REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO DENTAL SERVICES

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At Port Macquarie on Tuesday 23 August 2005

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The Committee met at 10.30 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. R. M. Parker
The Hon. I. W. West

CHAIR: I welcome everyone to the hearing of the Social Issues Committee. As you would know, we are dealing with dental services, which we will talk mostly about, and the funeral industry. The Committee has two other inquiries, but we are not dealing with those today. I acknowledge that we are appearing today on the land of the Biripi people, and I pay tribute to their elders. I understand that the media will be present. There are rules that apply to all committees, some of which are designed to protect your space and privacy. I would ask everyone, including Committee members, to turn off their mobile phones because they are unparliamentary.

To maximise the number of people we can hear from we have allotted a relatively brief time for each. Our first three witnesses will have 15 minutes each. We set aside a time for a forum for which six people have registered. They will have about six minutes each. The Committee will try not to ask questions any more than we really have to. We will rely on witnesses to state their case fairly fully. I will ask people to take the oath or make an affirmation and give their full name, which will extend to them the parliamentary privilege that we have.

LYNETTE CONSTANCE JAMES, Acting Secretary, Mid North Coast Fluoride Free Alliance, 31 Jack Richardson Drive, Yarravel, and

PATRICIA JOYCE WHEELDON, Secretary, Mid North Coast Fluoride Free Alliance, Summer Island Road, Kempsey, both sworn and affirmed:

Mrs JAMES: Thank you for this opportunity. Welcome to the standing committee. I would like to mention our recognition of the Biripi nation as the traditional owners of this land. I have come today wearing two hats, one as a representative of the Mid North Coast Fluoride Free Alliance and as a grandmother. Having recognised the Aboriginal community, I would now like to recognise the Dhungutti nation in the Kempsey area. I have had considerable dealings with the Aboriginal people there who have extreme concerns regarding fluoridation and dental services in their area. Indigenous people have a different genetic make-up to most other, or white, Australians or nationalities. They suffer a great deal from thyroid, diabetes periodontal and the like. No research to my knowledge—and I have asked for this from the Department of Health—exists on the damage or residual effects of fluoride on Aboriginal people.

I have had quite a considerable conversation with a Dr Archie Kalokerinos, who treated Aboriginals for many years, starting in the Collarenebri district. He was a researcher of renown and was awarded for his research into Aboriginal problems, including their inability to retain vitamin C and deficiencies in calcium, magnesium and phosphorus. These deficiencies set the Aboriginal people apart in so much as it will affect them dramatically if they consume fluoridated water. I believe it is totally negligent of this Government to promote fluoride without the benefits of research. It is not sufficient to say that it is okay because they have not seen people fall down in a dead faint. How can you estimate what damage is being done by the addition of fluoride?

I also refer to some American research, Masters and Copeland for one, who have done extensive research into the silicofluorides and their effect on blood lead levels. It also indicates that Aboriginal children are doubly affected by this, which creates behavioural problems, violence and other disorders. That is a big concern, particularly when we have done no research of our own. The other research that has been done is on increased dental fluorosis that is evident in African-American children. It is something like double. That is an extremely concerning issue for me. Dental fluorosis is about the only detrimental effect recognised by the Health Department and some authorities. I do not believe that is the only detrimental effect. However, as I am not a scientist or a researcher I can only go on the things that I have read and have learned since I have been researching fluoride. I do not believe that it is the answer for our dental problems. We have to look at the problems of sugar—sugary foods, drinks and things that are detrimental to the actual teeth—and not put a bandaid on them by putting fluoride in the water.

The other concern I have with the addition of fluoride in the water is that it is a toxic waste by-product. The Health Department claims that it is purified. I am yet to see any evidence of where it is purified. It is obtained from fertiliser factories, chimneys and pollution scrubbers. They take out the fluoride because the super phosphate is too toxic to put on the ground. They remove it. They have water sprays in their chimneys and that is the sludge, or the liquor that is made from that is what is

used in our water supplies. This has never been tested. The National Toxicology Program in America accepted it for testing in 2002.They have substituted sodium fluoride for hydrofluoro salicylic acid, or sodium silicofluorides, which have not been tested for their toxicity on humans. To say that they are exactly the same is, I believe, quite false. It is like saying that lead petrol and unleaded petrol are the same things. The toxic product is laced with all sorts of contaminants—heavy metals, arsenic and so forth. That is my major concern with the use of silicofluorides without research.

As a grandmother I am here representing my grandson, who has dental fluorosis. My grandson not only suffers pain and discomfort from his teeth because they crumble and break, and I have some photographs if you would like to see them because he is not allowed to come around to you. If you would care to have a look at the bottom right-hand picture of 12 months ago you will see brown stains on his teeth. The top left is where he was punched in the mouth only a short time ago and the stuff cracked out. He suffers psychologically. He suffers torment and abuse. He has been beaten and spat on, and called scungy mouth and yellow teeth. This is a psychological problem, and the impact of that is yet to be calculated. These are my very severe concerns. If you have a look at the statistics from the NHMRC, in the 1999 review they estimated that between 40 and 60 per cent of children have some form of dental fluorosis. This is an unacceptable level.

If you put it in bigger figures, 600,000 children out of one million are affected by this. It may not be that severe, but they are affected. As you know, if you smile the first thing people see is your teeth. It could affect your job prospects. It could affect your personality and so on. This needs to be very carefully looked at. World Health recommended monitoring, and World Health also recommends that we should be tested prior to having fluoride put in our water supplies. This is not done in this country. Estimates are not good enough. Thank you very much.

Mrs WHEELDON: The fluoride added to our water supplies is an industrial grade waste product with associated contaminants, such as arsenic and lead. I have not been able to determine the health benefits of lead. Mr John Irving, New South Wales Department of Health, states that EHC227 is the bible of governments throughout the world used when implementing fluoride. The section on kinetics and metabolism on humans, section 1.5, states that fluoride crosses the placental barrier. In infants 80 to 90 per cent of ingested fluoride is retained; 22 to 26 months is the critical period for damage to teeth according to the NHMRC. The WHO technical information booklet 846 on fluoride states that the ingestion retention rate for adults is between 75 to 90 per cent. EHC227 further notes that there is a narrow margin between benefits and detriment. When I first approached EHC227 I was surprised to find it was no endorsement of water fluoridation. EHC227 refers to fluoride's connections with osteocarcoma, hip fractures et cetera states that more testing is needed. No-one would believe this testing should take place via our water supplies.

The population has not been tested for individual ingestion of fluoride. WHO states that this is essential prior to introducing fluoride to water supplies. The NHMRC also state that. Why no testing? I have asked and have been given assurance by NSW Health—after four months and the intervention of the NSW Ombudsman to gain a reply to my four questions—that no testing is being undertaken as to ingestion rates regarding fluoride, and no testing into fluoride-induced arthritic symptoms. Despite requests from NSW Health, no testing into the Aboriginal population has been presented. I have with me, an email from NHMRC Principal Research Fellow regarding testing of possible adverse effects that states:

> We did not consider fluoridation in this study (because there was no information on it) nor have we ever conducted any research into its influences on hip fractures, or any other health outcome.

Arthritis Australia states that fluorosis causes bone pain, not arthritis. Mr Chris Crawford, Chief Executive Officer of the North Coast Area Health Service, in reply to my questions, gave two examples of the effectiveness of fluoridation. Both of those are overseas research—one Mexican and one United States of America. Both show that the population is being overfluoridated "above the upper tolerable intake limit and well above the upper limits of the proposed safe threshold for fluoride intake". Water cannot be used in dialysis machines with fluoride still in the water. It has to be treated. A very high proportion of individuals, with diabetes and other kidney complaints live in this country.

Note the Australian Drinking Water Guidelines 2004 states that kidney impaired individuals retain up to three times the quantities of ingested fluoride. Fluoride is easily overdosed and is responsible for such health problems as dental and skeletal fluorosis, thyroid problems—it has an

inhibitive affect on thyroid function—and is being linked with osteosarcoma in young males. Eleven unions at the Environmental Protection Agency in the United States of America, representing 7,000 professionals, have called for a halt to water fluoridation owing to the connection between osteosarcoma in young males and that chemical in water supplies. I feel NSW Health have the responsibility to first "do no harm".

The ADA and the AMA have not been able to address one of the issues sent to them. They merely reiterate support for fluoride and do not intend to ask for any research themselves. They do acknowledge, however, that they are private bodies and perform no research. It is hard to believe the ADA still states that there is no proof of harm from amalgam fillings while WHO states that these do contribute to the mercury load in our systems and NHMRC state that one should not have amalgams if one is pregnant, a child or a person with kidney disease.

Note that the Australian Research Council for Population Oral Health, Child Dental Health Survey 2000, shows better permanent teeth in unfluoridated Hastings/Macleay than in 37-year fluoridated Sydney. Save Our Kids Smiles 2004 shows better permanent teeth again in unfluoridated Hastings/Macleay than in fluoridated Nambucca. I have a bundle of affidavits signed by professionals opposed to fluoridation. They are concerned with the health implications. There has been no public consultations. Public meetings we have had have been arranged by concerned residents and health department officials refuse to attend. Only one-sided information received via the media.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You referred in your submission to Dr John Spencer whose 2004 books states unequivocally that water fluoridation is a safe and effective and economic for the prevention of tooth decay across a large group of people—

Mrs JAMES: I am sorry, I do not agree with that because if you also look at John Spencer's research, which was done with Jason Armfield, on the consumption of non-public water, implications for children, caries experience, he also states "The effect of consumption of non-public water on permanent caries experience was not significant." Now if it is not significant how it can be a benefit?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is non-public water. The non-public water may be fluoridated or unfluoridated. In other words, I think he is saying that this non-public water is not a significant thing because there is not much of it.

Mrs JAMES: No, it was a comparison between the two. His comparison stated that the effect was not significant so whether you are on fluoridated water or non-fluoridated water, Spencer and Armfield do not consider it to be significant.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I cannot get the context from your two sentences. You said "The effect of consumption of non-public water on permanent caries experience was not significant." That suggests to me that non-public water is not having any effect. In other words, he is talking about the effect of public water then the question is whether the public water is fluoridated or unfluoridated? He said the amount of non-public water, which presumably means either bottled or tank water.

Mrs JAMES: Yes, it was a comparison between fluoridated public water and non-public water was tank and bottled water. That is on the front page of his study.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would be unusual if that comment was totally consistent with a monograph he had written excising his own research, that is what I am saying, in terms of using this man's expertise?

Mrs JAMES: The man has obviously got two different opinions at two different times because it is quite clear that the difference is not significant. Whether it is effective, I would say it is not effective, and I certainly disagree with its cost effectiveness because you only use a very small proportion, in fact about 1 per cent of that water is consumed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In his book he said that the cost effectiveness is 80:1—for every $1 you put into fluoridation you get $80 worth of dental health.

Mrs JAMES: I have not seen that so I cannot comment on it. If you look at the cost of dental fluorosis to children's health and their psychological attitudes and also the restorative costs of fixing those teeth which is not covered by public dentists—they just rip them out instead of fixing them—I do not think that has been estimated. So I cannot see how they claim it to be totally cost effective.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have medical evidence that this is dental fluorosis?

Mrs JAMES: I do have a report from a dentist, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because my understanding is that dental fluorosis is cosmetic rather than structural.

Mrs JAMES: If you look at the York review you will also find that they did not find it to be cosmetic. I have an email from Professor Trevor Sheldon of the York University who was chairman of that report here. I can provide the document. His statement on dental fluorosis is that "the review found water fluoridation to be significantly associated with high levels of dental fluorosis which was not characterised as just a cosmetic issue." They did extensive systemic study worldwide of literature and came to those conclusions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said there are behavioural problems due to fluoride you suggested—

Mrs JAMES: Silicofluorides. This is evidence from Masters and Copeland.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In Aboriginals—

Mrs JAMES: In Americans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Appended to your submission is some data showing that the indigenous children have a higher incidence of dental caries than non-indigenous children, and I think that is indisputable. If they have got less fluoride why do they have more behavioural problems? Is that inconsistent?

Mrs JAMES: I did not say that they had the behavioural problems but on the evidence from America, and the lead levels in the blood in African-American children, they have found that they are double the lead levels. It affects the brain—dopamine, I believe it is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but surely the lead levels in American children is different from the fluoride levels in Australian children?

Mrs JAMES: That would be very interesting if we could ever find out. If they ever do any research, and do not refer us all to America, then we may have something that we can compare it to. But this country has done no research.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Fluoridated water is not the main source of lead, is it?

Mrs JAMES: Apparently it is increased with the silicofluoride and the uptake of lead. I have got the research there if you would like a copy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would be interested.

Documents tabled.

(The witnesses withdrew)

CHAIR: I acknowledge another member of the Legislative Council, a local resident, the Hon. John Tingle is present and is very welcome.

BARBARA JUNE GRANT-CURTIS, member of Citizens Against Fluoridation, C/- J Helson, 24 The Plateau, Port Macquarie, 2444, affirmed and examined:

CHAIR: What do you want to tell the committee?

Ms GRANT-CURTIS: I have already delivered a written submission on my behalf and on behalf of the Citizens Against Fluoridation. When I did that I sent off a carton of documents numbered 1 to 74, and accompanying letters from various persons, to the committee. I probably would not have much to add to that because it was a big carton that cost me $10 to send. If you have looked at them and seen my comments on those documents you will know what I am talking about. But I am dead set against fluoridation. I speak because of the acknowledgment by even the health authorities and the pro-fluoridationists that at least 1 per cent of the population is sensitive or allergic to fluoride. We are having more and more people who have chemical sensitivity problems, multiple chemical sensitivity, and I am one of them. We have a lot of people who have children that are full of the problems of attention deficit disorder—my family has that as well.

We have all these problems. We have been tested for sensitivities and we have multiple chemical sensitivities. We have been treated with desensitisation methods so we are well aware of what this all about. At the same time, I would say, that on the evidence other people have given, I will not go over, except to say that when they mention the effects of fluoridation, the qualities of fluoride, it has been long suspected—not only suspected, pretty much believed—that fluoride is a carcinogen. We have now had confirmation of that in the 80 surveys that suspected that, in the suppressed evidence that is showing up in scientific studies in the United States of America that are now being investigated, the suppression of evidence by a professor from Harvard University.

If we want to see more cases of osteosarcoma in young males we will keep on putting toxic and dangerous fluoride into our water supplies. The argument is that fluoride is necessary because us oldies have proved, by our lack of teeth and our rotten teeth, that we did not have fluoride and that is the reason why we have such dental problems. I can assure you that I was born in 1933 in the Depression years. I went through all that, and so did my family. We went into the war and our diet was absolutely lacking. I will not use any words to describe it. Of all the people in that era I can think of no-one in my extended family or my acquaintances in the Nambucca area and all the areas round about that would have looked like being within a bull's roar of having an adequate diet.

