REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO DENTAL SERVICES IN NEW SOUTH WALES

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At Sydney on Thursday 16 February 2006

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The Committee met at 9.30 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. C. J. S. Lynn
The Hon. R. M. Parker
The Hon. I. W. West

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

CHAIR: Have you received the prepared questions that the Committee sent you?

Professor SPENCER: Yes, I have.

CHAIR: Would you like to make an opening statement before we go to questions or do the questions sum up your work?

Professor SPENCER: I will attempt an opening statement. My statement would really be to use the phrase that I will attribute to the United States Surgeon General in his report on Oral Health and Dental Care only a few years ago where he described oral disease and disorders as a silent epidemic. It is an epidemic because oral diseases are among the most prevalent diseases affecting people in the Australian community. Nearly all Australian adults experience the most common forms of oral diseases like dental decay and gum disease to varying levels of severity.

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

These are less obvious and they are certainly quieter consequences than death and I think it is because of that that we might use this label that it is a silent epidemic but there is another interpretation that I would like to put on the notion of a silent epidemic and it really is that that silence is, in part, a reflection of our inactivity about those who carry most of the burden of dental disease in the community. There is a relative silence in our policy response to a reasonably well-documented epidemic, one which we can reduce and one which we can certainly manage much better than we currently do. That is my opening statement.

CHAIR: Some of our earlier questions seek expansion and in some ways may seem a bit obvious, such as: can you describe the main obstacles to patients receiving treatment via public dental services?

Professor SPENCER: There is a combination of two main obstacles. The first is a resource scarcity issue in public sector dentistry, and the resources available to meet the needs and demands of the eligible population for public sector care, even at a superficial glance, are inadequate. That leads to a series of consequences in how those services have basically been organised and delivered, and that is basically characterised by a range of what I would call implicit rationing strategies. These are things which one can get into some literati on about because you could have decay, which is a consequence of the long waiting list for dental care; deflection, which also occurs when people abandon their hope to actually obtain care from public dental services and seek care under their own resources in the private sector or give up seeking care altogether; dilution, which is reducing down the amount of service that is actually provided to individuals who receive service so that the available resources can be spread across a greater number of people, but that also has a hard edge to it, that is, that the actual level of care that is provided can be regarded as frequently being inadequate.

Then there are some deliberate priorities that are sometimes put in place—and New South Wales happens to be one of those States that has some deliberate priorities put in place that target subgroups of the eligible population so we not only have a means-tested eligibility for public dental care but we then apply further prioritisation within those that actually receive care. Those sorts of obstacles have led to a service that has, over the last 25 to 30 years, become dominated by emergency dental care, with long waiting lists for more comprehensive general dental care and really fewer resources being allocated and devoted to meeting the general dental care needs of the eligible population.

CHAIR: Your research demonstrates that disadvantaged groups and people in the lower socioeconomic groups of society have less access and consequently poorer oral and general health. Can you give us your findings in that regard?

Professor SPENCER: The first thing that I will say is that the findings are of people who work with me and rarely am I the hand on the tiller on some of these sorts of pieces of research but, certainly as a group, we have put together information that characterises the access of both children and adults in Australia to dental services and certainly demonstrates that disadvantaged groups, those of low income and those without private dental insurance and those that live in relatively disadvantaged areas in Australia experience slightly more dental disease but they receive much less dental care for their disease they experience and less comprehensive dental care than others.

If they have more untreated dental disease, that means that they experience more complex clinical consequences when the diseases that they have advances unchecked, so that they frequently present with much more severe manifestations of really common dental problems. Because their disease goes unchecked and advances further, they experience more interference with their normal daily lives, pain and discomfort, et cetera, tooth loss and other impairments. They certainly report that they experience much poorer oral health-related quality of life, which is a research theme that we have been following for some 15-odd years now at the University of Adelaide.

There are a number of links between poor oral health and poor general health. We probably should acknowledge that there are a number of different forms for that link. One of the first is that both outcomes—poor oral health and poor general health—can share the same risk factors, what is sometimes referred to as a common risk factor approach, and the co-occurrence of the risk factor certainly linking the two things is one level of the link between oral and general health. The best example that comes to my mind at the moment is smoking, where we know that smoking is a risk factor in terms of one's general health—cardiovascular disease and cancer and the like—but it is also a risk factor for advanced gum disease and for oral cancers as well, so that would be what we would call a common risk factor.

Risk factors frequently co-occur in individuals and we find that they actually are clustered among people who have certain social characteristics—at least there is a bias in their clustering with people who are disadvantaged in terms of their education, occupation and the like. There are some direct associations between oral and general health and I am sure that you have had these reported to you. For some there is stronger evidence and in other cases there is some evidence but not necessarily evidence that would lead some of us to say that there is a causal link between the two.

We know there are links, for instance, between early childhood care and otitis media—middle ear infections. We know there are links between both gum disease and diabetes and that is a bidirectional link. They seem to have an association, with each contributing to the other to some extent. We have slightly stronger evidence about the links between gum disease among pregnant women and preterm low birth weight babies—a costly endpoint in terms of the medical care system. Intervention studies are underway, even in Australia, based in Western Australia, looking at exactly that issue. We know that there are links between tooth loss and nutrition and this is a particular issue among our older adults as their tooth loss contributes to changes in diet and their nutritional intake, which contributes to loss of weight and a general deterioration in their health. We have numerous links in that sort of area.

Oral health can certainly impact upon the outcome of the treatment of general health problems or medically necessary dental care, which is a phrase that is used in academic circles. An example of this is the impact of one's oral health on the outcome of, for instance, valve surgery for heart disease. There are some interesting links between oral health and the success of some medical interventions. The last issue that I withdraw to your attention is the links between oral health and, in certain extreme cases, death.

We generally talk about oral diseases as not being life-threatening but I think that ignores the evidence with regards to a limited number, but a real number, of situations where oral disease is the contributing cause of death—swelling associated with infections of the pulpa tissue and the tissues around the apex of a tooth and around the jaws and blockage to the airway; aspiration of oral debris,

including tooth fragments from teeth that are breaking down with dental decay and aspiration pneumonia among the elderly; and there are at least some indications at present of septicaemias that actually have as their portal for entry into the body of the infection, the infected gum tissues. We need to at least acknowledge that oral health is linked to general health at multiple levels. That, of course, is what lies behind the frequent statement that oral health is an integral part of general health. Dental health is treated somewhat differently in policy, financing, organisation and other ways.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not also the case that people with sore mouths do not eat? They cannot chew. Is there not also a nutrition component?

Professor SPENCER: Certainly. Loss of teeth, change in diet and a reduction in the nutritional value of diet are well documented in the research literature. You are then linking subtle changes—not overt malnutrition—in nutritional deficits with subsequent outcomes. It is certainly a concern in relation to older adults and their health because they suffer most tooth loss and have the most impairment to their chewing capacity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have there been any cost-effectiveness studies of the cost to the State of not fixing teeth?

Professor SPENCER: The research evidence in that area is scarce and inadequate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We might have to rely on commonsense.

Professor SPENCER: It does seem commonsensical. Building the sort of evidence that we would all find convincing is a significant research undertaking and it is the sort of thing we have been unable to find investment for in Australia.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask you about some of the funding?

CHAIR: Before you get onto that, Ian and I have some questions arising out of what Professor Spencer has just said.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was in a hurry to get on to No. 4 in my enthusiasm for the questions!

The Hon. IAN WEST: I want to explore further the long-term costs because it seems to be an issue that we tend to gloss over. It seems obvious to me—I would be the wrong person to do the research, because I already have a conclusion—that the cost to the community is so amplified by the lack of preventative care that there must be some qualitative measurements we can make that would enable us to articulate the funding a little better. You answered the question fairly quickly. Can you explore it in a little more detail?

Professor SPENCER: I would like to emphasise two things in responding. First, there is an outcome in the cost of treating dental disease per se and the direct impact of that disease on people's lives. In that area we have somewhat more information about the cost-effectiveness and cost-benefit of different dental preventive approaches. We have rather less evidence about the extended potential series of links: poor oral health contributes to poor general health and by improving oral health one would improve general health and reduce wider health care costs. We are only scratching the surface of documenting those sorts of issues. I have read reports on the area of medically necessary dental treatment that have tried to come up with cost-benefit equations of the treatment of people's oral health prior to going into heart valve replacement surgery and the subsequent outcomes of that surgery. Treating the dental disease prior to that surgery was a very cost-effective approach in improving the outcomes and reducing the need for subsequent surgery and sometimes for the replacement of heart valves at a second round attempt at surgery later on.

The Hon. IAN WEST: Can I add an additional layer to the issue of the long-term cost to the community of the lack of preventative care? You mentioned the quality of life and the connection between oral and general health. In many geographical and low-income areas there is the added factor

of pain and associated violence, which has an effect on the community. If you have bad or aching teeth, not only do you not eat but also you are cranky. Has any thought been given to research in that area?

Professor SPENCER: Australia has questions in its national health survey with regard to what people call reduced or restricted activity. This can include calculations like days lost from school, but it can also include things like days lost from work and days of reduced normal activity around the home. People who answer these questions are also asked what was the health problem that caused the days of restricted activity. I have analysed that data only once; it was from a period in the 1980s. I can say that at the stage we looked at the data Australians lost about 1.5 million days of work due to dental problems. At that stage that was more than we lost from strikes, and strikes were an issue that seemed to occupy a great deal of political attention, but the loss of productivity in the workplace that arose from dental disease attracted no attention. You are absolutely right, there are consequences that flow into our economic cycles and our community at large.

The Hon. IAN WEST: And family relationships.

CHAIR: I have a couple of specific questions arising out of this. One relates to the amount of research that is necessary. In terms of some of the links you made, for instance between dental health and general health, do we have any idea of how rare or common some of those things are? You mentioned the direct link with death probably did not affect a great number of people, but there is a cost to the community in low birth weight or otitis media. Do you have any idea how widespread are the links to dental problems?

Professor SPENCER: Research is under way in areas such as pregnant women with gum disease and babies with pre-term low birth weight. One of the reasons it is being backed as a research project by the National Health and Medical Research Council is that clearly if there is the possibility of reducing—we call it the preventive fraction—pre-term low weight births through appropriate dental care for pregnant women, it will reduce the occurrence of a very expensive medical intervention. The easiest way to put the expense in context is the million-dollar baby tag that we sometimes hear about. Pre-term low birth weight babies soak up a great deal of resource in the public hospital system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this really related to dental care or is that just a marker? They must be multi-disadvantaged, surely?

Professor SPENCER: I was very careful to say you might potentially reduce some of those pre-term low birth weight occurrences. It is not just a marker: there is a biologically plausible underpinning for that association and there is a good deal of cross-sectional work drawing the link between the two. There is at least one intervention study already published in the literature where the provision of dental care led to a reduction in pre-term low birth weight births. It is that sort of background that has led to the research that is currently under way in Western Australia.

CHAIR: You referred to children and adults. I wonder whether some of the frightening effects you are talking about apply much less to children. We have had evidence in relation to New South Wales giving more emphasis to making sure that children get public dental services. There are also issues such as fluoridation and children having healthier teeth in general, but with differences in disadvantaged areas. Can you expand on children's situation?

Professor SPENCER: I would again reiterate the fundamentals. The experience of dental disease among children is important in and of its own right and there are consequences arising from dental disease for their personal development and the opportunities they enjoy. There are some quite direct health links as well. Otitis media is the easiest one to draw attention to. Again, this is not just association data. Intervention for what we call early childhood caries—dental decay that occurs in young children prior to starting school is probably the easiest way to describe it—led to a significant reduction in otitis media.

This is United States research, and it was a somewhat surprising finding to the researchers. It was done as a collaborative project between dental researchers and paediatricians in North Carolina. There are some reports that children who are experiencing more dental disease show slightly delayed growth and development issues. It would not be surprising to us in some respects that if children

experience a good deal of dental decay—and certainly children with severe early childhood caries do—their chewing and their enjoyment of food would be greatly altered and that could lead to changes to the nutritional value of the foods they eat and perhaps contribute to this slight delay. But that is, again, published evidence in the literature. It is not something that I have seen any research on in Australia.

CHAIR: Is it possible to say whether the kinds of public dental services, fluoridation and so on, that are provided limit the numbers affected to a relatively small number compared with other countries—or New South Wales compared with other States?

Professor SPENCER: Absolutely. Australia had an unmanageable, uncontrollable level of dental decay in children in the period immediately after the Second World War. We have seen on the back of two separate approaches a tremendous change in that. The first is the fluoridation of a good deal of our water supplies and a second has been the development of a school-based dental care delivery system, which has been able to provide early diagnosis and fairly prompt treatment for most children who experience dental decay. It has slightly wider ambitions than that but certainly in that area there has been tremendous change.

But only 50 per cent of Australian children at primary school level Australia wide use the school dental service. Of the remainder the vast majority use their own family resources and seek their care from private practitioners. But there is a small percentage of children who we characterise as being basically non-care seekers. It is generally in the area of somewhat less than 5 per cent of all children, who have long periods without any contact with dental providers.

The Hon. IAN WEST: Professor Spencer, can you give us your advice on how dental problems affect children's learning? Do they have more learning difficulties and behavioural problems at school? Do they have any nasal problems as well as problems with their ears?

Professor SPENCER: Some of those things I do not have any information on at all. What I can say is that Australian children used to lose a great number of days at school due to dental disease. I think this was one of the reasons why, when the school dental program was being discussed as an area of policy development, there was fairly strong support for it from teachers and parents associations and the like because they experienced the child with a dental abscess associated with their primary teeth who was clearly in distress but was present in the classroom and was probably not performing terribly well. These sorts of issues were well recognised. They are simply much less frequent now that we are in a vastly better situation with regard to child oral health in Australia.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On that subject, is the school-based system being dismantled? It seemed from dental therapists—they are the people who run it, are they not—that they are a dinosaur profession in the sense that no new people are joining it and their scope of work is very limited? Since no more people are joining it they are an ageing cohort, they will hit the wall in about a decade and there will be no-one to run school dental programs. Is that right?

Professor SPENCER: There are some elements in there that one would have to say are correct. First of all, no State in Australia has moved away from the basic position of the provision of school-based dental care. The program still exists in every State and Territory. There are certainly policies that have been implemented that are sometimes targeted to care within the eligible school population. There are policies that have introduced co-payments for people who are going to receive school dental care. There have been a number of changes but every State has a school dental service. Therapists are the main staff members in the provision of dental care in that system. The work force projections for therapists show a slight decline in their numbers over the decade from 2000 to 2010. But there are programs that are training people who can register and practice as dental therapists in most States of Australia right now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I gather they are not going into that aspect. The training is more comprehensive at Newcastle. They had other options that were better funded and they may well not go into that system. Is that not a serious possibility in terms of work force planning?

Professor SPENCER: I am not fully aware of how the percentages of people coming out of what we call the dual programs within Bachelor of Oral Health degrees could practice both as dental hygienists and as dental therapists. I am not absolutely certain what proportion are choosing to enter dental therapy and what proportion are entering dental hygiene. But there is a proportion of them and my recollection is that in South Australia it is about a quarter to a third who have chosen to pursue dental therapy as their main career path. What you are raising in the latter part of your question or comment is that these career paths have different levels of remuneration and maybe different career opportunities and people are going to make choices about which one they pursue. So there is an issue for the school dental services in every State and Territory to make working as a dental therapist a first-choice option for at least some of those people coming through the Bachelor of Oral Health programs.

CHAIR: Arthur, do you want to turn to the funding questions?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On question three, we have heard a lot about the triage systems and the fact that they are being done by unqualified people on the telephone. You spoke a bit about rationing in varying forms. Is triage not just a form of rationing and saying that if your teeth are not falling out and you are not in agony then we will put you as a lower priority and say that the ship is sailing along fine?

Professor SPENCER: I think we have to approach the whole area of trying to create the right balance between what we call emergency dental care and general dental care in a fairly careful manner. What I would prefer as a starting point is that we seek to provide more comprehensive general dental care to more people. We recognise that emergency dental care is band-aid dental care for the most serious of the presenting complaints of a person. It does not attend to more than the one main complaint. It does not intervene to limit the progression of any other dental disease. It does not intervene to prevent future dental disease. So there are a lot of shortcomings in emergency dental care other than the relief of pain and discomfort that might be associated with the main complaint.

What people are trying to do is to put in place mechanisms whereby more general dental care can be provided by creating some level of priority among those currently seeking emergency dental care. There are some incentives in the system in that, when the waiting list for general dental care is so long, it actually drives most people who might seek public dental care into wanting to visit for an emergency visit because they can achieve that visit generally within 48 hours. If you ask those individuals whether they needed dental care in that sort of urgent fashion 20 per cent of them will say straight off the bat that no, they did not. So priority systems that filter out the first 20 per cent who do not even consider that they are emergency patients would seem to be quite a realistic and rational way to start the process.

But there are many others on that list who are presenting for emergency dental care who have relatively minor and certainly not acute dental problems and certainly not dental problems that need to be treated urgently. What we would prefer to see is those people identified and, instead of them visiting for emergency care, we would prefer to see them streamed into proper, comprehensive general dental care as soon as is practicable. The problem we have at the moment is that "as soon as is practicable" is sometimes years into the future.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the triage system is like running a health system with only emergency departments and saying the rest of health does not really matter in the sense that we do not have enough resources to do it anyway.

Professor SPENCER: What happens is that all the resources simply get distorted towards the emergency departments. There are some dental clinics in Australia that have closed their lists for general dental care patients and only seek emergency patients. Even the mix of people who come through as emergency patients includes everyone from an acute dental emergency, with bleeding, trauma or a swollen face—but they are a very low percentage of the people who present for emergency dental care—through to people who have minor discomfort with their teeth, their gums or their dentures. The triage system is a way of trying to pick those who are being most affected by their experiences of dental problems and give them priority. To save the resources that would normally go for treating those who are not high priority for general dental care would be more beneficial in the long term for the patient.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you comment on the responsibility of Federal and State governments? That is question four.

Professor SPENCER: I will add the end of the question, which says, "with respect to funding". I will start with some comments about the funding. Historically, States and Territories have been the providers of hospital services, and the public sector provision of dental services was a component of that model of hospital services at each State and Territory level. In fact, in a number of States and Territories the dental services were departments of major public hospitals. That was their origin. The Commonwealth Government until the referendum of 1946 did not have any health powers as such. But the referendum, which was passed, and the constitutional amendment in 1946 opened the door for the Commonwealth to be involved in the provision of hospital benefits, medical and dental services. So the constitutional power that enables the Commonwealth, or the Federal Government, to be involved in the direct provision or the subsidising of medical services also exists for them to be involved in those areas in dental services.

There has also been a second power under which the Commonwealth can be involved in the provision of dental services, and that is in the grants power. The Commonwealth can grant moneys to the States and Territories along the terms and conditions that it might stipulate. We have seen that twice in the last 30 years in the area of dental services. We saw it with regard to the development of the school dental service, initially under a Labor government but continued for six years under a Coalition government. We have seen it more recently in the Commonwealth dental health program in the early 1990s. So there are at least constitutionally two different avenues through which the Commonwealth may choose, if it wishes, to be involved in the funding of dental services in a more direct way.

Historically, the service provision has been a State responsibility. That seems to be where we are sitting right now. But we have seen the Commonwealth, or the Federal Government, engage in areas that were previously regarded as a State responsibility to provide services. We have seen the Commonwealth engage in those in numerous other areas of health and welfare, aged care and disability services. I would suggest that the recent COAG arrangements with regard to mental health are all examples of where these sorts of decisions can change.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do the HECS allocations for dentistry cover the cost of a dental student, and if not what is the shortfall?

Professor SPENCER: The HECS allocations received by universities are a combination of central university costs—libraries, gym, administration services, capital works and infrastructure—that go towards dental education, but they also cover the direct salaries and expenses of academics and support staff, and dental schools. Generally it is that the level of funding received within the faculties of health sciences for their dental schools is less than half of the real cost of providing the education of a dentist at our universities, and a reasonably large proportion of the remainder is made up in a number of different ways.

A large contributor is State health budgets through the provision of clinical services and the support for clinical services in our dental teaching clinics. They are somewhat underwritten by research funding that universities receive. My area is a good example of this: we are a research area, but research-employed staff are engaged in the teaching of dental students so that there is a sort of cross-subsidisation from research to education. There is a certain amount of philanthropy that is occurring that is underpinning dental education at our universities through foundations, and there is a degree of entrepreneurial income raising along other lines that dental schools use to try to match the shortfalls that they feel they experience.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Professor Schwartz has given the figure of $23,440 per annum as a total equivalent full-time student load payment from the Commonwealth. What percentage of the full cost of training a dental student per year is that?

CHAIR: If you read the next sentence, the next sentence of the letter says 19.5.

Professor SPENCER: I am going to say I am not a dean and I do not deal day to day with the education of dental students. I am what I call a has dean: I have been a dean and I have resigned

from that. I certainly do not have up-to-date information on getting down to the nitty-gritty of the financing of the education of a dentist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As a has dean, did the university take a fair whack of the money allocated? Did you actually get the money that you were allocated federally, or did they take a large percentage of it? What percentage does the University of Sydney take?

Professor SPENCER: I have no knowledge of what the University of Sydney takes, but every university will take a portion, a central subvention, to cover the university's costs of the presence of a dental school that it wears centrally out of the funds it receives from the Federal Government.

CHAIR: You cannot ask someone from the University of Adelaide to tell you what the University of Sydney does with its money.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I did say something like that somewhere else.

CHAIR: How does funding for public dental services in New South Wales compare to that in other States and Territories?

Professor SPENCER: This is not an area that the Australian Research Centre for Population Health has any role in surveillance or monitoring. We are not supplied with information from State and Territory governments or their health departments that give an immediate answer to that question. What I can say is that when I looked at the National Oral Health Plan, which has in its appendices some information about the expenditure at a State and Territory level for the year 2001-02, New South Wales spent 22 per cent of the total amount of funds spent in Australia on public dental services. I would simply ask you to draw the conclusion from that: Does New South Wales have only 22 per cent of the eligible population for public dental services in Australia and the answer, of course, is no. It has a much larger population proportion than that. That is an indication that New South Wales spends less proportionately on public dental services than its population proportions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not pulling its weight?

Professor SPENCER: Its weight against the Australia demographics.

CHAIR: We have had some evidence in relation to different policies in different States, and I think you mentioned a couple of them earlier—means testing and co-payments et cetera. I guess those things complicate comparisons in that in some States, I think Western Australia is one, the recipients of public dental services are making a co-payment, whereas in New South Wales, for instance, they are not. Is it possible to put all those things in the mix and work out a comparison?

Professor SPENCER: I am sure it is possible. It is not a task that anyone actually asks us to do, so we do not do it. State and Territory dental directors, and health departments generally, would have an idea of per capita expenditure they make against the eligible population base. But that data does not tend to make its way into the public domain frequently.

The Hon. CHARLIE LYNN: Could you tell us if this has been a trend or is this something that has dropped recently, or has it trended down, the proportion of spending?

Professor SPENCER: This is moving away from the realm of the hard data, but if you look back over time there has been fairly longstanding concern that our two most populous States spend less on public dental services than the remaining States and Territories. There is this quite a well-understood pecking order among the States in who has had a history of having a more highly developed public dental service, both a school dental program and an adult program, who employs more dentists and how much is spent per head. Certainly the position seems to have been longstanding and not something of recent origin. There is a very great historical issue, and that is that the two populous States were the last States to become engaged in expansion of the school dental program in the early 1970s.

That was expansion that was funded by the Commonwealth Government under the grants power, they were tied grants to both the capital-based development of the school dental service and the recurrent costs of the school dental service. They ran for some—I will have to get the number of years correct—six or seven years. The capital and the recurrent expenditure were almost entirely picked up by Federal or Commonwealth funds. Some States hit the ground running and were very quick to make use of those types of funds. The States seemed to lag behind in the development and then, of course, when grants for capital land recurrent expenditure began to be wound back in 1981, those States that were less developed stayed in that position relatively basically ever since.

CHAIR: Can you tell us about the impact that private health insurance has had on the funding of public dental services?

Professor SPENCER: I looked at this question and first thought, "There must be something more to this." In a sense the obvious answer is that private health insurance has no direct impact upon the funding of dental health services. No private health insurance rebates are paid to public dental services for the provision of care to people who might even hold private dental insurance, which is something that deserves some consideration. So there is no direct flow of funding, but there is an indirect effect and, clearly, the indirect effect is probably what you want me to answer.

CHAIR: Yes.

Professor SPENCER: In theory, private dental insurance can influence the demand for public dental services. In fact, if we look at the record for why the 30 per cent private health insurance rebate was introduced we find that the main rationale is to reduce the demands upon the public hospital system by encouraging people to seek their care within the private hospital system. Less than 20 per cent of those eligible for public dental services, which is about 35 per cent of the adult population in Australia, have all have had private dental insurance. Whenever we study it, it comes out in the high teens, between 17 and 20 per cent. That insurance could assist them, and I am sure it does assist some of them, in using private dental care instead of demanding public dental care.

That is important because it is at least some of the demand for public dental care being drawn off and supported, and being expressed in the private sector. But for every one person who is eligible who has private health insurance there are four people who are eligible for public dental care who do not have private dental insurance. An issue that I certainly have written about is that for every one person who is eligible and to have private dental insurance there are another five people who are ineligible who have private dental insurance. The target efficiency of this particular policy area in the dental domain is something that is of considerable concern.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is about 20 per cent, or even less?

Professor SPENCER: In a sense it is about that sort of level. But one is picking up the private dental insurance costs for five people. For every additional person that you pick up who is actually eligible for public dental care who might have private dental insurance and who, therefore, would seek their care privately and not express it in the public system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is 150 per cent at 30 per cent per person?

Professor SPENCER: I beg your pardon?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which is 150 per cent at 30 per cent per person. You are paying five lots of 30 per cent, which is 150 per cent of the cost of the treatment.

Professor SPENCER: I do not do my mathematics that way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you can see where it is coming from?

Professor SPENCER: But on the other hand I can understand what you are saying. This is quite an important issue in the broader scheme of things because it is quite different to public hospitals and private hospitals, which is where the policy initiative was directed. All I would say is that if one were considering the area of private health insurance and public subsidy of it one might want to consider can its efficiency with regard to dental services be improved? Can we improve the equity with which that policy applies within the dental sector?

CHAIR: When we look at it, it is not a very clear question and I apologise for that. You are quite right that we were thinking of indirect impact. But I guess the other part of it that has been raised is that the private health insurance rebate, specifically in this case in relation to dental services, has had a big impact on the income-earning potential of the dental work force and an impact on, for instance, shortages of workers in public dental health services. There has been a whole shift of workers and services towards people who have private cover. Obviously, there is an argument that those indirectly affected have been important also.

