 35 to 44 at the moment in 1989..... because of fluoridation the mean number of decayed and filled teeth, which is the load that people carry, will drop from 15 per person to about 10.

The next..... the numbers of teeth will increase in these age groups.....in the age group 45 to 54, the number of permanent teeth in that age group will increase from 50 million to 80 million..... 1999 the number of teeth in the age group of 59 to 64 will increase from 20 million to more than 60 million. These are the most dramatic things that are happening, and suddenly people will be aware of the effects, just like the tsunami hitting Southeast Asia; suddenly the people in dentists' waiting rooms will have a totally different profile. But the number of teeth requiring treatment for caries will halve in the age groups below 35 years but double in the age groups above 55 years.

So because of fluoridation the decay requiring treatment will go from 6.5 million down to 3.5 million.....for the age group of 55 to 64—these are the baby boomers—that is going to go from 3 million to 7 million.

These are really dramatic findings and show why there is a desperate need to address the looming problem of the lack of dental services and lack of dental staff to deal with these problems. That is what I wanted to say by way of introduction, to introduce the need for this review.....

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 1, Paragraph 4: *I will attempt an opening statement. My statement would really be to use the phrase that I will attribute to the United States Surgeon General in his report on Oral Health and Dental Care only a few years ago where he described oral disease and disorders as a silent epidemic. It is an epidemic because oral diseases are among the most prevalent diseases affecting people in the Australian community. Nearly all Australian adults experience the most common forms of oral diseases like dental decay and gum disease to varying levels of severity.*

What is more interesting about this statement—and I think it needs a little bit more thought—is why it would be regarded as a silent epidemic. It might be regarded as silent because I think people frequently suffer in silence with regards to their experience of dental problems. Dental problems certainly affect people's daily lives in subtle ways through discomfort and sometimes more serious levels of pain, which impacts on normal daily functions like eating, speech, sleep and concentration. The problems cause anxiety, embarrassment and isolation, even extending through into issues such as employability.

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 1, Paragraph 10: *Then there are some deliberate priorities that are sometimes put in place—and New South Wales happens to be one of those States that has some deliberate priorities put in place that target subgroups of the eligible population so we not only have a means-tested eligibility for public dental care but we then apply further prioritisation within those that actually receive care. Those sorts of obstacles have led to a service that has, over the last 25 to 30 years, become dominated by emergency dental care, with long waiting lists for more comprehensive general dental care and really fewer resources being allocated and devoted to meeting the general dental care needs of the eligible population.*

There Is Insufficient Dental Workforce To Deliver Dental Services

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005, Page 1, last Paragraph: *"There is in fact a significant increase in demand in the community for dental services and yet a significant reduction in the capacity to manage this"*

Chesterfield Evans, Hearing 29th June 2005, Page 4, Paragraph 2: *"There has been a 58% increase in the hospitalization of children under five for dental care and an 80 % rise in hospitalizations for children five to fourteen. Why is that?"*

A/Prof ZOELLNER (Chairman of APOH) In Response, Page 4, Paragraph 5: *"it probably reflects the fact that they are simply not getting treatment at an earlier stage. There is no proper control for these patients. So, of course, if your capacity to treat has gone down you cannot help these patients before they accumulate so much disease and have such severe problems that they require hospitalisation."*

CHESTERFIELD-EVANS, Page 4, Paragraph 6: *"So the reason that there is more hospitalisation is that there is less treatment available earlier?"*

A/Prof ZOELLNER (Chairman of APOH) In Response, Page 4, Paragraph 7: *"Yes, I think so."*

Mr MOORE (Director NCOSS): Hearing July 5th, Page 19, Paragraph 5: *".....both levels of government, in our view, must tackle the skills shortage and looming crisis in dental practitioners."*

CHAIR: Hearing July 5th, Page 63, Paragraph 12: *.....Are there enough (Workforce) being produced in New South Wales, and in Australia in general?*

Mr WILSON (President NSW Aust. Dental Assoc.): *The statistics that we have been able to find from the surveys that have been done all point to there being a shortage.*

Whichever way you cut and dice it, there is a shortage. It is just a question of how big the shortage is. Depending on what the environment is or what point of view you are coming from, that might vary a bit, but essentially there is a shortage.

There is probably a worse distribution problem overlaid on that shortage, which means that many geographic areas suffer considerably.

CHAIR: *And the public sector suffers?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Yes. I think it is reasonable to say that, yes, the public sector will always have a few problems with that, if it is the last in line from the point of view of funding and resourcing, yes.*

CHAIR: *Is that current shortage going to get worse in the short term?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Our research and statistics says that it will, yes.*

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): *If you look at research that is carried out by organisations like John Spencer's unit down in Adelaide, it is all pointing to that it will really kick in, in around 2015. I think it might be 2013 when the big shortages start to happen.*

CHAIR: *Because of the age structure?*

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): *It corresponds with the big retirement of the baby boomer generation.*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page 26, Paragraph 9: *..... We provide child dental services to kindy, years 2, 4, 6 and 8 in most cases. If a clinic is understaffed that is an area that is affected and we may take out a grade or we will assess the situation and it would take us longer to get around those grades in a year.*

Later On Page 26, Paragraph 12: The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is the waiting list too long for them to have ongoing care anyway?*

Ms OSBORNE: *We on the North Coast are not in a position to provide preventative care for adults at the moment.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *In fact, you cannot offer it to them?*

Ms OSBORNE: *No.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So you cannot provide ongoing maintenance to the people who want to have it?*

Ms OSBORNE: *No, we have not got the resources to do it.*

Later on Page 27, Paragraph 8: The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *The committee heard evidence of a patient with Alzheimer's disease who needed a partial denture and has been waiting for a very long time.*

Ms OSBORNE: *For dentures?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do they have difficulty getting them?*

Ms OSBORNE: *There is a set budget for dentures so we provide as much care as we can within it.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *When the money runs out so do the dentures. Is that right?*

Ms OSBORNE: *Yes, it is like any budget really.*

The Hon. ROBYN PARKER: *For how long are the 2,000 people on the waiting list? Did you say 2,000 people were triaged and a further 2,000?*

Ms OSBORNE: *Yes, waiting for treatment.*

The Hon. ROBYN PARKER: *So 4,000 people and 600 children?*

Ms OSBORNE: *Yes.*

The Hon. ROBYN PARKER: *For how long are the 4,000 people on the waiting list?*

Ms OSBORNE: *I have got figures for each code. I will give the worst scenario. Patients that have rung in and have been triaged and are code 6, which may be like a check up—code 1 is "I have been hit in the*

mouth"—someone has been waiting since 15 January 2001. It is not necessarily a check-up but it is something in that category.

The Hon. ROBYN PARKER: *Are they reassessed because in 2001 it might have been a check-up but in 2005 it might be all their teeth need to be taken out?*

Later On Page 31, Paragraph 8: CHAIR: *So they are waiting for a specialist?*

Ms OSBORNE Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page 26, Paragraph 9: Yes.

CHAIR: *Who is not available in the area?*

Ms OSBORNE: *Yes. There are many waiting for orthodontic care. We have an orthodontist who visits Kempsey and Coffs Harbour clinics. We have 127 waiting for an orthodontic assessment or to have a consultation. When they have had the consultation we would have 130 waiting for treatment.*

CHAIR: *So that person is not there very often. If he visits Coffs Harbour and Kempsey there are not that many days each year when he is there?*

Ms OSBORNE: *No. On two days a month they visit Coffs Harbour and they visit Kempsey 1.5 days a month. We have a dentist who flies in and flies out from Westmead orthodontists one day a month and also a paediatric dentist.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So is one orthodontist treating the whole of this area—an orthodontist who flies in for 1½ days a month?*

Ms OSBORNE: *No, an orthodontist who works locally works with us. I think it is about 0.5, five days a month. I will check that for you. One from Westmead comes one day a month.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So that is your whole orthodontic service?*

CHAIR: *It would be about two weeks a month?*

Ms OSBORNE: *Yes. When you look at the disease that is waiting to be treated I do not think we should be worried about how much orthodontic care we get.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are you saying that orthodontics is not very important?*

Ms OSBORNE: *I am saying that if you have people waiting and losing their teeth the money could be prioritised.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It does not matter at what angle their teeth might be sticking out; as long as they are not rotten it is fine. Is that not what you are really saying to me in a rather polite way?*

CHAIR: Hearing August 31st, Page 3, Paragraph 7: *..... Could you tell us a little more about the general state of the dental health of the people you see? You mentioned earlier the young woman who lost a tooth and who would probably never get it replaced.*

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, *There are two things. The indigenous population has very poor 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 equation. Because of the drought they cannot afford to leave the property to go to a dentist. So all those sorts of things come into the equation. A lot of them put up with a lot of pain and a lot of*

poor teeth and oral health because of that. So in general I would say it is really bad. Before I was here I was in Hobart in Tasmania for 10 years in my private practice there.

The work I do out here, even though it is general dentistry, is like being in an emergency department all the time, if that makes sense. I am just doing band-aid dentistry and fixing up. Over the last couple of years or so we are doing some preventive work. Some people have been through and have had their oral health brought up to a standard. They then come back for recalls. You are counting those people on a couple of hands rather than them being the majority. It is a question of funding and a need for more dentists. As I said before, by the time you band-aid one and he or she comes back again you are really doing something more on the next one. Since November I have been working for the Greater Western Area Health four half days a month, but it is the same there. You are fixing as much as you can but there are not the dentists so that people can see them.

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st, Page 19, Paragraph 8: *..... Essentially we see community demand for our services outstrips the supply we are currently able to provide.*

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st, Page 20, Paragraph 8: *They (Private Practitioners) are very busy themselves. They find it difficult to recruit junior dentists into their practices. They find it difficult to sell their practices when they are looking at retiring, so generally they are very busy with private patients. We are asking them to see public patients on top of that and we are asking them to see the public patients at a rate that is less than what they would normally charge. So, it is difficult to get them to participate. I think it is fair to say that in the smaller communities dentists often participate out of social conscience.*

Mr GOWIN: Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation, Hearing August 31st, Page 38, Last Paragraph: *.....The oral health and all the risk factors for poor health outcomes, whether that is about smoking or alcohol. I suppose it is about screening populations, giving them the best advice and giving them the best follow up treatment we possibly can. When we looked at doing the health checks we talked to everyone. Obviously, if you are screening for something you need to be able to manage those results and to provide good follow up.*

The one thing about dental we knew would be difficult would be to provide follow up.

At one stage we debated whether it was worthwhile doing the dental screening aspect of the check. We did not feel confident in being able to follow up those people appropriately.

We decided we needed to collect that data and then do something about it post check. I suppose that is where we are at now. It is basically what you know. People have pretty poor oral health now. It is what we do with that information and how we best provide the follow up.

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic: Hearing August 31st, Page 49, Paragraph 8: *.....The major threat to its operation is sourcing dentists. If we cannot get the dentists we will not operate. It has been an ongoing problem for a long time. It continues and I think it is getting worse. Therefore, the main aim of our submission is to seek ways of overcoming the problem of attracting dentists, not just to Broken Hill but also to rural and regional New South Wales and Australia, from what I can gather.*

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic: Hearing August 31st , Page 50, Paragraph 12: *Currently we have one full-time dentist and we have just been lucky in the past couple of weeks to secure two locums but they will only be with us for six weeks. We take what we can get but it is not conducive to good dental treatment planning, et cetera. Until those locums arrived we had only the one dentist for approximately six months. As of yesterday I have just negotiated with another dentist. He will be coming out here at the end of September on a fly in fly out basis to work three to four days a week but he will be based in Adelaide. I cannot remember the last time we had an Australian-trained dentist working for us. The lass we have full time at the moment, we have sponsored her through the immigration scheme. She is an Irish dentist. The two locum dentists we have are two Irish boys in Australia on a working holiday. The dentist we have coming at the end of September is an Indian dentist who is sponsored by an organisation called Dentist Job Search. It is a recruitment agency.*

CHAIR: *Do you put a lot of time and effort into recruitment?*

Mr NETTLE: *It is my major job, yes.*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 29 to 30, Last Paragraph: *What I wanted to say as my opening statement is to just refer to some oral health trends that identify why this issue is before the Legislative Council; it is because dentistry is in a rather unusual state and what we have to cope with. During the next 20 years there will be two important things happen: firstly, there will be a dramatic decline in endentulism—that means people with no teeth will continue. in 1979,..... if you take people aged 65 to 74, you will see that approximately 60 per cent of them had no teeth in 1979. Due entirely to water fluoridation and the use of fluoridated toothpaste we can see now that the people with no teeth in that age group is about 40 per cent. By 2020 that would be down to 10 per cent.*

So the impact of that is that the number of teeth that are not being extracted now, and because they are still in people's mouths of my generation, is going to rise dramatically.in the age group of 35 to 44 at the moment in 1989..... because of fluoridation the mean number of decayed and filled teeth, which is the load that people carry, will drop from 15 per person to about 10.

The next..... the numbers of teeth will increase in these age groups.....in the age group 45 to 54, the number of permanent teeth in that age group will increase from 50 million to 80 million..... 1999 the number of teeth in the age group of 59 to 64 will increase from 20 million to more than 60 million. These are the most dramatic things that are happening, and suddenly people will be aware of the effects, just like the tsunami hitting Southeast Asia; suddenly the people in dentists' waiting rooms will have a totally different profile. But the number of teeth requiring treatment for caries will halve in the age groups below 35 years but double in the age groups above 55 years.

So because of fluoridation the decay requiring treatment will go from 6.5 million down to 3.5 million.....for the age group of 55 to 64—these are the baby boomers—that is going to go from 3 million to 7 million.

These are really dramatic findings and show why there is a desperate need to address the looming problem of the lack of dental services and lack of dental staff to deal with these problems. That is what I wanted to say by way of introduction, to introduce the need for this review.....

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 14, Paragraph 4: *.....we have an aggregate shortage in the dental work force. It is a shortage that at least the published projection work indicates will run through at least into 2015. In fact, some people believe that if we do not take various remedial actions that it will worsen during the next decade because there is an age bulge. We talked about the ageing aspects of the dental work force. There clearly needs to be an increase in the aggregate supply. There also needs to be considerable attention to distributional issues. The geographic distributional issue is obviously high in most people's mind. Also there are sectorial distributional issues: How do we obtain a work force for public sector care delivery?*



LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 21, Second Last Paragraph: *There is a major problem there. As an example, Westmead Dental Clinical School is one of the major areas for accessing patients to train specialists. In 1980 when that clinical school opened there were approximately 20 specialists working in it. You will be able to find out the exact figures later from other people. It is my understanding those specialist numbers have not increased at all in that 25-year period.*

Dentists Are Un-Evenly Distributed, So That Rural Areas Have Very Few Dentists Available

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005, Page 6, Paragraph 6: *"I would say that if you are in a rural area you are just grateful to find a dentist anywhere. You can drive for hours to find a dentist—you can have your toothache and your abscess—and rural dentists are rather busy doing real dentistry."*

CHAIR: *But in richer areas—the cosmetic dentistry areas, the cosmetic surgery areas—depending on the affluence of the area? Dentists are more concentrated in, for instance, the eastern suburbs?*

A/Prof ZOELLNER (Chairman of APOH): *"Absolutely. It has the highest concentration of dentists in NSW. It goes up to... about 80 per 100,000,*

but if you are living in the Macquarie area (Please Note Error in Transcript ... was originally Wentworth, Correct Area is Macquarie, accurate figures available on Page 32 of the APOH submission)it is in the order of about 17 dentists per 100,000 patients."

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing 29th June, Page 38, Paragraph 4: *"..... distribution of manpower is definitely very, very inequitable in relation to rural areas.*

.....You do not have many professionals out there but you also have extremely bad access out there. That has direct health implications. The little we know about the oral health situation is that there are these inequities in health as well.

For instance, the oral health situation among children in rural areas is much worse off than in the major cities.

This is also related to the fact that a lot of rural areas do not have water fluoridation as we have in Sydney and in a number of intermediate city areas.

I looked at a very crude measure. I looked at the number of one- to four-year-olds admitted to hospitals for dental problems. That is (ONE OF) the most frequent reason why one- to four-year-olds are admitted to hospitals in New South Wales.

If you look at where they come from, you will find that the rates in those areas that do not have water fluoridation is 10 times higher than in those areas with water fluoridation."

CHAIR: (Discussion Continues) *"Do you mean literally 10 times higher?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Discussion Continues) *"It is probably more than 10 times but 10 times is enough. If you look at the rates, they are really dramatic. It is very scary. We are talking about entirely preventable disease."*

Mr MOORE (Director NCOSS): Hearing July 5th, Page 19, Paragraph 5: *"..... The New South Wales Government must firmly grapple with providing better opportunities and incentives for dentists to practise in disadvantaged and rural communities"*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th, Page 32, Paragraph 7: *.....So particularly in rural areas, transport difficulties exacerbate the problems....."*

CHAIR: Hearing July 5th Page 37 Paragraph 3: *You referred at the beginning to transport difficulties being a major concern in rural and regional areas. Can you throw more light on that? For instance, you talked about the role of community transport as important for people accessing seminars or information sessions.*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Yes, indeed.*

CHAIR: *Is community transport used much to access dental services?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Yes and no. Transport is the number one issue for older people. Whenever we go out for any consultation on any subject—it does not matter what it is, where it is—transport is the big issue that we come back with. It manifests itself in many different ways but particularly for older people who are getting to the stage where they are no longer able to drive themselves and where public transport is not available to take them to the services that they need.*

We talk glibly about community transport being the solution. It is and it is not. It certainly solves some problems. For medical and dental appointments it can be a boon and a blessing. When combined with the difficulty of getting a dental appointment, the transport issue is a complicating factor.

The other point about community transport is that where it is available it is generally in strong demand and it also has a cost factor. In my own neck of the woods—I live at Nelson Bay—to access the public dental service in Newcastle it is \$42 to take the community transport down to Newcastle. That is a significant amount of money on top of whatever fee might be charged.

CHAIR: *That is \$42 return.*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *I actually think that is one way, depending on whether it is a special appointment or whether you can hitch a ride on the bus that happens to be going down at that time anyway.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): *Hearing July 5th, Page 41 Last Paragraph: In rural areas transport was raised as a major barrier to accessing services. Particularly for people in outlying towns, there is no public transport to the regional centres. Within regional centres there are also transport difficulties for people on low incomes. They must take at least two buses to get to a dental service. So the implications of this lack of access to services and the lack of prevention results in ever worsening dental health.*

Ms GRANT-CURTIS: *Hearing August 23rd, Page 6, Paragraph 6: I tried to get access to some dental care through our mid North Coast dental service at Taree. They said, "We have got no idea whether or not you are going to be able to get this. We will take your details. What the waiting lists are we do not know." So I ended up going to the local dental care unit at Port Macquarie. They are supposed to have two dentists there. One of them resigned some months ago and they cannot get a new one. The other one is not on duty and they do not know when they will resume dental care. Even if they do, they do not do cappings. The only experience I have had of going to seek help from the dental care unit over the last few years on the couple of occasions that I did so—on one occasion it was for an abscessed tooth— was that they ripped them out.*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, *Hearing August 23rd, Page 26, Paragraph 9: We provide child dental services to kindy, years 2, 4, 6 and 8 in most cases. If a clinic is understaffed that is an area that is affected and we may take out a grade or we will assess the situation and it would take us longer to get around those grades in a year.*

and later in Paragraph 11: *Do we have difficulty filling our dental positions? Well, yes we do have difficulty*

Hearing August 30th, Page 1, Paragraph 11 Mr SULICICH, Manager Infrastructure, Broken Hill City Council: *I think we need more dentists in Broken Hill. It has been pretty well known around the city that that is what the town needs. There are not enough dentists in the city. Again, I think council would support that.*

CHAIR: *Do people travel out of Broken Hill for dental services or do they go without?*

Mr SULICICH: *Again, I am not totally familiar on how they go about that if they cannot get dental services. I suggest there is a significant waiting list and if it is urgent they have to travel outside Broken Hill.*

Hearing August 30th, Page 3 Paragraph 9, THOMAS ERIC KENNEDY, Councillor, Broken Hill City Council,:*What is lacking in Broken Hill is the public service. Until about two years ago it was carried out by the Town Dental Clinic, which is now the Barrier Dental Clinic. It was a really good service. People could go there and they were seen. They went there in emergencyand since then they have not had a dentist so they have been contracting it out to private dentists. Those private dentists focus on the private patients and public dentistry and public patients have suffered. I have had many people come to me—in the tens rather than singular—saying they were waiting up to three weeks, at least three weeks, to have emergency treatment and they could have excruciating tooth pain and still would not be seen any earlier. The private dentist had to take care of his private patients so he had a set period of at least three weeks, which is two weeks more than the State requirement to be seen in seven days.*

These people were told to go to hospital and get antibiotics to relieve their pain to some degree. In most cases the antibiotics had little effect, so they were in severe pain and suffering for that entire three weeks. They were not given the opportunity to save their tooth. When they went to the private dentist it was extractions only. So, if you had a toothache the only way they could be seen publicly was to have their tooth removed.

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st , Page1, Paragraph 11: *I am the sole dentist employed at the Royal Flying Doctor Service [RFDS]. I cover an area of 640,000 square kilometres.....At the moment I am also doing some work for the Greater Western Area Health Service, as it does not have a dentist.*

.....Only really difficult oral surgical cases are referred. The problem with referring them is that there are not too many places to refer them to. They have to cross State lines and go either to Mildura or to Adelaide, there being no oral surgeon here.

CHAIR: Hearing August 31st , Page 2, Paragraph 3: *Does that mean you are pretty much covering the need to your satisfaction?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service : *Absolutely not. We need another dentist or two, 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 is not a list of people waiting.*

I guess the other thing is dentures, which are horrific. The budget I have for dentures has not changed in 7½ years. You take teeth out of people to get them out of pain. By the time you get back to getting them a denture when they get up on the list, their other teeth have worn out and need taking out because they have been overused. There is just a real cycle that goes on.

CHAIR: *What sort of period are you talking about between taking out some teeth because people are in pain and when they might get a denture?*

Dr MAYNE: *Basically, they will not get a denture. The amount of money that we have had allocated for dentures would probably make six or seven dentures. So it is really hard in that whole area to prioritise who needs the dentures and who does not. It is quite sad to tell a young girl or a young man who has a front tooth missing that they cannot have the denture because they are not on the priority list.*

CHAIR: *Hearing August 31st , Page 3, Paragraph 7: Could you tell us a little more about the general state of the dental health of the people you see? You mentioned earlier the young woman who lost a tooth and who would probably never get it replaced.*

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, *There are two things. The indigenous population has very poor 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 equation. Because of the drought they cannot afford to leave the property to go to a dentist. So all those sorts of things come into the equation. A lot of them put up with a lot of pain and a lot of poor teeth and oral health because of that. So in general I would say it is really bad. Before I was here I was in Hobart in Tasmania for 10 years in my private practice there.*

The work I do out here, even though it is general dentistry, is like being in an emergency department all the time, if that makes sense. I am just doing band-aid dentistry and fixing up. Over the last couple of years or so we are doing some preventive work. Some people have been through and have had their oral health brought up to a standard. They then come back for recalls. You are counting those people on a couple of hands rather than them being the majority. It is a question of funding and a need for more dentists. As I said before, by the time you band-aid one and he or she comes back again you are really doing something more on the next one. Since November I have been working for the Greater Western Area Health four half days a month, but it is the same there. You are fixing as much as you can but there are not the dentists so that people can see them.