As for dental care, when we rode our bikes to school 5½ miles away we had a school dentist come once every couple of years to have a look at our teeth. He would say, "Hell, what a mess", and out would come another two or three teeth and we would ride our bikes home again. So that was the dental care that we got, that was the diet that we got and that is the reason why our teeth are in the situation that they are. Adding to that, our teeth are in the situation that they are because in all this hoo-ha about fluoridation, we have no dental services. I am in the process now of trying to access dental care. About 10 days ago I was eating my muesli, chomping away with my few remaining teeth, and I chipped off a piece of my bottom tooth. It is now cutting my lip and my tongue.

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

I am not prepared to have yet another tooth ripped out. I did not like it when they ripped out the abscessed tooth. When I went to the private dentist to get attention I could not afford the $800 that would have been necessary to do that. Being a pensioner on a base amount of $13,000 a year to run myself, my home, my car and my various commitments to fluoridated water rates and things like that, I find it quite difficult to spare the money for the gap payments that are now being included in my life for medical care, diagnostic care and now to pay for private dental care. I ask the Committee to

consider that. I will not go on too much about what the other people have spoken about other to say that this idea of fluoridation occurred half a century ago.

We have done a little since then. We might have learned a bit about thalidomide, debendox, pesticides, herbicides and recently virox and all those sorts of things. If we are not doing any research how do we know what is happening to people's general health? I resent the fact that fluoridation only ever advances a proven dental health measure and no consideration is ever given to general medical health. That is my contention. As far as I am concerned we cannot at least acknowledge what the National Health and Medical Research Council and the World Health Organisation stipulate in their so-called support for fluoridation, which has been in force now for 50 years. We now have a huge dental crisis, after fluoridation, of 65 to 75 per cent of the population of New South Wales for a period ranging up to 50 years.

We are not going to do the urgent research to study the fluoride intake prior to putting fluoridation in—fluoride intake from every source that we are now subjected to. We are not doing the research into what is happening afterwards. How can you say that you can go with a flawed method that is believed to reduce dental decay when you are not doing any research? That is where I stand at the moment. In 1991 we had a compulsory referendum in this area. The results of that compulsory referendum showed that every ratepayer, 20,500 people, said no to fluoridation. Eight and a half thousand people acquiesced or said yes. We tried in this recent current push for fluoridation. There was a huge outcry here. But we were denied the opportunity to have a referendum.

The papers have been full of protests about this happening. We called forums at which the public health department, dentists and everybody else refused to speak. So as far as we are concerned there is no democracy in this, there is no consultation and there is no warning of possible side effects or adverse effects to general health. There is compulsory mass medication and it is not even based on an assessment of a person's state of health or his or her consumption or use of water. If you can say this is science, well, holy cow, I do not want to know about it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying there is a lack of research into the dose of fluoride that Australians get?

Ms GRANT-CURTIS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, there is so much in the water they are getting. It is assumed how much water they drink, but that may be variable. Indeed, the amount of fluoride in the water may be variable. You are saying that they are getting too much?

Ms GRANT-CURTIS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is why fluorosis is happening?

Ms GRANT-CURTIS: I did not mention fluorosis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But those adverse effects are happening?

Ms GRANT-CURTIS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mentioned lead and arsenic.

Ms GRANT-CURTIS: No, I did not even say that. An earlier speaker said that. I am referring to other health matters that I have not mentioned. I mentioned osteosarcoma in young males; that was one thing I did mention. I could mention a lot of others, which are to do with arthritis, hip fractures, osteoporosis, interference with metabolism, thyroid, hormone function, and various other health aspects.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mentioned the distinction between sodium fluoride and sodium silicofluoride.

Ms GRANT-CURTIS: No, I did not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not in your submission?

CHAIR: Some of the things that the Hon. Dr Arthur Chesterfield-Evans is mentioning are in your written submission.

Ms GRANT-CURTIS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These things are in your written submission. I am referring to your written submission. Are you happy to take on those points on as well?

Ms GRANT-CURTIS: Yes I am happy to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not said that today, that is true.

Ms GRANT-CURTIS: I misunderstood you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that there is a distinction between sodium fluoride and sodium silicofluoride.

Ms GRANT-CURTIS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that sodium silicofluoride causes behavioural disorders in children?

Ms GRANT-CURTIS: Yes, because of the contamination of lead and other heavy metals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the silicofluoride is not the problem; the problem is the contaminants in it?

Ms GRANT-CURTIS: No, I did not say that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that sodium fluoride is not as big a problem as sodium silicofluoride?

Ms GRANT-CURTIS: I do not really know because it is a long while since they have used sodium fluoride. I am not a scientist. I have a heap of scientific papers at home that refer to the damage that silicofluoride does. I cannot say that I have any memory of what sodium fluoride does, but if we are going to talk about sodium fluoride, pharmaceutical grade, we would then get into the aspect of whether there is any way near cost-effectiveness because of using a pharmaceutical grade product as against an industrial waste product.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I suppose the bottom line, though, is that if there is a contaminant of lead and arsenic—which I think you refer to in your submission—people who drink fluoridated water have higher lead and arsenic levels than people who do not drink fluoridated water. In other words, are all the other sources of lead and arsenic in the environment like petrol—

Ms GRANT-CURTIS: We do not have lead in petrol now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but we did have and it was a significant source of contamination. Are you saying that there is high level of arsenic and lead in our kids, in adults or in anybody who drinks fluoridated water with silicofluoride than there is in people who do not drink fluoridated water?

Ms GRANT-CURTIS: No, I cannot say that because I am not a scientist and I have not done the studies. I believe that the evidence in America—as previous speakers have mentioned—showed

that lead levels were blamed for the mental disturbances and the juvenile delinquency problems. Those were mentioned as being factors contributing to those problems in America. As I said when I first started, I referred to what the previous speakers have spoken about on those things. This is only part of the papers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not think anyone would dispute the fact that a high lead level in children is detrimental. The question for us to determine is whether or not it is in fluoridated water and whether that is a factor in the lead dose in kids.

Ms GRANT-CURTIS: I cannot say because I do not really know. I can only quote the scientific papers that say so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They say that the lead in fluoridated water is a problem?

Ms GRANT-CURTIS: It is a problem. It is an additive problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should we be looking at whether there is lead in fluoridated water in Australia?

Ms GRANT-CURTIS: I suggest that we should be looking at the whole issue of silicofluoride, even fluoridation in general, to see what damage it is doing. How can we say when no research is being done?

The Hon. ROBYN PARKER: I am interested in the dental fluorosis issue. Your assertion is that it is caused by fluoride in water?

Ms GRANT-CURTIS: Yes.

The Hon. ROBYN PARKER: Are there other causes of dental fluorosis?

Ms GRANT-CURTIS: They say that some medications, such as tetracycline, cause fluorosis. I do not know of all the others. I have had no experience of it. As I said, I am not a scientist or a doctor.

The Hon. ROBYN PARKER: So in that instance how are you able to determine that dental fluorosis is caused by fluoride rather than antibiotics or other sorts of things?

Ms GRANT-CURTIS: I cannot determine it, but I do refer to the scientific papers on it. I cannot say it; I refer to the scientific papers on it. They are showing that. That is what I say.

The Hon. ROBYN PARKER: Currently, a decision about fluoridating water has been made by the water authority, which has referred the matter to NSW Health. Is that correct?

Ms GRANT-CURTIS: Yes.

The Hon. ROBYN PARKER: Does your association believe that that is an inappropriate way of referring it?

Ms GRANT-CURTIS: We have letters in our files showing the amount of pressure that was bought to bear on our council to take on fluoridation. In fact it was a directive from the Department of Health. That is what happened here. That is despite the huge outcry in the press and that was despite the results of the 1991 referendum. That is despite the 2,500 people who collected signatures ad hoc for a petition against having fluoride put into our water.

The Hon. ROBYN PARKER: Why do you think NSW Health made that decision?

Ms GRANT-CURTIS: I think it is taking the simplistic idea of dealing with dental problems. It is sidestepping any responsibility as to whose responsibility dental health is—Federal or State. Under the constitution it is a Federal responsibility. The funding is lacking. They are not

providing any other services. The experience that my friends and I are having is that you will not get dental remedy at your dental clinic. You cannot access it. If you cannot pay privately, you are in a deal of trouble.

The Hon. ROBYN PARKER: That is different issue from fluoridation though.

Ms GRANT-CURTIS: This is a dental inquiry; it is not just dealing with fluoridation.

The Hon. ROBYN PARKER: That is right. You have made some assertions that children's behaviour is affected by fluoride in the water. That being the case, do you have evidence to suggest that children living in areas where there is no fluoride in the water are better behaved?

Ms GRANT-CURTIS: I have no evidence.

(The witness withdrew)

LISA CHRISTINA INTEMANN, Councillor, 10 Joshua Close, Wauchope, affirmed and examined:

CHAIR: Perhaps you could make your statement and then there might be some time for Committee members to ask some questions.

Cr INTEMANN: I expected some questions, so I have not prepared very much. I am happy to take questions. I will make a brief statement. My concerns regarding fluoridation are twofold. First, it is my understanding from the evidence that fluoridation does not actually assist in the reduction or the prevention of tooth decay and furthermore that the excess consumption of fluoride in various forms can be detrimental to human health. My second concern is the manner in which it is being brought to us. Page 6, I think it is, of the code for the Fluoridation of Public Water Supplies Act 1957 says that the water supply authority is expected to have undertaken community consultation prior to referring the matter to New South Wales Health. We have letters from offices of the Department of Health indicating that they specifically delayed the introduction of the discussion locally until after council elections last year so that we could not engage in community debate. I am not privy to all of the discussions with the mayor, et cetera. Nevertheless, it certainly was indicated to me that we, as the council, were not given an option.

It was basically that we fluoridate and, therefore, remain in the good books with the department or we do not fluoridate and we could suffer loss of income through funding in the future. It was also suggested that if we did not fluoridate now and be given 100 per cent funding for the fluoridation at a later time the State Government may come and tell us to fluoridate without providing funding. I have letters, and can provide them to you. I have already given a submission. I am taking your offer to provide other information. Additional to that we have held two public meetings here and invited the Department of Health to attend. They have declined to attend, saying that it was of no benefit to anyone to discuss the relative merits of scientific papers. Again, I have letters confirming that and will provide them to you. We now have documentation from both the Australian Dental Association and the Australian Medical Association suggesting that they have not done any research into fluoride and its effects on health.

I would like to encourage you to consult particularly with other countries that have made the decision not to fluoridate recently. In 2005 it was Scotland. In 2004 it was South Africa. In 2003 it was Basel in Switzerland. That city kept fluoridating for 40 years after the rest of Switzerland stopped. In 2003 they stopped fluoridating on two grounds. Firstly, the lack of evidence for any effectiveness on tooth decay and, secondly, evidence of adverse risks to health. We have asked questions in Parliament. The Minister answered on 28 May, I think it was, inviting me to contact the Chief Health Officer to clarify any issues. We have since made contact with the Chief Health Officer and the Minister, who is now the Premier, but received no reply. This has been a constant battle over more than the last year. I now have a file this big of letters that have been sent. Replies that come back to us are standardised.

In speaking with officers of the Department of Health I am told that they simply are acting under directions and it seems that they are not entitled to engage their own minds on this issue. My biggest concern about this whole thing is the lack of research. Fluoridation may appear to be a neat idea and a neat way to address dental decay, but if it has adverse effects on health and if this Committee has already come to the very real realisation that dental and general health have been separated out that may provide the reason why this has come to be such a popular policy, despite the evidence of risks to health. I am now available for questions. Thank you.

CHAIR: Do think there are any benefits of fluoride in water?

Cr INTEMANN: The documentation can tell you, and I have looked across all fields both pro and con, and it appears that fluoridation may reduce tooth decay by a fraction of one decayed tooth per 12-year-old child. That is averaged across the population, of course. No studies appear to have been done on adult teeth at all. I would have to say that dentally, if we took fluoride out of the equation from everything else, there may be a benefit. However, since around the mid 1990s the majority science view appears to be that fluoride does not beneficially affect us by being consumed but by being put on the teeth. I certainly can provide you with the documents attesting to that. I heard you talk about silicofluoride.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am happy to talk about silicofluorides. Are you saying that silicofluoride is harmful in itself or harmful only because of its contaminants?

Cr INTEMANN: I think both. Again, I will provide you with the documents from the National Toxicology Program in America. Again, silicofluoride suffers from the same lack of research as fluoride generally. But it appears that traditionally, and they wrote this in the report for the National Toxicology Program, there was a presumption originally that silicofluoride, which is SIF6, did not dissociate through products. Specifically when it is added to water it just went straight to silicon and fluoride—complete dissociation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying it does or it does not?

Cr INTEMANN: That was their presumption that it did. Yes. The experimental evidence, and, again, this is written by the National Toxicology Program, shows that those presumptions have not been upheld by the experimental evidence. They now believe that it dissociates through silicon tetra fluoride, which is fairly well known as being not good for health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is FL2, two fluoride ions and a tetra fluoride silica?

Cr INTEMANN: It is four. Apparently we put it in water as SIF6, after the sodium salt or the acid, and the presumption was that immediately it dissociates down to elements, basically. It seems pretty illogical. However, the experimental evidence now suggests that it dissociates down through these other products, including SIF4, silicon tetra fluoride, which is known to be not good for health. The other aspect of it is the contaminants, and I can provide you with several chemical data sheets from companies that provided it and also a freedom of information regarding contaminants. I am happy to provide those.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there are some contaminants, is the amount of them significant in terms of the difference between those who consume water treated with sodium silicofluoride and those who, presumably, drink tank water or something else?

Cr INTEMANN: I do not know what contaminants are in tank water.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us assume that there are none. Basically we are trying to see whether the fluoridated water is doing harm. That is what the inquiry is partly about. Is there any evidence that those who have the water that has sodium silicofluoride with the contaminants that are inherently in the sodium silicofluoride that is being used result in those contaminants in higher concentration in the people drinking fluoridated water than those drinking non-fluoridated water in Australia?

Cr INTEMANN: I have not looked at the contaminant issue. I certainly will look through my material, of which I now have 12 big folders, and endeavour to find something on that for you. However, I would like to underscore the statement by saying that one of our greatest concerns is the lack of research in any aspect on this matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is your contention that there have not been studies of fluoride in Australian populations? If they have not studied the fluoride coming out of people drinking fluoridated water then they will not have studied the amount of other things coming out of them either. I can see that the lack of data on your behalf does not prove that fluoride is good. It merely says that there is not evidence.

