REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO DENTAL SERVICES IN NEW SOUTH WALES

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At Sydney on Wednesday 3 August 2005

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The Committee met at 2.00 p.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. K. F. Griffin
The Hon. C. J. S. Lynn

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

BARBARA HAYES, Honorary Treasurer, New South Wales Dental Assistants Association, 497 Mowbray Road, Lane Cove, sworn and examined:

CHAIR: In what capacity are you appearing before the Committee?

Ms VERN-BARNETT: As Honorary Secretary of the New South Wales Dental Assistants Association.

Ms HAYES: As Honorary Treasurer of the New South Wales Dental Assistants Association.

CHAIR: Would either of you like to say anything by way of opening, before we get to the questions that we have prepared?

Ms VERN-BARNETT: Just briefly, if I may. Our submission was restricted to the one particular topic, the workforce issue. As far as I am concerned personally, I have been involved with the association since 1975, which is probably too long. I also have some knowledge, and I suppose opinions, of how things are done in the public health service, having worked occasionally as locum in a public health service and in a dental department, because my husband happened to be in charge of and involved with the dental clinic at the Royal North Shore Hospital for about 40 years. Most of the evidence that both Barbara and I have is hearsay, so we are probably cannot give the Committee many figures in any way, shape or form. The answer that we will give are from our years of experience, rather than from anything factual that I could help the Committee with. We may not be able to answer some of the questions on the list with which we have presented.

CHAIR: It may be helpful if could answer them in part, and if you could get further information for the Committee you could come back to us with that. Barbara, did you want to say anything before we start?

Ms HAYES: No. I think Kathy has covered our opening comments.

CHAIR: Could you tell us about the role of your association, criteria for membership, your membership in rural and regional areas, whether you have a code of conduct, and whether you have a complaint or discipline functional at all?

Ms VERN-BARNETT: The Dental Assistants Association is a very small organisation, hence our honorary positions. We wear two hats: one is industrial, as we are a registered union of employees; and the other is professional. I guess in the last few years we have concentrated more on the professional side. We do have a code of conduct. We have a code of ethics which was laid down by the association some years ago. I have a copy of that, and I am happy to present that if you wish me to do so. Basically, our aims are to look after dental assistants, whether or not they are members, because our membership is not very large. We see our role as educational. We do not discriminate. Obviously, we educate anyone who is interested in being educated in the role of dental assistants. As far as disciplinary matters are concerned, I am happy to say it has never happened; we have never needed to use any sort of disciplinary powers. But, obviously, our aim is to look after any dental assistants in need of help, either industrially or educationally.

CHAIR: Can you throw some light for us on how you see the distinctions between the various allied professions?

Ms VERN-BARNETT: I suppose I could say that we are the lowest rung on the ladder.

CHAIR: In salary or in importance?

Ms VERN-BARNETT: Both.

Ms HAYES: Definitely in salary.

Ms VERN-BARNETT: We happen to think that we are a quite important key member, because our duties are strictly non-clinical. We are there to assist the clinician; we are there to assist in dental therapists, hygienists or whoever happens to be the operator. We are quite adamant about maintaining the standard that we are not clinical at this stage.

There are an awful lot of duties that dental assistants perform, and that has increased enormously in the last 15, 20 years as technology has increased. Basically, that is about it. We like to think that a well-trained dental assistant can take the burden of even running a practice off the shoulders of the dentist.

CHAIR: So the overall majority of your members would work with a dentist. Hygienists, therapists, et cetera, there would not be nearly as many dental assistants working with them?

Ms VERN-BARNETT: What I failed to mention at the very beginning is that our association looks after private practice rather than the public health system, although we obviously have contact with some of the public health dental assistants as well. For that reason, obviously, the dental assistants we deal with work mostly with dentists in private practice.

CHAIR: Can you tell us something about training and the extent to which there is a career path?

Ms HAYES: The Dental Assistants Association offers, at the moment, certificate 3 in dental assisting, which is a certificate 3 level. We offer that to existing dental assistants and to new employees in the area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who provides the certificate 3? Is it a TAFE course or do you run it?

Ms VERN-BARNETT: Both.

Ms HAYES: It is a TAFE course and we are a registered training organisation so we run a certificate 3 course for students.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many students do you graduate each year?

Ms HAYES: It varies greatly.

Ms VERN-BARNETT: It changes from 12 up to 32 last year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there an award if they get the certificate 3?

Ms VERN-BARNETT: Yes, there is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note that in your submission you say that if they graduate they get the sack. Presumably that is because they have to pay them more once they have graduated than if they have not.

Ms VERN-BARNETT: It can happen, yes, and it has happened but it is improving.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they do not all get the sack.

Ms VERN-BARNETT: No, they do not. That happens mostly under the traineeship scheme. There is now a traineeship in place for dental assisting, and it is a two-year traineeship. So at the end of those two years the person who is involved as a trainee is likely to get the sack.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the dentist is likely to get a trainee for two years which is subsidised?

Ms VERN-BARNETT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Once they graduate, kicks them out, gets another one who is also subsidised so he never pays the full price. My dentist seems to have a different young girl every time I go in there, and I wondered why this was.

Ms VERN-BARNETT: It could be many reasons. I am happy to say that there are many enlightened dentists out there who see the value of keeping their staff.

The Hon. CHARLIE LYNN: You mentioned before that you graduate between 12 and—

Ms VERN-BARNETT: Anywhere between 12 and 30.

The Hon. CHARLIE LYNN: Is that just the association or is that New South Wales?

Ms VERN-BARNETT: This is just us.

The Hon. CHARLIE LYNN: How many would graduate through the TAFE system and yourselves?

Ms VERN-BARNETT: Unfortunately I do not have any recent figures but I did work within the TAFE system a number of years ago, and at its peak they were putting through 1,200 a year. It is nowhere near that number now.

The Hon. CHARLIE LYNN: What do you think the demand would be?

Ms VERN-BARNETT: The demand just keeps increasing. There is an enormous shortage of qualified dental assistants out there.

The Hon. CHARLIE LYNN: So there is an increasing gap?

Ms VERN-BARNETT: Yes, very much so.

The Hon. CHARLIE LYNN: What is holding back that gap being filled? Is it because of the wages and conditions?

Ms VERN-BARNETT: To a large extent, yes.

The Hon. CHARLIE LYNN: You mentioned that underutilisation of well-trained, suitably qualified staff frequently results in a lack of job satisfaction. Can you perhaps amplify a bit on what you mean?

Ms HAYES: Currently there is no official recognition of the training required for dental assistants. They are trained very much by the dentist on the job. Those dental assistants who are very committed to the profession decide that they want to increase their knowledge and skills. They undertake the certificate 3. So it is not a prerequisite for employment and it is not a requirement of employment in the private sector. In the public sector it is a little different now. A new public award has come in which recognises a certificate 3, and in actual fact it is a prerequisite now for them in public practice.

The Hon. CHARLIE LYNN: What opportunities does a dental assistant have for increased career development and training to become more than a dental assistant or are they forever a dental assistant?

Ms VERN-BARNETT: Reasonably limited. In larger dental practices now there is a progression, I guess, for the likes for instance of Barbara who is still working as a practising dental assistant who has now reached the status of a practice manager where increasingly practice managers take on the role of running the practice and take it off the shoulders of the clinician. But at this stage there is no recognised articulation into other courses for instance. As you obviously know, there are

hygienist and dental therapy courses available in New South Wales. At this stage the universities have not recognised formally the certificate 3 as a prerequisite or even a slightly higher level, which is a certificate 4, where they actually specialise in things like dental radiography or oral health promotion.

CHAIR: Would the universities give any credit for subjects studied at the TAFE level?

Ms VERN-BARNETT: Not at this stage. Nothing formal has been arranged yet.

The Hon. KAYEE GRIFFIN: I go back to a comment you made about the change in technology with dental assistants over the past 12 to 15 years. Can you elaborate on the changes that have occurred?

Ms HAYES: I would love to, as I can probably go back the 30 years. Thirty years ago we would bundle up instruments and throw them into a nice boiling water cauldron and they would come out in 10 minutes and we would use them again. Nowadays, there is so much legislation involved. Infection control in Australia is at an extremely high standard in dental surgeries and the training that is required for a dental assistant to participate in all that infection control prerequisite, all the monitoring, the recording that is required now, is quite huge. The task is enormous. What is actually happening is that dental assistants are now doing a lot of infection control duties and it is limiting their time at the chair side, actually physically assisting. So the duties that have increased, the work load that has increased for dental assistants is enormous, even in the past five to seven years. It has become quite onerous, especially the recording and the documentation.

Ms VERN-BARNETT: Also, computerisation is increasingly being introduced into practices. But as well as that, the techniques in dentistry and the materials being used, even in the few years since I have left the actual practice of dental assisting, has just been enormous. Techniques have changed and the way people are treated has changed. The public's perception of what dentistry should be like has changed and dental assistants have a role in that. Communication is incredibly important.

The Hon. KAYEE GRIFFIN: Can you perhaps explain a little bit about what is involved in the certificate course?

Ms VERN-BARNETT: There are seven units of competency that have been recognised nationally, and the training is on the job and off the job. We would like to think that we are covering the off-the-job component of it but the trainee must be practically working in a situation. The way the trend has gone with education, as you are most probably aware, in technical education a lot of it can be done on the job. But, depending on the type of practice they are in, they may not get the variety that is required for them to be able to achieve a certificate 3, and that is where we feel we fit as a training provider, covering all those. Obviously the most important aspects of those seven units of competence are infection control and occupational health and safety but everything else that goes with it. It is quite comprehensive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the problem in essence that the dentist's vote with their wallets and say, "I'd rather have a less qualified person who is cheaper than a more qualified person who is more expensive"?

Ms VERN-BARNETT: Some do.

Ms HAYES: That does happen in private practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they would make a decision that they would have to train this person every time they start with a new one of mixing their amalgams or their chemical, the white ones, the new ones, and as far as the protocols for their sterilisations and handling the instruments or whatever and writing it up in the books.

Ms HAYES: It has become too much for the dentist to do that. The extra training that is required has become too time consuming for the dentist to spend the time training staff. We believe that it has reached a stage in Australia that dental assistants should be trained formally.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would say that the Committee should recommend that dentists may not use unqualified people to do these tasks in the interests of presumably the maintenance of hygiene and a good standard of dentistry across the board.

Ms HAYES: That would be our ideal recommendation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the essence of what you are saying. You are asking for some legislative muscle, if you want to put it that way, to reinforce the status of your profession in the public interest.

Ms VERN-BARNETT: And to acknowledge that as a career step, obviously. There is very little career move for dental assistants while the dental assistants certificate 3 is not recognised by the universities in the Bachelor of Oral Hygiene. You have a lot of very committed dental assistants who want to progress in their sphere but do not have that recognition. They spend many, many years on a very low rate of pay before they can actually get recognition.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they are getting replaced because the certificate 3 has an award level, which presumably is higher than the traineeship, if they then progressed to a more expensive situation from the dentist's point of view, will they not get into trouble worse than before? Are we not demanding things in the market here?

Ms VERN-BARNETT: I do not think that money is the only driver or wages are the only drivers. It depends entirely on the type of practice. It could be a little suburban family practice where what the dentist required of his assistant would be very different to one in the centre of Sydney or just across the road in Macquarie Street or a multi-member practice where they have a number of dentists where the trainees might be rotating or their responsibilities could be very different. So when I say underutilised I really feel that sometimes dental assistants who have any sort of ambition to further their education or to keep learning and bettering themselves, the opportunities are not always there for them in the workplace. But there are plenty of other places that they can go where they can further their ambitions if it is recognised. So it is not always money.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they are going to take over as practice managers, however, that is a separate set of skills than chair side sterilisation, and presumably that is management of resources, and someone may be competing against secretarial staff for those sort of jobs, would they not?

Ms VERN-BARNETT: Our argument is that if you want somebody to do the job properly they should have been starting off at the coalface and learning as they went along. There are plenty of practice managers who have done management courses who come in and who do not have a clue about what goes on in that surgery and they need to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It could cause a revolution in management theory.

Ms VERN-BARNETT: Yes.

CHAIR: I am not sure that you will have much to say about question three because it is specifically about public dental services but we welcome your comments on, for instance, the greater use of para-professionals.

Ms VERN-BARNETT: Yes, we have always felt, and from a personal point of view I have actually worked with dental therapists and I have the highest regard for them. I think that they often handle situations that a dentist either would not want to or is just incapable of coping with, to be perfectly frank, particularly with children.

CHAIR: So you are saying that they are worth having in any case but in a situation of a grave shortage of dentists in the public sector they are an even more important group to be considered.

Ms VERN-BARNETT: Yes. In terms of paragraph (b) I have done a little bit of homework which I am not particularly happy about. I have been told that as of June approximately 614 full-time

equivalent dental assistants were employed in the public service. I know for a fact that there are many who are employed on a casual basis so this figure is very rubbery.

CHAIR: So, that number of 614—

Ms VERN-BARNETT: It could be a lot more.

CHAIR: It could also include a lot of people not doing very many hours a week?

Ms VERN-BARNETT: Yes.