The Hon. IAN WEST: *Hearing August 31st , Page 17, Paragraph 8: You indicated that in remote areas, as opposed to areas that are not remote, tooth decay was something like double. You mentioned the word "double" and you then mentioned the words "six times".*

Dr MAYNE, Dr MAYNE; Dental Officer, Royal Flying Doctor Service: *Six times was for children, was it not?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Yes.*

The Hon. IAN WEST: *In relation to the indigenous population are you saying that in remote areas the general population is double what it is in areas that are not remote?*

Dr MAYNE: *Yes, it is.*

The Hon. IAN WEST: *On top of that indigenous people are worse again.*

Dr MAYNE: *They are worse again, yes. I do not know whether it is double. All I know is that every time I go out there I know I am going to be seeing people for several visits to try to get them back to good health. So yes. The thing is double and then the indigenous is double again on top of that.*

The Hon. IAN WEST: *Double on top of double?*

Dr MAYNE: *Yes.*

CHAIR: *Are you comparing it with the people you saw in your practice in Hobart?*

Dr MAYNE: *There is no comparison.*

CHAIR: *They are very different?*

Dr MAYNE: *It is very different. I did more extractions in 12 months here than I did in the 10 years I was in private practice. You are doing more of that and you are doing more repairing. It is time, funding and everything. It is a slow process. You are slowly getting on top*

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st, Page 19, Paragraph 8: *..... We feel the population that is eligible for public dental services in the greater western is a particular disadvantage. To pick up on what Lyn was saying, we have significant socioeconomic concerns. In the greater western, 7.2 per cent of our population are Aboriginal. In the old far west it was about 10 per cent, so it is a significant proportion of our population.*

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st, Page 20, Paragraph 4: *..... We have a difficulty filling positions. It has always been difficult to get dentists to work in rural areas. In the past few years we found it difficult to get dental therapists as well, and dental prosthetists - there are not many in rural New South Wales, so we tend to not have many positions for those clinicians.*

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic: Hearing August 31st, Page 49, Paragraph 8: *.....The major threat to its operation is sourcing dentists. If we cannot get the dentists we will not operate. It has been an ongoing problem for a long time. It continues and I think it is getting worse. Therefore, the main aim of our submission is to seek ways of overcoming the problem of attracting dentists, not just to Broken Hill but also to rural and regional New South Wales and Australia, from what I can gather.*

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 28, Paragraph 1: *Obviously, there are quite different issues for dentists in the private and public sectors. As I wrote in my submission, there is a relatively oversupply of dentists in the private sector, particularly in Sydney, yet there is a huge undersupply of dentists in the public sector and also in rural areas.*

Public Dental Services Are Particularly Under-Staffed Relative To Community Need

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 2, Paragraph 2 *"..... requirements for dental visits will increase by 25 per cent nationally to 2010 but the increase amongst those eligible for public care is predicted to increase by 33 per cent.*

In New South Wales the eligibility criteria for public dental services are the most generous of all States. It extends to adults with health care cards, pensioner concession cards and to the Commonwealth seniors health card holders and dependents. It also covers preschool and full-time school students to the age of 18 yearseni. In New South Wales approximately 50 per cent of the population is estimated to be technically eligible for care compared to approximately 30 per cent in Victoria or Queensland."

COMMENT FROM APOH: Although 50% of the population in NSW is eligible for public treatment, less than 10% of dentists work in the public system. Reducing eligibility levels to those of other States would not help, as current capacity could only expect to service less than 10% of the population at very best. Probably this is an over-estimate, as public patients have more complex problems and have most of the community disease burden so that the public system could probably currently cope with only about 5% of the population.

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th, Page 32, Paragraph 7: *The things that have been raised with us are the cost of private dentistry and the availability of public dental services, both in relation to waiting lists, distance and transport difficulties.*

As we understand it the problems that exist across the State—and they have been raised with us in the places that we have been—are long waiting times and the difficulty of getting dental treatment, in particular, emergency dental treatment.

Some of the consequences of that are that older people, and particularly low income older people, choose not to pursue dental treatment. That exacerbates their oral health problems. Oral health being one of the key determinants of primary general health, the consequences of poor oral health show up in the general health of an older person. So there can be quite serious complications and flow-on effects.

Ms DAVIES (Public Dental Patient): Hearing July 5th, Page 45, Paragraph 6: *I talked to staff of one of our services where this voucher system is in operation. From what they said, the reason why it is in place in this particular regional centre is that there is no capacity in the public dental system, so there are young people just automatically going onto the voucher system.*

The process is that the person has to go to the public dental service to get the voucher and make an appointment with a private dentist. Apparently there are slots. Private dentists usually have a slot allocated for emergencies on a particular slotted day type of thing. They make the appointment and go to the private dentist and have the treatment done.

My understanding is that it is the same sort of process though with the public dental. If there are other problems identified, you only get the value of the voucher. Then you have to go back to the public dental

service and get another voucher and go through the process again. From my discussions there, the problems that are encountered in this system are that there is a limit on the voucher. They said it was about \$120 so that does not necessarily get you very far.

That raises transport issues, particularly in this particular regional centre. The public dental service is not centrally located. It is in a residential area, so that means two buses for most people to be able to get there and then you have to get to the private dentist.

From talking to people who work in oral health, they said that one of the problems of the voucher system is actually that not all dentists will want to participate in it because they are not reimbursed at the same rate that they would get for a private practice. There is also additional paperwork associated with it. There is also a bit of an issue about trying to find dentists who are prepared to do it.

The Hon. IAN WEST: *Would the maximum \$120 tend to correlate with an extraction?*

..... CHAIR: *Jo, did you say that, regardless of where you may live, you cannot get a voucher by using the 1300 number? You must go to a clinic or wherever to get a voucher.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): *You must go to the public dental—*

CHAIR: *And then presumably there is another wait before you take your voucher to a private dentist.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): *Yes.*

Ms DAVIES (Public Dental Patient): *I had to ring up and go to the dentist. They had a look and said, "Right, that's the tooth". They wrote a letter and gave me the voucher. I took the letter and the voucher to a dentist—I had to find a dentist who would take it because not all dentists in Liverpool took it. I then had to make an appointment with him and wait. I then went in, gave him the letter and he took out that one tooth. It was over a couple of days.*

CHAIR: *Was your voucher an open voucher? Did it have a dentist's name on it? Was it up to you to find the dentist?*

Ms DAVIES (Public Dental Patient): *No. They told me of one who accepted it—they knew there was one who accepted it. For some reason I could not get in there so I found another one. The dentist wrote on a separate piece of paper which tooth had to be taken out so when I went in to the dentist—I do not know how much the voucher was for—he took out that one tooth. He did what the public dentist had written down for him to do.*

COMMENT FROM APOH: APOH Estimates that Vouchers cost about 4 times more for delivery of service as compared with identical treatment within the public dental system, so that Vouchers are a highly ineffective and expensive way to deliver public dental services

Chair: Hearing 29th June 2005, Page 3, Paragraph 6: (with reference to dental therapists) *"So there is insufficient establishment of jobs in the public system? The need is there but because the jobs are not provided – " A/Prof ZOELLNER (Chairman of APOH) Agrees*

Ms Vern-Barnett (Hon Secretary, NSW Dental Assistants Assoc): Hearing 3rd August, Page 8, Paragraph 7: *I think the tragedy of that in the public system is that we have gone back to the bad old days. It is all extractions now rather than trying to save teeth. We were trying to educate the public for years and years. Now it is emergency treatment and more often than not it is extractions. By the time the patient gets to be seen it is beyond being able to be saved. It is quite tragic to think that despite fluoride, despite all the things that the profession itself has instituted to try to save people's teeth for as long as possible, we are now getting back to the days where unfortunately people are likely to wear dentures again before much longer.*

Ms GRANT-CURTIS: Hearing August 23rd , Page 6, Paragraph 6:So I ended up going to the local dental care unit at Port Macquarie. They are supposed to have two dentists there. One of them resigned some months ago and they cannot get a new one. The other one is not on duty and they do not know when they will resume dental care.

Hearing August 23rd , Page 33, Paragraph 7: CHAIR: Is it possible for you to estimate what that figure might be if you had a dream budget, you did not have any vacancies and you could get as many dentures as you liked?

Ms OSBORNE, Area Manager, Oral Health, North Coast Area Health,: I looked to see what was the recommendation of the Organisation for Economic Co-operation and Development [OECD] of dentists per 100,000 of population. It was 56 dentists per 100,000 of population, which means that we would need to recruit another 117 to cope with the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you have 14?

Ms OSBORNE: Yes.

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st , Page 1, Paragraph 11:..... At the moment I am also doing some work for the Greater Western Area Health Service, as it does not have a dentist.

The Hon. KAYEE GRIFFIN: Hearing August 31st , Page 4, Paragraph 6: How does that (administration) impact on the rest of your work?

Dr MAYNE; Dental Officer, Royal Flying Doctor Service: I am doing that on the days I would be doing my administrative work. I guess I am just getting more organised and getting my administrative work out of the way in half a day. I fly basically four days a week and have one day to do the administrative work and order in the stock and all that sort of thing.

CHAIR: You do not have any staff to do any of that?

Dr MAYNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st , Page 9, Paragraph 17: You said there is a demand for two or three dentists?

Dr MAYNE; Dental Officer, Royal Flying Doctor Service: In my view. If we could get another two or three dentists, this whole area could be better serviced.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are meeting only less than half the demand, then?

Dr MAYNE: I would like to think not, but yes, when you say it like that. What I am saying is you could have one flying, one at Maari Ma and one in the town at all times.

CHAIR: When you say that, you are talking about public dental services?

Dr MAYNE: Yes, not the private. There are three private dentists in this town.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are there are enough private dentists covering the private demand?*

Dr MAYNE: *Yes, I think so. I think there are more people are in the public need in this town than there are in the private.*

Ms CUTLER, Director, Clinical Operations, Greater Western Area Health, Hearing August 31st, Page 19, Paragraph 9: *.....The major issues we have in public health care are probably very similar to what we have in many of our other services. Probably two of the major issues are workforce and distance.*

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 28, Paragraph 1: *Obviously, there are quite different issues for dentists in the private and public sectors. As I wrote in my submission, there is a relatively oversupply of dentists in the private sector, particularly in Sydney, yet there is a huge undersupply of dentists in the public sector and also in rural areas.*

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 57, Paragraph 14: *..... As far as I know there is only one other person in my situation in the public service and she is in Queensland.*

CHAIR: *What do you mean in your situation?*

Dr DUCKMANTON: *Who is an endodontist. There are approximately 100 endodontists in Australia, of which two are in the public service. It is a rather unique situation.*

Dental Clinicians Cannot Be Attracted To The Public Service Because Of Poor Wages And Conditions

A/Prof ZOELLNER (Chairman of APOH) Hearing 29th June 2005, Page 3, Paragraph 7: *"About 20% of all currently established positions for dentists are unfilled because you cant possibly attract dentists to such low-paying jobs in the public system, particularly in country areas"*

Professor SCHWARZ: Hearing 29th June, Page 34, 3rd Last Paragraph: *..... because if you give people a choice—if you come out of university with a loan debt burden of \$150,000 that you need to pay back over a limited number of years, and you get an offer to be paid either \$40,000 a year or \$100,000 a year (In The Public System) , my answer is usually, "Well, that's a no-brainer. I would take the \$40,000 a year job, right!" That is essentially the choice that many of our graduates have*

Mr WILSON (President NSW Aust. Dental Assoc.): Hearing 5th of July, Page 55, Paragraph 9: (With reference to the Public Dental System of NSW) *Morale is a big issue for people in the service. I started my practising career as a public sector dentist. I did 18 months working in the clinic of Royal Newcastle Hospital. I am sure you know where that is, Robyn. Those days the patient load was large but the acute services could be dealt with pretty much the same day or the day after.*

We had allocated clinic times to deal with courses of treatment. People are getting seen initially as emergency patients and then going on to courses of treatment. Within three to six months they would have their basic problem dealt with. There was a lot of denture provision and so forth. It was a clinic of some 15 dentists. I understand that that clinic now is down to something like 6. The population of Newcastle has not got any less. The eligibility criteria have got wider. As to the demand on that service, I could not imagine what it must be like trying to cope with that on a day-to-day basis.

I did 18 months in that service. We got to help with a lot of things. There was on staff an oral surgeon and we got to help with motor vehicle accident cases. We got a wide range of experience, even though we might not have had a lot of experience on the very high-end type dentistry developments that were going on then. I am talking 25 years ago. You got good solid grounding.

Unfortunately, I think the people who have to try to make that service function now really get to deal with only the emergency services and trying to get people out of trouble. That is the most they can do with the resources they have.

For me 18 months was a good grounding and I went on to other things.....

The Hon. ROBYN PARKER: *That correlates with evidence we have had from groups such as Burnside about just doing emergency one-off treatment to get people out of trouble. This morning I asked Terry Clout from the Hunter New England Area Health Service about facilities and the provision of resources to public dentists and whether that was keeping pace with current practice. He thought it was. Do you have a comment on that and whether it reflects on morale if it is not up to date?*

Mr WILSON (President NSW Aust. Dental Assoc.): *My patients—the people who are coming to see me because they cannot get in—would say it is not. The service is not available. The amount of vouchers going out to private dentists in my area means that the service is not able to cope with the demand that is being put on it. Anecdotally the people working in the service are finding it extremely difficult to continue to do so.*

The Hon. ROBYN PARKER: *Is the equipment they are using up-to-date?*

Mr WILSON (President NSW Aust. Dental Assoc.): *It was always lagging. Even in my day some of it was up-to-date and some of it was not. I think that is probably a separate and different issue. I think the manpower is more of a problem for them than anything.*

Ms FRANKS (President NSW Dental Therapists Assoc): *Hearing, August 3rd, Page 22, Paragraph 9: The Central Coast. In that area we have lost two full-time dental therapists in the past six months. We recruited successfully in New Zealand and got a very nice young lady from New Zealand to come over. She lasted two weeks, until she realised she was getting \$18.90 an hour. She wanted to live in Sydney and further her career. She was a new graduate of the bachelor of health science from Auckland University, but she just could not afford to live on \$18.90 an hour.*

The Hon. KAYEE GRIFFIN: *Is that because there no way to recruit anyone from here because of the diminishing numbers in New South Wales?*

Ms FRANKS (President NSW Dental Therapists Assoc): *Recruitment and retention of dental therapists is a huge issue. The dental therapists who have come out with a diploma in the past five years have probably moved on; they last, on average, about 12 months in the job. They move on to utilise their skills in other areas. A lot of them do hygiene so that they can work in the private sector.*

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): *Many of the dental therapists who have qualified in the last five years or a little longer, as Kay said, worked in the public sector for a very short period of time and, due to conditions and pay, have gone on to do a hygiene conversion course, and then go to work in the private sector, where they are not utilising their dental therapy skills at all. They are practising hygiene, performing scaling cleans and giving preventive instruction. That is a great loss to our profession. These people have trained in dental therapy but, because of those adverts aspects of the profession, have left it.*

Ms FRANKS (President NSW Dental Therapists Assoc): *At great cost to the community.*

With Reference To The Lack Of An Appropriate Award For Prosthetists

Mr KEY: *Hearing August 3rd, Page 46, Paragraph 16: It is idiotic. With the desperate staff shortages, they are starting more and more to come to us and ask what they should pay these people. There is no award. The first thing that you need to do is create an award in the public sector because a prosthetist coming in on the highest technician wage has nowhere to go. He is as good as he is going to get for the rest of his life.*

AND LATER ON PAGE 47:

Mr KEY: *Hearing August 3rd, Page 47, Paragraph 9: No. There were two awards. I had to testify at the technicians' award and at the dental assistants' award. Those two are the only ones that have a new award. The dental hygienists in a public hospital are paid less than a dental assistant, which is incredible when they have a degree. Prosthetists do not exist and dentists have not been reviewed yet.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *In short, it is something of a muddle in the sense that they are all paying below the market, which is why they cannot get any public dentists.*

Mr KEY: *Yes.*

Ms GRANT-CURTIS: *Hearing August 23rd, Page 6, Paragraph 6:So I ended up going to the local dental care unit at Port Macquarie. They are supposed to have two dentists there. One of them resigned some months ago and they cannot get a new one. The other one is not on duty and they do not know when they will resume dental care.*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page26, Paragraph 11: *Well, yes we do have difficulty. We have some solutions or some ideas that we think would assist us with that.*

Every time we do have a vacancy we advertise it through all the normal ways whether it be dental journals or local media or national media. We find that that is very unsuccessful.....

CHAIR: *Is that the whole range of dental positions?*

Ms OSBORNE: *Mainly dentists. They are the ones that the system falls apart when they are missing.*

Further on Page 27, Paragraph 5: The Hon. ROBYN PARKER: *Why do you have difficulty filling those positions. Is it wages?*

Ms OSBORNE: *Yes, I have some of the reasons here. We feel that the State award has not been reviewed for a long time so there is no incentive for dentists to work with us.*

That also goes for specialists and dental therapists whose award has not been reviewed for quite some time. So there is not a financial incentive to work with us.

There is a Rural Dental Officers Incentive Scheme, commonly known as DORIS, and that is \$20,000 that dentists going to rural locations get on top, but that has not been adjusted for quite sometime.....

If you work in Newcastle you get the same incentive scheme as you would working in Moree which clearly is a much more difficult area to recruit to. We feel it should be adjusted from a radius point of view as well.

Our clinicians tell us that they would feel that this is a better place to work if there was a stronger clinical leadership and a stronger career path for dentists within the structure and if they had a broader scope of work to do.

.....yes we do do a lot of emergency work, and that is what we do. As much as the community does not like only receiving that, neither do our dentists like providing it. It does not give them that broad scope.

Later

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page42, Paragraph 8: *There was one question that was just asked, that is, whether there was an adequate number of dental services for the eligible population. I think we touched on that and we agreed that there was not. I referred earlier to the OECD number. I was also asked what improvements should be made to fix that.We can see that we do not cope with tertiary care as it is anyway.I think that there needs to be a review of the awards that I mentioned before so we can continue to attract good health professionals. I think we need to advocate for additional auxiliary placements at university so we have auxiliaries ready to provide that health promotion and education, if that is the way we go. The work force is already busy treating and we will need an additional work force.*

Later

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page44, Paragraph3: *If you talk to our clinicians you will see that they feel very intimidated by the amount of demand on them. They leave quite frequently because they cannot cope with the demand. I think we have to find some way of making it a reasonable workload. Demand is one of them.*

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd, Page 46, Paragraph 3: *We had a lot of trouble recruiting dentists when the funding came through. We took the usual avenues of advertising in the local papers, the Sydney Morning Herald, the Australian, dentists job search and the Koori Mail. We did not get a lot of response that way.*

Later:

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd, Page 49, Paragraph 11: *It includes Durri and Biripi as well who are in partnership with area health to promote services so that we are not using the same services. I would think that we would like some changes made in the public dental service as well that would be in line with probably the same things as the Mid North Coast Area Health Service would like to see, that being water fluoridation. We support the fluoridation of water. We would like to see an increase in the provision of funding to the areas of most need, including Aboriginal health and prioritising and increase the level of funding for dentures, a recruitment strategy for the placement of clinicians in rural areas and some financial incentive for public dentistry in rural placement. We feel that there are not the same rewards as through the private sector. As with area health, the State award needs to be increased for all clinicians.*

CHAIR: *Is it possible to attract enough dentists away from the money they can make in private practice?*

Ms HARRIS: *I think it is very difficult. One thing that we have in this area going for us is that we are on the coast and so it is a lovely area but I think a lot of dentists would prefer to be in Sydney or be working in the private sector.*

CHAIR: *Their salaries would need to be substantially increased or a big increase in idealistic young dentists, or both?*

Ms HARRIS: *I would think so. Another way would be to open up more placements at university for the dental work force.*

CHAIR: *That is not just dentists but dental assistants and therapists?*

Ms HARRIS: *Yes, therapists as well.*

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, Hearing August 31st, Page1, Paragraph 11:..... *At the moment I am also doing some work for the Greater Western Area Health Service, as it does not have a dentist.*

The Hon. KAYEE GRIFFIN: Hearing August 31st, Page 4, Paragraph 2: *How long have you been doing the western area health work?*

Dr MAYNE: Dr MAYNE; Dental Officer, Royal Flying Doctor Service: *Since November last year.*

The Hon. KAYEE GRIFFIN: *Because they lost their dentist?*

Dr MAYNE: *They lost their dentist 12 months before that.*

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st, Page 20, Paragraph 5: *If I could tell you about the unfilled positions that we currently have. Of the 28 staff positions we have two vacant positions that are full-time for dentists, one in Broken Hill and one in Orange. We do have one overseas-trained dentist who has filled a third vacant position we had in Orange. Dental therapists is emerging as one of our really difficult areas to recruit to. We have full-time vacancies in*

Condobolin, another one in Orange, another one in Bourke, a part-time position in Wentworth, and we have a maternity relief position in Broken Hill at the moment that we have been unable to fill. That represents 30 per cent of a dental therapist workforce, a 30 per cent vacancy rate at the moment

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st, Page 26, Paragraph 17: *Is that because you have difficulty recruiting prosthetists?*

Mr KUMM: Oral Health Manager, Greater Western Area Health Service: *That is correct. There is only one person in Broken Hill who has his own prosthesis.*

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 22, Paragraph 5: *The 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, so there is not that attraction.*

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 28, Paragraph 7: *If we are looking at the public sector, obviously we talked earlier about health funds and the impact of health funds, and I think that other people have commented that the private health insurance clinics have caused problems for the public sector because there is a pool of dentists who do not wish to work in private practice. Previously they worked in the public sector, but now the pay and conditions in the private health insurance clinics are much better than those offered by the public sector. It is no surprise that young graduates and senior dentists would prefer to work for private health insurance clinics.*

This problem will become far worse if corporations enter into the provision of dental practice, which may occur soon after the change in legislation. You will then also have large corporate practices that can employ dentists. One thing that public dentists have stated is that they really would like to have the same pay and conditions as the dentists working in the private health insurance clinics, and I do not think that is an unreasonable comment from these people. Obviously, if you want to have dentists working in the public sector offer them the same pay and conditions that the private health insurance clinics are offering them and you may have more chance of getting dentists working in the public sector.

CHAIR: *The oversupply of dentists in Sydney in the private sector has not driven down their incomes?*

Dr HUTCHINSON: *I think it has, but not to such an extent that they will be willing to work in the public sector with the way the public sector is at the moment. Morale is dreadful. The college has Fellows who are in the public sector and I have talked to some of these Fellows. Most of them have said, "Please don't use my name when you make these comments." For example, I know at the moment that the dental supply houses are refusing to supply dental materials to the Sydney Dental Hospital because the bills have not been paid. You have dentists who are there who can work, but they cannot work because they do not have the materials to work with. The funding obviously is in a parlous state.*

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 53, Paragraph 14: *I would like to answer that question, Madam Chair. We feel that the main issues are: retention and recruitment; lack of a defined, flexible career path for dental officers and other dental groups; time pressure, due to the high number of patients that we face on a daily basis, which is 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. Significantly, there is a lack of experienced clinical support, in the sense of senior*

clinicians. It is a very young work force, and a relatively inexperienced work force. I am thinking of mentoring and specialist support for the junior dental officers and technical staff.