Professor SPENCER: Private health insurance is a driver for demand for dental services in Australia. But it certainly is not the only driver in the increase in expenditure on dental services over the decade 1992 through to 2002. A range of other fairly significant drivers exists, and I would see it as only one factor. In general I have argued that private dental insurance is not the greatest stimulant to demand for dental care in Australia that it is in other countries with which we generally compare ourselves, like the United States of America, but it will be a factor in that equation.

CHAIR: Would you run through the major factors for us?

Professor SPENCER: If we are talking about the increase in the nation's expenditure on dental services, the rate of which certainly has been considerably higher than health services in general and higher than the growth in GDP, the drivers are a combination of our population growth, the ageing of our population, and an interaction with oral health trends—for instance, the retention of teeth among our middle-aged and older adults. So we have some demographic-cum-oral health underpinning that I think is a fairly significant driver, for a start.

There are some direct impacts from things like infection control concerns, which we believe led to a fairly significant step up in expenditure on dental services in the early part of the 1990s. There is a significant impact from technology being applied in the diagnosis of dental conditions but also from increasing the complexity of some treatments available for dental conditions. Only then would I start to add some issues to do with the expectations of people in the community and their ability to express those, and that is where private health insurance comes into the scene. So I guess it is a contributor, but in respect of the sorts of things that you have raised, it is only a contributor amongst what is always an interesting mix of forces that are at work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has it pushed up the cost of vouchers? And is the cost of private consultation much more expensive than salaried consultations in terms of the quantum of health services delivered by vouchers as opposed to the quantum of services delivered by salaried staff?

Professor SPENCER: I have no direct evidence of how the vouchers systems are working in Australia. In fact, most States do not have any involvement in a voucher system as such. However, a number of States have done cost analyses by comparing the provision of dental services in public dental clinics versus imputed costs in the private sector. These often use standard fee scales, for instance, like the Department of Veterans Affairs licensed dental officer fee scales for private sector fee costs. Those sorts of reports are available on the public record. Like with most of these things, one needs to be very careful about their interpretation; what sometimes looks like a deficiency in one sector can change to being an inefficiency if one uses a subtly different measure of the level of productivity and how people seem to work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We do have a voucher system in New South Wales though, do we not?

Professor SPENCER: I do not use the term "voucher system". I imagine that you would have a publicly funded, privately provided dental care program that might work in rural areas, or

something of that sort, and that there might be a cap on how much is reimbursed. But whether it is actually in the form of a voucher system, I have to say I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, effectively, it is not your field?

Professor SPENCER: It is not my field, no.

The Hon. IAN WEST: Do you think that Medicare should be extended to cover oral health services, and why or why not? And do you have any other suggestions concerning the funding of public dental services?

Professor SPENCER: I have thought about how I might answer this question. Obviously, I am not going to give you my personal opinion; I will resort to what we can find in the academic research sense that would help shed some light on it. I have looked at what I think is the last, and maybe the greatest, of the formal investigations of the possible extension of Medicare into a range of other areas. This was the Medicare Benefits Review Committee work—the Leyton committee work of 1986. So this is a question that seems to be a bit of a perennial on our agenda.

Dental services satisfied all of the essential criteria that that committee had under consideration for extension of coverage under Medicare. They included: that the services were regarded as effective, and that there was broad community acceptance that dental services were an essential part of health care. I found that a very interesting criterion to reflect upon in 1986. That committee concluded that there was broad community acceptance that dental services were an essential part of health care. The committee found also that the services were efficient, that there were high standards of practice, that there was a general need, and that there was unmet need. So the committee considered that dental services met all of its essential criteria. However, in 1986 it was considered unrealistic, on the grounds of cost, and it was also considered that the dental profession considered it not warranted or undesirable to be covered under Medicare. I think exactly those considerations might lead to rather similar conclusions today.

As to what other alternatives could be available, I think there are almost a plethora of in-between stages of public support for dental services in the community. There is an area that I quite like to draw an analogy with, because I think there are some essential features of it which would be a great improvement upon our current situation, and that is if we organised our public funding of dental services somewhat along the lines of the family allowance payments, or of the provision of child care fees, where there is some sliding scale as to the level of public subsidy that people in the community receive. I think there is a lot to be learned from looking at some other public subsidy policies in the health and welfare area.

That might give us guidance on other ways of tackling the issue, first of all, of the subsidy for low-income Australians, the sort of people who are eligible for public dental care at a State and Territory level now, but also for the lower-income Australians, those who earn at or around, sometimes below, the average earnings of an Australian but who at the moment do not receive any access to our direct public subsidies through public dental services, but also who are probably not in a financial position—at least many of them are not in a financial position—to purchase private health insurance, even with a 30 per cent rebate. So I think there are some middle grounds that would be well worth exploring.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If we were to ask you for your private opinion, hypothetically, as to whether Medicare should include dental services, would you be able to say yes?

Professor SPENCER: I am not going to offer an opinion about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you describe what has happened with the oral health plan as implemented so far? Has it been successful? And what is the position in New South Wales?

Professor SPENCER: The national oral health plan is comparatively lukewarm from the press. We ought to recognise is that it was only endorsed by all Ministers of the States and Territories

and the Federal Government in 2004, so it is relatively early days; we are less than two years out from its endorsement. The most significant issue with the national health plan is that it is acting as a backdrop against which individual States and Territories are drawing up what might be regarded as somewhat compatible State-level or Territory-level oral health plans. I think it is also acting as a subtle pressure on States and Territories to improve their performance in both the oral health of the population but also access to dental care, because it provides at least a framework for benchmarking and monitoring of key performance indicators that I think all States and Territories will adopt.

All of this could be strengthened and formalised by much stronger leadership at a national level from the Federal Government with regard to the national health plan, and that would be regardless of whatever funding arrangements, or lack of funding arrangements, there are between the Federal Government and State governments for the provision of dental services. I certainly believe that our Federal Government has responsibilities above and beyond the issue of its potential involvement in the funding of dental services. It has a responsibility to provide leadership in the areas of assessment of oral health problems in the community and access to dental care for the population. I think it has responsibilities in leading policy development and in the evaluation of the implementation of policies, such as the national oral health plan. And I think it has a role to play in influencing, if not being directly involved in, ensuring that Australians have access to adequate dental services. Some of those functions it could exercise right now, even without altering any of the arrangements between the Federal Government and the States and Territories with regard to the funding of dental services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it a bit like a bill in a restaurant: everyone agrees that it is right, but no-one will pick it up?

Professor SPENCER: What I can say is that at the moment we have a very fragmented and unco-ordinated response to the national oral health plan, and that States and Territories are moving at different paces to consider it and implement what they might be comfortable to implement from within the plan as a whole. All of that could be sped up and could be more far-reaching if we had national leadership and a true partnership between our Federal Government and our State and Territory governments on that matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I take that as a yes. Do you have any recent figures on the make-up of the dental work force in New South Wales in terms of the number of dental practitioners, including numbers of allied oral health workers, and whether they working in the private or public sector?

Professor SPENCER: I assume by "recent" you mean later than the published information from us for the year 2000. We publish information on the dental work force in Australia, including State and Territory level breakdowns, on a three-year cycle. The 2003 publications are available in areas like the allied dental work force—dental therapists, hygienists and prosthetists. The dentist work force report is being put together at the moment, and I think it is close to going into production for publication. So the 2003 data would be the latest data that we have available, and it is soon to be publicly released through the Australian Institute of Health and Welfare in Canberra.

CHAIR: Would it be possible for us to get some advanced information—because we have to table our report by 31 March.

Professor SPENCER: Certainly. Some of it is in the public domain, and we would be very happy to look at that. It could be that it will be on the institute's forthcoming publications schedule, maybe for late February or something like that.

CHAIR: Perhaps we could liaise with you about that.

Professor SPENCER: We are funded by the Australian Institute of Health and Welfare as part of what I call ARCPOH, the Australian Research Centre for Population Oral Health. We are funded to monitor the work force on an annual basis. But our reporting cycle is a three-year reporting cycle.

CHAIR: Do you have any comments to make on the situation in New South Wales perhaps compared to other States? For instance, Arthur mentioned the ageing of the dental therapist work

force. Obviously, New South Wales is an importer of dentists, either from other States, including South Australia, or from overseas. Are there particular comments that you would like to offer in relation to New South Wales, as to the balance of the work force, its adequacy, and so on?

Professor SPENCER: I think the most important issue is to recognise that New South Wales is really no different. The important things are the similarities that New South Wales shares with the other mainland States that have a capacity in their universities to educate both dentists and other allied dental professionals. New South Wales, in the national scheme of events, is probably more similar than it is different to the general position of most States and Territories. It has an aggregate supply shortage. The report that we produced for New South Wales in 2002 documented that New South Wales had a shortfall in its capacity to supply services against the projected demand for dental services from within this State. That shortfall arises for the same reasons as it does nationally and in most of the Australian States and Territories.

CHAIR: Does that include the difficulty of filling vacancies in the public dental services?

Professor SPENCER: The issue with those rural dental services and public dental services in terms of the labour force is that the shortfalls are always felt first and will be felt hardest by those areas that generally have difficulty in recruiting their slice of the dental work force anyway.

CHAIR: New South Wales is no different in that aspect?

Professor SPENCER: New South Wales has an extensive rural-based population, as well as its population in Sydney and surrounds. It has a large public sector program in terms of just the number of people that one needs to recruit to maintain that service over time. It is suffering exactly the same sorts of issues as exist for everyone-else in that area. The reason why I am emphasising the similarities, the sameness, there is that it seems to me one has to keep in mind that no State is an island unto itself when it comes to issues of the labour force. It simply is not feasible for any State to think that it can somehow put a border or a boundary around this problem and produce more graduates out of its own universities and that will solve its problem as a State. Our dental work force has free and easy mobility to practise in any one of the eight States and Territories of Australia under reciprocal registration and mutual recognition issues. So no one State can solve this problem on its own. What we do need is a co-ordinated national strategy.

The Hon. IAN WEST: I do not think you are right, but keep going.

Professor SPENCER: Maybe I will make my last comment a little bit earlier: every State has to contribute to the solution.

The Hon. IAN WEST: A percentage of people travel, but many people stay in the State that they train in.

Professor SPENCER: The issue there is our national pool of entry into Australian dental schools see universities like the University of Adelaide Dental School with a minority, generally under 15 per cent, of its intake actually being South Australian-origin students. We could come to the University of New South Wales and ask exactly the same question of its dean, Professor Eli Scwhartz, and he might be able to inform you of what percentage of the intake into New South Wales, into that school, is New South Wales in origin. We have very much a national perspective to the entry selection and entry into our universities. That complicates the issue of putting up a boundary approach to how do we tackle this issue.

The Hon. IAN WEST: I would be so bold as to suggest that the majority of people who train in New South Wales as dental therapists would actually operate in New South Wales.

Professor SPENCER: Therapy, you are probably in safer territory in that sort of area because therapy has only recently been incorporated into university-based degree programs. At least up until recent times it has been sometimes run as an unaccredited, closed educational program offered by State health departments. That gives you a great deal more control. What I was indicating was at least within our national universities, our tertiary education system students have the opportunity, reinforced by a decision of the High Court, to apply to any university they wish. This is

leading to some very interesting responses in most States and Territories at the moment, that is, trying to reintroduce some level of quota for students of local origin. This problem is talked about just as much in South Australia as what it would be in Western Australia as what it would be in New South Wales.

CHAIR: We might take up the Hon. Charlie Lynn's suggestion and call the Hon. Ian West as a witness. The Hon. Robyn Parker will ask the next questions.

The Hon. ROBYN PARKER: You touched on some of the issues facing the dental work force. In particular, we are interested in New South Wales but, as you say, the issues are present across the whole country. In this inquiry we are looking for solutions. Do have any suggestions for solutions to the problems?

Professor SPENCER: There are two. I would start with the generic issues. I know I might somewhat disappoint you if I do not focus on New South Wales but we have an aggregate shortage in the dental work force. It is a shortage that at least the published projection work indicates will run through at least into 2015. In fact, some people believe that if we do not take various remedial actions that it will worsen during the next decade because there is an age bulge. We talked about the ageing aspects of the dental work force. There clearly needs to be an increase in the aggregate supply. There also needs to be considerable attention to distributional issues. The geographic distributional issue is obviously high in most people's mind. Also there are sectorial distributional issues: How do we obtain a work force for public sector care delivery? There are probably occupational distributional issues: Do we think we have got the right mix of dentists and allied dental professionals?

These are the larger issues that we are trying to grapple with. They are dealt with, to some extent, within the national oral health plan. The direction is certainly outlined there. But what we have at the moment, as I have tended to term it, is a fragmented and unco-ordinated response to that sort of issue. A work force is one issue where I would argue strongly that you need strong national leadership, in part because the components are complex mixes of Federal responsibilities in the Education portfolio and State responsibilities in the Health portfolio. That clearly to me says that there needs to be an intersectorial approach and a partnership of different levels of government if we are going to move forward well there. I can only emphasise the need for that level of co-operative participation in addressing the dental work force issue.

The second area I think we have got to give great attention to is we certainly need, what I call, more dentists for the main street. Dentists are the backbone of the dental profession in Australia—85 per cent of dental care in the country is delivered by dentists. One needs to make sure that that backbone is well supported, and it is a private-sector backbone. Main street is the strip shopping centre in suburban areas where dentists practice. We do need to be increasing the supply of dentists in that sort of environment. But we also need to have running in parallel with that quite specific programs that are going to address the issue of the rural distribution of the dental work force, where we can recruit, retain and support dental personnel in rural areas and where we can do the same for their role in the public sector. At the moment the great difficulty is that we simply do not go about recruiting or attempting to retain or supporting dentists in either the public or the private sector in rural practice in anything like the ways we have seen emerging through our medical colleagues and we certainly have got no particular plan in place that seemed to be substantial and having a meaningful impact on recruitment into public sector dentistry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think there is a shortage of people in preventative dentistry? We have had evidence if there were much more prevention, as in corrective dentistry, you could lessen the load of dentists in the medium term.

Professor SPENCER: I think we have to be very careful in the area of our assumptions about the impact of adding additional providers to the dental care mix. When we add an allied dental professional to the dental team, we do not just substitute that provider for some of the services that the dentist would previously have provided. We do not just do that. We also create a complementary area of new work, which is an expansion of both the provision of services and the demand for services. It is quite possible that we could add allied dental professionals that simply create new additional work which previously would not have been demanded or provided.

CHAIR: Can you give us an example of an area where this may happen or has happened?

Professor SPENCER: These are always complicated mixtures. I would have to say the research in this sort of area is grossly underdone. We have looked at, for instance, dental hygienists and their involvement in the provision of services in private dental practices. Certainly, from some of the evidence that we had, a dental hygienist is a substitute for a dentist in the provision of the services which they are allowed to provide, which are mainly what we would call the more preventative services and the lower level interventions for periodontal disease or gum disease. They will substitute for a dentist in the provision of a great many of those services within the dental practice and 30 per cent of their role might be that substitution. But the remaining part of their role seems to be the provision of services that were not previously provided by that dental practice to the patients that sought care from it. So there is an increase in the rate of provision of preventative services and periodontal services, which simply were not provided previously. We think that is about 70 per cent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting as a consequence we had better not have these people because they will discover work for themselves and cost more? Is that the corollary?

Professor SPENCER: All I said is we have to look at these things very carefully because they are not necessarily the solution to our labour force issues. It might be the solution to reshaping the mix of dental care. It might draw the mix of dental care in the direction of preventative services and periodontal services, but it is not necessarily as great a contributor to the issue of the differential and supply and demand for services.

The Hon. IAN WEST: You unlock demand in the higher echelons of the socioeconomic strata?

Professor SPENCER: It could do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it might reduce demand in the lower echelons, might it not, if people do not need so many teeth filled?

Professor SPENCER: Then we simply get ourselves into the study of the long-term efficacy of access to good dental care. Certainly there will be a reduction in future disease levels in certain disease areas. Certainly there will be vastly improved oral health quality of life.

The Hon. IAN WEST: For people who can afford it.

Professor SPENCER: I suggest to you there will still be a need for dental care and there will still be a strong demand for dental care.

CHAIR: We have had evidence that suggested for a relatively small work force there is a very complex mix of specific jobs with very firm boundaries between them. Some of them are perhaps more historical, like dentists. Do you or does the institute have a view on whether the work force, the different titles and the boundaries as to what people can do, is overcomplicated? Is there a need to simplify or re-examine those areas?

Professor SPENCER: First, I am not representing the institute; I am not here on behalf of the Australian Institute of Health and Welfare; I am here as a dental academic at the University of Adelaide and the director of a research centre. Occupational distributions are largely historical and are complex issues. I do not believe there is any good, empirical information that we can point to and put on the table saying that this clearly indicates that one sort of distribution is necessarily a lot better than others. The evidence for that is available if we look at comparable countries. We can find countries that have entirely dentist-dominated provision of dental services and very limited roles for any allied dental professionals. We can also find countries that have made extensive use of school-based dental therapists or countries which make no use of dental therapists per se but which make extensive use of dental hygienists: We can find any of those combinations. If the empirical evidence existed that any one of these things was a vastly superior arrangement than anything else, it seems to me that more countries would have moved in similar patterns. The fact that they have not suggests a strong historical and perhaps personality —

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Economic?

Professor SPENCER: They could all study the economics of their delivery systems and presumably come to conclusions about them. But these things have not been rationally researched and debated. They are much more emotive and personal issues than that.

CHAIR: Speaking as an academic from the University of Adelaide, do you think that a different mix would be better?

Professor SPENCER: There is very good reason to have a strong interest in getting an appropriate team approach to the delivery of dental services. We can see the movement in the development of stronger teams in other areas of health care. It is commonsensical that a team approach with interesting combinations of skills and competencies is appropriate for dentistry as well. The main driver for how that team should be constructed is what sorts of services the individual members are best at providing, and what value we place on increasing certain types of services. So, if we want to increase the provision of preventive services to children in Australia, which is what we did in the early 1970s, then a school-based dental therapist would be an appropriate dental professional to introduce. If we want to increase the provision of certain services now, then we need to look at who has the skills and competencies to be able to deliver that in an efficient way and ensure they have a presence in the dental team.

CHAIR: What is your opinion of fluoridation? We have asked every witness appearing before this inquiry this question.

Professor SPENCER: We have had a history of being involved in research on the effectiveness of fluoridation in Australia. I certainly have a history of being engaged in advocacy in relation to water fluoridation. Most recently we held a workshop in Adelaide under the banner of the National Advisory Committee on Oral Health. It no longer exists, but it requested that it be included in the meeting and the use of fluorides in Australia was an action item in the National Health Plan. The workshop was strongly of the view that water fluoridation should continue in Australia, because it is effective, efficient, socially equitable and safe. It is a population strategy to prevent caries. We are also of the view that water fluoridation should be extended with support from all levels of government to as many people living in non-fluoridated areas of Australia as is possible. We remain firmly convinced that water fluoridation is the population-level cornerstone of our prevention of dental caries in children, adolescents and young adults. The evidence for its effectiveness in the adult age groups is not well developed, but there are studies, including a very nice piece of work in Australia among young adults showing clear evidence of the effectiveness of water fluoridation in the prevention caries and improved oral health in those who have lived all their life in fluoridated areas. We remain convinced that this is the key starting point in sensible preventive policies for oral health.

CHAIR: What would you like to see come out of this inquiry? This is another question we ask all witnesses.

Professor SPENCER: The first thing I always ponder when I note that an inquiry is being conducted is that we are not submitters to state and territory level inquiries. We see our role, and have a role, at the national level and we are happier to comment on what we see as the national-level picture and national-level issues. But we are always pleased to see engagement with the issues by any of the States and Territories and a willingness to consider solutions, because we are fundamentally keen advocates for improving oral health of Australians and improving their access to good dental care. So, we would hope that out of an inquiry such as this that New South Wales shows a willingness to partner with other States and Territories in pursuing the actions and objectives that have been laid down in the National Health Plan and will be seeking to partner with the Federal Government in moving issues forward more quickly, and certainly more extensively than will otherwise be the case if oral health and dental care are dealt with only at a state level.

CHAIR: Thank you very much for appearing. We will be in touch regarding whether we can get advance information from the publication of the 2003 data.

(Short adjournment)

LEONE JUNE HUTCHINSON, General Practitioner and Chair of the New South Wales Regional Committee of the Royal Australasian College of Dental Surgeons, Shop 21, 67 Elizabeth Drive, Liverpool, sworn and examined, and

ANDREW MACDONALD HOWE, University of Sydney, Foetal Toxicology, Faculty of Medicine, Member of the Regional Committee of the Royal Australasian College of Dental Surgeons, 64 Castlereagh Street, Sydney, affirmed and examined:

CHAIR: You are both medically qualified and work in medical areas, do you?

Dr HOWE: No.

CHAIR: You said that you were a general practitioner?

Dr HUTCHINSON: A general dental practitioner.

CHAIR: And you are in the faculty of medicine, Mr Howe?

Dr HOWE: Yes, my primary degree was in dentistry and I have a PhD in the faculty of medicine.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are a foetal toxicologist. Might I ask why you are on the College of Dental Surgeons?

Dr HOWE: My primary degree was dentistry. I also practise part time. Foetal toxicology, as you probably know, has a bit to do with dentistry these days. There is a lot of evidence coming out about the harms of periodontal disease and the effects on the foetus as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you research the effects of dental health on foetal toxicology, do you?

Dr HOWE: No, I do not. That is not my area of expertise.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So in fact your primary job at the university does not relate to dentistry?

Dr HOWE: No.

CHAIR: We sent some prepared questions to you but would you like to make an opening statement first?

Dr HUTCHINSON: Just a general statement. We would really like to thank the Committee for giving us the opportunity to give evidence today. It is an important area that we are looking at and it is an area that needs to be addressed. There are many people within our community who have a lot of dental needs that are not being currently addressed and the college thanks you for allowing us to put our ideas forward.

CHAIR: Dr Howe, would you like to say anything before we start with questions?

Dr HOWE: No, I think the opening statement by Dr Hutchinson is fine.

CHAIR: Our first questions relate specifically to the work of the college. Can you tell us about the courses that the college runs, its other activities, your target audience and how many dental practitioners participate?

Dr HUTCHINSON: Because there is so much information that I would like to cover, I thought it might be better if I tabled some documents on those issues. These documents from the

college explain most of the questions you have asked about the courses and activities. We can then talk about dental care in New South Wales, if that suits the Committee?

CHAIR: Yes, that is fine.

Documents tabled.

Dr HUTCHINSON: Our target audience is stated in the documents also but it is the proportion of dentists who are particularly interested in improving and extending their knowledge of dentistry and improving the quality of care that they provide to their individual patients. It is a post-graduate program and it is voluntary, obviously. We represent 10 per cent of practising dentists in New South Wales. A large proportion of specialists are fellows of the college. The elite 10 per cent of dentists in New South Wales would be fellows of the college and approximately the top 6 per cent of practising general practitioners are fellows of the college.

CHAIR: How do you define "top 6 per cent"?

Dr HUTCHINSON: It is our assertion, as the college, in that we demand, firstly, that the study program and the examination are relatively onerous and intensive and our students go through a two-year program of tutorials. In the case of the affiliate in general practice, there is also a practical component; there are preliminary primary scientific subjects which are studied for the primary degree and we also demand continuing education—300 hours of continuing education over a five-year period. It is our contention that the dentists who are willing to undertake these programs and then commit to a fairly heavy body of continuing education are those dentists who really have a passion for providing top quality dental care to their patients and ensuring that the care that they provide is the most up to date, the most accurate and the best quality care that can be provided.

CHAIR: Would it be possible to give us some idea of who your fellows are in terms of overwhelmingly in private practice? Are academic heavily represented amongst them?

Dr HUTCHINSON: We have a smattering of all of those groups. As I said earlier, most specialists would be fellows of the college; it would only be a small proportion. I have to say that I do not have exact figures. The college does not hold exact figures. When fellows are admitted they state at their admittance whether they are a specialist, a general practitioner or an academic but there is no particular need for them to update that. Someone who goes in as a general practitioner and subsequently trains as a specialist may be listed on our records as a general practitioner, so we cannot be certain. The figures I have given you are approximations. Approximately 40 per cent of the fellows would be general practitioners. The rest would be specialists and academics.

CHAIR: So overwhelmingly in private practice?

Dr HUTCHINSON: The general practitioners mostly would be in private practice and the specialists, also, would be predominantly in private practice. Obviously the academics would not be.

CHAIR: While we are still on the work on the college specifically, how are your courses funded and what sort of collaboration do you have with the universities with respect to what you do?

Dr HUTCHINSON: The courses are self-funded. The college receives no grants from the Government at all, so the courses are budgeted on what it costs to run the courses and they are paid for by the people who participate in the courses. Yearly in New South Wales we collaborate with the University of Sydney for a conjoint meeting. Our convocations are run purely by the college and they are biennial. Other States may have other relationships with universities. I am not sure, being the Chair of New South Wales regional committee, but we have a collaboration with the University of Sydney for academic matters.

CHAIR: And you really are New South Wales focused?

Dr HUTCHINSON: Yes, I am New South Wales but the college is Australasian. It involves New Zealand and Asia as well as Australia but because it is a New South Wales committee I am here to represent the New South Wales regional committee.

CHAIR: And are the courses you are talking about in New South Wales for members of the dental profession practising in New South Wales or do they vary from that?

Dr HUTCHINSON: The course we run in collaboration with the university is open to all dentists registered in New South Wales and, in fact, dentists from interstate if they were interested in coming. We run other scientific afternoons, which are for fellows only. The convocation, normally, is for fellows only, although there are some others we allow. Enrolled candidates are allowed to attend and members of the periodontic academy are allowed to attend but predominantly the convocation is for fellows only, and that is run not as a State initiative but by the college as the overall Royal Australasian College.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had evidence that the training of post-graduates in the universities is suffering, in Sydney certainly. Are you picking up that slack with the college running private courses?

Dr HUTCHINSON: Are you talking about specialist training?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes?

Dr HUTCHINSON: There is, at the moment, discussion occurring between the college and the universities. I have to say that personally I am not involved in those discussions at the moment and because they are ongoing I would rather not comment particularly, but there are discussions occurring. Certainly, we do have a memorandum of understanding with the periodontics department at Queensland University and this is the sort of thing that the college is looking to progress throughout the Australasian region.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the college basically picking up the slack for what used to be done in universities by academics?

Dr HUTCHINSON: I see your point. I really think I am not qualified to comment on that because I am not involved in the negotiations that are occurring.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who should we ask about this?