Cr INTEMANN: Yes. I will provide further information. Thank you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said there is a sensitivity to fluoride in 1 per cent of the population. Given that fluoride is an element one would not think it would not have an allergic reaction. What would you say is the basis of that sensitivity and what evidence is there for it?

Cr INTEMANN: When you say that fluoride is an element, yes, that is true. But that does not necessarily mean that people are not sensitive to it. Fluoride is the most electro negative of all the elements, and part of why they suggest it—again, I can provide you with information regarding those sensitivities, which have been done for a long time, coming up with this 1 per cent of the population—is that it appears that part of the difficulty is that because fluoride as an element is so electronegative it forms a very strong bond with hydrogen and still has electro negativity left over to interfere with biological processes. Our biological process is very finely tuned, as you would know, and very dependent on a constant normal within the body. Fluoride interferes with that. That is my understanding. I am happy to send you more information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: However, electro negativity is only one electron, if you want to put it that way, or one unit of charge so that a hydrogen plus and a fluoride minus should cancel out, should they not, although in a polar molecule they will develop a flickering cluster of other molecules around it? Are you still saying that ionic matrix is still having health effects?

Cr INTEMANN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there any other examples of such?

Cr INTEMANN: We talked before about dental fluorosis. Both dental fluorosis and skeletal fluorosis got their names because it is known that they are caused by consumption of fluoride. That is how they got their names. It is a very well-documented relationship between excess fluoride consumption and weakening of the bone and teeth.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that the lack of monitoring of the dose of fluoride in the New South Wales or Australian population means that the possibility of widespread fluorosis has not been eliminated and may, indeed, exist? Would that be your contention?

Cr INTEMANN: I would suggest that in the modern world we are consuming a lot more fluoridated products in the form of medication for instance and that the addition of extra fluoride through the water is biologically compromising a percentage of the population. That is number one point.

[*Interruption*]

[My second point concerns research and management, that is if you want to build a cost effective dental system then you won't do this. It confounds the whole situation.] [1]

There is an amount of fluoride in modern consumption which is one thing and we, as a population, need to be dealing with what are the effects, I don't know. But if we are adding it to the water as well, I believe, two things follow: first, people have got an unregulated dose because we do not know who is drinking the water, how much, et cetera and, second, it confounds your whole research, adding something extra there. If fluoride really is not very good for our health then we are adding something which is confounding the situation. But you are confounding the research situation as well because it is being added through the water so we have no idea how much people are consuming. And so it effects both your health situation and the research situation because we do not know what is in there and how much people are consuming.

(The witness withdrew)

[1] Clarification added at request of witness.

Mr ROBERTS: Madam Chair, I have a statement from an academic:

> This chemical has so many dangers it should be banned. Putting it in the water supply is like starting a time bomb. Cancer, heart trouble, premature senility, both mental and physical, are conditions attributable to water supplies treated with it. It is making us grow old before our time by producing symptoms of aging such as hardening of the arteries.

Now, what substance do you think that person could be referring to that is quoted on 32 different Internet sites? Any guesses? He was talking about chlorine. Despite the scientific evidence that chlorine is a cancer risk, environmental activists are, in fact, encouraging the abandonment of chlorine in the water supply. In Peru, environmental fundamentalists quoting the EPA, encouraged the government to suspend water chlorination in 1991. This resulted in a massive and unnecessary epidemic causing more than one million cases of cholera and 19,000 deaths. I am not suggesting, of course, that the people opposing fluoride here have a hidden agenda to abandon the use of chlorine when the special pleading against fluoride belongs in the same chemical bag as chlorine.

The analogy with fluoride ought to be obvious. Fluoride is an industrial strength chemical, a co-product of the salt industry. In high doses, it is extremely poisonous and reactive though its benefits and risks have been exhaustively tested over many decades. It is a substance once used in warfare as a poison—we drink it, shower in it, wash in it and even soak clothes in bleach—and no-one ever mentions the war. Abandoning the chlorination of our water without any suitable replacement would threaten the lives of all us, so exactly what are we missing out on by turning our back on fluoride? I will use figures from the York review, which seems to have as many interpretations as it has readers. Fluoridation reduces the number of people with tooth decay by an average of 15 per cent. What is the population of the Hastings/Port Macquarie municipality? Sixty thousand people? That translates into 4,000 people free of dental decay. We are talking the equivalent of the entire population of Wauchope.

As a high school teacher for 30 years in that town, I have taught more than 4,000 children who drank from our water supply, many of whom suffered from untreated dental decay or filled or missing teeth which, believe me, looks a hell of a lot worse than dental fluorosis. That is reason enough to make me an enthusiast for fluoride—because the people who need it most are the children of this valley and they would have no vote in the sort of local plebiscite some are urging us to adopt. The scaremongers would spook such a referendum, as they do with nearly all referenda, and the community would lose its wisdom teeth. That is why fluoridation should be part of a cohesive national policy, not subject to the whim of local government authorities inevitably intimidated, at certain times and places, by a minority of opponents. Nor should this vocal minority deny me what is an accepted right of the citizens of every State capital except one, and 350 million people throughout the world—the fluoridation and chlorination of my water for my health and my community's health. Professor John Harris, Centre for Social Ethics, Manchester put my position this way:

> In considering the ethics of fluoridation ... we should ask not are we entitled to impose fluoridation on unwilling people, but are the unwilling people entitled to impose the risks, damage and costs of failure to fluoridate on the community at large."

The World Health Organisation [WHO] states:

> Research has shown that fluoride is most effective in dental caries prevention when a low level of fluoride is constantly maintained in the oral cavity. The goal of community-based public health programs, therefore, should be to implement the most appropriate means of maintaining a constant low level of fluoride in as many mouths as possible.

The WHO Expert Committee on Oral Health Status and Fluoride Use in 1994 also state:

> The question of possible secondary effects caused by fluorides taken in optimal concentrations throughout life has been the object of thorough medical investigations which have failed to show any impairment of general health.

Only one scientist has ever won the Nobel Prize twice and that is Linus Pauling. He said:

> Over a period of more than a decade ... I have reached the conclusion that the presence of fluoride ion in drinking water ... is beneficial to the health, especially because of the protection that it provides against dental caries, and that there is no evidence for detrimental effects comparable in significance to the beneficial effects.

If it was good enough for him, it is good enough for me and obviously good enough for the rest of us.

Mrs McKAY: I represent the Hastings Safe Water Association, which has been around since 1989. Our group is totally opposed to the use of fluoride. There is no place for fluoride inside the human body. We have researched scientific literature and understand that there is no proof, double blind scientifically acceptable studies—certainly not done in Australia, but there is not one in the world and if you ask for it like Dr Doug Everingham, a former Federal Minister for Health, who could not get it, you will not receive it—that fluoride prevents dental decay. It is not a nutrient. It is not only not essential to life it is incredibly harmful and has no place in dentistry or in our water.

Bottle fed babies are being overdosed in fluoridated areas. How many parents who have bottle-fed their babies since 1991 have been notified by the NSW Health department that the National Health and Medical Research Council in its 1991 Report into the Effectiveness of Fluoridation reported that average fluoride levels in infant formula in Australia were of a concern in fluoridated areas? It reported that most of the best-known brands of infant formula in powder form, unreconstituted, contained high levels of fluoride and that one well-known brand contained 3.74 parts per million. I canot name the brand, but it is there. If that formula was then reconstituted with fluoridated water at 1 part per million then the baby would be receiving well over 400 per cent of what the recommended daily dose is considered by the Health department.

The National Health and Medical Research Council [NHMRC] report was concerned that "the duration of infant formula usage is a risk factor for dental fluorosis" Dental fluorosis is the first sign of fluoride toxicity: a great start to life for thousands of Australian babies. Any parent whose child drank bottled infant formula in a fluoridated area since this 1991 report was handed down has been overdosed every time they had a bottle of infant formula. The parents would be well within their rights to seek some answers from the Health department as to why they were not warned by baby health services and by their medical advisors. The NHMRC recommended in 1991 the ingestion levels of fluorides. This has not been done by our Health department and the NHMRC has not followed up on its own report done 14 years ago.

The authorities are shamefully lacking and in this case I would say they have been negligent. They did know but have done and said nothing. They continue to fluoridate the water of Australia, and consider adding it to unflouridated areas, but they have not monitored the present ingestion levels of all Australians. Until they do this and report honestly we are victims of their negligence. I urge the committee to write to the National Health and Medical Research Council and ask them for a copy of their March 1991 report and then ask why they have not acted on their own report. In 2005 there is so much fluoride in the atmosphere, food, beverages, medications and as part of the industrial world that for most of us it is more a matter trying to lessen the intake rather than needing more.

In the early 1990s Don Mackay, my husband, did a small survey in our local area—Grafton, Tamworth—and came to the conclusions that there are more dental therapists in fluoridated towns than in unfluoridated towns which does effect the level dental caries, if you cannot access services. He went to see what the ratio of dental therapists to children was in local fluoridated and unflouridated towns. There was a curious consistency with one dental therapist. In a six-month period, that therapist had 1,200 appointments. Fluoridated Tarnworth had 5,737 children in the same age range and had the services of three dental therapists: two worked full-time and the other worked a 20-hour week and in six months there were 2,100 appointments. Fluoridated Grafton had 5,000 children aged 5 to 12 and had the service of two dental therapists: 1 full-time, 1 for three days and the other 1 half-day at McLean. Fluoridated Taree had 3,496 children aged 5 to 14 and had the service of 1 dental therapist. In six months that dental therapist had 1,065 appointments. It was really clear that in unfluoridated Port Macquarie we were severely lacking in dental therapists, so lessening our children's acess to free dental service.

We do not know what the figures are now but I would be surprised to see any changes in the child therapist ratio. I think this has to be looked into and they are not doing these sorts of studies. We have heard so much about the magic bullet fluoridation, as if it is some mystical cure-all but a report in the *Sydney Morning Herald* earlier this year brought to light the fact of exploding levels of decay in the western suburbs of Sydney, whereas in more affluent North Sydney rates were steady. Both areas are fluoridated, and have been for 37 years, but what is revealed by those findings is that it is access to good dental care, education on good dental hygiene and nutrition which makes the difference.

We believe that the Health department and dental educators are too closely linked with sugar producing corporations. This has happened in the ADAs promotion for dental health and the research foundation are on a honour roll of financial donors with compaies such as Coca Cola, Wrigleys, soft drink manufacturers, Colonial Sugar Refinery, Arnotts, Cadbury Schweppes, Kelloggs and Scanlon Sweets. They are the people that are helping dentists do their training, and I thought you would be interested in that. They never published that list again. I want to table some DVDs we made in 1991 and it was the only time we could get the Health department—

CHAIR: Yes, we will pass some resolutions later to formalise that.

Ms TURNER: I am the chairperson of the Central Coast Pure Water Association Incorporated which is based in the Gosford and Wyong areas. I have some information on the association. Ladies and gentlemen of the committee and the gallery, I think you for the opportunity to present our submission to this important inquiry. Since writing the submission we have been researching other relevant information with regard to the use of fluoride in the water supply, our food products and in the wider environment, including the safety of workers who have to deal with this poison. I will try to cover some of our findings in this paper, as I address concerns raised in our submission.

Firstly, let me say that the Department of Health officials often make incomplete public statements regarding fluoridation. Although the Australian Dental Association admits that fluoride is a toxin it rarely makes that public statement or give warnings on the use of fluoride. To cover this, I refer to a 1999 glowing report on fluoridation by the United States Centre for Disease Control [CDC], which cites fluoridation as one of the century's greatest public health successes—we hear this all the time—a statement that is often quoted by public health representatives. But what you will not hear from them is that this very same report hints that the alleged benefit from fluorides may not be due to ingestion. I quote from this report, which states:

> Fluoride's caries preventive properties initially were attributed to changes in enamel during tooth development because of the association between fluoride and cosmetic changes in enamel and a belief that fluoride incorporated into enamel during tooth development would result in a more acid resistant mineral.

The CDC report then acknowledges new studies, which indicate that the effects are topical rather than systemic. I quote:

> However, laboratory and epidemiological research suggests that fluoride prevents dental caries predominantly after eruption of the tooth in the mouth and its actions are primarily topical for both adults and children.

This being the case, how can the health department continue to insist on the addition of fluoride to the public water supplies knowing that the dosages cannot be controlled as with prescribed medications and also knowing that a percentage of the population is diagnosed as having severe allergic reactions to fluoride? The truth about dental decay is that more and more evidence shows that fluorides and dental fluorosis are associated with increased tooth decay. Increased tooth decay is why we are all here at this inquiry today. Thirty-eight years of fluoridation in Sydney and 40 years of fluoridation in Tasmania have not overcome or assisted to overcome this problem. There needs to be a better answer. In the 1940s the American medical and dental associations had all editorialised against fluoridation, and leading scientists were also worried about adding fluoride to the water supplies stating:

> Although model teeth are somewhat more resistant to the onset of decay they are structurally weak. When decay does set in the result is often disastrous.

That comes from the Christopher Bryson book entitled *The Fluoride Deception*. It seems we are all seeing the results of structurally unsound teeth now in Australia. Added to this, there is a shortage of dentists, proper dental health education and support. Governments are looking for a cheap fix by insisting on fluoridation. Instead we should be working together to have dental care incorporated into Medicare and to address the issue of low socioeconomic groups deprivation of dental care. We are also very concerned about the amount of fluoride we are ingesting from other sources.

Fluoride is now present in just about every product that we eat, drink, take as medication, or in coated cooking utensils such as teflon frypans. It is also in the air that we breathe. The United States Environmental Protection Authority estimates that the total intake from pesticide residues on food and in fluoridated drinking water alone to be 0.095 kilograms per kilogram per day. That means that a person weighing 70 kilograms takes in more than 6.65 milligrams per day. Once again, we have to rely on American reports because there are no reports in Australia.

CHAIR: We will have to rely on your written version of your report as you have run out of time.

Mr SMITHERS: I am a councillor on Coffs Harbour City Council but it is definitely not in that role that I appear today. Today I appear simply as an individual. The mid North Coast area is economically disadvantaged. Dental problems correlate strongly with economic disadvantage. If there is one correlation it is between wealthy and poor areas. Reintroduction of government-funded dental services is essential if we are to address this issue. Safeguards can be implemented to ensure that those who can afford private care do not use subsidised services. A preventive approach such the Teeth For Life campaign is supported, the funding for that to be commensurate with the scale of the problem.

As part of the preventive approach the school syllabus needs to continue to highlight issues and to continue to educate regarding healthy diet and good personal hygiene. The State and Federal governments must accept responsibility. At present, local government has been virtually forced to fluoridate water supplies at an ongoing cost to it. Dental care is not a local government responsibility. If local government were to be contributing funds to medical care there may be a number of other issues that are of high priority; I do not know. Despite the calls for the review of the efficiency, effectiveness and safety of fluoridation, the State refuses to fund this issue.