We have a major problem with deskilling. Because of the relatively limited range of treatment options that we can provide for our patients, the dentists employed in the public sector, as well as the support staff and technical staff—let us say dental assistants—do not gain the experience in the broad range of treatment modalities that are routine in the private sector, to the extent that in country clinics they do not make dentures; they basically do emergency treatment. It is quite accepted among those who work in the public sector that we are not expected to do exotic, very expensive treatments, but I am talking about basic dental treatment modalities—nerve treatments, limited crown and bridge, caps and bridges type of treatment, and dentures. We see those as the main issues.

CHAIR: You have not mentioned pay.

Dr LAIN: These are the issues facing our work force, but pay is next. We thought we might address that matter in our response to question three.

CHAIR: We have heard from others, for instance our witnesses this morning, about the problem of deskilling and the limited range of services. The lack of career path has been mentioned before. You talked about the lack of experienced clinical support. Earlier today someone suggested that at Westmead the senior specialists tend to have been there for quite a long time resulting in a lack of turnover and the problem of how to get new people. I suppose that is quite different from the point that you are making about the lack of experienced support.

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: I think the problem is that you tend to retain specialists who are perhaps a little older, because their expectations and demands from life are not as great as those of the younger person. The problem is finding people in the middle, those with five or six years experience who would come into the public sector and work. They are the ones who are particularly missing. It is very good to have lots of junior dental officers, but you have to realise that junior dental officers are able to carry out only a limited number of services, compared with an older practitioner, because they do not have the experience. Therefore, there is not anybody much available to do any mentoring, and that is a big problem. You have young people and experienced specialists at opposite ends, and nothing in the middle. So one of the big problems, of course, is to attract and retain such people. As you alluded to, Madam Chair, it is all about salaries. If you do not have competitive salaries, you are not going to get those people coming into the public sector; you are not going to attract them in the first place, and they are not going to stay in the sector at all. That is the biggest problem we have.

Dr LAIN: I think it is particularly acute in the rural setting; that middle level of maturity of clinical experience is lacking.

CHAIR: You mentioned time pressure. Are you suggesting, by the figures you gave us, that to some extent people walk in and must be seen? Is time pressure not properly managed by an appointment system or an allocation of time per client?

Dr LAIN: To a certain extent that is an administrative matter, but there are a lot of people who are eligible for public dental treatment, and they are presenting in increasing numbers. Dental pain is a very unpleasant sensation. We have a lot of eligible patients, and we see the numbers. As human beings in the health care profession, it is stressful to see the pile of files mounting up in the in-box, and we have to get through the day. That really is what I am referring to when I speak about that aspect. That has an impact on staff.

CHAIR: So, in a sense, you are trying to do more than you really should be doing?

Dr LAIN: More than you are comfortable doing.

The Hon. IAN WEST: Those workloads obviously create morale problems and mean you cannot provide a service that you would like to provide?

Dr LAIN: Absolutely. This is within the context of realising, as I mentioned before, we are not offering Rolls Royce treatment; we are offering practical help to people in trouble. But time pressure certainly is an

issue—as is reflected sometimes in some absences, or in people expressing disappointment and a negative attitude to the in-box.

CHAIR: So are you mostly doing extractions and fillings?

Dr LAIN: No. It is palliative in the sense of extractions to a certain extent, and it would be true to say that many of these teeth could be saved if we could offer more comprehensive treatments. We also do nerve removals, endodontic treatment, which in many cases is an alternative to extraction. Until recently, in some clinics we were not able to carry an endodontic treatment or nerve treatment through to completion. It takes three or four visits perhaps, and the instruction was that we could only really do the first stage and not put people on a waiting list for completion. But, recently, that has been addressed, as I understand it, at the Sydney Dental Hospital.

CHAIR: You did not talk about pay because that is in our next question. What is your view on the current state of wages for dental health workers?

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 57, Paragraph 6:: *Basically, without being venal about this, it does seem to lie at the heart of a lot of the problems. The salaries are too low. We are losing people to the health fund clinics, which is fine for them but has an impact on the age of our work force once gain. We see the State award issues as career path and salary being tied together. It is not just salary; it is the very limited classifications or tentative career paths. The pathways are so limited that once you have been in the public sector for seven years that is it. As a dental officer certainly that is it. This is very similar for other groups. The dental prosthetists do not have an award. They are paid as dental technicians. Further to that, the dental technicians in 2003 had an alteration to their new award and received a significant salary increase. Recruitment is no longer a problem for dental technicians in the Sydney Dental Hospital. Retention, however, is because of the lack of career path.*

CHAIR: *Is there a career path in private practice whether you are a dentist or one of the ancillary services? You become a dentist and you stay a dentist or you become a dental assistant and that is where you stay. Is not the problem of career path in a sense built into a specialised occupation like dentistry?*

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: *I guess you could say that, Madam Chair, but the public sector has always tried to provide more job satisfaction perhaps then private practice, especially for dental assistants. Dental assistants have the opportunity to move into administration and run a large clinic or assist staff in a large clinic. The problem they have got there is their recently updated award from 2003 does not take into account the administrative load that these people have and also does not have a training wage. So even though they are significantly better off now than they were, there is no remuneration for those who are administering a clinic from the point of view of ordering stock, managing staff, that sort of thing. That is something that needs to be addressed as well. From the point of view of dental officers, dental hygienists and dental therapists, we cannot compare their salaries to private practice because that is just not a reasonable comparison. But you can compare them to what happens in the health funds, who see a similar sort of patient.*

CHAIR: *This is in the health fund-organised clinics?*

Dr DUCKMANTON: Yes, in the health fund clinics. Their salaries would be about 40 per cent, I would think, higher than what is happening in the public sector. Once again, it comes back to attraction and retention of staff.

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 64, Paragraph 6: It



also goes to the provision of the number of operators to manage the number of patients. If you have fewer operators the waiting list will be longer; if you have more operators you can get through more things. That is also part of the implication; that is, the waiting list is long because there are not enough people to service the need.

Public Dental Infrastructure Is Inadequate For Needs

The Hon. IAN WEST: Hearing August 31st, Page 33, Last Paragraph: *I want to ask a question about capital expenditure and whether any work is being done to overcome the obvious problems of equipment getting older and capital expenditure that needs to be done. I want to know whether there is some detailed work being done on costs of that.*

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service: *We prepared a full capital works planning list that we are currently costing. Replacing one dental chair or one dental unit we can generally do with funding that we have, particularly if we have been unable to recruit a dentist. We might have some funds left over and we can replace that equipment, although it is difficult because by the time you know that you have these funds it is close to the end of the financial year and we have no guaranteed rollover of funds from one year to the next. We can progressively replace some equipment and we are working on that, but the buildings are the things that we find really difficult because that requires more funds than we typically have available in one financial year.*

We desperately need a public dental clinic in Broken Hill. The Dubbo community dental clinic has far outgrown the size of the building. The Orange and Bathurst ones will be replaced as part of the Bathurst, Orange, Bloomfield hospital redevelopments, but Dubbo and Broken Hill will not be captured by those types of redevelopments. So often it is more about the buildings that we have trouble with in terms of capital funding, but we are not specifically funded to—I think we said we are funded \$37 per eligible person, and that is it. That is not \$37 plus a capital fund.

The Hon. IAN WEST: *That is merely operational?*

Ms FLOYD: *That is the only budget we get.*

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 28, Paragraph 9: *.....I know at the moment that the dental supply houses are refusing to supply dental materials to the Sydney Dental Hospital because the bills have not been paid. You have dentists who are there who can work, but they cannot work because they do not have the materials to work with. The funding obviously is in a parlous state.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is this because the Government does not pay its bills?*

Dr HOWE: *I think it is the Dental Hospital rather than the Government.*

Dr HUTCHINSON: *The funding that is provided to the Dental Hospital does not allow them enough money to pay the bills, so I presume that is what has happened.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So the dentistry does not get done?*

Dr HUTCHINSON: *At the moment there are patients whose treatments are being delayed because there are not the materials required to do that treatment in the Dental Hospital and the dental companies will not supply the materials until the bills are paid. That is how bad the situation is.*

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 55, Paragraph 9: *.....One of the problems is that a lot of the smaller centres do not have a lot of equipment or some of the more complicated equipment needed to do things other than take out teeth and put in temporary restorations. They may not have particular sorts of bands you need to put fillings in teeth; they may not*

have the files needed to do root canal therapy; they may not have what we used to call a rubber dam—but we do not call it a rubber dam any more because NSW Health has been particularly proactive and has removed rubber dams from the inventory, at great cost to everybody.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is it bad?*

Dr DUCKMANTON: *Supposedly.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is it toxic?*

Dr DUCKMANTON: *Some people have rubber allergies, so it is a problem for them. I think you will find that all of NSW Health is becoming latex-free.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Obviously, you do not approve of the removal of latex.*

Dr DUCKMANTON: *Not in some things. In some things it is certainly a problem. But I think in respect of rubber dams it is probably over the top a bit.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Who makes these decisions?*

Dr DUCKMANTON: *I am not too sure, but they certainly do not ask clinicians.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Surely, with clinical technology, you should ask clinicians. Am I missing something here?*

Dr DUCKMANTON: *I am just a worker, so to speak, and I am not asked for my opinion.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *No. But you are a clinical person of some seniority, are you not?*

Dr DUCKMANTON: *That is true. But I am not asked for my opinion.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are not some clinical persons asked for their opinions?*

Dr DUCKMANTON: *They may be, but they do not come and ask me for my opinion.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *But you would know, would you not, as you are at one of only two dental hospitals in the State?*

Dr DUCKMANTON: *Yes.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Surely your peer groups would know, if they had been asked.*

Dr DUCKMANTON: *I think it has got to do with money, but—*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Was latex a highly expensive product?*

Dr DUCKMANTON: *No, latex is not, but non-latex stuff is highly expensive.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is that the best way to spend dollars—on such technology?*

Dr DUCKMANTON: *I do not think so. But, as I said, that is not for me to decide; I just work there.*

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: *Hearing 16th February, 2006, Page 57, Paragraph 3: It would appear that some bills have not been paid. Are you aware of that?*

Dr DUCKMANTON: *I do not pay the bills, but I do know that we have suppliers who will not supply us.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you have materials that you cannot get because of that problem?*

Dr DUCKMANTON: *Not personally, but I have colleagues who certainly do. It is being addressed now, but they have had problems where they have not been able to get certain materials.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *They cannot then do certain procedures?*

Dr DUCKMANTON: *That is correct.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *People who need those procedures miss out?*

Dr DUCKMANTON: *They do not miss out. They are put off to a bit later date.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Presumably they get worse in the meantime?*

Dr DUCKMANTON: *People who are waiting for those sorts of things may be in a situation where they are stable and they are not really going to get any worse. Another six weeks probably is not going to make very much difference other than to annoy both the operator and the patient.*

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 64, Paragraph 7: *It is a funding issue rather than a salary issue, of course. There are just not enough dental chairs, and they are expensive.*

Aboriginal Dental Health And Services Are Poor

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd, Page 44, Paragraph 8: *The dental health status of the Aboriginal population is generally very poor. The adult population in particular experiences a high rate of dental decay and periodontal disease. Poor dental health has a range of consequences for a person and may include severe pain, infection and abscesses, which result in the extraction of teeth.*

Therefore many people are living without teeth, which affects their ability to eat. This has particular implications for people with complex health care needs, such as diabetes, because that person's ability to eat nutritious food is severely compromised. There are also social implications in terms of potential effects on self-esteem and confidence.

Later

Hearing August 23rd, Page 49, Paragraph 10: CHAIR: *How would you sum up the state of the dental health of your clients? Is it generally pretty bad?*

Ms HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service: *Yes, it is generally very poor, the reason usually being historically Aboriginal people are very fearful of dentists. I think that we have made a huge difference with the children in that we practice atraumatic dentistry: they are never forced to do anything. They are usually brought along very carefully, the treatment is done very slowly, and a lot of the clinicians have worked with these children—I have been in Aboriginal Medical Service for more than 10 years so I have built up a trust with the community and with the children that I treat.*

CHAIR: *What is the dental health of people in their 20s or adolescents?*

Ms HARRIS: *Again, very poor.*

CHAIR: *Much poorer than comparable non-Aboriginals?*

Ms HARRIS: *Yes, to the mainstream to non-indigenous people, very much so, those in the low socio-economic area from which we come with unemployment and lack of education.....*

Later

Ms HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service: Hearing August 23rd, Page 49, Paragraph 10: *There are quite a few referrals to oral surgeons. We would probably have close to one dozen a week that may need referral, particularly for difficult extractions with wisdom teeth.*

CHAIR: *That would be much higher than the rate in the general population?*

Ms HARRIS: *I would not think so, no. A lot of the teeth to be extracted are fairly broken down and are very difficult to extract with forceps, so surgical intervention is needed. They are certainly referred on in those cases.*

CHAIR: Hearing August 31st, Page 3, Paragraph 7: *Could you tell us a little more about the general state of the dental health of the people you see? You mentioned earlier the young woman who lost a tooth and who would probably never get it replaced.*

Dr MAYNE; Dental Officer, Royal Flying Doctor Service, *There are two things. The indigenous population has very poor health and very poor general health as well.*



The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st, Page 43, Paragraph 16: *It is fairly serious. It is six to eight times worse in Aboriginal groups in the far north-west than the average. That is the average for the whole of New South Wales, is it?*

Mr GOWIN: Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation: Yes. *That is how I understand it.*

CHAIR: *To take an example, in Wilcannia the figure for five and six-year-olds is given as seven times the New South Wales non-indigenous average?*

Mr GOWIN: Yes.

CHAIR: *The figure for the 12 and 13-year-olds is 2.5 times?*

Mr GOWIN: Yes.

CHAIR: Hearing August 31st, Page 44, Paragraph 6: *So your general answer would be that the state of general health amongst Aboriginal people in the area is not good and there is a big need for education and preventative work but it has to go hand-in-hand with a concern for living conditions, housing, general health and other sorts of issues? Dental health can only be seen as part of the bigger picture, would that be a fair summary?*

Mr GOWIN: Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation: Yes. *And I think that goes along with all aspects of health. It is difficult to talk about someone's obesity or drinking problems in isolation from the rest of their life. Certainly oral health would be no different.*

There Is A Degraded Dental Training Infrastructure, So That The Dental Workforce Can Not Be Easily Re-Built

A/Prof ZOELLNER (Chairman of APOH) Hearing 29th June 2005, Page 2, Paragraph 6: *"The educational infrastructure required to train the workforce is also degrading and is severely degraded relative to the past.... We feel it is failing now..... once it is gone – we will have to wait generations to rebuild the dental infrastructure of the State..... We do not believe in the cargo cult"*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June 2005, Page 8, First Paragraph *".. When you say we have to train our own, What is the state of dental education?"*

A/Prof ZOELLNER (Chairman of APOH): (In Response) Page 8, Paragraph 4, *"..... the level of education infrastructure in New South Wales is severely degraded. "*

Dental academic work is much smaller than it was. There is only one faculty of dentistry in this State. we have had a dramatic reduction in academic staff, significant reduction in the number of specialist academics from specialist areas such that now areas such as endodontics—crown and bridge—periodontics and paediatrics have no full-time academics...."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued discussion) *"At all?"*

A/Prof ZOELLNER (Chairman of APOH): (Continued discussion) *"At all. it is dangerous because when I was a student those departments were reasonably well represented.*

Operative dentistry, the bread and butter of dentistry, drilling holes, filling them, we used to have around about 10 full-time academic staff. We are down to two now. We are pretty degraded."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued discussion) *"But you cannot train students, presumably, when it has to be one to one for at least a period to see what they are doing. They cannot learn out of a book and then go straight into some person's mouth. You cannot increase student numbers if you do not have any demonstrators or teachers or tutors, whatever you want to call them."*

A/Prof ZOELLNER (Chairman of APOH): (Continued discussion) *"You are absolutely right. That is a huge problem and the level of supervision required for dental students during training is very very high.*

As you say, these students are handling high-speed drills, high-speed rotary instruments wielding scalpels and chipping bone out with bone chisels in patients. These are undergraduate students. They have to be very carefully supervised whilst working on patients because..... Our students are doing irreversible interventions every day. You have to stand over them and watch them like a hawk to look after the interests of the patients. It is very intensive. It requires very high levels of manpower, and we do not have the manpower at the moment.

We are able to employ some tutors coming from outside to help us with supervision. Of course, that is the only way we could possibly operate at the moment. But we do not have enough money to pay the tutors to come in. For a long time they were on a purely honorary basis in our faculty. Now they are being paid, but nowhere near enough to attract the number of quality tutors that we need to supervise our students. It is a huge problem—not enough resource."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29th, Page 32, Paragraph 4: *"If there are not enough dentists, what is stopping the university from getting that increased number and the increased funding for that number? What is stopping you from expanding?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued discussion) *"At the moment I believe that there is a sense of staff shortage in the faculty. We would need teachers. I mean, we would need to have a properly consolidated group of teachers who could actually teach these students in the clinics or elsewhere.*

At the moment I do not think that we would be prepared to actually take on more students. We have a very intensive program with a very low rate of students per staff. That means, as I say, that if we need to take on 10 or 20 more students, we would actually need several more staff ..."

CHAIR: Hearing June 29th, Page 33 Last Paragraph: *"If you take the question more generally to apply not just to the University of Sydney but to, say, Australian universities,..... are we producing too few people to provide dental services? We heard earlier that the profession is ageing. Are we are facing in the future a really grave shortage, or a greater shortage of people than we currently have?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Discussion continues Page 34) *"... I think it is relatively certain that we are facing a shortage. We have a certain shortage now.*

It is certainly going to be worse because there were quite a considerable number of people who were trained through the sixties, seventies and probably up to the eighties and then a much lower number of dentists were being trained.

Of course, these are essentially my generation who will be retiring in probably 10 years time or will start retiring in bigger numbers, and there will not be the same number of new graduates coming into the profession to take over.

At the same time, the population is increasing and the population is ageing as well, which creates different types of more complex treatments. Say a patient on average needs one hour of service a year and 20 years from now they have retained their teeth, they have more complex treatment needs and so on.

.....John Spencer suggested some years ago that the country, as a whole, needed to produce 120 dentists more per year and that would then be distributed across the six dental schools.

I do not think that was generally accepted. The numbers were taken on advisement and nothing was done to try to approach that in an organised way."

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing 29th June, Page 35, Seconds last Paragraph: *"..... The problem for the faculty of dentistry, which is unique in the university, is that we cannot put 80 students in my class in a lecture theatre and lecture to them from eight o'clock in the morning to five o'clock in the afternoon and then expect that after four years they will be able to go out and practise dentistry. I need to put each dental student at a dental chair with a patient who will actually train as a professional and be able to graduate as a safe dentist.*

If they were medical students, they do not have the same requirement. Medical students will go through their curriculum and will not be able to go out and practise medicine individually, independently, after they finish the medical program. They have to go through several years of rotations, internships and so forth, but that is not my choice. I have to actually produce dentists who can go out in society and work as professionals. That is what makes the dental program unique in the university and, to a certain extent, it gets certain recognition because the band that we are in, in terms of what a student is worth, is actually at the highest level in the university. It is not at the lowest level. The lowest level is a law student. "

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued Discussion Page 36) *"Sure, but it may not be enough even still?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Discussion Continued) *"That is true. It would be better to get more money, but I would hate to sit here and attack the university for not giving us enough money because I think that there are a number of factors in this whole relationship that is the reason why we seem to be struggling with the budget at the moment, which is not uniquely because of the funding formula in the university."*

Mr KEY: Hearing August 3rd, Page 44, Paragraph 16: *Once the commercialisation came into it, the other States picked it up. If it was going to be government funded, there was never going to be a prosthetists course in Victoria or Queensland. Our prosthetist course was government funded up until three years ago.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Who funded it—Federal or State?*

Mr KEY: *State.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Why did they pull the plug?*

Mr KEY: *It was the dearest course in TAFE.*

Ms BRADBURN: *It was too expensive.*

Mr KEY: *There was actually a whole year when there were no enrolments because of the budget worries.*

CHAIR: *This is the one that people now pay \$25,000 for?*

Mr KEY: *Then it went commercial and there is a waiting list of 60.*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page 42, Paragraph 9: *I think we need to advocate for additional auxiliary placements at university so we have auxiliaries ready to provide that health promotion and education, if that is the way we go. The work force is already busy treating and we will need an additional work force.*

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st, Page 28, Paragraph 6: *.....Not enough dentists are graduating in New South Wales. There are certainly not enough dental therapists graduating at the moment.*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th, Page 39, Paragraph 5: *What I have said is that enrolment per se is not affected by funding issues or by student fees, but recent increase in the intake from 40 to 80 has placed severe pressure on the faculty. There is insufficient academic staff, insufficient education infrastructure, and it is difficult to attract new academic staff. But the decision to push up the intake has not affected student fees. Students are now willing to pay that amount to get in.*

CHAIR: *Why was the intake put up?*

Associate Professor EVANS: *Because there was a recognition that it should not have been dropped down and because of this data coming out that has been there for all to see, but it has just been ignored.*

CHAIR: *In terms of work force shortages.*

Associate Professor EVANS: *Work force shortages, surely, and just the funding of dental education.*

CHAIR: *It seems therefore slightly contradictory, having reacted to Australian or New South Wales data, the university is now filling a quarter of the places with American or Canadian students?*

Associate Professor EVANS: *A quarter of the places, yes.*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 40, Last Paragraph: *We are in a situation where there has been undermining of the capacity of the university to train dentists and the facilities are not there or they are now very old and Westmead provides these facilities for us but we are under constant pressure. For example, we have just lost a conference room, which was previously taken out of student facilities and laboratory space when the faculty was run down a little bit, then a lot of the Western Sydney Area Health Service moved into that space, so now we need to grow again we have got no space to grow into.*

Yet we are under pressure to lose space. For example, recently there has been pressure from ophthalmology to have some of our dental space. We are housed in very substandard circumstances, when you look around. People are just squeezed into places and it is really not very good. So we cannot attract staff; it is very difficult these days.

In The University Of Sydney, About Half The Funding For Dental Education Is Captured Centrally And Not Directly Available To Teach Dental Undergraduate Or Post-Graduate Students

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29th, Page 29, 4th Last Paragraph: *"What percentage of the funding for dentistry is retained by the university as an overhead?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"I do not think I can answer that question actually, not right on here."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (continued discussion) *"Could you take it on notice? Would you be able to find the answer?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"Sure, but I just want to make you aware that that is not the way universities are funded and that is not the way the faculty of dentistry is funded."*

The way funding comes to dentistry is through a block grant that can be traced that comes from the Department of Education to the university as a whole. Then there is an internal funding mechanism in the university that then allows some money to be retained at various levels in the university for infrastructure and development, and then some of it will then come down to the faculty of dentistry. There is no line item, if you will, that comes to the university which says, "This is for dentistry", and then they take off 30 per cent and then send the 70 per cent to me, or the other way around. That is not how the university gets its money.

It really gets its block grant on the number of HECS places. So on that basis I could say, okay, the best grant that comes to the faculty of dentistry—we have 45 HECS places in the Bachelor of Dentistry program, we have 20 HECS places in the Bachelor of Oral Health program, and those moneys I can track, so to speak, but that is not all the money I get from the university.

So I will probably need to go home and think a little bit about it when I see the actual question spelled out. It is a very complex question; it is not easy."

Comment From APOH: Although only 30% or so of funding is now of "government origin" in the Faculty of Dentistry, it is important to appreciate that about 50% of all funds from fee paying students, local or international, as well as other income is taxed centrally by the University.