Dr HUTCHINSON: The university, I suppose, or perhaps call the federal president of the college, who would be more involved with those aspects.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this in the higher pecking order of the college or the academic stream of the college?

Dr HUTCHINSON: The president of the college is, of course, the overall head of the college and he would have more information on this issue.

CHAIR: When was the college established?

Dr HUTCHINSON: In 1965, I think. It is in your brochure.

The Hon. IAN WEST: At the top of the second page. As a matter of curiosity, is there some economic imperative or advantage to having Her Majesty Queen Elizabeth II give permission to use the name 'Royal'?

Dr HUTCHINSON: I think it is more a historical aspect. It actually occurred after the college was established.

CHAIR: In 1977.

Dr HUTCHINSON: I think there were some people in the college who thought it meant a certain amount of cachet. I have to say there is a little bit of controversy relating to that at the moment, as you can imagine. There is no commercial or financial advantage.

Dr HOWE: Returning to the earlier question about the relationship between training specialists, the college has worked alongside the university for many years communicating about the training of specialists but no formal arrangements have been made. Many of the specialties have required that the primaries of the college be sat before people are inducted into the specialist programs, but that has been a rather loose arrangement. The training of specialists requires a close relationship between the university and the teaching hospital, or the dental hospital at Westmead, because you need patients to treat in order to be taught. The university does not have patients but the teaching hospitals do. There has been an interrelationship between the teaching hospitals, the university and college. There has been a link between the three but there is no formal arrangement as far as I know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is the teaching hospitals are really the faculty and the faculty in the university is really only an office. The hard work is done in the dental hospitals. In a sense that is an academic point. The university structure covers the dental hospitals, does it not?

Dr HOWE: Yes, but I believe the problem is the difference in funding between the two, because the funding for the university is separate from the funding for the public hospital system. That is a question probably best asked of the public service and of the faculty itself, because that is where those arrangements are in place rather than with the college.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the primaries taught by the university?

Dr HOWE: No, the primaries are taught by the college. That is a re-examination of the principles of science that would have been learnt at university level. You sit a primary examination to enter the college, very similar to the way you would under the medical colleges.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surgical primaries presumably?

Dr HOWE: Yes, it is the same as a surgical primary. Once in the college you sit a secondary examination, which is a more clinical-based examination that takes place within the college. Even that examination takes place within the hospital system so the patients that are examined are within the hospital system. There has always been this close relationship, although it my not be formal, between the college, the faculty and the Department of Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There have been difficulties getting medical specialists to work in the hospital to do the training and examination through the universities. The salaries and research positions are such that they cannot get practitioners in those jobs. Has the same problem happened in dentistry?

Dr HOWE: No, it is quite the opposite. You have to work in the public system to gain the qualifications to become a specialist, so you cannot work in the private system as a specialist until you have done your time training in the public hospital system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not the problem in the medical system. The problem is not those who have already graduated, it is the training positions—the teachers. No-one wants to do the teaching job.

Dr HOWE: That is a problem.

Dr HUTCHINSON: There is a major problem there. As an example, Westmead Dental Clinical School is one of the major areas for accessing patients to train specialists. In 1980 when that clinical school opened there were approximately 20 specialists working in it. You will be able to find out the exact figures later from other people. It is my understanding those specialist numbers have not increased at all in that 25-year period.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have they dropped?

Dr HUTCHINSON: I do not think they have dropped, I think they are essentially the same. The actual numbers may have changed but the full-time equivalents have not improved at all. There is currently no specialist endodontist at Sydney Dental Hospital, for example, so there are quite large gaps in these areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the same people still teaching? Are they stuck there like dinosaurs with nobody new coming in?

Dr HUTCHINSON: To a certain extent that is the case. Some of them have been there for quite a long time and they are very loyal to the faculty, but they are coming to the end of their time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And no-one wants to work on that wage?

Dr HUTCHINSON: The wages are not at all attractive to specialists going into the teaching field in the university. They are quite considerably lower than they would be for the equivalent medical specialist and much lower than private practice, so there is not that attraction.

CHAIR: You say the number of specialists at Westmead has not grown in 25 years. Is Westmead treating a very much larger number of patients?

Dr HUTCHINSON: That is not something the college can answer. You would be better to save that for this afternoon.

CHAIR: Obviously, from the point of view of New South Wales Health, the number of staff at the teaching hospital is related to the number of people being treated. They are not primarily there to be specialists who provide postgraduate training through the college.

Dr HUTCHINSON: They are needed in that role. I think you would be better to ask the people from the public sector for the exact number and the details.

CHAIR: We have different evidence and opinions from people about the impact that private health insurance, particularly the 30 per cent rebate, has had on funding of public dental services. Do you have a comment to make on that?

Dr HUTCHINSON: In our submission we stated that we believe the Federal Government's 30 per cent rebate to private health insurance is not only an inequitable way of funding dental care to the community, but also a financially inefficient way. The college has not undertaken any of its own research on these issues because it is not within the college's purview. I am sure other people have referred to the health economists who have done that. We have merely read the statements made by those people and drawn our opinions from that. It is not a State Government issue despite the fact that we have been asked to comment on it. Our opinion is it would be a far better use of those funds if the money directed towards the 30 per cent rebate was taken from the rebate and directly injected into dental care in New South Wales. New South Wales' portion of those funds could be used to fund dental care directly. It is interesting to note historically that the original Federal Senate committee report that looked at the 30 per cent rebate and recommended it for private health insurance specifically stated that the rebate should not apply to ancillary services. Unfortunately, political opinion lay elsewhere and eventually it was applied to ancillary services as well.

The Hon. ROBYN PARKER: Can I clarify your comments? When you say applied directly to dental care do you mean bypassing the State Government's role? The State Government distributes dental resources at the moment.

Dr HUTCHINSON: When I say directly to dental care the point I am trying to make is that the college would not like to see the 30 per cent rebate removed from ancillaries and therefore removed from the pool of funds that helps fund some dental care and disappear into general revenue. The college is not proposing at this stage a model of how the funds should be redirected. I mean it is important the funds are redirected in some way into dental care because they are so badly needed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean the college would be happy, if you like, to see the money taken from that area provided it all went into dental services; in other words, into the pockets of dentists?

Dr HUTCHINSON: Not necessarily into the pockets of dentists, if you are talking about private practitioner dentists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Any dentists.

Dr HUTCHINSON: Any area of dental care, not dentists, but also dental hygienists—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As long as it went to the cause.

Dr HUTCHINSON: Yes, to the cause. We would like to see that money go into improving the dental health of the population of New South Wales.

CHAIR: That would be public dental services. Arthur talked about the pockets of dentists, which is an implication of private service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That was not what I meant.

CHAIR: You are basically saying the college's view is the money would be better directed to public dental services, whatever model of funding is required.

Dr HUTCHINSON: Yes, whatever model; even if we do not particularly agree with the model that eventually occurs it would be better than the existing situation.

CHAIR: We know that in the past people in the dental workforce in general were not keen on Medicare being extended to cover oral health services. Does the college have a view on that? Has opinion among dentists changed?

Dr HUTCHINSON: The general opinion amongst dentists is that experience has shown, particularly in Britain, that it is difficult to provide high-quality dental care within a Medicare-type program because of the way it tends to be focused. Dental consumers are not always well served by those programs. This is where dentists' concerns come in and also the college's concerns. The college would be quite happy to see a well-funded preventive program involved with Medicare. The problem with having a universal program for dental care under the purview of Medicare is that the financial aspects can become quite onerous. Dentistry is effectively a preventable disease for most people, and I am sure many other witnesses have made this point. Apart from people who are very medically compromised or have severe disabilities, dental disease is preventable.

The college's concern is that funding should be predominantly directed towards broad-based and effective dental programs. Again, if you look at the way the national health model in Britain was structured and the models they used, you see that the focus was on fillings because it is easy to audit fillings. It is difficult to audit half an hour spent discussing diet or oral hygiene with a patient. Therefore, the college is concerned the Medicare model would become focused on fillings and dentists would be more or less pushed towards providing a filling in order to support the overheads of their practice when in fact a better model would take into account a lot of time spent discussing diet, hygiene, fluoride, fluoride toothpaste, tooth mousse, and all those sorts of things. This is why the college also supports the use of dental hygienists in dentistry and the training of more dental hygienists. It is a difficult question to answer yes or no to.

CHAIR: I guess that a lot of medical practitioners would make exactly the same comment about the distortionary effects of Medicare. It is an awful lot easier to count pills prescribed than doctors discussing all kinds of issues with their clients.

Dr HUTCHINSON: I think even more so in dentistry, when it is so easy to count fillings placed as compared with ongoing treatments with patients to ensure that their dental health is optimal.

The Hon. IAN WEST: Are you saying that from an actuarial point of view it would be more cost-effective to knock out all a person's teeth at age 20 and put in dentures?

Dr HUTCHINSON: It probably would; I do not know. Perhaps we should not say that. It is certainly not a position that the college would promote at all. It is hard to say whether it would be cost-effective. I am not someone who could comment on that. It possibly might not be because losing your dentition changes your diet and this impacts on your general health. I do not know; I am not an actuary. I am sorry, as a dentist that is something we would not even dream of. That question came a little out of left field, I am afraid.

If I could go back to actuarial matters on dentistry and something that I am probably a lot more confident and happy about commenting on: prevention. I cannot focus enough on the aspects of prevention. It is a preventable disease. Dentistry is very affordable if it is treated in a preventable manner. I will give an example. If parliamentarians can talk about personal experiences, I will briefly talk about my own personal experience. Until the age of 17 I had two adult teeth extracted through decay at the age of nine and a further two extracted at the age of 15. By the age of 17, I had 17 filled teeth. Since 1974 I have had no new decay—none at all. I have had this conversation with my patients and I say to them, "What do you think happened in 1974?" The answer I invariably get is that fluoride was put in the water, which is not correct and is not logical because it does not explain why my incidence of decay changed and theirs did not.

What happened in 1974 was that I entered the faculty of dentistry and the first thing I was taught in those days was how to look after my own teeth. I altered my diet and I altered my oral hygiene and from being someone who would have been considered a high decay risk and a poor dental patient with poor oral hygiene, poor dental care and a poor dental outcome, in the last 32 years I have become somebody who has had absolutely no dental decay whatsoever. I think that shows what a preventable disease it is and how it can be turned around. To give another personal example, my children's dental bills, if they did pay them—and obviously they do not; I have two children—would be less than $1 a day per child, which I think anyone would admit is not expensive, because they have no decay. I could fund their dental bills easily from the money I save because they do not drink soft drink.

This is the important thing and the thing that the college really wants to emphasise: It is a preventable disease and it is a preventable cause of a lot of morbidity within the community. I know that Dr Taylor was here some months ago discussing the link between periodontal disease and heart disease. It is becoming more and more obvious how important these issues are. I am sure that Dr Howe would like to comment on neonatal health and dental disease.

CHAIR: Is this a good time for you to make that comment, given your expertise?

Dr HOWE: Yes. There is quite a bit of research being done into gum disease. Dr Taylor would have told you about gum disease and coronary artery disease. There are projects now coming to the conclusion that having gum disease during pregnancy is the same as smoking during pregnancy: the effect on low birth weight is exactly the same. I do not know whether you have been informed about low birth weight—

CHAIR: Professor Spencer said a little about it this morning but he did not go into any detail. He mentioned it as one example.

Dr HOWE: If you are born with a low birth weight you are behind the eight ball for the rest of your life. You have poor health outcomes, you have poor educational outcomes and you have poor job outcomes. So you will be put into a lower socioeconomic group purely because either your mother smoked or had gum disease during pregnancy. There are pilot projects being done now that have taken groups of women with gum disease, instituted oral hygiene techniques and that has returned them almost to the control group as far as the birth weight of their children. So we can see that it would save the community a lot of money if we could institute these preventive programs. These are not high-skill preventive programs that dentists need to be involved in; these are ones that dental therapists can put in place. So they are not expensive programs. The dentists certainly need to diagnose and oversee them but they are not complex programs. Certainly education in the community as far as oral hygiene

and gum disease would go a long way, as Professor Spencer would have pointed out, to preventing this disease.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the gum disease a proxy for smoking?

Dr HOWE: No, it has been correct for smoking. Although smoking does cause gum disease, the surveys that have been done have been corrected for smoking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, in other words, a non-smoking person with gum disease has just as bad an outcome in terms of the birth weight of their baby as a smoker.

Dr HOWE: Correct. They believe that is because of the infective products going through the mother's blood supply during pregnancy.

The Hon. ROBYN PARKER: As a non-clinician, can I clarify: Is a pregnant woman's poor oral health caused because they have poor oral health and get gum disease because of it or because hormonal changes are causing gum disease?

Dr HOWE: No, it is different. There is such a thing as pregnancy gingivitis. That is caused by a change in hormones, which makes women's gums bleed and produces gum disease that clears up at the end of pregnancy. This is women who have had gum disease before pregnancy and who have had gum disease throughout their pregnancy as well. These are women who basically have not been instructed in oral hygiene and have not had their teeth cleaned professionally going into pregnancy.

The Hon. ROBYN PARKER: Is there a push from obstetricians that dental hygiene should be part of the care of a pregnant woman?

Dr HOWE: These results have certainly been published in journals of obstetrics. However, I think there is so much going on at that time. I am sure that obstetricians do suggest that women have dental appointments and check-ups, most would say prior to pregnancy. But I think 60 per cent of pregnancies are unplanned so that certainly takes away from that situation. I am sure that there is a drive but it needs more community awareness of the link between gum disease and low birth weight.

The Hon. ROBYN PARKER: Do you mean some sort of campaign like the one for folate?

Dr HOWE: Exactly, like folate or Slip, Slop, Slap—any of the preventive programs that are run widely. If the community is informed it saves the problem of the obstetrician having to get their message across.

Dr HUTCHINSON: If you look at our submission you will see that we comment in there that we feel that more of the opportunities should be taken to bring preventive dental care to the awareness of people. For example, if we are looking at the very beginnings of life, every woman with a young baby attends a baby health centre yet we still have a situation where I think the major cause of general anaesthetic for the under-fours is dental decay. This is usually caused by putting the baby to bed with a bottle, putting honey on a dummy or something like that, and it is such a simple thing to stop that. The college feels that we really need to make the most of the opportunities that we have to educate people at a grassroots level.

CHAIR: We have questions further down about work force issues and the difficulty of recruiting people from rural areas and so on and also areas of socioeconomic disadvantage. It is obviously relevant to what we are talking about at the moment because the conditions you are talking about are much more prevalent in certain parts of the community, which tend to be the parts of the community that are less well served by the dental work force but also perhaps harder to reach through education campaigns and so on. Does the college have any strategies in mind or any ideas about how to address these issues?

Dr HUTCHINSON: The college currently is not involved in any programs itself because that is not our area.

CHAIR: What do you think, as representatives of the college, experts and people who have thought about these issues?

Dr HUTCHINSON: The college would like to see a lot more funding going into extensive public awareness programs, as Dr Howe said, like the Slip, Slop, Slap or the anti-smoking campaigns—the advertising that we see on television. As you said, a lot of these groups are difficult to communicate with but certainly if you did something along those lines it would go some way towards addressing some of these problems and bringing the awareness to people that dentistry is a preventable disease. After 25 years of practice, I am still astounded by how many people come to see me and do not realise that their dental disease can be prevented. They think it is something that is inevitable—that they will inevitably lose their teeth. As I said, the college really believes that a major preventive program like the anti-smoking program, the Slip, Slap, Slap or the Life Be In It campaign needs to have a lot more government funding. I know there are also areas that we have to look at within this Committee regarding the huge problems with dental disease that is already in the community. But if we do not address the preventive aspect we will be constantly chasing our tails with this issue. The preventive is the basis of the whole thing, and it really is so simple.

CHAIR: More specifically—and returning to your submission—how useful is the Oral Health Fee for Service Scheme? Can you expand a little on the college's support for a co-payment structure?

Dr HUTCHINSON: I think the college is in agreement with just about everybody else you have probably spoken to that the Oral Health Fee for Service Scheme is not efficient at all. It is not an effective use of funds. It serves nobody: it does not serve the dentists who are involved in it and it certainly does not serve the consumers of dental care who are trying to access dental care through it. The college supports a co-payment structure for the Oral Health Fee for Service Scheme if it does continue. Having said that, the preferred college model would be to redirect most funding into the public dental sector into dental clinics if possible. Where this is not possible, if the Oral Health Fee for Service Scheme is to continue, certainly the college supports an uncapped co-payment structure.

The reason the college is very specific about the co-payment being uncapped is that our Fellows tend to have higher cost overheads in their practices than the average dentist. Because of that, they obviously charge higher fees than the average dentist. Our opinion is that someone who is a consumer of dental services—be they privately or through a government-funded scheme—should be allowed to make the choice as to whether they want top-quality care or average care. As I have said before, we represent the top of the dental community. Patients should not be forced into a "beggars can't be choosers" situation, where they can only access care through the dentists who are able to provide care at a low fee cost. They should, if they wish, be entitled to access top-quality care from a dentist who is a fellow of the college and who spends a lot of time on continuing education and who has dedicated their practice to being a top-quality, high-service provider as long as the person is willing to make the gap payment that is required in order to achieve that dental care.

CHAIR: That would mean removing the means test, logically.

Dr HUTCHINSON: No, you misunderstand what I am saying.

CHAIR: From the fee for service scheme.

Dr HOWE: No. My point is about someone who is eligible for the fee for service scheme at the moment. For example, I work in Liverpool. I think there is one dentist in Liverpool who participates in that scheme out of approximately 25 or 30.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that most BDS dentists and, presumably, dental therapists do not do more training with you guys after they graduate?

Dr HUTCHINSON: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are representing a subset of dentists, which is the specialist sector, who do your training program?

CHAIR: Ms Hutchinson gave us those figures at the beginning. I think you said you represent 10 per cent of the dentists, but you represent a much larger percentage of specialists.

Dr HUTCHINSON: Also, there are many general practitioners who are Fellows of the college. I am a general practitioner.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of dentists who are practising, BDS-type dentists or dentists as in people who fill teeth as opposed to dental therapists who, presumably, do their own schemes, but of the dentists you are charging a premium for the people who are members of your college, is that right? What percentage is that?

Dr HUTCHINSON: I do not think I understand the question. You said we are charging a premium?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think you said that you were charging a premium, did you not?

CHAIR: No, the suggestion is that the co-payment be uncapped because people should have the right to choose a higher level of service based on expectations that people with higher qualifications are able to provide. Where so often a co-payment is capped, the suggestion is that it be uncapped.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are looking for a differential rebate? For example, if a specialist took out your appendix the specialist got more money than if a general practitioner took out your appendix.

Dr HUTCHINSON: I was coming to that later. The college also would suggest that there be a differential rebate. People, for example, who are Fellows of the college, who have made a commitment to a large load of compulsory continuing education have that recognised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But is there not an ongoing training requirement, such as in medicine, to remain registered, getting so many brownie points a year?

Dr HUTCHINSON: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No brownie points a year scheme?

Dr HUTCHINSON: No. There is in the college. You must maintain—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But not in dental registration?

Dr HUTCHINSON: No. Perhaps you need to talk to the President of the Dental Board, but I am almost certain I am on firm ground with that one.

Dr HOWE: Could I make one correction? Therapists are not in private practice. They are in the public system only. When you were commenting before about dentists and therapists, therapists are employed only in the public system. Perhaps you meant hygienists, who are employed in the private system but employed by a dentist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I meant non-dentists in the sense of BDS-based degree dentists who, presumably, have a different training program and different accreditation programs. Obviously, the college is not involved in those?

Dr HOWE: No.

CHAIR: The issues facing the dental work force, obviously in general your expertise lies more with dentists as such and whether they are the same type or what extent to which they vary for people in the private and public sectors.

Dr HUTCHINSON: Obviously, there are quite different issues for dentists in the private and public sectors. As I wrote in my submission, there is a relatively oversupply of dentists in the private sector, particularly in Sydney, yet there is a huge undersupply of dentists in the public sector and also in rural areas. The issues that face the dental work force are quite different from that point of view. One of the main issues that faces private dentists in Sydney is the inability to access dental hygienists. Because we traditionally have not had a training program for dental hygienists in New South Wales there is a huge shortage of them. For example, I probably would spend half to 60 per cent of my clinical time doing work that could be done by a dental hygienist, but I cannot obtain the services of a dental hygienist to do that work because they are just not available.

CHAIR: Is that related to the fact that your practice is in Liverpool?

Dr HUTCHINSON: Yes, that is part of it.

CHAIR: Would you find it easier if you were in the eastern suburbs or on the North Shore?

Dr HUTCHINSON: Yes, I would find it a lot easier in the eastern suburbs or on the North Shore. In the eastern suburbs or on the North Shore I probably would have a hygienist. Part of that is Liverpool, but if there were enough around I am sure that I could access one in Liverpool as well, which would free up my time to do more complex dental procedures, which I am trained to do.

CHAIR: Are there any other comments from either of you on the other issues facing dentists?

Dr HUTCHINSON: If we are looking at the public sector, obviously we talked earlier about health funds and the impact of health funds, and I think that other people have commented that the private health insurance clinics have caused problems for the public sector because there is a pool of dentists who do not wish to work in private practice. Previously they worked in the public sector, but now the pay and conditions in the private health insurance clinics are much better than those offered by the public sector. It is no surprise that young graduates and senior dentists would prefer to work for private health insurance clinics.

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

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

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

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

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

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

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

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

CHAIR: We can take this up with our next lot of witnesses.

Dr HUTCHINSON: They may not want to. I was more or less specifically asked if I could make that comment but not state names because they work within the system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We understand about that.

CHAIR: You have said a bit about encouraging dentists to work in the rural areas and public dentistry in general. So far you have stressed income. You also have talked about poor morale. Are there other areas that you would recommend that specifically need addressing?

Dr HUTCHINSON: The other thing that the dentists complain about is that they lose their skills if they stay within the public sector for too long. Because there are such limited types of procedures that are performed dentists are concerned that if they stay within that sector for too long they will not have those skills if they decide to go out into private practice later on. I am sure many of your other witnesses have talked about extractions rather than root canal treatments and that sort of problem. There is not a lot of job satisfaction for dentists in the public sector when they are not able to use their skills fully.

CHAIR: Would there be more variety of practice in rural and regional areas because of the difficulty of clients going elsewhere?

Dr HOWE: Overall, this is anecdotal, there is some dissatisfaction also with rural regions simply because the dental consumer in the rule region is not as aware of health initiatives and of treatments available. They are not as motivated towards having what dentists find the more interesting treatments performed. I have been told that there is some dissatisfaction. That is one aspect of rural practice that people are dissatisfied with.

CHAIR: People expect a filling or an extraction and that is it?

Dr HUTCHINSON: Yes. They are less inclined to have something interesting like a root canal treatment or an implant placed.

CHAIR: Having had a root canal treatment I am not sure that I would describe it as interesting, but if you are a dentist you might.

Dr HUTCHINSON: It depends on whether you are on the pointy or the blunt end of the file, I suspect.

CHAIR: It is easy enough in theory to work out ways to address the income and morale problems, but how would one address the concern about loss of skills—by a rotation?

Dr HUTCHINSON: Yes, the college support an intern system for newly graduated dentists and also a system of specialist training, which is a similar model to the medical specialist training. You would have dentists who went in as registrars and could then rotate through the country dental clinics and then they could be mentors for the interns, newly graduated dentists who could also rotate through the country areas. This would be one way of addressing manpower issues within the public sector and the rural community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this a model in other countries or other training systems within dentistry? We cannot be Robinson Crusoe here.

Dr HUTCHINSON: I think that Canada is doing something similar.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The United Kingdom has dental registrars in hospitals, does it not? Are they not based on medical model? I had a flatmate once who was.

Dr HOWE: Yes, they tend to be the ones that are going along a surgical pathway.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Oral surgery?

Dr HOWE: Oral surgery pathway registrars. I do not believe there is any system after graduation where you need to become an intern. However, I believe the Australian Dental Association also supports having an intern system for dentists. There is quite a lot of goodwill towards that system in the dental community, it is just that the funds to support that system do not seem to be available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But in the United Kingdom people start and do a couple of years in that scheme and then go back into general practice, so there is a pathway to specialist, but they have extra expertise and they then do work that is more than the average dentist does.

Dr HOWE: That would be similar to our college. That would be the Licensed Dental Surgeons. The college in the United Kingdom runs a very similar program to that where they are interned in the hospital, then they receive the Fellowship and then pass into general practice. I think that is the system you are talking about there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps an academic person could tell us about the different schemes that are possible.

CHAIR: The Secretariat can follow that up.

Dr HUTCHINSON: It is not something we can really answer. We might mislead you if we were to try to answer that.

CHAIR: A number of people have talked to us about the increasing specialisation and increasing breakdown in different areas of the dental work force. Do you have a view about that?

Dr HUTCHINSON: Are you talking about specialist dentists, or—?

CHAIR: No, dentists, hygienist and therapists and the different roles they play.

Dr HUTCHINSON: Firstly, the college feels that dental therapists are an unnecessary duplication of skills. All of the procedures that are provided by therapists can be provided by dentists and are provided, in our personal opinion, more effectively by dentists. If we are looking at the particular groups that we are talking about here, people who generally are eligible for public dentistry often have many other health problems as well. Again, they are more inclined to have more complex dental problems and drug—pharmacy medication—problems that need to be addressed. We believe that the best person to treat dental disease is a dentist. But the best person to prevent dental disease is a well-trained dental hygienist. The college encourages the training of more dental hygienists in the community so that we can improve preventive care within the community. We really do not need to train more people to treat a preventable disease. We need to train more people to prevent the preventable disease. It really is financially inconsistent to train more people to treat preventable disease.

CHAIR: What about the service in schools? Who should cover that, or would you change the way that operates?

Dr HUTCHINSON: Yes, we would prefer to see a model where dentists supported by dental hygienists worked in our school dental clinics. The dentist would be involved in any complex treatment that is required. The dental hygienist could do the cleaning and the preventive treatment, the sorts of treatments that are beneficial to children.

CHAIR: Would you continue the technicians? Is there still a need for technicians?

Dr HUTCHINSON: Yes, there is still a need for dental technicians.

CHAIR: And nurses as a separate part again?

Dr HUTCHINSON: Dental nurses are a terribly underappreciated sector of the dental work force community. A well-trained, experienced dental nurse can be a huge bonus to a dental practice. If their communication skills are good they can be as beneficial as a hygienist in improving preventive dentistry and preventive dental outcomes for people. Unfortunately, they are very underappreciated within the dental work force community. I think there is a strong argument for a more structured training program for dental nurses and dental assistance.