I recommend that the State pick up the bill for the ongoing cost of fluoridation because, if nothing else, it may prompt an overdue funding review. So fluoridation is not an elegant solution to the dental problem. It is enabled by dated 1957 legislation and it is continued without rigorous review—something that has been highlighted by other speakers. Over 99 per cent of water is not ingested by people. Town water is used for industry, washing and for various other uses. Overwhelmingly, it is not a drinking supply. With bottled water, water filters and the widespread availability of sugary drinks, the per capita ingestion of town water is probably decreasing and with it goes any beneficial effect that fluoridation might have.

The beneficial effects of fluoridation have been diluted by numerous factors, as mentioned, to a point where it seems to be increasingly difficult to prove a significant difference in permanent teeth between fluoridated and non-fluoridated areas. In our area, for example, the results of a review by Armfield and Spencer, show very little difference between the non-fluoridated mid North Coast, fluoridated Illawarra, Newcastle and a number of Sydney areas. In fact, the mid North Coast often is slightly better than those areas in relation to decayed, missing and filled teeth. As a councillor I was most unimpressed by the health department's handling of the fluoridation area in my local government area.

I will not go into that now, but it is detailed here. I think Councillor Intermann also alluded to that. An item that has not been discussed much day is the environmental effects of adding what is basically a toxic waste to a water supply. For a supply like Sydney I would estimate probably about two tonnes of this material are being added each day. There has never been any environmental impact statement done in Australia and there has been very little research overseas. In Canada there has been proof of issues such as fluoride in trout and salmon. They seem to have very high levels of susceptibility to fluoride. In oceanic waters fluoride levels are quite high but in freshwater ecosystems problems might be present.

I have concerns regarding the health risks of fluoride. These risks have not been proved and I would argue that they are impossible to prove. However, the York review has repeatedly commented on the low to moderate quality of data that safety conclusions are based upon. No matter what is said locally the York review is still the only global review of fluoridation that has taken into account almost every paper available. If the comments show that it does not matter what we at a local level are saying. I guess that that is the umpire's decision. I have written down just a handful of recommendations. I will table these papers in a moment.

I refer, first, to State and Federal dental service areas for the disadvantaged; second, to continued education on healthy diet and dental hygiene; and third, to a public inquiry into the effectiveness, efficiency, safety and environmental safety of fluoridation. Fourth, I have asked for a moratorium on expansion of the fluoridation program until that inquiry is completed. Fifth, I have asked the State to meet the ongoing cost of fluoridation. It is very expensive for local councils. Sixth, I would like a binding poll to be held before the community is fluoridated. Seventh, I would very much like a review of the Fluoridation Act 1957, which I believe to be totally undemocratic. I will give to the Committee two copies of these documents.

Mr EVANS: I represent FIND, which stands for Fluoridation is not Democratic. It is a Coffs Harbour-based group. I am not dealing so much with the safety of fluoridation today as we have addressed that at a community level. I am addressing fluoridation verses democratic rights and human rights in Coffs Harbour. In 1991 just over 70 per cent of the Coffs Harbour residents voted against the fluoridation of their public water supply. In June 2004, without adequate community consultation and with no reason to suggest that the community had changed its opinion about fluoridation, it was decided by five Coffs Harbour city councillors to hand the decision of fluoridation over to the New South Wales Director-General of Health—the same director-general who had never refused an application to fluoridate the public water supply referred under section 6A of the Fluoridation of Public Water Supplies Act 1957.

Not only did those five councillors not have a mandate from the community of Coffs Harbour to make such a decision on fluoridation; they were coerced by the chief executive officer of the Mid North Coast Area Health Service, Mr Terry Clout, to forget about democratic processes in return for additional cash incentives. The following extract is from correspondence between Mr Terry Clout and Mr Mark Ferguson, the general manager of Coffs Harbour City Council. You will get a copy of this later. Under the heading of matter five on page three Clout says:

> Given my view as to the likely position on recurrent costs I fought hard to obtain an agreement from the Director-General of Health for 100 per cent of the capital cost should the matter be referred under section 6A of the Fluoridation Act.

Mr Clout goes on to say:

> I also confirm that the Mid North Coast Area Health Service will provide to each council $20,000 for each of the 2004-05 and 2005-06 financial years to defray the cost of implementation of fluoridation of water supplies should a council refer the matter under section 6A of the Act.

Section 6A of the fluoridation Act again comes up. Section 6A, a copy of which is attached, is in effect an ironclad agreement to fluoridate the public water supply. Once a council has referred a fluoridation proposal to the New South Wales health department under section 6A and the director-general has made a directive, they have no further control over fluoridation. They must accept it even if they change their mind. They have no say about the type of fluoridation agent used and if that agent is changed at a future date it is the New South Wales Government's right to do so without any additional toxicological studies being undertaken. It is absolute craziness in any civilised society to be able to do that. Terry Clout also states:

> Inadequate community consultation occurred prior to the Mid North Coast Area Health Service taking the matter of fluoridation to local councils.

He had taken certain issues and decisions himself in the interest of public health and had "excluded mayors and general managers from certain aspects of the decision-making process." I think I live in a democracy. I have fought very hard over the last 20-odd years for my community and for their rights. I find it totally offensive that one man can try to influence the democratic processes in Australia. I would like to know how these democratic rights of a majority of citizens in a community can be taken away in such an arrogant and demeaning way.

We would like to know why the forced fluoridation of our public water supply without free and informed consent is not a criminal act. Given that the New South Wales health department is aware of these facts, the former Minister and current Premier is aware that fluoride is an equivocal carcinogen in high doses. He knows that because I told him that. He has also read the reports of the National Health and Medical Research Council [NHMRC] on this. He knows that it was recommended by the NHMRC to find out the levels of fluoride in the population before new fluoridation schemes were introduced.

He told me in a letter that the research had been started but that it was stopped by the NHMRC because of a lack of funding. The director-general and the Minister for Health have refused to apply any precautionary principle to this public health issue and have thumbed their noses at informed public debate and existing community views. Lies, bribery, bullying and propaganda have no place in our public health debates and no place in a democratic society. I have been through this before with Dr Peter Christopher over issues in Coffs Harbour and with Dr Ian Stanley.

CHAIR: Do you have a written document that you can give to the Committee?

Mr EVANS: I can give you that.

Ms HELSON: I am not going to make a big talk like everyone else has. They have covered everything. But there were two comments I heard that I felt I wanted to make a statement about. The gentleman that is a schoolteacher—forgive me, I cannot remember names, I am 85. Farm fluoridation—there was a test case on fluoride poisoning farmers' stock in Tasmania in 1989. The Government had to pay $65,000 in damages plus expenses. It is a poison and it does affect us. The stock ate the grass and, therefore, there were problems. The other gentleman from Coffs Harbour who just left, I am concerned because I thought I lived in a democracy. The schoolteacher gentleman said that I was taking away other people's freedom of choice. I feel they are taking away mine because they can get topical gels and supplements, and they can use toothpaste. If you take away my water I am done.

I am an alternative health person and, having read that the WHO requires certain tests to be done before fluoridation was given to us, I have had my blood tested for fluoride and insecticide. I do not have any. But, then again, because I am alternative health I grow a lot of my own vegetables. I cut down the sugar. Sugar was a poison my biochemist boss told me 60 years ago. I do not buy products that are processed if I can possibly help it. I make my own pickles, jams and things like that. I grow my own vegetables, as many as I can. Then, when I go to all this trouble to keep out of the health system's costing—I have only had my tonsils out—I am going to be forced to drink a poison. And I am a very high water intaker. I think that is about all I had to say.

CHAIR: Did you want to give us those documents?

Ms HELSON: That one you can have.

CHAIR: I realise that this morning has been a bit hasty, but, as you can see, we have tried to fit in as many people as we possibly can. We will resume at one o'clock with a number of witnesses. Committee members have to do a couple of things during the break. Anyone who is here is welcome to contact us in writing, by telephone or whatever. We have to end the session now. It may be possible to sort out a few things during the break.

Cr INTEMANN : Can we clarify that people are able to send you submissions?

CHAIR: Yes. Although we have a closing date, which was the end of May, we are always happy to accept formal submissions or other documents such as those that were tabled today.

Mrs MACKAY: Can I just say a quick thank you to the Committee because, shamefully, this is the only public consultation we have had. In the north of New South Wales three quarters of an hour is all the public has ever had. The rest of it has been rammed down our throats.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We set it up to hear from you guys.

(Luncheon adjournment)

BERNARD SMITH, General Manager, Port Macquarie-Hastings Council, Post Office Box 84 Port Macquarie, sworn and examined:

CHAIR: Do you want to make an opening statement, or would you prefer us to go straight into questions?

Mr SMITH: I am happy to make some comments to provide some background. I will speak about fluoridation and how Port Macquarie-Hastings Council has handled it over the past 12 months, if you are happy for me to address that.

CHAIR: Yes, particularly after everything we have heard this morning it would be good for you to have a chance to have your say.

Mr SMITH: It will go back a bit earlier than 12 months. Back in 1999 the Mid North Coast Area Health Service approached council with information regarding how council has dealt with fluoridation in previous years. You may have heard this morning that there was a referendum back in the early 1990s about it. In January 2001 we received correspondence from the area health service advocating the benefits of fluoridated water, and inviting me to a meeting with other mid North Coast mayors to discuss it. In March 2001 council engaged Hunter Water to provide some general information about fluoridation both from a technical and community point of view. Then in December 2003 we received an invitation, in effect, from the area health service advising of what was entitled a Decay Crisis Summit, which was to be held in the second quarter of 2004. Council subsequently attended that, which was a teleconference, along with other mid North Coast councils chaired by Dr Norman Swan.

At that time the issue re-emerged as a public issue and generated a significant amount of public discussion and debate. Obviously, it was firmly back on the public agenda. We had council elections in April 2004. We then found ourselves in the position of having two notices of motion at a council meeting on 31 May. I am sure the panel is aware, but there are two ways in which fluoridation can be introduced to the water supply. One through the council making the decision itself to fluoridate or, alternatively, it can refer the matter to the State Government-appointed body. Ultimately we had two notices of motion at a council meeting, one saying that we should not fluoridate and that we should conduct a public poll. The other one put forward a motion that it be referred to the expert panel that is set up under the Fluoridation of Public Water Supplies Act. Subsequently council resolved to refer the matter to that panel. I will briefly run through the resolution, if that is of benefit.

CHAIR: If it is lengthy you could give us a copy of it.

Mr SMITH: That might be easier. Effectively it said request the Government to establish the panel to consider the merits of fluoridation. If it found against it, council would not take any further steps. If there is a strong case then direct the council to introduce fluoridation, and there are some provisions about costs and subsidy as well. That, of course, was carried by council. That was passed on to the State Government and there was a gazettal on 6 August last year directing council to introduce fluoride to its water supply. There were a number of subsequent notices of motion, which reflected some of the varying views within the council. But, ultimately, it did not change the council's position, and I am sure you have heard about some of that this morning. In terms of where we are at the moment, we are finalising our detailed design. We expect the facility to cost in the order of $1.2 million. It will cost around $75,000 a year to operate. They expect to have a DA issued probably in the next two to three months, with it then operational in May or June of next year. Would you like me to go on?

CHAIR: We have asked for the background, which you have given us. We had specific questions about the cost involved and there have been some statements this morning about Health and the Government financing things, and the extent to which that was going ahead and the extent to which it influenced decision making. You have given us how much it will cost up front, but it would be good for us to know where the money is coming from.

Mr SMITH: In terms of the capital cost of $1.2 million, like any of these projects that has increased in recent times. In our recently adopted budget we have $1 million provided to be offset by

funding from the State Government of $1 million. Obviously, we will go back and have a talk to them about the additional funds. With regard to the recurrent cost, the mid North Coast offered $20,000 per year for the first two years. Obviously, that is insufficient and we have gone back and asked them for more money please. But the recurrent cost will be possibly $75,000 per year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are covered for only $20,000 for two years?

Mr SMITH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: $55,000, $55,000 and then $75,000 thereafter is your estimate?

Mr SMITH: Yes.

CHAIR: Is that a cost that will be quite stable? Is there any major maintenance-type issue that may come up every so often?

Mr SMITH: No. I would expect that cost to the relatively stable.

CHAIR: If the population increases, which is happening in this area, does that change anything?

Mr SMITH: It would not change anything. The plant is constructed, or will be constructed, to provide population growth. A lot of those costs are fixed in the sense of staff, et cetera. But it is catering for 70,000 people or 100,000 people. There will be a small amount of variable cost, but it is not going to grow exponentially or at the same speed as the population.

CHAIR: We wanted to talk to you about a number of issues in relation to the inquiry into the funeral industry, but it probably makes sense to finish dental services first. The only other specific question we had was about dental service provision. Perhaps we should finish the fluoride issues first, then go on to that and then go on to the funeral industry.

Mr SMITH: I will make one other comment. In terms of the council voting to it, it found itself in the situation of people wanting it to be able to on very technical and scientific issues, and it also found itself confronted with a large number of what would normally be described as credible and responsible organisations—medical organisations, dental organisations, even the CWA and most sides of politics for that matter—being in favour of fluoridation. Particularly given it was such a technical issue and they were in receipt of a lot of scientific information, which most people would not be able to interpret, and also given that, ultimately, it felt that the issue at large was more the domain of State Government than local government, they were a couple of important elements in their determining that the State Government was the most appropriate body to determine what should occur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This morning the committee heard evidence that kids in the Hastings Council area do not have more tooth decay than those in other fluoridated areas. Is that so? Did you not want to go into that technical data?

Mr SMITH: We received a number of presentations from Mid North Coast Area Health which that indicated that the degree of problems was greater here because of the fact that it was not fluoridated, yes, but we did have counter suggestions put forward as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the end you said, leave it to the experts?

Mr SMITH: Exactly.

The Hon. KAYEE GRIFFIN: What are the ongoing costs in relation to the process? How will they impact on council's management plan and future funding processes?

Mr SMITH: The principal ongoing cost, of course, is the $75,000. In the scheme of things we do not see it as a major impost. Our water situation, our water fund is generally in very good shape. I suppose it has got to be said that we are undertaking a lot of things in order to comply with State Government requirements as far as water is concerned. We are building a $20 million water treatment plant at the moment in order to comply with requirements. We obviously agree with that but ultimately I do not think cost was a major consideration for that and it will not cause any sort of realistic financial burden on the council. Of course, it is funded out of the water rates, not the general rate either.

