REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO DENTAL SERVICES IN NEW SOUTH WALES

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At Broken Hill on Wednesday 31 August 2005

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The Committee met at 9.45 a.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. I. W. West

LYN MAYNE, Dental Officer, Royal Flying Doctor Service, PO Box 463, Broken Hill, sworn and examined:

CHAIR: Dr Mayne, thank you for coming to give evidence today. Did you want to say anything by way of an opening statement before we commence asking questions?

Dr MAYNE: Only that I am pleased something is being done to look into dental services out here.

CHAIR: So they need it, do they?

Dr MAYNE: They need it.

CHAIR: Have you seen our questions?

Dr MAYNE: Yes, I have.

CHAIR: We will try to go through them but Committee members might also ask all sorts of other questions.

Dr MAYNE: No problem.

CHAIR: Let us just run through some of the facts. In your submission you state that you have one dentist who travels on the aircraft to nine locations. You then talk about facilities and so on. Would you just expand on that a bit? What locations, how many runs are made, et cetera?

Dr MAYNE: I am the sole dentist employed at the Royal Flying Doctor Service [RFDS]. I cover an area of 640,000 square kilometres. I actually go to 15 clinics once you include stations such Marrapina and Monolon. We stop off at stations and area people come into the station to be seen. I also cover Maari Ma Aboriginal Health Service. I do the dentistry down there for them. I also do the correctional services at Ivanhoe correctional health facility. At the moment I am also doing some work for the Greater Western Area Health Service, as it does not have a dentist. So I am doing all that. The Royal Flying Doctor Service clinics, I do approximately 150 and 160 odd clinics a year. I am seeing about 1,160 patients, clients or contacts.

The dentistry that I do is the same that you would get if you walked into any dental practice. I carry all the gear so I can perform examinations, restorations, extractions and surgicals. I do dentures as well and limited orthodontic work—only removable appliances rather than fixed banding or anything like that. I do root canals or endodontics. Only really difficult oral surgical cases are referred. The problem with referring them is that there are not too many places to refer them to. They have to cross State lines and go either to Mildura or to Adelaide, there being no oral surgeon here.

One of the private dentists does a general anaesthetic session at the hospital. I believe that is only half a day each month, so there is a long waiting list for that as well. I can do crown and bridge work. However, that is limited by prioritising the work needed. So those in pain or with lost fillings get priority over having some sort of aesthetic dentistry done like crown or bridge. I have done a limited amount of that in the 7½ years that I have been here.

CHAIR: So how long do people have to wait? Are they basically waiting for you to arrive on the aircraft and get to the clinic, or are there such long waiting times or waiting lists that you might not be able to deal with everyone at that centre on that trip?

Dr MAYNE: The amount of time I am in any one place is limited, I suppose, by the amount of time that we can be out on the plane. Usually the clinics start at about 10.00 a.m., by the time we get to wherever we are going. We leave at 7.00 a.m. but it just depends on where we are going. So about 9.30 or 10 o'clock, taking into account the time difference. We usually see the last patient at about 3.00 or 3.30 p.m. Depending on where we are, it can take us up to two hours to get home. I see an average of about eight patients during that time.

CHAIR: How do you work out which patients to see?

Dr MAYNE: Some locations have a nurse on the ground. They will take appointments and people will ring. A roster goes out monthly so they know where I will be on any one day. They can ring in for an appointment. In some places, such as Wilcannia, we have recently changed that to a turn up, which has been working a lot better. We are seeing a lot more patients there. So whoever turns up gets seen. We just give a time period within which they should turn up. I go to some places only once a month. In some of the more remote places like Tilpa-Hungerford, which has a population of 15, I probably go once every two months. So the towns like Wilcannia, which is larger, get three or four visits a month. Ivanhoe, Tibooburra and places like that are visited once a month. In two months I suppose I try to do the whole cycle.

CHAIR: Does that mean you are pretty much covering the need to your satisfaction?

Dr MAYNE: Absolutely not. We need another dentist or two, especially covering Maari Ma and some of the Greater Western Area Health Service at the moment as well. There is just not enough time. I am covering what I can cover to my satisfaction but I know that there is a list there all the time. I have been doing it for 7½ years. There is not a place I go to where is not a list of people waiting. I guess the other thing is dentures, which are horrific. The budget I have for dentures has not changed in 7½ years. You take teeth out of people to get them out of pain. By the time you get back to getting them a denture when they get up on the list, their other teeth have worn out and need taking out because they have been overused. There is just a real cycle that goes on.

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

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

CHAIR: You got onto the funding issue, which was our second question. Can you explain to us how your funding works? Is it specially allocated to you as a dentist, or do the expenses of flights and all the rest come out of general funding? How does the system work?

Dr MAYNE: The funding comes from three sources. The Greater Western Area Health Service gets the State funding, which is then given to the RFDS. Maari Ma gives us some funding for doing some clinics down there. Then the RFDS takes some funding out of their general funding to see the bush clinics. So there are three parts to it. But there is no direct funding straight to the RFDS.

CHAIR: There is no funding straight to it?

Dr MAYNE: No. The State funds go to the Greater Western Area Health Service.

CHAIR: Within the Royal Flying Doctor Service do you have funds specifically allocated for dental work?

Dr MAYNE: No. They take that out off the general funding to cover the costs there.

CHAIR: How is it decided how much you get, say, for dentures? Who makes that decision?

Dr MAYNE: That comes from the Greater Western Area Health Service, from State funding.

CHAIR: Is it complicated for you in dealing with the funding mix? Do you know what your budget is, or what you can afford to do?

Dr MAYNE: Yes, basically. Up until two years ago they had a tripartite agreement between the three, but that has not been signed for two years. That outlined how many clinics the Greater

Western Area Health Service wanted and how many Maari Ma wanted. The bush clinics were then up to the RFDS. That has not been signed for the past two years. So we are still doing it and, of course, everyone wants a bit more.

CHAIR: Why has it remained unsigned?

Dr MAYNE: That is a good question. I think everyone wants a bit more. It is about what you can give. One will blame the other and the other will blame the other one about who is signing and who is not.

CHAIR: We can ask each of those groups for their comments.

Dr MAYNE: That has remained unsigned. Maari Ma is now doing some well person's checks and things like that, so they want more clinics to follow them up. But there is no agreement as to how we are going to balance this and how it is going to work.

CHAIR: So it is trying to move to a more preventive method?

Dr MAYNE: I guess that is the intent. But you cannot do preventive work until you have fixed up emergency problems.

CHAIR: You have given us some of the details of where you go, those that you see and so on. Could you tell us a little more about the general state of the dental health of the people you see? You mentioned earlier the young woman who lost a tooth and who would probably never get it replaced.

Dr MAYNE: There are two things. The indigenous population has very poor health and very poor general health as well. The non-indigenous population is in the same boat because of its remoteness. It is little things like fuel prices to drive eight hours to see a dentist. That has to come into the equation. Because of the drought they cannot afford to leave the property to go to a dentist. So all those sorts of things come into the equation. A lot of them put up with a lot of pain and a lot of poor teeth and oral health because of that. So in general I would say it is really bad. Before I was here I was in Hobart in Tasmania for 10 years in my private practice there.

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

CHAIR: When you say that since November you have been working for the Greater Western Area Health Service four half days a month, is that because the flying doctor service does not have the funds?

Dr MAYNE: That is because the Greater Western Area Health does not have the dentists. So, the public patients in Broken Hill had no access to a dentist.

CHAIR: Except you, four half days a month?

Dr MAYNE: If you are a public patient in Broken Hill and you have a toothache you have to ring Dubbo, who then put your name on a waiting list. That list is faxed to the oral health manager here and he puts a priority on who sees them. One of the private dentists sees a few of them and then I see some of them, but that is their only means of getting to a dentist.

CHAIR: So, they have a voucher or an equivalent to go to the private dentist?

Dr MAYNE: Yes.

The Hon. KAYEE GRIFFIN: How long have you been doing the western area health work?

Dr MAYNE: Since November last year.

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

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

The Hon. KAYEE GRIFFIN: How does that impact on the rest of your work?

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

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

Dr MAYNE: No.

CHAIR: So the flying doctor service does not provide the basic kind of administrative services for you?

Dr MAYNE: With regards to dental, I do it all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you need to do that? Could someone else do that for you if there was someone else?

Dr MAYNE: I think ordering dental things is very difficult if you do not know what you are doing. I have been doing it long enough that it is not too hard. I do not have a dental assistant because I set up a student program. Because we are flying, to have a dental assistant and a student takes up too many seats on the plane.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you take a student with you?

Dr MAYNE: I take a student with me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you always have a student?

Dr MAYNE: Probably about half the time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you do not, you do not have assistance either?

Dr MAYNE: No.

CHAIR: Is this a student dentist or a student dental assistant?

Dr MAYNE: A student dentist. Just recently we have taken some dental hygienist students as well.

CHAIR: Where are they studying?

Dr MAYNE: The students I get come from Sydney, Adelaide, Melbourne and then Hong Kong, UK, Dundee, Wales and Germany. So, they come from overseas as well.

CHAIR: This is an arrangement between the flying doctor service and the universities?

Dr MAYNE: Yes. We have an affiliation with the University of Sydney rural and remote campus up here. We take the students on board and they fly with us, the same as the medical students.

CHAIR: How long does a student stay in the area?

Dr MAYNE: It varies. They come in for a week up to three weeks. It just depends on each individual student, what they want to get out of it.

CHAIR: Is it satisfactory from your put a view, having them as your assistant?

Dr MAYNE: I enjoy having a student, yes. It is great for them and it is great for me. I think when you teach you learn. When I first started, and I have been practicing dentistry for a long time, when someone asks you why, it is because that is what you did. It is good to reconfirm why you do things and have to explain it. To have a dental assistant, the funding does not really cover it, to cover all the areas and the dental assistant, whereas the students are coming on a voluntary basis. In their elective terms they are getting some one-to-one tutoring. They also get the chance to be with the flying doctor service, get the chance to work with Aboriginal communities and in rural and remote areas. Hopefully, that will make them see that dentistry in rural and remote areas is much more extensive and much more rewarding than perhaps it could be where you tend to refer all the time in the cities.

CHAIR: Does that work? Have you seen any of them, over your seven years, come back?

Dr MAYNE: Yes. Two girls from Scotland—one is actually working at the Barrier Dental Clinic now. She came back and worked here and has fallen in love. So it does work sometimes. Yes, they all keep in contact. We have had a couple back, so that is really nice.

The Hon. KAYEE GRIFFIN: You said the dentist that worked for the area health service, that that position had been vacant for over 12 months now?

Dr MAYNE: Yes.

The Hon. KAYEE GRIFFIN: Have you any knowledge of how extensively those positions have been advertised?

Dr MAYNE: I have not seen them advertised.

The Hon. KAYEE GRIFFIN: In working with the area health service, have you had any discussions in relation to the difficulties of getting someone else into that position or the reasons why the position cannot be filled?

Dr MAYNE: Not really. I have not spoken to anyone about that. I do not know how extensive they advertised. I certainly have not seen anything. With them at the moment also they do not have any rooms. My understanding is they had an agreement with the Mines Dental Clinic, which has now become the Barrier Dental Clinic, but that fell through. When they built the new hospital they demolished the dental room and went into this agreement. When that fell through they now have nowhere to operate from. I work out of the Morgan Street school dental clinic on the days that I work there.

The Hon. KAYEE GRIFFIN: The agreement you have for working with the area health service, does that have a finite date attached to it or is it just for as long as that position is not filled?

Dr MAYNE: Yes, for as long as we both agree it is working, I guess.

CHAIR: Is the equipment at the school dental clinic at Morgan Street adequate for the range procedures you carry out?

Dr MAYNE: Yes. They had to get in a few extra things because there are things that dental therapists cannot do that dentist do. I do not do any denture work at all. I just decided it was not worth it; it takes too much time, when there is such a longer waiting list of other things. But, yes it is. Any

dental surgery, whether it be a hygienist, a therapist or dentist, you will find it will be set up adequately. On the dentures, when I make dentures for the people out and about in the locations I fly to, I only go there once a month or once every two months and it can take them up to 12 months to get their dentures, given that it takes four or five appointments. That is not very satisfactory for them but is better than not having anything.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you more limited by time or by money?

Dr MAYNE: Money.

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

Dr MAYNE: More funding would give us another dentist. Then you would have double, you know what I mean?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the problem is not having enough money to pay a dentist or would you have an unfilled position? There are plenty of unfilled positions about, are there not?

Dr MAYNE: The dentist?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr MAYNE: Absolutely. There is an Australia-wide shortage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, if you had the money to pay a dentist, that does not mean you would have a dentist?

Dr MAYNE: I think my job is unique and we would get plenty of applicants.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You think it is a pretty interesting job?

Dr MAYNE: It is the best job.

CHAIR: There is a lot of travelling time?

Dr MAYNE: There is a lot of travelling time.

CHAIR: If you think of the number of things you can do in a day if you were doing them in Broken Hill and then the number of things you can do in a day if you have to fly to Tibooburra?

Dr MAYNE: Suddenly your clinical day is a lot shorter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are losing three hours a day sometimes?

Dr MAYNE: I think the furthest we go, yes, it is two hours flying for the day. So, you would lose two hours out of your day.

CHAIR: You are working a long day if you are taking off at 7.00 a.m.

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, you do not go overnight to lengthen the time?

Dr MAYNE: I have done in the past. I have done some what I call drive clinics up into Queensland, around the stations, where I drive to Naryilco station, set up and do the dentistry and then pack up and move on to the next one and stay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are Aboriginal communities you are talking about?

Dr MAYNE: No they are not, they are stations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a lot of work at that station? The people come from all around that district?

Dr MAYNE: Yes. I recently flew and did one at Innamincka station and in the day I saw 16 people. That is a fair day's work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a lot.

CHAIR: Do you have a special vehicle or do you just pack everything you need into a pretty ordinary car?

Dr MAYNE: Just into a four-wheel drive.

CHAIR: So, it is portable enough for you to do that without sacrificing—

Dr MAYNE: It is portable but heavy. Every day I take between 50 kilos and 120 kilos of gear, depending on where I am going. So, even in the hospitals like Wilcannia and White Cliffs, which have recently been upgraded and new buildings, they might have the dental chair and light and the bracket table, for example, but they do not have any drills or instruments or usable materials. So, I take all those.

CHAIR: When you say "I", presumably you have a student with you as well? So, when you went to Innamincka station, for instance, did you have a student?

Dr MAYNE: I had two with me that day. I had two students who were up from Adelaide, so that worked extremely well. An extra set of hands is always great.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do they set up another chair and go or do you just have an assistant who is a bit savvy?

Dr MAYNE: You have an assistant who knows what he is doing, or else I put them in a position of the dentist and I assist. Then you have someone cleaning and taking records and things like that, if you have three. The extra funding also would enable some of these clinics to be set up properly, to have the instruments there and hand pieces, other materials, so you are not carrying the weight on the plane and therefore one more person could get on the plane.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are displacing people with all this stuff you carry?

Dr MAYNE: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said there is a demand for two or three dentists?

Dr MAYNE: In my view. If we could get another two or three dentists, this whole area could be better serviced.

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

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

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

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

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

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would a therapist be able to do some of this work and a do you have enough therapists?

Dr MAYNE: There is one dental therapist in Broken Hill. At the moment she is on maternity leave. She flies out and covers some of the clinics I go to with the kids. They cannot do what the dentist can do and even after she has been there are some things she cannot do on the kids. Therapists cannot take out permanent teeth. So, if a child needs a permanent tooth extracted they have to be referred to me anyway. They cannot do root canals, they have to be referred anyway. They can do extractions on children's teeth and things like that. They have their limitations. As much as it would help in looking after the children, there is still going to be this pile-up of referred people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that some of the things they are not doing are merely because they are not allowed to do them, that they should be given more scope to do things? We had some evidence from the general therapists that they should have their boundaries expanded, as it were.

Dr MAYNE: Personally I do not believe that. I believe if you do a two-year course is you cannot possibly have the knowledge of someone who has done are five-year course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But some of them must have been practising in pretty desperate situations where they must have been able to do the best they can and perhaps stretch their boundaries a bit from experience?

Dr MAYNE: I would not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You must know what they do out there?

Dr MAYNE: Therapists?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr MAYNE: Certainly the therapist I am working with here refers it all to me, anything she cannot do or difficult children or extractions. They did a check on the children in Wilcannia last year sometime and there is still an A4 page of people and kids who need to follow from that, and they put a therapist out there for three months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have got pretty long waiting lists for the kids as well?

Dr MAYNE: This is an A4 of the children.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How long have they been on the waiting list?

Dr MAYNE: Since last year when they did the check-ups.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some of them have been on the waiting list for eight months of this year at least, so they have been honoured for a year?

Dr MAYNE: A long time coming, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously, those teeth are rotting away while they are on the list.

Dr MAYNE: Yes. The trouble is that a lot of them are very small children and probably with behavioural problems so they will need a general anaesthetic. We do not have facilities other than on that one half day at a month to do the general anaesthetic, and that is through the private dentist who does that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have to bring them back here, or the Flying Doctor has to bring them back here, anaesthetise them, and then take them back?

Dr MAYNE: No, they have to make their own way. We do not transport patients just for general dental work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the Isolated Patients Transport Assistance Scheme work very well for bringing them in?

Dr MAYNE: Yes, it can.

CHAIR: The therapist is employed by the area health service?

Dr MAYNE: Yes, that is correct.

CHAIR: It is really the school dental service partly?

Dr MAYNE: It is the school dental service, yes. Dental therapists are school dentist, as we know them.

CHAIR: There is no difficulty, from the sound of what you are saying, in co-operating between the two of you and working it all out?

Dr MAYNE: No, not at all. I guess that is one thing: When there is only one of each of you, it is easier to get on, so that works well.

CHAIR: Did they try to replace her when she went on maternity leave?

Dr MAYNE: Yes, they have been advertising.

CHAIR: And it has just not been possible to find someone?

Dr MAYNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The National Rural Health Alliance quotes figures from the New South Wales Department of Health Sydney 2001 that the Far West Area Health Service rural and remote hospital separation for the removal and restoration of teeth for 0 to 14 year olds is almost six times those of central Sydney. Would you agree that the amount of decay in kids is six times what it is in central Sydney?

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that is a reasonable estimate?

Dr MAYNE: Yes. I see kids for whom we have taken out all their deciduous molars, and in Sydney and Melbourne you just would not see that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you have a pretty dreadful dental situation with some of the kids?

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the adults as well?

Dr MAYNE: And the adults as well. I would say that the decayed, missing and filled ratio out here is at least double what it would be anywhere else.

CHAIR: Could you tell us why or give us the main reasons?

Dr MAYNE: Why? I guess number one would be the access to good dental care, travelling time and things like that. On top of that, there is no dentist to come in to here. Moneywise they cannot afford to go to the private dentist. Then there is fluoridation of water, Coke and Popper drinks—even when you go to the stations in remote places, they come in and pay for those Popper drinks and sports drinks because they are great to sip on all day and they just rot your teeth—and education.