This allows the University to state that it operates at a surplus, but pressures Faculties to the extent where service delivery (teaching / research) is compromised. Please see the APOH submission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June, Page 35, Paragraph 2: *"I understand that the funding formula is about to change for funding of Higher Education Contribution Scheme [HECS] places, within the university system, is that correct? If so, what impact will that have on your faculty?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued discussion) *"I actually do not know because I do not know that there are changes in the funding formulas."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued Discussion) *"You do not know that they are coming or you do not know what they are?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued Discussion) *"No, I do not know that they are coming."*

We had a forum in the faculty yesterday and I showed the staff the situation in the faculty of dentistry.

If I look at the income of the faculty of dentistry in 1999 the HECS grant produced 70 per cent of my income.

I looked at the HECS money last year; it produced 33 per cent of my income, so that means that 67 per cent came from somewhere else and that other income was produced by fee payers and other sources.

They are the things I know and that might continue down, but we are not really sure. I have looked at this graph and it is continuing downwards.

What the overall policy background is for doing it this way, I am not really sure, except that we know from the Commonwealth Government that they want the universities to find funds somewhere else because the Government cannot fund more,

but if you are talking about individual HECS places, I know that the HECS place is worth a certain amount—\$1,000—and I have not heard that that is changing."

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 40, Paragraph 11: *....To go back to the funding issue, it does not affect students but the effect of the increase in the number of impacts on the staff: only 50 per cent of the fees that are paid to the university actually reaches the faculty of dentistry; 50 per cent is retained by the university. We point out that the university does not own any of the infrastructure in relation to dentistry. All our offices and clinics where we teach the students are all provided by Westmead Hospital and the Sydney Dental Hospital.*

CHAIR: *And they do not charge the faculty or the university for those facilities?*

Associate Professor EVANS: *I do not think they do.*

CHAIR: *The university does rather well out of the faculty, does it not?*

CHAIR: Hearing November 14th , Page 41, Paragraph 5: *Can we say that with regard to the money that comes from the students, 50 per cent of it has gone from the university and is not, as far as you can see, used in your undergraduate programs?*

Associate Professor EVANS: *That is our understanding. It does not come to the faculty.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It goes from the faculty to the university's central administration.*

Associate Professor EVANS: *No. It is collected by the university, and the faculty gets half of it.*

The University Of Sydney Provides No Office, Clinical Or Pre-Clinical Facilities For Dentistry, With The Dept. Of Health Effectively Providing All Dental Training Infrastructure At Its Hospitals

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June, Page 38, Paragraph 10: *"You have a problem with few staff scattered over a number of locations in your faculty. Does the university provide you with many facilities?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued discussion) *"No."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued discussion) *"So you have to send your staff to Westmead and the dental hospitals?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued discussion) *"The university does not have facilities for the dental faculty because we live in the two hospitals. So the area health services provide our facilities. We use facilities on the main campus of the university for especially the two first years of dental students' lives, when they go to lecture theatres and so on and so forth. But it is essentially the two area health services that provide the physical framework for the dental faculty."*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th, Page 40, Paragraph 11: *.....We point out that the university does not own any of the infrastructure in relation to dentistry. All our offices and clinics where we teach the students are all provided by Westmead Hospital and the Sydney Dental Hospital.*

CHAIR: *And they do not charge the faculty or the university for those facilities?*

Associate Professor EVANS: *I do not think they do.*

CHAIR: *The university does rather well out of the faculty, does it not?*

Associate Professor EVANS: *It is similar to medicine in a way. Medical students are trained in hospitals. Medical students do not treat patients. Dental students are fully trained in patient care in all disciplines so that when they graduate they are fully competent as dentists. They are not specialists though. That is another three or four years training.*

CHAIR: *The women from the University of Newcastle correctly said that the dentistry is the second most expensive course.*

Associate Professor EVANS: *Yes.*

CHAIR: *After veterinary science, but one of the implications of what you are saying is expensive to whom?*

Associate Professor EVANS: *Yes.*

CHAIR: *Because if Westmead, its facilities and equipment are provided by the State Government, dentistry is not so expensive for the university.*

Associate Professor EVANS: *That is right,*

CHAIR: Hearing 29th June, Page41, Paragraph 5: *Can we say that with regard to the money that comes from the students, 50 per cent of it has gone from the university and is not, as far as you can see, used in your undergraduate programs?*

Associate Professor EVANS: *That is our understanding. It does not come to the faculty. The Hon.*

Dr ARTHUR CHESTERFIELD-EVANS: *It goes from the faculty to the university's central administration.*

Associate Professor EVANS: *No. It is collected by the university, and the faculty gets half of it.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Presumably, the faculty, not being particularly flush with funds, does not pay the health department for the premises at Westmead and is out-competed by the ophthalmology department. Is it all about money? Everyone does calculations on office space costs, or any other indoor space costs, and it tends to go to the highest payer.*

Associate Professor EVANS: *I am not sure that that is the case. I think we are just a small group who outmanoeuvred—and we are not the CEOs. It is down that end. Decisions are made that we do not know about, and we are just told, "You have to move out of the space." The Hon. Dr*

ARTHUR CHESTERFIELD-EVANS: *Is it office accommodation taking up what was your space in the conference rooms? Associate Professor EVANS: Yes. It is all part of Western Sydney Area Health Service administration.*

Comment From APOH: The Faculty of Dentistry is housed entirely within the teaching hospitals.

Dental Students Make Significant Contribution To Oral Health Service But Are Not Supported To The Same Extent As Medical Students

Dr MAYNE: Dental Officer, Royal Flying Doctor Service, Hearing August 31st , Page 19, Paragraph 1: *Dental students do not because to some degree they are seen as staff. They are my assistants. So they are fairly low down on the kick-off rate.*

CHAIR: *The system out here depends a lot on the voluntary placement of students, dental and medical? In relation to funding, in one sense, the system is propped up by students, otherwise that would need to be replaced?*

Dr MAYNE: *We do not do any funding for dental students.*

CHAIR: *The system would have to pay for people if you did not get students?*

Dr MAYNE: *I would need to have a dental assistant, yes.*

CHAIR: *So to a large extent the western part of New South Wales is provided with services for free because students are used?*

Dr MAYNE: *Because they use dental students, yes.*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 40, Paragraph 15: *It is similar to medicine in a way. Medical students are trained in hospitals. Medical students do not treat patients. Dental students are fully trained in patient care in all disciplines so that when they graduate they are fully competent as dentists. They are not specialists though. That is another three or four years training.*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 41, Paragraph 2: *when you look around. People are just squeezed into places and it is really not very good. So we cannot attract staff; it is very difficult these days.*

CHAIR: *In that sense, there is little comparison with the teaching hospitals for training doctors?*

Associate Professor EVANS: *That is right; it is not equivalent at all in that sense—and also because of the structure of the training. The hospitals are where the training of specialists occurs, too. Dentistry specialists are all trained by the university, so it is not funded in that sense.*

The Faculty Of Dentistry At Sydney University Is Up to 25% Over Budget Expenditure Per Year

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June Page 33, First Paragraph: *"Is your department running over budget, though, in endeavouring to pay staff that you have with your good teacher-student ratio that you are talking about?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): *"If you are asking me does the faculty have a deficit, then the answer is yes. But whether that is because we are over budget, I am not really sure."*

CHAIR: Hearing 29th June Page 33, Paragraph 7: *"..... We are trying to establish what you think about the argument that the funding and infrastructure for professional dental education is unsustainable at present....."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"If we look at the way in fact that it gets funded or actually sustains itself at the moment, if it were sustainable, we would not be here"*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 16th February, 2006, Page 7, Paragraph 5: *Do the HECS allocations for dentistry cover the cost of a dental student, and if not what is the shortfall?*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 7, Paragraph 6: *The HECS allocations received by universities are a combination of central university costs—libraries, gym, administration services, capital works and infrastructure—that go towards dental education, but they also cover the direct salaries and expenses of academics and support staff, and dental schools. Generally it is that the level of funding received within the faculties of health sciences for their dental schools is less than half of the real cost of providing the education of a dentist at our universities, and a reasonably large proportion of the remainder is made up in a number of different ways.*

A large contributor is State health budgets through the provision of clinical services and the support for clinical services in our dental teaching clinics. They are somewhat underwritten by research funding that universities receive. My area is a good example of this: we are a research area, but research-employed staff are engaged in the teaching of dental students so that there is a sort of cross-subsidisation from research to education. There is a certain amount of philanthropy that is occurring that is underpinning dental education at our universities through foundations, and there is a degree of entrepreneurial income raising along other lines that dental schools use to try to match the shortfalls that they feel they experience

Comment From APOH: The Faculty of Dentistry is chronically under-budget, with about \$1M under-funding relative to current expenditure. Please see the APOH submission.

It Is Not Possible To Attract Enough Dentists And Dental Academics From Overseas Or Inter-State

The Hon. IAN WEST: Hearing 29th June 2005, Page 8, Last Paragraph "We live in a global economy now. Can we not just buy in what we need? (dentists and dental academics)"

A/Prof ZOELLNER (Chairman of APOH): *"(continued discussion – Page 9).... there is a worldwide shortage of dentists. This is not just a problem with New South Wales or Australia, this is everywhere.*

I would say that you simply would not come. If you have enough get up and go to go somewhere you would not get up and go where everything is being degraded. That would be really silly. Why would you come to New South Wales to develop your clinical career when there is no opportunity for further development? Why would you come to New South Wales to develop your academic career when there is no opportunity for research or development? You would not do that. No, you will not be able to buy them.

You could try. Recently we had an applicant from South Africa for a professorial position at the University of Sydney. He came from a small provincial university, a tiny little town in the middle of nowhere in South Africa. Lovely guy. He was offered a professorial position in our faculty, but felt that he could not possibly take the drop in wages. It was actually better for him to stay in a small provincial university in South Africa than to come to Sydney. That sort of gives you an impression of where we stand.

If you cannot attract somebody from South Africa to a professorial position—our best paying, most prestigious, best supported position—you are not go to get a whole army of people to save you. "

CHAIR: (continued discussion) *"Is the implication of that that there is a worldwide shortage? Presumably, if New South Wales were the only place that was lacking then people would flock here because of the supply and demand equation. "*

A/Prof ZOELLNER (Chairman of APOH): (continued discussion) *"Yes. You are absolutely right, there is a worldwide shortage, a worldwide shortage of dental academics"*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29th, Page 32, Paragraph 6: *"Correct me if I am wrong, but you are having difficulty retaining staff and you are already seriously over budget consistently. Are those two statements not true?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"I would say probably not entirely. A lot of the staff has actually been in fact there for quite a while. I do not think it is retention as much as it is attraction."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (continued discussion) *"But you have a few diehards who are presumably dedicated or habituated and are staying on your books, and you are not getting new ones, so that must mean that your salary is a problem."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"Well, of course: that is, I think, well known. To be salaried in public health or public service is not as good as being out in private practice. This is not simply an Australian problem. This is a worldwide problem. But an academic institution cannot compete with private practice. That is just not possible."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (continued discussion) *"The fact that you have a dedicated work force or a long-term work force needs to be recognised because they are all going to get old and eventually go away."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (continued discussion) *"Exactly."*



Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 39, Paragraph 5: *There is insufficient academic staff, insufficient education infrastructure, and it is difficult to attract new academic staff.....*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 40, Last Paragraph: *We are housed in very substandard circumstances, when you look around. People are just squeezed into places and it is really not very good. So we cannot attract staff; it is very difficult these days.*

PETER MICHAEL DUCKMANTON, representing Professional Vocational Committee of the Health Services Union, Dental Specialist, Sydney Dental Hospital: Hearing 16th February, 2006, Page 61, Last Paragraph: *The flow-on effect is that there is fewer and fewer full-time university staff and, once again, we have to rely on part-time staff or honoraries. If we cannot get them or the part-time clinical staff, there are fewer people in the clinics supervising the students.*

Far Fewer Dentists Are Being Trained In NSW Than In The Past, And Many International Students Will Likely Leave After Training

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: Hearing November 14th , Page 38, Paragraph 10: *The current enrolment in the courses: The bachelor of dentistry course, which is a four-year full-time course for training dentists, has an intake of 80 per year. That recently went up from 40 per year to 80 per year. When Westmead was built, it was built for 120 students per year and there has been an erosion of that and it got down to 40 or 45 but for the last two years the intake has been 80. The three-year bachelor of oral health degree program, which is the new program this year, there were 15 students and from next year there will be 20 students from 2006. Across the four years of the program there are 46 full paying international students.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Out of how many?*

CHAIR: *Out of 240 roughly?*

Associate Professor EVANS: *Something like that. I can tell you that for next year, 2006, the intake of 80, there will be 45 HECS places, so the other 35 will be made up of either 20 or 15 international full fee paying students and the other 15 or 20 are local full fee paying students or vice-versa. I am not sure.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So you are only getting 60, assuming they all graduate, likely to stay in Australia?*

Associate Professor EVANS: *Yes.*

CHAIR: *Would you expect the 20 international ones to go back home to practise?*

Associate Professor EVANS: *Mostly they are from Canada and the United States and we expect that they will go back.*

CHAIR: Hearing November 14th , Page 39, Paragraph 10: *It seems therefore slightly contradictory, having reacted to Australian or New South Wales data, the university is now filling a quarter of the places with American or Canadian students?*

Associate Professor EVANS: Associate Professor, Head of Discipline, Community Oral Health and Epidemiology, University of Sydney: *A quarter of the places, yes.*

Dental Workforce Shortages Are Not Just A Problem For The Poor, But Already Impact The Middle-Classes

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005, Page 6, Paragraph 14 and going over to Page 7 Paragraph 1: *"there is this sort of idea that the problems we are talking about are problems of the poor and that is true, that these diseases are most prevalent in the poorest people and the most dependent people of the community, but it is also true that you can have as much money as you like but if you are in a rural area and there is no dentist and you have a toothache, who are you going to pay?"*

"The reason there is a shortage of dentists in rural areas and the reason that there is a shortage of dentists in the public service is that it is not as lucrative and not as pleasant to work in either of those two settings. As the work force dries up, as you have fewer and fewer dentists available, that is where you will feel the pinch first."

"it is only a matter of time until it starts to affect people in the cities. This is a middle-class problem for the people in the country now and it is going to be a middle-class problem for the people in the cities soon."

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing 5th July, Page 37, Paragraph 10: *Again, the issue is one of availability and timeliness. The group who falls between the stools are the ones who do not qualify for public services but do not have a high income. They are the ones that have the most difficulty in terms of cost.*

CHAIR: *The working poor.*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *The working poor, indeed, or the non-working poor in the older age groups: the self-funded retirees on limited incomes.*

The Hon. ROBYN PARKER: *In terms of those people, are you talking about the group that do not have private health insurance?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Many of them cannot afford private health insurance.*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): Hearing 3rd August, Page 7, Paragraph 13: *I think our clientele has increased too. There is a waiting list now, and once again I am talking private practice. The waiting list in private practice has now increased quite considerably because of the lack of dentists.*

CHAIR: *That is in private practice?*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): *Private practice.*

CHAIR: *Specifically in rural and regional areas?*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): *I cannot say. It is only anecdotal, once again, from what we hear, but we know there is very much underservicing of dental services to rural areas especially.*

CHAIR: *But you are not talking about increasing waiting lists in the city in private practice?*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): *Yes, there are, definitely.*

CHAIR: *Even in private practice?*

Ms Vern-Barnett (Hon Secretary, NSW Dental Assistants Assoc): *In some.*

CHAIR: *It comes back to the shortage of dentists?*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): *I know from personal experience, on the upper North Shore you can be booked for anything up to one month to three months and that is really booking solidly. That is quite a wait for people.*

NOTE: APOH suggests that the shortage in dental workforce commences in rural areas and the public sector because these areas are less lucrative and pleasant to work in, while with the progressive shortage in dental workforce, it metropolitan areas will experience significant dental workforce shortages

Mr KEY: Hearing August 3rd, Page 36, Paragraph 15: *Yes. Well, they would definitely have to be a practice with two chairs; not a single chair, otherwise it will not work. The dentists are so busy—those I worked with were booked probably six weeks to two months ahead—that to make a denture or even do a scale and clean just takes so much out of their day when they could be doing preventive work.*

.....

There Has Been No Real Planning For Dental Workforce In Australia With A Shortage Of 1,500 By 2010

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June 2005, Page 5, Paragraph 10: *"You have said that there is a shortage of dentists. Do you know what the number of dentists needed is and how do you calculate this? Who is responsible for this? Is this done properly?"*

A/Prof ZOELLNER (Chairman of APOH): (In Response) *"I wish that I could say that our planning for work force was rational and based upon some sort of sense and formula. As far as I can see it is not.*

We trained 120 dentists per year 25 years ago.

We went down to about 45 a few years ago.

We have gone up to 80 now.

About 20 of those are international students who will clear out of the country when they are finished.

Page 6 Continued

I do not think there is a plan

It is projected that nationwide there will be 1,500 dental personnel short by 2010."

CHAIR: Hearing June 29th, Page 30, Paragraph 5: (With reference to the number of dental and bachelor of oral health students per year at the University of Sydney) *"In terms of the students, who actually decides the 45 rather than 47, 42 or whatever?"*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued Discussion) *"...Why it was 20 and not 30 or 40 is obviously a good question.it is based on our assessment of how many students we can serve, so to speak, and that is, to a large extent, limited by the number of dental chairs that are available in the two teaching hospitals.*

The 45 higher education contribution scheme [HECS] places are not all the students that we have. We have another 35 students in the class. We accepted 80 Bachelor of Dentistry students last year but the 45 were the only ones that came from the Government, so to speak. The 35 were—"

CHAIR: (Continued Discussion) *"Private?"*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued Discussion) *"Private, effectively. Locally private, or international? "*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued Discussion) *"Yes, both local fee payers and international fee payers."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): Hearing June 29th, Page 34, Paragraph 1 *"... I think it is relatively certain that we are facing a shortage. We have a certain shortage now. "*

..... Paragraph 3"and nothing was done to try to approach that in an organised way."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29, Page 31: *"At some point, we have to determine how many dentists should there be."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued Discussion) *"Exactly."*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (Continued Discussion) *"And what is stopping the universities from graduating and training as well as getting the personnel to train and produce more dentists."*

Professor SCHWARZ (Dean of The Faculty of Dentistry, Syd Uni): (Continued Discussion) *"At this stage I think in fact that the limitation for taking on more students is that we are actually training most of our dental students in the two teaching hospitals. Unless we find alternative ways of training our dental students—for instance, sending them out in extended rotations like they are doing in Queensland now in their fifth year—we will be very limited in terms of being able to provide a basis for more students, just in terms of numbers."*

"Of course, if we get more students, we also get more income because these students would be fee producing, one way or the other. Those fees can be used to convert into sort of salary expenses and so on and so forth."

"Again, there are some issues that need to be looked at, but at the moment there are just not spaces in the two teaching hospitals that we actually use to produce more dentists. "

Ms FRANKS (President NSW Dental Therapists Assoc): Hearing August 3rd, Page 19, Paragraph 12: *"Yes, I think it is a little ad hoc type of solution to the ever-diminishing dental services. It is a bit of a knee-jerk reaction to get this course up and running and I do not think it has been really well thought out, in my personal opinion."*

CHAIR: *"We keep asking this question about why is there a shortage? Why are there apparently too few people being trained? And when you say "they" I guess the question is who is "they"? Who is responsible for, say, the fact that Newcastle is going to have a Bachelor of Oral Health and that, you would suggest, will lead essentially to the death knell of dental therapists? Who is really making these decisions? Is it the board? Is it a kind of an operation of a market sort of principle?"*

Ms FRANKS (President NSW Dental Therapists Assoc): Hearing, August 3rd, Page 20, Paragraph 2: *".....They will not come as a new graduate with a HECS debt to work in the public sector for \$18.90 an hour. So I essentially see that their options are to go to private practice where they can earn quite a bit more as a dental hygienist or use that Bachelor of Oral Health as a stepping stone to the Bachelor of Dentistry course, which would be their ultimate aim of becoming a dentist."*

CHAIR: *"Has this been planned? If your prediction comes true is that because people have decided that that is the way it is going to be or is it more ad hoc?"*

Ms FRANKS (President NSW Dental Therapists Assoc): *"No, I think the powers that be, the Sydney University, the academics, I think they really do want to see this hybrid oral health profession take off. I think there is a very genuine will that that takes off and is successful because we see that there is a place for that person within private and public sector, and as the association we support that; we see that as the next step. However, the barriers are that legislation is not allowing the dental therapists to work in the private sector; they would only have the opportunity to work in the public sector where the remuneration is poor."*



Mr KEY: Hearing August 3rd, Page 44, Paragraph 1: *On a national basis. For TAFE there is a national health training package which dental assistants come under—dental technicians and dental prosthetists—and dental hygienists did that, until they went to university. Once they were at university, it was no longer national.*

CHAIR: *What is it? Once you are at university, what is it? We keep looking for the answer to that question.*

Mr KEY: *It is university.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It seems like a shambles.*

CHAIR: *I am getting the impression suddenly that no-one is really in control.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *No-one is in charge.*

CHAIR: *No-one can answer certain questions.*

There Has Been A Lack Of Political Will And Leadership

The Hon. ROBYN PARKER: Hearing 29th June 2005, Page 5, Paragraph 6: *"Has there been professional agitation about this, representation to government?"*

A/Prof ZOELLNER (Chairman of APOH): In Response *"Yes, there has been. The Government has received ... and commissioned numerous reports. On page 49 of our submission we list only seven reports but there have been many others. Of those seven reports, there have been 86 separate recommendations that we counted.... Of those 86 recommendations only seven have been acted upon."*

The Hon. ROBYN PARKER:Continued *"What has been the explanation for the rest of them not being acted on?"*

A/Prof ZOELLNER (Chairman of APOH): In Response *"I think that there is a lack of political will. "*

Hearing August 23rd, Page 44, Paragraph 14 :CHAIR: *The dental association and others made that point about Federal responsibilities and where dental services should be. Medicare has often tied that to a strange bifurcation between dental health and general health. Why is it that we have ended up in a situation where dental health is treated as something quite unconnected? We heard a lot of evidence to the effect that dental health is closely related to a lot of other health issues. I guess that is tied in to some of the points you made earlier about capital works planning. You cannot treat dental health as a separate thing; it has to be more integrated.*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 1, Paragraph 7: *..... a silent epidemic and it really is that that silence is, in part, a reflection of our inactivity about those who carry most of the burden of dental disease in the community. There is a relative silence in our policy response to a reasonably well-documented epidemic, one which we can reduce and one which we can certainly manage much better than we currently do.*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 12, Paragraph 4: What I can say is that at the moment we have a very fragmented and unco-ordinated response to the national oral health plan, and that States and Territories are moving at different paces to consider it and implement what they might be comfortable to implement from within the plan as a whole. All of that could be sped up and could be more far-reaching if we had national leadership and a true partnership between our Federal Government and our State and Territory governments on that matter.

The Public System In NSW Is Inconsistent Across Area Health Services And Is Also Physically Degraded

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 29th June 2005, Page 8, First Paragraph "... what is the state of dental infrastructure? Is there enough equipment? "

A/Prof ZOELLNER (Chairman of APOH): In Response: *"The physical infrastructure for public dentistry is degrading. It is very patchy. There is no consistency throughout the public health system and in different area health service areas with regard to distribution/use of dental money.*

Each area health service defines its own priorities, has its own treatment philosophy a..... so that in some area health services equipment is probably better maintained than in others.

I was talking with somebody the other day from a rural area health service. He said, "You've got no idea what it's like."