CHAIR: Are there adequate public and private dental service provision in the local government area? Are there some parts of your area that are more poorly serviced than others?

Mr SMITH: We have not done any appropriate assessment of that in the sense of a detailed technical one and that is the bottom line. All we can rely on was the anecdotal evidence and the information from Mid North Coast Area Health. In fact, they were on the radio again this morning raising concerns about the lack of dentists and so forth. Really we cannot make a definitive statement on that. All we know is probably what everyone else hears.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there any difference between Port Macquarie hospital to other State Government hospitals? Has it now been handed back?

Mr SMITH: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is similar. It does not have a qualitative difference to other hospitals in cities of similar sizes?

Mr SMITH: I am not sufficiently versed to speak on that.

(The witness withdrew)

(Short adjournment)

CATHERINE ELIZABETH OSBORNE, Area Manager, Oral Health, North Coast Area Health Service, P.O. Box 694, Taree, 2430, sworn and examined, and

JOHN RUDD IRVING, Project Manager, North Coast Area Health Service, P.O. Box 694, Taree, 2430, affirmed and examined:

CHAIR: Do you appear in that capacity?

Ms OSBORNE: Yes.

Mr IRVING: Yes.

CHAIR: Do you want to make an opening statement and talk about some issues before we get into questions?

Ms OSBORNE: I received a series of questions to which I have prepared responses. I introduce myself, and it is probably important for the committee to know that with the severance of Taree and Forster from the Mid North Coast Area Health Service, and then joining up with Northern Rivers, some of the information I can give you is dependant on which data base I have sourced it from and I will qualify where it came from.

CHAIR: What public dental health services are provided in the area covered, particularly the mid North Coast? As you say the ones that have come in and out will affect that. How many dental staff are employed? Do you have difficulty filling dental positions? Are there currently any unfilled positions? How many private practitioners are providing public services?

Ms OSBORNE: In terms of the public dental services that we provide, our inter service is under a priority or a health program, that is a State Government program that has clear guidelines. We provide our services under those. We provide child dental services to kindy, years 2, 4, 6 and 8 in most cases. If a clinic is understaffed that is an area that is affected and we may take out a grade or we will assess the situation and it would take us longer to get around those grades in a year. In the child area we also provide a managed care program, that is a recall program. If we identify that children are at high-need or at high-risk to dental disease, whether that be socio-economic, or a family situation where other children in the family are at high risk or they have a heart condition, for example, they are put on a high-risk program and they are seen more frequently. That is at the operator's discretion so it may be decided that that child needs to be seen every three months or every year.

We provide services indirectly through the Durri Aboriginal Medical Service [AMS]. We provide them with a grant each year and that provides adult services—that has been done for quite some years. We provide specialist services in some of our clinics, orthodontic, oral surgery and paediatric services. We also provide pensioner denture scheme services through the voucher system and emergency services through the Oral Health Fee for Service Scheme. How many dental staff are employed in our service? This is all new North Coast data, so that is without Taree, Forster and up to Tweed Heads. We have got 83.86 FTE staff. The head count of that is 125 staff and our vacancy rate there just on the phone call area is actually 8.6, and I have got a breakdown of that.

Do we have difficulty filling our dental positions? Well, yes we do have difficulty. We have some solutions or some ideas that we think would assist us with that. Every time we do have a vacancy we advertise it through all the normal ways whether it be dental journals or local media or national media. We find that that is very unsuccessful and the most successful way we recruit is through dental agencies, job search agencies. We deal with two in particular, one in Coffs Harbour and one near Geelong in Victoria and that is how we fill our positions.

CHAIR: Is that the whole range of dental positions?

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of the 83 are dentists?

Ms OSBORNE: I have 14.4 head count of dentists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A small percentage?

Ms OSBORNE: Yes, the biggest percentage by far is dental assistants. There are about 80 of those.

The Hon. ROBYN PARKER: Why do you have difficulty filling those positions. Is it wages?

Ms OSBORNE: Yes, I have some of the reasons here. We feel that the State award has not been reviewed for a long time so there is no incentive for dentists to work with us. That also goes for specialists and dental therapists whose award has not been reviewed for quite some time. So there is not a financial incentive to work with us. There is a Rural Dental Officers Incentive Scheme, commonly known as DORIS, and that is $20,000 that dentists going to rural locations get on top, but that has not been adjusted for quite sometime. When I worked in Victoria we used to think that New South Wales was getting the cream of the crop because it was offering better salaries but now the States around us have increased and that does not have that bargaining value. We think it is a good idea, and other States have picked it up, it needs to be indexed to something.

If you work in Newcastle you get the same incentive scheme as you would working in Moree which clearly is a much more difficult area to recruit to. We feel it should be adjusted from a radius point of view as well. Our clinicians tell us that they would feel that this is a better place to work if there was a stronger clinical leadership and a stronger career path for dentists within the structure and if they had a broader scope of work to do. We will hear that, yes we do do a lot of emergency work, and that is what we do. As much as the community does not like only receiving that, neither do our dentists like providing it. It does not give them that broad scope.

CHAIR: Is emergency work mostly extractions?

Ms OSBORNE: Extractions or emergency fillings.

The Hon. ROBYN PARKER: That is because of the time a patient gets down the waiting list to get a service by a dentist?

Ms OSBORNE: It can be that. It can be that we find a lot of our clients access us just for episodic care. They are not really interested in having a general course of care. Some clients just want that and if they are asked if they want to wait and have preventative treatments they do not. So it is a mixture, it is not as black and white as it may seem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the waiting list too long for them to have ongoing care anyway?

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

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

Ms OSBORNE: No.

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

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can only offer episodic care?

Ms OSBORNE: Yes, that is the only thing we can offer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a waiting list?

Ms OSBORNE: Yes, we do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The committee has heard evidence that some areas have dropped the waiting list for a filling because they will end up coming in for an extraction urgently before they come in for the filling, therefore, there is no point in having a list. Do you have a list?

Ms OSBORNE: Yes, we have a list.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many are on the list?

Ms OSBORNE: I will explain the priority programs so that you understand what I am going to tell you. The priority program has a triage system which is a questionnaire that allocates a code for their severity or priority to a patient ringing in. People who have gone through that triage at Coffs Harbour, Kempsey and Port Macquarie clinics data, show that 2,542 patients waiting that have been prioritised to have treatment and 620 children. Those children would be people who have a school assessment program and brought in. That is not a figure that I am worried about. Those children are in treatment. Of the 2,542 that have had a triage they then see our dentist and prioritised clinically for their clinical priority and there are 2,334 of those.

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

Ms OSBORNE: For dentures?

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

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

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

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

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

Ms OSBORNE: Yes, waiting for treatment.

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

Ms OSBORNE: Yes.

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

Ms OSBORNE: I have got figures for each code. I will give the worst scenario. Patients that have rung in and have been triaged and are code 6, which may be like a check up—code 1 is "I have been hit in the mouth"—someone has been waiting since 15 January 2001. It is not necessarily a check-up but it is something in that category.

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

Ms OSBORNE: When they access us we say that if their condition changes to ring us. So there are people who, within waiting for their general care, do have episodic care. Not many people wait and do not tell us. If they are waiting and their disease is increasing then we see them.

The Hon. ROBYN PARKER: That was the worst—or the best as far as waiting the longest—what is the best, but the worst dental problem?

Ms OSBORNE: In code 1 we have to see patients within the criteria of 24-hours–we have no-one waiting for that. Within code 2, patients with a medical condition within the criteria—we have no-one waiting there, they are all seen. Code 3A, people that we need to see within five days, the next date there is eight, so we are a bit behind on those.

CHAIR: The eighth day.

Ms OSBORNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In one submission a lady has been waiting seven years for assessment.

Ms OSBORNE: Not on this list.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably she would be category 6?

Ms OSBORNE: She might have been Taree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She is in Wallsend.

Ms OSBORNE: The Hunter. From these dates she is not in this.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Somebody from Lismore had a similar problem and had to go private. Is Lismore in your area?

Ms OSBORNE: Yes. I am not making excuses; it is a fact. Taree and Forster were six or seven months ago. I can tell you what has happened in the past but in recent times I do not know how many dentists they have. I now only manage the Kempsey and Coffs Harbour clinics directly, but we are merging with other clinics.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many of those 80 people are dental technicians?

Ms OSBORNE: Dental therapists?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dental technicians are the ones who make the dentures, are they not?

Ms OSBORNE: No, it is contracted out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that the dental technicians and prosthetists passed a resolution that they simply will not make dentures at the price that the State has set. Is that correct?

Ms OSBORNE: No, not in our area. Some dentists left our pensioner denture scheme but I think over the last 12 months only one has left. That is normally because there are private businesses picking them up. So they are seeing private and public patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We heard evidence that the Prosthetists Association recognised it was not economic to do it at that rate. If you are using external subcontracted dental technicians, who effectively are from the same profession, apart from the fact that prosthetists examine the patients and technicians merely make from impressions that others have made, that decision has not affected the number of services you can purchase?

Ms OSBORNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If some of them are refusing to make dentures you must have difficulty in getting them made. You said that you make them until the money runs out. If prosthetists are saying that the level is so low their lead body will not make them at all, that seems to be a total disconnect.

CHAIR: In some parts of New South Wales they may be able to afford to refuse to make them for area health services because they get enough business in other parts of the State. But their situation may be different.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The evidence was that the cost structures are quite similar, in the sense that the materials used to make the dentures are quite similar.

CHAIR: The witness said that that is not happening in this area.

Ms OSBORNE: I have only one dental prosthetist who left in the last 12 months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Out of how many?

CHAIR: These are private ones?

Ms OSBORNE: Yes, they are all private.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they are not in your figure of 80?

Ms OSBORNE: No, they are not on the payroll. We purchase 33 prosthetists for the whole of the North Coast Area Health Service and we contract to 27 dentists under the oral health fee for service scheme.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the amount per prosthetist was put up with the award, the pensioner dental scheme—

Ms OSBORNE: There is a policy that governs the fee schedule. That goes up in July every financial year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if your budget did not rise more than that you simply would get fewer dentures for your money?

Ms OSBORNE: We do every year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You get fewer dentures for your money every year?

Ms OSBORNE: Yes. That goes up every year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But your budget does not go up?

Ms OSBORNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are getting fewer dentures per year with a population needing more dentures?

Ms OSBORNE: Yes.

The Hon. ROBYN PARKER: You referred to 600 children who had been triaged and who were waiting for treatment. Your comment was that you were not concerned about them because they were already in treatment. Who are they in treatment with?

Ms OSBORNE: Dental therapists. Normally they would be on this list because they had had a school assessment. Our program goes out on an itinerary of schools. It is controlled in a way that we manage it. So we go and visit schools. We could have gone to a school in town here that had 600 children in it and examined them. They would be categorised, prioritised and then treated. We would then go out again. I could come here next month and that would be a different figure.

The Hon. ROBYN PARKER: How long is the waiting list for children?

Ms OSBORNE: For children we have nobody waiting for code 1 and nobody waiting for code 2. For the next code, code 3 (a), we have four children waiting. For the next code we have nine, and then 3 (c), which is preventive treatment, has 140. Code 4 has 228, code 5 has 222 and code 6 has 217. So the lower codes are where the numbers are.

CHAIR: How long would they be?

Ms OSBORNE: Those children would be out of kindergarten to years 2, 4, 6 and 8.

CHAIR: How long is the wait for treatment? Are you able to give us the dates for adults?

Ms OSBORNE: Sure. There is one child waiting for code 3, which is 20 July 2005. When I got this information up I found that some of those children are also waiting for an orthodontic assessment. That skews the data a little but this is the true data. For code 3 (b) 22 June 2005; for code 3 (c), 5 April 2005; for code 4, 14 January 2005; for code 5, 1 April 2004—these are orthodontic children—and for code 6, 25 November 2003.

CHAIR: So they are waiting for a specialist?

Ms OSBORNE: Yes.

CHAIR: Who is not available in the area?

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

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

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

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

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

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

CHAIR: It would be about two weeks a month?

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

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

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

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

Ms OSBORNE: No. I think if they had severity they would be seen. There are different degrees of severity of orthodontic care. All the degrees of severity are eligible for treatment here. You can have someone with a traumatic bite, biting into the palate and stripping the palate—that is probably one of the worst—and he or she cannot eat. I am saying that that person would be a priority. We should have a service for that person. But for somebody who just feels that they want teeth like Kylie, then no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We heard evidence from the dental therapists that they could not get staff, that they were not being replaced in that their profession has been reorganised, and that they are dropping schools off their visiting lists. Is that happening here? If it is, to what extent is it happening? Are schools being dropped off their list?

Ms OSBORNE: No. We only have a vacancy of 0.6 for dental therapists out of our budgeted full-time equivalent positions. That person is being covered by a casual at the moment, so all hands are on deck.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are fully covered and you are not dropping any schools. Are you changing which schools get dental therapy?

Ms OSBORNE: We had a staff member in Coffs Harbour recently who was on WorkCover. So that figure went down to two. We saw people who were waiting. People might ring up the call centre. If a child rings up he or she would get care, rather than targeting that child with a prevention program. When she came back we started it again.

The Hon. IAN WEST: You mentioned that you managed the school dental program. Can you explain what you mean by "managed"?

Ms OSBORNE: Yes. It is set out each year. Each clinic has an itinerary of schools that it visits each year in those grades—kindergarten to years 2, 4, 6 and 8. We set it out. It varies in different clinics. Some clinics will examine all those schools in terms 2 and 3 and create themselves a list that is prioritised. Some clinics, like Coffs Harbour, will manage it. They will go and see the school of 600 children, treat those children and go to the next school.

The Hon. IAN WEST: So treatment is being done?

Ms OSBORNE: The children have a full range of treatment.

The Hon. IAN WEST: On the spot?

Ms OSBORNE: Once they have had their assessment they are brought into the clinic and they have their treatment at the clinic, including orthodontics and paediatric. They are referred up to Coffs Harbour from this area.

CHAIR: I am conscious of the fact that we might need to get later some of the data that you have prepared. It might be more efficient if we were to get that data later. I refer to question No. 2. I think you answered the question relating to private practitioners. With all these figures of waiting lists, it would be good to get a picture of just how many people were being seen in your area every month or each year. I think you gave us a number earlier for people with vouchers and for private practitioners doing those vouchers?

Ms OSBORNE: Over the last financial year—Taree and Forster for six months and clinics for the rest—we had 63,715 occasions of service. That number of 63,715 was our target and we achieved 61,189.

CHAIR: That is occasions of service?

Ms OSBORNE: Yes.

CHAIR: Does that include a child checked in a school?

Ms OSBORNE: A child checked in a school or someone needing all his or her wisdom teeth out.

CHAIR: That is regardless of the location?