CHAIR: None of the isolated communities has fluoride. Broken Hill does.

Dr MAYNE: Yes.

CHAIR: What about Wilcannia?

Dr MAYNE: No.

CHAIR: Of all the areas you go to, for instance, Broken Hill is the only one that is fluoridated?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Water supplies are not fluoridated, or do they all rely on tank water?

Dr MAYNE: A bit of both. Wilcannia, Ivanhoe and Tibooburra will have town water supplies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which are un-fluoridated?

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think the cause of poor dental health is known?

Dr MAYNE: The cause of it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been suggested that there should be some more research done. Do you agree with that?

The Hon. IAN WEST: Do you mean on fluoridation?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am reading from the submission which states that a study needs to be made of whether the cause of poor dental health in New South Wales indigenous communities is dire dental hygiene or a lack of fluoride.

CHAIR: Yes. You have said that it is all of them, but I guess the issue is whether we need to know more about the different factors you ran through for us.

Dr MAYNE: Personally I do not believe so. I think we all know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We should just get on with treating it, in other words?

Dr MAYNE: If you can get on with treating it and then get them to a level, you can move on to preventive care. While you are treating, you can do some education and preventive work and then we can move on. I think in these small places we have an opportunity to make a really huge difference because there is such a small community. We should be able to get them to a standard and then keep them to that standard. It is about diet, it is about fluoridation, and it is about access to a good dental service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As far as dentures are concerned, you have said that basically you cannot make them because it is too time consuming, considering the priorities that you have.

Dr MAYNE: And the limitation on the funding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And there is a limit on funding?

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you cannot afford the materials?

Dr MAYNE: The funding from the agreement we had was $5,000 a year towards dentures.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would give you about 10 sets?

Dr MAYNE: Less than that now.

CHAIR: I think that before you said seven sets.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that is seven sets for the whole of western New South Wales?

Dr MAYNE: Yes, and I have to then try to prioritise who gets those seven sets.

CHAIR: Where are they made? Is there a prosthetist in Broken Hill?

Dr MAYNE: No. I bring them back and send them to Mildura, actually.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To Victoria?

Dr MAYNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The money goes across the State boundary. No prosthetist is being paid? You do not have a prosthetist here?

Dr MAYNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you do not have a budget to buy prosthetic services other than the $5,000?

Dr MAYNE: That is the budget that is allocated to us, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I did not quite understand what you were saying about the lack of an agreement between the three funding bodies.

CHAIR: We will take it up again because the area health service is coming to give evidence next, and then the Aboriginal service will give evidence.

Dr MAYNE: Originally when I started here, we had a tripartite agreement between what was then the Far West Area Health Service, Maari Ma and the Royal Flying Doctor Service [RFDA]. That incorporated the funding, some of which came from Maari Ma, some from the Far West and some from the RFDS. Depending on the amount of funding they give us, that determines the number of clinics that they got in each location. Also out of Greater Western came the $5,000 for dentures, and $10,000 was put aside for repairs and maintenance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For dentures?

Dr MAYNE: No, for equipment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But when they do not sign the agreement, what happens? They do not put any money in, or have they not agreed where you go? How do you prioritise where the money is coming from? They must be still paying the money.

Dr MAYNE: They must be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Someone is paying the money, so what difference does the agreement make?

Dr MAYNE: That is probably above me.

CHAIR: Well, I guess it leaves everything frozen. I guess it leaves the funds frozen.

Dr MAYNE: It certainly does. They are sitting up there, frozen.

CHAIR: Why do we not take this up with the area health service that is giving evidence next?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because this witness is at the front line and knows the indications and practical consequences of the lack of signing, and that is what I am asking about. From your point of view, what difference does the fact that they have not signed make? What difference does it make whether they sign or do not?

Dr MAYNE: From my point of view, the lack of signing means that when they request that they want more clinics in such and such a location or this location here, then they cannot have that unless they forfeit the next in another location. That is the practicality of the situation to me. Unless we get an agreement together and sign an agreement so that the money is right and everything is right—the funding for the dentures has not changed in seven years and that needs to be looked at again. In seven years, I have actually managed to restore and extract some teeth to get mouths to the point that they need dentures, so maybe we should look at putting more funding into dentures to help the people who now can have those. By not having a signed agreement, the difficulty comes when they want more and they are not there. It is like this: Unless we have a signed agreement, you have to rob Peter to pay Paul.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Basically you are talking about more funding: What you would like from the agreement is that there should be more funding, and then you could do more things.

Dr MAYNE: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because at the moment your time is fully allocated.

Dr MAYNE: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is a zero sum game: For every bit more you do, you have to do a bit less somewhere else.

Dr MAYNE: Yes, that is what I am saying. For example, Maari Ma is doing well person checks, and in each location they go to do those, they then want more clinics in those locations to follow them up. But if they did that, under this existing agreement that is fine, but then the other locations lose out.

The Hon. IAN WEST: Are there any other mobile dental services?

Dr MAYNE: No, not in the area that I cover.

The Hon. IAN WEST: What is your practical, on-the-ground assessment as to the demand? I think you mentioned two or three dentists.

Dr MAYNE: Yes.

The Hon. IAN WEST: Can you advise us what that means in terms of dollars? Are you talking about demand in terms of prevention or emergency treatment?

Dr MAYNE: The last bit first—both. I do education and prevention at the same time as doing emergency. If someone comes in with just one tooth that needs extracting, for example, but I can see holes on one side, I can quickly place a temporary dressing and the temporary will help to save those teeth so that when they come back next time, I will not be extracting them. You try to do some oral health education at the same time. You try to take all of that in, to move the people forward.

The Hon. IAN WEST: So you have made your practical assessment of the demand?

Dr MAYNE: Yes.

The Hon. IAN WEST: And that is two or three dentists. Are you aware of any other methodology of assessing demand?

Dr MAYNE: That is based on my belief only. I believe this town needs at least one public dentist and I believe that Maari Ma, which services the Aboriginal communities and also the Aboriginal community from Menindee, which is only about an hour's drive away, a full-time dentist could be in those two places, and this is really conservative. I mean, if you wanted to assess 20,000 people—I mean, it is one dentist per 1,500 in the military, for example, so it is really conservative when I am talking about two or three dentists. But that would provide a service, if it all came under the one thing, that we could move people around—move the dentists around between the RFDS, Maari Ma and the Greater Western. To me, that is a package that would be looked favourably upon by young dentists. They would get the experience of those areas rather than just going to one area only.

The Hon. IAN WEST: That method of assessment would take into account the preventive care as well as emergency care.

Dr MAYNE: Absolutely.

CHAIR: When you say that you would move them around between the three, you would do that because of the attractiveness to the dentists, rather than for other reasons from the point of view of the patients?

Dr MAYNE: Every dentist has a different skill, I suppose, and moving them around would enable each to find their own. The other thing of course is that people do not like dentists, and sometimes that is just personal. Do you know what I mean? Having a choice gives a nice choice. It is attractive for the dentist, certainly. But I would also mention carrying all that gear and setting up your surgery every morning and packing it down every night and bringing it home is also very tiring. To be able to share that and just walk into a fully serviced clinic would be nice. I think that would be more attractive.

CHAIR: A couple of times you have mentioned the issue of equipment.

Dr MAYNE: Yes.

CHAIR: Would it work? I am not sure what the facilities are like in the clinics. What are they like? Are they closed up a lot of the time? Would it work in practice to have them set up as much more fully equipped clinics in the various centres?

Dr MAYNE: The clinics I am talking about, like Wilcannia, White Cliffs, Tibooburra, Ivanhoe and Wanaaring are health service facilities where they have a nurse.

CHAIR: So they are open five days a week?

Dr MAYNE: They are manned the whole time.

CHAIR: If each of those was more fully equipped, it would make your job a lot easier?

Dr MAYNE: And if you had two dentists. For example, if you had two fully equipped clinics, one in Wilcannia and one in Ivanhoe, you could fly into Wilcannia and then on to Ivanhoe every Monday and Friday with another dentist without carrying any gear. You could reasonably have one in each location on those days.

CHAIR: Do the people pay for Flying Doctor services?

Dr MAYNE: No, the health care cardholders, pensioners, spouses and dependants of, and seniors cardholders I think get it free. For people who are not on one of those, we charge a small fee for service. I might say in the last two years there have been very few people out here who are not getting a health benefit card or benefit of some sort. The fee for services pays for materials, the materials we buy.

CHAIR: Where does funding for the Royal Flying Doctor Service funding come from? Is it mainly from different governments?

Dr MAYNE: In general it comes from Federal and State governments.

CHAIR: Donations?

Dr MAYNE: Capital equipment is donations. All the equipment that I carry and that the doctors carry and the planes have to be from donations.

CHAIR: Is the fee for service set partly because the Royal Flying Doctor Service is perennially short of funds, or is it set to match, to some extent, what people might pay if they were going to a private dentist?

Dr MAYNE: It certainly does not match what you would pay if you went to a private dentist. It is set because, historically, they just had doctors who basically did not cost anything—they do not use anything—whereas when you go to a dentist you put in an amalgam filling. You might need a dressing in your root canal. A tube of that costs $60. The fee for service was set to try not to cost us any more for the materials that we use.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the situation getting worse?

Dr MAYNE: In what way?

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

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

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

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

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has the lack of a Federal scheme made a difference?

Dr MAYNE: Federal funding?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did that cut out before you came in?

Dr MAYNE: Yes. That was in 1996. I came here in 1998.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be another source of funds?

Dr MAYNE: Yes.

The Hon. IAN WEST: Is Federal and State funding for the RFDS dollar for dollar funding? Do you know?

Dr MAYNE: I do not think so.

The Hon. IAN WEST: Do you know the percentages?

Dr MAYNE: No, I do not.

The Hon. IAN WEST: You have probably answered this question in a roundabout way, but does the RFDS have a public position on fluoridation?

Dr MAYNE: Not that I know of, but I think we would support fluoridation of the water.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One of the options raised by administrative people has been the restriction on the eligibility for public dentistry as a solution to the lack of services. What would you say about that? Are there people who are getting these services who are not eligible and who should not get them?

Dr MAYNE: No. I think it is pretty hard to put any more restrictions on it other than there are at the moment. So far as I am aware the public system in this town gives them two visits a year. What other restrictions are you going to place on them to get it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People who are on higher incomes could be told, "You are getting a freebie that you should not be getting." Are there a lot of people coming in who could afford to pay but they do not?

Dr MAYNE: No, not many. Certainly in the area that I cover out there, if they are working at all they are charged a fee for service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are already charging the people who can afford to pay?

Dr MAYNE: Yes.

CHAIR: When you talk about the need and the change you have seen in some of the people you have dealt with over the period of seven years would you say in general that dental health coincides with general health? I am referring to the people you are seeing who have bad dental problems—the communities or the individuals. On the whole does the dental situation correlate with their general health?

Dr MAYNE: Yes and no. What we have not looked at really well is the correlation between dental health and general health and the fact that people with poor gum disease also have poor diabetes, poor sugar control levels, heart disease, strokes and things like that. The indigenous population has a higher incidence of rheumatic fever. Poor gum disease then puts them at more risk and things like that. I certainly believe there is a correlation between the two.

CHAIR: Do they need to be looked at as a whole person?

Dr MAYNE: Absolutely.

CHAIR: Would you have any suggestions? Do you think the Royal Flying Doctor Service is doing that because of the way in which you visit smaller centres?

Dr MAYNE: One of the things the Royal Flying Doctor Service does involves a primary health care team going out to these places. It works closely with doctors, the women's health nurse and the early childhood nurse. We all refer people amongst each other. If a doctor sees something orally those people are referred to me, and we see them that way. I think that that is a good system to get onto. The diabetes clinics, for example, have a podiatrist who comes out and does the feet of the diabetic patients. We need to extend that one more step and have them also go to the dentist. It is just about getting these programs up and running and incorporating these things into it.

CHAIR: When you travel are you travelling with doctors and nurses?

Dr MAYNE: Yes.

CHAIR: To some extent, because of the constraints of distance and the need to fly to a place, you are bringing that team together in a way that perhaps is lacking in other areas?

Dr MAYNE: Absolutely. Basically, the RFDS has doctors, a women's health nurse, an early childhood nurse and me. The Greater Western Area Health Service physios, occupational therapists, speech therapists, dieticians and mental health workers all fly with us, depending on the availability of seats and location. So as such there is a real primary health care team.

CHAIR: So a whole planeload of specialists descends on a small town or centre and you fix them from head to foot?

Dr MAYNE: One would hope so. That is the aim anyway.

CHAIR: Seriously, it is a model that has lots of advantages?

Dr MAYNE: Absolutely. The point about the gear being so heavy means that it is displacing one person from the plane.

CHAIR: Who gets left off?

Dr MAYNE: There is a priority list. You start at one end and you go down the list.

CHAIR: You would not find that one of your students gets left off?

Dr MAYNE: One of the medical students may be left off. Dental students do not because to some degree they are seen as staff. They are my assistants. So they are fairly low down on the kick-off rate.

CHAIR: The system out here depends a lot on the voluntary placement of students, dental and medical? In relation to funding, in one sense, the system is propped up by students, otherwise that would need to be replaced?

Dr MAYNE: We do not do any funding for dental students.

CHAIR: The system would have to pay for people if you did not get students?

Dr MAYNE: I would need to have a dental assistant, yes.

CHAIR: So to a large extent the western part of New South Wales is provided with services for free because students are used?

Dr MAYNE: Because they use dental students, yes.

The Hon. IAN WEST: You indicated that in remote areas, as opposed to areas that are not remote, tooth decay was something like double. You mentioned the word "double" and you then mentioned the words "six times".

Dr MAYNE: Six times was for children, was it not?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

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

Dr MAYNE: Yes, it is.

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

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

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

Dr MAYNE: Yes.

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

Dr MAYNE: There is no comparison.

CHAIR: They are very different?

Dr MAYNE: It is very different. I did more extractions in 12 months here than I did in the 10 years I was in private practice. You are doing more of that and you are doing more repairing. It is time, funding and everything. It is a slow process. You are slowly getting on top of it. As I said, I think we are getting there in some of these communities, but it is a slow process.

CHAIR: Thank you, Dr Mayne. We have peppered you with lots of questions for which you were not prepared, but you have been very helpful. Thank you for coming today to give evidence. I hope we have not taken you away from too many patients.

Dr MAYNE: Thank you.

(**The witness withdrew**)

LINDA MARGARET CUTLER, Director, Clinical Operations, Greater Western Area Health Service, 23 Hawthorne Street, Dubbo, and

JENNIFER GAI FLOYD, Oral Health Network Manager, Greater Western Area Health Service, 23 Hawthorn Street, Dubbo, sworn, and

MASON KUMM, Oral Health Manager, Greater Western Area Health Service, PO Box 457, Broken Hill, affirmed and examined:

CHAIR: You have received our questions?

Ms CUTLER: Yes.

CHAIR: And you have given us a submission. Would any of you like to make an opening statement before we get into questions?

Ms CUTLER: I will just make a very brief one. I thank you for the opportunity to provide the information to you. I would like to acknowledge the traditional owners of the land in Broken Hill, which is the Barkinji tribe. As I said, I am Linda Cutler, the director of clinical operations. The reason we have Jenny and Mason along is that we more or less represent all the different levels of rural health services in the area. Jenny has the perspective of the greater western from her past and present role as the network co-ordinator and Mason here on the ground at Broken Hill. So, just to give the different perspectives.

I know you have our submission and we are certainly happy to answer your questions. Essentially we see community demand for our services outstrips the supply we are currently able to provide. We feel the population that is eligible for public dental services in the greater western is a particular disadvantage. To pick up on what Lyn was saying, we have significant socioeconomic concerns. In the greater western, 7.2 per cent of our population are Aboriginal. In the old far west it was about 10 per cent, so it is a significant proportion of our population.

The major issues we have in public health care are probably very similar to what we have in many of our other services. Probably two of the major issues are workforce and distance. There are similar ingredients in many of the other services that we provide. We have various schemes currently in place to try to improve access, but I know you are aware of them through the submissions, so I will leave it over to you.

CHAIR: Can we just get straight first the geography? The greater western goes from where to where, because the boundaries have changed?

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

CHAIR: It would be well over half the State?

Ms CUTLER: We are about 58 per cent of the geography. It is challenging because when you look at it population-wise it is probably the population of Newcastle sprinkled across 60 per cent of New South Wales, about 294,000.

CHAIR: Where are you three based?

Ms CUTLER: Currently I am based in Dubbo. I have had a bit of a circular path in health in New South Wales. I started working in New South Wales around 30 years ago at Brewarrina as a registered nurse. Then I worked in Brewarrina, Lightning Ridge, Collarenebri, Walgett areas, went down into the Hunter for a while, came back out here to Broken Hill last year as the chief executive

and I am now based in Dubbo as clinical operations. Jenny is also based in Dubbo for the whole area and Mason is based here in Broken Hill.

CHAIR: Can you give us a picture of the dental staff you have; the difficulties you have in filling positions and the way in which private practitioners are used to provide public services? I guess that is all against the background of the need and how you measure that.

Ms CUTLER: I think I will let Jenny speak to that. That is certainly her area of interest and knowledge.

Ms FLOYD: Across the greater western area health we have almost 68 staff positions, full-time positions, for oral health services. Of those, 28 positions are dentists, dental therapists or dental prosthetists, people who actually treat patients. We have a difficulty filling positions. It has always been difficult to get dentists to work in rural areas. In the past few years we found it difficult to get dental therapists as well, and dental prosthetists - there are not many in rural New South Wales, so we tend to not have many positions for those clinicians.

If I could tell you about the unfilled positions that we currently have. Of the 28 staff positions we have two vacant positions that are full-time for dentists, one in Broken Hill and one in Orange. We do have one overseas-trained dentist who has filled a third vacant position we had in Orange. Dental therapists is emerging as one of our really difficult areas to recruit to. We have full-time vacancies in Condobolin, another one in Orange, another one in Bourke, a part-time position in Wentworth, and we have a maternity relief position in Broken Hill at the moment that we have been unable to fill. That represents 30 per cent of a dental therapist workforce, a 30 per cent vacancy rate at the moment

Private practitioners: From our count there are 64 private dentists who work in the area we cover. Of those, 36 participate in the oral health fee-for-service scheme and will treat public patients with vouchers for them but only 14 of those 36 will do denture work as well. So, 14 out of 64 are prepared to provide dentures to public patients with vouchers, and a little over half are prepared to provide emergency services.

CHAIR: So, you are saying it is a battle to get private dentists to participate or participate to the level you would wish them to?

Ms FLOYD: It is a battle. They are very busy themselves. They find it difficult to recruit junior dentists into their practices. They find it difficult to sell their practices when they are looking at retiring, so generally they are very busy with private patients. We our asking them to see public patients on top of that and we are asking them to see the public patients at a rate that is less than what they would normally charge. So, it is difficult to get them to participate. I think it is fair to say that in the smaller communities dentists often participate out of social conscience.