CHAIR: So, the number of full-time positions may be very much smaller?

Ms VERN-BARNETT: Yes.

CHAIR: So, with your comments on the numbers, so far everyone seems to agree we are not producing enough dentists or members of the allied professions in New South Wales.

Ms HAYES: Absolutely.

Ms VERN-BARNETT: It is quite interesting if you have been around long enough, as I have, to see the changes. Fifteen or 20 years ago we were told we had an oversupply of dentists. I do not know where they have gone.

CHAIR: We have asked this question of several witnesses so far. We are finding it difficult to get an answer that we can get our heads around.

Ms VERN-BARNETT: If you rely on statistics, most statistics, unfortunately, are out of date by the time you get them. I do not know what the answer is. I know the situation is drastic in the country and in regional areas. I have read some of the transcripts of the previous witnesses, and everyone has lots of opinions and very little practical suggestion as to how it could be overcome.

CHAIR: In the case of dental assistants, for instance, is there a shortage of applicants or is there a shortage of training places?

Ms VERN-BARNETT: A lot of them drift down to the city. I am talking about private practice. There seem to be plenty of positions in some regional areas, the larger ones. In the public system, of course, we have dental assistants who do not have work to do and that is why the casualisation, because they do not have dentists to work with. Training is available through the Open Training Education Network arm of TAFE. So, training is available and now, with traineeships as well, many country people avail themselves of that.

CHAIR: So, training is available, the people are available but the funds are not available to employ them?

Ms VERN-BARNETT: The pay in country areas is very much lower than in the city. In most private practices in the Sydney area people are being paid well above the minimum rate, the award pay, which is pretty appalling.

CHAIR: Roughly what would they be paid?

Ms VERN-BARNETT: In the city?

CHAIR: Yes.

Ms VERN-BARNETT: For permanent qualified employees, it could be anywhere between $16 and $25 an hour. It is closer to the lower range than the upper range.

CHAIR: What would they be likely to be getting in the country?

Ms VERN-BARNETT: If at all above the minimum rate it would probably only be a few dollars, not much.

CHAIR: This is partly because they are mostly women?

Ms VERN-BARNETT: Yes, very much so. We do not have too many men in the private sector, and their aspirations are obviously to become managers, so they do management courses.

CHAIR: And because there is a pool of women looking for employment and perhaps, particularly, for part-time employment, the wage rate can be kept down?

Ms VERN-BARNETT: Yes.

Ms HAYES: Especially in the country areas. Their wage is minimal basic award wage. In the city areas it is just so different.

Ms VERN-BARNETT: And their responsibilities are too. I taught externally for 15 years and the feedback I was getting from the students was that if they were not required in the surgery they used to mind the children or take them to school or do the family ironing or polish the silver. It was a pretty broad experience to put it mildly.

CHAIR: Is that still the case?

Ms VERN-BARNETT: Yes, I think so, but this is anecdotal.

CHAIR: But more the case in country areas

Ms VERN-BARNETT: Definitely in country areas. Maybe the outer west sometimes but not so much now.

Ms HAYES: 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: Private practice.

CHAIR: Specifically in rural and regional areas?

Ms HAYES: 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: Yes, there are, definitely.

CHAIR: Even in private practice?

Ms VERN-BARNETT: In some.

CHAIR: It comes back to the shortage of dentists?

Ms HAYES: 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.

The Hon. KAYEE GRIFFIN: The anecdotal information about waiting lists, is what you heard the very general sorts of dental work that need to be done, fillings and what have you?

Ms HAYES: That is interesting. In general terms I would say restorative dentistry has probably decreased. Once again, this is my own observation. The availability now of services such as bleaching, cosmetic dentistry, implant dentistry, endodontics—we see people now of my age who do not have new decay, we have teeth which are literally breaking apart from the old amalgam fillings we had at a very early age. So, when teeth break apart the restoration becomes very involved. You end up with crown work or implant work, that sort of thing. They are the areas that are increasing in metropolitan, in Sydney practices. There is not as much restorative dentistry as there used to be in years gone by.

Ms VERN-BARNETT: The affluent society and more glamorous jobs.

The Hon. KAYEE GRIFFIN: Presumably the waiting list you are referring to are probably for more involved work and longer periods at the dentists to have that work done?

Ms HAYES: Or more consecutive appointments. Endodontics takes three or four appointments, yes.

CHAIR: We had a question here about waiting lists and other problems for public dental services but you started telling us about those problems for private ones as well. Perhaps to get onto the public ones, everyone seems to agree on the shortages of staff, and I guess it follows that the waiting lists get longer and the period grows. Are there any other problems in the system, any other systemic flaws that you draw attention to?

Ms VERN-BARNETT: 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.

CHAIR: Is that regardless of the age of the clients?

Ms VERN-BARNETT: Yes. The dietary problems, which I am sure you have heard about, as well. My personal gripe has always been that dentistry has always been looked at as all dental. The oral cavity has been somehow kept separate from the rest of the body. As far as I am concerned it is the whole being that should be looked at and any dietary things, for instance, that are taught apply just as equally to oral health. So, when you see obese people walking out there, you know that whatever they have eaten is not going to do their teeth any good.

Ms HAYES: This happens in the public health sector, and I am talking more about adult teeth here, not children. In the adult public sector, because of the length of the waiting list, obviously they arrive with a much greater problem than could have been attended to earlier. But also the public sector—I may be corrected here—but I believe it does not offer endodontic treatment, root therapy treatment. So, that option is not there to those public patients, whereas the private sector has the option of implants and crowns. The public sector is extremely restricted in that area. 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.

CHAIR: Why, when you started in that, did you exclude children or young people? Why did you relate that to adults?

Ms HAYES: My only personal experience is in adults. They are the only ones we would see with fee-for-service vouchers.

CHAIR: I wonder whether adolescents, for example, would be turning up with a voucher saying extraction or whether it would be more slanted towards older age groups?

Ms HAYES: I have not experienced that. No, they are not eligible for fee-for-service vouchers, under 18s. I might be wrong in that. Your next group would be the more knowledgeable in that area, I do not know.

CHAIR: You have mentioned fluoride a few times. Does your association have an official position in support of fluoride?

Ms VERN-BARNETT: We are very much in favour of it.

CHAIR: Have you been for a long time?

Ms VERN-BARNETT: As a personal point I was given fluoride to take the moment I knew I was pregnant. That is how much our belief has been. From the family point of view I have four adult children and between the four of them I think they probably have four restorations. I have several grandchildren, who have been taught to clean their teeth properly with fluoride toothpaste, and they have had no dental problems. That is my personal experience, but I have also seen children in the public health system who have benefited hugely from it also. I know there is a problem out there making people understand the benefits of it but certainly we teach our trainees as well that fluoride is beneficial.

Ms HAYES: Having observed clientele that come through the doors now, most people under 27 would not have a restoration filling at all. Their teeth are in very good condition.

CHAIR: That in turn is part of the answer to the questions I was asking before about age groups, that if you know that the water has had fluoride in it, it you can say if you are under 27 this is what your teeth will be like—with exceptions, obviously.

Ms HAYES: Obviously there are exceptions. Personally I do not get to see a lot of disadvantaged public health patients, et cetera. I do not have personal experience of them. But definitely in the children we see they have perfect teeth.

CHAIR: I still have some more questions—although I think you have probably answered them—about persuading people to work in the public sector and in regional areas and whether wage levels are an issue. I guess the answer to that is yes?

Ms VERN-BARNETT: Dental assistants rush into the public sector because they consider it safer—or they did a few years ago—because of the systems, the protocols, the occupational health and safety particularly, and infection control that are in place and insisted on in the public sector, which are not always guaranteed in the private sector. Some of the larger practices, the more enlightened ones, definitely, but unfortunately there are still little suburban practices where a lot of the provisions laid down are ignored. Some people may not even be aware of them.

When parents ring us and ask us about their children going into this field over the past few years they have literally said, "Is it a safe place to work?" So the public has become much more aware and much more demanding.

CHAIR: So you are not talking about job security; you are talking about occupational health and safety.

Ms VERN-BARNETT: Yes, occupational health and safety more than anything.

CHAIR: To your knowledge, have there been higher levels of infection?

Ms VERN-BARNETT: No. It is a perceived problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are people concerned about getting AIDS from being a dental technician? Is that the negative perception?

Ms VERN-BARNETT: Generally speaking, people just want to have a safe place to work in. Yes, AIDS had a lot to do with it, yet I would say that HIV would be the least of their problems. Hepatitis is much more of an issue in a dental practice than HIV.

CHAIR: Hepatitis?

Ms VERN-BARNETT: One of the forms of hepatitis. B is not so much a problem but C is certainly a problem now because there is no vaccine for it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it is more resistant to autoclaving, is it not?

Ms VERN-BARNETT: No. Hepatitis C would be resistant to disinfecting but autoclaving is fine.

CHAIR: Are there other particular diseases? Is there a frequency of cuts and all kinds of minor things that could happen?

Ms VERN-BARNETT: Manual handling and ergonomics are issues for dental assistants—sitting the way they do, particularly for any length of time. That is quite an important occupational health and safety issue. Stress is very often a problem—which is not something that is often recognised or admitted to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a big improvement in chairs about a decade or two ago, was there not?

Ms VERN-BARNETT: We still have a long way to go.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Right. How big a problem are we talking about? What percentage of dental assistants in the private and public sectors would have a certificate 3?

Ms VERN-BARNETT: Not as many as we would like.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it 10 per cent, 90 per cent or you do not have a clue?

Ms VERN-BARNETT: Compared with public health, I would say it is a very, very much smaller figure in the private sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of what magnitude? Is that 30 per cent or 50 per cent?

Ms VERN-BARNETT: I honestly could not put a figure on it, I am sorry. I am very bad at figures anyway.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably none have been collected.

Ms VERN-BARNETT: No.

Ms HAYES: I do not think there would be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You might know how many graduates you have but you do not know where they have gone and you do not know how many have dropped out of the profession and gone into something else.

Ms VERN-BARNETT: We really do not have any records of that at all, unfortunately.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you would say what we said earlier: Dentists should probably have a qualified person doing their sterilisation and their disinfection and, as such, there should be some statutory recognition of the course you are doing.

Ms VERN-BARNETT: Very much so.

Ms HAYES: It also goes to reducing the occupational health and safety risks: If they are well trained they know why they are doing things and they know that they have been trained properly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms VERN-BARNETT: It would also attract a better quality of person to the profession, if I may put it that way. In many instances even today they are still considered "the girl". That is something that we have been battling for a long time—for some sort of recognition that this is actually a career option that has a certain amount of status attached to it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

CHAIR: Do you think there has been any change for the better over time? Do you feel as if you have made any progress or that you have been bashing your head against a wall?

Ms VERN-BARNETT: See this little purple patch? I always liken it to a drop of water going through a rock—it takes a long time to come out clear the other end. I would like to see the process speed up a bit.

CHAIR: A question that came to my mind before—it is fairly anecdotal on my part, I guess—is that in quite a lot of practices what you said about technological change, increasing complexity and so on has meant that there is often a senior assistant and a more junior assistant and there is clearly a status distinction between them. It may be that one has been with the dentist or dentists longer, but there is clearly a bit of a hierarchy of work. With the shift in terms of the importance of some of the new technology—sterilisation and so on—I wonder whether that may have advanced the status of assistants, or at least of some of them.

Ms VERN-BARNETT: Yes, to some extent that is true. The problems that I get telephoned about have changed from "The boss is doing terrible things to me" to "The senior dental assistant is not letting me do something or is harassing me"—we have had a couple of harassment cases between staff members. That is just a fact of life. I would like to think that is an improvement; that somebody who starts today has something to look forward to with a certain amount of training.

CHAIR: From that point of view, could you comment on whether it would be better for dental assistants, and perhaps for the population, if there were smaller numbers of bigger dental practices? It sounds as though some of the problems you are talking about stem from the traditional one-dentist practice on a suburban corner, with perhaps one assistant/receptionist. Maybe there is a more professional ethos in bigger practices, which is more the way GPs have gone in the medical profession.

Ms VERN-BARNETT: Yes, I think every way we go will have its own little problems associated. But certainly from the point of view of the career structure or some sort of kudos, yes, I think that could be beneficial for dental assistants. It should be beneficial to the principal of the practice as well, obviously.

CHAIR: Looking across the range of public and private dental services, do you have any comments about the size of a practice or group working together? Is it better to centralise the whole team of professionals and their expertise or is it better to spread them out as far and wide as possible?

Ms VERN-BARNETT: It is very hard to tell because there are now clinics and also companies formed that buy up practices and spread across the metropolitan area. That has brought with it a whole new set of problems as far as employment is concerned. So size is not always an advantage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have there been a lot of corporate purchases of practices recently?

Ms VERN-BARNETT: There have been a few.

The Hon. CHARLIE LYNN: What sort of problems does that introduce?

Ms VERN-BARNETT: From our point of view, one is that if they find out that someone happens to be a member of the union they are given all sorts of opportunities to leave. They do not really like the idea of somebody looking after them and telling them their rights. But we also tell them their responsibilities, so we are not red-ragging unions. However, there are still quite a few problems, such as unfair dismissal cases.