CHAIR: So you support specialising, but would also emphasise a team approach?

Dr HUTCHINSON: Absolutely. With modern dentistry, it is the only rational approach that will give the outcomes we want at a cost-effective price.

CHAIR: Is the pay of those people sufficient to attract enough people to be trained, and to work in and stay in the dental work force?

Dr HUTCHINSON: The aware rate for dental nurses is probably too low to encourage people to stay in the work force. Again, if I could give a personal example: my dental nurses have been with me for 20, 19 and 17 years, and the newest one has been with me for five or six years. But we pay well above the award rate, because we realise the importance of having those experienced dental nurses.

CHAIR: You said it was almost impossible for your practice to get a hygienist. Would higher pay rates do that, or is there just an absolute shortage of hygienists?

Dr HUTCHINSON: Hygienists are probably paid at a rate higher than the average dentist. It is a question of supply and demand, of the capital system. Hygienists are in such short supply that they are paid extremely well. That is why there are probably very few in the public sector; they are paid very well in the private sector. I could not afford to pay them any more than they are asking now.

CHAIR: What would you both like to see come out of our inquiry?

Dr HUTCHINSON: The main thing we would like to see come from this inquiry is a major—and I mean major—saturation, publicly funded preventive dentistry program, like anti-tobacco programs, like Slip, Slop, Slap, like Life Be In It. that is because if you look at dentistry and the evidence coming out about the inter-reaction between poor dental health and peridontal disease and heart disease and these sorts of issues, there is absolutely no logical reason why we should not be promoting preventive dentistry. We could probably get improvements in dental health similar to improvements in outcomes we have been getting with these other programs. So the main outcome we would like from this inquiry would be a major publicly funded preventative dentistry program, to raise awareness of the community to the modern aspects of dentistry, preventive dentistry; to the fact that dental disease is preventable, and is easily preventable—that it is not an inevitability that you will get decay, and that you should not get decay. People just are not aware of that. I do not believe the average person is aware of it. They are not aware of how to stop dental decay.

CHAIR: Such a campaign would need to run for years and years, as well as being very high impact in the short term. It would probably need to be like the campaigns you compared it to and go on for many years.

Dr HUTCHINSON: We do not have a problem with that. We would like to see that. It would need to be ongoing, particularly with our migrant populations. It could not be run for just a year, because many in the migrant communities coming in have virtually no knowledge of modern dentistry, and they would need to be targeted for preventive dentistry education. In addition, we would like more funding for public dentistry, particularly directed towards public dental clinics. We would like to see all water supplies fluoridated. We would like to see more use of contacts with pregnant

women and new mothers, to raise awareness of the preventive aspects of dentistry through prenatal clinics and baby health centres.

CHAIR: And home visiting and the other programs that exist.

Dr HUTCHINSON: All of those initiatives, and in some way incorporate preventive dentistry into that. As well as other aspects, such as measuring the head circumference, let us get the preventive dentistry message in there as well. Obviously, if the oral health fee for service program continues, the college would like to see an uncapped payment to allow clients of the oral health fee for service program to access the dentist of their choice, and not be forced to access one dentist out of 50 because they are the only ones willing to participate in the program.

CHAIR: But you would actually rather scrap the scheme, from what you said earlier?

Dr HUTCHINSON: Yes. We believe it would be better, where possible, to direct the funds into Westmead Hospital, Sydney Dental Hospital and public dental clinics, because that would have a beneficial effect on the teaching aspects for dental students and specialists. It would allow more control of what occurs. However, we are aware that there are times when that may not work, particularly in isolated rural areas that do not have a dental clinic. So there may need to be some other system used. Obviously, the college also would like to have differential rebates for people, such as fellows of college, who have undertaken further education and commit to continuing education.

CHAIR: Would you actually rather get rid of the Commonwealth's 30 per cent rebate scheme altogether, and replace it, as you said before?

Dr HUTCHINSON: Yes. We feel that is an inequitable way of funding dentistry, and that the money would be better spent if directed to funding of public dental care. It is also an inefficient way of funding dentistry when you consider that a lot of that money goes into advertising private health insurance and overheads for private health insurance, and not going directly into dentistry. Every time I turn the television on there is an advertisement for a private health insurance company. I do not see the rationale for putting government funding into a situation like that, when it could be going towards improving people's dental health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously, it would need to go beyond Westmead and the dental hospital.

Dr HUTCHINSON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would need clinics far more widely distributed, presumably training registrars as well.

Dr HUTCHINSON: There are clinics in most larger country towns. There is a clinic in the outer suburban areas; there are clinics in Liverpool, Fairfield and Bankstown. When I graduated 25 years ago there was what was called the trains, and new graduates went out on the trains. Many of them had a ball going out on the trains.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean dental trains?

Dr HUTCHINSON: Yes, dental trains. I think Dr Howe, who spent some time in the country, would know a little bit about dental trains.

Dr HOWE: Yes. A train set up with a dental surgery would be shunted off to a siding, and the dentists would spend a month in that country town on the train. Then the train would be hooked up, and go off to another centre.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They have now been abolished, have they?

Dr HOWE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: New Zealand has semitrailers that take surgery to the country.

Dr HOWE: New South Wales had a similar system. We had mobile caravans, but they were abolished maybe five or six years ago.

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

Dr HOWE: I think the problem basically was infection control.

Dr HUTCHINSON: Probably funding.

Dr HOWE: Funding and infection control, because they were run by dental therapists; it was a one-person show, and it was difficult to run the show.

Dr HUTCHINSON: If you are going to continue to do it, it needs to be funded and managed properly.

CHAIR: Dr Howe, did you have other things to add to the wish list?

Dr HOWE: No. We have worked on the wish list together.

Dr HUTCHINSON: Actually, I had not finished the wish list.

CHAIR: Keep going.

Dr HUTCHINSON: The wish list also includes that there should be instituted a system of specialist traineeships which matches the medical model, and also that the pay rates of dental specialists within the public sector should be linked to the pay rates of medical specialists within the public sector. I think that would go a long way towards encouraging dental specialists to work within the public sector. I think that is the end of my wish list.

CHAIR: You have not costed your wish list, I assume.

Dr HUTCHINSON: No. That is not for the college; that is for Parliament or somebody else to cost, I suppose.

CHAIR: Somebody else, yes. I thank you very much for coming and for being so creative and frank in expressing your views and the views of the college. It has been very useful. Thank you for your submission as well. I do not think there is anything we need to get back to you about, but if there is something that is not clear or on which we want a bit more detail, the Committee staff may give you a call.

Dr HUTCHINSON: I would be more than happy to answer any other questions.

(The witnesses withdrew.)

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

FREDRICK ALLAN CLIVE WRIGHT, Chief Dental Officer, NSW Health, North Sydney, Darcy and Institute Streets, Westmead, sworn and examined, and

DENISE MARGARET ROBINSON, Chief Health Officer, NSW Health, 73 Miller Street, North Sydney, affirmed and examined:

Mr CLOUT: I chair the northern New South Wales Oral Health Network, and I am a member of the New South Wales Rural Health Priority Task Force.

CHAIR: We have given you a lot of questions. Did you want to say anything by way of an opening statement, before we go into those questions?

Dr ROBINSON: Thank you, but I did not want to make an opening statement. However, I wanted to tender my apologies for the delay in providing our submission. I am aware that at our last meeting I gave certain undertakings that I was not able to adhere to, so my sincere apologies for that. We would be delighted to answer your questions.

CHAIR: The first is more of a factual question about the detail of the New South Wales Oral Health Promotion Framework for Action 2010 and the Aboriginal and Torres Straight Islander Plan, and how they are being implemented, and can we please have copies?

Dr CLIVE WRIGHT: The strategic oral health promotion framework was developed over a period of time, and it looks at health promotion up until 2010. It has been incorporated into the New South Wales oral health strategic plan itself. The overall strategic plan is not completed yet; it is with the department. So I am trying to dissect out the oral health promotion component for you. It sets priorities which include increasing fluoridation, increasing oral health and primary health care; increasing awareness in the population and community of the importance of oral health; strengthening the co-ordination, training and information services for oral health promotion; increasing partnerships with appropriate stakeholders; and a component of improving access to services.

The Aboriginal and Torres Strait Islander oral health promotion plan again is not completed in its entirely with respect to consultation. We have got a plan, the principles of which have been adopted and incorporated into other plans that we have been working on, but we are in the process of appointing an Aboriginal health project manager, who will be responsible for conducting the consultation processes with Aboriginal medical services and the Aboriginal community. In terms of copies, I have certainly got some elements of the health promotion program in response to question 2, which I can make available to you.

CHAIR: We are conscious that the Legislative Council has given us a reporting date of 31 March. We are anxious to get anything we can. If it is possible, we may be able to get advanced copies of material, if it is close to publication, for instance. The Committee staff can talk to you later about the supply of documents.

Dr CLIVE WRIGHT: Yes.

CHAIR: Presumably implementation plans are built into the documents you are talking about?

Dr CLIVE WRIGHT: No. It is a phased thing. The implementation has, in fact, been linked into the National Oral Health Program. What we have been doing is work with members of the co-ordinating group of the National Oral Health Action Plan. At our strategic meetings we have had Dr Martin Doolan participate in them, so we get feedback to ensure that we have got common linkages between programs. For example, if I go through some of the clauses within the document called "Healthy Mouths Healthy Lives" and then look at our framework of action, you can see the relationships between what we are doing and what the national action plan is. If I just take two or three and perhaps give these as examples?

CHAIR: Yes, please do.

Dr CLIVE WRIGHT: In the national action plan it says, for example, in clause 1.1: "Consider oral health as being integral to general health in the development of health policy and the health reform agenda." In our framework of action we have got a parallel in a whole series of our health promotion clauses, which, in summary, say: "Develop appropriate partnerships and integrate oral health issues into appropriate statewide policies and programs." We have discussions within those linkages now. For example, in terms of the blue book, which is the document that will go out to all new mothers, health professionals, we have discussions related to the oral health component within that document. So we are making those linkages that way. Another example related to it is: "Building community and health work force capacity and oral health promotion by collaboration of the oral health sector with policymakers and health community services and education, other human service providers and their associations, teachers organisations", and so forth. That is in the national program.

We have within our action framework a similar objective: "To build the capacity of general health care providers to improve knowledge and links between oral health and general health, identification of oral health conditions and pathways of referral with oral health staff and improving oral health promotion skills across the board." Another example would be water fluoridation where our two action plans align. In the national plan it says: "Extend fluoridation of public water supplies to communities across Australia with populations 1,000 or more." We have an identical objective in our program and we do have processes in place that are actually promoting that.

CHAIR: Does that have a time frame on it?

Dr CLIVE WRIGHT: There are no specific time frames in terms of where do you want an outcome. As we heard from the previous witnesses, we would like to see all of New South Wales fluoridated by 2015 or 2010. But we do have a plan that we work on with the area health services through what we call our Teeth for Health Program and we have a schedule, depending on the contacts and local government agencies under the leadership of the area health services.

The Hon. ROBYN PARKER: The forward plans are interesting. Would you respond to comments by previous witnesses today that in terms of New South Wales health priorities for dental care and current programs, per capita New South Wales is not pulling its weight in dental health funding? We have also heard stories that the dental health hospital is not being provided with supplies from medical supply companies because its bills are not being paid. Surely that shows a lack of priority and that you have not got it right to begin with, before you start looking at forward planning and other initiatives.

Dr CLIVE WRIGHT: I cannot comment on either of those two issues.

Mr CLOUT: I am happy to comment on both of those. I am not sure that I have got a definitive answer in relation to Westmead Dental School, because it is not in my area. In terms of having the funding that is there being used and being available for those services, there are clear guidelines and criteria for area health services in relation to the payment of bills. Creditors have to be paid within 45 days. There is no question that there have been some isolated examples that, I think, are quite well known in one area health service where that has been problematic but, I understand, has now been addressed. Certainly in my area health service—and I see the reports for the rest of New South Wales being a chief executive officer—that is not an issue in relation to the provision of health services, particularly for dental services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With respect, you are up the North Coast and you are telling us there is not a problem about the bills at Westmead Dental Hospital. Surely that is waffle.

CHAIR: Mr Clout listed a couple of other hats he wears when he described himself originally.

Mr CLOUT: I am in Hunter New England Health and I am aware of the financial position and the creditor position for all area health services in New South Wales. It is not waffle. There are

criteria to be met and they are met in almost every case. I have made it very clear that there have been some examples where there has been difficulty, but to my knowledge that has not been the case for Westmead and has not been the case for the dental school at Westmead. As I indicated, you would have to ask the chief executive officer of Westmead in relation to definitive issues. In relation to my area health service, which is Hunter New England, we meet our creditor bills—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the dental hospital pay its bills? Have supplies been provided? Are services not being delivered because those bills are not being paid? That is the evidence we have heard. I put it to you that you cannot answer those questions.

CHAIR: Perhaps the question could be taken on notice, Dr Robinson?

Dr ROBINSON: In relation to the specifics, I can simply say that this issue has not been brought to my attention. We have not received complaints at the department level that I am aware of in respect of this matter. This is the first time this has been brought to my attention. I am not an expert in that area. We are all aware of the department's policy with respect to creditors. As I say, I do not have the specifics. I will take that on notice, but it is not my area that I can respond to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask Dr Wright if he is aware.

CHAIR: The Hon. Dr Arthur Chesterfield-Evans, can we please have some order? The Hon. Robyn Parker asked the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was continuing that line of questioning.

CHAIR: Do not interrupt the witness. I am not sure whether the witness had finished answering the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He certainly had not. Nor is he likely to.

CHAIR: Had you finished your answer, Mr Clout?

Mr CLOUT: The second part of the question related to priority. From my perspective, there is always attention between all of the services for which there is a requirement to provide services, and oral health services have to compete with all of those. One can argue about whether or not it should have a higher priority or not. I think there has been a significant increase in the priority that oral health services have been given. I think that is particularly true in the rural areas. The question begs the next question of whether or not that has had an effect in terms of bridging the gap between the demand for those services and the capacity to provide those. That, I think, is a much more difficult question and one that my personal view would be that we probably have not broken the back of that one and we have got a long way to go. I do not think there would be much argument about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Wright, are you aware whether or not those bills were paid?

CHAIR: The Hon. Dr Arthur Chesterfield-Evans, the question has been taken on notice. We will get an answer to the question on notice. Has the review of the Oral Health Fee for Service Scheme been completed? If so, what was the outcome?

Mr CLOUT: It is still in the process, Madam Chair. It was commissioned, if you like, in October of last year with the following terms of reference: to review the policy directive on the oral health fee for service scheme—that is, PD2005_603; to benchmark against best practice and other jurisdictions—that would include the Department of Veteran Affairs scheme, which is a Commonwealth scheme; to look at alternative models of care for fee-for-service delivery; and to look at the fee-for-service pay rates. The membership of the group is from a broad background. It includes the Australian Dental Association, New South Wales branch, the Australian Dental Prosthetists Association, the area health service representation and community representations through the New South Wales Council of Social Services.

CHAIR: Do you have any idea when it is likely to be completed?

Mr CLOUT: We hope to have it completed by April of this year. We have had three meetings so far and we are moving towards final documentation that we can present to the department. But clearly, even in the presentation of the documentation to the department, it will have to go through department processes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Wright, how long have you been in your position?

Dr CLIVE WRIGHT: I have been in my position since the end of July of last year. So I have just celebrated my first six months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who is in the job before you?

Dr CLIVE WRIGHT: There was an acting chief dental officer, Dr Peter Hill.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was he full time?

Dr CLIVE WRIGHT: My understanding is he was full time. I would have to defer to—

Dr ROBINSON: He was full time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who do you report to?

Dr CLIVE WRIGHT: I report to the Chief Health Officer and Deputy Director-General of Population Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are based in Westmead?

Dr CLIVE WRIGHT: Yes, I am based in Westmead.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you staff from head office or from the area health service?

Dr CLIVE WRIGHT: Could you define what you mean?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many staff do you have?

Dr CLIVE WRIGHT: The staff are associated through the area health service. I am not too certain—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they direct reports or are you part of a team at Westmead and more or less a representative of them?

Dr CLIVE WRIGHT: The Centre for Oral Health Strategy is a distinct unit within the Westmead area health service, the Sydney West Area Health Service. We are a discrete unit. I report directly to the Chief Health Officer and I have a team that reports to me, but we are administered through the area health service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How often do you meet with the people from head office?

Dr CLIVE WRIGHT: At least once a week.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you met the Minister for Health?

Dr CLIVE WRIGHT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you liaise with his office as well?

Dr CLIVE WRIGHT: I do on a case-by-case basis when required to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think dentistry has been neglected in the area?

Dr CLIVE WRIGHT: That would be an opinion, sir. I am here—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not to give opinions?

Dr CLIVE WRIGHT: Just to give the facts.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Robinson, we have heard about the lack of infrastructure and teaching facilities at dentistry and how that has flowed on to the work force. Is there a shortage of training facilities in the department and in the university?

Dr ROBINSON: We certainly have substantial work force issues. I think that has already been acknowledged. This is within the public sector and there have been questions that have been asked as to whether or not there is the capacity to increase the work force. That is one of the areas that is being examined currently as part of the review. My knowledge of the infrastructure within the area health services is that this is quite appropriate and that in very few places would it be regarded as inadequate. I believe it is more than adequate in the majority of the area health services. However, there has been some suggestion that there should be an additional focus. I think this proposal has been put forward primarily by the University of Sydney that there should be an additional focus on capital expansion of services within the Westmead campus so that there is a potential then for additional infrastructure support and cohesion in terms of the academic staff from the Faculty of Dentistry. That was an understanding I gained from reading their submission rather than having had a direct conversation with them in terms of that issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there enough infrastructure given that there are fewer staff?

Dr ROBINSON: I believe there is enough infrastructure. The infrastructure that we now have is sufficient for us to train an additional 80 students per annum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In addition to what you have?

Dr ROBINSON: No, at present. Of those, a number obviously are HECS places and a number are privately funded places. However, the infrastructure, teaching and support is adequate to support 80 overall. Obviously, that is a matter of appropriateness as far as the number of students that the university is able to handle now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you were training 125, were you not?

Dr ROBINSON: Again from reading the submissions, my understanding is that in years past — and I believe that means some time ago — the faculties of dentistry were substantially larger. However, I cannot provide the specifics on the numbers or the years in which that was the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will they not need to be expanded to that level again?

Dr ROBINSON: Obviously the number of places at the university is outside my control; it is a matter for the universities and the Commonwealth Government and their negotiations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did the department sell its dentistry faculty building? It did, did it not?

Dr ROBINSON: I have no knowledge of that issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not know that it sold the faculty building?

CHAIR: When did this occur?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not know, but I believe it did. Is that not the case?

CHAIR: You are reading from a list of questions, so I assume you have some answers as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I understood that the faculty building was sold. It is interesting that you say there are facilities to train 80 when there were, some years ago, 125 —

CHAIR: This is an inquiry into the present and the future. I am not sure that questions about what happened before the time of any of our witnesses —

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the faculty building has been sold it will have to be bought back again to train the dentists.

CHAIR: The training of dentists is a matter for the Commonwealth Government and the University of Sydney. You are getting a long way from New South Wales Health. Perhaps we should get back to the questions sent to the department that deal with what is happening now. Comments have been made to the committee about the eligibility criteria in New South Wales for access to public dental services, which obviously varies from State to State. Can you give your view on the current criteria and how well they meet need and so on?

Dr ROBINSON: Certainly, as we have acknowledged in our submission, the criteria in New South Wales are regarded as more generous than in a number of other jurisdictions. Perhaps I can ask Dr Wright to provide an understanding of the situation in the other jurisdictions as well as in our own.

Dr CLIVE WRIGHT: In general terms, approximately 50 per cent of the New South Wales population would be eligible for public dental care. Over all other jurisdictions, about 33 per cent and 38 per cent of their populations are eligible for public dental care.

CHAIR: Is that a figure for the five States combined?

Dr CLIVE WRIGHT: Correct.

CHAIR: Or do they all fall somewhere in between?

Dr CLIVE WRIGHT: They will fall somewhere between that, except for Queensland, which is more closely aligned to New South Wales. They would be looking at a very high proportion, close to 50 per cent or so.

CHAIR: Is there any idea of reviewing those criteria?

Dr ROBINSON: The issue that we are grappling with is the concept that, because of our generosity, we are therefore expending less per head of eligible population. That has been stated in a number of places. It does not accurately reflect the commitment that New South Wales Health has given to the provision of public dental services and the increased amounts of money we have continued to place in the program. As I believe we have mentioned previously, this financial year we are spending $120 million on public dental services, which has increased substantially over time. Therefore, I believe that the Government and the department have fully expressed their commitment to the provision of public dental services.

The Hon. ROBYN PARKER: What percentage of the health budget is that?

Dr ROBINSON: I believe it is just over 1 per cent. If you want an accurate figure I would have to take that on notice. Would you like me to do that?

The Hon. ROBYN PARKER: That would be great.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we not play with statistics here? Can we do it in relation to public dental spending per head of population in New South Wales rather than per eligible person? Of course, that is not a realistic measure, as you are pointing out.

Dr ROBINSON: I suggest that it would be better to compare apples with apples and therefore look at how our performance rated in respect of the criteria that apply in other jurisdictions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We had evidence this morning —

CHAIR: Let the witness finish the sentence, please.

Dr ROBINSON: If we do so in any other way, that is, if we look at the population within New South Wales and the amount of funding, that represents its own distortion. The same applies when we have differential criteria. I do not believe it gives a fair picture of the commitment in New South Wales if we simply say that this is the amount of money and this is the population of New South Wales. It fails to take into account the needs in New South Wales, the provision of private dental services and dental services provided by health insurance funds. Therefore, it does distort the picture.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Spencer gave us evidence this morning that we are spending only 22 per cent of the money spent in Australia on public dental services and the population is far in excess of that. Surely that is comparing apples with apples.

Dr ROBINSON: We are aware that about 85 per cent of current dental services are provided in the private sector, if that is the reference that Dr Spencer was using —

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, he said that if you are spending less on public services per head —

CHAIR: He was comparing New South Wales' expenditure on public dental services. To be precise, he said that it was 22 per cent of the expenditure in Australia, whereas New South Wales' percentage of population of Australia is higher than that. He did not give the figure, but it is roughly one-third.

Dr ROBINSON: Thank you for that clarification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us cut to the chase here: Are you suggesting that the provision of public dental services in New South Wales is adequate?

Dr ROBINSON: I have said that I believe our commitment to the provision of public dental services is strong and that the Government has continued to inject additional funds into the provision of public dental service. It is without doubt that the withdrawal of the Commonwealth funding program did present us with a difficulty. However, we have been progressively moving to provide additional resources and I have no reason to suppose this commitment will not continue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that it is strong. I asked whether it is adequate.

Dr ROBINSON: We are currently providing approximately 1.4 million occasions of services, from memory, and each year we are servicing about 220,000 people.

The Hon. Dr ARTHUR CHSTERFIELD-EVANS: Is this adequate?

Dr ROBINSON: That is individual people. There is a needy group within the community that is using the services and taking them up substantially. We have a strong commitment to these services, particularly the provision of emergency services and the relief of pain and discomfort. We will then direct our attention to those who are eligible but who have somewhat less acute needs. We need to deliver the services within the available budget, and I am not in a position to make any comments in respect of policy in that regard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe the service is adequate, given that you have abolished waiting lists in many areas?

Dr ROBINSON: If you were to look at the consumer satisfaction rating in the Chief Health Officer's report you would find that the people accessing our services are satisfied; indeed, in many cases, very satisfied with the level of services that are being provided.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What about the ones who could not get access?

CHAIR: Given the time, it might be appropriate not to repeatedly ask the same question. Is there an opinion in New South Wales Health or in the Government about the view expressed in a number of submissions that Medicare funding should be widened to cover dental health?

Dr ROBINSON: Obviously that is a policy position that would be considered and taken by the Commonwealth Government. Our Minister has clearly stated in the past that he would like to see the restoration of commonwealth funding for this program, and has made reference in public places to the restoration of the previous program.

CHAIR: To Medicare? We have asked other witnesses a number of questions relating to private health insurance and the 30 per cent rebate, and also their opinion about Medicare being used. I realise that some of these issues are beyond the brief of New South Wales Health.

Dr ROBINSON: I agree; I am not in a position to give an opinion in that respect. However, one of the issues we have been looking at very carefully is the position we can take with respect to the Commonwealth's announcement of extended care programs and eligibility for people to access those programs under Medicare. The announcement indicates that people who have chronic conditions, should they be recognised by their general practitioners as having a link to oral health — and it has been recognised that oral health is part of general health — then there is potential under the Medicare program to access care within the private sector. That is something we will obviously actively encourage for those who are eligible.

CHAIR: I hope you brought the figures with you because it will make it easier. Do you have the figures for last year or this year on the different groups in the dental work force?

Dr ROBINSON: We can provide the figures in respect of the public sector; there must be some assumptions for the private sector. Dr Wright will do that.

CHAIR: Can you give us figures for each area in the public sector?

Dr CLIVE WRIGHT: In July 2005, there were 263.83 FTE dentists in the public sector; dental specialists, 33.31; dental therapists, 167.58; dental hygienists, 0.6; dental prosthetists, 10.8; dental technicians 61.7.

CHAIR: That is in the public sector?

Dr CLIVE WRIGHT: Correct.

CHAIR: Do we have any work force figures for the private sector?

Dr CLIVE WRIGHT: Yes, but we must apply some assumptions to make them comparable, in that the information from the register includes a proportion who might be practising interstate or overseas, or who might be practising part time. We have made an assumption that 75 per

cent of those who are registered are in practice in the State and that 84 per cent of those practising in the work force are in the private sector. That gives us a figure of 2,688 practising dentists in the private sector. We have data on the other groups, again by an assumption, and 10 per cent of practising dentists are specialists; so we are looking at 269.

CHAIR: That is in addition to the —

Dr CLIVE WRIGHT: Yes. There are no dental therapists in the private sector; 96 dental hygienists; 412 dental prosthetists; and 682 dental technicians.

CHAIR: Are the assumptions that you have made soundly based? That sounds a bit insulting, but are there within the industry sound reasons for making those assumptions, such as 84 per cent of the private sector?

Dr CLIVE WRIGHT: We believe so; we believe we can substantiate them.

CHAIR: They would be accepted by other people?

Dr CLIVE WRIGHT: I would hope so. We could definitely argue them strongly.

CHAIR: Thank you for that. That clarifies some things for us.