CHAIR: That difference in the money available particularly affects the provision of dentures too?

Ms FLOYD: It does. We tend to use the Commonwealth Department of Veterans Affairs fees as a benchmark when we are looking at fees for different services. In the New South Wales oral health fee-for-service scheme the fees are almost completely aligned with DVA. There is usually a six-month lag as DVA fees go up and the New South Wales fees take six months to follow. That is for emergency care like fillings and extractions. But for dentures, I am not sure historically how the rates were arrived at but they increase each year in line with the CPI and at the moment they are 30 per cent less than the DVA fees for dentures. So, most of those private dentists would provide dentures to DVA clients but they will not for our public clients.

CHAIR: Going back to your 68, you said a total of 28 see patients. What are the other 40?

Ms FLOYD: We usually work on a one clinician to one dental assistant ratio. That is effective and it meets infection control requirements. That would be another 28 staff as assistants and some administrative staff, which includes administration of those fee-for-service schemes that we operate.

CHAIR: The second factual and statistical question is the patient end of it. Can you give us an indication of the number of people seen, the number of people on waiting lists, the differences for adults and children, and so on?

Ms FLOYD: I have those figures for you. I can break them down.

CHAIR: If they are complicated, we may get you to give them to us and that will make it easier if they are total. But if you would run through the main part?

Ms FLOYD: That is fine. I have done these calculations based on the past financial year, 2004-05. Occasions of service in the greater western, we provided 78,837 occasions of service. Of those, 37,000 were adults and 40,000 were children. There was a small number of specialist services, in the range of around 1,200 services. Approximately 9,000 occasions were through the fee-for-service scheme, which was predominantly for adults, and the statistics for children, we assessed approximately 20,000 children in schools, so we checked their teeth at school. Of our patients, as Linda said at the beginning, we have a high indigenous population in this area. Approximately 13.5 per cent of the services we provide are for indigenous people.

CHAIR: Compared to about 7 per cent of the population?

Ms CUTLER: Yes. Interestingly enough, in the remote areas such as the old far west where our Aboriginal population is about 10 per cent, 20 per cent of our oral health clients are Aboriginal.

CHAIR: So it is roughly about twice.

Ms CUTLER: Yes, across the board.

Ms FLOYD: I can give you some waiting list data. On our adult waiting list at the moment, we currently have 5,704 adults, and 1,417 of those are waiting for dentures. For children, we have various waiting lists, although the number probably sounds worse than the actual true picture. There are 2,605 children who are currently on various waiting lists in the Greater Western Area Health Service. I guess the difference there is that probably most of those adults are waiting for treatment such as fillings and extractions, whereas the children who are waiting are likely waiting for other types of treatment, such as preventive treatment. The number of children on waiting lists varies greatly, depending on whether we have had difficulty recruiting staff. So where we are fully staffed, we generally do not have waiting lists for children.

CHAIR: What is the time on the waiting list?

Ms FLOYD: For adults who have pain, most would be seen within one week, or given a voucher in the Greater Western Area Health Service. Orange is a particularly difficult area for us. We have had difficulty recruiting. We do not have many dentists.

CHAIR: That seems surprising. You would think Orange would be okay.

Ms CUTLER: It is on the wrong side of the mountains.

CHAIR: Of all the places that people might not want to go, one would have thought that Orange would be very unlikely.

Ms CUTLER: Funnily enough, though, I think it is true outside of Sydney. As I said, I used to work in Hunter, and through some other work I was doing I was talking about oral health services in the upper Hunter in places like Muswellbrook and Scone. They cannot get dentists either. But the private dentists cannot get dentists, let alone the public sector.

The Hon. IAN WEST: Did I hear that there are 30 per cent vacancy rates for therapists?

Ms FLOYD: That is right.

Ms CUTLER: Therapists, dentist and prosthetists.

Ms FLOYD: The 30 per cent was just the dental therapists.

The Hon. IAN WEST: Are they the ones that generally do the children?

Ms FLOYD: That is right.

The Hon. IAN WEST: Obviously that has a bearing on why there are 2,600 on the children's waiting list.

Ms FLOYD: That is right. Historically we have not had waiting lists for children. It is something that has emerged only in the last few years.

CHAIR: And that is because of the shortage of therapists, or difficulty in attracting them that has emerged only quite recently.

Ms FLOYD: That is right.

The Hon. KAYEE GRIFFIN: Would Orange be the largest regional centre you have within the area health service?

Ms CUTLER: I think Bathurst is slightly tipping it at the moment because of the growth in Bathurst, but they are comparable.

The Hon. KAYEE GRIFFIN: But you do not have the same problems in Bathurst as they do in Orange?

Ms CUTLER: No.

Ms FLOYD: No.

CHAIR: Because they do not have to go over the mountains and travel a distance.

Ms CUTLER: That is right. Essentially, in a lot of our other services too, we do not encounter the same issues in Bathurst as we do at Orange—although, and I know that this is outside oral health, a lot of that is even specialty driven. Many of our specialists or our allied health specialists, et cetera, if there is a particular group that they want to work with, then sometimes this in Orange. We have no problem recruiting positions in Orange for anaesthetists. They are two areas in which people want to go to Orange and work. Essentially, across the board, Bathurst has a better rate of recruitment. We still have issues there, do not get me wrong.

The Hon. KAYEE GRIFFIN: Yet they are approximately 50 or 60 kilometres away from each other.

Ms CUTLER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But is the main hospital not in Orange, not at Bathurst? Has there not been a big change there?

Ms CUTLER: There is currently a redevelopment going on and Orange certainly has a higher number of specialties available. It is more of a specialist-based health service, along with, of course, the Bloomfield campus for psychiatric care. But, essentially, with the exception of emergency orthopaedic and specialties like cardiology and neurology, which are the top specialties, they would get their care in Bathurst. I am not sure, but we actually measure the local population to service locally. It would still be a high level in Bathurst.

CHAIR: What about Dubbo? Is it difficult to recruit in Dubbo?

Ms CUTLER: It is, across the board.

CHAIR: Is it worse than in Orange?

Ms CUTLER: Yes, it is. We actually run on a very much higher level in the area of needs staff in a whole range of services, overseas trained staff and agency staff. Dubbo is very much a sponge town for Greater Western. In many cases, although it is now roughly around the 25,000 mark, largely that is seen as population that has moved into Dubbo rather than the real growth in the area. As the other towns surrounding Dubbo are shrinking, they are just moving into Dubbo.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you mean the whole area? When you say "sponge town", you mean that it draws from around it, but it does not grow.

Ms CUTLER: Yes, as an area.

CHAIR: In relation to staffing, you have reminded me to ask whether overseas trained dentists and other dental professionals are a crucial part of the staff in the Greater Western.

Ms FLOYD: Of our 10 dentists positions, we have only one overseas trained dentist at the moment. It took around six months from when we determined that we wanted to employ the person. This person came from overseas and they wanted to come and work for us. It took six months to actually go through the immigration side of it and then to get Dental Board approval and ministerial approval for the appointment.

CHAIR: So you were recruiting them from overseas. They were not someone who migrated to Australia and needed approval, and so on?

Ms FLOYD: That particular person approached us in Orange but, yes, they were a resident overseas so they are on some sort of a visa. I am not sure of the details. One of the difficulties we have with overseas trained dentists is that we do need to provide supervision and support for these members of staff. The positions we have most difficulty recruiting to are the isolated positions. For example, we would like a dentist in Broken Hill but there is not a second public sector dentist here to supervise, mentor and support that person, so we find that often there are expectations of overseas trained dentists. We have vacancies and they would like to work for us, but the reality is that it does not work. We have to protect the safety of our patients.

The Hon. KAYEE GRIFFIN: How many staff would you have in Orange, Bathurst and Dubbo?

Ms FLOYD: Dentists?

The Hon. KAYEE GRIFFIN: Oral health people, as part of that total that you mentioned—the total number of people who come under the area health service?

Ms FLOYD: There would be two positions in Bathurst, three in Orange and the third position in Orange could be located in the general area, two positions in Dubbo and one position in Mudgee.

CHAIR: So that is seven out of your 10 dentists.

Ms FLOYD: That is where most of the population is. As I said earlier, in Orange we do not have support from the private sector to treat public patients. In the smaller towns we try very hard to work with the private practitioners. I mean, they need to maintain a viable practice as well, and sometimes fee for service works quite well in that it supports their practice. We do not want to send a public dentist into those towns, and if there is not enough work for a full-time dentist and both public and private miss out.

The Hon. KAYEE GRIFFIN: So in relation to the other three positions, one would be the vacancy in Broken Hill. Is that right?

Ms FLOYD: That is right.

The Hon. KAYEE GRIFFIN: Where are the other two?

Ms FLOYD: There is a .5 position in Balranald in the south and we have an arrangement with a private dentist in Bourke who spends approximately half his time treating public patients and the other half of the position would be just spread over the area health service in administration.

The Hon. KAYEE GRIFFIN: It was mentioned in evidence earlier today that there is a ratio in the military of one dentist to 1,500 service people. Do you have any sort of ratios about how many dentists should be servicing people per head of population? Is there any ratio that the area health services apply?

Ms FLOYD: Not within the area health service. The World Health Organisation certainly has a figure which I think is one per 3,000, but I have to check that.

CHAIR: So Army people are getting their teeth pretty well looked after.

Mr KUMM: Perhaps we should go and join the Army.

Ms CUTLER: Interestingly enough, I think there would be figures because every specialist college has a ratio of one per population that varies anywhere from 1:25,000 to 1:40,000, depending on the medical specialty. We will have to check that with the dental college. Dentistry of course would be different because of the high level of prevention and ongoing care, but that would be an interesting thing to look up. So I will take that on board.

CHAIR: Dr Lyn Mayne mentioned as a comparison that the military had 1:1,500, so she had been doing a comparison with the areas she services.

Ms CUTLER: Perhaps they could loan us some dentists.

Ms FLOYD: I think that no matter what that ratio is, distance is always another factor that we have to contend with. So if there is an ideal figure and it is 1:3,000 and if our staff have to travel to clinics, we cannot provide in the same way that you can in the metropolitan area.

CHAIR: Because so much of your work day is spent in travelling.

Ms CUTLER: We just lose productivity, which is true in most centres.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think the figures you gave us were that there were 68 positions in oral health of which 28 treated people. Is that right?

Ms FLOYD: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How come you have 40 people who are not treating people and 28 treating?

CHAIR: Twenty-eight are treating and then there are 28 assistants, et cetera.

Ms CUTLER: That does not include the dental assistants that assist each of the treaters.

CHAIR: So 28 are for the front-line services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Out of the 56, you have 22 who do not treat anyone. Is that right?

CHAIR: There are 12.

Ms CUTLER: That includes all the secretarial support people who make the appointments and people at the call centre.

Ms FLOYD: That is right. We have call centre staff who take the telephone calls.

Ms CUTLER: There is the call centre, the triaging for the greater west and the people who do the ordering of supplies and keep the clinic stocked.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are happy with that ratio of treaters to organisers?

Ms FLOYD: I am very happy with that ratio, I think it is quite reasonable. I mean, many private practitioners would have two support staff for each private practitioner, one to assist and one to manage the other aspects of the practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Though admittedly you would have economies of scale in paperwork, presumably.

Ms FLOYD: We would.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have two dental positions that are unfilled and you have 5.5 dental therapists positions unfilled. Is that right?

Ms FLOYD: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I notice you said that you were having trouble in that only 14 of the 64 private dentists would do dentures. Is that because the level of funding for dentures is below what is economic for them to do it?

Ms FLOYD: That is right.

CHAIR: We did run through this before.

Mr KUMM: Yes, the Department of Veterans Affairs [DVA] rate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not quite clear. The New South Wales rate and the DVA rate are significantly different, are they not?

Ms FLOYD: That is right, 30 per cent.

CHAIR: There is a 30 per cent difference. That is what Jenny said before.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are offering the DVA rate, not the New South Wales rate?

Ms FLOYD: No, we are offering the New South Wales rate because that is determined by a directive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And only 14 out of 64 will actually work at that rate at all?

Ms FLOYD: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And if you were to pay a higher rate, you would simply get fewer dentures. Is that the bottom line?

Ms FLOYD: We would get fewer dentures, but we would be able to provide the dentures to those who are most needy and in the right places, I guess you could say. But, yes, if we had no additional funding and the rates went up, we could provide fewer dentures. My concern at the moment is that somebody who needs the dentures may have to travel hundreds of kilometres to find a provider.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you give me the same answer for the people of Port Macquarie where they said that we simply buy dentures until we run out of

money, and then we stop buying dentures? Is that the answer you would give if I asked you what you do about dentures?

Ms CUTLER: There is no doubt that we do not purchase—I do not know that I understand your question. There is no doubt that once we expend the budget we have for dentures, we do not buy any more—I think that is fair comment—but we rarely get to that point in Greater Western because of a lack of access to funds. That is my understanding, but I am happy to be corrected.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, you cannot spend your money because at the rate for dentures, they will not even take your money.

Ms FLOYD: No, they will not, particularly private dentists. They tend to send the laboratory work to a laboratory, so they are actually also paying quite a high fee to a laboratory to have those dentures constructed. I have been told by dentists that they will lose money.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So do you actually have money left at the end of the year in your dentures budget because you cannot get anyone to make the dentures at the price you are offering?

CHAIR: You can take the question on notice, if you want to, if you need to check.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you understand the question?

Ms CUTLER: I understand the question. You are saying that, using a token amount, if we have $10,000 to spend on dentures or $1 million to spend on dentures—it does not matter—at the end of the financial year, have we spent the full $1 million or do we have $100,000 left because we could not find anyone to do dentures because they will not do it at the rate that we are allowed to pay?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is right. That is the question.

CHAIR: If you want to take it on notice, do so.

Ms FLOYD: No, I can answer that. We did actually receive enhancements over the past couple of financial years for dentures and we did spend the money that we were given on dentures.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: All of it?

Ms FLOYD: My concern would be that we would probably have provided some dentures for some people more quickly than other people who would have waited longer, so the equity was upset. But if we were given funding for dentures, we most certainly spent it on dentures. But, for example in Dubbo, we employ a prosthetist so that we can provide dentures in Dubbo. In other areas we have difficulty providing the dentures so we are not able to actually treat everybody equally across the area health service.

CHAIR: But you can spend your budget?

Ms FLOYD: Currently.

Mr KUMM: Jenny said that the laboratory is sent outside the area. They have to pay for freight charges and laboratory charges.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because you have difficulty recruiting prosthetists?

Mr KUMM: That is correct. There is only one person in Broken Hill who has his own prosthesis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I noted in the submission from Dr Claire Blizard, which is your submission, that with the pay rates of some of the positions, incentive

payments for dentists in particular, $20,000 can go to the Hunter rather than here for the same incentive. Have prosthetists also gone below the rate at which you are able to recruit them?

Ms FLOYD: Prosthetists cannot be paid that $20,000 payment. That is for dentists. It is difficult to employ prosthetists because there is no award in New South Wales for prosthetists working in the public sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot recruit them and you have to send the work out for that reason?

Ms FLOYD: Yes. There are some employed in New South Wales. I would have to take on notice that part of the question that relates to how they manage those employment arrangements.

CHAIR: We heard some evidence about that when we had hearings in Sydney. Before we move on to specific issues, Mason, did you want to make any comment about staff, recruiting issues, waiting lists and patient issues, specifically for the Broken Hill area, or is it pretty much the same as Linda and Jenny have outlined?

Mr KUMM: It is standard throughout the area. The only thing I would say is that waiting lists vary from area to area. It is very hard to comment on Broken Hill alone when we work with the Greater Western Area Health Service because they vary in every area. Waiting list times vary and denture waiting lists vary too. At this point I think Jenny covered most of it.

CHAIR: Is your area Broken Hill city?

Mr KUMM: No, I handle the greater western area, which is the lower western sector—Bourke, Lightning Ridge, Balranald, Wentworth and Broken Hill as well, with therapists as well as dentists.

CHAIR: So you are looking after the far western bit?

Mr KUMM: Yes, the original far western area.

CHAIR: And that area includes the 10 per cent Aboriginal population and 20 per cent service level that Linda mentioned before?

Mr KUMM: Yes.

The Hon. KAYEE GRIFFIN: When you advertise for the position that is vacant in Broken Hill where does your advertising go?

Mr KUMM: I have exhausted all avenues. Are we talking about therapist's position or the dentist's position?

The Hon. KAYEE GRIFFIN: You can comment on both.

Mr KUMM: For the therapist's position I have exhausted all avenues—newspaper advertisements, advertising in New Zealand and in Victoria. We have tried a number of areas. We are exhausted after trying to get the position filled, or a person here to provide that service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you use the web?

Mr KUMM: It is already on the web through the Greater Western Area Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not use Seek or an agency like that?

Mr KUMM: Depending on the human resources side of things, I would say it is probable that we advertised through those agencies. It is either Career One or Seek; I am not sure.

Ms CUTLER: I would have to double check. When I was out here last year in a different capacity we made a decision after some exhaustive advertising for a dentist. We went out and lobbied our local dentist for the fee for service scheme. We thought that would add to the sustainability of the service. By getting people on board that way we felt we were better off spending the money that way, even if we got slightly less service, so we would have a dentist all the time. We were faced with the situation of getting someone out here and the bottom line would be that either they would love the place or they would leave shortly after. We have had some changes in staff through that. We probably have not actively recruited for the dentist for about 12 months because we made the decision that we were just wasting our time. So we put other things in place.

The Hon. KAYEE GRIFFIN: Would the same apply to the vacancy in Orange? Would you have advertised in the same way for that position?

Ms FLOYD: We extensively promoted the position in Orange. We had one in Bathurst, one in Dubbo and one in Orange. We extensively promoted that to prospective new graduates at the end of last year. We conducted the interviews in Sydney at the Sydney Dental Hospital. We did it jointly. Even though we were the Greater Western Area Health Service at that point we were still operating under the banner of the three old areas. We did that co-operatively. Of those three positions we got a part-time position for Bathurst and a full-time position for Dubbo. There were two lots of graduated classes last year so we had an advantage.

The bachelor of dentistry students were graduating and the bachelor of dental surgery students. There were double the numbers of students so we had some success there. But for the Broken Hill position we made a decision that it was not a position suitable for a new a graduate at that time. Also, in talking about recruiting and advertising, we have dealt with dentist job search agencies. We have advertised in all the major metropolitan newspapers. We advertise online. Generally, if someone is interested in working for us we will step through the processes and then readvertise the position. But you can only throw so much money at the newspapers.

CHAIR: Is the major problem the shortage of dentists or the unwillingness of dentists to come to Orange or Broken Hill? Can you not tell which problem is the worse?

Ms FLOYD: I think it is both. Not enough dentists are graduating in New South Wales. There are certainly not enough dental therapists graduating at the moment.

CHAIR: But how important is the issue of the unwillingness to come?