The Hon. CHARLIE LYNN: Do you think there is discrimination against union membership?

Ms VERN-BARNETT: It is not spoken of but one gets the impression that that is the way it is going.

The Hon. CHARLIE LYNN: Do they have workplace agreements?

Ms VERN-BARNETT: Some do, yes.

Ms HAYES: The larger ones.

Ms VERN-BARNETT: Some of them do not give the dental assistant very much advantage at all. In fact, in New South Wales at the moment we still have a situation where anything below the standard of the award—which is pretty bad anyway—makes the document virtually illegal. But the person who signs that contract may not know that. That is part of the problem: There is quite a bit of ignorance out there among prospective employees, if you like, who may be very desperate to get a job of any kind; they do not care what it is. A lot of them are still saying to us, "We didn't even know you existed". You can imagine that, with an honorary committee, we have spread ourselves pretty thin already. I am sure that you have heard all this before.

CHAIR: We have heard some of it in the context of the Prime Minister but perhaps not in the context of New South Wales.

The Hon. CHARLIE LYNN: Would you see the increasing of their professional training development—a career structure that went to the top and being a dental office manager—as part of the solution to the challenges that you face? That involves being recognised by the university and having a career progression from when they enter until they eventually work up to running a practice as a technical manager.

Ms HAYES: It would give a lot of credibility to the position of dental assistant. At the moment a dental assistant has a very limited career. If you are not in a larger practice where you have that option to progress to practice manager, then it is just not there. We would also like to see dental assistants better utilised. They could undertake some duties, which they could be very easily trained for, that would offload the time span that the dentist must spend with the patient. Simple things, such as toothbrush instruction, could be done by a qualified dental assistant. That would give the dentist much more productive, income-producing time than sitting and talking to somebody for half an hour, explaining how to clean teeth. We would like to see dental assistants trained and also given extended duties for the things that they can undertake very easily. Unfortunately, that means a change to the Dental Practice Act because we are forbidden from doing anything like that.

The Hon. CHARLIE LYNN: A change to the Act?

Ms VERN-BARNETT: Yes, we would have to have the Act changed before there was any sort of recognition.

The Hon. CHARLIE LYNN: Have you put in any submissions as to how you think the Act should be changed?

Ms VERN-BARNETT: No, we did not get the opportunity but there has been talk about developing a code of practice, which I think I mentioned in our submission. We feel that that would give at least some form of status and a job description, because we still almost weekly get phone calls asking, "What is a dental assistant allowed to do?" We have to answer in a negative way.

The Hon. CHARLIE LYNN: Is that an outcome you would want to see from this inquiry?

Ms VERN-BARNETT: We would very much like to see that.

CHAIR: Charlie has asked the question for me—we usually ask at the end of evidence what witnesses would like to see come out of this inquiry. I think you have answered that, plus your comments before about salaries, status and so on. Have we missed a major area?

Ms HAYES: No. Our submission also said that we would really like to see better use of hygienists and therapists, especially in private practices because they are very underutilised in private practice.

CHAIR: Would you like to see more focus on the prevention of dental disease?

Ms HAYES: Yes.

CHAIR: Preventative dentistry.

Ms VERN-BARNETT: Definitely.

Ms HAYES: Yes, we have an aged care population now sitting in nursing homes and unable to access dental care. They have their own teeth. In years gone by you just collected the dentures and distributed them back again. That does not happen now.

The Hon. CHARLIE LYNN: Thank God for that.

Ms VERN-BARNETT: Hopefully, to the right person.

Ms HAYES: That has become a major issue in society today.

Ms VERN-BARNETT: One thing I failed to mention is that we would also like to see some form of pretraining before people enter this occupation, rather than being thrown in at the deep end—which is what mostly happens now. We run, in a very small way, an introductory course at the beginning of every year, but it is not really big or extensive enough to help people who are seriously interested in getting into this occupation. Very often they are middle-aged; they are not necessarily 16- or 17-year-olds.

CHAIR: Is it paid or unpaid?

Ms VERN-BARNETT: For the course that we run they have to pay a small amount towards it.

CHAIR: Is it introductory?

Ms VERN-BARNETT: It is a basic skills course. During that time we get them some work experience in practices that are very helpful and most of the time anyone who wants to seriously continue doing it gets a job within six months and continues. We have had some wonderful successes.

CHAIR: And they would then continue training with you or with a TAFE college.

Ms VERN-BARNETT: They could then go into a certificate 3 course.

CHAIR: Does TAFE offer the courses at a huge range of colleges or is it specialised at some?

Ms VERN-BARNETT: In the metropolitan area the course is now available at Sydney Dental Hospital. It is partly at Randwick TAFE now. There is a course at Blacktown. As far as I understand it, the Shellharbour course is still running and there is the Open Training and Education Network.

CHAIR: So it is fairly limited, but it can be accessed?

Ms VERN-BARNETT: It is better than it used to be.

CHAIR: If an issue arises from later witnesses we may contact you again.

Ms VERN-BARNETT: Thank you for the opportunity to appear here.

(The witnesses withdrew)

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

JANET WALLACE, Research Officer, New South Wales Dental Therapists Association, College of Dental Therapy, Westmead, sworn and examined:

CHAIR: Would you like to make a brief opening statement?

Ms FRANKS: Our submission is fairly succinct so I will not go over it. However, I would like to thank you for inviting us to speak on behalf of the New South Wales Dental Therapists Association. It is probably timely at this point to explain just what a dental therapist is. We are employed by the public sector and AMSs across the State. We provide treatment to 0 to 17-year-olds, which includes basic dental treatment, fillings, extractions, preventative care and oral health promotion. We have been doing that for a 30-year period in this State.

In its heyday we had four training schools that have produced over 700 graduates in that time. We have quite an extensive amount of dental therapists who have been trained at the expense of the community. However, at this point in time there are only 216 working.

CHAIR: When was the heyday?

Ms FRANKS: In the mid-70s early 80s we produced most of our graduates.

CHAIR: We will deal later with the decline, what has brought it about and its effects. Mrs Wallace, did you want to add anything?

Mrs WALLACE: No.

CHAIR: Could you tell us a bit about your association? Is it voluntary, and how many members do you have, how do you keep it going and how do you see your role?

Ms FRANKS: Our association is voluntary. We have 175 members at this point in time. We provide relevant professional information for that group. We lobby on issues on behalf of dental therapists, provide members with support pertaining to the profession of dental therapy and 216 work in the State, of which 175 are our members.

CHAIR: Do you have a code of conduct for a complaints code of practice?

Ms FRANKS: No. We are not in any way an industrial body. We do not have a code of conduct, but dental therapists, with their registration, are bound by the code of conduct set down by the Dental Board. We would expect that our members are au fait with that code of conduct and would adhere to that, but we do not have any kind of disciplinary role or anything of that nature.

CHAIR: Can the role of therapists be defined quite firmly to separate it from others and has that changed over time, particularly since the heyday of the very large number?

Ms FRANKS: It has a very defined role and a very defined scope of practice, which is covered by the Dental Act. We know that our scope of practice involves dentistry predominantly to children—the 0 to 17-year-old group. Legislative changes did happen but we gained very little from that in terms of our scope of practice. We were able to apply stainless steel crowns, which is a restorative-type technique. Very little changed for us as a group with the legislative changes, apart from the fact that we are required now to register and we supply the State coffers with $100 each for our registration. Apart from that, we got not much in the trade-off.

Mrs WALLACE: And if you compare us to other paradental professionals, hygienists work on adults and children, but they are basically hygiene-focused, which means that they do not actually cut cavities or take teeth out, so their focus is predominantly on the preventive side of dentistry, whereas therapists are the only other auxiliary that is a cutting auxiliary who has similar skills to a

dentist. Those skills, though, are set in a rigid scope of practice and we are only permitted to practise on children between the ages of 0 to 17.

CHAIR: What were the major things you were seeking when the legislation was amended?

Mrs WALLACE: The major issue was that we sought to gain private practice rights. Private practice rights are already in operation in all other States in Australia with the exception of the Australian Capital Territory, and that is being reviewed at the moment. We sought to gain that right in New South Wales. We also wanted the age restrictions lifted to 25. We also asked for registration, which we did gain, and we also asked for a position on the Dental Board because our profession is not catered for on the Dental Board. The Dental Board has a hygienist, who acts on behalf of therapists and hygienists. In our association's opinion it is not an appropriate way to go. Hygienists are not trained as therapists so they cannot advocate on our behalf.

CHAIR: So you did not gain any representation?

Mrs WALLACE: No.

Ms FRANKS: And in terms of the association, we felt that we had been given a pretty rough deal because the board makes decisions about our profession and we do not have a voice.

The Hon. KAYEE GRIFFIN: What is the reason behind wanting to extend the age group specifically up to 25?

Mrs WALLACE: 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: 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.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For a person outside the industry it is a little hard to understand the difference between therapists, hygienists, technicians, prosthetists, and so on. It seems like you people have been the school dentists for a large amount of time, checking the kids?

Mrs WALLACE: Yes.

Ms FRANKS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Now that public dentistry is more or less disappearing, you are asking, in a sense, to be the poor people's dentists, beyond looking after poor kids. I notice that in your submission you say that the fact there is less care in children maybe because dentists are not seeing low socioeconomic kids.

Mrs WALLACE: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And, therefore, they are not aware that it is not declining in some groups. That is effectively what you are saying in your submission, is it?

Mrs WALLACE: 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: Yes, and in adults too.

Ms FRANKS: And increasing.

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

Ms FRANKS: 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: 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: I think it is around 46 per cent.

CHAIR: How do you arrive at that?

Mrs WALLACE: We have, over the years, had different programs in the public sector that have collected data for schoolchildren and from that data we have gained that information.

CHAIR: But do you actually also know that once they have passed 17, for instance, they then never see a dentist?

Mrs WALLACE: No, because we are only making a judgment on that group that we treat.

CHAIR: I just wanted to clarify that because it sounded as if you were saying in their entire life.

Mrs WALLACE: No, in their childhood.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have only said that you want to put the age up to 25. Presumably, you would not know what the decay rate is in people from 18 upwards if you are not allowed to treat them.

Mrs WALLACE: But if you work in the public system, in a polyclinic where adult dentists work alongside dental therapists and we are a team then, yes, we do see what is going on.

Mrs WALLACE: We definitely do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why do you put the figure at 25? Why do you not put it at 95? If we talk to pensioners and we talk about the availability of public dental services, why are you saying 25 and not 95? Because you are making a realistic bid or what?

Ms FRANKS: Yes, because we think that is the more realistic age group that we can treat.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why? Because you are not trained to treat older ones or that is all you can do or it is all the load you can handle?

Ms FRANKS: Once they pass 25 often there are more issues that come into things. If you look at the over 25s that come into the public system, which is our area of expertise, you see that they move into more of the prosthodontics—they need false teeth basically—and their health becomes an issue. There are a lot of health issues for older people within the public sector that we see. So I think in our area of expertise 25 is a very realistic age group for us to treat.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are talking about general health being a problem, would it not be better to cut off at 45 or 50?

Mrs WALLACE: I think we have to be realistic with the changes that we are asking for. At the moment we do not have private practice rights, nor do we have the right to treat individuals after 18. I think we need to be realistic about what we are asking for, and dental therapists are not looking to replace dentists in that role; we are well aware of our limitations and we feel that our limitations could benefit that age group. We do not aspire to step into the dentist's shoes; we want to work with the dentist as a team, with them as the team leader and us in a team model of dentistry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if there is this huge vacuum in public dentistry where I think 30 per cent of people are eligible and 9.8 per cent of people in the public sector have a huge demographic problem that it is going to get worse as soon as a cohort retires shortly, what is it that a dentist can do that you cannot do?

Ms FRANKS: We are strictly keeping our practice to those low technological interventions, so the simple fillings, the reasonably simple extractions, the things that our training allows us to do. The more complex things which come with that older age group can then be catered for by the dentist. So in this fact I see that we are relieving them of the burden of the mundane type work that we could accommodate, leaving them to do the more complex treatments.

The Hon. CHARLIE LYNN: Would you act as a referral as well, like assessment and referral?

Ms FRANKS: Yes. And that happens now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I used to do pre-employment medicals on people who had been unemployed and were in their early twenties and some of them had terrible teeth situations and they simply could not afford to go to dentists. You would not attempt to fix all those though if they were very bad; you would assess the ones that had simple fillings and send the others on?

Ms FRANKS: We would welcome the team model that works quite well in the UK: we would work on the dentist being the specialist in the treatment planning and he would probably refer that down to us. We would do the simple technological restorations, that kind of thing, then we would probably refer down even then to a hygienist to get into the preventative area. So we see that the dentist would basically, I suppose, direct the play in terms of what is treatment planning, what is complex, what is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have the impression that they are cutting the number of you trained, is that correct?

Ms FRANKS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why is that? It is as if they are phasing out your profession, is that right? That was the impression I had. Have I got something wrong somewhere?