Ms OSBORNE: Yes; it is not weighted.

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

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

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

Ms OSBORNE: Yes.

CHAIR: Is that dentists in the public service?

Ms OSBORNE: Those are all dentists. That is like a standard. Very rarely do you find a standard recommendation of a ratio.

CHAIR: The OECD figure is dentists per population, but the figure of 14 is only dentists in the public service?

Ms OSBORNE: In the public service.

CHAIR: How many dentists are in private practice?

Ms OSBORNE: I do not have that figure.

CHAIR: Presumably it could be as high as the OECD figure, or higher?

Ms OSBORNE: Yes. The population that we care for would not be able to access services. They would not find it financially possible.

CHAIR: If we are looking at need the people that you are describing would not be able to access private dentists because of the cost?

Ms OSBORNE: Yes.

CHAIR: It is a very hard figure to come up with.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many people are on your dentures waiting list?

Ms OSBORNE: I do not have that figure, as I have not broken it down. I can get it for you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How long do they wait? We have heard that are a lot of people are waiting for a long time.

Ms OSBORNE: That would be fair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your glass might be half full but it is also half empty.

Ms OSBORNE: If you have a budget that has not gone up dentures tend to be the biggest cost. Salaries go up but you do not reduce your staff. Last financial year it cost $67 an occasion of service to provide services in-house. If I purchased one extraction from the private sector it would cost me $180. We try to keep our money in-house. We do not get a budget or a health fee for service. That is just if we have slippage from our salary budget if a dentist's position is not filled.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is costing you three times as much for services in the private sector as it costs if you do them in-house. At the moment you are fully staffed?

Ms OSBORNE: No. I did not get to that. We have dental officer vacancies of 2.8, a therapist vacancy of 0.6, which is covered by the locum, and 3.2 dental assistant vacancies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not have any dental technicians, so you are not making any dentures yourselves?

Ms OSBORNE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you not save money if you did that, or can you not recruit them?

Ms OSBORNE: In the past I have seen cost analysis to say that it is vital to do that, it is a better option to do it in house. However, on the North Coast most of our laboratories in house no longer exist. You would have to set up a laboratory to do it. If I were to do it could have capital costs of setting up a laboratory. You would have to do a cost analysis to see whether that was viable.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One of the dental therapists or prosthetists, I cannot remember which, asked about the real cost of public sector prosthetics and suggested that they were not realistically costed.

Ms OSBORNE: We do not pay enough?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People assume it is cheap when it is not.

CHAIR: Because other costs are not taken into account?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

CHAIR: But the buildings and laboratories?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were talking about the Dental Hospital. It was one of the last comments of one of the witnesses.

Ms OSBORNE: It is important that those sorts of places maintain their services because they are training facilities. Even if other areas are subsidised to support that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you are saving money, two thirds by doing this in house then maybe that is not comparable. When you said $67 per occasion of service, does that include checks only?

Ms OSBORNE: Yes, that includes everything. It would be a check up in school compared to going to theatre future and having four wisdom teeth out or specialist paediatric services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That $67 average is over a huge range of services, so when you say $184 for an extraction it is not comparable to the $67?

Ms OSBORNE: No. It is in there.

CHAIR: From other evidence we have heard it found that you do not have the vacancies or the difficulty in attracting staff that other parts of the States have.

Ms OSBORNE: On the seaboard I would say it is easier to get locums. We find it very difficult to recruit to some areas. We have a chronically vacant position in Kempsey. We were on a rotation with Westmead, rotating dentists through Durri, which set up that rotation and allowed with Justice Health. We have 0.6 of a dentist coming up, but we have a chronically vacant position in there. It is quite difficult to fill something on a permanent basis.

CHAIR: But on the whole it would be true to say that the mid North Coast is an easy place to attract people to, even compared to places like Geelong, across the mountains or southwest of New South Wales?

Ms OSBORNE: Yes.

CHAIR: From what we have heard the picture is much worse in other parts of the State.

Ms OSBORNE: Justice Health has run a locum program. Recently one of our dentists was away for one month and we put in to do it. Someone was missing at Moree and we said all right. I would prefer that the dentist go there because it is much harder to fill the position than it is to cover us. You were asking about how many people. The figures for the data base that we have had Taree and Forster in it, and suggest that more than 5,000 people fail to attend their appointments each year. That is based on last financial year. We struggle with that a great deal. We have dentists sitting, waiting for their patients to come and many do not come. If you look at how many people we have waiting, those figures would cancel out each other.

CHAIR: Do you know why? One would always expect that with these long waiting lists the number of people who fail to appear might go up. Is it because people move?

Ms OSBORNE: We think it is a few things. When you have chronic disease it has a few phases. When you have an acute phase you ring up and you have an appointment, then it can become chronic again. A toothache goes away and people do not come. That is one thing that is reported. We have another reason whereby people are on a health care card for a short period of time and they are eligible to see us, but then the appointed time comes they are no longer on the health care card. They are not contacting us and letting us know. They are the main ones that we know of. If you do not need the appointment because you are in pain then maybe you do not come.

The Hon. IAN WEST: Or you just give up.

Ms OSBORNE: These peoples have appointments and do not come.

CHAIR: How well ahead are appointments normally be made?

Ms OSBORNE: Books normally are made up about four weeks ahead.

CHAIR: They are here and eligible.

Ms OSBORNE: Most of our clinics provide a reminder service. Not all, but most depend on staffing.

The Hon. IAN WEST: Do you do any follow up to ask why they do not turn up?

Ms OSBORNE: Not formally, no. It is anecdotal.

CHAIR: Presumably you can deal with that by squeezing in more people because you know there is going to be a certain failure to turn up?

Ms OSBORNE: If a patient walks in in pain that patient can fill that spot. We do not get notice about them, that is the point. They do not come. It is not as though they ring and cancel.

The Hon. ROBYN PARKER: Someone could be on standby?

Ms OSBORNE: Yes, we have standby lists.

The Hon. ROBYN PARKER: And hang about in the hope that they are allowed to queue jump?

Ms OSBORNE: Yes, but sometimes the appointment is here. The patient has not arrived and we are waiting, but you cannot always fill it from someone on standby. Time is eaten away. But if we get people ringing in and cancelling we have standby, yes.

The Hon. IAN WEST: If someone came in, sat there and said, "I am here", and someone does not turn up you can do that?

Ms OSBORNE: Yes, if they are happy to wait.

The Hon. IAN WEST: If your tooth is bad enough you will wait.

CHAIR: Mr Irving, do you want to say something and tell us about Teeth for Life?

Mr IRVING: Do you want to move on to that?

CHAIR: We are almost there. We have hopped around it. Ms Osborne can then look at other things and we can come back to her. It probably is time that you told us about your program.

Mr IRVING: Thank you for asking. Would you like a preamble, or would you like to get straight into the questions?

CHAIR: Tell us what you do and how it has impacted on the community and how long it has been running?

Mr IRVING: In Australia oral health has been the subject of some considerable planning and discussion. The Commonwealth Government came out with this document called Healthy Mouths Healthy Lives 2004-2013, which is a planning document for the nation. Under that comes New South Wales, of course, and we have our own strategic planning document, which echoes much of what is in there. But when we are talking about the Teeth for Health Program or, as it was called back then, Teeth for Life I will start answering those questions. But why the name change from Teeth for Life to Teeth for Health is because a dentist on the North Shore registered Teeth for Life as his business name during this campaign and he asked us not to use it, so we deferred to his request and changed it to Teeth for Health. If you come across those two terms that is why. The aim of the project was to draw attention to the poor oral health in the community, which arose out of a discussion paper drafted at what was known then as the Oral Health Branch in Gladesville, which is now known as the Centre for Oral Health Strategies since the change in the structure of the department.

Another thing was to inform the community that dental disease was largely preventable and to also encourage councils to consider fluoridation of water supplies as a means of helping to reduce the level of dental decay. That is very much based on the recommendation about the effectiveness, safety and equitable nature of water fluoridation. They are talking about the main impact of the campaign, the first impact is the one that has been the hot topic of today, but it was to have water fluoridation accepted by the councils. All four councils in this region voted to refer, under section 6A, fluoridation to the Department of Health.

CHAIR: Which are?

Mr IRVING: Hastings, Coffs Harbour, Bellingen and Kempsey. So far all but Kempsey have received directions to fluoridate and, as the General Manager from Hastings said earlier, it happened on 6 August last year. The other impact about the Teeth for Health program is that fluoridation was only ever one part of it, but it has become the dominant fight for obvious reasons. Prevention really is the focus of the program and, apart from water fluoridation, you have diet, oral hygiene and what goes on at the dentist, such as fissure sealants and so forth to encourage the community to adopt a better diet, to reduce sugar intake, to indulge in better oral hygiene and, wherever possible, use dental applications such as fluoride or other types of sealants to reduce the likelihood of tooth decay.

In doing what we have been doing over the past two years, which is how long the program has been running, we have been able to develop partnerships with other health organisations, other health professionals, bodies such as local councils, that can undertake further prevention activities based around things such as diet and oral hygiene. I think we have developed a good basis for future partnerships simply because fluoridation has become such a hot topic, for want of a better description, and elevated the whole matter of dental health in the public arena. The other question is what has been the role of New South Wales Health or the area health service in promoting fluoridation of the local drinking water supply. I have cover lot of that already, but to hark back to the Act that governs what we do, as was mentioned earlier today there is section 6 and 6A.

Under section 6 a council can say, "Let's do it" and determine how they are going to do it or they can, as was the case here, agree with us that what we were doing was facing enormous dental health issues that had to be overcome. We are talking about the things I mentioned earlier, such as diet and hygiene, which required behavioural changes. Unfortunately, behavioural changes do not happen overnight. They take time. Some of us here have worked on anti-smoking campaigns for a long time, for example, and we know how long that has taken to achieve what it has achieved, and the battle still goes on. However, the impact of fluoridation is immediate. As soon as it is in the water supply it starts having a beneficial effect on the dentition. The reason is that once it is in our system through water it washes over about teeth continuously, providing what is known as remineralisation of the tooth enamel and, consequently, always battling against the scars that the acid and the bacteria in food create around teeth.

Obviously we pursued that option because our figures showed that the difference between fluoridated and unfluoridated councils was significant in terms of the dental health of the population. It was an obvious thing to pursue. We drew the attention of councils to the fact that from now on they would get 100 per cent capital cost of the works required to fluoridate the water supply and also our CEO graciously took $80,000 from Cathy Osborne's budget and gave that money to the councils to help defer recurrent costs of fluoridation. We did that in discussions with mayors. We went to council meetings. It was discussed openly there and councils voted in front of a public gallery on all occasions to go the way they did. In terms of what our role has been, it has been twofold. First, to draw attention to the disastrous dental decay levels that we face on the North Coast and, second, to show local governments how they could be involved and rectify the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The increased subsidies for fluoridation came straight out of the treatment budget, is that the bottom line?

Ms OSBORNE: No, when we were meeting with council that was an issue that was brought up, so we did some information sessions as the recurrent cost was something that was raised with us as a concern. Our CEO at the time felt that it was our intention, and it is always our intention, to move our direction towards prevention and promotion. The very real way of doing that was allocating money out of our budget to defray the costs of setting up. When you start something it always costs more.

CHAIR: Where does the capital cost come from?

Mr IRVING: The State Government provides the capital cost. It used to provide 50 per cent of the capital costs and now it provides 100 per cent.

CHAIR: That was not taken from Cathy's budget?

Mr IRVING: That certainly was not.

The Hon. ROBYN PARKER: What is the budget? What percentage of the total North Coast Area Health budget is dental or public oral health care?

Ms OSBORNE: The budget for the old Mid North Coast was $4.6 million. I understand the budget for the new North Coast will be about $8 million so that is joining it up with Northern Rivers and taking off Taree Forster.

The Hon. ROBYN PARKER: We know that in New South Wales it is 1 per cent of the total health budget, do you know what is the public oral health of the total budget of your area health service?

Ms OSBORNE: No, I could find out but I do not know.

The Hon. ROBYN PARKER: Would you take that on notice and provide that to the committee?

Ms OSBORNE: Yes. I know that the oral health budget does not have the rural distribution formula attached to it as other budgets do that are brought down to the area so it is not adjusted for socio-economic or Aboriginality factors in the community so that would be something we would recommend happen.

The Hon. ROBYN PARKER: Are you making those recommendations to your chief executive officer?

Ms OSBORNE: Yes, we do.

CHAIR: You mentioned information sessions with the council but were there no consultations with local communities?

Mr IRVING: To answer your question: Were information sessions or consultations with the local community conducted? I have written a reply and I will try to stick to it as closely as possible. In terms of explaining a 60-year-old initiative considered to be one of the greatest public health achievements of the twentieth century, and works well for 90 per cent of the population of New South Wales, there has been extensive community information undertaken. It has been on many fronts and it started in September 2003 in Port Macquarie with a forum on oral health prevention strategies held at the community health service here. A group of people from the community came along and gave their opinions on a range of subjects in relation to oral health prevention in discussing who they felt the high-risk groups were. We had guest speakers along who addressed the problems with those high-risk groups and they included infants, the indigenous, the elderly and teenagers.

We then went around and systematically briefed all the State and Federal politicians in the region and sought feedback from them on the question of oral health prevention generally and water fluoridation specifically. We also spoke to all the editors in the district explaining both things I mentioned before during 2003 and 2004. We liaised very closely with peak bodies, such as divisions of general practice, nursing and allied health professional groups throughout the area health service. We provided evening information sessions for pharmacists and dentists in Port Macquarie in 2004. We provided fluoride information via private and public dental clinics, and promotions were also held during Dental Awareness Month in those two years. We had briefings with the local indigenous peak body which was the Many Rivers council and it endorsed, both verbally and in writing, what we were doing.

The public face of the program commenced in earnest on 20 April 2004 and, as Mr Smith from Hastings Council mentioned earlier, that was a television hook-up between all four centres—Coffs Harbour, Bellingen, Kempsey and Port Macquarie—chaired by Normal Swan in Sydney. That was a thorough discussion of water fluoridation on all fronts. At each centre we had a public audience and we also had a specialist there to answer questions both on the television broadcast and live. They were well attended by the media and it became front-page news in all areas, and has remained a significant news item ever since. We undertook paid advertising campaigns on the radio, and in

newspapers. Dr James Wright was the radio face of our campaign. We placed information on the area health service web sites. We made presentations to service clubs and community and consumer health forums and groups such as the Country Women's Association. We provided full colour water fluoridation information brochures free-of-charge to all councils for distribution on the matter of water fluoridation.