Ms FLOYD: It is a major issue. We have been hosting student placements. Over the last four or five years we have spoken to final year dental students coming to our area for a two-week period. We often found that they already had employment lined up after graduating by the middle of their final year. That might be with a private practitioner that they have been assisting on a Saturday morning to get them through university. Their families are in Sydney and their experience beyond the Blue Mountains is very limited. They come to our clinics and say, "We would be happy to work here part time, although it is difficult part time Dubbo to Sydney", or, "We would be happy to work for you if we did not have to leave our families." I believe the problem is that we are not getting enough rural students into these dental programs.

CHAIR: Adelaide does not provide people who regard Broken Hill as a bit closer to home?

Mr KUMM: We advertise in Adelaide also. We have the same problem. If you think about it realistically, if you cannot get them into Dubbo or Orange you will not get them into the more remote parts of Broken Hill. We do have the students so it is realistic.

CHAIR: We gathered from talking to Lyn Mayne earlier that students are a pretty crucial part of her operation.

Ms CUTLER: They love coming to the RFDS. It has its own iconic status to attract people. Lyn does function largely without a dental assistant, so students have the opportunity to learn and to fulfil that role for her. So it does make a huge difference to her service. She does some work for us as well. She is excellent.

Mr KUMM: I give her a dental assistant, so she is very happy.

Ms FLOYD: I wish to make a comment about the dental therapist work force and what I said about getting rural students into programs. Many years ago the dental therapist intake was selected based on where the students came from. A certain proportion came from rural areas and a certain proportion came from the Hunter Valley. When we look at our dental therapist work force at the moment we see that most of them, on average, are 40 years old or a little over. Most of our staff actually date back to the time when rural students were taken into that program and they came back to rural areas—most probably not to the rural area that they grew up in, but to a rural area just the same. I guess that they have been the backbone of our service because they have worked for us for many years. Even if we do attract staff now they do not necessarily stay that long.

CHAIR: The evidence we took from them in Sydney suggested very much what you are saying. A large percentage of them were women whose partners were located in the area where they worked. So they had continued in the work force whereas perhaps otherwise they might have left because of where they came from and the fact that they had gone back and found their partners there. Would that be your experience as well?

Ms FLOYD: Yes, I think that is fair.

Ms CUTLER: It is one of our recruitment strategies. We marry students off to a local.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The submission from Dr Claire Blizard picked up a point that Jenny just made. You have a problem with dental therapists. I note that no dental therapists are now graduating. They will now be bachelors of oral health in the new degree and they will have the right to private practice. The suggestion is that bachelors of oral health graduates will not work in the public sector. The wage structure will be such that you will not be able to recruit them. Is that a problem you are worried about? Does that mean the situation relating to dental therapists and their substitutes is about to get even worse?

Ms FLOYD: I think that is fair. I think it is going to get worse. I went to a function—the launch of the bachelor of oral health program at the University of Sydney—and there were 14 students there. Some of those students were already aspiring to graduate and then do dentistry, which is admirable but it will not help our therapist work force situation. The predominantly female work force has been an advantage in that the lower wages have not been as much of an issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the bachelor of oral health students largely male?

Ms FLOYD: There is certainly more of an even mix now. I know from experience—perhaps I should add that my background is as a dental therapist—that the few males that have done dental therapy have largely left the profession because of the remuneration. In their families they are the breadwinners, so to speak. So for people who are graduating with a degree now and who can go and work as a dental hygienist in private practice I do not think our current award conditions will attract them. I am not sure about who those people are and whether they have a commitment to public dentistry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Already dental therapists have an ageing demographic, do they not?

Ms FLOYD: They do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We heard evidence to that effect. Are you certain that your waiting list is comprehensive? You said you had 5,000 on the one list—roughly 1,500 for dentures and 1,600 kids. Were those the figures?

Ms FLOYD: That sounds right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that a comprehensive list?

Ms FLOYD: It is a complete list of all the people we are aware of. I have done that through our information system for oral health so I can say it certainly counts everybody who is on one of our lists. However, waiting lists are a reflection of expressed need; they are not necessarily a reflection of outright demand for services. I will use an example from the past. An orthodontic scheme commenced in Dubbo probably 10 or 12 years ago. There was no waiting list for orthodontic treatment in Dubbo because there was no service. Once that service commenced within a few years there was a waiting list that could not be managed. I can speak only about rural areas; that is my experience. If people know that there is not much chance of accessing a service they do not ask.

CHAIR: So, the "real" waiting list might be quite a lot longer than the current list?

Ms CUTLER: It is hard to gauge the unmet demand. Because it is only people who ring up for the service they feel they can get who are on the waiting list.

Ms FLOYD: I think that is fair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Earlier you said you have waiting lists only for people in pain for about a week and that you can either give them a service or a voucher. Is that voucher sufficient to guarantee they can get treatment or is it like the dentures where sometimes the dentist will not do it?

Ms FLOYD: The current limit on the voucher is now $180. It went up on 1 July. A person could have a tooth filled or extracted and the diagnostic x-ray and the examinations within that cap. So, they could have the one offending tooth treated, however if they have two teeth that are aching, then the voucher may not cover that treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or if, incidentally, a whole lot of other work was discovered to need doing, it may not be covered?

Ms FLOYD: It would not be covered. The voucher is for relief of pain.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, the voucher will cover most cases but not all cases, is that right?

Ms FLOYD: It will cover the treatment in most cases for relief of pain. It will not cover root canal therapy if that is required.

CHAIR: But some of your dentists of their own volition may go a little bit further in what they provide when the person turns up with the voucher?

Ms FLOYD: They can negotiate with the patient about providing other treatment as a private patient.

CHAIR: I did not mean that so much. I meant maybe the voucher is not enough to cover the work that needs to be done but they will do it because you are sitting here?

Ms FLOYD: I know we have some dentists who might treat two teeth and the total of treatment might come to $200 and they know we will pay $180 and the bill arrives and they put a line through $200 and have written $180. So, they are accepting that we can only pay $180 and they have provided the treatment.

Mr KUMM: That is on a pricing guide too, with the size of the fillings and things like that. Sometimes they will put a larger size filling in, depending on the size of the problem. One filling could cost $100-odd.

The Hon. IAN WEST: But they would not ask the patient for $20?

Ms FLOYD: They are not allowed to.

Mr KUMM: No, they are not allowed to.

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

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

CHAIR: But for the children the picture is brighter?

Ms FLOYD: The picture is much brighter for children. We have had a comprehensive service now for many years. I think the dental therapy profession is turning 30 this year. Children get fissure sealants, which prevent decay in permanent teeth. They get oral hygiene instruction and they get dietary advice for themselves and their parents when they attend appointments. Mostly the treatment they receive is fillings but occasionally they require extractions. Generally they get timely care and they get holistic dental care. So, when a child leaves a service they have had all their treatment provided.

The Hon. IAN WEST: But have you not just indicated that you have this development within the therapist area? You have vacancy rates of 30 per cent. I understand from the submission that you are phasing out, because of occupational health and safety reasons, the mobile dental caravan clinics basically for the children at schools. That does not seem to fit with what you are saying about the children being adequately covered?

Ms FLOYD: Well, they have been. I guess the concern now is for the future. We are starting to see the waiting list develop now and we are starting to see areas where we are finding it difficult to provide services. We may reach a point where we cannot provide a holistic dental care for all children. What I can say is that when a child has an appointment in a dental clinic, they may wait to get seen but once they get seen they will get all their treatment needs provided.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are drawing a pretty bright picture here of kids who get to treatment. The National Rural Health Alliance, quoting figures from the Health Department in 2001, are saying that rural and remote hospital separations for the removal and restoration of teeth for nought to 14-year-olds in the far west are almost six times those in central Sydney. Would you accept that?

Ms FLOYD: There are some other risk factors for children that lead to them needing a general anaesthetic to have their teeth treated. If it is a hospital separation almost always they have had a general anaesthetic. They will often be children living in unflouridated areas who were perhaps drinking Coca-Cola from a very young age, or cordial.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that is not a valid index of the situation of kids in this area?

Ms CUTLER: I do not think we can say that. This is a total largely because I have worked in hospitals where we have admitted the kids for their teeth. It is normally their non-permanent teeth. Their baby teeth are in such—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are saying nought to 14-year-olds. A lot of kids have their permanent teeth by the age of seven.

Ms CUTLER: I do not disagree with that. But I would go to the point of saying that I have seen many cases where a child whose first teeth are in such bad repair for a variety of reasons that they are admitted and they are removed because of the health of their gums and their overall oral health, so that their permanent teeth will come into a better environment. I would like to crunch the numbers to look at what percentage of those nought to 14s that we capture, because that is considered a paediatric admission. But we would probably be able to look at that to see.

I think what Jenny is saying is that those people we do see get the full range of care. We are still saying it is 2,700 on our children's waiting list and they are sprinkled in specific areas across the State. Condobolin, because we have had the vacancy, is probably one of the major areas. We have put in a new dental clinic there. We have renovated part of the local hospital and the local community and shire have been very supportive in doing that. I met with the health counsellor there the other day because Condobolin and Lake Cargelligo are both concerned about the oral health of their children. We have just recently said we may well then recruit elsewhere, be it in Dubbo or Parkes, and send them out to each service, to see whether that would help.

The other thing in most of the recruitment issues we run into with all our health service providers is that people do not like to be a sole provider. We use outreach models for a lot of things so that even though we lose a little bit of productivity with some of the travel time, at least we are providing a service. It is something else that we just wear in the rurals because we would rather have three or four dental therapists together rather than one sprinkled all around the place. That is one of the strategies we are going to look at for that area.

CHAIR: You mentioned fluoridation. How many of these towns have fluoridation and with the recent campaign by NSW Health that we heard quite a bit about when we were in Port Macquarie, with the coastal councils signing up, so to speak, is much happening on that front in your area?

Ms CUTLER: There has been a lot of work done on that. The old Far West Area Health Service really ran a campaign to try to work with local councils to get them to sign up. There has been a lot of resistance in many of the rural communities that still see fluoride as a poison. That is my impression from certainly being involved in some of the discussions. My understanding is that we have 12 largish communities—over a thousand—that do not have fluoridation.

CHAIR: Many do.

Ms CUTLER: Total LGAs in the greater western is around—I am trying to think whether it is 18 or 29, it is a large number—and there has been some progress with four out of those 12 but there is another lot to target. There is another whole raft of populations on rainwater tanks and populations less than 1,000 people, so they are never going to have a fluoridated water supply.

CHAIR: So when you talk about, say, a town like Condobolin or Lake Cargelligo, and a concern in that community about oral health, are they the ones with fluoride?

Ms CUTLER: I do not know. Do you know, Jenny?

Ms FLOYD: Condobolin is fluoridated, and Lake Cargelligo is not. They are the same LGA, but we have not discussed that with that LGA at the moment. We need to deal in manageable chunks. We have targeted six of the 12 LGAs that we know do not have fluoridated water.

CHAIR: Is it Mudgee that has had a lot of publicity?

Ms FLOYD: Yes.

CHAIR: And that is in your area?

Ms CUTLER: Yes.

CHAIR: There has been a big backlash, I guess you would call it, there. Have they made the decision to go ahead or is it still under discussion?

Ms FLOYD: I only have anecdotal information. I would prefer not to comment.

Ms CUTLER: We are not clear.

Ms FLOYD: We have had support in Mudgee but there is an anti-fluoridationist movement in Mudgee that has also been very active and very vocal. I am not sure, because they have an election coming up. They are under administration so I am not sure how that places the decision.

The Hon. KAYEE GRIFFIN: That includes places like Rylstone, as well, does it not?

Ms FLOYD: Rylstone is fluoridated.

Ms CUTLER: It has fluoridation but is it central western shire now?

Ms FLOYD: Mid western regional. There are some LGAs where one community is fluoridated and one is not, but generally they either fluoridate or they do not. We have one LGA that is naturally fluoridated so it does not need to fluoridate. It is quite intensive for us. We generally need to take a public health physician or expert with us to refute the arguments about it being a poison and a waste product and all the other things that they have to say. In the past, dentists have tried to lobby for fluoridation. Ten years ago the dentists tried to lobby in Mudgee and were unsuccessful. So, we need not only the dental lobby groups who are talking about the benefits to teeth but we also need the public health experts who are explaining that it is not unsafe and it is an equitable way of improving the health of the population.

The Hon. KAYEE GRIFFIN: You said there are 12 councils and you are working with six at the moment?

Ms FLOYD: We have targeted six

The Hon. KAYEE GRIFFIN: Could you give us an idea of which councils—you can take it on notice—you are targeting and which councils in the western area are not fluoridated? That is a question on notice.

Ms FLOYD: Yes, I can provide you with that information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back to the definition or the seriousness of the problem of the teeth here? You are a bit reluctant to agree with the figures that nought to 14-year-olds are six times worse in hospital separations for removal and restoration of teeth?

Ms FLOYD: I just do not have the figures to comment.

CHAIR: I think we have agreed that they will take that on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell us how bad the situation is?

CHAIR: Also, the question that was raised included the phrase "hospital separations".

Ms CUTLER: I will have to look into that for you.

The Hon. IAN WEST: I want to ask a question about capital expenditure and whether any work is being done to overcome the obvious problems of equipment getting older and capital expenditure that needs to be done. I want to know whether there is some detailed work being done on costs of that.

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

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

The Hon. IAN WEST: That is merely operational?

Ms FLOYD: That is the only budget we get.

CHAIR: The other question that we have not tackled is our last one which refers to the submission from the area health service. Basically it says that if you again provide this service, you either have to increase funding or restrict eligibility, or do a combination of both, which I guess is a commonsense answer in a way. We just wondered whether you had any views about if it would be possible to restrict eligibility. I think we covered this partly before. You felt, Jenny, that it would be very difficult in this part of New South Wales.

Ms FLOYD: We know that our cardholders and pension cardholders are disadvantaged. It is a commonsense response in that if there is no more money, should we provide better care for less, or just relief of pain for many. I guess we would rather be providing holistic dental care that results in better outcomes for patients rather than just a bandaid approach of providing relief of pain. It would be very difficult to eliminate any of the currently eligible people because they are disadvantaged, although there are some differences between States in Australia. I know that in Western Australia, where they have a co-payment scheme, it means that if you are in receipt of an actual allowance from Centrelink, I think you pay 25 per cent of the Department of Veterans Affairs [DVA] fee, but if you have only a concession card, you pay 50 per cent. So there is some difference. I do not fully understand how all the Centrelink cards work.

CHAIR: And I guess it is a bit unfair to ask people with dental expertise from the health service to deal with these funding and financial issues.

Ms CUTLER: One comment I would make is that in the existing setup, from my understanding, we provide service to people who are 18 years and under at no charge. Anecdotally, when I worked in the Hunter, I had people coming to the public dental clinic there having their teenagers get routine fillings and things which we normally provide. There is a good range of care for children. I am not talking about Greater Western but that was certainly the case when I worked there. People I know do not have to have a concession card or anything else for anyone under 18, and I think that is something we should look at.

As much as I fully recognise that if we look after people's teeth until they are 18 we have a much better outcome for people when they are older, if people can genuinely afford to pay, I think they should. Unfortunately we have some people in the system who use the public dental system even if they have private health insurance. There would be a small number, but every dollar counts. I would certainly be interested in looking at something like having a health care card for kids over 14 or something like that, which would make a difference to our service as well, probably though to a smaller degree.

CHAIR: You would not apply that to a school dental service.

Ms CUTLER: No. The school dental service targets the younger age group rather than the teenage age group. This is more about seeking of care in the public dental clinics. I do not know what the quantity is. I cannot quantify that. It is anecdotal, but it used to surprise me, shall we say, in a negative way when I would see some of the individuals who were utilising the service.

CHAIR: Coming back to the issue of the bandaid approach or a holistic approach, I guess that is something you wrestle with the whole time. Would you all agree that you would rather look after fewer people properly than more people?

Ms CUTLER: I think there is no doubt about that.

Mr KUMM: Yes, I think we would opt for continuous treatment.

Ms CUTLER: Obviously, from my perspective, how that would work in practice would have to be through the Medicare system because, bottom line, we are not restricting people as to who they can go to and when they can go—those sorts of things. Certainly in relation to rural areas, I think the RFDS is a good model because it has extra funding. As Lyn Mayne says, if she has someone who can pay to have their teeth done, then they pay, but she also has a proportion of patients that she can see as public patients as well. She does a very good job of managing that mix in a captive audience, for lack of a better way to put it, or a captive community where that is easily done. To pick up on your point, to walk into a busy dental surgery in Dubbo or even some of the larger centres such as Parkes or Forbes and similar areas, that is a difficult call to make.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She commented that she believed there were a lot of people who could afford to pay but were not paying.

Ms CUTLER: She did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She did.

Ms CUTLER: That does not surprise me, but even then a lot of people pay the RFDS as well, so it is an extra in her case.

CHAIR: It is a sort of co-payment arrangement.

Ms CUTLER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that suggests that you have not got much room to move in terms of cutting eligibility criteria to spread your dollar further.

Ms CUTLER: No, but I think the full amount that the RFDS is funded for public dental is around the $140,000 or $160, 000 mark, or in that ballpark, a year. Obviously Lyn generates income from some of the other work that she does. I do not know what that is and I do not need to know, but it is a blend whereas in other places you are either public or you are not.

Mr KUMM: Broken Hill is a fairly unique sort of a place. We also have a contributor clinic here in Broken Hill which means public patients actually contributing to the clinic. We are quite unique in that.

CHAIR: We will be talking to them this afternoon.

Mr KUMM: That is where it does get a little bit easier for those patients to contribute to those sorts of clinics and hopefully have that treatment. It gives another option whereas a lot of other people do not have that option.

CHAIR: From your perspective, does that work well, having that extra option?

Mr KUMM: It does, but they are in the same sort of predicament as us for recruiting dentists as well and that is where it comes down to the waiting times and waiting lists.

CHAIR: The final point that we should ask you about is that Lyn mentioned the agreement with the Flying Doctor Service had expired, presumably a couple of years ago, and had not been signed. We promised her that we would raise it with you.

Ms CUTLER: I realise that. I think it is not the only one. The RFDS is currently under a Commonwealth review. There are four separate contracts that the Department of Health in New South Wales holds with the RFDS. Some of them are based out of here. There is a Broken Hill contract, the oral health, the Dubbo Base and another one. There was a preference by Clyde Thompson, the chief executive, to have one contract rather than the four individual ones. They used to have all different starting dates and those sorts of things.

When we started to do the work on that and then the Commonwealth review came, there was agreement that we would then wait to see what the outcome of the Commonwealth review was because potentially there will be some impact on that and on some of the contractual arrangements. The non-government organisation [NGO] grant for dentistry actually is an NGO grant that is annualised and they get the money, but the contract side of that is about the specifications about the service. Essentially we are still providing the money through to them. I suppose that they would have a level of just wanting to clarify the contract, but because it is under the NGO grand system, it is a bit separate to the others.

CHAIR: I think she also had a feeling that perhaps the money had been frozen because of time going on.