Dr ROBINSON: I would like to make the comment that assumptions are just that, and if those figures are critical to the analysis by this inquiry, then we obviously would appreciate the opportunity with respect to the private sector—we are confident of the public sector figures—to cross-reference with the ADA and the board so that we are clear. I will take your advice if you would like that to occur or whether you are comfortable with having—

CHAIR: If we are using them, the staff could check on that. I assume that the public sector figures are equivalent full time?

Dr ROBINSON: Yes, they are.

CHAIR: Particularly as you have 0.83 of a dentist. Some of those groups are presumably rising and some are falling. In the public sector we have heard evidence of shortages. The figures you have given us I assume are people, not positions, so there are a number of vacancies in some of those areas.

Dr CLIVE WRIGHT: That is correct, yes.

CHAIR: If, for instance, we wanted to know how many positions there were, we could get those from you?

Dr CLIVE WRIGHT: Yes, and they do vary quite markedly on a monthly basis. We would have to give you a specific time related to the inquiry.

CHAIR: And some area health services have a lot more vacancies than others, particularly in the rural areas.

Dr CLIVE WRIGHT: Correct.

CHAIR: Can you tell us about the dental labour force surveys?

Dr CLIVE WRIGHT: The dental labour force surveys are, in fact, Dental Board of New South Wales registration information so NSW Health does not actually have a role in providing the information. It all comes from the registration boards. What I think the confusion on the web site might be at this stage is that some of the data—and the most recent look that we had was just yesterday to check on this—relates to data being put up in one calendar year but being collected in a previous year so when you are getting confusion between 2002-03, it might well be that the data

relates to registrations with the Dental Board of New South Wales in the previous year. I have no knowledge of why we do not have 2005-05 surveys.

CHAIR: So if we want to follow that up we would need to talk to the Dental Board of New South Wales?

Dr CLIVE WRIGHT: Yes.

CHAIR: These questions are specific and varied because this is our final hearing and we are seeking to clarify matters from previous evidence or submissions. What is the purpose of the oral health work force group? Who is in it and what is it looking at?

Dr ROBINSON: The oral health work force group was formed in 2004 specifically to provide advice to the director general and to the Minister for Health, recognising that work force issues were absolutely critical in the field of oral health and with the move to gain as much broad and expert advice as possible. Dr Wright will actually take you through the terms of reference if that is convenient.

Dr CLIVE WRIGHT: The group was formed in September 2004, which was well before my time. It is there to provide advice to the Director General of NSW Health and the Minister of Health in relationship to five key points: firstly, developing a coherent oral health work force plan which is consistent with the New South Wales health work force action plan and taking into account the work force recommendations of the national oral health plan. That goes back to Healthy Mouths Healthy Lives.

The second point was to review and evaluate existing employment practices relating to recruitment and retention of the New South Wales oral health work force. The third point was to develop and evaluate proposals to address recruitment and retention issues. These would include looking at industrial awards affecting remuneration and working conditions and other employment conditions, incentives and benefits.

The Hon. IAN WEST: Can the terms of reference be tabled?

Dr CLIVE WRIGHT: Consider that done.

Terms of reference tabled.

The Hon. IAN WEST: In question one you talked about Healthy Mouths Healthy Lives, the national plan and the phased monitoring of that report. Can you provide information, either now or on notice, about the evaluation documentation, guidelines for evaluation, the actual delivery of the program that is being phased out until about 2010? At what stages will it be evaluated or could we perhaps have a copy of the evaluation document?

Dr CLIVE WRIGHT: I do not think we are that far enough down the policy process track, especially with respect to the work force papers, which are currently in the process of further consultation. I know Mr Clout would identify some of the issues related to the work force, especially in rural areas, that were canvassed by the work force group.

The Hon. IAN WEST: Not just the work force. You referred to the futuristic plan. I am interested in the phased monitoring and outcome of that and how you propose to do that in 2007, 2008, 2009?

CHAIR: We asked for copies of the plans but Dr Wright said in answer to questions 1 and 2 that they were not yet finalised. We asked for copies of those that were finalised before our reporting date. It is difficult for the documents to be provided if they are not yet completed.

The Hon. IAN WEST: It is important to know the objectives and that the evaluation will be monitored in a phased way.

Dr ROBINSON: If I might rephrase the question so that we are clear. What you are interested in is the way in which we are going to monitored the roll out of the oral health plan and how we are going to know if we have been successful in the roll out the various strategies?

The Hon. IAN WEST: Yes, and how you have monitored and evaluated some of the previous plans that have been the forerunner to you coming up with the current futuristic plan.

Dr ROBINSON: So you are really referring to the New South Wales oral health promotion framework for action, is that correct?

CHAIR: Yes, and there are other documents as well. In relation to the work force group, Mr West suggested the tabling of the terms of reference. Are there any outcomes yet? Is there a report and, if so, can we have a copy of it?

Dr CLIVE WRIGHT: The report is currently within the department going through the consultative processes.

Dr ROBINSON: Terry will speak to this, but basically this is a process that is ongoing and the first round of consultation obviously involved all of the experts, the associations, et cetera. There is now another round of consultations that needs to be undertaken with the area health services, who are the service providers responsible for attracting and retaining the work force and until that consultation has been completed and the department has had time to consider its report, it is not yet available for release.

Mr CLOUT: From the perspective of a area health service and the clinicians within area health services, one of the things we have been pushing for some time is to get recognition of the fact that in dental services there is a significant work force difficulty. There are lots of work force considerations being done in the very medical areas of the service but it has been really tough to get focus on the dental work force issues.

From my perspective the push has been from a rural perspective because from my perspective and certainly that of the rural health priority task force, there is a distribution and difficulty in terms of work force and a disparity between the services available in metropolitan areas compared to rural. We can argue as to whether or not the whole thing is adequate, but from that perspective there is a disparity between the two.

We have been pushing very much for the establishment of this work force committee which indicates a commitment to look at this specific issue. What it has enabled us to do, at least since it has come into being, is to get all the players around the table for the first time at the same place and identify the big rock priorities that we need to deal with. Has it had any impact? Certainly from the point of view of being able to get some additional dental students and dental officers in rural areas, we have had some progress. It has been patchy. From my point of view that part of it is not adequate yet, but it is better than having what we have had before, which is this general work force push and dental does not get a go.

It has got everyone together but from my perspective also—that is from a rural CEO's perspective or a rural task force perspective—there is a long way to go and we have a lot more things to address before we could feel at all comfortable that we have started to break the back of some of those work force issues. Without the work force issues being addressed, the issue of availability and access, where people live or specialty services going out is not going to happen.

CHAIR: How many dentists are part of the Dental Officer Rural Incentive Scheme [DORIS] and where are they?

Dr CLIVE WRIGHT: At this stage we can account for 79 dentists who are under DORIS. There are a couple of area health services that if you would allow me some time to follow up on I will provide you with the complete list.

CHAIR: Yes, please take that on notice.

Dr CLIVE WRIGHT: That, in itself, represents about one-third of the dentists in the public sector and those that are in rural areas, it often means 100 per cent, so if they are looking at the distribution, the distribution of DORIS holders really relates to the distribution of area health service rural components.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say 100 per cent, you mean full-time equivalents?

Dr CLIVE WRIGHT: Full-time equivalents, correct. So, Greater Southern, they are all DORIS.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But all the DORIS' are 100 per cent full time?

Dr CLIVE WRIGHT: No, not necessarily.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the 79 people might be only 40 full-time equivalent?

Dr CLIVE WRIGHT: Have we got it the right way round? Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are more dentists than there are full-time equivalents dentists?

Dr CLIVE WRIGHT: Yes.

CHAIR: So your 79 is the number of people?

Dr CLIVE WRIGHT: Correct.

CHAIR: Not the number of full time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So how many full-time equivalent people have you got?

Dr CLIVE WRIGHT: I was requested to find numbers of dentists, not their full-time equivalents. I can tell you, for example, that in Greater Southern we have seven effective full-time dentists and there are 12 under DORIS, so that means that a proportion of those are part time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But we need full-time equivalents, do we not?

CHAIR: Dr Wright is taking that on notice because he is waiting on figures from a couple of the area health services, so if possible we will have the full time equivalents as well as the number of people. What is your comment on the ADA's suggestion that the success of DORIS is questionable? Is it going to be reviewed? What else is going to be done to address the shortage of dental health workers in rural areas?

Dr ROBINSON: Yes, DORIS will be reviewed and, in fact, we are in the process of undertaking that at the present time. There are a number of other initiatives that have been set in place and I think we have detailed this in our submission in terms of improving the rural work force. You are aware that we have the student incentive program. We are developing and implementing a rural scholarship for a number of dentists who are undergoing training at the present time in their penultimate and ultimate year with a view to looking at having them work in the rural sector as an end result. We have also looked at the issue of graduate dentists. You are obviously aware there is a difference between medicine and dentistry in that with medicine we do not train the workforce to be ready to go out and work autonomously within either the private sector or the public sector, whereas that is the case for dentistry. One of the initiatives we have set in train is to attract new graduates to rural areas so that they can work and provide services in those areas in the public sector. This is being

done in conjunction with the various dental hospitals, which are able to recruit for us and refer those dentists to work on a rotational basis through the area health services.

Mr CLOUT: In answer to the specific question, my position is very simple: of course it is questionable and the reason is that it is an incentive scheme, not an answer. By itself it will not necessarily have a response that holds a person or persons in a rural setting and/or attracts them to it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It just bumps up their salary twenty grand for a full-time equivalent, doesn't it? Isn't that really all it does?

Mr CLOUT: Yes, I think that is true. The other part of the question related to what other things were being done. A number of things are being done and, again, we need to do more of them and continue doing them. One of the issues is about infrastructure. I heard Dr Hutchinson refer in a previous session to infrastructure and the trains that used to be—I am old enough to remember those, too—and they are now the buses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do they still exist?

Mr CLOUT: They do. We call them dental vans. There are some of those. They have two particular problems and an advantage. The problems are ones of infection control and occupational health and safety. They have been perennial problems for at least the last 20 years to my personal knowledge. The advantage is that you can go from place to place. The conundrum for us is how we overcome the occupational health and safety and infection control problems and yet provide services, particularly in rural areas where we need them so people have access as close as possible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These cannot be new problems, with respect.

Mr CLOUT: No, they are not new problems at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They must have evolved as occupational health and safety has evolved.

Mr CLOUT: Yes, they have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many of these caravans are there?

CHAIR: Let Mr Clout—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am trying to direct his answer, that is all. I am happy for him to give the answer.

CHAIR: Mr Clout is trying to tell us about something.

Mr CLOUT: I think I can address that. In the Northern Rural Network, which is North Coast-Hunter-New England, we have a program that commenced three years ago under which we are progressively pooling the funds available to us over time to replace dental vans with fixed dental services so that we do not have the problems but we have the access close to home. For example, we have been able to do that in five places within North Coast-Hunter-New England over the last three years. We have had the support of the department in doing that on a 50-50 funding basis. That is something that is being picked up. In terms of other things that are necessary, because capital works is not the only one, the student placement program has been quite successful. Another issue is getting specialist services into rural areas.

It is not conducive to retaining people, particularly dentists, in rural areas if they are just doing the grunt stuff and are not doing the work they need to do to get the range of professional services. Again, Dr Hutchinson referred to that. Over the last three years we have been able to get those specialist services in places such as Dubbo, Coffs Harbour, Grafton and a couple of others. That is progressing but, again, I think we need to do more of that. I do not think DORIS is an answer in

itself. My personal view is we have to have those other initiatives, but you will never be able to measure the individual components and say definitively something has had a result or it has not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could Dr Robinson give us a list of changes to the caravans, or vans, and the number of sites delivering services in New South Wales? It may be marvellous in New England and Hunter but is the same thing happening throughout the State?

Dr ROBINSON: I can certainly take that on notice. I am unclear at this point whether I am able to provide you with the extent of that information. I certainly do not have it to hand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably it exists.

Dr ROBINSON: I can only speak from my experience when I was in Southern Area Health Service, where we had a similar issue with respect to Pambula and the need to look seriously at the occupational health and safety issues and the capacity to provide a fixed site. I will take that question on notice.

CHAIR: Mr Clout, you mentioned the final year student placement program, which is referred to in question 11. How many students are participating and where are they, and what do we know about whether it works in the sense that they are likely to work in rural areas after graduation?

Dr CLIVE WRIGHT: There are currently 50 students a year in the University of Sydney's Bachelor of Dentistry course and every student undergoes a rotation. They do that usually in 12 blocks over two weeks. I have a list of a number of clinics, which I can work through or it can be tabled.

CHAIR: It might be easier to give it to us in writing.

Dr CLIVE WRIGHT: Secondly, a trial is being conducted this year in the Greater Western Area Health Service with four to six students who will undergo a four-week placement. That is trying to attest to the belief, and I think a prima facie case, that if students are exposed to experiences in rural areas—to answer your first question—they are more likely to go to those rural areas than students who have never had that experience. We see this in health, nursing and allied health services right across the board. If you do not have those sorts of placements there is little opportunity for people to gain experience. Although it might not be a major driver, it is certainly not acting as a barrier.

The Hon. KAYEE GRIFFIN: Is the department looking at similar plans in relation to the course being undertaken at Newcastle University? I realise the first lot of students have not graduated as this is only the second year.

Dr CLIVE WRIGHT: Correct. There are two elements to the relationship the University of Newcastle has with students. The first relates to the University of Adelaide and dental students coming from South Australia to have clinical placements in New South Wales. That is on a memorandum of understanding arrangement between those universities and specific area health services. Approximately 12 dental students do that. The second part is that we are most conscious that there will be a requirement for placement with the University of Newcastle and the University of Sydney's Bachelor of Oral Health programs. We have commenced the process of mapping appropriate clinics and appropriate supervision for when they come on line.

Mr CLOUT: Obviously, Hunter New England Area Health Service is dealing directly with the department, with Clive's branch and the University of Newcastle in relation to those placements across the rural components of our area health service and the North Coast.

CHAIR: In your submission you refer to overseas-trained dentists working under limited registration. Can you tell us more about that? How many overseas dentists are working under limited registration? Are they in rural areas and are they basically plugging gaps?

Dr ROBINSON: Before Dr Wright answers the specifics of that, I point out that the situation with respect to overseas-trained dentists is different from that of doctors. There is a group of overseas-trained dentists who are able under the current legislation to enter Australia and set up practice without any conditions on their registration. When the question is asked how many overseas-trained

dentists have limited registration, we are talking about overseas-trained dentists from only a specific number of places. Perhaps Dr Wright can explain that.

Dr CLIVE WRIGHT: To answer the first part of your question, we currently have five overseas-trained dentists in the State working under section 14 of the Dental Practice Act 2001. They are all working in rural areas. There are three main ways that overseas dentists can enter the profession and be registered in Australia. They can have immediate recognition of their qualifications—I am one of those fortunate ones, because New Zealand, the United Kingdom and Ireland fall in that category. They can be under limited registration in our jurisdiction under section 14 of the Act. That provides a relationship with the Australian Dental Council. If candidates are exempt from the preliminary Australian Dental Council examination—there are countries and graduating courses in Malaysia, Hong Kong, South Africa, Canada and some of the United States that meet that requirement—candidates can be enrolled in the ADC program and work under section 14.

The third category comprises those who are not from accredited graduating schools; they must sit the preliminary examination. If they are successful, they can be registered to practise under section 14. The rules governing registration under section 14 are that there be appropriate supervision and they follow the conditions outlined by the Dental Board of New South Wales with respect to their supervision and 12-month period and it is anticipated that they will complete the Australian Dental Council final examination. That can be extended on a case-by-case basis until they complete that examination. There is an agreement between ministers to have a broader role in promoting overseas-trained dentists through what is called the Public Dental Workforce Scheme. Our jurisdiction is a signatory to that and we use that section of the Act to facilitate those things. Is that relatively clear?

CHAIR: Yes. So you have five at the moment and they would be in the second group you described.

Dr CLIVE WRIGHT: They are under section 14. They would be in the second or third group.

Dr ROBINSON: We do not have any figures that will tell you how many dentists are free to enter and work without any restrictions on their registration because of the way in which the legislation operates at present. We cannot tell you how many have come from New Zealand, the UK or South Africa, where there is no restriction on their registration.

CHAIR: Would the Dental Board be able to give us those details?

Dr CLIVE WRIGHT: The Dental Board can probably give you the country of origin and qualifications.

CHAIR: Of who is registered?

Dr CLIVE WRIGHT: Correct. Once someone has completed the final component of the Australian Dental Council examination, they are registrable in any jurisdiction in Australia. An area health service does not necessarily ask whether a person is an ADC graduate or a University of Sydney graduate. It asks: 'Are you a registered dentist?'

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How much supervision is there of these limited registration ones?

Dr CLIVE WRIGHT: It varies according to the assessment of the Dental Board of New South Wales. It might vary from case to case.

CHAIR: Now for the last question—we are only half an hour late. It may be better for you to give us the details in writing; it is up to you. Our final question asks what particular preventive or oral health programs NSW Health is co-ordinating. If there is a list, we can take your answer in writing. If there is no list, I suppose we should ask why not.

Dr CLIVE WRIGHT: Both Terry and I have answers to this question that will mesh together. I think the first thing to remember is that there are four pillars of prevention in oral health

promotion when we talk about co-ordination. We have got the education and awareness programs. We have got the application of appropriate behaviour types of programs—oral hygiene instruction and teaching people how to do things. Then we have got the contact with provider programs, which are access issues related to constant reinforcement, and then we have water fluoridation. We could identify those four key areas as programs. Perhaps Terry will talk about the detail.

Mr CLOUT: When we talk about co-ordination, NSW Health includes the area health services, and we work together on that. There is a steering committee that includes the area health services and it is all done together. The promotion side of it, as has been indicated by Clive, has the four planks to it. It would make up 50 per cent, in rural areas anyway, of all the work that is done by other than our dentists—our dental officers—and probably 25 per cent of the work and time of the dental officers. And so it should, because as Clive rightly said there are four planks to the program. We will not in the future be able—regardless of whether it is Commonwealth and State together or what the policy is—to meet the treatment requirements unless we continue to provide the other three planks of it, are aggressive about it and put in the time and effort.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would Dr Hutchinson's suggestions be met in the sense of a Slip, Slop, Slap type of public education program and go into baby health centres—whatever they are called nowadays?

Mr CLOUT: I was nodding a fair bit when she was talking about those programs. My personal view—and I think it is well supported in NSW Health and broadly across the system—is that we need to have that very strong co-ordinated State, I would say national, approach if we are going to resolve it. The Slip, Slop, Slap, the breathalyser, the seatbelts and the AIDS programs were all done in a co-ordinated way, as cancer campaigns are also conducted. Yes, I would agree that that is the way it needs to be done.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this a pious hope or is there some plan for this?

Mr CLOUT: I do not think it is a pious hope. I think there are a lot of people working towards having that done but it is very, very difficult to get all the ducks in line—if I may use that term—that you need to put that together and then get all the parties co-ordinated to do it. But I have been encouraged by the fact that there has been a Commonwealth and State commitment to this, through the health Ministers' program, and it is on the agenda.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there some dollars in line?

Mr CLOUT: If it is on the agenda one would hope that that is what follows.

CHAIR: So that program fits into the first of the four areas that you mentioned, with some overlap. Fluoridation is separate, and we know about that. Then there is the more specific education awareness and the other you mentioned was access to services.

Dr CLIVE WRIGHT: I think we have to be very careful in public sector programs that we use a very strong evidence base, especially in health education and health promotion. In any program that we take on board we have got to have a very solid evidence base. Some of the programs that have been suggested in fact do not have a strong evidence base to support them in terms of delivering the outcomes.

CHAIR: Can you be more specific?

Dr CLIVE WRIGHT: For example, going into schools and providing health information on a classroom basis or even awareness programs that build up the expectation that you, together with clinical contact, will change a health outcome and that there are barriers to you being able to make that clinical contact. So I think we have to look very carefully in terms of those specifics of health education and health promotion programs that they do have an evidence base, they are sustainable in the linkages and perceptions that we create in the public image. If we cannot deliver in terms of the access components those programs themselves do not work.

Mr CLOUT: If I might add to that, I would suggest, with respect, that three out of the four of Clive's planks are in the prevention category. I think fluoridation, for example—

CHAIR: I did not mean that they were not in the prevention category. I meant that they were not in the Slip, Slop, Slap category.

Mr CLOUT: I would argue that they are and they should be. Unless you have that complete program of the four planks being done together, each of them will be hived off and it becomes a little program. It does not become a Slip, Slop, Slap program and it loses its effectiveness and will not get the support. What we are up against—all of us—is the fact that if you take all those programs we are at the moment, I would argue, losing the battle against the sweets and soft drinks campaigns, the takeaway food campaigns—the nutritional parts of it. Unless we have all of that together in one solid program that has the four planks to it and we have support at a Federal-State level, we have the ADA, the colleges and everybody behind it and running with it—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Advertising Standards Council.

Mr CLOUT: All of those. Unless we have that we will not have the ducks in line to make a dent in it. I think we need to have it all together. I made the mistake on fluoridation, so I can speak from my mistake. I was horrified when I went to the mid North Coast of New South Wales to find that all bar one town in my area health service at that time did not have fluoridated water. This was news to me—my ignorance. So we started a campaign in conjunction with the Department of Health. We had the evidence. I just ran off on fluoridation and I got squashed. I could not make it happen. We then regrouped. We came back and said, "We've got to have the whole program". We got the whole program together with the four components, we got all the ducks in line, we got the ADA behind us and we got the councils behind it and it is happening. It is still bloody hard work.

CHAIR: Are you talking about the Port Macquarie-Kempsey area, where the Committee visited and heard a lot of evidence?

Mr CLOUT: I am talking about Port Macquarie, Kempsey, Bellingen, Coffs Harbour and Tenterfield. Those are running. We are looking at the northern part of New South Wales—a big, big area if the work that is being done with the councils and communities and Rous Water up there is successful. That will affect hundreds of thousands of people for generations. That is the way to address the conundrum we have: no-one will be able to address the cost of treatment unless we address these factors.

CHAIR: So you are saying that if you just talk fluoridation you do not persuade people. You need to run a co-ordinated campaign that talks about oral health in general.

Mr CLOUT: Yes, because those who are opposed to fluoridation will then argue that the others are the answers and are not being done unless you are doing those concurrently and unless you have got that together. It was only in 1954 that the evidence showed that this was what should happen and started to happen. It is still a struggle. It is difficult. The local councils are in difficult positions and we are trying to work through that. The department's commitment to fund the capital works programs of any of those that will work with us and do it has been helpful and a major initiative but it is still hard.

CHAIR: We know that from our experience at a hearing at Port Macquarie.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Before we finish can I specify the components of the answer on how well the bills are paid? Can you give us means, medians, standard deviations of when they are paid and the time?

CHAIR: Arthur, I am sorry but the question has been taken on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but the question was not well defined.

CHAIR: I am sorry, but we are not revisiting it now. You can talk to the staff about exactly what we are doing but the question has been taken on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but I want to define it.

CHAIR: We will have available the transcript of the comment made by the other witness. It is not appropriate now for you to start talking about exactly what you want. The question has been taken on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We do not like waffly answers. We do get them.

CHAIR: But sometimes, Arthur, your questions are designed to get the answer you want, not the answer that someone wants to give you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, on the question of paying the bills I am only interested in the facts.

CHAIR: At this stage you are out of order. The question has been taken on notice. We know what was said by the witness before that gave rise to this questioning. I thank the witnesses for coming.

Dr ROBINSON: Thank you very much for your attention. We do appreciate it.

(The witnesses withdrew)

(Luncheon adjournment)

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

EWA JADWIGA BURY, representing Professional Vocational Committee of the Health Services Union, Dental Technician, Sydney Dental Hospital, 109 Pitt Street, Sydney, and

DENNIS RAVLICH, Industrial Manager, Health Services Union, level 2, 109 Pitt Street, Sydney, all sworn and examined**:**

RUSSELL CLIFFORD LAIN, representing Professional Vocational Committee of the Health Services Union, Staff Specialist, Sydney Dental Hospital sworn and affirmed:

CHAIR: All of you have seen the question we have prepared. Do any of you want to make an opening statement before we start asking questions?

Mr RAVLICH: I might make some very brief remarks. Firstly, thank you for the opportunity of appearing before the Committee to further embellish our information. Secondly, in the primary submission that was provided to you there are two relatively minor amendments that, for the sake of absolute clarity and correctness, we ought to attend to if at all possible. Of the original submission the first page after the cover sheet, under the heading "Introduction" there is a third paragraph, which constitutes a sentence that purports to put forward a view in relation to what may be occurring in the private sector. After internal discussions and reflection we think it is probably best that we remove that sentence and confine our commentary more to what occurs in public health and possibly then allow those from whom you will hear evidence or submissions in relation to the state of the dental profession in the private sector to give a more authoritative view on that.

CHAIR: That is fine in terms of our questioning, but submissions are on our web site. If you want us to delete something we have provision, as a Committee, to discuss that and do it. But the horse has bolted in a sense because it has been there for a while. The remarks you have made will be in the transcript, which is, in a sense, an apology and a correction. Are you happy to leave it at that?

Mr RAVLICH: As long as we have the record that we thought to correct that. Again, mindful of the Chair's comments, on the further page where it talks about staffing levels there is a reference to "work strain injuries", which should be work-related injuries. We did not want there to be a view that we were talking specifically about repetitious strain-type injuries as opposed to injuries in a general sense. The other final comment is that in the introduction there is a reference to the three colleagues and workplace representatives we have here today, members of the Dental Professional Vocational Committee. I thought that I would put that into context very briefly with what the Health Services Union did some years ago for a variety of the professionals we cover in public health, which was to establish various committees that were designed to look at the specific professional and often, in turn, the industrial issues that related to the profession.

This one certainly was formed with a view to cover the full range of professionals and technicians and the like that work in the broader field of dentistry, with the view that dentistry ought to be seen as a holistic approach rather than just a profession made up of dentists or a particular field of classification. We found that terribly useful in the last couple of years to help to inform us as a union as to the issues of both the broader professional groups involved as well as the interaction and what needs to be done to better aid that broader group in public health.

CHAIR: But, as you have stressed, the group comprises people in the public dental sector.

Mr RAVLICH: Absolutely, yes.

CHAIR: Will you or someone else answer our first question about the membership of the union and how that is made up across the different aspects of the dental work force?

Mr RAVLICH: Largely I will specialise in the non-clinical questions, which, hopefully, will be the fewer today. But most certainly, I think we reflected this in the submission, we reflect more than 500 members across the public health system in relation to dentistry, and that includes a variety

of professional groups, such as dentists and dental assistance, dental therapists, dental technicians, hygienist, radiographers and prosthetists. Obviously, that would be dispersed throughout the State of New South Wales in the public health setting.