Public forums were held in Bellingen, Dorrigo and Urunga. A public debate with a leading anti-fluoridationist was held in Bellingen before an audience of approximately 200. More than 10 council presentations were undertaken and many of them were public council meetings, as I mentioned before, where a vote was taken on it. There were many replies to lots of correspondence which emanated from very few sources but the replies were sent. We also answered questions from interested councillors and elected members. We have had meetings with ratepayers. There has been ongoing media interest and interviews and, of course, as we were told earlier there have been a number of forums run on water fluoridation that we may not have attended but they certainly contributed to public awareness of the matter. A number of councillors have regular newspaper columns and so forth where they talk about it. Petitions on fluoridation were distributed throughout the area, and I think all those things combined go to show that there was a large amount of information out there, a lot of it generated by us providing community information on water fluoridation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I noted you attended this morning's session at which a number of points were raised by the anti fluoridationists, for want of a better name. I presume you are familiar with their arguments? Do you have comments on some of their points or should I lead you through some?

Mr IRVING: Yes, certainly lead me through.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They said there were no studies abut the levels of fluoride in people who have fluoridated versus non-fluoridated in terms of the levels in their body. Presumably that means their 24-hour urine outputs or whatever measure you have of fluoride inputs. Is it true that no studies have been done in Australia of fluoride levels in people in fluoridated and non-fluoridated areas?

Mr IRVING: The studies in Australia—I cannot answer that exactly because what happened was in both 1991 and later on in the 1990s the NHMRC examined, particularly in the later one, more than 2,000 submissions which looked at the very issues that have been raised here today, and came to the conclusion that water fluoridation was safe and effective. The best evidence I have suggests that there has not been any change in the human condition in relation to water fluoridation since that time and that the matter has been the subject of ongoing investigation. In Australia the NHMRC was charged with doing that earlier and it is still their job to look at these things comprehensively. Their next review is due and needs to be done, but when it is going to be done I cannot say.

I am sure with a group such as the NHMRC being involved and receiving the huge amount of submissions it receives generally, they would look at that in more detail. Having said all that there is certainly sufficient evidence overseas to show that there is no concern for the amount of fluoride we are receiving through our water supplies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean there is very little danger of overdose? Is that what you are saying that the therapeutic index is very high or low?

Mr IRVING: That's it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The gap between a therapeutic and a toxic dose is large?

Mr IRVING: Yes, the gap between the two is large.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is not much danger of overdose?

Mr IRVING: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And fluorosis is not a problem?

Mr IRVING: Fluorosis is certainly not a problem in Australia in terms of being a health problem. It is a cosmetic problem. One just has to look around this room, for example, to see that it is just not evident in the severity in which it is often described as being evidence.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say there is very little fluorosis in the population?

Mr IRVING: There is very little other than cosmetic fluorosis in the population. There is this thing called Dean's index which was done in the 1930s which said that if there is one part per million of fluoride in the water then one can expect X-amount of fluorosis in the teeth, and not much has changed since that time. The prediction remains true. The interesting thing is that fluorosis occurs in non-fluoridated areas as well as fluoridated areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The committee received figures that there was about a 50 per cent incidence of fluorosis. Presumably you would define that as cosmetic fluorosis?

Mr IRVING: In Australia the incidence of cosmetic fluorosis is less than that as far as I can understand, but I would have to double-check that figure. But there is certainly no fluorosis from optimally fluoridated water that can be described as being a health problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If people are getting fluoride in their baby food or toothpaste—I do not know what other foods are high in fluoride, I am not a nutritionist—and you add fluoride to their water, is there a chance that they would then get a high incidence of fluorosis and have a greater than necessary dose of fluoride?

Mr IRVING: The margin for safety is certainly still there to overcome any problems in relation to it but you have to swallow the toothpaste for it to cause fluorosis, and you have to do it at a very young age because you won't get fluorosis once you have got past your baby teeth.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean adults cannot get fluorosis?

Mr IRVING: Adults cannot get fluorosis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why?

Mr IRVING: Because it is all to do with the make-up of your teeth initially and nothing to do with the exposure of your teeth to topical fluoride afterwards.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you finally develop your permanent dentition, which is when one is 8 or 12?

[*Interruption*]

CHAIR: I am sorry but we cannot have contributions from the gallery.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have any comment on the York review which I gather was the review of fluoridation and the evidence thereof in England which seemed to be far less positive towards the practice of fluoridation than previous respectable recommendations?

Mr IRVING: The interesting thing about the York review, of course, is it is a systematic review of all the literature, and that is where its importance lies. There are people that say it is a case against water fluoridation, but certainly on balance it suggests the evidence does not warrant saying "Stop fluoridation now". Nowhere in that document does it say "Cease fluoridation". It may say

"More research needs to be done in this or that area" but the overwhelming empirical evidence of everyday life overshadows any doubts that we may have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you say the York review is neutral and says we should not change, we need to do more research? In other words, do not change the status quo or are you saying it is basically pro-fluoridation with reservations or it is neutral? Your reply suggested that there is other data. Was the York review comprehensive?

Mr IRVING: Oh yes, I agree with that. The fact is that it is more in favour of water fluoridation than not in favour of water fluoridation. Very good evidence of that is the Irish Government's current review of water fluoridation in which the York review, which is also known at McDonough et al, is cited as evidence backing the efficacy and safety of water fluoridation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the York review and the NHMRC reviews meet the Cochran standards?

Mr IRVING: The York review, very much does, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it is pro-fluoridation you would say?

Mr IRVING: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On that basis you would go ahead with the recommendations?

Mr IRVING: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should fluoride be topical or systemic? A paper cited this morning said it should be and had better effects as topical? In your introduction you talked about topical fluoride.

Mr IRVING: That is right. I think it is generally agreed now that once the fluoride is in the drinking water it gets into your system and it is in your saliva and it is constantly bathing your teeth in fluoride. The fluoride then re-mineralises enamel in the teeth that has been damaged by acid and that acid is caused when we eat food, by and large. For every bit of damage that acid does the fluoride can go along and repair it. That is one of the beauties of it, in the water supply it is always there whereas if you have a supplement or something to clean your teeth, it peaks and troughs whereas if it is consumed with water then its ability to do something positive for our teeth is enhanced.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that why toothpaste is not making much difference?

Mr IRVING: Toothpaste makes a difference. It is one of the contributors to reducing dental decay in Australia. Life is limited, if you like, by the fact that it comes and goes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And people generally do not swallow it.

Mr IRVING: And people generally do not swallow it.

CHAIR: There are tablets.

Mr IRVING: Fluoride supplements are the same. Unless it is dissolved in water and you are sipping that water progressively throughout the day you will get these peaks and troughs. So the benefit is there but not for as long.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you said that the topical effect is systemic in the sense that you ingest it—it is then in your bodily fluids; it is then in your saliva and

it is then applied topically by your saliva—you are saying it is a topical mechanism but systemically it is underlying that. You are saying that systemic and not topical is the way to go, even if it affects it.

Mr IRVING: Topical helps as well. Where are you going to get topical? You will get it from toothpaste, in the dentist's surgery, or through mouthwashes. It is the convenience of having it your water that makes it attractive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That makes it perpetually topical, as it is really systemic?

Mr IRVING: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If that is the case why is the evidence for fluoridated water not as strong in adults as it is in children? Presumably the adults would be getting, as you said, the pitting caused by acids immediately fixed up by the saliva full of fluoride. If that is the case why is the evidence not as strong in adults?

Ms OSBORNE: I imagine the evidence is just as strong. I am in territory in which I am guessing a bit. I imagine that it is just as strong in adults. It is just that survey measurements generally are taken of the child population. The adults are not surveyed to the same degree. Pockets of surveys have been done on adults. The ones that I know about show that there has been a difference between those consuming fluoridated water and those not consuming fluoridated water. One particular study was made of members of the armed services. That study might even have been done by John Spencer. That study, which dealt with adults, showed similar differences.

CHAIR: Ms Osborne, you said that you would give us a copy of the material that you prepared for us. Anything we did not properly cover is likely to be resolved by that. Is there anything that arose out of our questions that you did not get to deal with?

Ms OSBORNE: There was one question that was just asked, that is, whether there was an adequate number of dental services for the eligible population. I think we touched on that and we agreed that there was not. I referred earlier to the OECD number. I was also asked what improvements should be made to fix that. With the new chief dental officer there is a move within the State Government to work towards prevention promotion and to make that our target. If that is the case I think there should be funding to run both those programs—the prevention and promotion program and tertiary care.

We can see that we do not cope with tertiary care as it is anyway. At a local area health service level when that strategic direction comes down we need to prepare our work force for that shift in the services that they provide. I think that there needs to be a review of the awards that I mentioned before so we can continue to attract good health professionals. I think we need to advocate for additional auxiliary placements at university so we have auxiliaries ready to provide that health promotion and education, if that is the way we go. The work force is already busy treating and we will need an additional work force.

CHAIR: By auxiliaries do you mean people who are not dental therapists?

Ms OSBORNE: Dental therapists are dental hygienists. Bachelor of oral health is a new auxiliary. Whilst it is very controversial I think the State Government should have a look at reviewing the eligibility for services. I have mentioned that one thing might be a period of qualification when you are on a health care card. If you are going on and off a health care card and putting your name down for services and you are then not eligible they is room to look at the number of people that we can service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You want fewer health care card people to be eligible? Is that the bottom line?

Ms OSBORNE: I think the eligibility should be reviewed. We see people with senior cards and other States do not. I think you could look at different eligibility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those are seniors. What about people going on and off health care cards? What about young people who are unemployed?

Ms OSBORNE: That is just my opinion, but it is something that could be looked at.

CHAIR: Would you broaden the eligibility?

Ms OSBORNE: I would narrow it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have done medicals on people who were about to get their first job for a long time. When I looked into a mouth full of cavities I would say, "I think you should spend your first pay check on a dentist." Each person would respond, "No way, mate." So do you think that is realistic?

Ms OSBORNE: I do think that is realistic. I think that you are reviewing a service that is not coping. If we continue to say, "Okay, give me $4.6 million next year", I will not be able to do it. I cannot provide it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are simply finding ways of cutting your clientele, are you not?

Ms OSBORNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not looking at the needs of the people. Your point of view is, "If I have this much butter, how many bids bits of bread can I spread?"

Ms OSBORNE: Is that not what it is about?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I would not have thought so.

Ms OSBORNE: Within the range of things that need reviewing I think that is one of the things that needs reviewing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the shortage of public dental services should be treated by restricting eligibility for them?

Ms OSBORNE: Because you have a work force that will not cope. All the people going onto pension cards now will all have their own teeth. John Spencer is now looking at a ratio of teeth per dentist, which we have never done in the past—we have always looked at people. We are saying that the work force will not cope with the amount of people that we have got to see. It is projected not to cope.

CHAIR: You are saying that if the work force is going to stay the same, or the budget is going to stay the same—

Ms OSBORNE: We have every indication that our budget will not increase.

CHAIR: Would it be better to increase the budget rather than to increase the work force?

Ms OSBORNE: You could look at eligibility. If you do not it just means that the people who put their names down to have a check up will just have their services stopped. We will not see them. Somewhere along the line we have to be honest in what we can provide.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are going very well but you are not coping now and you will not be able to cope in future unless you cut eligibility?

Ms OSBORNE: Who said I was going well?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That was what I implied from the way in which you spoke about the waiting lists.

CHAIR: I think you misunderstood.

Ms OSBORNE: If you talk to our clinicians you will see that they feel very intimidated by the amount of demand on them. They leave quite frequently because they cannot cope with the demand. I think we have to find some way of making it a reasonable workload. Demand is one of them.

CHAIR: It means either cutting demand or increasing supply?

Ms OSBORNE: Increasing services, yes, please. Give me double my budget and we will be happy to see them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So could you spend double your budget?

Ms OSBORNE: Easily. I would have to build new dental chairs. If you doubled my budget in Kempsey I have only two dental chairs. I would have to have two more chairs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that would be a small problem in the relative scale of things?

Ms OSBORNE: Yes.

CHAIR: Then you would need extra dentists.

Ms OSBORNE: Then you would have recurrent money.

CHAIR: Are there any other things on your wish list?

Ms OSBORNE: I think you should look at having a fully capital funded works program for oral health. It is often included in the area health service. Nambucca is not on the service plan and we are thinking about putting it in. When people ask, "Why are only two people servicing my area?" it is because of the ad hoc way in which services have been allocated. I think if it were allocated in a systematic way in response to demand we would see better results. I think the Federal Government needs to recognise its responsibility in this area. The Australian Dental Association does not advocate that oral health should be in Medicare. The Federal Government has grants for certain things. I am happy either way but I think it should either be running a preschool program where people are targeted before they get dental caries or disease or it should assist us with the aged population, with which we will not cope in the near future.

CHAIR: The dental association and others made that point about Federal responsibilities and where dental services should be. Medicare has often tied that to a strange bifurcation between dental health and general health. Why is it that we have ended up in a situation where dental health is treated as something quite unconnected? We heard a lot of evidence to the effect that dental health is closely related to a lot of other health issues. I guess that is tied in to some of the points you made earlier about capital works planning. You cannot treat dental health as a separate thing; it has to be more integrated.

Ms OSBORNE: It has to be more integrated, yes.

(**The witnesses withdrew**)

SUSAN ELIZABETH HARRIS, Dental Therapist-Dental Manager, Durri Aboriginal Corporation Medical Service, 1 York Lane, Kempsey, affirmed and examined:

CHAIR: We have given you some questions. We wanted to ask you mostly about dental services but also a little about the funeral industry. Do you want to make any sort of statement before we start?

Ms HARRIS: I have prepared a statement. If you do not mind I will read it so that I include everything. I represent Durri Aboriginal Corporation Medical Service. I am a dental therapist and manager of the dental services at Durri Aboriginal Medical Service. At this point I would like to acknowledge the traditional landowners, the Biripi people and the elders, and give my apologies from Steven Blunden, Chief Executive Officer of Durri Aboriginal Medical Service. He is also on the board of the Northern Oral Health Network. I would just like to give you a little bit of background into the organisation that I work for and an overview of our dental program.

To date Durri AMS has undergone many developments and has recently relocated to extensively larger premises, and is located on the river in Kempsey's the central business district. The Child Dental Program was first introduced in 1989 with the implementation of an early intervention program, which entailed a school-based child dental treatment program and the delivery of dental education programs to the community. The program was managed and staffed by dental therapists and a dental assistant. The introduction of the Commonwealth Dental Health Program in 1995 provided Durri with funding to recruit dentists to provide dental treatment to the adult Aboriginal community. However, in June 1997 the Commonwealth program was abolished and Durri was unable to maintain a comprehensive adult dental service. Seven years on, following numerous reports, submissions and lobbying, State Health released funding to the Aboriginal Health Branch to implement an adult dental program at Durri AMS.