Ms CUTLER: No.

Mr KUMM: We have never veered off that agreement. It has not lapsed. We have not veered off that at all. We still abide by that agreement.

Ms CUTLER: But I will take that on board because if that money is not going through there for some reason, I will take that on board. I meet with Clyde regularly.

CHAIR: That would be good. This Commonwealth review of course relates to the fact that the service goes way over the New South Wales border and involves several States.

Ms CUTLER: It is actually Australiawide review of the RFDS because the RFDS, although many people see it as one organisation, is actually run from memory as four separate organisations under a governing body. There is the south-eastern section, which is what we are under here, which actually covers New South Wales, a little bit of Queensland, a little bit of the Northern Territory and a little bit of South Australia. It is just where they do their clinics. Essentially there is also Victoria and Tasmania and the other branches cover the rest of Australia. It is an Australiawide review of how the RFDS is set up and governed and provides service.

CHAIR: Do we need to look at that in terms of dental?

Ms CUTLER: From an oral health perspective, I would not think so because the only link with RFDS would be this one NGO grant in Broken Hill. The rest of New South Wales would not be influenced by that and the contracts that I have alluded to would be mainly around patient transport and ambulance.

CHAIR: I think that covers that. Probably the easiest way for you, particularly in terms of the things you have agreed to take on notice, is for us to get the transcript which will clarify the issues of what you said and what we want and what you said you are able to do. The secretariat will liaise with you. It may also be a matter of you giving us the figures you had. You ran through them fairly quickly and it might be clearer to see them in the way you have set them out.

Ms FLOYD: That will be fine.

Ms CUTLER: I could leave you the one page that has most of the figures on it for now.

The Hon. KAYEE GRIFFIN: I move:

That the Committee accepts the document.

Motion agreed to.

Document tabled.

(The witnesses withdrew)

JASON PETER GOWIN, Co-ordinator—Annual Health Checks, Maari Ma Aboriginal Corporation, Argent Street, Broken Hill, affirmed and examined:

CHAIR: You are appearing on behalf of the Maari Ma Aboriginal Corporation?

Mr GOWIN: Yes.

CHAIR: As you have probably gathered from listening to the other witnesses, we tend to move around with different Committee members asking different questions. Would you like to make an opening statement and tell us about the service, or shall we go to questions?

Mr GOWIN: Only if you think it is relevant, I could tell you a bit about the health checks, although that will probably come out. I have made some photocopies of what the health checks do and some of the statistics we are a getting regarding dental matters for kids and adults.

CHAIR: You will be able to give as copies of that?

Mr GOWIN: Yes. I have run off a dozen copies. I was not sure what was needed.

CHAIR: That will be really good. You received the questions that we prepared, did you? We prepared 12 questions to guide us in talking to you.

Mr GOWIN: No.

CHAIR: That did not arrive?

Mr GOWIN: No. I have been in Ivanhoe for the past few weeks so I have not had time to chase them up.

CHAIR: We will give you a copy of the questions. They are mostly fairly obvious questions. The material that you have probably covers some of them. The first few questions are factual questions about the service. Some of them have probably been answered in this written material. If so, you can just say it is all there. Can you tell us how the service is funded and, specifically, where the funds are allocated for dental services, or just how that has worked out?

Mr GOWIN: I think the money for the well person's health check comes straight from NSW Health. I am not sure about the exact figures but I think roughly there is a quarter of a million dollars for the next two or three years to run health checks in our region. So a part of the health check is having a dental person present who screens everyone who goes through. He or she does an assessment of someone's teeth and grades the level of follow up. So none might be needed or it could be low, which is within the next six months. Medium would be the next four to eight weeks, or high might need immediate treatment. So part of that pool of money pays for the dentist to be involved in the screening. Then I guess it is how we try to manage those numbers post health check.

CHAIR: So the service really works out how much of those funds are going to the dental side of things? It is not that you get a sum of money that can be used only for dental services and nothing else?

Mr GOWIN: No. So far as I understand it, there is a pool of money and we try to expend it as best we can to cover the key elements of the health check. That ties in with Maari Ma's chronic disease strategy, which is all fairly recent. It is obviously looking at diabetes, hypertension and high cholesterol. As part of that it is also looking at oral health.

CHAIR: Do you try to regard a person as a whole person and look at that person's oral health as part of looking at his or her general health?

Mr GOWIN: Yes, for sure. The oral health and all the risk factors for poor health outcomes, whether that is about smoking or alcohol. I suppose it is about screening populations, giving them the best advice and giving them the best follow up treatment we possibly can. When we looked at doing

the health checks we talked to everyone. Obviously, if you are screening for something you need to be able to manage those results and to provide good follow up. The one thing about dental we knew would be difficult would be to provide follow up.

At one stage we debated whether it was worthwhile doing the dental screening aspect of the check. We did not feel confident in being able to follow up those people appropriately. We decided we needed to collect that data and then do something about it post check. I suppose that is where we are at now. It is basically what you know. People have pretty poor oral health now. It is what we do with that information and how we best provide the follow up.

CHAIR: When did you start the Health Checks program?

Mr GOWIN: In our region, Menindee in February this year was the first one. There used to be the old upper sector of the Far West—Bourke had the kids checked, Collarenebri, Goodooga, Enngonia and Weilmoringle. They had an annual health check up there. We had Menindee in our area in February and we had Ivanhoe in the last two weeks.

CHAIR: That is why you have been in Ivanhoe?

Mr GOWIN: That is why I have been in Ivanhoe, yes.

CHAIR: So it is still very early days?

Mr GOWIN: It is early days, yes. We are close to finalising all the data sheets and the finished product. We really started from now, basically. Things changed quite a lot of after Menindee and now things will change slightly after Ivanhoe. But we are fairly close to being happy with what we have. That is not only us; it is obviously also our partners—the flying doctors and the department of rural health as well.

CHAIR: You have already said a bit about the staff question. You had to work out whether you would go ahead with the check if you could not do the follow up. What sort of staff do you have available to you in the dental area?

Mr GOWIN: We are trying to fit in with the existing service, which is the Royal Flying Doctor Service.

CHAIR: So you have Lyn?

Mr GOWIN: We have Lyn, yes.

CHAIR: Lyn talked to us this morning.

Mr GOWIN: Yes. I suppose there is a structure and a service that meet the needs they are designed to meet. We found fairly quickly that, because it is structured and provided in such a way, it is difficult to tap into what is there. Obviously they are fairly busy with what they are doing or because of that existing structure it is difficult to find a way around the structure, if that makes sense. We need to work with what we have, and what we have cannot suitably manage what we are finding. So finding another way to that end point is difficult because the structure that is there is set up in the way that suits or works best for that organisation.

CHAIR: It works for the Royal Flying Doctor Service?

Mr GOWIN: Yes. The way people present and where the flying doctors visit. From our understanding their contract with the Greater Western Area Health Service is to provide a certain number of clinic days per community and those sorts of things. That is an ongoing thing. It is difficult to work within that. So we screened about 200 people in Menindee and about 50 people needed dental follow up. Menindee gets one day a month when people can come into town. They already have waiting lists.

If we were to put another 50 people on top of that waiting list it really could not be managed. Wilcannia gets four days a month. So for about the last six months we have been pinching one day a month from Wilcannia to try to slot in. Also Peter Hill from Justice Health comes out. He provided a couple of clinic days for Menindee and also a day for the local prison population. In spite of all that I think we managed to get an extra 12 days for the Menindee well person health check people. There are still 20 odd people waiting to be seen.

CHAIR: So you had 50 and it is down to 20?

Mr GOWIN: Yes.

CHAIR: Of the 30 people who have been looked after have they had pretty full treatment and so on? They are not waiting to go back for multiple appointments?

Mr GOWIN: No.

CHAIR: So those 30 people have been pretty much been looked after?

Mr GOWIN: Yes. That is what has taken so long. Sometimes people need to come back two or even three times for their care to be complete.

CHAIR: So even with those 50 you obviously had a bit of a priority list?

Mr GOWIN: Yes.

CHAIR: That is the category here. The 50 on the list obviously all had a reasonably serious need?

Mr GOWIN: Yes. I am not from Menindee but I work very much with local health workers out there. They really need to put people on a bus so they can bring over eight people at a time. Things change fairly quickly when there is a funeral, or people go away or travel. You can book in those eight people but when you go to pick them up on the day you might be struggling to find three or four. It makes it difficult when you have Lyn waiting to see these people and they do not turn up, for whatever reason. Even though it is only 100 kilometres away that travel seems to take its toll on people turning up. Off the top of my head out of all the dates we organised probably only once or twice have the days been completely full.

CHAIR: So you need a few reserves?

Mr GOWIN: Yes. We need to bring in a couple of extra people because the chances are that at least two will not turn up on the day. It is a lot of work by local staff not only to round up those people but also to stay with them all day so they do not wander off, get sidetracked and not turn up.

CHAIR: Who co-ordinates it all? It is a big job. You have the Royal Flying Doctor Service, Justice Health, Maari Ma, the Menindee community, Ivanhoe and all the others. Are you the person who is trying to put all that together?

Mr GOWIN: Yes. I suppose it is me and a cast of thousands. Communication obviously is the key. Even then it is difficult at times. I have to work with Mason, Lyn and Anne Wakatama.

CHAIR: She is the medical officer from the Royal Flying Doctor Service?

Mr GOWIN: Yes. Obviously there is a history with dental services in Broken Hill and existing contracts. I do not know anything about them. Often I have to wade through those things as well.

CHAIR: We are trying to understand how it works. It sounds very complex. Obviously it is quite complex. The needs here are quite different from the needs in other parts of New South Wales. It sounds as though it works because a relatively small number of people know one another and can talk to one another.

Mr GOWIN: Yes. One would have to debate whether it was working.

CHAIR: Can you tell us?

Mr GOWIN: Again, using Menindee as an example, we had the health check in February and we only just managed to see over half those people who were waiting to be seen. So we are almost getting to the point where we will have another health check at Menindee in the middle of next year. So you think, "Is it worth continuing to push to get the existing 20 people seen?" Or you think, "There is another health check coming up next year and the chances are we will have similar numbers again needing dental follow up." So we are back on that same treadmill.

CHAIR: It has taken you six months to get through 30 and you have another 20 to go?

Mr GOWIN: Yes. Again there are staffing issues at Menindee. They are a bit short staffed at the moment. The health workers who are working there are pretty much juggling many different programs. We have to ask them to take a day out of their week. It is probably more than a day because they need to contact people and see who is interested in going over. They then need to make sure that those people are right on the day. So it is probably a good two or three days work. Then that person has to come over to Broken Hill with them and drive them back home. As I said, kids and adults were also being screened in Ivanhoe over the last couple of weeks. It seems as though about a quarter of the population that we screen will need follow-up treatment. The way things are at the moment, the existing service just cannot manage those sorts of numbers.

CHAIR: Is that because of staffing shortages, or is it because funding, et cetera, simply does not provide enough staff?

Mr GOWIN: The impression that I get is that it is difficult to get dentists anyway.

CHAIR: If, for instance, the vacancy for a dentist at Broken Hill had been filled, say, in February when you did the Menindee screening, would you have been able to have looked after all those 50 people by now?

Mr GOWIN: It probably would have provided greater flexibility in treating those people. As it stands, it is one day a month. If people are to come back two or three times or, for whatever reason, they cannot get over for that month, it drags out to three and four months. I do not know. I imagine that people would lose interest after a while. If it has been six months and you have not heard anything about your dental follow up I imagine that a lot of people would have forgotten about it. We tried to arrange to have someone for a week or a fortnight. We were bussing people over for those two weeks to try to bring those numbers down.

When Justice Health came over for that week I think he managed to see about 20 odd people from Menindee in those two days. But obviously a lot of those people needed ongoing and follow up treatment. He could see a couple or more people a day than Lyn because he has a dental assistant working with him. So the sterilising and whole process is much faster. We knocked on every door that was available in Broken Hill to try to find someone who could do an extra week or two weeks to really put a dent in that number of 50. We were not able to do it.

The other side of that is that in a place like Wilcannia there is a dental clinic at the health service. Again, because Lyn has all the equipment, she travels around with it. Even if we could get a person to go out there for a week or two weeks after a health check, there is no equipment there for them to use because Lyn Mayne needs the equipment that she has to travel around the region.

CHAIR: Even if you could import someone for two weeks he or she would need an extra set of equipment because Lyn takes hers from place to place?

Mr GOWIN: Yes. A good example of that is Justice Health, a blessing. We got a phone call to say there was funding for a person to come out for a week at a time. We said that would be great. It was lucky that the Morgan Street clinic was not being used because I think the dental therapist there was on maternity leave, and through Mason he was able to arrange that. Because it was a school we

were not able to take prisoners there for legal reasons so we used the Maari Ma primary healthcare service here but that meant that Mason had to take all the equipment from Morgan Street and put it up to Maari Ma. Then, when Lyn was there on Friday they had to take all the equipment back. So, there was a fair bit of mucking around. Justice Health offered to come out again as recently as last week I think but we could not facilitate it. We were not able to move all the equipment around again to repeat what we did before. I am not sure of the reasons why.

CHAIR: You need to tell Justice Health to come in the school holidays.

Mr GOWIN: Yes. They were prepared to come out for a week but we could not put them anywhere, which was a crying shame because hardly anybody was turning a dentist away for a week. It was disappointing, obviously.

CHAIR: That would be overcome if there was a clinic attached to the hospital, for instance?

Mr GOWIN: Yes. If we had a functioning clinic somewhere we could drop somebody in for a week or a fortnight with stand-alone equipment and those sorts of things. That would be great. I think that is what Maari Ma is looking at. They are getting prices at the moment and looking at what sort of equipment would be needed so we can facilitate that. This is going back to that original thing of trying to work around the existing flying doctor structure, not to discredit what they do but just being more flexible and seeing how we can provide follow-up service.

CHAIR: When we were talking to Lyn she was saying if she could be doubled, if there was another dentist there, that would go a long way, if not the whole way, towards filling all the needs you are talking about.

Mr GOWIN: Yes.

CHAIR: We have looked at funding and staffing. What geographical area do you cover?

Mr GOWIN: I am sorry I did want to bring along a map and some population numbers. We are pretty much Tibooburra, Broken Hill, White Cliffs, Wilcannia, Menindee, Ivanhoe, Wentworth, Dareton, Balranald.

CHAIR: So it is all the way from the Victorian border to the Queensland border?

Mr GOWIN: Yes, and hugging the South Australian border I suppose.

CHAIR: Not all that far east?

Mr GOWIN: No. Ivanhoe is obviously the one furthest east.

CHAIR: That is not a huge population in some ways but there is a lot of need in that area?

Mr GOWIN: Yes. Like you say, obviously Broken Hill has 20,000 and there are a few in Dareton and Wentworth so it may be 30,000 all up for the region. I am just guessing.

CHAIR: What is the Aboriginal population?

Mr GOWIN: I think it is about 14 per cent. I have seen it.

CHAIR: Approximately 4,000?

Mr GOWIN: That sounds about right.

CHAIR: You have told us a bit. We have not had time to look at your document but does it tell us all we need to know about the health checks program or the things you would like to tell us now about how you organise it?

Mr GOWIN: I put the data sheet we are currently using but the thing about the data sheet is that it does not have the dental survey. The dentist has her own data collection sheet that she fills out.

CHAIR: Could we get a copy of that?

Mr GOWIN: I did not bring one today, but I can certainly get you a copy.

CHAIR: Then you have the aims of the program, and so on.

Mr GOWIN: Just on the dental data collection. All that goes to Adelaide. There is an organisation, a dental headquarters down there, that collects all the information.

CHAIR: It might be Professor Spencer, perhaps?

Mr GOWIN: I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is at a national level you are talking about?

Mr GOWIN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At a national level, information on comparative dentistry is collected in Adelaide, is it?

Mr GOWIN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be John Spencer, would it not?

Mr GOWIN: I am not sure of the name. I only hear it referred to as an organisation. But that is where Sandra sends all her data.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You may have heard me ask the last group for comparative figures as to how serious the problem of unmet need is here. They took it on notice. You have here, in a sense, the figures on the third page of your submission that you just handed us about the decayed, missing and filled teeth.

Mr GOWIN: Yes.

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

Mr GOWIN: Yes. That is how I understand it. They were handed to me from Sandra, the dentist who does our screening, and that is how I read it, yes.

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

Mr GOWIN: Yes.

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

Mr GOWIN: Yes.

CHAIR: So you have given us the figures for adults and children in the different communities that you go to to do the health checks and you have some of the general issues, including the issue of fluoridation and the lack of that in small communities. Do you have a view, does the health service have a view, on fluoridation?

Mr GOWIN: Yes. I think the research I have read is that it seems to make a difference to kids. My only reservation—this is a personal view—is that I am not quite sure how much tap water kids are drinking anyway. Certainly in Broken Hill the water quality has been pretty poor at times and most people I know tend to drink bottled water anyway. When people talk about fluoridating water, that is fine, but it needs to go along with other more effective measures rather than that being the cure to kids bad teeth. It needs to be one of a number of strategies to assist in improving teeth.

CHAIR: But as far as you know there is not an official view on the issue on the part of Maari Ma?

Mr GOWIN: No. Again, I suppose it is what the evidence is suggesting and being swayed by that. It is your basic oral health that is more important than fluoridating water, I would imagine.

CHAIR: I am not sure how easy it is to ask the questions here about the percentage of clients who attend for dental treatment. Would you make any comments about the Aboriginal people in your area? Do most of them attend the service? Do they attend any service? Is it a matter of really having to go out and persuade people that they should seek treatment? Can you give us a bit of a picture?

Mr GOWIN: I would imagine that most people would only go if they were in severe pain or had infection. As far as going for a regular check-up, that just would not happen. Again, without generalising, I think tooth brushing is fairly low amongst the majority of the Aboriginal populations in our region. There are reasons for that, with overcrowding, having somewhere to keep your own toothbrush. If you have many kids running around the house, the chances of you being able to keep hold of the toothbrush very long. All those environmental factors would play a big part in that. If Mum and Dad do not brush, the chances are it is not going to be a priority to get the kids to brush their teeth as well. I would say if people are in pain, that is when they will present. I guess that is the philosophy of where the annual health checks come from. Instead of waiting for people to be sick you are being proactive and trying to get out there and give advice and pick up things early so they can be managed more effectively in the long term.

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

Mr GOWIN: Yes. And I think that goes along with all aspects of health. It is difficult to talk about someone's obesity or drinking problems in isolation from the rest of their life. Certainly oral health would be no different. I guess it is how you perceive what is important. It might be important to have regular health checks and look after our teeth, but if you have not been brought up that way it is not something you would probably even consider. How do you change that way of thinking?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This checking of healthy people is pretty bold and innovative holistic stuff. Are you getting special funding for that or is it just an initiative you have taken?

Mr GOWIN: No, we did get at the end of last year through NSW Health—and I am not sure who played what role—a lump of money to do this health check over the next two or three years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you got any personnel? I notice you have referrals to dieticians and quite a lot of people here—mammograms, dieticians, GPs, mental health teams, SHNs, WHNs, what are they?