Mrs WALLACE: The training has changed. Initially dental therapists were all awarded a certificate after two years of training and then in 1994 that certificate was then upgraded to a diploma

status. Currently, there is an upgrade for certificated dental therapist to increase their qualifications to diploma status and there is a pilot running at the moment, but this year there is a new form of dental therapist that is called the oral health therapist—Bachelor of Oral Health—that is being offered at Sydney University, and that is a degree course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So what will the difference be between one of those new ones and a dentist?

CHAIR: And a dental therapist or a dentist?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying it is an upgrade of a dental therapist from two years to three years and presumably they can already do fillings, so they would be doing more complicated fillings at least?

Mrs WALLACE: No, not complicated technical therapy dentistry at all. Their degree is a combined degree so they will come out with a hygiene component like a hygienist and the dental therapist as well. So they will have private practice rights; they will be able to go out into the public and the private sector and practice those skills.

Ms FRANKS: But as legislation stands, in the public sector they can practice their dental therapy skills; in the private sector they can use their hygiene skills. So they are in fact a hybrid of the hygienist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the hygienist will be phased out as well with this new degree, will it?

Mrs WALLACE: No, there are several places within institutions within Australia that will continue to offer the hygiene course. In fact, Newcastle is offering it this year and there are 52, I think, students in that course. Unfortunately, in the Sydney course it is a much smaller group.

CHAIR: To people like us, or certainly for me and I think for most of the Committee, we have got a series of fairly rigid distinctions between a number of groups in the dental area; a lot of those distinctions seem to be historical—and you have been explaining how they have changed over time—and there seem to be some suggestions from some of those groups that someone else should be phased out but not us. There is obviously a bit of a competitive situation. I think the dental association, for instance, is suggesting the phasing out of training of therapists, which is why I have hopped in now because I think Arthur's question is about whether the Bachelor of Oral Health is a de facto replacement for therapists.

Ms FRANKS: I think the Bachelor of Oral Health is actually the death knell of the profession of dental therapy.

CHAIR: And is that an intended, deliberate thing or is all of this happening a bit like Topsy?

Ms FRANKS: 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: When I talk about the death knell of dental therapists I think perhaps what has happened is in order to upgrade our qualifications to provide educational opportunities for dental therapist that we have been really lobbying for, the University of Sydney course has 14 placements for oral health professionals when they graduate, of which they do this dental therapy component. However, when I say the death knell of the profession, what that will mean is legislation does not change to allow dental therapists to work in the private sector, the pay scales that a dental therapist

would be on to come into the public sector to pay off a HECS debt and to further their career as a dental therapist, I think, is the death knell of the profession.

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: 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.

The Hon. CHARLIE LYNN: So would you see a more evolutionary approach being more appropriate in that you stay as a dental therapist, you can train there, work in the private sector, but have the opportunity then to go to the next level and then ultimately to go to being a fully qualified dentist? Would that be a satisfactory career path?

Mrs WALLACE: It may be a career path that some existing dental therapists may be interested in, but I think that the fact is that most dental therapists that are already working have no intentions of becoming a dentist and are quite happy performing their scope of treatments. I think, as Kay was saying, some of the entrants into the Bachelor of Oral Health are using that as their stepping stone into dentistry, but for the existing work force that is not the case.

The Hon. CHARLIE LYNN: So if the existing work force was able to go to the private sector, for example, that would do a lot to allay the problem of dental waiting lists and so forth?

Mrs WALLACE: Yes. We feel that that certainly would make a big impact because there are different areas within New South Wales where we have very severe shortages of dentists and other areas that are able to service their patient load quite well. If dental therapists could go into the private sector they could go to remote and rural areas and also city areas, wherever the need, but into areas where the dentists are at a short supply; they could work within a team system and they could certainly make a difference. That will also enable the public sector to cope a little bit better because it is spreading the resources are little bit.

The other aspect of it is that as a dental therapist currently we are only permitted to work in the public sector. It limits our profession in the aspect that some of the profession would like to work different hours—possibly at night, on the weekends—in the private sector. So that would increase the availability of services as well.

The Hon. CHARLIE LYNN: Have you been consulted by the Australian Dental Association, or the New South Wales branch, in regard to the development of the profession? For example, I notice it says in your report that they have recommended that the training of dental therapists should be phased out. Was that done in consultation with you?

Mrs WALLACE: No.

Ms FRANKS: No.

The Hon. CHARLIE LYNN: So you see that as a major flaw in their deliberations?

Ms FRANKS: Yes.

CHAIR: I was going to come back to the point when Mr Lynn was asking you about what people in your existing work force might do if these opportunities were available. Can you give us a quick picture of the work force? Is it mostly female, for instance? Is it getting older because of the way in which perhaps the numbers have dropped?

Ms FRANKS: It is predominantly female. Out of the 216 practising dental therapists in this State three are males that actually pick up a handpiece and fill and drill. It is an ageing work force; the average age of a dental therapist is around 43 years of age. It is predominantly part-time, so it suits women who want to work part-time.

CHAIR: Is it reasonably spread between metropolitan and regional and rural?

Ms FRANKS: Reasonably. We have been doing a survey of our members and I think you find in rural areas, some areas like the North Coast where it is quite nice to live, they are adequately staffed, but if you look in places like Cootamundra, Wagga Wagga, those kinds of places way out west, there is a shortage of dental therapists. It is not as bad in the public sector as the shortage of dentists. I cite the example of Cootamundra: there is one dental therapist that services the child population in that area; she work three days a week, but the public dentist that works there comes one day a fortnight. So while the therapist numbers are not ideal in that area, the dentist numbers are considerably worse.

CHAIR: So would it be true to say that dental therapists cover the State more adequately than dentists partly because that female sort of middle-aged work force is an available pool because they are living in rural and regional areas and are willing to work for less income?

Ms FRANKS: I would say that is a very fair comment. They are willing to work for less income; more flexible hours; and often dental therapists in the past—considering a lot of them were trained in excess of 20 years ago—went back to the place they originally came from. So they went back to the country. They came specifically to be trained to go back to the areas that they came from. And that was a push with dental therapists in regard to who they recruited back in the seventies, to return those women to areas where they originally came from.

Mrs WALLACE: The other point to consider is that currently dental therapists can work only in the public sector, whereas dentists are able to go and work privately, and that is a big issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have said there is already a shortage of dental therapists, we all agree there is a terrible shortage of public dentistry, it sounds as though you are on a pretty bad wage, and you want to expand into the higher age groups, where you feel there is a need for that. In the public sector, I would argue there is plenty of need. You want to be able to go into the private sector. If you could go into the private sector, where there is still a huge shortage of dental services, would there not be a huge exodus of dental therapists from the public sector into the private sector such that the public sector crisis would just get worse?

Mrs WALLACE: That has not been the case in other States of Australia where dental therapists have been given the right to practise privately. Many of the States have found that a good percentage of their work force have retained their public sector employment, and some have retained public sector employment and also gone and worked in the private sector in the hours they are not working in the public sector. There has not been a mass exodus in other States.

Ms FRANKS: Predominantly, our work force have been in the job 10 or more years. They have quite a vested interest in superannuation. They have families. Public sector employment is quite attractive when you get four weeks off a year. That was one of the barriers that the Department of Health put up when the legislation was being changed. But if we look at the Queensland model and Victorian dental therapists, that just has not been the case; there has not been a mass exodus.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, in essence, you think you have had a pretty bad deal legislatively in New South Wales?

Mrs WALLACE: Yes, we do.

Ms FRANKS: Absolutely.

The Hon. KAYEE GRIFFIN: If I could go to the question relating to primary school dental checks. Does the public dental service provide primary school dental checks? If so, how often? And to what extent are rural schools serviced in this process?

Mrs WALLACE: The public sector has had a school dental assessment program in operation since 1996, when it was first implemented and known as the Save Our Kids' Smile program. Currently, we call it the SAP program, the school assessment program. Various area health services target different grades, and it is their decision as to how they run the program. But, in the area in which we work, we target students in kindergarten, year 3 and year 6. They receive a dental risk assessment. It is important to emphasise that it is a risk assessment; it is not a full dental examination. From that assessment, they are coded and given literature to take home to their parents or care givers, and they are triaged on the computer system that we run. Depending on their needs, they are allocated an appointment either within 24 hours in the case of an emergency, or it can be up to some months if they just need a general checkup. All schools in all areas are eligible to receive these assessments, but the reality is that in some areas the shortage of clinicians means that the area health services must make decisions on culling out certain schools. Because of that, it is not an equitable system. The up side of that is those who do not participate in the school assessment can access the service via the call centres, going through our questionnaire, and still get dental treatment that way.

CHAIR: How is this culling done?

Mrs WALLACE: It would be done in different ways in different areas. For instance, we have to have consent forms signed, and if we find a school has a very low consent rate, we perceive that perhaps that school does not need to have an assessment, or that it will not participate in the assessment. Or, for very high fee-paying schools, there is a perception that people sending their children to those schools can seek private dental treatment. But, as I said, anyone who is culled out for assessment can still access the service, so that we are not discriminating against anyone in that respect.

Ms FRANKS: We also looked at the decayed, missing and filled rates.

CHAIR: The school's rate over time?

Ms FRANKS: Certainly, on the previous year's response. If we find they have a high decay rate, we target that school. But the reality is that in most areas we have increasing school populations and a decreasing number of dental therapists to do the work. In fact, the area in which we work—

CHAIR: Which are is that?

Ms FRANKS: 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: 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: 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: At great cost to the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a bridging course to get you into the bachelor of oral health? If there is a bridging course to get you into hygiene, and dental therapists are going to this new hybrid of bachelor of oral health, is there is a bridging course that can give you that upgrade? It is only one more year than you did, is it not?

Mrs WALLACE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even though some of you may have done it a little while ago.

Mrs WALLACE: Newcastle University is offering a bridging course next year, but that is only to give you the hygiene skills so that you could then work in the private sector.

Ms FRANKS: We need the legislation to be changed so that anyone who goes through that bachelor of oral health hygiene component can then, when they have that qualification, go into the private sector and practise hygienic and dental therapy. Without the change in legislation, that will never happen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does this effectively mean that nobody except dentists can drill fillings in the over 18-year-olds? Is it the situation that it is a statutory monopoly in the private sector?

Mrs WALLACE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And in the public sector it is not?

Mrs WALLACE: No. We are the only paradental professional that has a restricted working environment. Dental assistants, dental hygienists, dental technicians, dental prosthetists and dentists are all permitted to work in the private and public sector. We are the only profession in dentistry that is limited to public sector practice.

CHAIR: And that is only in New South Wales and the ACT?

Mrs WALLACE: Currently. And the ACT is reviewing its Act now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are kind of dinosaurs in the sense that you are no longer being trained in the way you were trained, you are restricted to the public sector, and because of your pay and conditions your numbers are not expending?

Mrs WALLACE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, in a sense, there is a cohort which could do more but which is not being allowed to do more?

Mrs WALLACE: Definitely. We are a very controlled group.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A group that has training but is not being fully utilised from the State's point of view. You would argue that the way your profession is being managed is dumb in terms of the total use of brainpower and skills in this State in dentistry?

Mrs WALLACE: Definitely. As Kay said, dental therapists have been practising dentistry on children for 30 years. In New South Wales in that 30 years we have not had any incidents where there have been any issues relating to dental therapists related to their scope of practice.

Ms FRANKS: Nobody has been disciplined because they have gone outside their scope of practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that you are not doing anything very daring?

Ms FRANKS: No. It means we are smart.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the obvious alternative explanation.

Mrs WALLACE: We know our limitations, and we know what we are trained to do and what we are not trained to do, and we do not go outside the that box. We do not seek to go outside that box. We want to practise in our scope of practice. We want the age restriction changed, but we perceive that we have an opportunity to work with dentists. We do not want to set ourselves against dentists. There are some fantastic dentists out there who support dental therapists wholly and solely and know the benefits that we have for the community. We seek to be in a team environment where we can assist them and work beside them, hygienists, technicians and prosthetists in a model similar to that which is working in the United Kingdom.

Ms FRANKS: We really want to break down that historical barrier of them and us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It does seem that, if your pay is pretty dreadful, and you are restricted to the public sector, and there is a huge shortage of dentists everywhere, you would be mad not to go to the private sector if you had the opportunity.

Ms FRANKS: Not everyone will, because a lot of therapists have been in the public sector for a long time and have superannuation and long service leave, et cetera.

Mrs WALLACE: Flexible work practices, and those kinds of things which the public sector offers.

Ms FRANKS: So there will not be a mass exodus from the public system. That has not been the case in other States.

CHAIR: We wanted to ask each association whether it has a formal position in relation to fluoride.

Ms FRANKS: We are very supportive of fluoride. We practise in an area that is quite unique in that half of the area is fluoridated and half of it is not. We have miles of statistics showing that areas that have a fluoridated water supply have a reduced incidence of decay rates in the age group that we treat.

CHAIR: This is the Central Coast?

Ms FRANKS: Yes. Gosford is not fluoridated and Wyong is fluoridated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give the Committee some statistics to show the difference in the schools there?

Mrs WALLACE: Certainly.

CHAIR: That would be very helpful. Are those schools matched demographically income-wise and so on?