CHAIR: Is the membership concentrated in any particular area? Do you have proportionately fewer dentists but lots of hygienists or assistants?

Mr RAVLICH: Yes, the proportions would vary based on the number of people employed in those occupations. As a rule of thumb there are a considerable number of dental assistants, but not as many number of dentists and I guess that profile is reflected in our membership base.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because the salaried ones tend to be in the union and the non-salaried ones are not?

CHAIR: It is public sector only.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are only public sector?

Mr RAVLICH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not cover the people in the private sector?

CHAIR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even dental technicians and dental assistants?

Mr RAVLICH: We have very limited coverage in the private sector. We really are, if I might use the term, at the bottom end of the scale in relation to the professions. It is more dental technicians.

Dr DUCKMANTON: In relation to dentist membership, to my knowledge—I do not have the exact figures in front of me—the majority of dentists working in the public sector in the city, at least, are members of the Health Services Union [HSU]. At one stage we were members of the Public Service Association, but we swapped over the membership with agreement sometime ago. In my experience, most members of Sydney Dental Hospital are members of HSU—dentists and dental assistants, dental technicians, prosthetists and most people there. In the country areas it is not quite as concentrated. At Westmead they have proportionately fewer dentists than they do the dental assistants. There are some splinter groups that also come into play. There is a dental officers group, which is a very small and new group, and does not really represent too many people at all. But I think you could say that a large number of dentists, dental specialists, dental technicians and dental assistants in the public sector are represented through the Health Services Union.

CHAIR: What are the main issues that face the dental services work force across all those occupations? The second question is: Are the main issues the same for private and public sector workers? You may not want to particularly comment on the latter question, but obviously there will be issues that are very different for public sector workers.

Dr LAIN: I would like to answer that question, Madam Chair. We feel that the main issues are: retention and recruitment; lack of a defined, flexible career path for dental officers and other dental groups; time pressure, due to the high number of patients that we face on a daily basis, which is approximately 85 patients seeking emergency treatment at Westmead hospital, 150 people telephoning through the call centre to get access to the Sydney Dental Hospital and the satellite clinics servicing our area health service, and about 50 to 100 walk-ins daily at the Sydney Dental Hospital. That presents a fairly significant time pressure due to the high throughput of patients. Significantly, there is a lack of experienced clinical support, in the sense of senior clinicians. It is a very young work force, and a relatively inexperienced work force. I am thinking of mentoring and specialist support for the junior dental officers and technical staff.

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

CHAIR: You have not mentioned pay.

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

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

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

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

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

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

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

Dr LAIN: More than you are comfortable doing.

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

Dr LAIN: Absolutely. This is within the context of realising, as I mentioned before, we are not offering Rolls Royce treatment; we are offering practical help to people in trouble. But time pressure certainly is an issue—as is reflected sometimes in some absences, or in people expressing disappointment and a negative attitude to the in-box.

CHAIR: So are you mostly doing extractions and fillings?

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

Dr DUCKMANTON: Madam Chair, I would not like you to get the impression that only emergency treatment is done. That is in one department of the hospitals and in some clinics. There are other departments, specialist departments and some of the clinics outside—but not too many of them—where more comprehensive treatment is carried out. The problem is that there is such a large number of patients who are in immediate need that the more complicated treatments often just cannot be done, and this leads to operator dissatisfaction—you get sick of doing simple things over and over again, and that is not what you are trained at dental school to do—because you do not get to experience the whole gamut of dental treatment. In my own particular field, I receive an awful lot of referrals for things that are very simple, and which you think could be done in the external clinics throughout the State, but, for whatever reason, they are not. This involves patients travelling to Sydney for dental work that is relatively straightforward, often to be told that nothing can be done for them, and that the tooth needs to be extracted.

CHAIR: What is going wrong that they are coming to you rather than being handled locally?

Dr DUCKMANTON: I think that has to do with the time pressure in the clinics, the equipment they have in the clinics, the staff experience that they have in the clinics, and the deskilling that goes on in some of the clinics. The fact is that if you do not for several years do some of the complicated treatments, you do not want to do them because you have lost confidence in your ability to do them.

CHAIR: Even though, from your point of view, it may be relatively simple?

Dr DUCKMANTON: Yes. But you have to remember that I spend all of my day looking through a microscope at little holes in teeth, and for me that is pretty straightforward, but for other people it is something completely different and out of this world

The Hon. IAN WEST: Although you talk about funding, time constraints, the experience of the clinicians, the workloads, the staffing levels, the deskilling issues and the quality of care issues, you do not appear to be mentioning anything about the actual equipment.

Dr DUCKMANTON: Well, we will get to that. One of the problems is that a lot of the smaller centres do not have a lot of equipment or some of the more complicated equipment needed to do things other than take out teeth and put in temporary restorations. They may not have particular sorts of bands you need to put fillings in teeth; they may not have the files needed to do root canal therapy; they may not have what we used to call a rubber dam—but we do not call it a rubber dam any more because NSW Health has been particularly proactive and has removed rubber dams from the inventory, at great cost to everybody.

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

Dr DUCKMANTON: Supposedly.

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr DUCKMANTON: Yes.

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

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

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

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

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

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

CHAIR: Is the union officially represented in consultations on various issues?

Dr DUCKMANTON: It is from the point of view of workplace relations, and in changes to departments, et cetera, with the amalgamations. We have what we call a joint consultative committee, which meets once a month with hospital administration.

CHAIR: On occupational health and safety issues?

Dr DUCKMANTON: That sort of thing, yes.

CHAIR: But not in terms of consultation about clinical matters or materials?

Dr DUCKMANTON: No, not about materials.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Materials are critical to the purchase and delivery of dental services, are they not? I mean, there are huge opportunity costs if you use the wrong ones.

Dr DUCKMANTON: We are not necessarily using the wrong ones. I think in many ways it is very good to be a latex-free environment. But I still think that for some things you need to have latex products available, and this is one of those.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would appear that some bills have not been paid. Are you aware of that?

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

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

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

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

Dr DUCKMANTON: That is correct.

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

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

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

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

CHAIR: We may come back to a number of these issues because certainly, for instance, they are relevant in relation to rural areas. Can you tell us at this stage whether the issues you see are similar to the issues in other States? Is New South Wales particularly lacking in terms of the number of people, the restriction in the procedures they do and, therefore, the deskilling, the lack of career path and so on?

Dr DUCKMANTON: I am not really too aware of that. I do have colleagues in other States. As far as I know there is only one other person in my situation in the public service and she is in Queensland.

CHAIR: What do you mean in your situation?

Dr DUCKMANTON: Who is an endodontist. There are approximately 100 endodontists in Australia, of which two are in the public service. It is a rather unique situation. I know that in other States, for example in Victoria, they have a co-payment scheme for anything that is complicated, for dentures, crowns, bridges, molar endodontics. I think a similar thing might exist in South Australia. What happens in Western Australia I have got no idea, I am sorry.

CHAIR: The co-payment scheme means that the public sector in that State is able to do the more complex procedures with flow-on effects?

Dr DUCKMANTON: Yes, that is true. The patients contribute to some of the cost of the materials and further procedures that they are having done.

CHAIR: Whereas New South Wales takes the lowest common denominator sort of approach?

Dr LAIN: Sydney Dental Hospital has recently introduced a form of co-payment for a type of denture—a metal-based partial denture rather than an acrylic- or plastic-based partial denture, a cheaper type. We do have, strictly speaking, one particular aspect of dentistry that does include co-payment.

CHAIR: This is even for people who are eligible—

Dr LAIN: Absolutely. You cannot get access to the Sydney Dental Hospital basically without a health care card.

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

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

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

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

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

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

CHAIR: When you talk about a career path, how would that work for dental officers? You have answered that question in relation to dental assistants. Other than moving into administration, what else can be done to create a career path?

Dr DUCKMANTON: I think you will find the Department of Health has got a plan in place where they have outlined three different streams, maybe four different streams, that people can move into: administration, clinical, research and teaching. This is a proposal they have put forward just recently, I believe. So they are looking at it from that point of view. From the point of view of a practising clinician, they should have the opportunity for research and teaching because I think it is

our duty to give back to the profession. So there is a career path there moving out of clinical, not totally doing clinical, and doing some teaching and some research and to have support for that sort of thing.

CHAIR: That would be possible in the hospitals, I presume?

Dr DUCKMANTON: That is possible in the larger centres.

CHAIR: Would it be possible in the regional or rural areas?

Dr DUCKMANTON: Not without a rejigging of the structure. People do higher degrees, do not get me wrong, in the rural areas but they have to do it by themselves. One of the other points we will come to about IT, I would like to make some comments about that sort of thing as well.

Dr LAIN: The issue of private practice versus public practice, I was in private practice for 22 years. I practised in the military, both ashore and at sea. Now I practise in public practice. If you forgive me for using this word, they are different paradigms. The reward system is entirely different. It is a different world. The career path in the private sector is such a different animal that I do not think you can relate the two. It is strictly a public sector issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say that they are different paradigms, in the private sector presumably as your practice builds you get paid slightly more and you do to the procedures that interest you more. As you build that aspect of your practice you become known for that. In a sense, you specialise within your practice, is that right?

Dr LAIN: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You choose an area and you develop it. If you do well the customers come, is that so?

Dr LAIN: That is correct. I guess generally that is correct. We are talking about generalist dentistry, not private specialists. You may lean towards looking after children more; you are allowed to follow your interest. But basically your reward system is financial. There has been a long history in this country of private practice dentists getting involved in tutoring and teaching and putting back into the profession later. In a sense, that is a career path to become honorary teachers to students.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is when you want to do fewer mouths per day.

Dr LAIN: And you can afford to, possibly so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that universal? Do a lot of people do that or do most people stay in private practice until they phase out and play golf?

Dr LAIN: Historically that was certainly the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it still happening?

Dr LAIN: Not so much nowadays. The profession has changed, I guess. I would think it is fair enough to say that there are not as many mature private practitioners willing or able to contribute their time free of charge or for token fees to teach students. Also, the other issue is they are not necessarily accepted. Their lack of familiarity with certain educational themes may preclude their involvement in teaching.

CHAIR: As to the award, you mentioned different groups of the work force and different dates. You sort of went in and went out again. Are negotiations under way at the moment for any sectors of the work force with the department or through the commission?

Mr RAVLICH: I think Peter alluded that in late 1990s the previous union that covered these groups or the profession was inherited by the HSU. I guess what we inherited in the late 1990s into the

early 2000s was a series of awards that covered the plethora of people who contribute to that activity. When we refer to an award, we are probably referring to at least six separate documents that then do not necessarily have historically any particular connection to one another. Then when this union, for example, did take up in good faith and made an assessment to take up the issue for a couple of those awards, primarily for dental assistants and dental technicians, it was opposed by the employer, the Department of Health. That was the decision, I think, referred to by Russell in 2003 where there were significant pay increases and, as importantly, a changed classification structure, which reflected more closely the qualifications, competencies and skills now required as opposed to definitions or even in some instances the lack of any definitions.

However well-intentioned that was and a good outcome for a number of people in those classifications, it then created subsequent internal tensions in historical relativities and those who perhaps even have a higher qualification have been even superseded by those with a lesser qualification. Against that background, discussions that we have with the department and people like the Premier's Department are somewhat stifled, if you like, by things known as the Memorandum of Understanding where we have negotiated outcomes for, say, a wide group of people that we may cover in public health—similar to arrangements that have been entered into with the teachers, nurses or police officers. However, the price of attaining often a general wage increase has been the preclusion of us from being able to take up matters with, if need be, the commission, despite the fact that we may even discover gross inadequacies.

At this stage we probably would identify the reason we need to draw this group together so that we can address issues as to internal relativities. I think we need to look at issues as to what those rates for each of those classifications ought to be and we ought to then reflect that, if you like, in a modern variation of what those people actually now do rather than a reliance on definitions which, in many instances, may have been developed in the 1970s or 1980s. It certainly is a frustration for those that we represent and a frustration for us that we are caught in this bind. We are attempting to do the most good for the most number of people, but the opportunity or unavailability then to address some of these more pressing needs may not be available to us formally. It does not preclude informal discussions, and they often occur. I guess the track record of the Department of Health and the particular bureaucrats there has been traditionally to oppose any increase for any classification, generally speaking. That is obviously driven by imperatives that they must presumably respond to. So it does make it very difficult to address the issue politically across the board.

CHAIR: You have probably already dealt with our fourth question to a large extent in terms of encouraging people to go to rural areas and into public dentistry in general. What you said about public dentistry probably covers it. Is there anything else you would like to add about encouraging people to go to rural areas, other than the problems you have already talked about?

Dr DUCKMANTON: Mention was also made of IT, or the lack of IT. One of the problems with rural practice is that you do not have ready access to specialist help. You can ring someone, but it would be good if we had a system of video conferencing or sending radiographs quickly electronically to get a provisional diagnosis to give a rural practitioner who may not have as much experience as a specialist in a teaching hospital and to provide assistance and guidance with a case. Something like that would alleviate the feeling of isolation that many rural practitioners in the public sector experience.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that not exist already for medicine?

Dr DUCKMANTON: Such things exist for medicine, but they do not exist for dentistry as far as I am aware.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is simply a question of taking the technology across to your area.

Dr DUCKMANTON: That is true. Once again, it probably gets back to dollars.

CHAIR: But the equipment could be shared if it were in the right place.

Dr DUCKMANTON: Yes. It would work at Westmead perhaps, which has a medical and dental facility close together. But our closest medical facility is RPA, which is quite some way. We have microwave links. These are things that should be explored.

CHAIR: Do private practitioners in rural areas have access to these things, or do they rely on traditional referrals?

Dr DUCKMANTON: I think they probably rely on traditional referrals, but I do not see any reason that the public sector should not raise the standards and be the flag bearer for such things.

CHAIR: What about your view on current university training of dentists and oral health workers?

Dr LAIN: We feel strongly that today's graduates have very much less experience. They have not extracted as many teeth and so on. They have not done as much and they require more support in their early years. In fact, there are discussions among senior clinicians about the possibility of some sort of intern year. At the Sydney Dental Hospital they have had to bring in a new graduate program to support these people and to guide them. It is a much less experienced work force.

CHAIR: What has happened in the university course, or is it the lack of spaces in teaching hospitals? What has caused the change or is it a planned curriculum change?

Dr LAIN: I think it is possibly a planned curriculum change. A feeling has emerged that certain activities, such as oral surgery and more complicated nerve treatments, are postgraduate activities and you require postgraduate training to go there. There is a minimum skill set that is different from the minimum skill set that past generations of graduating dentists had. There is a move towards postgraduate training.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this a forced situation? Are they doing fewer cases in their undergraduate years so they have to be kept in nappies longer when they graduate? Is it not simply because the same number of tutors are being spread over a longer period? Is this driven by necessity, a shortage of tutors, or by a need for experience? If they have less experience in the five years they spend as undergraduates —

Dr LAIN: It is different across the different States. New South Wales has a three-year science degree that provides entry into a postgraduate four-year dental degree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if they have not done enough teeth in those four years you would have to give them more time in the postgraduate years to catch up on what they would otherwise have done in the four years. Is this an improvement or are they not as good at the end in terms of experience and do they need more afterwards?

Dr LAIN: The second option. They do have not as much because that is the plan.

CHAIR: This is a fairly common pattern across professions. A lot more time is being taken and more emphasis is placed on postgraduate experience. Whether it is formal internships or whatever, it seems to be the case in a range of professions, not necessarily only in the medical area.

Dr LAIN: That is true. However, historically in dentistry the idea was that graduates would be able to fly by themselves; they would be able to go to the bush and be safe.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are we saying that more time is being wasted in the sense that there are not enough tutors to train them as undergraduates?

CHAIR: I think that question was answered.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but not very specifically.

Dr DUCKMANTON: The program now takes four years; originally it was five years. The first two years of the five-year program were pre-clinical and the next three years were clinical. The

first two years now are the first two years of medicine. Then they do two years with some dentistry one day a week. Then they do the clinical subjects. So, what we used to do in three years is now done in two years, even though the teaching year might be longer. This causes problems for university staff because they do not get time to do their own research; they spend all their time teaching. The flow-on effect is that there is fewer and fewer full-time university staff and, once again, we have to rely on part-time staff or honoraries. If we cannot get them or the part-time clinical staff, there are fewer people in the clinics supervising the students. Once again, you end up with graduates who are not as well rounded in all fields of dentistry as they might have been compared to the old course.

CHAIR: There is a view, is there not, that it is better for people to have experience after graduation under supervision and that an internship-type arrangement is better for the profession?

Dr DUCKMANTON: If there is the ability to provide the internship. I do not see the public health system in New South Wales having the capacity to do that in dentistry.

CHAIR: Do you think it would be a good thing? They would do their degree and then do an internship. Is that desirable?

Dr DUCKMANTON: It would be better to teach what we can when they do their basic qualification. That is a much better way to go because it opens up many more opportunities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you go back to the five-year course?

Dr DUCKMANTON: I am not in the faculty, so I cannot answer that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you would have an opinion.

Dr DUCKMANTON: I certainly have an opinion, and it is that the four-year course could be re-jigged to allow more time for clinical things.

Dr LAIN: I agree. Being a clinical person and seeing the lack of confidence, general experience and procedure experience, whether it is a five-year course or whatever, they need to do more practical work prior to graduation.

CHAIR: Do you think any other State has a better model than New South Wales?

Dr LAIN: I personally prefer a five-year course. I do not see a need for a three-year pre-dental or pre-med-type course. You need very careful student selection. One of the problems in the past was that many of the dental students missed out getting into medicine by two marks and did not really want to be there.

CHAIR: So they did dentistry because they did not get into —

Dr LAIN: It was second choice; they did not really want to be there. This was one way of addressing that. They elect to do dentistry and they prove they can do a three-year university level course and pass it and manage their lives. They are supposed to come into the profession as more mature people and choose to do dentistry.

CHAIR: Is that not working?

Dr LAIN: I am not involved in that level in the faculty.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a pretty expensive selection criteria method. Does the theoretical excellence they have achieved in the meantime have any spin-offs as far as you can see?

Dr LAIN: Not as far as I can see in the oral surgery department or the extraction area. Perhaps we will find some genius researchers in the future from this bunch

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather research is being squeezed.

Dr LAIN: Pardon?

CHAIR: I think it was a throwaway line, not a question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He can comment. It is a question; I said that I gather research is being squeezed and I wanted him to say whether that was true.

Dr LAIN: "Squeezed" meaning what?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said they were spending more time teaching and doing less research. From the point of view of people doing research, these people might be genius researchers, but if they do not get a research position or the teaching load is too heavy, it will not happen.

Dr DUCKMANTON: That is true.

CHAIR: Reference was made in your submission to managers giving clinical direction to dentists. What do you mean? Don't laugh like that!

Dr LAIN: As a philosophy, we would say that dentists should manage dentists. When we use the term "clinical instruction", we are not referring to someone leaning over your shoulder and telling you how to drill, but making decisions that impact on your clinical activities. For example, in the rural areas a significant number of managers have a background in nursing or dental therapy, not as dentists. They are organising rosters and deciding on appointment times appropriate for certain treatment activities in a relatively uninformed way. They are also making decisions about materials and equipment purchases. I guess they get advice from the clinicians, but they make the decisions on different bases from that of a clinician. We had an example at Westmead Hospital when the suction was turned off at 6.00 p.m. and dentists cannot survive without clinical suction. The manager in charge of this aspect was nonplussed when he was asked to continue the suction past that hour when emergency patients and late finishing patients continued on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it very expensive to have suction?

Dr LAIN: Not at all.

CHAIR: Why did you smile so broadly?

Dr DUCKMANTON: I have a philosophical viewpoint that dentists should manage dentists. This is, once again, the career structure that we alluded to previously, that some dentists decide that after 15 years of dentistry they are sick of patients yelling at them in the public sector, so they go off into administration where they will be able to yell at other people in a legal way. But, jokes aside, it is just a philosophical point of view. Only a dentist can understand what is going on in another dentist's mind when it comes to patients, equipment, materials, research needs, courses and so on. Hopefully, they will not look at the beans as much as those who administer a money pot and how it might be dispensed.

CHAIR: This argument has been around for generations. It is probably why we are all smiling. There are many other sides to the argument, including whether it is appropriate to turn the best dentists, doctors, engineers, teachers and so on into administrators.

Dr DUCKMANTON: That is a very good point. Some dentists would probably better off as administrators and others should remain as clinicians. The problem is who should make the selection.

Dr LAIN: If a new structure offers a definite career path that can fit the professionals' need to pursue that administrative career path, with the scientific and personal understanding of this particular field.

CHAIR: Would it be important to enable people to go in and out so that one did not necessarily have to be a dentist for a certain number of years and then become an administrator for the rest of one's career? Could there be a more flexible arrangement?

Dr DUCKMANTON: That would keep a lot of people happy and give them more interest. I have spent the past 22 years looking at people's teeth and I still find that interesting. To leave that for five years and go back would be very scary. I would want a lot of retraining before I did that. However, that sort of opportunity should be there for some people, and the opportunity for some form of training to keep them up to speed would be good.

The Hon. IAN WEST: I refer to the question of managing of waiting lists on page five of the submission of 27 May and the comments made by someone from Wollongong or Illawarra. Would you care to make some comment on that?

Dr LAIN: It is a fairly strong statement. Perhaps this illustrates the question we just addressed; that is, that this member from Illawarra perceives that management, who almost certainly would not be a dentist there, has a different driver to the clinician.

The Hon. IAN WEST: That obviously goes to the issue of the ability to provide preventive care.

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

Dr LAIN: It is a funding issue rather than a salary issue, of course. There are just not enough dental chairs, and they are expensive.

CHAIR: Moving on to question 8. We have touched quite a few times on whether or not your members are limited to providing acute care because of issues like waiting lists and so on. Is there anything further you need to say about that or have you covered it?

Dr LAIN: Only to emphasise that it basically just delays the problem. The pathology will progress. They are still eating.

CHAIR: Prior to lunch both Dr Wright and Mr Clout spoke vehemently about the need for a preventive approach and other witnesses have drawn comparisons with the Slip Slop Slap campaign and the anti-smoking campaign. They have said quite strongly that dental decay is preventable and it would make such a difference to so many people if the community could be convinced that that was the case and could learn how to take care. Would your members support that approach and support a complete shift away from the kind of care that you are doing at the moment to the preventative approach?

Dr LAIN: I do not think that is the choice. We would wholeheartedly support preventive dentistry and fluoridation in general is a concept and the profession as a whole has been a driver historically in introducing fluoridation but the reality of the existing disease is still there. There are also issues of immigration where many of the refugees and people coming to our country have significant dental problems and there are significant groups of pathologies in our community who have ongoing and increasing amounts of decay.

There are certain groups in our society associated with high rates of dental disease and the numbers of those groups are not decreasing. And I do not think you can just throw all the resources, if there are a limited number of dollars, at prevention because the existing pathology—there is still so much of it that needs to be caught up with and addressed.

CHAIR: You would hope that it could be phased out but it will take decades.

Dr LAIN: Emergency public dental treatment being phased out?

CHAIR: You would hope that the problems you have just identified would come to an end if we get the preventative stuff right, but you are saying that it may well take decades?

Dr LAIN: And internationally I do not think it has been solved. Massive amounts of money have been spent on education programs and this has not eliminated the significant need to treat public eligible patients in emergency situations for significant amounts of disease.

CHAIR: You have said, although perhaps not in so many words, that funding is too limited to provide the kind of service that you believe should be provided.

Dr LAIN: Absolutely. New South Wales provides less than other States on a per capita basis. Basically that results in insufficient facilities and insufficient staff—salaries being a different issue.

CHAIR: That one sentence almost says it all. You have a proposal about a specific private health insurance dental rebate for low-income earners. Can you expand on that?

Dr LAIN: No, I cannot.

Dr DUCKMANTON: We are not too sure where this came from. It sounds like a grand idea but I am not sure how it would work or how anyone on a low income would afford health insurance to be able to apply for the rebate. Maybe what is being suggested is that the Federal Government, I would guess that would be, would be prepared to fund—or maybe the State Government through vouchers—eligible patients to attend private practitioners with vouchers for payment for simple services, but there are some problems with vouchers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has not that system been going on for years? My dentist used to do it and he said that the hassle factor was not worth it?

Dr DUCKMANTON: That is true. It does happen in some areas and not in others. I think it depends more how many dental operators they have in particular health services. I am not an administrator so I cannot tell you. I do not have very much experience with it but I assume that is what it is talking about. The person who actually put this proposal forward is on annual leave and we were unable to get clarification on it.

CHAIR: In terms of affordability we started off with Professor Spencer, who said that Australia-wide of 35 per cent of people eligible for public treatment about 20 per cent of those do have private insurance. When we were talking about the useful use of public money he made the point that different States have different levels of eligibility and New South Wales has more people eligible.

Dr DUCKMANTON: Of all the patients I see, none of them would have private insurance. Most of them do not even have the bus fare to get home.

CHAIR: Would that be the experience of all of you.

Dr LAIN: Yes.

Dr DUCKMANTON: Yes, we are dealing with people who do not have the means to have private health insurance.

Dr LAIN: We are talking about between 30 per cent and 60 per cent of the fee rebated. The scheme which the private funds operate—when I was in private practice patients were often under the impression that they would receive the full most common fee rebated but that is not the case. You could not survive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean then that the practitioner has to collect the balance from someone who did not expect to pay it and has not got it anyway?

Dr LAIN: Absolutely, in some cases. It is possibly a wilful ignorance in some cases.

CHAIR: You have answered this question in part in relation to the award. Has the union talked to NSW Health about this range of issues and what has been the response or the outcome?

Mr RAVLICH: Certainly at various levels there have been discussions with NSW Health on an ongoing basis, and that is not just by the Health Services Union—obviously, they interact with a number of groups as professionals. Certainly it is our understanding that Health has commissioned—I am not sure if that is the right word—but certainly has recently received some feedback from a particular committee to look at the crisis in oral health and how that is delivered in public health. I think they are currently considering that.

I think that report or view will probably reflect on many of the things that both Russell and Peter have indicated and probably much of what you may have even heard earlier today that there is the crisis about retention and attraction. It is really about how you measure a productive service? Certainly, waiting times and waiting lists are important but that should not be the only measure to determine what is cost effective. It does not take into account optimum. The department often does not have the experience to take into account the need to balance the vacancy rates and to ask what is the opportunity costs to the public and to people who cannot access the service for six weeks. Does that then make the problem cumulatively greater in a month's or year's time?