In January 2004 Durri AMS was able to provide a dental service that included a child and adult component. The Adult Dental Services is provided with the Assistance of Western Sydney Area Health Service, Westmead Centre for Oral Health and the Rural Placement Program. Two visiting dental officers from the team of approximately 10 dental officers rotated to provide general and emergency dental treatment at Durri. Funding restraints at Durri has limited the employment of dental officers to 1.2 positions. Therefore Durri has negotiated agreements with North Coast Area Health Service and Justice Health to assist those services with the recruitment of a dentist, that being 0.8 of a dental officer position, which Durri cannot afford. Child Dental Services is provided by dental therapists, 1 position, and when necessary child patients may be referred to the dental officer.

The dental program is supported by two dental assistant positions and one dental receptionist position. When the budget allows, casual auxiliary staff are employed to assist with the ever-increasing clinical load. The dental clinic has three operational dental units or chairs, and a mobile dental unit known as the Molar Patroller, an Isuzu truck fitted with a dental chair and equipment, which presently is not operational because it needs upgrading.

CHAIR: The truck or the chair?

Ms HARRIS: Both, but the truck mainly. The dental program offers emergency and dental care. General dental care includes restorative and preventive treatments and is supported by dental health education and social programs to individual clients, schools and community groups. The ideal service provision is the delivery of general treatment, which includes restorative and preventive treatments. Due to lack of funding emergency care takes prevalence and long waiting lists for adult general treatment continually grow longer. The dental health status of the Aboriginal population is generally very poor. The adult population in particular experiences a high rate of dental decay and periodontal disease. Poor dental health has a range of consequences for a person and may include severe pain, infection and abscesses, which result in the extraction of teeth.

Therefore many people are living without teeth, which affects their ability to eat. This has particular implications for people with complex health care needs, such as diabetes, because that person's ability to eat nutritious food is severely compromised. There are also social implications in terms of potential effects on self-esteem and confidence. Budget restraints do not allow for the

provision of dentures at Durri. The very long waiting lists at mainstream public dental programs and the high cost of private dental clinics have resulted in many people living without teeth. The poor state of dental health is much more prevalent in the adult Aboriginal population because funding for the provision of a comprehensive adult dental program has been fragmented and inadequate and lacked continuity. Our vision for our dental clinic is to improve the dental health status of Aboriginal people in culturally supportive ways to reduce overall health benefits. That wraps up my overview of the program. If you would like to ask questions, I hope I can answer them.

CHAIR: You have answered a number of our prepared questions, particularly in giving us a picture of where you started and how you got where you are. You probably have answered our questions about the services you provide and the staff you employ. Do you have difficulty recruiting dentists, the answer to which is yes, but I suppose your arrangement with Westmead for rotation solves a large part of that.

Ms HARRIS: That is right. We had a lot of trouble recruiting dentists when the funding came through. We took the usual avenues of advertising in the local papers, the *Sydney Morning Herald*, the *Australian*, dentists job search and the *Koori Mail.* We did not get a lot of response that way. We had links with Westmead through some research programs that were done through Durri and the Bellbrook community, so we established links at Westmead and we were able to have an agreement with Westmead that they supply our dentists for us. That is on a yearly agreement. It very much depends on Westmead's recruitment as to whether they flow on through to Durri and then on to area health as well.

CHAIR: Does that solve the recruitment problem in the short term?

Ms HARRIS: It has, but as I had it depends on Westmead's continual agreement with us. Dental officers have been very hard to recruit. We find that dental therapists are easier to recruit. The reason being that they are restricted to employment through area health or through government organisations. They cannot work in the private sector. They are easier to recruit. Dental assistants are also easier to recruit. Very often we make those positions Aboriginal designated. We train the dental assistants as well in house. Very often that can change through OTEN, courses in Sydney where they can do a certificate in dental assisting and in dental health promotion.

CHAIR: They get the certificates while they are with Durri?

Ms HARRIS: That is right, and then they are qualified.

CHAIR: Do they go on to jobs in other dental services, or do they tend to stay with Durri?

Ms HARRIS: A few have gone on to dental therapy and enrolled in colleges down there. I think there are a couple of Aboriginal dental therapists who have gone through and a couple of Aboriginal dentists as well. I think there may be only two in the State when I last heard. A lot of the staff is recruited from the wider community.

CHAIR: We asked a number of questions about the geographical area you cover and whether a majority of Aboriginal people normally come to you?

Ms HARRIS: Yes, they do.

CHAIR: What statistical information can you give us?

Ms HARRIS: The geographical area we cover is from Port Macquarie extending up the coast to Macksville, the Nambucca Valley and west to Bellbrook and Wauchope. That is the area that we cover.

CHAIR: Services south of Port Macquarie are left to Taree, Biripi and so on?

Ms HARRIS: That is right, Biripi, Taree and further up towards Grafton is Boganaroo, another Aboriginal medical service. Just recently a medical service has been set up in Coffs Harbour. Durri oversees that medical centre because it is only very new.

CHAIR: Most Aboriginal people in that district come to Durri?

Ms HARRIS: Yes, definitely.

CHAIR: Could you give us any idea of the numbers?

Ms HARRIS: I can probably let you know. In Kempsey itself there are probably 3,000 4,000 Aboriginal people who reside in the Kempsey area. If you are looking to the outlying areas, probably about 7,000. I cannot give you the exact number that accesses the Aboriginal Medical Centre, but a large proportion does rather than the hospitals or other medical centres in the town. Durri bulk bills. There is certainly a need there and a lot of clients for them to provide a service.

CHAIR: Do any of the people who might otherwise be your clients go to private dentists?

Ms HARRIS: Aboriginal people?

CHAIR: Yes.

Ms HARRIS: No.

CHAIR: Because they cannot afford it?

Ms HARRIS: Exactly. That is right.

CHAIR: Do you send people to private dentists?

Ms HARRIS: No.

CHAIR: You are not able to use vouchers or any of the other systems?

Ms HARRIS: We had a voucher system prior to being funded for our dental program ourselves where we referred them privately on a voucher system.

CHAIR: But once you got funded you could not do it?

Ms HARRIS: There is no longer a voucher system.

The Hon. IAN WEST: Is it because you are not eligible?

Ms HARRIS: It is mainly because we have limited funding and it is much better to have the clients attend a service.

The Hon. IAN WEST: You cannot do both?

Ms HARRIS: No.

CHAIR: Who is eligible to come to you for dental services?

Ms HARRIS: Any person who identifies as Aboriginal. We do not set a requirement that they are on a health care card or a pension card. Across the board Aboriginal people are seen. We also see non-indigenous people as well if they present at Durri for emergency care.

CHAIR: Do you get many of those?

Ms HARRIS: We do find that we have a lot of inquiries. We may get walk-ins off the street, but we have taken on the Information System for Oral Health, which is a data base and a client management system, but we are a stand-alone system, which means that there is no call centre. Anybody who rings us gets to speak to the clinician. We are more accessible to the public that way.

CHAIR: Can you give us an indication of how many clients attend Durri each month or year?

Ms HARRIS: Yes.

CHAIR: Do you have any statistics on that?

Ms HARRIS: I can give you the figures for the last financial year.

CHAIR: If you have the details we can take a piece of paper or get it from you later.

Ms HARRIS: I jotted it down in pencil. In the last financial year, July 2004 to June 2005, there were 1,535 appointments through the adult clinic.

CHAIR: And children?

Ms HARRIS: I do not have the exact figures for children, but I can provide you with that.[2] It would be heading towards the 1,000 for children. Of the adult 1,500 appointments, 633 were for extractions, 492 were for restorations and 88 were for temporary restorations. That is just a breakdown of service provision.

CHAIR: Do you have the same experience that we have heard about from other area health services where a large number of extractions would not have been necessary if the patients had been seen and helped earlier?

Ms HARRIS: Certainly, yes. Particularly because our program has been set up only in the past 12 to 18 months those people that were receiving no service before certainly need to have extractions now. We do have a waiting list as well. Would you like the figures of those waiting lists?

CHAIR: That is the beginning of 2004?

Ms HARRIS: The beginning of 2004. At present the waiting list has 328 on it. Originally there were 569 on the waiting list and as of now 241 of those clients have been seen, leaving approximately 328 still on the waiting list for adult clients. There is no waiting list for children because our child program has been going for around about 14 years now and we have that under control.

CHAIR: Do you prioritise your waiting list? For example, one of the 328 is really serious will they get in this week?

Ms HARRIS: Very much the same as Area Health on a general waiting list, those with compromised health, with complex health needs are usually brought up the list.

The Hon. ROBYN PARKER: Once a person reaches the top of that waiting list to they have their whole mouth reviewed or do they only get treatment for one problem and then go back on the waiting list to have the rest of their issues dealt with?

Ms HARRIS: No, the waiting list is for general treatment. When they are called in for their first appointment they are assessed, a treatment plan is drawn up and they are seen until their treatment is completed and then someone else will be brought off the list. That is mainly why we have a waiting list so that the treatment is not fragmented so that you are not seeing somebody for a restoration and then six months later calling them in for another one to find that that needs extraction at that stage.

CHAIR: Do you have a problem with people not turning up for appointments?

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[2] Figures provided by the Durri Aboriginal Corporation Medical Service state that there were 625 child dental appointments and 1,535 adult dental appointments at the Durri ACMS Dental Clinic from July 2004 to June 2005.

Ms HARRIS: Yes. We have a high level of fail-to-attend appointments as well.

CHAIR: The committee heard that from the people from the Area Health service.

Ms HARRIS: I heard that.

CHAIR: Why does that happen?

Ms HARRIS: Very often appointments for the Aboriginal population are not that important. The medical clinic where they see the doctors there is no appointment basis there. It is first come, first serve and a dental clinic cannot be run without an appointment system. The community is getting used to the appointment level. If they fail to attend an appointment we give them another opportunity to come. After three fail to attends they are put back at the end of the waiting list. We give them the opportunity to improve, more or less, before they are placed at the end of the waiting list again. I can see some improvement in it for those clients who are genuine about being on the list and wanting to complete their general treatment.

The Hon. ROBYN PARKER: In terms of the transient nature of members of Aboriginal communities, if someone moves to another area, say Redfern to visit relatives, do you send on their details?

Ms HARRIS: Yes, we can do that. We do see a lot of Aboriginal people who are not residing in the area that will come in for emergency care, which they are provided with care. We do not see people that live outside the area for general treatment.

The Hon. ROBYN PARKER: So the message is out to come to Durri for emergency care?

Ms HARRIS: Yes.

CHAIR: How would you sum up the state of the dental health of your clients? Is it generally pretty bad?

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

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

Ms HARRIS: Again, very poor.

CHAIR: Much poorer than comparable non-Aboriginals?

Ms HARRIS: Yes, to the mainstream to non-indigenous people, very much so, those in the low socio-economic area from which we come with unemployment and lack of education. We have started with the children and we find there is a level of education now and the actual child dental health is improving. We have not had a lot of time to work with the adults yet.

CHAIR: Do the children also get looked at at school through the area health service?

Ms HARRIS: Through the area health service they do if they indicate consent they are reviewed, assessed and very often they will come to us with their code.

CHAIR: You have a mobile patroller that is not currently working?

Ms HARRIS: No.

CHAIR: Are there home visits? How do you cater to people in Bellbrook or further out?

Ms HARRIS: There are no home visits at the moment.

CHAIR: They come to Kempsey.

Ms HARRIS: Yes, normally. Clients from Wauchope, from the land council are usually transported over by someone from the land council. They may come in a group. We provide a morning for Bowraville as well as Wauchope and it will not be long before we are hoping to introduce the Bellbrook community into the dental clinic.

CHAIR: Do those from Macksville/Nambucca come in with the Bowraville group?

Ms HARRIS: That is right, and if they have transport they come on their own. But the mobile dental unit was acquired through a demonstration grant in 1996. It was a one-off grant that was only limited for 12 months. After that 12-month period we did not receive any funding to upgrade it, to continue maintenance and the running costs and we had lost the Commonwealth Dental Health Program, so the funding came out of our limited child budget. Just over the years we have not had the funding to maintain the mobile patroller. We have an expression of interest that we have submitted to the Department of Community Services proposing funding for an early intervention dental program, targeting families that reside in isolated and rural and remote areas. We are hoping to utilise the mobile patroller again and take the service to the community if we receive funding for it. I would think the same as area health, we are under-funded. We would like a bigger budget as well.

CHAIR: The committee has received a number of submissions that are critical of the level of services provided by the public system, particularly in regional and rural areas. I do not know whether that question is important for you because I am not sure how much need you want to make of the general public system or how much you prefer to seize Durri as a stand-alone?

Ms HARRIS: We actually work with area health, we are in partnership with them.

CHAIR: How does that work?

Ms HARRIS: The partnership?

CHAIR: Yes.

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

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

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

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

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

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

Ms HARRIS: Yes, therapists as well.

The Hon. IAN WEST: How do you explain the partnership with area health? I am visualising two separate operations but you say it is not?

Ms HARRIS: We are two separate operations but we work together to plan strategies on how we will overcome some of the health problems.

The Hon. IAN WEST: From a strategic planning and promotions point of view?

Ms HARRIS: That is right. We have separate budgets and management but we do work together.

The Hon. IAN WEST: Is one thing on your program to get that mobile patroller working?

Ms HARRIS: That is correct.

The Hon. IAN WEST: It sounds like a great promotion: the kids would love it.

Ms HARRIS: It is very visible in the town as well because it is a big white truck painted in Koori murals which depicts the river, the area and the coast. You cannot miss the truck.

CHAIR: Does Durri refer many people on for services such as orthodontic work? How often does it happen? Is your service so overwhelmingly those basic extractions, restorations and so on that you do not have much call for those services?

Ms HARRIS: We do have a call to refer and that would be in the case of surgical extractions. Our dental officers would refer onto area health to see a specialist oral surgeon and sometimes they are even referred onto Coffs Harbour and John Hunter Hospital and sometimes down to Westmead Centre for Oral Health.

CHAIR: Once that happens the patient would go onto the ordinary waiting list for the various grades for priority?

Ms HARRIS: That is right they go on the area health waiting list. They have to meet the area health criteria of being on a health care card or a pension card. We do also refer our child clients on to the orthodontist for orthondtic assessment and they are also placed on a waiting list, as with the mainstream.

CHAIR: How many in a year are referred?

Ms HARRIS: There are quite a few referrals to oral surgeons. We would probably have close to one dozen a week that may need referral, particularly for difficult extractions with wisdom teeth.

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

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

CHAIR: I think we have covered the dental area. Thank you for giving evidence today.

(**The witness withdrew**)

(**The Committee adjourned at 4.00 p.m.**)