And I am sure he is right. He was saying, "I've got chairs that don't work. I've got drills—"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: (in response) *"The ones with a bit of string around them?"*

A/Prof ZOELLNER (Chairman of APOH): ..(Continuing response).. *"It is pretty grim, actually. Having said that, some area health services are probably well equipped, but there is no consistency.*

It seems to me that you should not be punished if you are a public patient who has the misfortune to live in an area health service that does not have quite the same priority as another. "

A/Prof ZOELLNER (Chairman of APOH): Hearing June 29th Page 15, Paragraph 7 (with regard to waiting lists and times across area health services in NSW) *"I have heard that at Westmead, for example, there might be a waiting list of around 20,000 people. That is an area that actually has a major dental teaching hospital where we have a large number of dentists available to treat those patients.*

In other area health services there is really nowhere to register, I suppose, your concern or your need for treatment, so I suppose the waiting list is totally academic in those areas.

Another figure I have heard used is a statewide waiting list of 160, 000, but I have no way of knowing how real that is. I am only passing on hearsay.

..... The waiting times are going to be very important and they will vary enormously from area to area. As I said, each area health service has its own policy, its own way of doing it. There is a lack of consistency in governance in the area of health across area health services, and so that does cause us some problems."

Dr HILL (Principal Dental Officer, Ex Acting Chief Dental Officer, Justice Health), Hearing, July 5th, Page 9, Paragraph 6: *"I certainly believe that on an area basis we need to have a streamed oral health service.*

One of the things to come out of this is that a wide range of services in different areas around the State does things differently.

I think we are keen to stream our oral health services, and that is a much better model."

Dental Insurance Mechanisms Are Inadequate And Do Not Recognize The Importance Of Dental Health

A/Prof ZOELLNER (Chairman of APOH), Hearing 29th June, Page 11, Paragraph 2, *".... patients are able to receive a measure of support from health insurance for dental treatment, but there are usually limitations on how much money can be awarded per year for different types of treatment...."*

Chair: (Continued discussion) *"Could you argue that the private health insurance system for dentistry has helped skew whether the money is going to the areas of greatest need?"*

A/Prof ZOELLNER, (continued discussion) *"... Yes.....Significantly more government money is devoted to supporting dentistry via private insurance than is now being spent of directly supporting public health dentistry."*

Tony Abbott was saying..... that the Federal Government is now spending four times more on dental services than ever before. But of course, all of that is going into the private insurance system"

.... Discussion Continued into paragraph 7 "... it is quite strange that Medicare, for example, does not seem to have any real role in supporting dentistry."

If you have a face full of pus, that is not considered to be a medical problem.

Whereas, if you have a boil on your backside, that is considered to be a serious medical problem, there is a Medicare number for it, you can get your antibiotics and medical treatment and it is all covered.

But if you have a face full of pus, you are told – "I am sorry, that is dentistry, it is not really an issue"."

Mr MOORE (Director NCOS): Hearing July 5th, Page 19, Paragraph 5: *" In the longer term, dental health as a primary health care service must be funded by Medicare."*

CHAIR: Hearing July 5th, Page 20, Paragraph 10: *"Do you see an anomaly with the growing amount of money? I think the New South Wales health people said \$350 million is going out of private health insurance ancillary benefits for dental care and yet dental care is not included in Medicare. Do you see that as an anomaly in the funding system or in the attitude to oral health?"*

Ms EDMUNDS (Sen. Policy Officer NCOS): (Continued discussion) *"I think certainly, and if you look—this is just anecdotal information being shared with us—that money tends to be spent on, I guess, wealthier people having more cosmetic dental interventions as opposed to socioeconomically disadvantaged people actually getting just basic oral health treatment. So it is really splitting that divide even more."*

The Hon. ROBYN PARKER: (Continued discussion) *"One of the things you have recommended in one of your submissions—and congratulations on your submission, it is very comprehensive—is taking away the 30 per cent rebate from the Commonwealth and putting that money into public community health services. Surely that will mean a lot of people would drop out of private health care and then put more pressure on the public system? Are there not lots of people who take out private insurance primarily because of the dental provisions within that?"*

Ms EDMUNDS (Sen. Policy Officer NCOS): (Continued discussion) *"Yes and no. People were in private health insurance previously to the 30 per cent rebate, and there was an increased take-up when the 30 per*

cent rebate was introduced. However, that is now showing to be dropping, regardless of the 30 per cent rebate. Is it being that effective and is it providing the services that it needed? And, as I said, would that money be better spent if you addressed the oral health problems early? That stops the need for these long-term ongoing issues, and also impacts on the health system in general. If you treat the oral health issue before it becomes a general health issue, it is obviously better all round. So I do not think necessarily that removing the rebate will stop people from having private health insurance or from getting treatment."

Mr MOORE (Director NCOS): Hearing 5th July, Page 21, Paragraph 11 and going onto Page 22: *I guess the point I would come back to is: had Medicare been paying for this as a general primary health care provision we would not be having this discussion.*

The Hon. ROBYN PARKER: *Would we not—*

Mr MOORE (Director NCOS): *No.*

The Hon. ROBYN PARKER: *—because Medicare pays for public health care generally and we are still having discussions about shortages of doctors in rural and regional areas, the lack of availability of public health care and the New South Wales Government failing to provide adequate public health care?*

Mr MOORE (Director NCOS): *But we are not having discussions about four months to 18 months waiting lists in front of GPs, are we?*

The Hon. ROBYN PARKER: *Well, aspects of public health, are we not having discussions about that?*

Mr MOORE (Director NCOS): *Sure, about aspects, but we are talking about basic primary health care. We are not having those discussions.*

The Hon. ROBYN PARKER: *What about waiting lists for elective surgery?*

Mr MOORE (Director NCOS): *Different deal. We are talking here about basic primary health care.*

The Hon. ROBYN PARKER: *Still Medicare funded things.*

Mr MOORE (Director NCOS): *You have to make a comparison, in our view, between a dentist in private practice working with his or her clients in that community and a GP in private practice doing the same things. The problem is that at the end of the day the dental work force or the dental profession and others way back then won the battle to keep out of their perception of socialised medicine.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July, Page 41, Paragraph 9: *Costs were identified as a major barrier. The literature shows that there is an average cost of \$295 per hour for dental treatment.*

Only 3 per cent of concession card holders have private insurance, and even then there is a limit to the number of treatments they can receive, which is very problematic if you have not been able to access services for years. Obviously people are showing up at the public dental services with major problems that will not get solved necessarily in one treatment.

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July, Page 42, Paragraph 3: *.....We considered that it would be ideal if Medicare was expanded to include oral health and if there was joint State and Commonwealth funding for additional programs. I know at the moment though that this is a State inquiry, but given the dire situation in relation to oral health, we believe that the State has an obligation to.....*

Dental Services In NSW Are Inadequately Funded And Are Lower Than In Any Other State Or Territory

A/Prof ZOELLNER (Chairman of APOH): Hearing 29th June 2005, Page 5, Paragraph 3: (With regard to NSW) *"Some States do it much better than we do it. Again, many of the things that we are talking about are national-level problems. New South Wales is exceptional in that we do it worse than anyone.*

We have the lowest level of funding of all other States and Territories. So we are exceptionally bad, but I would not say that everything is great in the other States.

We should try to lead the other States. We have pretensions to be the premier State. We should be premier in more ways than having more decay; we should be premier in having the best dental service available. We are the wealthiest, largest State. Let us do it better."

Mr Clout: Hearing 5th of July, Page 5: "There has been a massive increase in the funding, as Dr Robinson talked about,"

COMMENT FROM APOH: This is inconsistent with the accepted low funding levels of NSW

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July Page 42, Paragraph 3: *.....given the dire situation in relation to oral health, we believe that the State has an obligation to take immediate and substantial action. Current funding per capita for oral health in New South Wales is the lowest compared to the other States. We believe it should be brought into line with that of Queensland, which is the highest level.*

The Hon. ROBYN PARKER: Hearing July 5th, Page 59, Paragraph 11: *In terms of the funding, and specifically State funding, given that New South Wales is the lowest of any State or Territory, what representations has your association made to the State Government about that very issue, if any?*

Mr WILSON (President NSW Aust. Dental Assoc.): *I would say up until this year we have had very little effect on getting to talk to the State Government about funding for dental services. We have made several approaches over the years about the problems of the public sector dental scheme but generally no one was interested in listening.....*

Dr FISHER (CEO, NSW Aust. Dental Assoc.): (Second Last Paragraph, Page 59) *..... I suppose, as one point, when a budget comes out it is very hard to actually find the allocation to oral health in New South Wales—*

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): *We still have not found it.....*

.....CHAIR: (Page 60, Paragraph 2) *There was an increase in this year's budget in New South Wales. Not a huge increase, but have you managed to find that in the budget papers?*

Mr RUPASINGHE (Policy Officer, NSW Aust. Dental Assoc.): *We have heard various figures from 113 up to almost 120 million. But one of the things that we would say is particular disappointing is that*

if you look at the financial year 1996-97 when the Federal Government stopped the Commonwealth dental health program, that year New South Wales—combined Commonwealth and State funds—was spending \$103 million.

Almost a decade later we are only up to \$109.7 million, so less than a \$7 million increase in almost a decade.

That is a pretty damning indictment really.

COMMENT FROM APOH: Only \$7M increase in NSW public dental funding over 8 Years, Significantly less than the Inflation Rate

The Hon. IAN WEST: Hearing July 5th, Page 63, Paragraph 6: *The funding is traditionally shrinking. It is inadequate, to state the obvious.*

Dr FISHER (CEO, NSW Aust. Dental Assoc.): *As everyone agrees.*

Dr FISHER: Hearing July 5th, Page 60, Paragraph 5: *..... we have certainly received reports from people in area health services where they would say that not all of that is able to be spent, so therefore it gets redirected into general revenues.....*

COMMENT FROM APOH: If this is correct, then even less than the currently officially recognized dental budget is actually spent on dental services in NSW.

It is also clear that if this is the practice, that Area Health Services have no incentive to spend dental funds on dental services, as any unspent monies become available to support any other expenses that the Area Health Service might consider more important. (A handy few million dollars every year)

The Hon. Dr ARTHUR CHESTERFIELD-EVANS, *Hearing August 23rd, Page 30, Paragraph 9:: If the amount per prosthetist was put up with the award, the pensioner dental scheme—*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health,: *There is a policy that governs the fee schedule. That goes up in July every financial year.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So if your budget did not rise more than that you simply would get fewer dentures for your money?*

Ms OSBORNE: *We do every year.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You get fewer dentures for your money every year?*

Ms OSBORNE: *Yes. That goes up every year.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *But your budget does not go up?*

Ms OSBORNE: *No.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So you are getting fewer dentures per year with a population needing more dentures?*

Ms OSBORNE: *Yes.*

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd, Page 44, Paragraph 9: *Budget restraints do not allow for the provision of dentures at Durri. The very long waiting lists at mainstream public dental programs and the high cost of private dental clinics have resulted in many people living without teeth. 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.*

CHAIR: Hearing August 31st, Page 2, Paragraph 7: *You got onto the funding issue, which was our second question.Is it specially allocated to you as a dentist, or do the expenses of flights and all the rest come out of general funding?.....*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *The funding comes from three sources. The Greater Western Area Health Service gets the State funding, which is then given to the RFDS. Maari Ma gives us some funding for doing some clinics down there. Then the RFDS takes some funding out of their general funding to see the bush clinics. So there are three parts to it.*

But there is no direct funding straight to the RFDS.

CHAIR: *There is no funding straight to it?*

Dr MAYNE: *No. The State funds go to the Greater Western Area Health Service.*

CHAIR: *Within the Royal Flying Doctor Service do you have funds specifically allocated for dental work?*

Dr MAYNE: *No. They take that out off the general funding to cover the costs there.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st, Page 2, Paragraph 7: *Are you more limited by time or by money?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *Money.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Why is that?*

Dr MAYNE: *More funding would give us another dentist. Then you would have double, you know what I mean?*

CHAIR: Hearing August 31st, Page 34, Paragraph 5: *The other question that we have not tackled is our last one which refers to the submission from the area health service. Basically it says that if you again*

provide this service, you either have to increase funding or restrict eligibility, or do a combination of both, which I guess is a commonsense answer in a way. We just wondered whether you had any views about if it would be possible to restrict eligibility. I think we covered this partly before. You felt, Jenny, that it would be very difficult in this part of New South Wales.

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service: *We know that our cardholders and pension cardholders are disadvantaged. It is a commonsense response in that if there is no more money, should we provide better care for less, or just relief of pain for many. I guess we would rather be providing holistic dental care that results in better outcomes for patients rather than just a bandaid approach of providing relief of pain. It would be very difficult to eliminate any of the currently eligible people because they are disadvantaged,*

CHAIR: *Some of our earlier questions seek expansion and in some ways may seem a bit obvious, such as: can you describe the main obstacles to patients receiving treatment via public dental services?*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 1, Paragraph 9: *There is a combination of two main obstacles. The first is a resource scarcity issue in public sector dentistry, and the resources available to meet the needs and demands of the eligible population for public sector care, even at a superficial glance, are inadequate.*

CHAIR: Hearing 16th February, 2006, Page 8, Paragraph 6: *How does funding for public dental services in New South Wales compare to that in other States and Territories?*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 8, Paragraph 7: *This is not an area that the Australian Research Centre for Population Health has any role in surveillance or monitoring. We are not supplied with information from State and Territory governments or their health departments that give an immediate answer to that question. What I can say is that when I looked at the National Oral Health Plan, which has in its appendices some information about the expenditure at a State and Territory level for the year 2001-02, New South Wales spent 22 per cent of the total amount of funds spent in Australia on public dental services. I would simply ask you to draw the conclusion from that: Does New South Wales have only 22 per cent of the eligible population for public dental services in Australia and the answer, of course, is no. It has a much larger population proportion than that. That is an indication that New South Wales spends less proportionately on public dental services than its population proportions.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not pulling its weight? Professor SPENCER: Its weight against the Australia demographics.

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 8, Last Paragraph : *This is moving away from the realm of the hard data, but if you look back over time there has been fairly longstanding concern that our two most populous States spend less on public dental services than the remaining States and Territories. There is this quite a well-understood pecking order among the States in who has had a history of having a more highly developed public dental service, both a school dental program and an adult program, who employs more dentists and how much is spent per head. Certainly the position seems to have been longstanding and not something of recent origin. There is a very great historical issue, and that is that the two populous States were the last States to become engaged in expansion of the school dental program in the early 1970s.*



CHAIR: Hearing 16th February, 2006, Page 65, Paragraph 3: *You have said, although perhaps not in so many words, that funding is too limited to provide the kind of service that you believe should be provided.*

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: *Absolutely. New South Wales provides less than other States on a per capita basis. Basically that results in insufficient facilities and insufficient staff—salaries being a different issue.*

The Oral Health Fee For Service System Is Not Cost Effective

Hearing August 23rd, Page 34, Paragraph 3: Ms OSBORNE, Area Manager, Oral Health, North Coast Area Health:Last financial year it cost \$67 an occasion of service to provide services in-house. If I purchased one extraction from the private sector it would cost me \$180. We try to keep our money in-house. We do not get a budget or a health fee for service. That is just if we have slippage from our salary budget if a dentist's position is not filled.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is costing you three times as much for services in the private sector as it costs if you do them in-house. At the moment you are fully staffed?

Ms OSBORNE: No. I did not get to that. We have dental officer vacancies of 2.8, a therapist vacancy of 0.6, which is covered by the locum, and 3.2 dental assistant vacancies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not have any dental technicians, so you are not making any dentures yourselves?

Ms OSBORNE: No.

Ms FLOYD: Oral Health Network Manager, Greater Western Area Health Service, Hearing August 31st, Page 20, Paragraph 6: Private practitioners: From our count there are 64 private dentists who work in the area we cover. Of those, 36 participate in the oral health fee-for-service scheme and will treat public patients with vouchers for them but only 14 of those 36 will do denture work as well. So, 14 out of 64 are prepared to provide dentures to public patients with vouchers, and a little over half are prepared to provide emergency services.

CHAIR: So, you are saying it is a battle to get private dentists to participate or participate to the level you would wish them to?

Ms FLOYD: It is a battle. They are very busy themselves. They find it difficult to recruit junior dentists into their practices. They find it difficult to sell their practices when they are looking at retiring, so generally they are very busy with private patients. We are asking them to see public patients on top of that and we are asking them to see the public patients at a rate that is less than what they would normally charge. So, it is difficult to get them to participate. I think it is fair to say that in the smaller communities dentists often participate out of social conscience.

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons: Hearing 16th February, 2006, Page 26, Paragraph 4: I think the college is in agreement with just about everybody else you have probably spoken to that the Oral Health Fee for Service Scheme is not efficient at all. It is not an effective use of funds. It serves nobody: it does not serve the dentists who are involved in it and it certainly does not serve the consumers of dental care who are trying to access dental care through it.

Comment From APOH: Please See Appended Document Which Outlines The Objections APOH Has To the Oral Health Fee For Service Scheme

Introduction Of Co-Payments May Not Improve Things

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st , Page 15, Paragraph 13: *One of the options raised by administrative people has been the restriction on the eligibility for public dentistry as a solution to the lack of services. What would you say about that? Are there people who are getting these services who are not eligible and who should not get them?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *No. I think it is pretty hard to put any more restrictions on it other than there are at the moment. So far as I am aware the public system in this town gives them two visits a year. What other restrictions are you going to place on them to get it?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *People who are on higher incomes could be told, "You are getting a freebie that you should not be getting." Are there a lot of people coming in who could afford to pay but they do not?*

Dr MAYNE: *No, not many. Certainly in the area that I cover out there, if they are working at all they are charged a fee for service.*

Comment From APOH: Please See Appended Document Which Outlines The Objections APOH Has To the Introduction of Co-Payments.

Senior NSW Health Officials Demonstrate A Lack Of Awareness Of The Low Levels Of Public Dental Funding In NSW

Mr Clout: Hearing 5th of July, Page 5: *"There has been a massive increase in the funding, as Dr Robinson talked about,"*

COMMENT FROM APOH: This is inconsistent with the accepted low funding levels of NSW

It is also inconsistent with the only \$7M increase in NSW public dental funding over 8 Years, Significantly less than the Inflation Rate (See testimony of M Rupasinghe page above)

The Hon. ROBYN PARKER: Hearing July 5th, Page 6, Second last paragraph and going onto page 7: *"You said that funding was available generously in New South Wales. How does funding for dental health in New South Wales compare with funding in other States?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"I will have to take that question on notice. I am not aware of the specifics. I noted that certain of the submissions that were put before you recognise the fact that, if you look at the eligible population, the amount per capita in New South Wales is considered to be less than in other States. But I do not have the particular quantum amounts. I am happy to provide those, should you wish"*

The Hon. ROBYN PARKER: (continued discussion) *"Yes, please. A number of submissions have pointed out that we are the poorest State in terms of funding per capita for dental health."*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"I will also take the opportunity to present it on an apples-and-apples basis too because, as I mentioned, the criteria that we have in New South Wales are more generous than exist in any of the other States. So I will make sure that you get an accurate representation."*

The Hon. ROBYN PARKER: (continued discussion) *"Granted, but if you can provide the per capita then we will be comparing apples with apples."*

COMMENT FROM APOH: The figures provided in the APOH submission were obtained from NSW Health, and are expressed on a Per-Capita Basis, Not on the basis of eligible population so that NSW is in-fact the lowest funding State ... The comparison is already "between apples and apples"

The Hon. ROBYN PARKER: Hearing July 5th, Page 8, 3rd Last Paragraph: *"Have you made submissions—...—to the New South Wales Government requesting increased funding for oral and dental public health?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"The budget process for NSW Health incorporates an assessment of the need for the services and the"*

application of funds in accordance with that need. Obviously there is a large acute care service that needs to be provided as part of Health and the budget that is allocated to dental services is a component of that. It is under ongoing review in accordance with any enhancements that we gain, and certainly we look at every opportunity to see whether there are additional resources that can be put into oral health."

Mr CLOUT (CEO Hunter New England Area Health): (Continued discussion onto page 9) *"From my point of view, I have been in the public health system in New South Wales for more than 20 years, for the last seven of those as a chief executive and an advocate for oral health services and funding. Yes, I have made numerous submissions and a large number of those have been responded to. I am part of the rural health task force—I am sure you received a submission from them. I agree with that submission very strongly. The Government's response to the rural health task force included additional funding for oral health services in rural communities. In addition to that, there has been an increase in funding for every area health service every year for the last four years I am only going back 4 years because I cannot accurately remember beyond that—..... In addition, there was an important program that Dr Robinson referred to. As chair of the Northern Rural Health Network I made a submission for the fluoridation of the water supply. It is not just the fluoridation of the water supply; it is actually an integrated public health promotion and prevention program that includes fluoridation as one of its core components. We sought additional funding from the Government, through the department, to support that program. We were granted an additional \$100,000 a year for two years to run that program, which we matched from our mainstream health funding, other than oral health funding, within the area."*

COMMENT FROM APOH: Neither of these responses clearly indicate either clear advocacy for or an increased commitment to funds for treatment of dental disease

The Hon. ROBYN PARKER: Hearing 16th February, 2006, Page 34, Paragraph 6: *The forward plans are interesting. Would you respond to comments by previous witnesses today that in terms of New South Wales health priorities for dental care and current programs, per capita New South Wales is not pulling its weight in dental health funding? We have also heard stories that the dental health hospital is not being provided with supplies from medical supply companies because its bills are not being paid. Surely that shows a lack of priority and that you have not got it right to begin with, before you start looking at forward planning and other initiatives.*

FREDRICK ALLAN CLIVE WRIGHT, Chief Dental Officer, NSW Health, North Sydney, Darcy and Institute Streets, Westmead,: *I cannot comment on either of those two issues.*

TERRANCE JAMES CLOUT, Chief Executive, Hunter New England Area Health Service, Lambton Road, Lambton: *I am happy to comment on both of those. I am not sure that I have got a definitive answer in relation to Westmead Dental School, because it is not in my area. In terms of having the funding that is there being used and being available for those services, there are clear guidelines and criteria for area health services in relation to the payment of bills. Creditors have to be paid within 45 days. There is no question that there have been some isolated examples that, I think, are quite well known in one area health service where that has been problematic but, I understand, has now been addressed. Certainly in my area health service—and I see the reports for the rest of New South Wales being a chief executive officer—that is not an issue in relation to the provision of health services, particularly for dental services.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *With respect, you are up the North Coast and you are telling us there is not a problem about the bills at Westmead Dental Hospital. Surely that is waffle.*

CHAIR: *Mr Clout listed a couple of other hats he wears when he described himself originally.*

Mr CLOUT: *I am in Hunter New England Health and I am aware of the financial position and the creditor position for all area health services in New South Wales. It is not waffle. There are criteria to be met and they are met in almost every case. I have made it very clear that there have been some examples where there has been difficulty, but to my knowledge that has not been the case for Westmead and has not been the case for the dental school at Westmead. As I indicated, you would have to ask the chief executive*

officer of Westmead in relation to definitive issues. In relation to my area health service, which is Hunter New England, we meet our creditor bills—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the dental hospital pay its bills? Have supplies been provided? Are services not being delivered because those bills are not being paid? That is the evidence we have heard. I put it to you that you cannot answer those questions.

CHAIR: Perhaps the question could be taken on notice, Dr Robinson?