We need to broaden our understanding of how you measure and cost the public interest in this, which ultimately is to the benefit of the community. We all, even we as a union, are grappling with that conceptually and trying to now approach that debate in a much more wider field rather than this rather narrow industrial framework that previously has been the hallmarks of these discussions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you done something to get an award for hygienists within the public sector? I gather there is not one and they are not hiring any. Have you tried to address that?

Mr RAVLICH: The limitations of the industrial framework we live in and the opportunity for us to vary or create a new award, other than in some very prescribed circumstances, are currently not available to us. Often what will occur is that de facto classifications that exist in other awards or elsewhere in the system are used as a basis of remuneration. I think it was previously suggested that the technicians rate, which was the subject of some increases in 2003, now is used as a default setting, if you like, for another group of people.

Certainly we would be more than happy, as you can imagine, to sit down and engage in these sorts of discussions if it could be a genuine attempt to improve or consolidate industrial instruments that cover what activities these people do in the workplace that leads to that connection to a direct benefit to the community they serve and that we do try to address issues about attraction and retention and grapple with attracting people to rural areas, which is obviously not unique to this profession but ambulance officers, teachers and police had to grapple with and come up with unique circumstances to resolve that.

But again too often we approach this in an industrial mindset and framework and progressively work our way through the awards or suggest that the general increase will be sufficient to resolve the issues of those employees when quite clearly it is not because we are not starting off with a level playing field. If we ever got to a level playing field, perhaps there could be an argument that a general increase would always be the answer but unfortunately that is not the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I gather that certain functions that hygienists do, like making their own dentures, do not get done within the public sector because of a lack of an award. Surely you could make a case that if someone were on an award it would save money because, at the moment, it all gets farmed out to the private sector.

Dr DUCKMANTON: With respect, I think you are getting hygienists confused with prosthetists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, sorry, that is right.

Dr DUCKMANTON: Prosthetists certainly do not have their own awards and that is one of the big problems at present. One of the areas, which I am not prepared to name, were paying their prosthetists as dental officers to attract prosthetists to the service. This can happen in some areas but if you want to attract a dentist, do you pay a dentist as a medical officer—that might be one solution—or a dental specialist as a medical specialist to attract them and retain them. Maybe that is a lateral thinking solution.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are getting around your own bureaucratic regulation, in a sense.

Dr DUCKMANTON: But it is industrially illegal.

CHAIR: This is interesting but our next witnesses are waiting. Thank you for your evidence. I do not think you have taken any matters on notice but we will contact you if we need any further clarification.

(The witnesses withdrew)

JOHN GIBBS, General Manager, Pacific Smiles Group, 2 Verdant Drive, Greenhills, and

DAVID CHARLES WRIGHT, Director, Pacific Smiles Group, 2 Verdant Drive, Greenhills, affirmed and examined:

CHAIR: Do you want to make an opening statement or does our first question about the background of the Pacific Smiles Group and the nature of your operations give you an opener to tell us about yourselves?

Mr GIBBS: Pacific Smiles Group is a private dental organisation; it is an incorporated company. It is based in regional Australia, west of Newcastle, but it has dental care centres in a stretch from Sydney to Foster, so all our locations are in New South Wales. We have seven locations. Most of them are known as Pacific Smiles Dental Care Centres, but two are known as NIB Dental Care Centres. We manage the NIB Dental Care Centres on behalf of that health fund. Our organisation does two things: we provide fully serviced dental care centres—these are larger centres than you would traditionally expect in the private sector. We do not involve ourselves in one or two-chair dental centres. We have taken a different approach over the last few years and our centres are typically eight to 11 chairs. We have 60 dentists who base their practices at our premises and we have about 120 employees. We are the largest private, non-insurance dental care group in Australia.

CHAIR: You stressed non-insurance.

Mr GIBBS: I say that only because HCF, for example, which runs a number of dental care centres throughout Sydney and suburbs is a larger dental organisation than ours in total but is annexed to a large insurance company. We are purely and simply a small organisation, a company which runs dental care centres.

CHAIR: But operating along similar lines.

Mr GIBBS: Very much so. We have taken an approach that is very much along the lines of running large efficient centres in key locations, particularly in rural and regional Australia because that is where the company was founded. Increasingly we are looking at sites in cities and suburbs and other locations in rural and regional Australia.

CHAIR: So you have plans to expand beyond Sydney-Foster?

Mr GIBBS: That is correct.

CHAIR: In New South Wales only?

Mr GIBBS: No, we are looking at interstate expansion in the longer term.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I clarify that: presumably you pay the doctors a percentage of what they earn, or is it time-based and you rent the rooms for so many dollars an hour?

Mr GIBBS: It is effectively renting the rooms on a time basis but the way that structure works is that the dentists have their own practices. They provide clinical services to the patients in their own names using their own Australian Business Numbers. We simply provide a serviced surgery concept. It is a bit like a private hospital with visiting medical officers coming and using the theatre facilities. We provide fully serviced surgeries for those dentists to base their practices.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What about the disposables they use?

Mr GIBBS: That is all included. As I say, they effectively pay a fully serviced rent. We provide the staff and the consumables, we undertake the front office and administrative functions and the marketing functions. It means it is a walk-in walk-out practice, which is again very much like a VMO using the theatres in a private hospital. That is how we have designed the organisation and that is how we have structured our large dental care centres.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is like Mayne Health's system.

Mr GIBBS: I am not familiar with Mayne Health's system but it is probably something along the lines of independent practitioners, which I believe is the way a lot of hospitals and medical centres and those sorts of things function.

CHAIR: I think you said you had 60 dentists and about 120 employees. Are the employees predominantly qualified in the various dental ancillary areas or are they clerical and administrative staff?

Mr GIBBS: They are both, but we try to have all our staff multiskilled, so we engage in a lot of training for ancillary staff. They undertake the necessary certificates so they are qualified dental assistants and we also train them in the front office and admin functions. We try to have a very flexible workforce and one that is fully trained in both admin and clerical responsibilities.

CHAIR: Do you have hygienists, prosthetists or technicians, or is it dentists and assistants?

Mr GIBBS: At this point in time we do not have hygienists or prosthetists, we have dentists and ancillary staff.

Dr DAVID WRIGHT: We do not have auxiliary staff in that range.

CHAIR: Does that mean if someone wants one of those services they are referred elsewhere?

Dr DAVID WRIGHT: The dentist is the prime caregiver in our organisation, particularly in rural and remote areas. They are the key person to contact to provide and maintain the care throughout the service.

CHAIR: In effect the dentist acts as the hygienist as well.

Dr DAVID WRIGHT: The dentist covers that range of care, much the same as a GP would cover many types of care across the broad spectrum of general practice.

CHAIR: What if someone needs a denture, for instance?

Dr DAVID WRIGHT: The dentist covers that component.

CHAIR: I think we have probably asked most of question 2. You do not provide a special service such as a denture but the dentist may organise that himself or herself.

Dr DAVID WRIGHT: We have specialists working within our dental care centres that provide services such as prosthodontics, oral surgery, orthodontics and periodontics. We have an internal referral mechanism as well if people need those specialist areas.

CHAIR: Could someone be referred from one of your seven centres to another or are you talking about the service being within one centre.

Dr DAVID WRIGHT: We can do either. For example, in the Newcastle area we have an orthodontist who also works in Sydney, so there is that opportunity to support our general dentists.

Mr GIBBS: In terms of referral patterns and systems, there is no requirement by the organisation over any of the individual practitioners. They exercise complete authority in their clinical decision-making and their referral decision-making. One of the points we tried to get across in our paper that may be a little different from what is going on in dentistry in Australia today is that we have no trouble attracting dentists. I know that that is a problem in the public sector and in many areas of the private sector, not only in rural and regional Australia but also in some suburban areas. It can be very difficult to recruit and attract dentists. One of the things we put together is a very clear delineation of clinical and admin at our top level—a board of management and a board of clinical decision making, and we do not interfere. Someone like me who is not a clinician does not interfere at

all in any aspect of what a dentist does. For that reason dentists have been highly attracted to the model and the systems we have put together.

The Hon. ROBYN PARKER: Is it only that attraction that means you are able to recruit dentists regularly? Are there other aspects that may attract them to work for your organisation?

Mr GIBBS: There are many aspects. We provide the dentists with an educational allowance. We do a whole lot of things that make it very attractive, not the least of which is a collegiate atmosphere in a larger dental care centre with general dental practitioners and specialists visiting on certain days. A whole lot of things are happening there that make it a much more attractive workplace for dentists, we believe—and certainly the numbers seem to indicate that—than working in a solo practice or in a partnership with one other dentist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably you can also get better utilisation of your chairs, and so on.

Mr GIBBS: That is very true. That is one of the measures we put in place for efficiency and we try to get maximum use of the chairs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your clinical decision makers presumably make good decisions about the types of materials that are used, which makes dentists happy. Skimping on things like that or using difficult or inferior materials is a source of some irritation, I gather, in some practices. It is a controversial aspect, is it not?

Dr DAVID WRIGHT: In the clinical management field in our company the dentists in each clinical centre have input into the types of materials that we use. They make the clinical decision about the types of materials they use in that centre. However, our education function backs that component as well by emphasising best practice and evidence-based practice. There is a combined effort in that situation where the clinician who wants to use a type of material on their patient also has input into our best-practice component.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a uniform standard?

Dr DAVID WRIGHT: We do not have a set of standards but we refer to the clinical evidence-based practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not have one material for the rich and one for the poor. I know the British National Health Service's private patients were using different materials from those used by the NHS patients because of cost. Do you have anything like that?

Dr DAVID WRIGHT: No. The materials are the same in our dental care centres for whatever range of patient comes in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they would be charged the same as well whether they can meet the cost or not.

Dr DAVID WRIGHT: I am not with you on that.

CHAIR: Why don't we wait until we have asked question 3 about who the patients are and then come back to those questions. I think the answer depends on who the patients are and whether they are exclusively private. Mr Gibbs, you said you have no difficulty recruiting and that that is quite different from the situation elsewhere, but we have heard that there is an oversupply of dentists in Sydney, particularly the Eastern Suburbs and North Shore areas. I guess the area from Sydney to Foster would not generally be an area where it is difficult to recruit, whereas if you follow through with your expansion plans and perhaps go further west in New South Wales, the situation could be different.

Mr GIBBS: Yes. I have no doubt there are more difficult areas than those in which we currently operate. Certainly it becomes more difficult as you move away from the coast and into more

remote locations. As a private organisation we assess that very carefully before we build a new centre. A new centre costs in the region of $1 million so we act very carefully before we build one. Typically we will make sure we are appealing to the profession before we make any such investment. One of the truisms we have come across is that if you do not keep the professionals happy—the dentists—there is little hope for improving services anywhere.

CHAIR: Is it public knowledge where you might operate next under your expansion plans or is it commercial in confidence?

Mr GIBBS: It is only commercial in confidence to the extent that in some cases those opportunities are acquisitions and the parties we are dealing with have signed confidentiality agreements with us. We are looking in the Sydney basin, further up the coast of New South Wales, the south of New South Wales, Victoria and parts of Queensland.

CHAIR: Are your patients exclusively private or do you participate in the Oral Health Fee for Service Scheme? If so, do you ever waive fees? Question three is quite detailed.

Dr DAVID WRIGHT: Some of the dentists who work within our facilities do offer care to the Oral Health Fee for Service Scheme. It is the same as any private grouping in rural and remote areas, where you get some uptake and some who do not. But I am comfortable and happy that we do participate in the Oral Health Fee for Service Scheme.

CHAIR: Would it be a small minority of your 60 dentists who participate?

Dr DAVID WRIGHT: It would be. We find that more participate in rural areas than in city areas.

CHAIR: So the overwhelming majority of the patients would be private.

Dr DAVID WRIGHT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they are only break-even ones or are even loss making in order to build some goodwill in the town.

Dr DAVID WRIGHT: That is part of the component. The Oral Health Fee for Service Scheme is an opportunity to increase your market exposure in that area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But presumably it is only break even. Is it economic?

Dr DAVID WRIGHT: It is not a big money spinner by any means.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a percentage less than the private fee, is it not?

Dr DAVID WRIGHT: Yes, it is.

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

Dr DAVID WRIGHT: I could not give you that.

CHAIR: We have that information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a fair bit, is it not? Therefore, that is obviously straight off your top—it is not off your margin; it is off your gross.

Dr DAVID WRIGHT: It is off the top. One of the ways of managing it is by placing the patients in set slots of time to enable us to see them within those slots.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When there is not a big demand.

Dr DAVID WRIGHT: When the demand is less.

CHAIR: If a fee were to be waived in order to help a patient would that be a decision for the individual dentist who rents the chair rather than for Pacific Smiles as such?

Dr DAVID WRIGHT: Yes, it would.

Mr GIBBS: Correct.

CHAIR: So you would not necessarily have the data on how commonly that was done because the decision would be a matter for the individual dentist rather than company policy.

Mr GIBBS: We would be able to access that data. We would know to the extent that things are being discounted or waived or any of those sorts of things. I do not have that information with me today but we would have access to that sort of data. It is very much an individual dentist's decision to participate in such plans in the first place and, secondly, to waive fees under such plans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are not wearing the loss for that.

Mr GIBBS: We are in a sense because effectively the revenue that a particular dentist makes from a day's work we take a share of by leasing the service space. So were a dentist to provide that type of service all day it would affect the dentist and also Pacific Smiles.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So he is not renting the chair for a specific amount and if he does not make any money—

Mr GIBBS: That is correct. It is more along the lines of the rent being more like a turnover rent than a floor space rent.

Dr DAVID WRIGHT: May I go back a little and look at the Oral Health Fee for Service Scheme. It is not overly attractive to many private practitioners because of the limitations on the range of services that are available. If you were doing that type of dentistry day in, day out you would be restricting your practice and indeed deskilling. So it is certainly not something that I, as a dentist, would like to do day in, day out. But I certainly participate in the scheme.

CHAIR: We have heard evidence to that effect from a number of people. Would most of your clients have private health insurance with dental cover? Does your data show that?

Mr GIBBS: Not most but quite a lot—about half our patients.

CHAIR: Is that a fairly static percentage? Is it growing?

Mr GIBBS: It is reasonably static; it does not move a lot from one year to the next.

CHAIR: If it is about half, would there be a difference in the services being sought by people depending on whether they have that cover?

Dr DAVID WRIGHT: There is a component that people do mention they are members of a health fund when they come to see you as a practitioner. But the type of care is obviously a relationship between the practitioner and the patient and is made by the determination of an informed consent.

Mr GIBBS: To add to that—correct me if I am wrong, David—those who are privately insured tend to take more of a preventive approach to their dentistry than those who are not because they know that they may have those two free check-ups per year and many of them use those two free check-ups per year, whereas those who are not privately insured are more coming in on a reactionary-type basis.

The Hon. ROBYN PARKER: I must declare a conflict of interest as I was in a Pacific Smiles dental chair yesterday. In your submission you talk about a public-private partnership. Can you explore that a little for us? How do you see this working in terms of the provision of public dental services?

Mr GIBBS: A year ago this month another director of Pacific Smiles and I went and visited some of the groups in the United Kingdom. In our opinion some of the groups were not faring particularly well, either financially or operationally. However, one group in particular had struck upon a way of providing services to a particular population through a contract with the National Health Service. In fact, this contract was so structured that it provided outstanding services to those patients and it also provided the satisfaction needed for that group to attract dentists. They, like Pacific Smiles in Australia, were having no problem at all attracting dentists. There were two reasons for that. One was that the dentists were able to not be deskilled; they were able to provide a variety of work to both public and private patients but in a public clinic setting. They were also able to be financially rewarded commensurate with their expectations as a professional. Those two things combined allowed them to be able to fulfil that contract.

It was a capitation contract. It was a contract whereby the purchaser, the Government, was able to delegate some risk to the provider. The provider carried that risk by simply having a given amount of money per patient on that program so that the funder knew specifically and precisely up front how much that program was going to cost them for the full year and then the risk was delegated to the provider to provide the service to that population. This model seemed to be working for all parties—it seemed to be working for the funder, it seemed to be working for the dentist and it seemed to be working very well for the patient. I guess the PPP that we have put together, or the pilot scheme proposal, is based very much on that particular model in the southwest of England. Did you wish to add something, David?

Dr DAVID WRIGHT: I think there is a great opportunity to establish a PPP, but as a pilot scheme initially, to determine, one, its usefulness, its feasibility and all of its enterprise and determine whether it is meeting the needs and demands out there. The UK experience certainly has had a partnership between private and public facilities and practitioners and it certainly appears to make a much better range of dental care available to lessen the opportunities of deskilling the dentists.

The Hon. ROBYN PARKER: Surely that is based on a reasonable compensation to the dentists providing the care. That would mean for your pilot program in New South Wales that the New South Wales Government as it is currently funding dental health would have to increase its remuneration to dentists, would it not?

Mr GIBBS: There is an aspect to it that overcomes that need. The reason for that is the way that it has blended public dentistry at certain hours of the day and private dentistry at the beginning and the end of the day. Because of that the dentist's remuneration is not purely based on public remuneration. It is also based on private remuneration in that same clinic. Because of that blending—that intertwining of the public and the private—it takes some of the pressure off the need to increase public funding. It is very much like David was saying a moment ago: were he, as a dentist, to provide voucher patient services all day every day it would not only be not financially rewarding but professionally deskilling. These clinics found that the way around that is to allow those dentists to also do some private work at certain hours of the day. What you are saying may have an element of truth in terms of the funding element for the public component but the dentist's remuneration is not completely reliant upon the public purse, and that is one of the beauties of the system.

The Hon. ROBYN PARKER: Do you think that you would be able to do more preventive-type care of public patients rather than being reactionary and pulling teeth and doing the basic work?

Mr GIBBS: That is certainly the experience of the UK group but perhaps David could add to that from a clinical point of view.

Dr DAVID WRIGHT: I think where you have the market for dentists to do a wider range of dentistry and skills—in particular, preventive is a key component of Pacific Smiles and general dental practice in private—you have got the opportunity that that will occur. But it is not a given that it will occur. One of the ways that it can occur is that it is available, accessible, affordable and it is there. In

my experience within public dental facilities there are very few dentists in that practice. When there are, they are widespread. There are limited hours. The access is small by comparison with what is available in the private sphere and there are more opportunities within the private sphere to perform that service across a greater range of hours and opening a greater number of dentists. By having it in a mixed public-private facility you have got the opportunity for that to occur. At present, my experience in the public arena is that it is widespread but it is very, very small.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this an HMO model to some extent—the capitation model with comprehensive service?

CHAIR: What is HMO?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A health maintenance organization, the American health insurance.

Mr GIBBS: I think the way it differs from a HMO is that under a HMO—or at least my understanding of a HMO—is that you have an insurance or some other body being the payer controlling the access to that service and in fact directing patients as to when and how they may be referred and treated. In this case, the payer—at least for the public patients under this proposed pilot—is the Government. Unless the Government were wishing to act in that sort of role I would not see it as featuring as a HMO. It would very much be a capitation scheme without those HMO connotations. In other words, there would be a certain amount of money per patient, per year. Those patients would be required to attend for their preventive treatments. From the preventive treatments any further work that is required would be provided to those patients and under the pure scheme there would be no further payment in respect of those patients to have that work that is required to bring them up to a standard of ongoing preventive care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The problem with HMOs is that technically any care you need is covered in the capitation fee but in practice it is not and it is very dependent on the demographic—what demands are made of the HMO.

Mr GIBBS: That is very true. I think where the HMO model becomes distorted is when there is delegated risk to a provider and the provider begins to say, "We can't do this, that and the other". I think right at the beginning of anything like this there needs to be clearly specified what treatments can be provided under the model and the hours of access to such a model. If those things are specified up front the outcome that you have described may not eventuate.

CHAIR: How is the Government or the taxpayer assured that the services provided are appropriate in quantity and quality?

Mr GIBBS: We have looked at this model from the point of view of cost and from the point of view of outcomes. Certainly the Government or the taxpayer would need to be absolutely assured that there are demonstrable and measurable outcomes. Those outcomes can be in terms of clinical indicators or the number of treatments provided. There are a number of different key performance indicators that could be put in place to ensure that adequate performance is being provided by the providers under such a model.

CHAIR: And your model allows for those indicators to be put in place?

Mr GIBBS: It does, in fact.

Dr DAVID WRIGHT: We also have, as part of Pacific Smiles group—we talked about the peak clinical body that we have—a clinical audit system that is in place that measures such things as critical incidents, but also it is looking practically at the audit system of what is provided and the type of care that is provided by agreement with the independent dentists. They participate in the process as much as we do.

CHAIR: One of our earlier witnesses today made a comment that it was really easy to audit fillings, but much harder to audit preventive care in particular, which she was saying more in sorrow than in anger, I think. Is that the case?

Dr DAVID WRIGHT: I would certainly agree there, but I think that the import of preventive care is a long-term process.

CHAIR: But how do you audit it? That is the point she was making. Obviously it is what we should be doing, but it is very much harder to be sure that it is being done than for governments, taxpayers or someone to audit it.

Dr DAVID WRIGHT: Also, it is difficult to say that input has resulted in that outcome in many ways. Oral health education, for example, is very hard to measure—it has been across the world very difficult to measure—but there are certain systems in place, particularly in the United Kingdom and the Scandinavian countries, that have measures and outcomes relating to child dentistry and ranging from their decayed, missing, filled teeth index relating to their surfaces of teeth that are covered by plaque, et cetera. But ranging through that range are also some very good studies relating to such services as oral health care in the elderly and the institutionalised whereby the type of care and the carers' knowledge is related to the type of care provided and also the outcomes for their clients and patients. But there are measures available, and I think that in a PPP that has to be spelled out fairly soon and fairly significantly in the first place.

The Hon. ROBYN PARKER: Do you know the percentages of your privately insured patients who have taken out that insurance specifically for dental care in spite of the fact that they may be eligible for public dental care?

Dr DAVID WRIGHT: I do not have that information available, but I believe that some work was done by the Australian Institute of Health and Welfare sometime ago in a national dental telephone survey that related to some of that information.

CHAIR: Professor Spencer gave us a figure this morning. Basically, roughly one-fifth of people eligible for public care had private insurance. That is an Australia wide figure, I am pretty sure, not a New South Wales figure. A lot of what you have said already is partly an answer to question 6 about how you think access to public dental services in rural and remote areas can be improved. One suggestion you would make is by means of a PPP rather than specifically public dental services. Do you have any other suggestions?

Mr GIBBS: When we started to do some work on this model we looked at what works on the private side. That may be translatable it may not be, but, certainly, when we look at the cost side of things we look at fragmentation, which is more expensive than consolidation and we wonder whether even in regional areas there is scope to have rather than a network of smaller clinics where you may have the isolation effects on the professionals and the deskilling effects, a larger more centralised close to transport hubs, et cetera, public facility with those other features that we have talked about already with some hours of the day.

CHAIR: Bringing the patient to the clinic?

Mr GIBBS: That certainly is another option. From the professionals point of view and the operational point of view we believe that is probably the more attractive model in terms of being able to get the dentists there in the first place and then provide the services cost effectively. We believe also that it is more cost effective to have a motivated work force than a demotivated one and we believe, again, that type of structure, that type of environment, at least for us on the private side works more effectively and has much greater motivational effects than having smaller clinics. We have been involved in smaller clinics, so we have seen both sides. That really is a model we have been looking at in terms of the PPP, a larger clinic plus those other features, the professionals being able to provide certain hours of the day to private patients. When we have a look at some of the statistics and papers it seems to us to be the ambulatory adult population in Australia who are most greatly missing out on dental services—not children, but this adult population. Very much we saw that that might be the particular area that these types of clinics would focus on.

CHAIR: Do you think Medicare should be extended to cover oral health?

Mr GIBBS: That is a very, very difficult question to answer. When you look at patients in need, obviously the reaction to that would be yes, of course. But there are so many different aspects and levels to that question. In the first instance what we need to look at is an efficient delivery model, and that is what we are really here to present today.

CHAIR: But those who cannot afford your model, what about them? Given the criticisms that are made of the adequacy of public dental services some people would suggest that the funding problem is insuperable. Dental health is part of general health. Is it not time we revisited Medicare covering dental health as well?

Mr GIBBS: The first part of your question was what about those who cannot afford the services that we provide currently. I presume you mean through our private clinics?

CHAIR: Yes.

Mr GIBBS: I guess that is why we developed this model, because we believed that could provide those services. Of course, we have not done a full financial impact study of what that would mean per head of population or per head of eligible patient, but certainly that would be a more accessible model than purely private clinics.

The Hon. ROBYN PARKER: Have you presented that model to the New South Wales Minister for Health?

Mr GIBBS: No, we have not, but we have presented it to the Hunter-New England Area Health Service.

The Hon. ROBYN PARKER: How was it received?

Mr GIBBS: The concept was received well, but it was one of those things that the devil is in the detail. Certainly we would need to look at how we could provide universality of access to eligible patients and those types of things. Dr Wright was there with me.

Dr DAVID WRIGHT: I would support that. It was well received. But, again, there needed to be some further work done in that process, such as providing information back.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is your PPP, is it?

Mr GIBBS: Yes.

The Hon. ROBYN PARKER: Did they acknowledge that it would be difficult to achieve with only 1 per cent of the health budget going towards dental health care in New South Wales?

Mr GIBBS: We did not really get down to that level of detail.

Dr DAVID WRIGHT: It really is hard in that perspective to put the relationship between funding models and also the type of provider models that we have placed here today. One of the things that I felt that we could offer in that process was a working partnership with the public arena into a public-private mix, and certainly a progressive and innovative way of getting some progress in this quagmire.

Mr GIBBS: The reason we suggested the pilot is to be able to work out a lot of those costings. Certainly, we can do some more financial modelling, but running a pilot for a defined period of time probably would be the most effective way to determine the impact on all parties concerned.

CHAIR: Thank you very much for coming, giving us a lot to think about and raising things that other people have not raised with us. Did you have something that your were going to give us, Mr Gibbs, or was it your submission that you were looking at?

Mr GIBBS: I have my submission, but I also have a copy of the presentation on the PPP, which we could provide to the Committee.

CHAIR: Thank you. After looking at that we may get back to you seeking further information or clarity.

(The witnesses withdrew.)

FRANCES CLARE CUNNINGHAM, General Manager, New South Wales, Australian Health Insurance Association, affirmed and examined:

ANGUS CAMERON NORRIS, General Manager, Health and Benefits, MBF Australia, Bridge Street, Sydney, sworn and examined:

CHAIR: I note the email you sent to us about the difficulty of consulting people, given that you said you received our questions last Friday. You can give us an opinion insofar as you can go, or we can arrange for you to get back to us later. It is always difficult for us putting hearings together, finalising witnesses and preparing questions a long time in advance, but we understand that when you represent an association its members have a right to their view. Let us know if there is a problem area and then we can determine the best way to deal with it. Would you like to make an opening statement before we get into those questions?