Ms FRANKS: Yes. There is quite a powerful lobby group on the Central Coast, headed by Tony Abbins, who used to be the Chief Medical Officer, New South Wales, and the Dental Therapists Association are part of that lobby group, trying to persuade Gosford council to change its mind on the fluoride issue. That would be one thing that the association would really like to get across: we feel it is

not the role of local councils to decide whether fluoride should be included in their water supplies; that that is a decision for the Department of Health. We wholly support the change to that legislation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would certainly appreciate statistics from comparable schools.

CHAIR: You might move that the Committee formally request that information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do so.

CHAIR: You have probably given an answer to my next question. You have told us the things you have pushed for regarding legislative change. You are still seeking legislative change in the age 25 and private practice and so on. Is there anything, even more generally or more specifically, that you should put on the record while you have this opportunity?

Ms FRANKS: I think it needs to be said that dental therapists have been treating the most needy of the community for the past 30 years, and we will continue to do so. We are not pushing our own barrow to get private practice rights or to rush off to private practice and make a fortune. That is not the reality of it. We still care about the community and I think it is indicative that there are 216 of us still left and have done so for quite some time. I think that indicates our genuine concern for the children of this State.

CHAIR: I thank you for your evidence.

(The witnesses withdrew.)

REGINALD FRANCIS SCOTT, OAM, President, Dental Technicians Association, sworn and examined:

CHAIR: Are you appearing on behalf of the association?

Mr SCOTT: Yes.

CHAIR: Do you want to say anything to start with?

Mr SCOTT: When I received the invitation I thought, "should I respond or should I not?" I certainly passed the invitation on to the Dental Prosthetists Association, because it represents dental prosthetists and I do not. Technicians are not allowed to treat private patients for dentures where prosthetists are. I thought I might give a little bit of a history of the association in this respect. It was formed in 1937 and its aim was to get dental technicians registered and, from that group of registered technicians, advance to dental prosthetist. I think I mentioned in my submission that the registration of technicians was passed through Parliament in 1975 and the amending legislation enabling dental technicians to become dental prosthetists passed through Parliament in 1978. If one looks back through the *Hansard* of that political jewel, if you like, there are some 160 hours of debate in both houses, and I think I listened to all of them. The one I remember well was the Hon. Cyril Cahill, MLC, who spoke for three hours and 21 minutes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was this a filibuster?

Mr SCOTT: That is the term they called it.

CHAIR: We still have no time limits and some of us have still been known to speak for too long.

Mr SCOTT: Somebody has beaten him.

CHAIR: Lots of people have beaten him. That is nothing.

Mr SCOTT: That was in Sir Harry Budd's time when he was the President of the upper House. He ruled him out of order. He was repeating himself, which he was not. Anyway, that is some of the history. The membership of that particular association consisted of probably 95 per cent of people who were breaking the law in New South Wales. They were breaching the Dentists Act.

CHAIR: Because they were dealing direct.

Mr SCOTT: They were dealing with the public.

CHAIR: What is the situation now? Did it work? What has changed?

Mr SCOTT: When I started in Macquarie Street in 1948 or 1949 my tutor probably dealt half and half with dentists and private patients. My next guy at Eastwood would have been about 95 per cent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Private patients?

Mr SCOTT: Of private patients. I started my business at Five Dock in 1970 and from 1978 I never worked for any dentists. I was being a naughty boy breaking the Dentists Act.

CHAIR: So since 1978 you have been totally law abiding?

Mr SCOTT: Yes. What happened to the Dental Technicians Association, when the amending legislation passed in 1978 those people felt that there should be a separate organisation for dental prosthetists and as people became registered they joined that particular association, so the Dental Technicians Association lost members every year. There was no point in paying two. So today the number that I represent is probably a little over 20 people who have stayed there for the purpose of

saying, "thank you". I do not know the reason. I thought I might just put you in the picture there. My purpose of coming in was I thought maybe I could add something to the Committee. I am sure the Australian Dental Association has indicated the shortage of dentists throughout New South Wales, and I do not know whether it has put up a proposition like the medical profession where the Government subsidises doctors to go to country areas. It could be in the form of—

CHAIR: We have had a lot of different suggestions that we would like to talk more specifically with you about your area of expertise.

Mr SCOTT: That is fine.

CHAIR: So your association is quite small but that is because most of the people you represent now or represented in the past were dealing with the public anyway so once that change was made that distinction is rather artificial.

Mr SCOTT: That is correct. There is a need for a Dental Technicians Association. There certainly is.

CHAIR: Why?

Mr SCOTT: We used to represent them industrially but that proved to be a financial problem to us.

CHAIR: Does the association—

Mr SCOTT: We no longer represent dental technicians publicly now.

CHAIR: Does the association of prosthetists do the industrial representations?

Mr SCOTT: No. My colleagues are here to help you. It is a professional association; it has no industrial coverage. I think I said in my submission that I was foundation president of the prosthetists association from 1978 until 2000. I want to make the point clear that my colleagues here will be representing the association; I am not.

CHAIR: In terms of the actual work of technicians or prosthetists and so on, that has obviously changed over the period we are talking about.

Mr SCOTT: It sure has.

CHAIR: So therefore the demand and the nature of the service have changed.

Mr SCOTT: First, there was an apprenticeship system. In 1975 that was removed to a full-time course which approximately takes four years. Once being a registered technician you can enrol in the prosthetists course which I think this year is two years. My assistant just finished it six months ago. It was two and a half years so it did take six and a half years to be a prosthetist. I think one of your questions is: why should they be employed in the public sector? The advantage of that is that, unlike the dentist today, full denture construction, that is complete upper and lower dentures, is not in their training course. But once registered they can go out and make full upper and lower dentures but that is another issue.

CHAIR: Is anyone else trained to do it?

Mr SCOTT: Prosthetists are.

CHAIR: But technicians no longer are. So what is in the technicians—

Mr SCOTT: No, I am saying that dentists are no longer trained. The advantage of the prosthetist is simple. He or she understands the technical work that goes into the fabrication of dental appliances, namely removable dentures, and the prosthetist understands that clinical side of it. So he has knowledge of both areas. There is that shortage of dentists in the public sector. I think Westmead

employs two prosthetists and I think Sydney dental hospital two. I could show you a document here where the association tried back in 1980 to get prosthetists, once registered, employed in the public sector and that is it, I think, all over Australia and New South Wales.

CHAIR: Is that because of a funding issue essentially?

Mr SCOTT: I think it is a decision of the hierarchy that controls the employment of them.

CHAIR: But made for what reason do you think?

Mr SCOTT: I have no idea. The main prosthetists are employed in health fund dental clinics during the prosthetic work but not employed in any numbers in the public sector in hospitals.

CHAIR: Is the demand for prosthetic work decreasing?

Mr SCOTT: This was an argument back in the 1970s against registration; with fluoride, there will be no need for dentures. I am as busy today as I was 10 years ago. Maybe there are less full upper and lower dentures, yes.

CHAIR: If you are still as busy, perhaps you could give us an indication of to what extent the clients have changed? Are they younger or older? You just said, for instance, less demand for full upper and lower dentures. Can you give us a bit of a summary?

Mr SCOTT: The age of most people who would be wearing complete upper and lower dentures would be well over their sixties but there are some 30, 40 and what have you.

CHAIR: But in terms of the work you do, can you give us a snapshot of what the demand might be now and the work you do now compared to, say, 10 or 20 years ago?

Mr SCOTT: Definitely less full dentures with the increase of crowns and bridges and people are keeping their natural teeth longer with the advantages of fluoride. It is a proven fact that fluoride decreases tooth decay. I had three sons. My wife took those F tablets and I think my oldest fellow is 42 and he has one or two fillings. There is no argument that fluoride works. I listened to the previous speakers because I have a friend on the Central Coast. On fluoride, Gosford just lost the battle with getting fluoride in again, yet Wyong has fluoride. I am sure the record books will show that there is less decay in children's teeth where it is.

CHAIR: Would you agree with those previous witnesses that it should not be a decision for local government; it should be a decision for—

Mr SCOTT: It should be a Government decision.

CHAIR: And you are in favour of fluoride being added.

Mr SCOTT: One of the fellows who was against it was a member of the upper House, Hubert O'Connell, the chemist. He did not like fluoride.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did he sell F tablets?

Mr SCOTT: I do not know. He probably did.

CHAIR: What other comments would you make about changes?

Mr SCOTT: One of the main problems that I have is the dentures for pensioners scheme. I negotiated that scheme with the health Minister and the Health Commission. It was finally agreed to in May 1980. How the fee schedule was derived, at that time the Australian Dental Association fees for a complete upper and lower denture were $250. It so happened that at the same time the Dental Prosthetists Association suggested minimum fee was exactly the same figure, $250. Whether we were right or not at the time we said we would give the Government a discount. So, we discounted that

figure to $210, gave them a $40 discount. Today, there is about a $600 difference between what prosthetists get for the upper and lower denture to what they might charge for their private fee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So this is a comparable decline in percentage to the Medicare rebate compared to the AMA fee?

Mr SCOTT: I do not know how they derived it. If you look at the agreement of that—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As a person who works in general practice, I can say that the Medicare fee for many things is now about half, a little over half, the AMA fee and that would be comparable as a percentage, I would think, and it has declined over a comparable period, has it not? That was around when Medicare came in, was it not?

Mr SCOTT: Probably. I also negotiated the fee with Veteran Affairs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has that gone down as well or has that stayed close to the ADA fee?

Mr SCOTT: In 1985 the association fee was $460 and we offered the Federal Government a saving, so we gave them a $50 discount—$410. Today, veterans' fees are $980 for that upper and lower denture in comparison to the pensioner dentures scheme of $667, somewhere near that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the private fee is somewhere around $1,600, I think you said?

Mr SCOTT: $1,300.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is only half the discount for the veterans?

Mr SCOTT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that paid better?

Mr SCOTT: I am sure Mr Key, who will be speaking later, will—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you clarify for me, basically, that it seems there has not been an advocacy group. Who was the advocacy group industrially for the prosthetists and the technicians if your group does not do that?

Mr SCOTT: Neither do the prosthetists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the Health and Research Employees Association?

CHAIR: I think you are saying that you view yourself as a professional association?

Mr SCOTT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are mainly salaried?

Mr SCOTT: No—sorry?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you mostly salaried or mostly in private practice?

Mr SCOTT: Private practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do not have an industrial association at all?

Mr SCOTT: No.

CHAIR: If you had more prosthetists, as you argue, for instance, in public hospitals, at Westmead and so on, that may be different, but the very small number you mentioned, two at each—

Mr SCOTT: I am saying that the people from the prosthetists association would be better to answer that, but while I have been president there is no intention whatsoever to become an industrial organisation for prosthetists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not quite clear of the difference between a technician and an association. The technicians are not in the public sector. What is the difference?

Mr SCOTT: The technicians are registered to do the technical work for dentures, crowns, bridges and all of those appliances, for dentists. They can be self-employed in a dental laboratory. They work at the Dental Hospital. There might be some 40 dental technicians in the Dental Hospital. They can operate their own laboratory. They can work for prosthetists. They can work for dentists. A prosthetist is a dental technician registered under the Dental Technicians Act but they have a further qualification that allows them to see private patients for removable dentures only and mouthguards.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would be in a laboratory or with a dentist taking your impression or whatever, not as an independent person dealing independently with the patient?

Mr SCOTT: Prosthetists examine the patient and make the removable dentures for them without any referral contact with the dentist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The technician does not?

Mr SCOTT: The technician can only do work on the order of a dentist or a prosthetist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, in a sense, your profession is historically restricted and it will not expand?

CHAIR: Mr Scott went through this because he said at the beginning his association now has only 20 members.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, so presumably your members will not try to become prosthetists because they have an adequate income?

Mr SCOTT: They are all prosthetists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are not registered as such?

Mr SCOTT: Yes, they are.

CHAIR: They are but there are no longer any people left who are unable to deal directly?

Mr SCOTT: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is an historical word, not an historical profession anymore?

Mr SCOTT: No.

CHAIR: So even the 40 people working in the Dental Hospital—

Mr SCOTT: They belong to the Arial group, whatever it is.

CHAIR: So they are not registered to deal direct with the public, presumably?

Mr SCOTT: Some of them may be.

CHAIR: But they do not have to be?

Mr SCOTT: No.

CHAIR: Whereas most other people have changed the way they deal?

Mr SCOTT: There would be prosthetists registered in New South Wales working at the Dental Hospital as dental technicians, looking for positions as prosthetists.

CHAIR: They may not deal direct but they would have the right to if they moved on?

Mr SCOTT: Yes.

CHAIR: Do you think that was a good change?

Mr SCOTT: The evolution of the prosthetists?

CHAIR: Yes.

Mr SCOTT: Most definitely.

CHAIR: Is there any argument to return to the former system?

Mr SCOTT: None whatsoever. All States and the ACT, except Western Australia, registered prosthetists, and New Zealand and Tasmania. Tasmania was the first in 1957; Victoria, 1972 and New South Wales, 1978. I can tell you each year.

CHAIR: So it is generally agreed all around Australia and elsewhere?