DENISE MARGARET ROBINSON, Chief Health Officer, NSW Health, 73 Miller Street, North Sydney: In relation to the specifics, I can simply say that this issue has not been brought to my attention. We have not received complaints at the department level that I am aware of in respect of this matter. This is the first time this has been brought to my attention. I am not an expert in that area. We are all aware of the department's policy with respect to creditors. As I say, I do not have the specifics. I will take that on notice, but it is not my area that I can respond to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask Dr Wright if he is aware.

CHAIR: The Hon. Dr Arthur Chesterfield-Evans, can we please have some order? The Hon. Robyn Parker asked the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was continuing that line of questioning.

CHAIR: Do not interrupt the witness. I am not sure whether the witness had finished answering the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He certainly had not. Nor is he likely to.

CHAIR: Had you finished your answer, Mr Clout?

Mr CLOUT: The second part of the question related to priority. From my perspective, there is always attention between all of the services for which there is a requirement to provide services, and oral health services have to compete with all of those. One can argue about whether or not it should have a higher priority or not. I think there has been a significant increase in the priority that oral health services have been given. I think that is particularly true in the rural areas. The question begs the next question of whether or not that has had an effect in terms of bridging the gap between the demand for those services and the capacity to provide those. That, I think, is a much more difficult question and one that my personal view would be that we probably have not broken the back of that one and we have got a long way to go. I do not think there would be much argument about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 16th February, 2006, Page 40, Paragraph 2: Can we not play with statistics here? Can we do it in relation to public dental spending per head of population in New South Wales rather than per eligible person? Of course, that is not a realistic measure, as you are pointing out.

DENISE MARGARET ROBINSON, Chief Health Officer, NSW Health, 73 Miller Street, North Sydney: I suggest that it would be better to compare apples with apples and therefore look at how our performance rated in respect of the criteria that apply in other jurisdictions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We had evidence this morning —

CHAIR: Let the witness finish the sentence, please.

Dr ROBINSON: If we do so in any other way, that is, if we look at the population within New South Wales and the amount of funding, that represents its own distortion. The same applies when we have differential criteria. I do not believe it gives a fair picture of the commitment in New South Wales if we simply say that this is the amount of money and this is the population of New South Wales. It fails to take into account the

needs in New South Wales, the provision of private dental services and dental services provided by health insurance funds. Therefore, it does distort the picture.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Dr Spencer gave us evidence this morning that we are spending only 22 per cent of the money spent in Australia on public dental services and the population is far in excess of that. Surely that is comparing apples with apples.*

Dr ROBINSON: *We are aware that about 85 per cent of current dental services are provided in the private sector, if that is the reference that Dr Spencer was using —*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *No, he said that if you are spending less on public services per head —*

CHAIR: *He was comparing New South Wales' expenditure on public dental services. To be precise, he said that it was 22 per cent of the expenditure in Australia, whereas New South Wales' percentage of population of Australia is higher than that. He did not give the figure, but it is roughly one-third.*

Dr ROBINSON: *Thank you for that clarification.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Let us cut to the chase here: Are you suggesting that the provision of public dental services in New South Wales is adequate?*

Dr ROBINSON: *I have said that I believe our commitment to the provision of public dental services is strong and that the Government has continued to inject additional funds into the provision of public dental service. It is without doubt that the withdrawal of the Commonwealth funding program did present us with a difficulty. However, we have been progressively moving to provide additional resources and I have no reason to suppose this commitment will not continue.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You said that it is strong. I asked whether it is adequate.*

Dr ROBINSON: *We are currently providing approximately 1.4 million occasions of services, from memory, and each year we are servicing about 220,000 people.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is this adequate?*

Dr ROBINSON: *That is individual people. There is a needy group within the community that is using the services and taking them up substantially. We have a strong commitment to these services, particularly the provision of emergency services and the relief of pain and discomfort. We will then direct our attention to those who are eligible but who have somewhat less acute needs. We need to deliver the services within the available budget, and I am not in a position to make any comments in respect of policy in that regard.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you believe the service is adequate, given that you have abolished waiting lists in many areas?*

Dr ROBINSON: *If you were to look at the consumer satisfaction rating in the Chief Health Officer's report you would find that the people accessing our services are satisfied; indeed, in many cases, very satisfied with the level of services that are being provided.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *What about the ones who could not get access?*

CHAIR: *Given the time, it might be appropriate not to repeatedly ask the same question. Is there an opinion in New South Wales Health or in the Government about the view expressed in a number of submissions that Medicare funding should be widened to cover dental health?*

Dr ROBINSON: *Obviously that is a policy position that would be considered and taken by the Commonwealth Government. Our Minister has clearly stated in the past that he would like to see the restoration of commonwealth funding for this program, and has made reference in public places to the restoration of the previous program.*

Comment From APOH: Despite the significant gap in time between the two occasions when Dr Robinson appeared before the committee, Dr Robinson still seemed unaware that comparisons in dental funding between States were made on a per-capita basis

There Is A Failure Of The Responsible Senior NSW Health Officials To Recognize The Need For Increased Levels Of Service Provision And Educational Infrastructure In The Public System

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 1
Paragraph 5: *".....Oral diseases are in large part preventable conditions, and almost 90 per cent of the tooth loss that we see at present is due to dental caries and to periodontal disease. These are preventable and treatable, and much of that tooth loss is avoidable.....
..... 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,"*

COMMENT FROM APOH: There is no mention here or elsewhere in the testimony of Dr Robinson, or Dr Clout of a need for increased delivery of dental services, only of improved prevention.

Although prevention is clearly important, it fails to recognize and manage the high current levels of disease.

By stating that 90% of dental disease is preventable, the impression is given that the main responsibility lies in prevention.

Although the same could be said of both diabetes and cardiovascular disease, for which about 90% are preventable through improved diet and exercise, nobody would accept that the main expenditure of these diseases should be in prevention only, with only limited funds for treatment of active disease. Dental disease should be considered in the same way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 16th February, 2006, Page 38, Paragraph 7: *Dr Robinson, we have heard about the lack of infrastructure and teaching facilities at dentistry and how that has flowed on to the work force. Is there a shortage of training facilities in the department and in the university?*

Dr ROBINSON: *We certainly have substantial work force issues. I think that has already been acknowledged. This is within the public sector and there have been questions that have been asked as to whether or not there is the capacity to increase the work force. That is one of the areas that is being examined currently as part of the review. My knowledge of the infrastructure within the area health services is that this is quite appropriate and that in very few places would it be regarded as inadequate. I believe it is more than adequate in the majority of the area health services. However, there has been some suggestion that there should be an additional focus. I think this proposal has been put forward primarily by the*

University of Sydney that there should be an additional focus on capital expansion of services within the Westmead campus so that there is a potential then for additional infrastructure support and cohesion in terms of the academic staff from the Faculty of Dentistry. That was an understanding I gained from reading their submission rather than having had a direct conversation with them in terms of that issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Is there enough infrastructure given that there are fewer staff?*

Dr ROBINSON: *I believe there is enough infrastructure. The infrastructure that we now have is sufficient for us to train an additional 80 students per annum.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *In addition to what you have?*

Dr ROBINSON: *No, at present. Of those, a number obviously are HECS places and a number are privately funded places. However, the infrastructure, teaching and support is adequate to support 80 overall. Obviously, that is a matter of appropriateness as far as the number of students that the university is able to handle now.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *But you were training 125, were you not?*

Dr ROBINSON: *Again from reading the submissions, my understanding is that in years past — and I believe that means some time ago — the faculties of dentistry were substantially larger. However, I cannot provide the specifics on the numbers or the years in which that was the case.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Will they not need to be expanded to that level again?*

Dr ROBINSON: *Obviously the number of places at the university is outside my control; it is a matter for the universities and the Commonwealth Government and their negotiations.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Why did the department sell its dentistry faculty building? It did, did it not?*

Dr ROBINSON: *I have no knowledge of that issue.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You do not know that it sold the faculty building? CHAIR: When did this occur?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *I do not know, but I believe it did. Is that not the case?*

CHAIR: *You are reading from a list of questions, so I assume you have some answers as well.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *No, I understood that the faculty building was sold. It is interesting that you say there are facilities to train 80 when there were, some years ago, 125 — CHAIR: This is an inquiry into the present and the future. I am not sure that questions about what happened before the time of any of our witnesses*

— The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *If the faculty building has been sold it will have to be bought back again to train the dentists. CHAIR: The training of dentists is a matter for the Commonwealth Government and the University of Sydney. You are getting a long way from New South Wales Health. Perhaps we should get back to the questions sent to the department that deal with what is happening now. Comments have been made to the committee about the eligibility criteria in New South Wales for access to public dental services, which obviously varies from State to State. Can you give your view on the current criteria and how well they meet need and so on?*

Comment From APOH: This Contrasts Strongly With The Opinion Of Others Concerned With Oral Health As Well As The Experience of Patients In The Public System

Mr MOORE (Director NCOSS): Hearing July 5th, Page 19, Paragraph 4: *".....The lack of adequate dental services in New South Wales, especially for low-income households and in several rural areas, has become a tragic feature of health care. The evidence pointing to links between poor oral health and other key health outcomes demands this, let alone the shabby access to service that many now experience.*

Both the Commonwealth and New South Wales governments must get much more involved. In the Commonwealth's case there is no excuse for it not to implement a more public dental program immediately that targets reducing the massive waiting lists for services.

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 1, Paragraph 7 *"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."*

COMMENT FROM APOH: It is recognized that the Area Health Services Act 1997 requires an obligation of area health services to maintain community health, but no commitment to improved service provision is mentioned by Dr Robinson.

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th, Page 32, Paragraph 7: *The things that have been raised with us are the cost of private dentistry and the availability of public dental services, both in relation to waiting lists, distance and transport difficulties. So particularly in rural areas, transport difficulties exacerbate the problems. As we understand it the problems that exist across the State—and they have been raised with us in the places that we have been—are long waiting times and the difficulty of getting dental treatment, in particular, emergency dental treatment. Some of the consequences of that are that older people, and particularly low income older people, choose not to pursue dental treatment. That exacerbates their oral health problems.*

CHAIR: Hearing 5th July, Page 33, Paragraph 3: *The first barrier you mentioned was the cost of private services. Are you talking about people who are eligible for public services but because of access problems, long waiting lists or whatever, seek private dental services instead and that is when the cost becomes an issue?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Particularly in emergency circumstances often the issue is one of cost.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing, July 5th, Page 42, Paragraph 1: *Our service users reported an array of problems, including chronic pain, abscesses, cavities and much more serious problems as well. They highlighted issues of ongoing pain and how they tried to get around ongoing pain, including using antibiotics, through going to a GP to get antibiotics, and pain killers.*

*A couple of people reported **trying to pull out their own teeth.** A young person talked about trying to pull out teeth with pliers but found that they could not because it was too painful.*

Service users talked about the impact on diet of not being able to eat certain foods and not being able to bite into an apple. Some of them talked about subsequent weight loss.

There was a lot of concern about the impact on people's appearances, such as people missing rows of teeth. This has an impact on people's self-esteem and may lead to stigmatisation as people are perceived to be a certain sort of person because their teeth are not in good repair.

..... Into Paragraph 3..we believe that the State has an obligation to take immediate and substantial action.

Ms DAVIES (Public Dental Patient): Hearing 5th July, Page 43, Paragraph 1 and onwards: *I have really quite bad teeth. I have had experiences with the dental system. I started off with my back teeth which were rotting. Rather than filling them, they just pulled them straight out. I have since found out—I went with my mother to her dentist who has been her dentist for years. He had a free look at my teeth. They had pulled teeth out that did not need to be filled, that could have been filled, being my back teeth, so I have no longer any back teeth.*

Two of the teeth they pulled out, they left roots so I still have roots in there and it is still quite painful. The other thing is that I would ring up to make an appointment because I had a hole in my tooth and to get it filled. By the time I got to my appointment in a couple of months, that tooth had deteriorated so much, they had to pull it out. It had fallen out by the time I got my appointment.

I have got to get dentures. I am 25 and I have to get dentures.

I have been on that waiting list for two years and it has just come up now. In the meantime my teeth have just been getting worse and worse. Whereas before I just had to get back teeth, now I have to get front teeth. That is to do with the waiting. Because of having to wait so long, my teeth deteriorated in that time and I was a priority. I

was in pain for a lot of that time. I would stay up nights. I went through scripts of Panadeine Forte. It is just the worst pain you could imagine.....

CHAIR: (Page 44, Paragraph 11: *Each time you had a new tooth giving problems, so you went on a new waiting list basically.*

Ms DAVIES (Public Dental Patient): Yes.

CHAIR: *And each time, for an individual problem?*

Ms DAVIES (Public Dental Patient): Yes.

CHAIR: *Was there ever any treatment or any planning to look at what was going on in your mouth in a general way?*

Ms DAVIES (Public Dental Patient): *No. Just recently, because I am getting the dentures, they have made a plan for me.*

COMMENT FROM APOH: Despite the rhetoric by Dept. of Health Officials regarding implementation of preventive strategies, there is no evidence of a preventive approach used for patients already seen.

This reflects failed understanding by Dept. of Health Officials that dental disease is chronic, and once established, requires life-long treatment. Patients with existing caries, fillings and periodontal

disease, require regular health maintenance so that effective prevention includes high levels of treatment delivery

Further discussion of a lack of proper involvement of treatment as a preventive strategy is illustrated in the transcript below of the Hearing in which the Australian Dental Association presented

The Hon. ROBYN PARKER: Hearing 5th July, Page 57, Second Last Paragraph and going into Page 58 *But with fee for service they go back into the pool and back onto the waiting list after the one-off visit?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Nine times out of 10 you would never see them again. If the patient is a marginally eligible patient and they have a reasonable experience with the oral health fee for service scheme they might ask you what it will cost to fix something else and they may become some sort of regular patient on a part-time basis.*

The Hon. ROBYN PARKER: *So there is no ongoing maintenance of their records then? They do not go back to a pool somewhere; you would keep a record of that patient for that one-off visit? The next dentist they go to has a record of their one-off visit, et cetera?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Yes, that is right. I do not know what the system is at the area health service but they do not ask us to send in a detailed medical record of the patient. The material that goes back to the area health service nominates what was done by item number. In other words, they know which tooth was taken out or which tooth was repaired and how big the repair was.*

CHAIR: *So there is a complete lack of any kind of clinical history for most?*

Mr WILSON (President NSW Aust. Dental Assoc.): *I would say so, yes.....*

CHAIR: *I was just going to say, the impression we got, talking to the Burnside people from the other side of the equation, is that one of their criticisms is you never get to see the same dentist twice. They are talking more perhaps about Sydney experiences that you do not see people twice, although that is not because of choice, but they do not see people twice either and they think it would be better if they did.*

Mr WILSON (President NSW Aust. Dental Assoc.): *That is a criticism that has been levelled at both public sector clinics and health fund clinics for many years because of the turnover of staff, and it goes back to that recruitment and retention issue. When I worked as a public sector dentist, patients used to ask to see the same dentist again, and wherever possible we did it. I could not imagine that would be easy to organise under the current circumstances and from what I see, it is very difficult for them to provide any more than emergency care, so there are not too many return visits.*

Ms HAYES (Hon Treasurer, NSW Dental Assistants Assoc): Hearing August 3rd, Page 8, Paragraph 10.....*Having worked in a practice that participated in the fee-for-service scheme, I know we get people arriving with vouchers that say extract such and such a tooth—no options, no choices no nothing. In private practice the dentist is used to offering best practice dentistry, that is you give your client the options—this is the first option for this tooth, otherwise we can do this or that. In public health I do not have that. Your option is—and they will only pay us for—extracting that tooth. That is a bit of an incongruity in the service there. In private practice I think the dentists struggle with that.*

Mrs WALLACE (RESEARCH OFFICER, NSW DENTAL THERAPISTS ASSOC): Hearing August 3rd, Page 16, Paragraph 8: *We feel that the age group from 18 to 25 is a group that we can have an opportunity to make a difference to. In the public sector, which is where we work, once you get to 18 you have to be seen by the adult services. In adult services in the public sector the waiting lists are unbelievable. You do not get*

preventive treatment. Many patients do not get restorative treatment and there is a focus on relief of pain. The therapists association feels that if we have the opportunity to increase our age range to 25, we could focus on that group.

That group is fairly disadvantaged for many reasons, one of which, of course, is that they have gone into adulthood and there are a lot of things that are available to them, such as fast food, fast living and all sorts of things that relate to dental health and general health. Also, this age group may be attending TAFE, university or doing apprenticeships so their income is very limited. We felt that if we could have the age restriction lifted and we could get private practice rights, this age group could seek treatment from us in the private sector and we could provide it in the public sector, and it could make a very real difference to the dental health of that age group.

Ms FRANKS (President NSW Dental Therapists Assoc): *Children can see us until they turn 18. In terms of dental treatment that then caters for them, it drops off considerably. Whilst they are in the 0 to 18 age group they get a reasonable service. If they are then unlucky enough to be on a low income and move into the public sector adult section of dental services, the only treatment that they can expect at that time is extraction.*

CHAIR: Hearing 16th February, 2006, Page 64, Paragraph 10: *Prior to lunch both Dr Wright and Mr Clout spoke vehemently about the need for a preventive approach and other witnesses have drawn comparisons with the Slip Slop Slap campaign and the anti-smoking campaign. They have said quite strongly that dental decay is preventable and it would make such a difference to so many people if the community could be convinced that that was the case and could learn how to take care. Would your members support that approach and support a complete shift away from the kind of care that you are doing at the moment to the preventative approach?*

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital: *I do not think that is the choice. We would wholeheartedly support preventive dentistry and fluoridation in general is a concept and the profession as a whole has been a driver historically in introducing fluoridation but the reality of the existing disease is still there. There are also issues of immigration where many of the refugees and people coming to our country have significant dental problems and there are significant groups of pathologies in our community who have ongoing and increasing amounts of decay.*

There are certain groups in our society associated with high rates of dental disease and the numbers of those groups are not decreasing. And I do not think you can just throw all the resources, if there are a limited number of dollars, at prevention because the existing pathology—there is still so much of it that needs to be caught up with and addressed.

Senior Health Officials Also Seem Confused In Reference To The Advice That They Have Sought

Ms BRADBURN: Hearing August 3rd, Page 40, Paragraph 9: *What we have found quite interesting with this oral health fee-for-service scheme that was introduced in August last year is that in the documentation it says that the fees were set in consultation with the ADA and the dental prosthetists association. Our name is actually listed in the documentation yet no-one from our association had any dealings with anyone from NSW Health, which is another thing.*

This confusion by senior health administrators is not limited to NSW, but is seen throughout the State and Federal Systems, with No Clear Commitment to improved services expressed in the National Oral Health Plan

CHAIR: *I guess the other issue here is that, in a sense, it is all an argument on paper unless the funding is available to actually pay the salaries of the people who might be attracted to work, if the salaries are adequate.*

Mr KEY: *The national advisory committee up at the top wrote the oral health plan for Australia and then went to the State Health Ministers. Really, it was all very idealistic going through, but without funding, we might as well not have had it. The money is just not there.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are you talking about the oral health scheme?*

Mr KEY: *Yes, or the oral health plan. There is a plan that came from the national advisory committee.*

CHAIR: *Yes, we have a copy.*

Mr KEY: *It is the National Advisory Committee on Oral Health [NACOH]. They formed this national oral health plan and it was to go to all the State Health Ministers to start implementing but, again, if there is no money—*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It is fairyland stuff.*

Mr KEY: *That is right.*

Three Strategies By NSW Health For Oral Health Are Outlined By NSW Health, But None Of These Involve Increased Levels Of Treatment Of Existing Disease

Strategy 1: Oral Health Promotion Projects

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 2, Paragraph 5: *"The New South Wales Government has also demonstrated its leadership in the area of the prevention of dental disease through the Teeth For Life project that has resulted in implementation of a range of oral health promotion strategies,"*

Strategy 2: Fluoridation

(Continuing discussion to bottom of page 2 and up to paragraph 2 Page 3) *"particularly water fluoridation in the mid North Coast of New South Wales since 2002. 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, Bellingen and Moree have now referred the decision on the fluoridation of their water supplies to the director-general. The Director-General of Health, having sought the advice of the Fluoridation of Public Water Supplies Advisory Committee, has directed the above councils to commence fluoridation by November 2005....."*

Strategy 3: Priority Oral Health Program

(Continuing discussion Page 3, Paragraph 2) *"The third component of the New South Wales oral health reforms was the introduction of a priority oral health program in July 2001.*

This provides a more equitable system to assist in assessing patients on the basis of medical and dental needs as well as socioeconomic and other risk factors.

This triage protocol commences from the first contact by the client, requesting access to priority oral health care, and enables the completion of the specifically designed questionnaire that is administered by staff either face-to-face or by telephone."

COMMENT FROM APOH: The "priority oral health program" is a triage protocol and rationing device, largely delivered by non-clinically trained staff over the telephone. It does not deliver increased levels of care and has caused significant concern amongst both clinicians and patients regarding the appropriateness of having non-clinical staff make diagnosis by questionnaire over the telephone.

It is important to note that although the priority oral health program is intended to ensure that patients in acute pain are seen at least within 5 days, that very often the system is unable to keep up with demand and patients may wait with intense dental pain for much longer (10 days is not unusual).

It might also be noted that "triage" is a battle-field strategy for assigning treatment priorities, and generally inappropriate for the

peace-time management of chronic diseases such as caries and periodontitis. Triage includes a category of "beyond help", in which no treatment is offered.

Dental disease is typically chronic (caries and periodontitis), so that proper management involves control of existing disease together with maintaining fillings / periodontal conditions already treated and preventing new disease from occurring. Triage is an inappropriate approach for the control of chronic disease.

An example of where this triage approach is demonstrably inappropriate is provided by the testimony of Ms DAVIES (Public Dental Patient) in the Hearing on July 5th, Page 43 through to 44 (relevant portions marked elsewhere in this analysis), and is also underscored by the further comment below:

Ms TAYLOR (Caseworker, Uniting Care Burnside): Hearing July 5th, Page 44, Paragraph 2: *..... I have worked with numerous young people, through the Macarthur Youth Services, who have had exactly that same experience—of teeth being pulled out that did not need to be pulled out, of comments being made like, "We would prefer to pull it out as opposed to putting a filling in because a filling could come out in a couple of years anyway, so you would have to come back. You would be better off if we pulled it out."*

..... When you call up that line, they will actually say to you, "How much pain do you feel that you are in?" so that they can work out how long they are going to give you before you receive treatment.

CHAIR: *Do you get involved as a worker in perhaps making a judgment or appealing on behalf of someone?*

Ms TAYLOR (Caseworker, Uniting Care Burnside): *I have advocated on behalf of young people before. One of the examples is actually in the submission of a young man I worked with who had a brain injury and who had a lot of pus and gunk coming out of an abscess in his mouth. His entire face was swollen.*

He did not know anything about the community dentist but when I told him, he phoned them up. They said the earliest he could get in, with his level of pain and everything else, was within a month.

I advocated for him and was able to get him in there to a place within the next few days, but he had to travel from where he was living in south-west Sydney down to Bowral to access that service. He needed to be there by eight o'clock in the morning, which is a very difficult thing for someone with his level of disability to do. Then they treated it at that time and it was not suggested to him to have any follow-up checkups or anything after the tooth was pulled out.