Mr GOWIN: Women's health nurse and sexual health nurse.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have staff sufficient to deliver the referrals once you find the problems?

Mr GOWIN: Yes, we are pretty right except for dental. We have people in our organisation at Maari Ma like the flying doctor with the GPs referrals. We have a dietician at Maari Ma. A

women's health nurse is offered through the flying doctor service. She visits. The sexual health nurse is based here in Broken Hill. Mental health team again, it accesses our community. So it is just about creating lists for them to see when they go out there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there enough of those?

Mr GOWIN: Yes. Again, we are just travelling down that road now, what they are able to cope with and those sorts of things. Again, mental health was something we debated, whether it should be included and would we be able to provide adequate follow-up and those sorts of things. I guess the mental health wanted to be involved and they wanted to be there to provide follow-up. Often people talk about wanting to be more proactive in regard to screening and accessing populations but I suppose time and money prevents that, so while we are out there doing these sorts of things why not put in a couple of simple questions regarding what we call social and emotional wellbeing. If we get a couple of scores that are a bit high we encourage people to see the mental health service the next time they come to town and put them on a waiting list and those sorts of things. So far so good, it seems to be working all right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How about Quit? Do you have any resources for that?

Mr GOWIN: We have had some pretty exciting things happening in Quit right now. Twenty-five people at Menindee have just started from the well persons health check in February. They are on a quit smoking program now. We bought the NRT at cheap prices and are basically giving it to clients very cheaply. We only just had a meeting saying that 25 people have been off the cigarettes for four weeks now and it is going quite well.

CHAIR: You said you got a lump of money, I think was the phrase, from NSW Health and the program started in Menindee in February. Did you say it goes for two years?

Mr GOWIN: I think the funding is for two years.

CHAIR: You mentioned that Menindee would be done again in the middle of next year, for instance.

Mr GOWIN: Yes.

CHAIR: Is an evaluation built in by NSW Health? Is someone looking at how the program is going and what it is achieving as you go along?

Mr GOWIN: Yes. Apart from providing the six-monthly report on what we are up to with the program, probably people above my level are taking that data and having discussions about what we are seeing and how we are managing it and those sorts of things. I suppose I am being left alone to do the on-the-ground stuff while people above me are looking at what we are finding and how we can best manage it.

CHAIR: In due course a committee like ours for instance would be able to get access to some sort of report of an evaluation on how many people were seen, what it showed, how the treatment worked, what the outcomes were and so on?

Mr GOWIN: We have a data manager at Maari Ma and it is her role to make sense of all these figures over time. Being able to report back to funding bodies and those sorts of things is obviously really important, but also from Maari Ma's point of view, it is knowing that what we are doing is actually doing the right thing and is sort of having an effect where we want to see change.

CHAIR: Correct me if I am wrong, but is the funding for the program really to do the checks but then the difficulty in relation to dental services is finding someone to carry out the treatment?

Mr GOWIN: Yes.

CHAIR: The program funding does not provide the treatment.

Mr GOWIN: No. I think that up until now we have sort of been saying that we will find the money. We will spend the money and then we will find ways of replacing the money when the time comes. The Quit Program was a good example. Because we had all these people wanting to quit, we wondered what we would do with them so we had to find a way to offer them the best Quit Program or advice that we could and then we had to spend I think approximately $15,000 on nicotine replacement therapy. We did not budget for that in the well person's health check program, but we thought we needed to spend that and maybe down the track we could put in a proposal for nicotine replacement therapy. It is almost discovering things as we go along and then looking at how we can manage.

CHAIR: But you really have to find the funds out of your own internal ongoing funds?

Mr GOWIN: Yes.

CHAIR: Related to that in terms of dental service, are you able to refer people to private dentists? Are you able to say, "There is someone with a real emergency that will really have to have some treatment or some help somewhere". Can you do that?

Mr GOWIN: If someone is privately covered or can afford to pay then they can see a dentist in Broken Hill.

CHAIR: Or operate through the Flying Doctor Service.

Mr GOWIN: Yes. There would just be quick access to the Flying Doctors. I think if someone is in obvious pain, I imagine they would go to the top of the waiting list and would see Lyn at the next available time.

CHAIR: The fact that you have all this extra knowledge about people's needs does not necessarily advance you to the next step in terms of services.

Mr GOWIN: No.

CHAIR: Are you able to do any preventive work?

Mr GOWIN: I suppose that a big part of what Sandra does when she is screening is health promotion. Apart from everyone getting a toothbrush and toothpaste, she spends time explaining how to brush and why to brush. Certainly with parents and their kids, she emphasises the importance of brushing.

CHAIR: Sandra was employed before the health checks program?

Mr GOWIN: She works for herself. I guess it is like a consultancy basis. Whenever she works for us, I suppose she gives us a bill for the time. But she has been involved in all the health checks we have had out this way.

CHAIR: But you were already using her before the health checks started.

Mr GOWIN: Yes.

CHAIR: So, again, it is something that comes out of the ordinary activities.

Mr GOWIN: Yes.

CHAIR: You have put some effort and some money into preventive work in the area of oral health?

Mr GOWIN: Yes. I think that final page—I have just copied that from Maari Ma's regional business plan. It is relevant to what Maari Ma is able to achieve in regard to part of the healthy start program. It is sort of looking at kids and what can be done to improve kids' teeth.

CHAIR: So you have got the healthy eating and the dietician as well as the more specific dental health staff.

Mr GOWIN: Yes. Central to all of this area is employing a dental therapist.

CHAIR: If you can find one.

Mr GOWIN: Yes, if we can actually get one.

CHAIR: We heard from the area health service people talking about the difficulties and the fact that the therapist here is on leave and they have not been able to replace her.

Mr GOWIN: Yes. It will be interesting to see how they get on with getting that person.

CHAIR: We have probably pretty much covered the rest of our questions. What sort of comments would you make about the level of service or the state of public dental services that are provided in the far west region or this part of the world? Are you critical of them? How would you go about improving them?

Mr GOWIN: I do not know, but I guess they are not particularly sensitive to indigenous populations.

CHAIR: Can you give us a bit of detail?

Mr GOWIN: Probably it gets back to what I said before. We do not do anything to kind of capture that target group that we know have really bad teeth. We are kind of waiting for them to turn up at the health service or on those dental days to get work done.

CHAIR: So there is no real outreach program?

Mr GOWIN: No.

CHAIR: There is no attempt to go to their communities and start from the bottom upward?

Mr GOWIN: No, and again that is not a criticism of existing services. That is just the way it is structured. Unless you look in someone's mouth, I do not think you will actually find out whether there is a problem there or not in the majority of our Aboriginal populations. I think the service is probably okay for people who make appointments and go along and sort of realise that their teeth are a priority. There is probably a reasonable service there but for a big proportion of our Aboriginal population, unless they are turning up, then there is nothing being done. Certainly if the parents have got bad teeth, then their kids have got bad teeth. I would say that is probably where it is falling down quite badly and that has been highlighted by the small figures we have on the screening that we are doing. There are a lot of bad teeth out there.

CHAIR: How would you overcome that? Do you have any suggestions? Should it be done through the Aboriginal Medical Service network, for instance? Does it have to be Koori people doing it for Koori people?

Mr GOWIN: Yes. Being biased, working for Maari Ma, I think we might be a bit more sensitive or may find maybe slightly different ways of providing a service for people out there. Again, it is dependent upon things like a dental awareness, but even simple things: like, if we could have our own dental kit and have access to a few dentists who are happy to come out a few weeks of the year to deal with the people after the well person health checks, then I think that would certainly be a start to just get the kids brushing their teeth at least once a day.

I know that not all kids go to school. The schools tend to be a bit overwhelmed anyway, but if we could just get a teeth brushing program commenced at schools in the morning and even if there was a health worker who went along there in the morning and got the kids to brush their teeth in the

morning before starting school, that would mean that people would know what it is like to have clean teeth. I think that would be a start.

CHAIR: Do any of the local schools have health workers attached?

Mr GOWIN: Not the schools.

CHAIR: But there are nurses and so on in the clinics.

Mr GOWIN: Yes, and Aboriginal health workers who work at the clinics. I think there have been a couple of isolated cases where teeth brushing programs have started in schools. Like in most cases, when the person who is driving that sort of leaves and it falls over, it does not get picked up again.

CHAIR: But personally, you think the school is a good place to start and work outward from?

Mr GOWIN: Yes. Again, I think everyone wants the schools to fix everything, but at least the kids go there and there are facilities there for them to be able to have their own toothbrush by putting it in a case with their name on it. They could access that every morning. It is not just the schools, but everyone, I think, should be brushing teeth, promoting holistic health care and giving people more knowledge about what it is to be healthy, to feel healthy, and those sorts of things.

CHAIR: Would you be pessimistic or optimistic about the chances of making improvements?

Mr GOWIN: One of the points I made in the submission—I might be wrong—but there seems to be a lack of decent research or best practice and how to go about this. We do not have a blueprint to show that this is what has worked in a particular community. In most areas we know what is best practice for diabetes and high blood pressure and those sorts of complaints, but as far as brushing teeth is concerned, we do not really have any good research to say that this is what we should be doing in the schools or in the homes about getting people to change their diets. Maybe that is because having bad teeth is not a risk factor for early death, but I think there is research to say that that might be changing. Perhaps it has not had the priority that other health complaints have.

CHAIR: Are these aspects the poor relation in the health area in general?

Mr GOWIN: Yes. It is usually heart disease, cancer and road trauma and those sorts of things that are priorities, but you do not see oral health or dental treatment up there.

CHAIR: I think we have covered the questions we had to ask. We will be able to have a better look at the document you have given us. There was a question that we asked you to get back to us on. We can sort that out with you later when we have had time to look at the transcript. One of the staff will liaise with you about more specific information.

Mr GOWIN: It was the dental survey, and I can get those to you.

CHAIR: Yes.

Mr GOWIN: Did you want them soon, like today?

CHAIR: Whenever possible.

Mr GOWIN: I can probably drop them back this afternoon, and that will be fine.

CHAIR: We are really grateful to you for giving us the time and for putting the work into today's hearing. We will not be pushing for you to get back to us this afternoon.

(The witness withdrew)

(Luncheon adjournment)

LAWRENCE ROSS NETTLE, Manager, Barrier Dental Clinic, 168 Beryl Street, Broken Hill, sworn and examined:

CHAIR: Are you appearing on behalf of Barrier Dental Clinic?

Mr NETTLE: Yes.

CHAIR: Do you wish to make a statement?

Mr NETTLE: Yes. I have a short statement that I would like to make.

CHAIR: Since we have been here quite a number of our witnesses have told us about the history of the mines clinic, the town clinic, the Barrier Dental Clinic and so on. We would like to hear whatever you think is relevant of past history. We have heard quite a bit, one way or another, from different witnesses. You might want to fill us in a bit to start with.

Mr NETTLE: All right. First of all I would like to thank you for the opportunity to appear here. I must state that I am not a dentist; I am a business manager of the clinic. Because of that I had a look through the questions that were sent out. In relation to anything of a clinical nature I asked the dentists at the clinic to give me their information. If there are any matters of a clinical nature I will be passing on their information. Basically, our clinic is a very viable clinic. It provides an essential service to its members.

It is a unique clinic. The major threat to its operation is sourcing dentists. If we cannot get the dentists we will not operate. It has been an ongoing problem for a long time. It continues and I think it is getting worse. Therefore, the main aim of our submission is to seek ways of overcoming the problem of attracting dentists, not just to Broken Hill but also to rural and regional New South Wales and Australia, from what I can gather. Would you like me to give you a brief overview of our clinic at this stage?

CHAIR: Yes. It is probably easier for you to do that and we can then ask you questions if there is anything missing or anything we are not clear on.

Mr NETTLE: The Broken Hill Mines Dental Clinic was set up in the late 1940s by the mining companies. They got together to provide a dental service initially for their employees. There was an early setback when it was set up because there was no provision in the Dental Act for a clinic of such a nature to be set up. So they had to alter the Dental Act for the Broken Hill Mines Dental Clinic to become established. We moved into our current building in the early 1950s. That building has seven surgeries plus an operating theatre and room for five dental technicians.

In its heyday they were all used and originally they had five dental technicians employed there. It started off seeing just the employees of the mine. Over a period of time it started to see their spouses and then their children. The employees on the mine paid so much out of their wages to go to the dental clinic, but it was also heavily subsidised by the mining company. I can remember as a child going to the clinic when no fees were payable at the clinic; it was covered by the mine. That changed over a period. With the demise of mining we obviously did not need the six or seven surgeries and all the dental technicians, et cetera, at the clinic.

In the meantime, because that clinic was only open to mine employees, I believe the town employees got together and set up a clinic. The only way they could open the clinic was to have it on the hospital premises. They would have had a lot of problems with the Australian Dental Association [ADA], et cetera, getting another clinic like the mines clinic to open. So they set it up on the hospital premises and that was virtually for anybody employed in the town. Over the period when the hospital was knocked down and rebuilt the town dental clinic operated out of our building. There were still two separate clinics but they operated out of the one building.

In 2001, with the demise of Pasminco, they no longer put anything into the clinic whatsoever. The two clinics merged to become the Barrier Dental Clinic. Our constitution states that any person, being a natural person, is eligible to be a member of the clinic. So anybody in the Broken Hill district or anywhere can join and become a member of Barrier Dental Clinic as it is now. That clinic charges $2 a week membership fee for a member. It does not matter whether you have a spouse and six kids or whether it is just you, it is $2 for membership and your dependants can come to the clinic. We charge treatment fees now but, as I stated in my submission, because it is a not-for-profit organisation owned by its members, we keep those treatment fees at a minimum.

Comparing our fees to the fees that were published by the ADA in July 2004, on average our fees are 30 per cent lower than private practitioners throughout Australia. Obviously there are some fees that are closer to it. Those fees are generally those that we need to send away and get dental technicians to do outside work. They are closer to the standard fee but most of our consultation fees, et cetera, are a minimum of 30 per cent lower. That is deliberately done to keep our members happy and to provide a service to our members. I suppose that is about it.

CHAIR: How many members would you have?

Mr NETTLE: We have 2,000 paying members but that equates to nearly 5,000 clients when you take into consideration their families.

CHAIR: Out of a population of roughly what?

Mr NETTLE: Roughly, Broken Hill is sitting at about 22,000.

CHAIR: So it is quite a percentage of the town?

Mr NETTLE: Yes. There are a couple of classes of members. We have members who are called retired members. They have worked for 30 years on the mines. They virtually do not pay a membership fee because they have been in the mine clinics for so long. They do not pay membership fees but they do pay treatment fees. So everybody pays a treatment fee. Some of those retired members have left town but they still retain their membership and come back here for dental treatment.

CHAIR: As you said, there was a subsidy but that stopped in 2001. What about the premises, the seven surgeries, and so on? Are they owned by the clinic?

Mr NETTLE: Owned by the clinic, yes.

CHAIR: How many dentists and others do you have there now?

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

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

Mr NETTLE: It is my major job, yes.

CHAIR: Going back, you have the two locums starting shortly and I think you said the one dentist has been by herself for six months?

Mr NETTLE: Six months, yes.

CHAIR: What did you have before that?

Mr NETTLE: Before that we had two or three dentists but again they were locums. One came for three months and just before Christmas we had a locum there for about eight weeks.

CHAIR: Again they were overseas trained?

Mr NETTLE: Yes. The one just before Christmas was an Australian dentist but he had been in the UK 15 years and he just came back to Australia. The only reason he came out and was working is that he has a Malaysian wife and he needed to stay in Australia to get her citizenship. He was virtually semiretired.

CHAIR: What other staff in addition to dentists do you have?

Mr NETTLE: We have naturally me. We have a receptionist, who is a trained dental assistant, and we have one part-time dental assistant who works four days a week. In April we put on a trainee dental assistant and we have one casual that we can call on. So, it is not just dentists who are the problem. With dental assistants we are covered at the moment but if we have sickness or holidays we become very stretched. We are very stretched at the moment with three dentists and a dental assistant. If any of them take crook we will be pushing to have a dental assistant.

CHAIR: And it is just as hard to get a dental assistant?

Mr NETTLE: Yes. Most of the dental assistants who were trained now have families and if they are looking for work they are only looking for casual or part-time work. That is the reason we have just put on a trainee.

CHAIR: Does that person go to the TAFE college?

Mr NETTLE: No, she has to do it by correspondence here. It is a certificate 3 in dental assisting. She does it through Australian Business Ltd. They will send out a workplace assessor to assess her at the time, but it is all on-the-job training.

CHAIR: You do not have any dental technicians or prosthetists?

Mr NETTLE: No, there are no dental technicians in town at all. All of our dental repair work or denture repair work or dentures, crowns or bridges go to either Mildura or Adelaide.

CHAIR: If it was not for recruitment difficulties, would there be any other problems?

Mr NETTLE: As far as our clinic is concerned, no. That is our major concern. I did mention, and I notice it was a question there, that we have had final-year dental students out here as placements. Because we are a private clinic, they only come out and stay with us for a day and all they do is observe. They do not do any work whatsoever. I have spoken to those dentists and told them that we are quite prepared to take on a first-year graduate, there is no problem with that, but the big thing we find is that none of them want to come to the rural areas for a length of time. They will come out for six weeks. The majority of reasons they give is that they have family ties and they will not leave their families.

CHAIR: You have answered most of our questions, well done. One question specifically to you: you note in your submission that you no longer provide services for public patients. Can you go into the reasons for that, when you decided that and why?

Mr NETTLE: It was before my time as manager.

CHAIR: How long have you been there?

Mr NETTLE: I have been there just over 12 months. I spoke to the previous board. The main reason they stopped doing it was because the rate of remuneration was just not viable. Plus, all the administrative and reporting work that was required by the health system just put an extra burden on our staff. As I said in there, some of the dentists refused to see public patients. From what I can ascertain, the main reason for that was the dentists were extremely limited in what they could do with the patients because of the system that was there. Because of that limitation they copped a lot of abuse from the patients because they were not getting what they thought they required.

CHAIR: You mean by limitation, if there had to be an extraction that it was professionally unsatisfying or that the patient came expecting their whole mouth to be fixed up?

Mr NETTLE: Yes. Basically it was for relief of pain and they could see a whole lot of other work needed to be done. They have a duty of care to their patients and all they were doing was fixing, or sometimes temporarily fixing, one little problem. They could not do a full service to the patient who required it. The other reason was that the majority, not all of the patients but the majority, who presented, their personal hygiene and their oral hygiene left a lot to be desired.

CHAIR: This all occurred before you became manager?

Mr NETTLE: Yes.

CHAIR: Because that was when the decision was taken to stop dealing with public patients?

Mr NETTLE: They did have the contract with the Far West Area Health Service, as it was at that stage, to provide a full service but virtually it became unworkable.

CHAIR: So, presumably, that contract is now filled by another dentist in town?

Mr NETTLE: Yes.