Mr SCOTT: The dental profession fought against it but eventually we won the day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How do the pensioners get their dentures done if they are being done effectively at half price? Presumably they would be last in the queue every time? Can you do that at a profit or is it more or less a charity job?

Mr SCOTT: My colleagues will further answer that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are still working in the field, though, are you not?

Mr SCOTT: Yes. I do not do any pensioner work. I practice at Five Dock and patients are patients of the Dental Hospital only. The Dental Hospital does not allow private practitioners to do work in their area. Originally, when we signed the agreement, the patient had the freedom of choice to be attended to either at the Dental Hospital or by private practitioner, whether he be a dentist or a dental prosthetist. That freedom of choice has gone long ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They had the freedom but no-one wanted to do them in the private sector, is that the problem? They still have the freedom theoretically, do they

Mr SCOTT: No. In the metropolitan area, under that area of the Dental Hospital, they have to attend the Dental Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To get their dentures?

Mr SCOTT: Yes. So you have the elderly people who have to travel by public transport and what have you. What I would be interested in, if the Dental Hospital as ever done a survey of what it cost it to produce, if it took in the rent of the room and the wages.

CHAIR: That is something we can take up with the Health Department and others.

Mr SCOTT: It would be of interest to find out exactly what a complete denture cost it.

CHAIR: Mr Scott, you have said a few times that we should ask the prosthetists those questions. As you know, they are our next witnesses and we are pretty much up to their time. Is there any issue that we raised with you that we have not taken up?

Mr SCOTT: Waiting lists are another thing. I do not believe they have one because it is so extensive a time. I have had people wait two years for dentures.

CHAIR: You mean under the pensioners scheme?

Mr SCOTT: Yes, at the hospital.

CHAIR: But you cannot speak of that directly from your own experience?

Mr SCOTT: No. I hope that is of some benefit to you.

(The witness withdrew)

GRAHAM JAMES KEY, Vice-President, Association of Dental Prosthetists Inc New South Wales, 7/2 Johns Avenue Gordon, and

JENINE ANNE BRADBURN, Secretary, Association of Dental Prosthetists Inc New South Wales, 7/2 Johns Avenue Gordon, sworn and examined:

CHAIR: Were you here for most of Mr Scott's evidence?

Mr KEY: We heard the whole of it.

CHAIR: As you know from that, a lot of questions were coming out and clearly the situation has changed over time. I guess your group is now the dominant group. There were a few issues that he said we should ask them, but having heard him and also having made a submission, is there anything you want to say before we go into questions?

Mr KEY: Just to let you know that if anything about a national thing comes up I can talk about that as I am the national president. I am vice-president of New South Wales. The Dental Technicians Association did evolve into the dental prosthetists association and much of that work was Mr Scott's.

Ms BRADBURN: He is our grandfather.

Mr KEY: He led us into what we have today. The association is a very professional association in all senses of the word.

CHAIR: Tell us a bit about your association: how many members you have, how you operate, what kind of structure you have, and so on?

Ms BRADBURN: The Association of Dental Prosthetists is a professional body that represents dental prosthetists in New South Wales, but we are also part of the larger body that represents the Australian Dental Prosthetists Association, and we are also members of the International Federation of Denturists, which is a worldwide professional body representing the dental prosthetists and dental denturists across the world.

Mr KEY: Same person, different title.

Ms BRADBURN: Throughout Australia you will find that dental prosthetists have slightly different legislation governing them. Here in New South Wales we are allowed to do removable prosthetics as well as mouthguards, and we are now doing implant over dentures for patients as well. We deal directly with the public, as opposed, like Reg said, to dealing with another clinician. All of our background is as dental technicians who have gone on to do our extra study. Within New South Wales we are governed by the New South Wales Dental Technicians Registration Board, and within our association we have several categories. We have practising members, non-practising members, student members and retired members, so we have four different categories. We have 216 practising members, 12 non-practicing members, 26 students and six life members.

CHAIR: Does that 216 comprise most of the practicing prosthetists in New South Wales?

Ms BRADBURN: In New South Wales registered as of today there were 412 dental prosthetists.

Mr KEY: Not all practicing.

CHAIR: some could be retired, for example.

Mr KEY: Yes, or they could be still working as dental technicians even though they have the qualification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have a bit over half the total number?

Mr KEY: Yes. You asked before about the distinction. The closest to a dental technician is a pharmacist, who works under prescription. A dentist or dental prosthetist passes a prescription onto a technician who sits and makes the appliance, whereas prosthetists have done another formal and totally separate qualification that allows them to deal direct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the difference that you take the impression and then take it across. Presumably you have the impression and then you make the prosthesis from that, do you?

Mr KEY: That is right. The impression will be sent, by courier mostly, to a technician and the technician works on it from there and sends the work back. The dentist or prosthetist then moves to the next stage, does the work and sends it back to the technician who does the technical work and sends it back again. Everything that goes in your mouth is made by a dental technician but the person dealing direct with the public is either the prosthetist or the dentist. The advantage of a prosthetist that they can do both. If they see the patient they also their prosthetist's hat off and become the technician. So the person seeing the patient is doing the work, which makes it a much better product. You can visualise the patient in your head if you are doing the technical work.

Ms BRADBURN: You do find that the lines become a little bit more muddied in some situations. As I said, a lot of technicians may be registered as prosthetists but not working as prosthetists as such; they would still be sitting in a laboratory doing lab work for a clinician.

Mr KEY: As an example, you were talking about the public sector. At Hornsby there is a person working as a dental technician, but because Hornsby Hospital does not employ prosthetists—he is a prosthetist—he is actually merely to do the technical work, even though he can see patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does he get less money for that?

Mr KEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that that is the reason he is being paid as a technician.

Mr KEY: Well, no because if he was working as a prosthetist they would not have to be paying the dentist, who earns a lot more money, to do it.

Ms BRADBURN: He has other skills, and I think that is one of the things we our wanting to bring out. The health system could actually be utilising the skills of a dentist in those areas and utilising our skills to make dentures, freeing up dentists to do the work they can do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Every case you would see a dentist would not have to see.

Mr KEY: That is right and, as Mr Scott said, it is our field now; is not the dentist's field any more.

CHAIR: They are not trained at all?

Mr KEY: They are trained. They are trained in a small capacity but in our training on dentures alone we do six times the training they do. They are trained in vastly greater areas than us, but in the areas of removable prosthetics we are much better trained.

Ms BRADBURN: The system actually works very well. I suppose I am probably a very good example of that. I work for a fairly large health fund that has its own dental and eye-care centres in which we employ three dental prosthetists, who make up probably 90 per cent of the prosthetic work. On the days that we work dentists are freed up to do purely restorative and preventive dentistry. That will give you an idea of how it works in a large clinic environment.

CHAIR: In a clinic is most of the production work done by people in a lab essentially working as technicians regardless of their title or training?

Ms BRADBURN: Yes. We have an on-site laboratory at two sites and that is overseen. They do all of the work there. As a prosthetist I see patients in the clinic within the health fund and what I will do is one day a week I see my patients and I do any chair-side work that needs to be done at that time. If not, I give it to a technician to carry out the rest of the work for me. I do not physically myself do any of the technical work in the lab as such.

CHAIR: How does that work out in terms of number of people required? There must be some rule-of-thumb ratio, such as one prosthetist to every three people in the background.

Ms BRADBURN: We tend to do it very differently because there are different service mixes. We also do crown and bridge work and orthodontic work is also needs to be done out of the labs. So that is very different. It is hard to give you an indication of that. If I was to be seeing the amount of patients you would need at least one and a half technicians for each prosthetist that is working. That is just off the top of my head.

CHAIR: How many dentists would you need?

Ms BRADBURN: I will give you the example of where I work. At the moment we have probably 55 dentists across two centres and we have 12 technicians.

CHAIR: How many are prosthetists?

Ms BRADBURN: Three.

Mr KEY: My private practice work was in Maroubra and I was in partnership with two dentists and technician. The four of us were partners in Maroubra Dental. It was the same thing only on a much smaller scale. The two dentists were working full-time, I was teaching half-time and working half-time and the laboratory had five technicians doing all the dentists' work and my work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Taking impressions is a fairly small part of the job in terms of the total time taken to produce the prosthesis?

Ms BRADBURN: Yes, very much so.

Mr KEY: You see the patient five to six times before the procedure comes to an end. You have to take occlusal registrations, you have to look at the teeth in a works mould and you have to make sure that everything is correct before you move on to actually finishing these two things that are going in the mouth. It is quite an involved and very accurate process and that is why you need to skills of people who are doing it all day every day. The dentists I worked with specifically wanted to become partners with me because they did not want anything to do with dentures. They wanted to do the crowns and orthodontics, the high-end work and they left me to do what I was trained to do well.

CHAIR: Just for completeness, how many dental assistants were employed in the two practices you are giving us examples of?

Mr KEY: In ours there were six.

CHAIR: And, in yours?

Ms BRADBURN: Off the top of my head we have 1.25, I think it is, for every dentist employed. They do have a ratio and I could get you the information on that.

CHAIR: That is on an equivalent full-time basis?

Ms BRADBURN: Yes.

CHAIR: They may well work casually or part-time?

Mr KEY: Yes.

Ms BRADBURN: I do believe that the health fund I work for made a submission to the Committee and expects to be here anyway at some point.

CHAIR: Given the mix we have had today it is useful to get the percentages.

Mr KEY: In the mix of teamwork, Maroubra would have employed a dental hygienist if they could have got one. They would have had one in a minute but they just couldn't get one.

CHAIR: There are just not enough.

Mr KEY: No, just not enough.

Ms BRADBURN: We have five employed at the organisation for which I work.

Mr KEY: As we are saying, this is working in private practice; it should be working in the public sector.

CHAIR: Is the mix appropriate? If we are talking about what dental services—say, in the private sector for the moment—should look like in five or 10 years' time, would you say we should have dentists and prosthetists, we should have the lab people?

Mr KEY: Definitely.

Ms BRADBURN: I believe the dental team is definitely the way the dental profession is going to head. We are seeing a lot of smaller practices being set up. You may find that prosthetists will not be on-site full time; it will be one or two days per week perhaps, or a couple of half days here and there, but I think the team concept is really where we are headed. You are getting very specialised expertise in a particular area.

Mr KEY: I teach dental prosthetists at the Dental Hospital and I would say that every time a group graduates possibly 60 per cent of them joint a dental practice, as opposed to opening up on their own, because they see the benefits of working with dentists. If there is an unhealthy mouth, a dentist is on the premises and can fix it and then refer the patient back; and the dentist can see the benefit because they do not have to make the dentures. They have the expert there who can make the dentures and they can get on with what they do really well. I see that trend happening more and more every day because our technicians who become prosthetists have a relationship with the dentists already. They have worked for them as a technician in private practice and the minute they graduate that relationship continues except on a different scale.

CHAIR: Is that pattern connected to a tendency for the practices to get bigger, moving away from the small one-person practice?

Mr KEY: 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.

CHAIR: How does all this relate to the public part of dentistry?

Mr KEY: We are saying this could be a model. This is the type of model we would be looking at. Dental prosthetists are not employed in the public sector because there is no award for them. In respect of the ones that are employed, the hospitals have to make it up. They are either at the top of the grade technicians' award or at the slightly lower grade dentists' award.

CHAIR: Like the example that you gave about Hornsby.

Mr KEY: Yes. But in Hornsby he is not employed as a prosthetist, even though he is one. He could be seeing patients there now, but he cannot because they will not let him.

CHAIR: Is that because they have made a deliberate decision in terms of structuring, or is there a bit of a historical hangover?

Mr KEY: Historically, to be honest, the dentists in the public sector are older. They went through the fights that Reg Scott was talking about earlier. Whereas the younger dentists want to work with prosthetists, the older ones are still fighting the old battles. Therefore, they are not employing prosthetists, whereas I know Gosford and I think Wyong have just employed one each. They are starting to come in and all of a sudden they are asking: What do we pay them? How can we get them in?

Ms BRADBURN: The pay rates have to be considered. Even by starting them on a first-year dentist rate or a higher rate dental technician, that is still not equitable to what they could be earning in private practice. I know that there are always some inequities there, but we are talking about some fairly huge discrepancies in the pay structure.

CHAIR: Is this another area where there is a shortage of trained people so that the private sector sucks up most of them and there really are not enough to go around?

Ms BRADBURN: We found, like everyone else, with the oral work force there is a shortage. We found that that was probably more so in the last couple of years because New South Wales was the only training body for Australia. We are hoping to see that that will change because we have two new courses, one in Victoria through RMIT and one through Griffith University. The dental prosthetists course up there has become a Masters course. We are hoping that will bring through more people and that that will make a change, so that we will be sucking people from our State into other States as well. We were and are recognised as one of the leading training body in Australia. We are leading the way as far as the training of dental prosthetists is concerned.

CHAIR: I would have thought that that might mean that the other States would have been desperately short and we would have been not quite as short.

Mr KEY: The other States are. We are not as short. We have 412, as Janine said, South Australia has 20 and still has no training facility. I have three flying into Sydney every week to train.

CHAIR: And yet we gather that dentists are being trained at the University of Adelaide and recruited to work in New South Wales.