Dr CUNNINGHAM: Yes, I would. Thank you, first of all, for the opportunity to represent the Australian Health Insurance Association to the Committee today. The Australian Health Insurance Association [AHIA] is the major industry association for private health insurance firms in Australia. The association represents 26 registered health benefits organisations [RHBOs], which, together, cover 93 per cent of the privately insured population in Australia. I have a list of the members.

CHAIR: It would be useful if you could give us that.

Dr CUNNINGHAM: The association was established in 1971. Its principal objective is to advance the interest of all its members in relations with governments, the media, contributors and other organisations involved in the health care field. The association also provides an information and advisory service to members in relation to issues affecting their operations. In addition, the association has a role in co-ordination of industry activities and in education through the Organisation of National Conferences and Industry Meetings. The membership of the AHIA is voluntary for private health insurers. In addition to the AHIA, the Health Insurance Restricted Membership Association of Australia [HIRMAA] is an industry association representing 14 health funds, primarily smaller, restricted membership health funds.

Private health insurance firms are regulated by the Federal Government through the Commonwealth Department of Health and Ageing and the Private Health Insurance Administration Council [PHIAC]. There is also a private health insurance ombudsman. Regulation of private health insurance largely is through the National Health Act 1953. As at September 2005 a total of 3.7 million people in New South Wales, or 52 per cent of the population, had some form of private health insurance. From September 1999 to September 2005 there has been an increase in the proportion of the privately insured population with dental coverage, up from 73 per cent to 79.5 per cent in New South Wales and from 74 per cent to 80.5 per cent nationally. There has been a noticeable increase in this proportion in recent years.

The fact that 3.2 million people in New South Wales take out ancillary cover—45.1 per cent of the population in December 05—shows they value their purchase. The ancillary products cover more than just dental care. However, we draw your attention to the fact that dental benefit payments make up more than 50 per cent of the total ancillary benefit payments. I will stop there because I think the other sections go to the questions that you have asked.

CHAIR: You have certainly answered those factual questions that we started with. I would like to clarify something, because you were going quite fast there: you said the percentage with dental coverage has gone, I think, from 73 per cent to 79 per cent.

Dr CUNNINGHAM: That is out of the total proportion who have some form of private health insurance in New South Wales.

CHAIR: I did not quite catch the figures you gave us about ancillary benefits.

Dr CUNNINGHAM: It was 45.1 per cent in New South Wales. It has been on the increase in recent years.

CHAIR: And a large part of the payouts relate to dental matters.

Dr CUNNINGHAM: More than 50 per cent.

The Hon. ROBYN PARKER: Has that had anything to do with the Federal Government 30 per cent rebate? Can you tie it to that at all in terms of the uptake of that health insurance?

Dr CUNNINGHAM: We have generally charted the impact of the rebate on the uptake in private health insurance. Before the introduction of the rebate, health insurance coverage levels were running in the 30s. So there has been a huge upswing, combined with the introduction of lifetime health cover.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the tax incentives.

Dr CUNNINGHAM: And the tax incentives as well. So it is a whole package of incentives. Then, more recently, we had the introduction of the higher levels of rebate, from April 2005. Before that, there was a 30 per cent rebate, applicable to all, and from 1 April there was an increase: for those aged 65 to 69, a 35 per cent rebate; and then, above age 69, it is a 40 per cent rebate.

The Hon. ROBYN PARKER: Would you view that rebate as a positive? And if it were to be taken away, what do you think would happen?

Dr CUNNINGHAM: Absolutely. It has succeeded in making private health insurance very affordable in Australia. Do you have any additional comment on that?

Mr NORRIS: Quite clearly, the government incentives over the last number of years—and there have been a number of those individual incentives which together make up the total—have led to an extraordinary boost in the uptake of private health insurance. If that 30 per cent rebate were to be taken away, we would be talking about an impact on over 45 per cent of the total population. It would probably be fair to assume that it may revert back to what the uptake was prior to those incentives, which was extraordinarily low.

Dr CUNNINGHAM: And that would impact on the elderly population, because of the higher levels of rebate now too.

CHAIR: Do you have any idea of the extent to which dental coverage has been a motivating factor in people taking out private insurance, or is it too complicated an issue to say that?

Dr CUNNINGHAM: I think our answer to question 5 explains the different types of insurance. It might be timely to describe the different hospital coverage and ancillary coverage, because dental is part of ancillary coverage.

CHAIR: You are the experts, so if they are dealt with in different orders, that is fine.

Dr CUNNINGHAM: Health funds may have several "tables", as they are called. So that, in additional to hospital coverage, of course there is some dental coverage within the hospital tables, because where patients are treated as inpatients in private hospitals, or as private patients in public hospitals, or whether they are inpatients in day surgeries for dental care, that is part of the dental coverage as well. But, generally, we are speaking about dental coverage through the ancillary tables. In those ancillary tables, health funds may have several tables covering the ancillaries area, including coverage of dentistry. Different tables usually provide for different levels of coverage and different annual financial limits. For example, a basic plan might cover only general dental care, not major dental, and may target young singles.

For each fund, the higher cost tables provide more comprehensive dollar coverage. Under the coverage of general dental services, the services covered could include diagnostic procedures, consultations, X-rays, preventative procedures, oral surgery, endodontics, root canal therapy, restorative services, and special dental services coverage may include the following: periodontics,

special root planing, oral surgery, endodontics, root canal therapy, general services, and high cost dentistry—for example, crowns, bridges, dentures and orthodontic.

There are a number of health fund approaches to payment of dental benefits. Some of the approaches are as follows: a fixed dollar benefit per stipulated service, for example, a dollar amount per consultation or up to a specified amount; a benefit as a percentage of the dentist's fee; a combination, for example, a percentage, but up to a dollar limit; there may be limits on coverage of particular services, for example, two examinations per person per year; financial year limits per person or per policy; there may be different separate limits for general dentistry, specialist dentistry and high cost dentistry. The orthodontic financial limit may be per lifetime. Some funds may give a maximum combined limit for two consecutive years, and some funds offer an increase in the annual dollar limit via loyalty bonus.

Some health funds also have dental networks, or preferred provider arrangements, and through these networks they can assist in access to dental care in specific locations for their members and, in addition, may apply limits to maximum charges for reimbursement to dentists. Increasingly, preventative dental items have been reimbursed at a higher level than other dental services. The funds are guided in what they do by the rules inherent in the Australian Dental Association's dental schedule about what is clinically appropriate. It should be noted that, in addition to ancillary coverage for out-of-hospital dental services, as I said before, hospital insurance will also cover oral health services provided on an inpatient basis, whether for overnight services or day hospital services. So that is a range of the types of premium structures.

CHAIR: Do consumers really know? It sounds a bit like what happens when you are getting a telephone: there are so many different plans that you find yourself switching off because you just cannot—

Mr NORRIS: What Frances has outlined there is a combination of what a lot of funds do. A single member within a single fund ancillaries is probably relatively simple to understand. You receive a benefit either at an item number level, or it could be that there is a maximum per year. And, also, dentists are very well informed. Normally, dental assistants within a practice are given full financial consent, and so they become experts as well, so they assist the members through it. But it can be complicated.

You asked: Is it a motivating factor to take up private health insurance? It is very hard to measure, even when you do focus groups—and industry and individual funds are continually doing that. I think most people now take it for granted that dental is a core base of ancillary services, and that is probably represented by the fact that 50 per cent of the total benefits paid by any health fund in ancillary is purely for dental. So it is obviously a very important item with an ancillary suite.

CHAIR: Do families vary very much in terms of the importance they place on dental coverage and dental services, depending on, for instance, the stage of life of their children or the age of the people concerned—or is this just getting into a grab of detail?

Mr NORRIS: Are you asking me as a father?

CHAIR: No. In terms of your focus groups and your marketing and so on, I am wondering whether particular family circumstances make certain sorts of cover much more attractive or important to them?

Mr NORRIS: Health insurance is about mitigating risk. People who are risk averse are probably more inclined to take out insurance for their house, their car and everything else, and health insurance probably has a degree of that to it. But the reality is that everyone knows that you will need to go to a dentist. You do not necessarily know that your house is going to burn down, but you can guarantee that you will need to go to a dentist at some stage. If you have children, you can probably guarantee that you are going to have to start to dig deep into the pocket for braces and everything else that goes with that. It is a calculated purchase. But we have found that preventative dental coverage is being asked for very much more by our membership base. I think there has been a whole campaign over the last number of years about awareness of health, and dental health has not been exclusive from that.

CHAIR: I think you said, Dr Cunningham, that there has been a tendency to increase the amount payable for preventative work.

Dr CUNNINGHAM: Yes.

CHAIR: Compared to repair work, I suppose. One of the issues that we have faced is that sometimes it is harder to measure preventive work, as compared to extractions and fillings and those kinds of things. What sort of work is particularly rewarded by the health insurance?

Dr CUNNINGHAM: I will defer to Mr Norris on that question.

Mr NORRIS: As a purchaser of the services on behalf of members, no matter whom we are dealing with, be it a dentist, a physiotherapist or a cardiac surgeon, we are asking for quality measures, quality standards in the first instance, and then we start to look at: Are there any measurements of clinical outcome studies? Dentistry is extremely hard on the preventative side, but I suppose it is an intuitive decision by both a health fund and a dental provider to know that prevention is better than cure. The reality is that a number of health funds offer three consultations and visits per year for dental health checkups, some health funds pay for oral hygiene advice, and so on. That is trying to reinforce the value in prevention. So it is a focus of trying to take a holistic approach, rather than one of just cure. But it is very hard to measure.

CHAIR: Can you give us any of the dollar figures that we have asked for, say for an average premium?

Dr CUNNINGHAM: Yes. The cost of an average hospital and ancillary premium in New South Wales—that is, the combined premium—is $1,521 for a single membership, and $3,042 for a family membership. The cost of an average ancillary premium in New South Wales is $528 for a single membership and $1,055 for a family membership. These figures are the full premium cost prior to the application of the rebate. Hence, the rebate assists Australian families in making private health insurance coverage affordable.

The insurance premiums will differ between funds, State, product, product features, et cetera, and will be based on a health fund's own actuarial assessments about service utilisation, provider charges, changes in clinical treatment and technology, and appropriate benefit levels. Those factors will have a different weighting depending upon whether it is a combined hospital and ancillary product, as opposed to an ancillary product only. Health fund premiums are priced by reference to, and weighted according to, individual modalities, their utilisation levels and their benefits paid levels and annual benefit limits.

CHAIR: In question 4 we asked how much of that average premium constitutes dental coverage. Is it not possible to answer that because dental is almost always within the ancillary benefit?

Dr CUNNINGHAM: Yes, it normally is within the ancillary benefit.

CHAIR: So we cannot separate it out?

Dr CUNNINGHAM: No. But, as some indication, I did pull out some figures on ancillary benefits paid in New South Wales. Normally, when the statistics are presented through the regulatory agency, they present New South Wales and ACT; they do not separate out the ACT because the premiums offered are for New South Wales and the ACT. But, to give you an example: for the last financial year, 2004-05, dental benefit payments were 52 per cent, and then it dropped down to 16.2 per cent for optical, physiotherapy 7.2 per cent, chiropractic 6.3, pharmacy 4.5, and so on. The other ones will be podiatry, natural therapy, ambulance, acupuncture, psychology, prostheses, hearing aids, speech therapy, preventive health services, occupational therapy, osteopathy, dietetics and other.

CHAIR: The second one was physiotherapy, and what was its percentage?

Dr CUNNINGHAM: The second one was optical, 16 per cent, and physiotherapy was 7 per cent.

CHAIR: It is a big gap, isn't it?

Dr CUNNINGHAM: It is big.

CHAIR: From 52 per cent.

Dr CUNNINGHAM: Yes, it is.

CHAIR: There would be no real difference in terms of eligibility for coverage. If you need physiotherapy and you get it, it is covered at the same rate. There is not a different set of rules for dental work?

Dr CUNNINGHAM: No.

CHAIR: In fact, dental work may be more restrictive in terms of the number of services a year.

Mr NORRIS: When you get into the complexities of actuarial work and so on—which I try to keep well away from myself—the reality is when people buy an ancillary product it is for the whole suite of ancillaries. Invariably, people buy it because they know they are going to use it. I wear glasses so I know I will be claiming for optometry. My children wear glasses. I am an expensive member. The same goes for dental, physiotherapy, chiropractic. Pharmacy is an increasing modality being used by members, specifically aged members because they get great relief through the ancillary product for drugs that are not PBS covered and have to buy over the counter as referrals from GPs and so on. It is very hard to quantify what bit is for which. What we can always go back to is that over 50 per cent of the benefits that we pay out are for dental. If you were to try to align at 30 per cent of the rebate, what part of that is dentistry? It is not relative. Fifty per cent of the benefits are paid out purely for dental.

CHAIR: Therefore, the 30 per cent rebate is proportionate to that?

Mr NORRIS: No, the 30 per cent rebate is proportionate to the price of the premium only. It is not relative to the benefits. The 30 per cent rebate applies to the whole product. There are members who may not use dental in any given year but they will use optometry, pharmacy, physiotherapy, all sorts of things within the ancillary suite. But the next year the whole mix changes because they then use dental.

CHAIR: That question is meaningless then, because the way it is structured you cannot divide the rebate into sections.

Mr NORRIS: It is not that you cannot, it is just that it is impossible because it is not relevant. What is relevant is the 30 per cent rebate to affordability of coverage, to take out a cover and have access to what is more and more becoming primary health care. We talk about ancillary and I think we can be quite flippant about that. A lot of this is actually primary health care and general practitioners probably refer people directly as well because that is the only place that people can get access.

The Hon. ROBYN PARKER: Given that, should some of those ancillary benefits be merged into a general health insurance product? We have received a great deal of evidence about the health and wellbeing benefits of good dental care. People have less cardiac problems. We heard about neonatal low birth rates due to gum disease. Should dental procedures move out of ancillary and into the general health product? If so, what would that do to public health insurance policies?

Dr CUNNINGHAM: I think that goes to the structure of private health insurance under the National Health Act. Historically, private health insurance has been structured so that there are these separate tables, the hospital tables and the ancillary tables. I think that really is more an issue for the Australian Government under the National Health Act and how health insurance might be structured.

CHAIR: The definition of an ancillary is covered by the Act. Each individual company does not make a choice about the definitions?

Dr CUNNINGHAM: Actually there is more flexibility in ancillary. There is not under hospital tables. But under ancillary there is a little bit less burden of regulation compared with what is under the hospital tables.

CHAIR: The fact that you can or cannot offer something still does not change the fact that it is defined as ancillary? You cannot move it into the more fundamental hospital table.

Mr NORRIS: No. Under current regulations and legislation you could not do that. Your question is interesting. I suppose part of the response from anyone should be that the decision should be based on does it limit the ability of Australians to continue to afford health insurance and, if so, how that might that be mitigated? The other part to that is once you move something into hospital you are given an enormous amount of regulation within the Health Act and community rating apply significantly within the hospital products as compared to the ancillary. It could have some disadvantages attached to it.

Dr CUNNINGHAM: Some funds do offer combined products—hospital and ancillary products. I suppose that goes some way towards that approach.

CHAIR: There has been a suggestion that health insurers could provide a basic dental cover at a low price to help solve the problem of low-income earners getting access to dental services. Do you have any comments on the proposal? Could it be done from an industry point of view?

Dr CUNNINGHAM: We do have a comment on it. Of our members there is one fund that does have a dental-only product and that is for members who have hospital coverage with that fund. There has been a very low take-up of that product, as we understand it.

CHAIR: Which fund is it? Do they offer it in New South Wales?

Dr CUNNINGHAM: Yes, they do. It is BUPA.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The pommie one.

Dr CUNNINGHAM: It operates as HBA in New South Wales.

Mr NORRIS: I am not quite sure what the question is in that as an industry or as an individual health fund I am not sure that we have been asked to consider a way in which we could open up access to people who currently cannot afford private health insurance. Is that the question?

CHAIR: It has been a suggestion put to the Committee, amongst all the different submissions. We wondered if you had comments on its desirability and feasibility.

Mr NORRIS: The Australian health system is a dual system of both public and private. In my view, that works very well. In fact, it could be expanded to allow people who may not be having access to primary dental care. Where they could access primary dental care, I think all of us would support it both as an industry and as an individual fund. The actual practicalities of it, I have no idea because if something costs $1,000 in costs and benefits to pay a dentist and you want to charge $300 then it is not feasible. That is the reality of it. Philosophically, I do not think anyone would be in disagreement that we should try to make every Australian have access to primary dental care.

Dr CUNNINGHAM: Under the National Health Act health funds have to apply community ratings. That means they have to charge all comers the same for a particular product. They cannot charge people on a lower income less.

Mr NORRIS: We could not design and sell a product at let us say $100 a year and exclude anyone from being able to purchase that product.

CHAIR: How does BUPA do it?

Dr CUNNINGHAM: That product would be actuarially rated. It might be why there has not been a huge take-up.

Mr NORRIS: I do not think you should be too confused about that. I do not know too much about that product but it is related to the fact that you must have hospital cover as well. It is not a standalone product. Probably the actuary has offset it. It may even be running at a loss but that would be offset through the hospital component.

The Hon. ROBYN PARKER: In other countries it is possible for employers and organisations to take out dental plans on behalf of their employees. What do you think about that idea? Would that be possible and popular in Australia?

Dr CUNNINGHAM: I think it is not really encouraged under the Australian system because we do not have fringe benefits tax deductibility here. If there were a change in that it could become more attractive to employers.

CHAIR: Should Medicare be extended to cover oral health services? Why are you laughing?

Dr CUNNINGHAM: We see matters regarding Medicare and its extension as really largely a matter for the Australian Government. However, historically, the health system in Australia, as Gus alluded to earlier, has seemed to work fairly well with a balanced public-private system. We would see that continuing into the future. In fact, it is one of the features of the Australian system that is admired by a lot of international countries.

CHAIR: The suggestion by those who do argue that Medicare should be extended is that it would make no difference to the public-private mix. It would mean that dental services would be treated like medical services.

Mr NORRIS: If you are talking about the whole suite of dentistry or you are talking about just some item numbers that cover oral hygiene and so on, it is an interesting concept. The whole thing comes down to affordability to the Commonwealth Government and all the State governments.

Dr CUNNINGHAM: And to taxpayers.

Mr NORRIS: And to taxpayers as to what service you are talking about and what you would be paying for them. Don't forget, as health funds we cannot set the price. We do not set the price for dentistry, dentists do. It would be interesting to see what the uptake of that would be. I think even previous witnesses were quite open about the fact that some of the schemes in place now do not offer the appropriate financial incentive for dentists to embrace it and the quantity of services, down-skilling and so on is an issue. Philosophically, again, if people are not getting access to something they really need, then sure.

The Hon. IAN WEST: Philosophically you have no objection. You are talking about how it is implemented.

Mr NORRIS: Yes.

The Hon. ROBYN PARKER: Again philosophically, you would think that public dentistry should be a greater component of funding from the State.

Dr CUNNINGHAM: Historically it has been a role of the State Government. As I said, we see it as a matter for the Australian Government. We do not have a formal position on this as an association. Historically, yes, it has been a matter for the State Government and the dollar contribution from the State in the public sector is quite slow in New South Wales compared with other States, significantly lower.

The Hon. IAN WEST: Are you sure that BUPA is the only one that offers the service? Does not the Druids Friendly Society offer that service?

Dr CUNNINGHAM: That may be.

Mr NORRIS: For a standalone dental product?

The Hon. IAN WEST: Yes.

Mr NORRIS: I am not sure.

Dr CUNNINGHAM: They are not one of our members.

Mr NORRIS: They are part of the closed funds.

Dr CUNNINGHAM: It may be some of the funds that belong to another association.

CHAIR: They are the ones with closed or limited memberships?

Mr NORRIS: Yes.

CHAIR: For example, I do not think the Teachers Federation health fund is here. That is because you have to be a member of the federation to be a member of its health fund.

The Hon. IAN WEST: Do you say that 24 and 25 are not members?

Dr CUNNINGHAM: Sorry, they are.

Mr NORRIS: To the best of our knowledge, that is the product that has been brought to our attention. It may not be the case. There may be one or two others, but they would be very very minor or very small, or we would be aware of them.

CHAIR: Have you given consideration to any way in which private health insurance could be made more affordable to lower income earners?

Dr CUNNINGHAM: One of our concerns is with the significant rise and the upward trend in the increasing dentist's charges over the last 10 years. New South Wales has seen an increase in dentists' charges of 129 per cent and utilisation increases of 50 per cent. The rise in the dental segment of the health price index, which is greater than the consumer price index over the period September 1995 to June 2005, was 60 per cent. This has to be factored into any product design. Funds alone do not determine price, as the underlying costs are set by dentists. All funds are concerned that their premiums are as low as possible so that more Australians can afford private health insurance. Individual funds may develop products to attract different segments of the market, including say a less comprehensive lower cost ancillary product. However, funds cannot control dentists' charges and in the end it is often the health funds that bear the brunt of criticism on the impact of charges over which they have no control.

In that regard funds are already paying back 90 per cent of their premiums to their members as benefits. Having said that, those who tend to take out ancillaries coverage, as Gus mentioned, including dental coverage, are generally those who expect to use the product in the near term, unlike normal insurance—for example, fire, house, car. Given that funds are bound by the rules of community rating, there is no possibility to risk-adjust premiums, thereby reducing the premiums for some potential contributors. I should note that some network arrangements, or preferred-provider arrangements, have been introduced by some health funds, and these arrangements assist not only in providing access to dental treatment but also in providing certainty regarding the cost to members. Hence, such network arrangements can assist in ensuring access to affordable dental care.

An issue that has been raised with the Private Health Insurance Ombudsman by New South Wales consumers relates to their experience where dentists have not provided informed financial consent. There is a clear need for improvement in the provision of informed financial consent to consumers by dentists.

CHAIR: Is that dentists in general?

Dr CUNNINGHAM: Yes.

CHAIR: I think you said that in New South Wales over the past 10 years dental charges have gone up 129 per cent and services have gone up 50 per cent. We have been given all sorts of figures, but I do not think we have been given such a short, sharp picture. Where have those figures come from? Are they increases across the board or are they based on people with a private cover.

Dr CUNNINGHAM: That is our data from within the association.

CHAIR: So it would be data relating to people with ancillary benefits and making claims?

Dr CUNNINGHAM: That is right.

CHAIR: So your actuaries show that over the past 10 years the cost has gone up.

Dr CUNNINGHAM: Yes.

Mr NORRIS: It is not just that our actuaries have shown; we receive the charges received by dentists.

Dr CUNNINGHAM: They put it on the claims; it is from claims data provided by the health funds.

CHAIR: That would be why we have not received such a short, sharp picture of those costs before.

Mr NORRIS: The ADA could have given it to you; they are the ones who charge.

CHAIR: It may well be that we heard from the ADA. It has people in the gallery. We heard from them a long time ago.

The Hon. ROBYN PARKER: They might like a right of reply now.

CHAIR: They can always have that, but not today.

The Hon. ROBYN PARKER: We have asked everybody the same question. You have presented some compelling statistics today that have stretched our imaginations. What do you hope will come out of this inquiry from your association's point of view?

Dr CUNNINGHAM: We hope there will be a broader understanding of the role of private health insurance and its significance and importance for at least the 45 per cent of the population in New South Wales who are members. That percentage would be a lot higher in a number of electorates as well. Private health insurance has a significant role in covering in the ancillary areas, not only dental services but also a range of other services.

Mr NORRIS: My hope would be that whatever conclusions or solutions are reached there are solutions that see the public and private sector coming up with the way forward rather than one pitted against the other. Forty-five per cent of the population has private health insurance; 45 per cent of the population has hospital insurance. It is a significant part of the community. We play a very strong role within the purchase of health services, and I think the answer really is between public and private, the ADA, government and the providers. I think the answer is there.

Dr CUNNINGHAM: I am happy to check on whether Druids do cover the dental only product and provide that information.

The Hon. KAYEE GRIFFIN: You referred to the Ombudsman's comments. I presume that people are going to dentists because they are in pain or they have a major dental issue and the dentist does not tell them about the costs before the work is done and they are presented with the bill.

Dr CUNNINGHAM: That is certainly how I understand it.

The Hon. KAYEE GRIFFIN: There is no discussion beforehand about what the cost might be?

Dr CUNNINGHAM: Yes.

Mr NORRIS: I am unaware of the Ombudsman's comments, but as a health fund representative I find the informed financial consent for dental probably better than in any other modality across the health sector. Because it is such an expensive item dentists take time to explain the charges. There may be isolated cases or misunderstandings, but most of the complaints we receive in regard to lack of informed financial consent are in the surgical and anaesthetic area.

The Hon. KAYEE GRIFFIN: Was the Ombudsman's comment a specific comment in a report?

Dr CUNNINGHAM: No, I contacted the Ombudsman prior to coming to give evidence today and he raised that as an issue with me.

CHAIR: It is not something we can get through a web site, written report or anything else from the Ombudsman?

Dr CUNNINGHAM: He publishes regular reports, but I do not know whether that has been mentioned in his reports.

The Hon. KAYEE GRIFFIN: I assumed it may have been in a report and that he said there were X complaints on this specific issue.

Dr CUNNINGHAM: He would certainly have the data.

CHAIR: Given your email, Dr Cunningham, I am not sure we feel any need for you to lodge anything at a later date. Do you feel there are areas you did not touched on because you wanted to consult members of the association? Do you feel you have anything to add later? If you do, you are welcome to contact us, but we are getting towards the end of the inquiry. From our point of view, you have answered the questions we put to you.

Dr CUNNINGHAM: That would be fine with us.

Mr NORRIS: The HIA has a specific HIA ancillary working party, and I am sure they would be willing to assist in providing any information or assistance the committee might need in finding a way through this. That is a resource you may have available.

CHAIR: That is something we might check. Dr Cunningham, it might be useful for us if you were to give us a copy of the notes you were reading from, because of the names and details and statistics. If you are not comfortable giving it to us now, you could do so later.

Dr CUNNINGHAM: We will do that.

CHAIR: Some times it is a great help for Hansard and for us to get those things. Thank you very much for appearing before the committee. Your contribution has been very useful and you have cleared up a lot of misconceptions.

Dr CUNNINGHAM: Thank you for the opportunity to present.

(The witnesses withdrew)

(The Committee adjourned at 4.40 p.m.)