CHAIR: You have told us how many members you have. Did you tell us how many people you see? I do not think you did.

Mr NETTLE: Last financial year we saw nearly 4,500 patients.

CHAIR: That was when you had two or three dentist? No, you only had one dentist?

Mr NETTLE: We had one dentist this year but from April through to about May, June last year, at one stage there, we had five dentists. Again, they were only locums who are only here for a short period of time.

CHAIR: Do you put people on a waiting list and when a locum turns up you would clear a whole lot of your waiting list?

Mr NETTLE: When we had just the one dentist, our waiting list was about two to three weeks to get in to see somebody. Since we have had the locals, when we get the spare dentists we initiate the recall system. That is one of the services we provide for our members and the members have requested it back. When they come to see us and their treatment is completed, they fill out a form on whether they want to be recalled in six months or 12 months. At one stage it was about 18 months before we could recall anybody. With these two locums that we have now, we have got that back to maybe 15 months before we can recall.

CHAIR: What happens if you have an emergency? Do you squeeze them in?

Mr NETTLE: Yes. We set aside from nine o'clock to 10 o'clock every morning. One dentist will do that. Whether we have the one dentist or five dentists, one dentist sets aside from nine to 10 o'clock in the morning and that is when we deal with the emergencies. That time is generally used only to treat pain and then we get them back in, to fix the problem fully.

CHAIR: What sort of degree of more difficult, specialised or complicated services do you refer on to somewhere else?

Mr NETTLE: Just about everything. Basically our services are just general dentistry. The majority of it is restrictive or preventive work. We do dentures, of course. It depends on the dentists themselves. We might do some oral surgery but most of the stuff gets referred to dentists in Adelaide—any specialist type of work.

CHAIR: Does the membership of the clinic mean that they get any financial assistance?

Mr NETTLE: No, it does not.

CHAIR: So if they have to go to Adelaide, for instance, the whole thing is something they have to meet themselves.

Mr NETTLE: That is correct, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you must be looking down the barrel a bit, are you? You have a quarter of the town covered by people paying and sometimes you have not got a dentist. They are paying and sometimes you cannot necessarily deliver the service. Is that a problem?

Mr NETTLE: At this stage, we have not had a dentist but, yes, it puts the pressure on us when we have only one dentist and our waiting time blows out quite considerably. That is our main concern. We saw this inquiry. Our main concern is how we attract dentists to come to the rural areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But your fees are 30 per cent lower than average fees. In your submission you say that it is very difficult to meet the dentists' demands in terms of how much they want to be paid. I think you said $100,000 was what you thought was reasonable or a little over, but then they will request $156,000 plus commission on bridge work and plus air tickets to one of the capital cities.

Mr NETTLE: That is so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is obviously putting your total cost up quite a lot, and for bridge work, presumably the patient has to cough that up, or you do.

Mr NETTLE: Yes. We would try to run at a break-even point because we are a not-for-profit organisation. We try to run at break even and keep enough money aside for capital replacements, et cetera, so we have to make some surplus. It is not a great surplus. We try to run at the break-even point. At that $100,000-$120,000-odd a year, we are comfortable. Again it depends on the output of the dentist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some are quicker than others?

Mr NETTLE: Definitely. Some are a lot better than others. At that $600 a day plus air fares plus et cetera, et cetera, it is not viable for us to do it, so we just cannot employ them at that rate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are between a rock and a hard place if there is a shortage of dentists and prices are going up while you are trying to keep your prices low: Is it economic for members to be members.

Mr NETTLE: That is correct, yes. The membership fee that we charge actually subsidises the treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, of course. People do not mind paying $2 a week if they get cheaper treatment when the crunch comes.

Mr NETTLE: Yes, that is correct. We can survive paying a reasonable rate. I have been on the net and had a look. Dentists who are two or three years out of university are working in Sydney for

$80,000 a year. We are offering $425 a day plus accommodation, which includes gas and electricity, and they will not come out here. That equates to a package of approximately $125,000 a year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That should be enough to cover it, you would think. It is just a conceptual step for them, is it not?

CHAIR: What about dentists from Adelaide? We have heard some evidence that for some time the University of Adelaide has produced more dentists than South Australia needs whereas the University of Sydney has produced fewer dentists than New South Wales needs. In terms of the economics and willingness to travel and so on—

Mr NETTLE: I think the people from Adelaide would be quite welcome and would be quite willing to come to Broken Hill. I was speaking to our dental insurers the other day and they had just been to a conference in South Australia. They said that the dentist in Mount Gambia, which is a reasonably sized rural town—there is one dentist in Mount Gambier—his books are booked up for three months, so South Australia has the same problem we have got.

CHAIR: They used to have perhaps a surplus, but no longer.

Mr NETTLE: I have heard stories—and these are only stories—and people have said to me, "I know somebody who is a dentist in Adelaide and they cannot get work in Adelaide, but they will not come out of the city." The two Irish boys we have got now, I spoke to them and they said that through their travels around Australia they find it very difficult to get work in Sydney, Melbourne and Adelaide, but going into the rural areas they have not got a problem anywhere. One of the recruitment firms that we use I was speaking to on the phone the other day. They said they have had dentists in Sydney complaining that they are not making money and that they are doing it tough because there are so many dentists in the capital cities.

I am at a loss to understand why someone coming out of university cannot come out into rural areas—and we are not unusual in what we are offering. A young bloke could set himself up for life. I think it is to do with the ethnic backgrounds with their family ties and lifestyle. It is just that for some reason they will not come out. I heard one story of one who was going to an Orange placement and the person who put him in the placement asked him how he was going and what he thought about it. He said that he was petrified because he was going out to the country areas.

CHAIR: The bush.

Mr NETTLE: Yes.

CHAIR: Interestingly enough, when we spoke to the area health representatives, apart from the vacancy here for a dentist in the public service, there are two vacancies in Orange. The fact that people would not go to Orange has struck us as interesting, given that it is that much closer to Sydney and the size of it and the closeness to other large places.

Mr NETTLE: I think the Great Dividing Range is a bigger barrier than what a lot of people think it is. In my previous business life, we tried to organise conferences and everything, but to get people from Sydney to come over the Great Dividing Range, even to go to Bathurst and Dubbo is a big challenge. I think the other comment that I would like to make is that according to my information the University of Sydney this year is taking on 80-odd new students and 65 per cent of them are full fee paying students. That might be a university problem that has been forced on them by the Federal Government, I do not know, but it seems to me that with 65 per cent of full fee paying students, that limits the places that rural students are able to go into.

The majority of rural students just cannot afford to pay the fees. To my mind there has to be some sort of targeted approach to get rural students into these courses. I am not saying that they would all come back to rural areas, but you would have more chance of getting rural people to come back to rural areas. I have put two kids through university but not to do dentistry. I wish I had changed their minds. I know what it has cost me because there was not a university in Broken Hill. We had to pay for accommodation and everything, so somehow it has to be made a target system. Some provision has to be made for rural students to try to get them to come back.

CHAIR: As you state in your submission, they have to be Higher Education Contribution Scheme [HECS] places, not full fee paying places.

Mr NETTLE: I have no problem with HECS, which I think is a good thing, but they have to have some financial advantage to go to university and to come back.

CHAIR: Would some sort of bonding system work, do you think, such as bonding people for two or three years?

Mr NETTLE: I think that it would, but how would it go with restrictive trade practices and all the other laws that come into it? We have discussed that ourselves at the clinic—that we may put somebody through university.

CHAIR: Give them a scholarship?

Mr NETTLE: Give them a start and to get them to come back, provided that they adhere to it. But is it a legal minefield?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they would sign a contract providing for an obligation to either come here or pay you back 20 per cent more than they got. That would represent a bit of a loss for you because the 20 per cent would not cover much, but still you could give it a go.

Mr NETTLE: Yes. I think that bonding and that sort of thing is a thought. I think what they are doing with medical students at the moment—they are bringing them out to the rural area—gives them a taste of the rural area. I think it is a perception problem of people in the city. If you can get them out here to see what it is like, maybe they would have a change of mind.

CHAIR: Could the course have more emphasis on people doing an internship or whatever it is called during the course and put more emphasis on non-metropolitan placements?

Mr NETTLE: I think that would be an advantage, to just get them out here to any of the rural areas and to show them that it is not really as bad as they think it is.

CHAIR: If these problems are not solved, what is the future?

Mr NETTLE: Well, the future for our clinic, if we cannot get dentists—we have funding and we have money available so we are very viable—all hinges on dentists. Basically with the number of clients and the members we have, if we fall over it will put a bigger strain on services. When I say "if we fall over", the only reason we would fall over is because we did not have dentists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And so the whole town would be in an even worse position.

Mr NETTLE: Dead right, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would be the strongest bidder, if you like, for a dentist here?

Mr NETTLE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you fail over, that would simply go straight to the public dental schemes, the Flying Doctor and the other systems that are trying to support it, and they would be in a worse situation again.

Mr NETTLE: Undoubtedly. A lot of our clients are retired mine workers and I assume they would be eligible for the public system as well, if they so chose.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it had any dentists to deliver.

Mr NETTLE: Yes.

CHAIR: From what you said earlier, the stories you have heard about dentists in Sydney and Adelaide not necessarily making an income, perhaps there is not such a shortage of dentists overall, if they could be encouraged to go to the right places. Some evidence we have heard suggests that the universities are not training enough dentists. The average age of dentists in New South Wales has climbed quite considerably. As those older dentists retire, the shortfall will get even worse.

Mr NETTLE: Yes.

CHAIR: Some of the gaps are being filled more and more by overseas trained dentists. I did not know that anyone has mentioned to us before that there are some people hanging on, so to speak, in Sydney and not earning the income to which they feel they are entitled.

Mr NETTLE: I found that information by just going onto the net. There is a site on there that I think is called PayChecks. You enter a profession and you compare regions with the regions and what people are getting. The average wage of a second or third year dentist was $69,000 but the majority of them were getting $80,000, so obviously some of them were getting a lot less. That is why I stated in my submission and it is my belief—and I have been in this job 12 months—that money is not the main concern.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a perception problem.

Mr NETTLE: Yes.

CHAIR: Even if for instances the University of Sydney was to be encouraged to train a lot more dentists, that would not necessarily solve the problem.

Mr NETTLE: I do not think it would, no.

CHAIR: Because the majority of them would still stay in Sydney.

Mr NETTLE: Yes. That is why I say not that they are training the wrong type of person but that they are not targeting the right type of person or making enough places available for that target group.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would ask for a quota of, say, 10 per cent of all student intakes to come from country areas?

Mr NETTLE: Yes. That would be a help to the system. I do not believe it is a thing that will be fixed overnight. I think it will be years before this happens, but we need to make a start now.

CHAIR: Could the profession be restructured so that, for instance, in the new Bachelor of Oral Health course and so on more of the less expensive people could be trained to do more of the procedures that are currently legally limited to dentists?

Mr NETTLE: Yes, I think that is a step in the right direction. But, again, the only place you can do the Bachelor of Oral Health is in Sydney or in Newcastle.

CHAIR: As you said, in Broken Hill you have trouble recruiting dental assistants. We have heard that the public service has trouble recruiting dental therapists as well?

Mr NETTLE: Yes.

CHAIR: So here there is trouble recruiting people right through the different levels of the profession?

Mr NETTLE: I think some of it has to do with the fact that even the clinics are not prepared to train. A step that I have taken since I have been manager is to put on a trainee. But at the same time

three years ago we put on two trainees. One of those trainees left us in April this year to go and be an apprentice hairdresser because it is not really what she wanted to do. The job of a dental assistant is a demanding job. It is a backbreaking and a demanding job. When you look at the award rates of pay it is not very high at all. We pay above the award rates here just because we need to. It is supply and demand. But when I put on the trainee I looked at the wages rates available for that traineeship and she could have gone to Big W or Woolworth's and stood behind the till and earned more money per hour. But the argument can come back to me as an employer: why would I want to pay her more money when she does not know what she is doing.

CHAIR: What about the other trainee who started three years ago?

Mr NETTLE: She is still there.

CHAIR: She also did the course by correspondence?

Mr NETTLE: Yes.

CHAIR: Does that work satisfactorily from the point of view of the clinic? That working in the clinic plus the correspondence course is adequate for training?

Mr NETTLE: Yes, it is. The job is mainly on-the-job training and the theory component is more at the bottom. It is not ideal but it does work, yes.

CHAIR: Thank you very much for coming today and for giving us so much information in half the time that we allowed for most of our other witnesses. It has been very useful for us. I do not think we asked you any questions on which you needed to get back to us.

Mr NETTLE: No.

(**The witness withdrew**)

GREG COCKS, Chief Executive Officer, Dental Centre, 51 Iodide Street, Broken Hill, sworn and examined:

CHAIR: In what capacity are you appearing?

Dr COCKS: I am here today at the request of your Committee to give evidence pertaining to the inquiry into dental services in New South Wales.

CHAIR: Do you want to start off by making an opening statement? Do you want to say a few things to us before we ask you questions?

Dr COCKS: Have you seen the submission that I made to your Committee?

CHAIR: Yes.

Dr COCKS: I do not really have anything to add at this moment, but I will at the conclusion of any questions you may have for me.

CHAIR: You have seen the questions that we were running through earlier?

Dr COCKS: Yes. I am fully conversant with the issues that you are dealing with.

CHAIR: How many dental staff do you have at your clinic?

Dr COCKS: I employ six full-time paradental assistants at my practice. In the past I have employed registered dentists and I have been fortunate enough to attract another registered dentist to come and work for me as of Monday next week.

CHAIR: So at the moment you are the only dentist, but you will have two?

Dr COCKS: I am a sole private practitioner.

CHAIR: When you refer to six paradental assistants, what is the mix?

Dr COCKS: The mix is a full-time dental hygienist registered with the Dental Board of New South Wales, a practice manager and four full-time dental assistants.

CHAIR: Is that an unusually high ratio of dental assistants to dentists?

Dr COCKS: You will see from my submission that the practice I run is what I would call a premium private practice where we try to provide the best possible treatment under all circumstances to the people who pay us to do the treatment. We need that level of staff to provide the sort of service that we provide.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are dealing with the top of the market. Is that what you mean?

Dr COCKS: No. I deal with people across all spectrums, but we charge what I regard as a fair and reasonable fee. I need that sort of level of assistance to provide that service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say it is fair and reasonable what is defined as fair and reasonable? Are you charging more or less than the average dentist? Are you charging at the top of the market? Presumably you are for Broken Hill, but you may not be for the State as a whole, is that right?

Dr COCKS: You would be in a better position to answer that than I would. If you looked at my submission you would see that we charge our time out at $420 an hour for my services and $120 an hour for the preventive and hygiene services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have no idea whether or not that is a lot as I am not a dentist.

Dr COCKS: You would be aware that there is no fair or recommended fee for dentistry in Australia now. The way we judge our fees in comparison with our peers is by looking at research done by the Australian Dental Association which surveys dentists on an annual basis to see what they are charging for services that are identified by specific item numbers. My fees are probably in the upper level, but they are certainly not any higher than you would expect for the sort of service that I provide.

CHAIR: Do you have difficulty attracting staff or filling positions?

Dr COCKS: I would suggest that recruitment and retention of registered dentists is the single biggest issue that we face as a profession.

CHAIR: As a profession in New South Wales or Australia-wide? You are not just referring to Broken Hill?

Dr COCKS: I would be referring to dentistry as a whole in Australia.

CHAIR: Is it particularly difficult in this area or in regional and rural areas as a whole?

Dr COCKS: It is certainly more difficult to attract professional registered dentists in Broken Hill than it would be if I were in Port Macquarie, Ballina, Coffs Harbour or metropolitan Sydney. It is far more difficult.

CHAIR: What about the dental assistants? Is there a difficulty in recruiting them as well? Do you train them or do you recruit them?

Dr COCKS: We train our own dental assistants and, at any given time, we would have at least one trainee assistant doing some part of an accredited training course.

CHAIR: An earlier witness was talking about the need for trainees to do their training by correspondence, plus on-the-job training at the practice. Is that the way you do it as well?

Dr COCKS: Yes. We employ trainees to do on-the-job training. They do an accredited correspondence training course that might take up to four years by the time they have done their dental assistants' training, their radiography training, their dental health education training and the fancy radiographic equipment training. So it is quite a long course, but it can be done on the job. Although it is a reasonably onerous thing to travel, I have trained nine assistants since I first started working here in Broken Hill in 1981.

CHAIR: Do they stay? Do you have trouble either attracting them in the first place or staying for the duration of the training thereafter?

Dr COCKS: I am very fortunate. In the time that I have been working I have been able to retain most of the staff that I have trained. For example, I have two women who share a job and who were both trained by me. They came to my practice as 15-year-olds and they are both 35 now and they share a job between them. So I am very fortunate in that respect.

CHAIR: Is there similar stability with the hygienist?

Dr COCKS: I am the luckiest dentist in the world. Just over there you will see the best hygienist in the country. She has been working now for me for 14 years. I did not train her but we obviously have some rapport. You were asking about money earlier. I guess money is a big issue. If you pay people a suitable salary and provide them with the right environment to flourish then you can see what happens.

CHAIR: Looking at the questions we have prepared we have a question about whether or not you make dentures or send them somewhere else. We should also ask you about the other more

difficult or more specialised services—the extent to which your practice provides them or the extent to which you send people to Mildura, Adelaide or whatever.

Dr COCKS: You will see from my submission that we make, on average, 20 units of denture work a week. That roughly equates to 10 patients a week for whom we would provide full denture services. You will see from the submission that the majority of those patients are holders of Commonwealth Government health care cards. So they are either pensioners or health care cardholders because of their unemployed status. The reason they seek treatment from me is that they are unable to access these services elsewhere in Broken Hill at this moment in time.

CHAIR: So they are eligible for the public service but the public service just cannot provide dentists?

Dr COCKS: I cannot comment on why they come to see me. All I know is that I can provide the services they require and I am happy to do so.

CHAIR: Do you provide that service at a cheaper rate, or do you charge the full rate? Are you handling them as public patients or as private patients?

Dr COCKS: I do not treat any public patients, as you call them, in my practice. The people who see me pay the fee that they are quoted when they ring up. Sometimes we use our discretion and we might charge a patient who has a pension card. You are probably aware of the Veterans Affairs fees. Ten per cent of my practice comprises Veterans Affairs cardholders. I am prepared to extend that similar discount to patients who have health care cards, based on their pension status. I should say that when people ring and ask for a quote on how much a set of dentures is we charge them the full fee that we would normally charge. Then we use our discretion based on discussions with the patient.

CHAIR: I think you said you have been here since 1981. Did you ever handle public dental service patients?

Dr COCKS: I provided service to health care cardholders under various State and Federal government schemes up until 1995.

CHAIR: And you decided to opt out of it?

Dr COCKS: I decided to opt out of it, yes.

CHAIR: Can you tell us why?

Dr COCKS: There were major issues with finance.

CHAIR: They just simply were not paying enough to cover costs?