Mr KEY: Yes. The ratios in the other States are a lot smaller. But now that Victoria and Queensland are running the course, it will get back to normal. That is a good thing. New South Wales could not train the whole of Australia.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the oral health scheme about pension dentures?

Ms BRADBURN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note you say in your submission in August 2004 the members voted to withdraw their services to the New South Wales oral health scheme because it was no longer economically viable to continue. So, effectively, rather than waiting three years you will wait forever. Is that it? Presumably those employed in the public sector, be they technicians or prosthetists, will do all the grist that comes to their mill and presumably some of them will be in the oral health scheme—or, if they are done by the hospital—

Mr KEY: If they are done by the hospital they are just employees. The technicians do not become part of this; it is only the prosthetists and the dentists who will be seeing the patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If a pensioner came in and needed dentures presumably if there was not a prosthetist the dentist would take the impression and give it to the employed technician and the hospital would produce the dentures for them.

Ms BRADBURN: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The fee is irrelevant there, is it not, because it is being produced by the hospital? It would not be a separate item, would it?

Mr KEY: No, there is not. But we were saying that withdrawing the services is all private sector because we only have half a dozen at the most prosthetists employed in public hospitals.

Ms BRADBURN: We are talking about the overflow that comes out into the private sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of which there is not many.

CHAIR: So this is not the voucher.

Ms BRADBURN: Yes, this is the voucher service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So pensioner dental services done in the private sector are withering anyway because of economic factors, are they not?

Ms BRADBURN: Yes, they are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And this is the final kybosh on the prosthetists doing this in private practice.

Ms BRADBURN: There is still a demand for it. There are still patients who cannot get into the public hospital system. There is a huge demand. A conscious decision was made by the members of the association to withdraw their services purely on the basis that we were paid less than what a dentist was paid for the same service item number as well as the fact that we could just not afford to any longer keep operating as a charity and doing this sort of work. Our overheads are the same as what a dentist has to see those patients. We are treating them the same as what a dentist does. Therefore, the need is there to be paid the equivalent fee to what a dentist is paid for that service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the pension dentist scheme is roughly half the ADA fee, is it not?

Ms BRADBURN: And we are paid less again.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So what are the actual fees in the pensioner dental system for you, and for dentists and the ADA? What are the comparable fees in the market?

CHAIR: If it is easier for you, you can take that question on notice.

Ms BRADBURN: I cannot give you the ADA but I can give you the fees for a couple of item numbers. If you are looking at a 711 or 712, which is a full upper or a full lower denture, and you are looking for a dentist, the oral health scheme rebate is $447.80. The dental prosthetist is given for the same work $369.50. That is a difference of 28.5 per cent. It is significant dollars for doing the same work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is the pensioner dental scheme; this is not the market.

Ms BRADBURN: No, this is just—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is your standard fee? Do you have a standard fee?

Mr KEY: There is no recommended fee. We are not allowed to put out a recommended fee. But we have surveyed the members and probably the average would be up around—

Ms BRADBURN: $700 for that same work.

Mr KEY: For a single denture.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if I go to a prosthetist I cannot get a price. I negotiate my own price, in a sense. There is no benchmark, like a medical item number.

Mr KEY: No, there is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are saying that there is a huge difference. You are basically better trained than a dentist in terms of making prosthetics anyway so you are saying that it is pretty inequitable and it is already pretty marginal in terms of what the market would pay.

Mr KEY: That is right. And at the last annual general meeting the members came to the executive and said, "We can't keep doing this". Basically, it is like charity work. They really feel sorry for the people and they want to keep doing it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which is the way a lot of doctors see Medicare.

Mr KEY: Some of these people are working 70 or 80 hours a week; they are that busy. To knock back somebody who is willing to pay you $1,400 or $1,600 for a top and bottom denture to see somebody that you will get $680 for is very hard for a private practitioner.

Ms BRADBURN: I think it also got to the point where prosthetists were saying, "If I go to the dentist that I work with"—and a lot of them are working in practices with these guys—"that dentist can do the work and get more but the patient comes to see me and I get less." Where does that become equitable?

CHAIR: How does it work if someone comes to a practice? Is a practice like a legal entity?

Mr KEY: No.

CHAIR: Is it noted whether the dentist or the prosthetist does the work?

Mr KEY: You have a provider number. If I do it, you have to put it in. If I put it in as Sean's provider number, it would be fraud.

CHAIR: So in that sense it is like Medicare.

Mr KEY: Yes. But the difference with Medicare is that under Medicare the doctor can charge more. They do not have to bulk-bill. We have to bulk-bill; we have no choice.

Ms BRADBURN: We cannot ask for extra.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you cannot have a gap for the pensioner.

Mr KEY: It is totally against the rules. If we charged a fee we would be struck off.

Ms BRADBURN: It would be one of our recommendations that that could be looked at. Other States offer the co-payment option to bulk up the difference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So this is a State Government fee; this is not Federal because Medicare excludes the mouth.

Mr KEY: That is right: Medicare forgot about us.

CHAIR: Dentists and so on argued against being included.

Mr KEY: They did in the beginning but they are not any more.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, they did this year—amazingly enough.

Mr KEY: I was on the National Advisory Committee of Oral Health and it was very much trying to get back onto Medicare.

CHAIR: There is a mix of opinion I guess.

Mr KEY: I do not think that will happen anyway.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think the ADA argued against it. I am not sure how recently but it was in the last couple of years.

Ms BRADBURN: 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.

Mr KEY: For a long time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you are not happy about that.

Ms BRADBURN: It is another thing that riled a lot of members and caused us to get to the point where in November last year they said they wanted to withdraw their services.

CHAIR: Had that scheme been in the making for quite a long time?

Ms BRADBURN: It was. It is the follow-on from the old dentures for pensioners scheme, which we were not happy with.

Mr KEY: But this year all the practitioners were asked to sign contracts with their local hospitals and they had to accept the fee. That was the crunch: They had to sign that they would accept this fee. That is when they came to us and said, "We're not doing it". Once they stopped signed those documents NSW Health contacted us and wanted to talk again. But for 10 years they would not talk. Their reasons for not talking—

CHAIR: So there is a bit of a stand-off at the moment.

Mr KEY: They said that they did not have the money to pay any more so how could they give an adequate fee if there was no money?

CHAIR: So the situation at the moment is that the scheme is there on paper but in terms of prosthetists it is not operating.

Mr KEY: There would be some still doing it.

Ms BRADBURN: For some people, particularly in some of the rural areas, that is obviously their bread and butter money and, as an association, we are not about to recommend that people withdraw their services if it is their livelihood. You have got to be fair to them too.

CHAIR: Would this be one of those areas where a fee in a rural area and the same fee in Sydney is a bit silly in terms of cost?

Mr KEY: Not necessarily. I have practised in the country and in the city and the costs are pretty close.

CHAIR: So there are more costs in the practice—the equipment and all the rest of it—than in the real estate, for instance.

Mr KEY: We buy the same equipment from the same supply company. We actually have to pay extra to get it to us in the country

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you save a bit on rent but your other costs are the same.

Mr KEY: That is right.

Ms BRADBURN: You may not. We discussed this last night at our meeting. Some of our rural members are not paying any less than we are paying in the city, given that there is an oversupply of rental properties in Sydney. That is, in itself, not necessarily a valid argument in those terms.

CHAIR: On the argument about the difference between what is offered to you people and to dentists, I guess there is a general difference across the board in that dentists get paid more.

Mr KEY: Only in the public sector. In private practice they do not. In private practice you negotiate your own fee.

CHAIR: But on the whole would dentists, in effect, negotiate higher fees? Is there a status difference or a perception difference?

Mr KEY: There is a perception. But I think now more prosthetists are joining practices the perception is that the dentist refers to us and they look to us almost as specialists—we are not specialists but the patient tends to think so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the status is equal.

Mr KEY: Yes.

CHAIR: So an ordinary fee-paying patient who comes along and needs a variety of work—

Mr KEY: But the guy in the country who has a little shop on the corner by himself could possibly charge less than the local dentist up the road. But, again, when I was in Tweed Heads that was not the case. I was charging slightly more than the dentists in Tweed Heads.

Ms BRADBURN: You would also find that a lot of the practices may not be employed on a salary per se; it could be on a commission basis in terms of it is a 40:60 spread or whatever, depending on what to bring into the practice on income, which is not unlike if you are a dentist and employing another dentist. You are just looked at as a dental practitioner in terms of that. There would be a percentage split according to what you bring into the practice.

CHAIR: For completeness and because of the questions that we asked some of our earlier witnesses, who are prosthetists? We found, perhaps not to our surprise, that almost all dental assistants and almost all therapists are female. The therapists are an ageing group, they are obviously lower paid than a lot of other groups and so on. Are there any generalisations that we can make about prosthetists?

Mr KEY: Males dominate.

Ms BRADBURN: Very much so.

Mr KEY: Technicians, not so much. It is funny but the progression from technician to prosthetist does not have the same equality. I do not know whether it is the $25,000 it costs to enrol in the course. I do not understand it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean that more male technicians go on to be prosthetists?

Mr KEY: Yes. About an equal split of females and males train to be technicians but there is not an equal split of prosthetists.

Ms BRADBURN: That has changed. The classic is that when I went through the technicians course probably 15 years ago I was one of two females in 15. But now you find a big difference. When I went through the prosthetist course I was the only female in my course. We are now seeing a lot more women come through the profession, which is nice.

Mr KEY: I have a theory—which is not confirmed—that there are more male prosthetists because back in the day when being a technician was an apprenticeship they tended to take on males. Now it is not—you apply for a course and you do it—and more females are coming through but the majority of them do not enter the prosthetist world.

CHAIR: Other witnesses talked about whether too few people were trained in their field and whether the work force was ageing. Arthur asked some women, as nicely as he could, whether they were dinosaurs. In terms of your group, are enough people being trained and coming through? Is it a growing or a stable work force?

Mr KEY: As we said, there were not enough because we had to train the whole of Australia. Now that we are concentrating on New South Wales I feel that it is adequate. But the Government does not fund the prosthetist training. It is run through public teaching but it is totally self-funding.

CHAIR: What do you mean?

Mr KEY: Students pay $25,000 a head to do it.

CHAIR: Where is the course held?

Mr KEY: At the Sydney Dental Hospital but it is run through TAFE. It is at the hospital. For example, the course costs $250,000 to run for a group of 10 so it is $25,000 ahead. There is no profit and no loss. If there was bigger demand you could take more students.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there HECS fees in that?

Mr KEY: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you cannot get a HECS loan for it.

Mr KEY: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why is that?

Mr KEY: It is TAFE.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: TAFE does not have HECS.

Ms BRADBURN: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is because it is TAFE.

Mr KEY: There is HECS in Queensland.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think it should be a university course and you could get some HECS—since you are earning the same and doing much the same thing as dentists?

Mr KEY: You could not get HECS because the technicians would be the university undergraduate degree and the prosthetist would be the Masters degree, which you would not get HECS for anyway.

In Queensland, you do a three-year Bachelor of Dental Technology and then you do a 12 months masters degree. The Higher Education Contribution Scheme [HECS] payment is on the dental technology side of it and the masters degree is fully commercial.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can get a HECS for any other masters degree, can you not?

Mr KEY: Not for this one, at least not at Griffith University. Griffith University is very much a cost recovery basis. They put their programs on to make a profit as opposed to normal universities.

Ms BRADBURN: We are currently in negotiations as an association with some of the universities. You referred in one of your questions to a career path and we are trying to look at that for dental prosthetists in terms of whether there are alternatives out there to a university degree that are available to us and what way could we go in that. That is something that we are looking at and trying to encourage.

CHAIR: Do you think that there is a demand for that among your members?

Mr KEY: There appears to be.

Ms BRADBURN: I think there is, yes. This is me now, but I do believe that to be recognised as equals with dentists is an issue. They are a bachelor and we need a qualification in order to do that. The fact that I have a diploma and an advanced diploma really does not somehow see the qualifications on a level with the dentists, clearly on an academic basis.

CHAIR: Does some of that distinction help to explain that disparity in the fee you mentioned before?

Mr KEY: Yes, I think it would, but it does not explain the actual training. The hours of training are equal to much more than an undergraduate degree.

CHAIR: But I guess there are a lot of other professions in the area of the work force where a university qualification traditionally means a certain sort of level.

Mr KEY: The fact that it is now a masters program in Queensland indicates the way that it is going. Probably by 2007 in New South Wales there will be a partnership between TAFE and the university for a Bachelor of Dental Technology, so TAFE will have an exit point at diploma but then there will be another year added on. It looks like it will be in Newcastle where the Bachelor of Oral Health is that will be running the one-year course on top of the other, and then we still need negotiations with the prosthetists of the Newcastle university. They are talking about entry into the Bachelor of Oral Health as well, but that is 18 months away.

CHAIR: Whom do you see as being the decision makers in terms of what appears to us to be a very complicated mix of training? You say that the Griffith University is doing this and it looks as though it will be Newcastle doing that.

Mr KEY: It is pretty much what the industry dictates.

CHAIR: On a national basis, as you mentioned before?

Mr KEY: 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.

Mr KEY: I think the national health training package that is run for all sectors other than university is an excellent system.