CHAIR: *Again, it is treated as one tooth, one place?*

Ms ALLEY (Policy Officer, Uniting Care Burnside): *Yes. We found that across-the-board basically with the people we talked with, both service users and staff. The pain is being treated, but nothing else in the mouth.*

CHAIR: Hearing July 5th, Page 36, Paragraph 4: (With reference to the public dental system) *In terms of preventative care or looking at the client in any holistic way, it is not happening in your experience.*



Ms DAVIES (Public Dental Patient): *No. Six years ago I had a full mouth of teeth and now I think I have eight teeth.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st , Page 11, Paragraph 1: *We should just get on with treating it, in other words?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *If you can get on with treating it and then get them to a level, you can move on to preventive care. While you are treating, you can do some education and preventive work and then we can move on. I think in these small places we have an opportunity to make a really huge difference because there is such a small community. We should be able to get them to a standard and then keep them to that standard. It is about diet, it is about fluoridation, and it is about access to a good dental service.*

Current Identified Priority Areas For NSW Public Dental Health Ignore The Bulk Of Disease In The Majority Of NSW Citizens

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 3, Paragraph 9: *"The key strategies under way as part of our oral health or operational plan are to focus on children, older adults and Aboriginal and Torres Strait Islanders using evidence-based programs for children 0 to 8 and their families....."*

COMMENT FROM APOH: Caries increases by four-fold with onset of adolescence, and the largest increases in disease have been in young and middle-aged adults. None of these groups is identified as requiring priority.

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: Hearing August 31st , Page 2, Paragraph 4:. *I guess the other thing is dentures, which are horrific. The budget I have for dentures has not changed in 7½ years. You take teeth out of people to get them out of pain. By the time you get back to getting them a denture when they get up on the list, their other teeth have worn out and need taking out because they have been overused. There is just a real cycle that goes on.*

and later

..... The amount of money that we have had allocated for dentures would probably make six or seven dentures. So it is really hard in that whole area to prioritise who needs the dentures and who does not. It is quite sad to tell a young girl or a young man who has a front tooth missing that they cannot have the denture because they are not on the priority list.

Waiting Lists In NSW Are Very Long

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing June 29th Page 15, Paragraph 3: *"Could I just ask a last question about waiting lists?"*

A/Prof ZOELLNER (Chairman of APOH): (continued discussion) *"As you know, we have solved the problem of waiting lists in New South Wales by not having them. It is much better now that we do not actually keep track; it is not a problem. "*

The Hon. IAN WEST: (continued discussion) *"Very efficient. "*

A/Prof ZOELLNER (Chairman of APOH): (continued discussion) *"It is very efficient. Numbers are bandied about, which are completely unofficial. I have heard that at Westmead, for example, there might be a waiting list of around 20,000 people. That is an area that actually has a major dental teaching hospital where we have a large number of dentists available to treat those patients.*

In other area health services there is really nowhere to register, I suppose, your concern or your need for treatment, so I suppose the waiting list is totally academic in those areas.

Another figure I have heard used is a statewide waiting list of 160, 000, but I have no way of knowing how real that is. I am only passing on hearsay.

..... The waiting times are going to be very important and they will vary enormously from area to area. As I said, each area health service has its own policy, its own way of doing it. There is a lack of consistency in governance in the area of health across area health services, and so that does cause us some problems."

Mr MOORE (Director NCSS): Hearing July 5th, Page 19, Paragraph 5: *"..... In the Commonwealth's case there is no excuse for it not to implement a more public dental program immediately that targets reducing the massive waiting lists for services. "*

CHAIR: Hearing 5th July, Page 33, Paragraph 3: *The first barrier you mentioned was the cost of private services. Are you talking about people who are eligible for public services but because of access problems, long waiting lists or whatever, seek private dental services instead and that is when the cost becomes an issue?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Particularly in emergency circumstances often the issue is one of cost.*

Ms HARRIS, SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, Hearing August 23rd, Page 44, Paragraph 9: *.....The very long waiting lists at mainstream public dental programs and the high cost of private dental clinics have resulted in many people living without teeth.*

Hearing August 30th, Page 4 Paragraph 5, THOMAS ERIC KENNEDY, Councillor, Broken Hill City Council: *.....this is a problem that has been ongoing for a long time, is the denture program. We have people in Broken Hill who have been on a waiting list for 10 years. A lot of these people actually died before the list had come to their name, yet they still rang up the people to say, "Your time has finally come to be on the list", and have been told that the person is no longer living.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st , Page 8, Paragraph 16: *You have got pretty long waiting lists for the kids as well?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *This is an A4 of the children.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *How long have they been on the waiting list?*

Dr MAYNE: *Since last year when they did the check-ups.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Some of them have been on the waiting list for eight months of this year at least, so they have been honoured for a year?*

Dr MAYNE: *A long time coming, yes.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Obviously, those teeth are rotting away while they are on the list.*

Dr MAYNE: *Yes. The trouble is that a lot of them are very small children and probably with behavioural problems so they will need a general anaesthetic.*

Senior NSW Health Officials Demonstrate A Lack Of Awareness Of The Waiting Times For Routine Dental Treatment As Well As For Emergency Dental Care

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 3, Paragraph 3: ".....*It is our standard that patients in need of emergency care should be seen within 24 hours, while patients reporting less urgent needs are prioritised following a standardised procedure and are registered to have their health condition assessed, in the same way as when people seek a medical appointment.*"

CHAIR: Hearing July 5th, Page 4, Paragraph 1: "*And what sort of waiting time do they normally then find they have?*"

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) "*As I indicated, for those requiring emergency care, our objective is to see those clients within 24 hours.*"

With those who have less urgent conditions, there are alternative standards that apply.

If you have a situation where you have some complaints or pain, it may take perhaps two to five days for your appointment to come, perhaps.

For people who are wishing to access the service in terms of routine assessment and preventive care, the waiting time could be considerably longer."

CHAIR: (continued discussion) "*Such as, for example?*"

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) "*It may be several weeks, or it may be several months."*

COMMENT FROM APOH: Patients in the public system report waiting for years, up to 7 years in one area health service

Comment From APOH: This Contrasts Strongly With The Experience Of People Dependent Upon The Public Dental System As Well As Of Those Who Work In The Area

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing 5th July, Page 41, Paragraphs 8 and 9: ".....*The main ones (Issues) of those are waiting lists and costs.*"

We found that waiting times to access public dental services varied across different parts of the State. For adults, in one regional centre the waiting list was seven years; emergencies were being seen more quickly. In Sydney reports of waiting periods varied from four weeks to two years, and the shorter end probably would have been for emergencies.

So people who are in pain are at least waiting up to a couple of months in pain before they are being treated. There are long waiting periods for dentures. One regional service centre—the same one with the seven-year waiting period—reported that a service user waited for up to three years without teeth for dentures. There have been similar waiting times reported for dentures in Sydney.

For children we found there generally seems to be shorter waiting periods. One service in Sydney has a 10-day waiting period for children who are in pain. We found in one of our regional centres that the situation is very difficult with children of primary school age only being able to be referred from the school dental visit to the clinical service; that is their only way of accessing the clinical service.

Mr MOORE (Director NCOS): Hearing July 5th, Page 19, Paragraph 4: *".....The lack of adequate dental services in New South Wales, especially for low-income households and in several rural areas, has become a tragic feature of health care. The evidence pointing to links between poor oral health and other key health outcomes demands this, let alone the shabby access to service that many now experience.*

Both the Commonwealth and New South Wales governments must get much more involved. In the Commonwealth's case there is no excuse for it not to implement a more public dental program immediately that targets reducing the massive waiting lists for services.

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th, Page 32, Paragraph 7: *The things that have been raised with us are the availability of public dental services, both in relation to waiting lists, distance and transport difficulties.*

So particularly in rural areas, transport difficulties exacerbate the problems. As we understand it the problems that exist across the State—and they have been raised with us in the places that we have been—are long waiting times and the difficulty of getting dental treatment, in particular, emergency dental treatment.

Ms TAYLOR (Caseworker, Uniting Care Burnside): Hearing July 5th, Page 44, Paragraph 2: *..... I have also had comments on those extremely long waiting lists.*

Ms VORASARN (Family Support Worker, Uniting Care Burnside): Hearing 5th of July, Page 46, Paragraph 6: *As to the waiting list, I think Ann was pretty lucky that she was only on the waiting list for dentures for two years.*

Ms DAVIES (Public Dental Patient): *Yes, I was very lucky.*

Ms VORASARN (Family Support Worker, Uniting Care Burnside): *I have one client who has been on the waiting list to get dentures for five years and she still has not got them. Ann is probably one of the lucky few.*

Ms DAVIES (Public Dental Patient): *I am pretty sure that the longer you wait, the more your mouth shrinks. I have a friend who has just got her dentures after seven years. Her face is sunken in and the dentures are making her mouth stick right out.*

I work with children in school holidays and I have just started freelance film-making. You have to get up and talk in front of people. I used to smile a lot. It has been a huge impact on my self-esteem. I have lost heaps and heaps of weight because I cannot eat. There is so much that I cannot eat. I cannot eat hot stuff or cold stuff because of the holes that are left—it hurts. I cannot eat hard stuff—I cannot eat an apple, for example. I do not have the back teeth that everybody uses to chew with. I have to chew with my front teeth. My front teeth are now breaking because they are not designed for chewing everything. Because I am doing that it is now destroying my front teeth.

CHAIR: *Keo, did the client you were talking about have a lot of teeth left? Was that person's need for dentures considered greater than another person's? Was there a priority?*



Ms VORASARN (Family Support Worker, Uniting Care Burnside): *She has only been with the organisation for about a month. We run groups and I have only seen her twice. When Jo went to do the consultation with our service users and we were talking about waiting lists she said—she does not talk much or smile much so you do not really see her teeth but you can see that she is having difficulties talking so she would rather not talk—"I've been on the waiting list for five years and I couldn't be bothered chasing it up; I thought I would just wait and when my time is up, it is up".*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing August 31st , Page 8, Paragraph 16: *You have got pretty long waiting lists for the kids as well?*

Dr MAYNE: Dental Officer, Royal Flying Doctor Service: *This is an A4 of the children.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *How long have they been on the waiting list?*

Dr MAYNE: *Since last year when they did the check-ups.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Some of them have been on the waiting list for eight months of this year at least, so they have been honoured for a year?*

Dr MAYNE: *A long time coming, yes.*

The Chief Dental Officer Is: Based In An Area Health Service, Isolated From Main NSW Offices, And Subordinate To Less Informed NSW Health Officials

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 16th February, 2006, Page 34, Paragraph 6: *Dr Wright, how long have you been in your position?*

FREDRICK ALLAN CLIVE WRIGHT, Chief Dental Officer, NSW Health, North Sydney, Darcy and Institute Streets, Westmead: *I have been in my position since the end of July of last year. So I have just celebrated my first six months.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Who is in the job before you?*

Dr CLIVE WRIGHT: *There was an acting chief dental officer, Dr Peter Hill.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Was he full time?*

Dr CLIVE WRIGHT: *My understanding is he was full time. I would have to defer to—*

Dr ROBINSON: *He was full time.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Who do you report to?*

Dr CLIVE WRIGHT: *I report to the Chief Health Officer and Deputy Director-General of Population Health.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You are based in Westmead?*

Dr CLIVE WRIGHT: *Yes, I am based in Westmead.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you staff from head office or from the area health service?*

Dr CLIVE WRIGHT: *Could you define what you mean?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *How many staff do you have?*

Dr CLIVE WRIGHT: *The staff are associated through the area health service. I am not too certain—*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are they direct reports or are you part of a team at Westmead and more or less a representative of them?*

Dr CLIVE WRIGHT: *The Centre for Oral Health Strategy is a distinct unit within the Westmead area health service, the Sydney West Area Health Service. We are a discrete unit. I report directly to the Chief Health Officer and I have a team that reports to me, but we are administered through the area health service.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *How often do you meet with the people from head office?*

Dr CLIVE WRIGHT: *At least once a week.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Have you met the Minister for Health?*

Dr CLIVE WRIGHT: *Yes.*



The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you liaise with his office as well?*

Dr CLIVE WRIGHT: *I do on a case-by-case basis when required to.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you think dentistry has been neglected in the area?*

Dr CLIVE WRIGHT: *That would be an opinion, sir. I am here—*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Not to give opinions?*

Dr CLIVE WRIGHT: *Just to give the facts.*

Senior NSW Health Officials Perceive No Pressing Need For Change

The Hon. ROBYN PARKER: Hearing July 5th, Page 9, Paragraph 5: *"In an ideal world what would you like New South Wales to adopt from those other States?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (response) *"I think it is fair to say that if we continue to focus on the delivery of acute care services and on fixing up the disease after it has occurred, we are constantly going to have to battle to keep up with demand. We really need to look at a different approach. We need to look at addressing the factors that are causing the problem. It is not much good having your ambulance down the bottom of the cliff when people are just falling over it. So you have to put your barricades up at the top. We need to address, firstly, the issue of fluoridation because we know that gives us a very quick win. It gives us a big decrease in the rate of caries, it makes teeth tougher and it is much more difficult then to get the caries."*

COMMENT FROM APOH: 90% of NSW is already fluoridated, so that increased fluoridation is unlikely to have a great effect on global caries experience

continued response: *"We need to get that education to the mothers and babies, to link in with the maternal and child health services. We need to have oral health partnerships so that maternal and child health nurses can look at the mothers, see what their teeth are like and give them the treatment so they do not then pass on the bugs to the babies which in turn gives the babies the problems and they have bad teeth by the time they get to school. We must look at the issue of diet and nutrition, in particular, the sugars that our kids are consuming—Coca-Cola, Pepsi, carbonated drinks and acidic drinks in particular. We are creating an environment in their mouths which means that their teeth are going to be subject to decay. We need to change our orientation."*

COMMENT FROM APOH: These preventive initiatives are laudable and currently unresourced, but although having the potential for long term benefit, fail to manage the current and growing disease load of a largely dentate and ageing population.

It is important to appreciate that once a tooth is filled, it must be regularly re-filled to maintain the filling.

There is no mention of increased services to address treatment needs and the model outlined by Dr Robinson foreshadows no real change.

Mr CLOUT (CEO Hunter New England Area Health): (Continued Discussion) *"I wish to add to that. I think we look very broadly for best practice and for things that will work. We do not just look in other States; we look internationally. We are picking up and doing things that are being done in other States and other places. We are looking at them and saying, "We are not doing that. We need to pick it up." A good example of that is the Oral Health Fee for Service Program. We said, "There are work force shortages. We have 83 per cent of dentists and dental services being provided in the private sector. We have problems in rural areas. How do we overcome it?" So we have a mixed model where there is fee for service. We ask private practitioners to pick up work to complement the work that we are doing specifically in the public sector. Having said that, there are things that we are doing that other States are picking up."*

COMMENT FROM APOH: The Oral Health Fee for Service Program is recognized as patchy and estimated as 4 times more expensive than service within the public system

"The Information System for Oral Health Program has been picked up by quite a number of other places. Queensland is picking up that program and it is running with it. "

COMMENT FROM APOH: The ISOH System is simply a data-bank recording treatment delivered in the public system. It does not provide increased services

"Your question referred to what I would like in an ideal world. I think the program we have at the moment is the right program. I support it strongly. I have no problem with saying to 50 per cent of the population of New South Wales who are eligible under our open criteria—I could be wrong on that percentage, but it is pretty close to that—that the triaging and prioritising system we have in place means that people who have an urgent need get it first. We put money into prevention, assessment, health promotion and education. We see that as the main longer-term solution. It is strongly supported and the only way to go. We then say to others who are covered by that criterion, "For less urgent work there is a waiting time." I strongly support that model. I think it is the right model. It is no different from the model that we use anywhere else. Issues of policy above and beyond that are different issues. I think they are issues for people like you to deal with rather than for people like us. But the general strategy that is being put together by looking interstate and internationally, picking the eyes out of it and seeing what will work, I think is the right strategy. In a best possible world I would like us to put a little more effort into finding solutions to the inexorably difficult issue of how one provides health services in general and, specifically, oral health services, to rural and remote communities. I have worked in those communities in senior positions for a long time now. I am loath to be critical because I have not been able to find solutions to some of those issues. They are longer term, significant and social issues for which we have to continue to strive to find solutions. But I think the model is the right model. In an ideal world I would like to see it continued for a long period."

COMMENT FROM APOH: Mr Clout believes that despite the widespread concern, in an ideal world, he would like to see things continue as they are for a long period.

DENISE MARGARET ROBINSON, Chief Health Officer, NSW Health, 73 Miller Street, North Sydney, Hearing 16th February, 2006, Page 39, Second Last Paragraph: *The issue that we are grappling with is the concept that, because of our generosity, we are therefore expending less per head of eligible population. That has been stated in a number of places. It does not accurately reflect the commitment that New South Wales Health has given to the provision of public dental services and the increased amounts of money we have continued to place in the program. As I believe we have mentioned previously, this financial year we are spending \$120 million on public dental services, which has increased substantially over time. Therefore, I believe that the Government and the department have fully expressed their commitment to the provision of public dental services.*

Comment From APOH: This Contrasts Strongly With The Opinion Of Others Concerned With Oral Health As Well As The Experience Of Patients In The Public System

Mr MOORE (Director NCOSS): Hearing July 5th, Page 19, Paragraph 4: *".....The lack of adequate dental services in New South Wales, especially for low-income households and in several rural areas, has become a tragic feature of health care. In our submission to this inquiry we are proposing measures that would address both the critical short-term problems faced by consumers and also some of the longer-term*

sustainability issues that must be resolved if we are to have adequate and quality dental services available to all in the future. The evidence pointing to links between poor oral health and other key health outcomes demands this, let alone the shabby access to service that many now experience.

Both the Commonwealth and New South Wales governments must get much more involved. In the Commonwealth's case there is no excuse for it not to implement a more public dental program immediately that targets reducing the massive waiting lists for services.

In the longer term, dental health as a primary health care service must be funded by Medicare. The New South Wales Government must firmly grapple with providing better opportunities and incentives for dentists to practise in disadvantaged and rural communities and both levels of government, in our view, must tackle the skills shortage and looming crisis in dental practitioners."

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): Hearing, July 5th, Page 32, Paragraph 7: *The things that have been raised with us are the cost of private dentistry and the availability of public dental services, both in relation to waiting lists, distance and transport difficulties. So particularly in rural areas, transport difficulties exacerbate the problems. As we understand it the problems that exist across the State—and they have been raised with us in the places that we have been—are long waiting times and the difficulty of getting dental treatment, in particular, emergency dental treatment. Some of the consequences of that are that older people, and particularly low income older people, choose not to pursue dental treatment. That exacerbates their oral health problems. Oral health being one of the key determinants of primary general health, the consequences of poor oral health show up in the general health of an older person. So there can be quite serious complications and flow-on effects.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): Hearing July 5th, Page 47, Paragraph 2: In our submission we give an example of someone who did not have an interpreter and ended up having quite a number of teeth removed because they did not understand what they were saying yes to. It is not appropriate—and it is against the guidelines—to be utilising family members as interpreters.

COMMENT FROM APOH: A lack of adequate consent for treatment due to lack of translators could be a significant frequent problem requiring action

The Hon. IAN WEST: Hearing July 5th, Page 49, Paragraph 13: *Did you indicate earlier that a number of your peers and friends have had similar difficulties?*

Ms DAVIES (Public Dental Patient): *Yes. I know a lot of people who cannot afford the dental system. I know many people who walk around holding their jaws because they have toothache. Quite a few of my friends have had abscesses and their faces have swollen up. About three weeks ago my friend's eye would not open because the whole side of her face was so swollen. I work a lot with groups of disadvantaged people. The people that I know in those groups cannot afford—as I cannot afford—to go to a private dentist. Once your front teeth start going it really affects yourself esteem. So I know a lot of people who cannot afford it.*

The Hon. IAN WEST: *And they cannot afford health insurance?*

Ms DAVIES (Public Dental Patient): *No.*

The Hon. IAN WEST: *It is out of the question?*

Ms DAVIES (Public Dental Patient): *Yes.*

A Formal Submission From NSW Health Was Not Made In Time For The Commencement Of The Dental Inquiry

The Hon. ROBYN PARKER: Hearing July 5th, Page 1, Paragraph 4: *"Madam Chair, may I ask how long Dr Robinson's opening statement will be? I am aware we have not received a submission from the department. This seems to be like a submission that is taking up our time for questions."*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"I have another page, but I am happy to defer to the Committee. A submission is in preparation and we have been given an extension to 31 July. We aim to have it to you before that time."*

The Hon. ROBYN PARKER: (continued discussion) *"Why is it so late?"*

The Hon. ROBYN PARKER: Hearing 5th of July, Page 6, Paragraph 2: *"Dr Robinson, can you explain why we do not have a submission from the department?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"A submission is nearing finalisation. It is our intention to get it to you as soon as possible. We did seek an extension sometime back and we were advised that it would be acceptable to have a submission to you by 31 July."*

The Hon. ROBYN PARKER: (continued discussion) *"Why did you need an extension of time? Why was the department not able to present a submission to this inquiry on time?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"We were originally advised that the inquiry was going to be held somewhat later in the year so we had not commenced our preparation. But, as I said, it is nearing finalisation and will be with you very shortly."*

The Hon. ROBYN PARKER: (continued discussion) *"Who advised you that the inquiry was going to be later in the year?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"I am sorry, I cannot give you the specifics on that. That was just my understanding. "*

The Hon. ROBYN PARKER: (continued discussion) *"Nevertheless, other groups have been able to put— (comment by Chair) —submissions in on time— (comment by Chair) —and the department has not been able to— (comment by Chair) —which is pretty poor, I would have thought— (comment by Chair) —from a department that is leading on health and funds health in New South Wales, and dental health in particular. "*

Numerous Reasons Are Offered For Past And Future Inaction In Implementation Of Improved Dental Services

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): Hearing July 5th, Page 3, Paragraph 8: *"..... oral health work force issues which are clearly a national issue in Australia and we accept that there is a co-ordinated effort required by each jurisdiction..... "*

COMMENT FROM APOH: There seems little or no evidence of effort to coordinate activities across State jurisdictions to address workforce. It is implied that little can be done without waiting for other States to act in concert.

Mr CLOUT (CEO Hunter New England Area Health): Hearing July 5th, Page 9 Last Paragraph and onto Page 10 *""Your question referred to what I would like in an ideal world. I think the program we have at the moment is the right program. I support it strongly." I strongly support that model. I think it is the right model. But I think the model is the right model. In an ideal world I would like to see it continued for a long period."*

COMMENT FROM APOH: Mr Clout believes that despite the widespread concern, in an idea world, he would like to see things continue as they are for a long period.

The Hon. ROBYN PARKER: *"When you talk about the Commonwealth funding—and a number of people have made the same comment that funding public oral health would improve the situation—how does that sit with a lack of funding provided by the New South Wales Government compared to other States in Australia?"*

Ms EDMUNDS (Sen. Policy Officer NCOS): *"We do not want to see it become, well, the Commonwealth should deal with it, therefore it is not a State responsibility. We still argue and believe that the State should take better responsibility and put more funding into oral health and recognise its im portance in the general health. "*

However, at the same time there used to be a Commonwealth Dental Health Program. It was reasonably effective when it was implemented, so there is a requirement for the Commonwealth to have that responsibility as well. I guess our ultimate goal would be to see Commonwealth responsibility. However, that does not mean that the State does not have a responsibility at this point in time."