Dr COCKS: I could have coped with that but I could not cope with the extraordinarily long time it took for my bills to be paid. I pay my staff on a weekly basis. I pay my dental technician, who now resides in Mildura, on a monthly basis, and at some stages it was taking up to three months to get payment.

CHAIR: But you find DVA is more efficient?

Dr COCKS: DVA plays within 15 days of receiving my invoice. The money is paid by electronic funds transfer and there are never any issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it was simply that the Commonwealth Government was not paying its bills on time?

Dr COCKS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not paying for services on time?

Dr COCKS: No, it was the State Government of New South Wales.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that was the State Government scheme, the voucher scheme?

Dr COCKS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, you do not use vouchers for that reason?

Dr COCKS: No, I have not treated a public patient in my practice personally since 1995.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that was why you stopped?

Dr COCKS: The reason I stopped was the failure of them to pay their bills within a reasonable amount of time and the fact that the money I was receiving for the services I provided was not satisfactory for me to meet my obligations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The voucher is what percentage, roughly, of the service you would provide to private patients?

Dr COCKS: I cannot comment on that accurately.

CHAIR: It was 10 years ago, I guess?

Dr COCKS: It was 10 years ago. I would suggest from memory it was somewhere around 50 per cent of what I was charging the other patients in my practice. We made a decision as a team that it was unfair to be charging people who came to us as private patients our normal fee and having people line up alongside them at the desk and getting their treatment for nothing. They were more difficult to treat, they did not keep their appointments. There were a number of other issues, but I would regard those as peripheral issues. The main issue was lack of satisfactory funding and the long time it took to receive payment.

CHAIR: Did you also find that the kind of treatment you could offer was more on the emergency end, extractions, et cetera, and that therefore you had professional issues about the sort of treatment that the vouchers would pay for?

Dr COCKS: Once again, that was 10 years ago and a number of different schemes were operating. Historically the State Government has paid for the pensioner dental scheme and rudimentary emergency services. For a short time the Federal Government had the Commonwealth dental scheme going, which operated in a similar manner. As to whether the funding was satisfactory to provide the sorts of services I would provide normally to my other patients, I did have a major issue with that. We have tended to provide a holistic service, and we were not able to do that. But once again, that was really a peripheral issue. The main reason was finance.

CHAIR: When you say you provide a holistic service, can you tell us a bit about the dental health of your patients and the way you focus on the prevention area and the whole oral health area? Do they turn up when they are in pain? Are they regular patients that you see a lot?

Dr COCKS: You will see from my submission that we see an average of between 40 and 50 new patients each month. That is roughly 2.5 per day. That is made up of new patients who choose for whatever reason to come and see us, and 8 per cent of those people live outside of this postcode area, and we call them itinerants or travellers. The people who come to see us, we would like to think that when they come to see us we have tended to their chief complaint. People generally ring because they have a chief complaint. We divide it into two areas. They have come because they want a comprehensive dental examination or they come because they have a specific problem, not necessarily relief of pain but a specific problem.

At the initial consultation we would endeavour to ascertain their reason for coming and attempt to address that problem on that initial visit. At the same time, because of the way we charge

out, we always do a comprehensive oral examination including radiographs and photographs where necessary, and we spend a lot of time talking to these people about the preventive aspects of dental disease. An initial appointment at our practice generally takes somewhere between 40 and 45 minutes. I would spend 30 to 35 minutes myself, and members of my staff would spend as long as it takes to get the message across after that. Hence you can see why we need perhaps a higher number of staff per dentist ratio than you might normally see.

CHAIR: Do you find that your patients appreciate that work in that framework and take your advice?

Dr COCKS: We have 5,247 patients on our record sheet. They are culled every four years. We would regard almost 48 percent of those people as regular attenders. They come and see our dental hygienist and take advantage of the dental hygiene recall program that we offer. Once these patients have had that course of treatment after their initial consultation they would then come back and have recall visits with our dental hygiene department.

CHAIR: Is there anything you feel we have missed that you would like to tell us?

Dr COCKS: No, but I have two questions and then a closing statement.

CHAIR: Okay, go on?

Dr COCKS: You have heard from the other dental caregivers and organisations involved in providing those services since you have been here. It is an onerous task working in this area. Do you think that the evidence you have heard from these other people reflects what you have heard in other parts of the State?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is difficult to answer that. Yes would be the short answer.

CHAIR: So far we have had hearings in Sydney, last week we were in Port Macquarie and this week in Broken Hill. They are the three parts of the State we have taken evidence in. Of course, we have had written submissions and some of the people who have given us oral evidence have travelled to do so.

Dr COCKS: Do you think there are any issues that have been raised either verbally or in submissions that pertain uniquely to this area?

CHAIR: No, probably not. They are matters of degree, I think, in difficulties in recruiting dentists, for instance. We have not heard much here about the issue of fluoridation but we have heard a lot about that issue on the North Coast. On the whole, I think the issues are pretty much the same except recruitment and service provision issues are more difficult in rural and regional areas than in metropolitan areas. And the public provision of services has problems all over the State.

Dr COCKS: Because I am unfamiliar with the provision of services in the public arena, is there any public dentistry occurring in this district, from what you have heard today?

CHAIR: Yes. Well, we have spoken today to Dr Lyn Mayne from the flying doctor service and also to the Aboriginal medical service. Also, we had people from the Far West Area Health Service, including one person from Broken Hill. Of course, when we say the area, they were talking, as they said, about 58 per cent of the State. We got them to come here to talk to us, one from Dubbo and one from Orange.

Dr COCKS: So, I could go away very enlightened if you would tell me what happens in the public health service?

CHAIR: I am afraid we would be delighted to if we had the time. We have yet to hear from Mr Devlin. We may have to say read our report. We have terms of reference to answer a whole series of questions and to report on specific matters. That would involve us giving some descriptive account of dental services in general.

Dr COCKS: Is Rebecca here today? Hello, Rebecca. We have corresponded by email. Did you receive an e-mail I sent you yesterday afternoon?

CHAIR: No, we left Sydney yesterday morning. We had evidence here yesterday, mostly on the funeral industry, another inquiry we are doing. You said you had a closing statement?

Dr COCKS: Yes, I have.

CHAIR: How long is that going to take?

Dr COCKS: I am happy to vacate the chair now and you can hear from Brian and then if you are interested I can talk to you about that afterwards if you have time.

CHAIR: As I said, we have a plane to catch. That is why I am asking how long is your closing statement?

Dr COCKS: I think is more important that you hear from Dr Devlin. It will take some minutes.

CHAIR: Would you like to give it to us? We can take in away with us. We can resolve to accept it as a tabled document.

Dr COCKS: It will probably have more impact if I spoke while you are all here. But I think you need to hear from Brian.

(The witness withdrew)

BRIAN THOMAS JOSEPH DEVLIN, Dentist, 153 Williams Street, Broken Hill, affirmed and examined:

CHAIR: I am not sure when you arrived but you obviously heard some of questions we were asking Dr Cocks. We wanted to run through pretty much the same sorts of things with you to get a comparative picture. Did you want to start with a statement?

Dr DEVLIN: No, you can fire away.

CHAIR: The first couple of questions are the factual, statistical types. You could start by telling us about your clinic, how many dental staff you have, any recruitment difficulties you might have, how many patients you deal with, and so on?

Dr DEVLIN: I am a sole practitioner. I took over a part-time practice in 2002. Prior to that I had nine or 10 years with the Town Dental Clinic. As you may have heard, the Town Dental Clinic became, after a merger with the Mines Dental Clinic, the Barrier Dental Clinic. I have a fair experience in both public and private practice in Broken Hill. Currently as a sole practitioner I employ two or three nurses and an apprentice dental technician, who is approximately half way through her course. We had some issues at the start of the apprenticeship because in New South Wales, to train a dental technician, it is only by full-time diploma course in Sydney. We had to fight a fair bit via Peter Black and find some relevant people in the education department to help us so that Shelley, who is the apprentice, was able to do her course through Melbourne but receive the funding and recognition for her course via New South Wales.

CHAIR: Did she have to go to Melbourne?

Dr DEVLIN: Yes.

CHAIR: Does she do it all by correspondence?

Dr DEVLIN: I think there are three or four or five block sessions a year that she travels down for, and they are a fortnight each time. The requirement from our side of things for her training is that she is to complete a certain number of cases per year during her four years of the course. That is the reason why I have been able in a reasonable fashion to draw upon the pensioner denture waiting list and utilise that to maximise her exposure and experience during her training.

CHAIR: So she is actually making dentures.

Dr DEVLIN: Yes.

CHAIR: Whereas before you were sending the work to Mildura?

Dr DEVLIN: Mildura, Adelaide or Sydney.

CHAIR: Did you start training her because of an inability to recruit in the area or because you had been sent someone to start from scratch?

Dr DEVLIN: There had not really been a technician here in Broken Hill for several years. I took it upon myself. It is really not a profit-making exercise at all. I think I am barely covering costs but it was more a long-term thing for the town. It is something that is required. Whether Shelley ends up staying with us or setting up on her own is not a factor either way.

CHAIR: When you say there you draw on the pensioner denture waiting list, you mean from the list of the public dental services.

Dr DEVLIN: That is right, yes.

CHAIR: We heard previously that the remuneration for dentists in that respect means that there is a bigger gap than there is with other services between the usual private rate and the public rate.

Dr DEVLIN: Yes.

CHAIR: For instance, we had evidence this morning relating figures to the Department of Veterans Affairs [DVA], and the gap being bigger for dentures than for other things.

Dr DEVLIN: Absolutely, yes. That is correct. Depending on the type of case and the requirements for the patient, there can be 40 per cent or more of a difference in price.

CHAIR: So you are doing this because you feel someone should.

Dr DEVLIN: Well, yes. After I took over the practice, there was some motivation for me to. Also for a period of time we did some of the emergency dental work. The actual scheme was not quite a voucher system but it was just an arrangement that we struck up with the area health service to at least have somebody doing something for these people because there was just nothing going on. After the Barrier Clinic decided that it did not want to be part of the emergency patient treatment scheme, there was nothing going on in a public dental service fashion.

At that stage I was still building up the practice from what it was. I thought that I had a bit of time here and there and I would do what I could to get it going while the area health service was extracting the digit, if you like, and sorting out the system for the long term. Unfortunately I then got swamped. Management being management, if they could be seen to be doing something by having somebody doing something, namely me during my little bit, that was keeping the monkeys off their back. It soon got to the point where the practice was actually suffering, if you like, because I was getting swamped by the amount of work through the public scheme.

It got to the point where we had to think about it and we thought that if we did not do something ourselves, it would just go on and on and it would make no difference to the administrators involved, but we would be the ones suffering as well as the patients because we could not cater for everyone. So we pulled the pin on that.

CHAIR: When was that?

Dr DEVLIN: Towards the end of last year, 2004. We got a pretty bad reaction such that it even got into the papers that we had actually abandoned public patients, which was pretty bad form to my mind from the area health service. But I took the view that there was some ignorance there and that those sorts of things just tend to float by. You just get on with your work and you do not rise to the bait.

CHAIR: But you continued to deal with the people requiring dentures, or that was about the same time that you were really starting in that area.

Dr DEVLIN: Yes. As the capability of the apprentice got to the stage in her training that she was able to complete the whole case, we thought, right, we could now go ahead with the work.

CHAIR: Did you put a limit on the number of people you were talking about?

Dr DEVLIN: No. For some, we do it in a block with a set number of patients. Once we have just about finished that block we say that we will take another 10 or 12, or whatever it is.

CHAIR: So you control the number of patients who are coming to you.

Dr DEVLIN: Yes.

CHAIR: By dealing with the area health service?

Dr DEVLIN: Yes, locally. What will happen in the future with the change to the Greater Western Area Health Service is really too early to tell. I am not sure how the dental administration locally will be affected. I think we have got a good relationship with the people we deal with as far as the bill payment goes. We do not have a great drama as far as that goes.

CHAIR: Do you deal with Mason Kumm?

Dr DEVLIN: Yes, Mason Kumm.

CHAIR: You deal with him rather than dealing with the head office, wherever it may be, and there is now one in Dubbo.

Dr DEVLIN: No, we do not deal with Dubbo. Dubbo tends to be restrictive, if you like, in the process.

CHAIR: Can you give us a bit more detail of the size of your practice, the number of people you see and the kinds of procedures that you carry out?

Dr DEVLIN: Okay.

CHAIR: You know, just the special sort of ways in which you deal with people's oral health.

Dr DEVLIN: The way that I operate is that really I am the central focus of the entire operation of the surgery. I take ultimate responsibility for everything that happens on the surgery side. I rely upon my staff to assist in that fashion but I am the sort of practitioner that likes to be involved with every facet of what happens with the patient.

CHAIR: You prefer to be a sole practitioner?

Dr DEVLIN: Yes.

CHAIR: Even if Broken Hill were swarming with dentists looking for work? You would still rather be a private practitioner?

Dr DEVLIN: Sometime ago—and I am not sure if Greg touched on this—there has been some consideration through the University of Sydney by various means of having not quite an indenture system of graduates but also a rotation of final year students. There have been various machinations and combinations of considerations among those two entities, the students and the graduates. Last year we put a proposal to the health service to assist in that fashion. I have always liked working with students and they learn so much more from having time with myself or Greg because of the different ways that people work. They pick the brains out of the best way that they can see how to work.

The proposal was to have the health service meet the costs of salaries and liabilities, et cetera, but they would have the mentorship of myself and/or whatever practitioners to assist and therefore have a foot in the door of having these new graduates or final year students getting the exposure. It has always been the case in isolated areas such as Broken Hill that getting the person here is the biggest problem. Then there is always a proportion of people, once they get here, who either like it or they do not. You tend to find some like it, and I was one. If they like it, they stay. If they do not, fairly soon you find out that they do not, and they go, and that is fine. I always say to people not to persist in a place where they do not like it. I have worked in a number of small towns and there were some places I did not like. I did not feel right, but in Broken Hill I found myself welcomed and accepted.

CHAIR: So you are a local now?

Dr DEVLIN: A B grader, if you like. The number of people I see would be approximately 250 to 350 a month. I do not flog myself. I did not take over this practice to set any records or anything. It is just a matter of enjoying the work and providing a service that is effective and is appreciated by the patients.

CHAIR: Are they mostly long-term, regular patients?

Dr DEVLIN: Yes. There is always a flux of patients, as Greg said. There are a number of people who are itinerant. They travel through town and they come for a short time. I did not really have time to analyse fully the exact mix of people, but we would have 30 or 40 new patients in every month.

CHAIR: So your number is fairly static and you are more or less happy to leave it that way?

Dr DEVLIN: It is more of a demand thing and how you actually want to run the practice to suit how you would like to work. If there were more people coming to town, that would be fine, but it would be variable as to how much work they would have.

CHAIR: But at the moment the combination of you, Dr Cocks and the Barrier Clinic, et cetera, caters adequately for private patients.

Dr DEVLIN: Reasonably well. I think if there was a public clinic, that would pretty much stitch it up. It would alleviate the problem to a great degree.

CHAIR: Would a public clinic take many patients away from you, for instance? Would many of your patients be eligible, if public services were adequate?

Dr DEVLIN: Maybe a little—whatever—but most people prefer to stay with a practitioner they have confidence in. A problem that you can find in a public clinic is variable numbers and experience and retention of practitioners. It does not do a lot for the confidence of the patient if they see someone different each time. I am not sure if Ross Nettle covered that topic but certainly it was the case from when I was working at the Town Clinic. You would have a flow-through of dentists and they would say, "Oh, it is someone different each time."

CHAIR: And a flow through of patients—more coming and going of patients?

Dr DEVLIN: To some degree there is a bit of that. But so far as my surgery is concerned, we have a fair proportion of our regulars. We are quite happy with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you do much public work?

Dr DEVLIN: At the moment it is purely with the public pensioner denture scheme.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are one of the dentists that does the pensioner denture scheme?

Dr DEVLIN: Yes.

CHAIR: Is there anything we have not covered?

Dr DEVLIN: I wanted to respond to one of your questions.

CHAIR: Is it fluoridation?

Dr DEVLIN: Broken Hill has been fluoridated for many years. I can think of several other areas in the country where fluoridation is responsible for dropping caries rates by approximately 50 per cent, or you could attribute fluoridation to a reduction of caries in that area by around about 50 per cent. The rest we could probably put down to Colgate commercials, regular mental reminders, the role of dental surgeries as well as back ups for people to maintain their own health.

CHAIR: Obviously you are a supporter of fluoridation?

Dr DEVLIN: Yes, I am.

CHAIR: Yesterday we heard evidence that suggested that, because of water supply problems in the district and the water being rather unpleasant, an estimate—and I do not know how accurate it is—of 85 per cent of people are not drinking town water.

Dr DEVLIN: They do not drink the town water, yes, that is true. Fluoridation is most effective in children, which is why it was invented. Fluoridation started off its history in America, in Texas. Children had what they called Texas teeth. They were quite brittle but they were not decayed; they were mottled brown. They realised that the ground water they were using was quite high in fluoride and that is when they watered it down and it had this effect of fluoridation.

CHAIR: With the water problems in Broken Hill we are interested to know whether those percentages, or anything like them, are correct. How long would it take to show up in the teeth of children? How long would it take to show up amongst your patients?

Dr DEVLIN: The water quality problem has probably been around for a good three or four years. So if you had somebody who was not exposed to regular fluoride from that means, the lack of benefit might start to show in the next couple of years. But that is as far as permanent teeth and secondary teeth are concerned.

CHAIR: Was there another question we missed on that you wanted to comment?

Dr DEVLIN: Yes. As a comparison between how you rate the oral health of various public patients and private patients, the interesting thing I find is that Veterans Affairs patients who are quite regular sometimes remind us that they are due for their next check up. They are almost knocking on the door. Because they are regularly maintained, even though they are on this Veterans Affairs scheme, by and large they tend to be fairly stable and oral disease is at a relatively manageable level.

CHAIR: Most of them would be aged 80 or more?

Dr DEVLIN: No. If you include Vietnam veterans you are going from people aged 50 and up. Private patients can be excellent but, as with any form of dental treatment, more often than not it is only as successful as how well the recipient looks after the work. If their intention or their commitment is not there they can be not much better than some of the public patients.

CHAIR: So you are saying the Department of Veterans Affairs people are probably looking after their teeth or having their teeth looked after better than any of the other groups?

Dr DEVLIN: Yes. Some of them are excellent patients.

CHAIR: But speaking as a group their teeth are better?

Dr DEVLIN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you see motivation as a key aspect in whether or not dentists get good results?

Dr DEVLIN: Yes, absolutely. It has been known since the 1970s that drilling and filling teeth do not prevent disease. In the long term the accent upon the resolution of disease problems is half hard labour and half prevention for at least 10 years I would say.

CHAIR: Thank you very much for coming and for giving evidence. I do not think we needed anything by way of statistics or factual stuff from you.

Dr DEVLIN: No.

(**The witness withdrew**)

(**The Committee adjourned at 3.06 p.m.**)