Ms BRADBURN: And it really did bring all the States into line. We had some concerns over the fact that there were different qualifications coming out across Australia for dental technicians and prosthetists. We believed that the training package really did do some good things for that and get all the States on like-minded training paths.

CHAIR: And you were happy with the degree of consultation and the involvement?

Mr KEY: Yes.

Ms BRADBURN: We were very involved in that. It was excellent.

Mr KEY: There is no longer an Australian National Training Authority [ANTA]. The skills council is not quite as consultative as ANTA was, but this is currently under review and so it is not as necessary.

CHAIR: As you mentioned before, about the way in which other States are now training their own people, it sounds as if that was a fairly successful co-operative and agreed process.

Mr KEY: 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.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you talking about $25,000 per year?

Mr KEY: No, for the course. The course costs $25,000.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For two years tuition?

Mr KEY: Yes.

Ms BRADBURN: It is interesting because the dental prosthetist course that is a run out of the University of Sydney draws its patients from the public health system. When I went through the course, it was at a different location but that is what we saw. We treated patients for the full day that were drawn from the health system, so you were getting free dental services provided by the students for those cases.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have heard evidence that the lion's share of the payment for the training of dentists is from the central Sydney area health service and western Sydney based in the Dental Hospital and Westmead, and the amount of on-campus training of dental students is quite small. They jump in with the medicos for a couple of undergraduate items. Is it not then ridiculous that you are full fee paying more or less side by side in the dental hospitals, and they are in some sort of HECS deal in the dental hospitals? It is quite anomalous in the sense that the State Government is paying for most of both.

Mr KEY: Yes, but the technician part of our training is government funded, and it is $1,020 a year. So if a technician trains full time for two years at a very subsidised rate through TAFE —

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do two years as a dental technician and then you do your prosthetist rate for $25,000.

Mr KEY: Yes.

Ms BRADBURN: It is perceived as being like a postgraduate course.

Mr KEY: They are saying that postgraduate courses are not government funded.

CHAIR: They are both full time.

Ms BRADBURN: No. The prosthetist course is part time.

CHAIR: It is two years full time for the technician and then two years part time.

Mr KEY: That is right.

CHAIR: Maybe it would be the equivalent of a year full time.

Mr KEY: That is why at the university it is one year.

Ms BRADBURN: The prosthetist course is one day a week. It is a very full, long day. It is one day a week and you see your patients during that time. You then go home and do the laboratory work in your own time in that week turnaround for those patients that you have seen.

CHAIR: You are already qualified as a technician.

Ms BRADBURN: It is a very stressful course. It is free laboratory work for the hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say "go home", do you mean go home to your own little workshop at home or do you have a laboratory somewhere, presumably?

Mr KEY: Yes, a laboratory.

Ms BRADBURN: Yes, our laboratory, wherever you have set up.

Mr KEY: These are qualified technicians.

Ms BRADBURN: We have all got our businesses somewhere as technicians.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the wages structure such that you would make up that $25,000 fairly quickly?

Mr KEY: It would be equivalent, yes. The fact that there are about 60 on the waiting list to get into the course in New South Wales shows us that it is still a high demand course. It went from government funded to commercial without a glitch as far as the waiting list goes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if you are asking the Government to chip in, it would not look like a smart investment.

Mr KEY: No. The fact that it is a postgraduate course and not the first course makes it very hard to justify.

CHAIR: Are their enough people coming out of it?

Mr KEY: It appears at the moment there are enough prosthetists coming out. Whether there are enough technicians coming out is the other question because the laboratories are screaming for more staff all the time and we are not turning out enough technicians. But with the prosthetists, because it is commercial, really you could almost do more or less, depending on how many are needed because it is totally based on how many you want trained.

CHAIR: Getting back to the focus of our inquiry on public dental services, how would we get more services provided by prosthetists into the public health service?

Mr KEY: You need them in the public service.

Ms BRADBURN: You have to have both. I think there is a combination of the two that needs to be done. You will not be able to get everyone to a centralised area to have services provided for them, so you will still need that top-up.

CHAIR: The clinics and the hospitals in regional and rural areas have to start having prosthetists on staff.

Mr KEY: That is right. Hornsby was the first hospital to employ a prosthetist as a prosthetist. That guy left and went into private practice and the new dentist in charge decided he was not going to employ a prosthetist any more. He employed somebody who was a prosthetist, but he would not let him work as a prosthetist.

CHAIR: He did it as a technician.

Mr KEY: 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.

CHAIR: You are coming back to that career path issue.

Mr KEY: Yes. He or she could be 25 and will be on that wage at 65. There is no progression.

CHAIR: Would a prosthetist be in the same position? Would it not necessarily be a fairly flat structure in terms of career?

Mr KEY: No, because with awards in the hospital, technicians start at level one and go up to level four, so there is quite a disparity. I think there are about six or seven levels for dentists and they start at quite a low rate and work their way up. But there is no pathway to distinguish between a young prosthetist and a very experienced prosthetist and a pathway so that, if they want to have kids, they can stay in the public sector. There has got to be a pathway so that they get more money and progress into a senior role, and there just is not that pathway.

CHAIR: So unless they are incredibly idealistic or whatever it might take, what kind of incentives will be needed to attract people from the private sector into the public sector?

Mr KEY: I spoke to the health union that represents them, just the health union in hospitals, and they have put in an award case of something like an award structure of dentists at 8 per cent less.

CHAIR: At each step?

Mr KEY: At each step, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that that is realistic?

Mr KEY: Yes, very much so.

CHAIR: The dentists are paid enough, are they, to be comparable?

Mr KEY: 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.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And your situation is even more muddled than most. Is that not really the situation?

Ms BRADBURN: In a nutshell, yes.

Mr KEY: There is an oral health work force group that meets and is trying to muddle this out. The former acting chief dental officer was trying to work it out without having to go to industrial relations so that there could be some agreement on what a prosthetists award could be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Without the court fees, as it were.

Mr KEY: Yes, that is right. But the trouble is that there is a new person in the chair now and there has not been an oral health work force meeting for a couple of months, waiting for the transition. That group is working on it, but that does not involve the union either, which is putting in its own case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely, if they are putting in another case separately, the union will still be battling on in the courts. If they are not in the tent, they will be fighting outside the tent.

Mr KEY: Again, they have to be invited to these things.

CHAIR: The union covers only some of the groups under discussion. For instance, they do not cover any prosthetists.

Mr KEY: The prosthetists are covered by them.

CHAIR: If they are working in the public hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The glass is still half full rather than half empty. The glass still has something in it.

Mr KEY: Yes.

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.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is like language teaching.

Mr KEY: The Australian Dentists Association put quite a scathing editorial in its magazine about why they should have these meetings if there is no money because we are just talking fairyland, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Like tobacco control plans.

CHAIR: We will be here until seven o'clock! It is my job to look at my watch and clock, occasionally.

Ms BRADBURN: There are also some interesting things that could be done to simplify the process in which the current oral health scheme works. One of the things brought up is that by the time the patients are actually dentally fit—we can only work as dental prosthetists in an apparently healthy mouth. It is important that when we are making dentures we make sure, particularly with partials, that their mouth is healthy. By the time a patient has got their assessment done, they have their voucher and have turned up on our doorstep as a patient, apparently healthy, the time lapse has been so long that they are not actually dentally fit any longer to go ahead with the denture and you are almost fighting—

Mr KEY: You have got to send them back.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the teeth you were going to hook their denture onto is now rotten.

Ms BRADBURN: They are going back to the dentist to have that done and it just goes on like that.

CHAIR: How do we solve that sort of problem?

Ms BRADBURN: There is a good system that they talk about with Veteran Affairs. As dental prosthetists we are individual providers; we do not need to work under the instruction of a dentist and therefore we should be able to, like we do with our own patients, make the assessment on patients from day one. We ring up and say, "Are they eligible for a new set of dentures? Have they had them in for X amount of years?" Yes or no, you start the treatment if they are ready. Then your time lapse is a lot less.

CHAIR: But the Department of Veteran Affairs [DVA] is a fairly generous funding system, is it not?

Mr KEY: It is, but all the other State denture pension schemes are linked to DVA.

CHAIR: You mean that they operate in the same way?

Mr KEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And New South Wales does not?

Ms BRADBURN: It does not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is New South Wales unique in that?

Mr KEY: Yes.

Ms BRADBURN: From what we understand, yes.

Mr KEY: Not all States have a scheme at all but the scheme in the Australian Capital Territory is totally linked to DVA.

CHAIR: When you say "linked", do you mean operates in the same way?

Mr KEY: No. If DVA gives a fee rise, it is automatic that the State will give the rise and Victoria and Tasmania are the same. Not all States have a scheme at all.

Ms BRADBURN: And I think they were saying that Victoria actually operates in a similar sort of way with their processing of claims for their dentures for pensioner schemes or the equivalent.

Mr KEY: The patient now has to be assessed by the hospital first and then sent out. It works within the hospital structure as well. With our student dental prosthetists, a patient comes down with a voucher from upstairs which says that they have a clean bill of health. They got that voucher a year ago and they then went on the waiting list for dentures.

CHAIR: So as long as there is a huge waiting list—

Mr KEY: Yes, and before we let the student see them, we examine them and quite often they go back upstairs. The poor buggers have just waited a year. It is pretty hard.

CHAIR: So there needs to be more flexibility or understanding of that.

Ms BRADBURN: Also, there needs to be the option available because under the current scheme there is no availability for patients to be having metal framework for cobalt chrome dentures, which do, in the long term, support the teeth a lot better. They actually help to maintain the teeth better there; they are not as bulky and in the long term they are much better for the mouth. At the moment the current scheme only allows a patient to have an acrylic denture, which can often cause the patient to lead down a path where they are going to have full dentures eventually.

If there was an ability to introduce the cobalt chrome denture and then perhaps patients could top-up if they have a choice between the two, that could also be an available option. I think the co-payment option certainly needs to be examined here in New South Wales.

CHAIR: What is the difference in cost between the acrylic and the cobalt chrome?

Mr KEY: Simply the cost of the cobalt chrome—

Ms BRADBURN: The casting.

Mr KEY: Which is about $200 for a laboratory to cast it. We generally in the industry—and dentists too—refer to acrylic dentures as gum strippers. If they have not got a full denture when they start, they will have one by the end.

Ms BRADBURN: We do not actually make them in the health fund that I work in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they are the traditional plastic ones?

Mr KEY: They are.

Ms BRADBURN: Yes.

Mr KEY: For partial dentures, and Veteran Affairs will only allow their patients chrome dentures. They will not let them have acrylic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are a technological advance, are they?

Mr KEY: They have been around for 50 years.

Ms BRADBURN: It is not like it was only yesterday or anything.

Mr KEY: It is just that they are dearer. You have got to pay for the laboratory to cast the chrome and the patient cannot say, "I will pay you $200 to have the lab cast it." They are not allowed to and we are not allowed to accept it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is an issue of materials as well as in terms of quality?

Mr KEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And presumably if you are very marginal with the pensioner dental scheme, if you were not boycotting it, as the resolution was, you would presumably have to make it out of the acrylic. You would not have the chance of making it out of cobalt chrome?

Ms BRADBURN: There is no item number to be making it out of cobalt chrome.

Mr KEY: The basial acrylic denture is worth $190 from the denture for pensioner scheme. How could we pay $200 to get a casting made?

Ms BRADBURN: Your lab fees are more than that for dentures in most cases.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But aren't you the lab fee?

Ms BRADBURN: Not necessarily, and this is one of our arguments. This is where it is very different to what it was once before. The lab fee could be the same as what a dentist's would be. You could be sending your lab work out to another technician. You may not be doing your own work.

Mr KEY: But also the argument is: Why should a prosthetist not charge for his or her own lab work? It is like saying "I am going to do that for nothing. That part of my training I will do for nothing".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But does not the prosthetist do all the lab work or is there someone doing casting who is yet another technician?

Ms BRADBURN: Someone is doing casting.

Mr KEY: A separate person usually does the casting. It is a specialised area of technician training.

Ms BRADBURN: And there are prosthetists out there who employ technicians to do all of their lab work—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They just do the clinical work.

Ms BRADBURN: That is it. That is where the difference is.

Mr KEY: It is just one finish we support forever. I have worked in a country practice and I worked in a city practice and there is a big difference. At Tweed Heads I was seeing patients commonly in their 30s. In Maroubra I am barely seeing anybody under 50 or 60, so fluoride is a factor.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I move that the document referred to by the witnesses be tabled.

Document tabled.

CHAIR: You anticipated my fluoride question. I think you have told us pretty clearly what you want to see come out of this inquiry. You have been peppered with questions but it has been very useful.

Mr KEY: Having the answers to the set questions in writing gave us time to answer other questions.

CHAIR: Is there anything we have missed.

Mr KEY: I do not think so.

CHAIR: We may want to ask further questions later if something is not clear.

Mr KEY: We do apologise that Martin Dunn, the State President, was not able to be here. He is ill.

CHAIR: Thank you for your attendance. We will contact you if we need further clarification.

(The witnesses withdrew)

(The Committee adjourned at 5.07 p.m.)