The Hon. ROBYN PARKER: *"Does the Constitution of Australia put dental health care as the Federal responsibility?"*

Ms EDMUNDS (Sen. Policy Officer NCOS): *"It does. It is in the constitution."*

COMMENT FROM APOH: There is a long standing tendency for State and Commonwealth Governments to discard responsibilities on the basis that it is the role of the respectively opposite partner of

government. This is further reflected in the discussion immediately below:

The Hon. ROBYN PARKER: Hearing July 5th, Page 22, Last Paragraph and going onto Page 23: *Have you made submissions to the New South Wales Government about the level of funding for public dental care?*

Mr MOORE (Director NCOS): *We have in each year in our prebudget submission.*

The Hon. ROBYN PARKER: *What has the response been?*

Mr MOORE (Director NCOS): *I think it would be fair to say, "It's the Commonwealth's responsibility."*

The Hon. ROBYN PARKER: *That has been the response from the State Government—that it is the Commonwealth's responsibility?*

Mr MOORE (Director NCOS): *Yes.*

The Hon. ROBYN PARKER: *What is their response when you write submissions about the level of funding for other health care provisions?*

Mr MOORE (Director NCOS): *I am trying to think in other areas, no, we haven't got enough money.*

The Hon. ROBYN PARKER: *Have you had a written response from the New South Wales Government stating that it is a Commonwealth responsibility?*

Mr MOORE (Director NCOS): *I think we did originally a couple of years ago when we were first raising this issue. NCOS has been raising this for a very long time as others appearing before you have said.*

COMMENT FROM APOH: Similarly, the State-Commonwealth Issue Is Noted By Others:

The Hon. ROBYN PARKER: Hearing, July 5th, Page 38, 4th last Paragraph: *Are many of the problems as a result of lack of funding and resources?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *Funding is always a difficulty. As we said in our submission, we do note that the Commonwealth does have constitutional responsibility. Of course, the Commonwealth program was in place for a number of years. Personally, I think it is very sad that things fall between the two levels of government.*

We have these endless arguments over who should fund what. I would dearly love to see the present discussions that the Council of Australian Governments has initiated about what I understand is the delineation—it is a lovely word, isn't it—of responsibilities between Commonwealth and State in Health. I would like to see it pick up some of these issues.

CHAIR: *As far as you know, dental issues are not included in those discussions?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *I have not heard it mentioned.*

CHAIR: *We should check. So if the Commonwealth takes over all the hospitals you would like it to take over the dental services as well?*

Mrs BARR (Chair, Ministerial Advisory Council on Ageing, NSW): *I live in hope that the levels of government in this country will learn to work together for the benefit of the community.*

The Hon. ROBYN PARKER: Hearing July 5th, Page 21, Paragraph 6: *Was that Commonwealth program designed as a long-term program or was it a short-term program to alleviate the fact that the States in Australia had failed to deliver public dental care and the waiting lists were enormous?"*

Ms EDMUNDS (Sen. Policy Officer NCOSS): *I cannot tell you. I do not know if Garry has an understanding of where it actually started from. I know that it was successful while it was implemented. I know the attitude seemed to be, well, we have dropped the waiting lists, we do not need it anymore, which ignores the ongoing oral health needs and changing oral health needs. I guess it would be saying, "Okay, we have treated everybody with measles so we don't need to run a measles program anymore." That ignores the fact that all these illnesses will continue to crop up."*

The Hon. ROBYN PARKER: *Was it because once the GST was introduced the States got increased funding and therefore should be able to provide better care?*

Mr MOORE (Director NCOSS): *"Can I say to you that the Commonwealth knocked over this program in 1996- 97, the GST deal was 2000 plus—"*

The Hon. ROBYN PARKER: *"Was the program designed to finish at that point though? "*

Mr MOORE (Director NCOSS): *I think the argument was that it was about to see what impact it would have on the existing level of waiting lists or not, and the decision about whether or not it was to be continued was to be taken in light of that. It never reduced the total waiting lists. As Sam said, it certainly made a difference. I guess the point I would come back to is: had Medicare been paying for this as a general primary health care provision we would not be having this discussion.*

COMMENT FROM APOH: Withdrawal of the Commonwealth Dental Program is often cited as the cause of NSW difficulties

CHAIR: Hearing July 5th, Page 58, Paragraph 9: *Would it not be better to scrap the whole system and put dental services under Medicare so that you did not have to have the sort of struggle in the public system and the kind of half-privatised vouchers and then a private system?*

Mr WILSON (President NSW Aust. Dental Assoc.):

a) The problem with that is, I think I mentioned before in answer to an earlier question that part of dental disease is controllable, to a degree, by the patient; it depends on the patient's choices and the patient's lifestyle and so forth and how much they are prepared to take responsibility for looking after themselves.

b) The investigations of putting the industry under Medicare that have been done in the past have certainly come to the conclusion that that would be an extremely expensive thing for any government to do and there would be some question as to whether the taxpayer would be prepared to fund it to that degree.

CHAIR: *What about the view of the dental association? In the past dentists have opposed the idea. Is that still your position?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Yes, it would be for those reasons more than anything. We just do not think it would be supportable. We put a submission in to the Senate select committee in 2003 about exactly that issue. So it is still policy for it not to be included under Medicare.*

c) It would be an administrative nightmare; it would be very difficult to run. Part of the criticism of DVA, for instance, is that the cost of administration is quite significant on both sides of the fence, both from the department's side of things and also from the practising dentists' side of things. The form filling out and submitting and all of that sort of thing is costly for us, it is costly for them to do and a scheme like Medicare

will do that, but I think it would be a pretty brave fiscal move for any government to include us under Medicare. And I think you are not going to do that from a State point of view anyway, are you?

COMMENT FROM APOH: It is important to recognize that the ADA has traditionally stood against inclusion of dentistry in Medibank/Medicare, likely in the same way that the Medical profession also opposed this initiative at the time Medicbank was introduced.

The three reasons (a,b,c) indicated by Mr Wilson above should be viewed in context of the following points:

a) The fact that dental disease is largely preventable does not explain exclusion from medicare. If the same criteria were applied to heart disease and diabetes, for example, neither of these two mostly preventable diseases would be included in medicare.

b) Medicare expenses for dental treatment could be readily contained if limited (at least in the first instance) to caries control, preventive treatment and relief of pain including extraction and root canal therapy. In addition, there would be savings in medicare by patients going directly to dentists for treatment instead of inappropriately obtaining antibiotics and pain-killers from medical practitioners for dental infections.

c) Administration of dental medicare would be no more difficult than for medicine and could be stream-lined if need be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hearing 16th February, 2006, Page 7, Paragraph 1: *Can you comment on the responsibility of Federal and State governments? That is question four.*

ANDREW JOHN SPENCER (Professor of Social and Preventive Dentistry and Director of the Australian Research Centre for Population Oral Health, University of Adelaide): Hearing 16th February, 2006, Page 7, Paragraph 1: *I will add the end of the question, which says, "with respect to funding". I will start with some comments about the funding. Historically, States and Territories have been the providers of hospital services, and the public sector provision of dental services was a component of that model of hospital services at each State and Territory level. In fact, in a number of States and Territories the dental services were departments of major public hospitals. That was their origin. The Commonwealth Government until the referendum of 1946 did not have any health powers as such. But the referendum, which was passed, and the constitutional amendment in 1946 opened the door for the Commonwealth to be involved in the provision of hospital benefits, medical and dental services. So the constitutional power that enables the Commonwealth, or the Federal Government, to be involved in the direct provision or the subsidising of medical services also exists for them to be involved in those areas in dental services.*

There has also been a second power under which the Commonwealth can be involved in the provision of dental services, and that is in the grants power. The Commonwealth can grant moneys to the States and Territories along the terms and conditions that it might stipulate. We have seen that twice in the last 30 years in the area of dental services. We saw it with regard to the development of the school dental service, initially under a Labor government but continued for six years under a Coalition government. We have seen it more recently in the Commonwealth dental health program in the early 1990s. So there are at least constitutionally two different avenues through which the Commonwealth may choose, if it wishes, to be involved in the funding of dental services in a more direct way.

Historically, the service provision has been a State responsibility. That seems to be where we are sitting right now. But we have seen the Commonwealth, or the Federal Government, engage in areas that were previously regarded as a State responsibility to provide services. We have seen the Commonwealth engage in those in numerous other areas of health and welfare, aged care and disability services. I would suggest



that the recent COAG arrangements with regard to mental health are all examples of where these sorts of decisions can change.

Committee Members Expressed Surprise And Or Shock At The Testimony Offered By Witnesses

The Hon Ian West: Hearing June 29th, Page 9, Paragraph 7 (With regard to the low wages of dental academics and under-funding of dental training) *"Can you not just ask for more money?"*

A/Prof ZOELLNER (Chairman of APOH) (in response), *" Well, yes, we have. But strangely enough, it has not worked..."*

The Hon Robyn Parker: Hearing June 29th, Page 9, Last Paragraph: (With reference to dental service, health and academic infrastructure) *"The whole thing is quite alarming. It is certainly an eye-opener already, and we are only at the beginning of this inquiry Obviously, dentistry is lagging way behind in terms of other health services, and they are probably lagging behind in terms of other States as well"*

CHAIR: Hearing 5th July, Page 15, Paragraph 2: *"Why is the only university in New South Wales that trains dentists training fewer dentists than it used to?"*

Dr ROBINSON (Chief Health Officer / Dir.Gen. Popn Health/ NSW Health): (continued discussion) *"I am afraid that is not a question that I am in a position to an answer."*

CHAIR: (continued discussion) *"We do not seem to be able to find anyone who can answer that question."*

CHAIR: Hearing 5th July, Paragraph 5: *It is a pretty grim picture that you have painted of what your clients tell you.*

Ms ALLEY (Policy Officer, Uniting Care Burnside): *That is right. It was not much fun doing the consultations, actually.*

Ms DAVIES (Public Dental Patient): Hearing July 5th, Page 43, Second last Paragraph and onto Page 44 *.....Just recently, because I am getting the dentures, they have made a plan for me. " But originally, they would just look at the one that was hurting and do that too. Then I would say, "Well, this one is bad", and he or she—the dentist—would say, "Well, you have to leave. Ring up the referral line and make a whole new appointment for that too."*

The Hon. ROBYN PARKER: *That is ridiculous.*

Ms DAVIES (Public Dental Patient): *Even he could see that this one needed to be done, right then and there, but they would only do the one tooth. I could not even make the appointment there. I had to leave, ring the referral line and make a whole new appointment, and that could be a couple of months.*

Ms TAYLOR (Caseworker, Uniting Care Burnside): *Ann's situation actually is not an exception. ...*

The Hon. ROBYN PARKER: Hearing July 5th, Page 59, Paragraph 11: *In terms of the funding, and specifically State funding, given that New South Wales is the lowest of any State or Territory, what representations has your association made to the State Government about that very issue, if any?*

Mr WILSON (President NSW Aust. Dental Assoc.): *I would say up until this year we have had very little effect on getting to talk to the State Government about funding for dental services. We have made several approaches over the years about the problems of the public sector dental scheme but generally no one was interested in listening. So we are really glad to see this inquiry happening.*

The Hon. ROBYN PARKER: *But you are a peak organisation. You are the dental association for New South Wales. You telling me that the department and the Minister are not in communication with you and are not responding to your concerns?*

Mr WILSON (President NSW Aust. Dental Assoc.): *Until recently I think that is probably a fair summation of what has been happening for the last five years.*

The Hon. ROBYN PARKER: *Your members must be outraged by that.*

Mr WILSON (President NSW Aust. Dental Assoc.): *I think their dealings with the Government have generally desensitised them to that.*

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health, Hearing August 23rd, Page 30, Paragraph 18: *.....When you look at the disease that is waiting to be treated I do not think we should be worried about how much orthodontic care we get.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Are you saying that orthodontics is not very important?*

Ms OSBORNE: *I am saying that if you have people waiting and losing their teeth the money could be prioritised.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *It does not matter at what angle their teeth might be sticking out; as long as they are not rotten it is fine. Is that not what you are really saying to me in a rather polite way?*

Ms OSBORNE: *No. I think if they had severity they would be seen. There are different degrees of severity of orthodontic care. All the degrees of severity are eligible for treatment here. You can have someone with a traumatic bite, biting into the palate and stripping the palate—that is probably one of the worst—and he or she cannot eat. I am saying that that person would be a priority. We should have a service for that person. But for somebody who just feels that they want teeth like Kylie, then no.*

Hearing August 23rd, Page 43, Paragraph 5: The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *I have done medicals on people who were about to get their first job for a long time. When I looked into a mouth full of cavities I would say, "I think you should spend your first pay check on a dentist." Each person would respond, "No way, mate." So do you think that is realistic?*

Ms OSBORNE, Area Manager, Oral Health, North Coast Area Health: *I do think that is realistic. I think that you are reviewing a service that is not coping. If we continue to say, "Okay, give me \$4.6 million next year", I will not be able to do it. I cannot provide it.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You are simply finding ways of cutting your clientele, are you not?*

Ms OSBORNE: *Yes.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You are not looking at the needs of the people. Your point of view is, "If I have this much butter, how many bids bits of bread can I spread?"*

Ms OSBORNE: *Is that not what it is about?*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *No, I would not have thought so.*

Ms OSBORNE: *Within the range of things that need reviewing I think that is one of the things that needs reviewing.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *So the shortage of public dental services should be treated by restricting eligibility for them?*

Ms OSBORNE: *Because you have a work force that will not cope. All the people going onto pension cards now will all have their own teeth. John Spencer is now looking at a ratio of teeth per dentist, which we have never done in the past—we have always looked at people. We are saying that the work force will not cope with the amount of people that we have got to see. It is projected not to cope.*

CHAIR: *You are saying that if the work force is going to stay the same, or the budget is going to stay the same—*

Ms OSBORNE: *We have every indication that our budget will not increase.*

CHAIR: *Would it be better to increase the budget rather than to increase the work force?*

Ms OSBORNE: *You could look at eligibility. If you do not it just means that the people who put their names down to have a check up will just have their services stopped. We will not see them. Somewhere along the line we have to be honest in what we can provide.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *You are going very well but you are not coping now and you will not be able to cope in future unless you cut eligibility?*

Ms OSBORNE: *Who said I was going well?*

Dr MAYNE: *Dental Officer, Royal Flying Doctor Service: Hearing August 31st , Page 4, Paragraph 7: I am doing that on the days I would be doing my administrative work. I guess I am just getting more organised and getting my administrative work out of the way in half a day. I fly basically four days a week and have one day to do the administrative work and order in the stock and all that sort of thing.*

CHAIR: *You do not have any staff to do any of that?*

Dr MAYNE: *No.*

CHAIR: *So the flying doctor service does not provide the basic kind of administrative services for you?*

Dr MAYNE: *With regards to dental, I do it all.*

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: *Do you need to do that? Could someone else do that for you if there was someone else?*

Dr MAYNE: *I think ordering dental things is very difficult if you do not know what you are doing. I have been doing it long enough that it is not too hard. I do not have a dental assistant because I set up a student program. Because we are flying, to have a dental assistant and a student takes up too many seats on the plane.*

Appendix:

APOH Review of the Oral Health Fee For Service Scheme and Discussion of the Possible Introduction of Co-Payments

Review of the NSW Oral Health Fee For Service Scheme And Discussion Of The Possible Introduction of Co-Payments

Executive Summary:

The Current Oral Health Fee For Service Scheme (OHFFSS)

- Low wages compared with private practice and a lack of appropriate award for prosthetists has resulted in failure by NSW Health to recruit and retain enough dental clinicians
- There has been a consequent blow-out in the dental waiting list (*increased from 160,000 to 215,000 from 2004-2005*) and failed emergency services
- The Oral Health Fee For Service Scheme (OHFFSS) has been operating as an emergency measure to manage acute service deficiencies
- The OHFFSS is very expensive, so that service delivered in this way costs about four times more than treatment within the public system.

APOH Recommends A More Cost-Effective Alternative To The (OHFFSS)

- Improvement of recruitment and retention of dental clinicians by:
 - An immediate increase in public dentist salaries by 30%
 - Introduction of an internship period for dental graduates
 - Establishment of an award for dental prosthetists
- APOH estimates a \$ 9.3M saving if the OHFFSS were replaced by these measures
- This would also greatly reduce waiting lists and improve emergency dental services

Co-Payments Have Been Discussed As A Possible Source Of Funding

- Co-payments would increase funding by only 20%, leaving dental services still under-funded, and representing an unfair cost-shift by a State with the lowest per-capita dental funding in Australia
- Co-payments for dental services would be inconsistent with the wider health system, and if introduced would require numerous exemptions
- Co-payments undermine social equity, and would likely increase dental disease in the most destitute, with only the slightly better-off public patients being able to afford public dental service

(APOH can be contacted through the Chairman, A/Prof H Zoellner: hzoellne@mail.usyd.edu.au)

The Oral Health Fee For Service Scheme

Failed Recruitment and Retention: Basis For the Oral Health Fee For Service Scheme

The severe problems in recruitment and retention of dentists and prosthetists created by the low wages in NSW Health relative to the private sector have made it impossible to treat public dental patients in a timely manner.

With between 60 and 70 positions for dentists in NSW Health chronically unfilled, and only seven prosthetists working for NSW Health, very often the only option for management of acute dental pain or the preparation of dentures has been for NSW Health to issue "vouchers" in the Oral Health Fee For Service Scheme (OHFFSS). Patients must then independently seek a private dentist or prosthetist prepared to deliver the acutely needed service. This emergency measure inevitably delays treatment, but does at least offer some hope of relief to patients who would otherwise receive no treatment at all.

The High Cost of The Oral Health Fee For Service Scheme

APOH has estimated that the direct cost to NSW Health of dental services delivered through the OHFFSS is approximately four times higher as compared with the cost of delivering the same service within the public system by public dentists.

In view of the fact that on a per capita basis, NSW spends less than any other Australian State on public dentistry, and about half that of Queensland and the Northern Territory, the OHFFSS is wasteful of the very limited available monies. If mechanisms could be found for simply employing more dentists and prosthetists, then much more service could be provided for the same or even less expense.

APOH Proposes A More Cost-Effective Alternative – Wages And Awards

APOH strongly recommends an immediate 30% increase in salary for dentists, as well as introduction of an internship period for all graduating dentists.

These measures, together with improved opportunities for professional development within the public system, are suggested as sufficient to greatly improve recruitment and retention of dentists.

Also, prosthetists currently have no award within the NSW Health system, and this is a significant barrier to the full utilization of prosthetist services by NSW Health. APOH also recommends introduction of a State award for prosthetists competitive with prosthetist wages in the private sector.

APOH believes that introduction of these measures would result in a substantial increase in service capacity by NSW Health, and that this would obviate the need for the OHFFSS in all but the most unusual circumstances.

On the basis of the figures provided by Minister Hatzistergos to the NSW Legislative Council on the 12th of October 2005, approximately \$21.5 M were spent on vouchers in 2004-2005, representing about 20% of the total budget and slightly more than salaries for dentists (\$20,325,500 in 2004-2005).

APOH estimates that an increase in dentist salary by 30%, together with introduction of an internship, would increase in the number of NSW public dentists from 240 to a total of 300. This would raise the total NSW public dentist salary cost to \$32.5 M and represent a saving of approximately \$9.3M compared with the OHFFSS whilst reducing waiting lists and delivering much more timely service to patients needing acute care.

Co-Payments As A Possible Source of Funding

It has been suggested that co-payment by patients for public dental services might provide much needed additional resources, while a precedent has been established for this in other States. With regard to a review of the OHFFSS, co-payments have been suggested as a mechanism for reducing reliance on this scheme for urgent service.

Points in Favour of Co-Payments And Limitations On These

20% Increase In Funding By The Most Destitute: - An Unfair Cost-Shift?

It becomes important to consider the potential income from co-payments in comparison with the potential disadvantages.

On the basis of the following assumptions in line with arrangements in other States: Assuming co-payments for dentures are set at \$200; Co-payments for other services would be \$25 per visit with a cap of \$100, the average number of appointments being 4 appointments per patient; Child and emergency service would be exempt; The figures provided by Health Minister Hatzistergos to the NSW Legislative Council on the 12th of October 2005 are accurate: APOH estimates that the total income from co-payments would be about \$24.9 M. Some costs would be incurred in collecting these funds, estimated at about \$1.7M, so that co-payments would increase funding for dental services by about 20%.

However, if the NSW government used this as a principal mechanism to improve funding of dental services, it would still leave public dental funding in NSW significantly behind that in other States, where comparable co-payments are charged but where State governments still invest up to twice as much money per capita over and above funding from co-payments.

It would seem extremely unfair, for the NSW Government to uniquely shift a significant proportion of the cost of public dental service onto the public patients least able to afford it, whilst failing to meet the norms established at a National level in other States.

It must be asked if a modest increase of 20% in funding is a reasonable gain relative to the under-investment by State Government and the potential disadvantages of co-payments.

Funding From Co-Payments Will Be Ineffective Unless Properly Re-Invested

Although there may be some merit in seeking mechanisms for better funding dental services and potentially reducing waiting times, it is clear that this would only happen if the monies generated were used to improve recruitment and retention of dentists and prosthetists. A clear commitment to use of the incoming funds from co-payments in this way would be important before implementation of such co-payments.

Would Personal Payments Increase Patient Compliance For Prevention?

Also, it has been suggested that by making personal financial investment in routine dental service, patients may develop a more serious commitment to preventing dental disease through improved oral hygiene.

Again, there may be some truth in this, however, it must also be noted that patient adherence to preventive measures appears largely independent of the money spent by patients. This is particularly evident in private dental practice, where patients often fail to respond to preventive dental educational advice despite bearing the full cost of treatment.

Points Against The Introduction of Co-Payments

Co-Payments Are Inconsistent With Other Health Services

The principles and practice of treating dental disease are in every respect identical to those for treatment of other parts of the body. APOH believes that the current barriers between dental and medical services are both artificial and destructive, while APOH is committed to closer integration of oral health with the wider health team.

APOH does not accept that public patients with infection, trauma, deformity or other disorder of the mouth should be uniquely financially disadvantaged relative to patients with disorders of other body parts. This is particularly so for patients with complex medical problems and other special needs who require regular and high quality dental services. Aged patients, more often dependent upon the public system for a wide range of health services, would be specifically disadvantaged relative to many other groups in the community.

Co-payments for dental services in the absence of similar co-payments for other medical services would work opposite to the cultural and structural changes necessary for long-term improvement of community oral health.

Social Equity Is Eroded By Co-Payments

The underlying question of social equity must be considered with regard to co-payments by the most impoverished, seeking dental service in the public system.

Although a modest \$25 co-payment per service may at first glance not seem substantial, for many of those seeking public dental services this may constitute over 10% of available funds. Single people living on an unemployment allowance, for example, may find it difficult to budget the necessary \$25 for dental treatment, particularly since NCOSS has demonstrated that their income falls well short of actual living expenses. Should co-payments be introduced, a means test to protect the most destitute would be important.

It seems likely, that one effect of introduction of co-payments would be that the most desperately poor will avoid treatment, and that instead the slightly better off will become the principal users of public dental services.

The Need For Exemption From Co-Payments

In addition to patients who should be exempt from co-payments on the basis of means testing, APOH suggests that children should also be exempt. This is because of the importance of preventive services in children for the future oral health of the community. Similarly, consistent with the spirit of publicly available emergency health care in the hospital system, exemption from co-payment would seem reasonable in cases where emergency dental services are provided.

Co-Payments As a False Economy

Experience elsewhere is that co-payments reduce the up-take of services by patients coming-off waiting lists, and that this is accompanied by increased dental disease due to a reduction in prevention and maintenance. Co-payments thus appear to represent a false economy, with the advantage of increased income and reduced initial costs being later overwhelmed by the disadvantage of higher emergency and management expenses.