REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO DENTAL SERVICES IN NEW SOUTH WALES

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At Sydney on Tuesday 5 July 2005

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

The Hon. K. F. Griffin
The Hon. R. M. Parker
The Hon. I. W. West

DENISE MARGARET ROBINSON, Chief Health Officer and Deputy Director-General Population Health, New South Wales Department of Health, 73 Miller Street, North Sydney, affirmed and examined, and

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

PETER ROBERT HILL, Principal Dental Officer, Oral Health Services Manager, Justice Health, PO Box 150, Matraville, sworn and examined:

CHAIR: Dr Robinson, do you wish to make an opening statement?

Dr ROBINSON: Yes. First, I wish to acknowledge the traditional owners of this place, the Gadigal people of the Eora tribe. In my capacity as Chief Health Officer and Deputy Director-General Population Health of the New South Wales Health Department, I have responsibility for the Centre for Oral Health Strategy. It is one of the five centres that are under my direction, the others being the Centre for Aboriginal Health, the Chronic Disease Prevention and Health Advancement Centre, Epidemiology and Research, and Health Protection. While I have only been in the role of Chief Health Officer for a short period, I have had experience in the delivery of public oral health services in the past when I was the CEO of the former Southern Area Health Service and also as the Executive Director of St Vincent's Hospital, Sydney.

Oral diseases are in large part preventable conditions, and almost 90 per cent of the tooth loss that we see at present is due to dental caries and to periodontal disease. These are preventable and treatable, and much of that tooth loss is avoidable. Oral health is an integral part of general health, and oral health status can be regarded in general terms as a risk marker for general health. Many of the risk factors for oral health are the same as those for systemic disease. These are diet, smoking, poor hygiene, stress, alcohol or substance abuse, and injury. Many risk factors for systemic disease also impact on oral health, and the resulting diseases often occur together.

I am convinced of the need to introduce a population oral health approach in New South Wales that better addresses the risk factors by population-based and targeted health interventions. This would be an approach that currently utilises both the dentists and dental and other health professionals from both the public and private sectors to promote good oral health and to reduce oral disease. To address the oral health of the whole population makes sense in fulfilling the obligations of our area health services where they are obligated to promote, protect and maintain the health of the community as defined under the Health Services Act 1997.

The various research reports commissioned by New South Wales Health, the Australian Institute of Health and Welfare and the dental statistics research unit at the University of Adelaide also support a population health approach. We are also committed to implementation of the relevant sections of the national oral health plan—indeed, I have just now accepted the chair of that particular monitoring group—to see how the various jurisdictions in Australia progress against the development of the national plan. We will use this wider preventative approach also in health more generally, and it is an approach that we have taken in our futures planning and strategic planning for the next 15 to 20 years across health in general.

In terms of service provision, approximately 85 per cent of dental services in New South Wales are provided in the private sector by private dentists, with their fees being paid by individuals and with refunds going from private health funds where the individual has ancillary cover. Public dental services are provided in dental teaching hospitals, community health centres and school-based clinics, with clinical care provided by dentists and dental therapists. Some public care is also provided in the private sector through a fee-for-service scheme. Public dental services are provided to an eligible subpopulation in each State of Australia, and while the eligibility criteria vary from State to State the key criteria are age—that is, children—and holding a relevant Centrelink concession card, mainly health care concession cards and pensioner concession cards.

Holding of these cards is based on criteria determined by Centrelink and normally related to income benefits, and is controlled by the Federal Government. This means that there is a strong

interrelationship between eligibility and socioeconomic status. There is a strong relationship between low socioeconomic status and dental disease. By definition, public dental patients are likely to experience more dental disease, and more advanced dental disease, than those who are in higher socioeconomic status groups. Services provided to the eligible population include a range of preventative general and some specialist care, but there is a gap between demand and the capacity to supply.

In 2000 the Australian Institute of Health and Welfare noted that the needs for dental services were increasing because of population growth, increased tooth retention and a rising awareness of oral health and expectations in the population. It was estimated that requirements for dental visits will increase by 25 per cent nationally to 2010 but the increase amongst those eligible for public care is predicted to increase by 33 per cent. In New South Wales the eligibility criteria for public dental services are the most generous of all States. It extends to adults with health care cards, pensioner concession cards and to the Commonwealth seniors health card holders and dependents. It also covers preschool and full-time school students to the age of 18 years. In New South Wales approximately 50 per cent of the population is estimated to be technically eligible for care compared to approximately 30 per cent in Victoria or Queensland.

The cessation of the Commonwealth Dental Health Program in late 1996 had a major impact on all States, with waiting times for care increasing dramatically. In the first year following the cessation of the Commonwealth Dental Health Program, there was a 62 per cent decrease in the number of adults treated in New South Wales. In 1995-96 there had been 440,000 adult patients who received care; in 1997-98, this figure fell to 172,000. In response to the withdrawal of the plan, most States have introduced a variety of demand reduction or demand management techniques and all States except Queensland and New South Wales have introduced a co-payment scheme whereby the patient pays their contribution toward the cost of the service.

The Australian Government provides subsidies to those who can afford private health care insurance through its 30 per cent health insurance rebate and it has been estimated that as over 8 million Australians access private dental services using their private health insurance, approximately $350 million of the $2.2 billion cost of the rebate goes to dental services. The New South Wales Government continues to support the reinstatement of the Commonwealth Dental Health Program and a national approach to future oral health planning.

In April 2000 the New South Wales Government announced, as part of its oral health reform package, major increases in funding to public oral health services. Since July 2001 the current spending on oral health programs in New South Wales has increased from $72.5 million to approximately $120 million in 2005-06. In addition, New South Wales Health funds $3 million per annum toward Aboriginal health services, largely through the Aboriginal Medical Services. The New South Wales Government has also demonstrated its leadership in the area of the prevention of dental disease through the Teeth For Life project that has resulted in implementation of a range of oral health promotion strategies, particularly water fluoridation in the mid North Coast of New South Wales since 2002.

As a result of the initiative taken by the Mid North Coast Area Health Service and the Centre for Oral Health Strategy, councils at Coffs Harbour, Hastings, Kempsey, Bellingen and Moree have now referred the decision on the fluoridation of their water supplies to the director-general. The Director-General of Health, having sought the advice of the Fluoridation of Public Water Supplies Advisory Committee, has directed the above councils to commence fluoridation by November 2005. The local data gathered during these campaigns demonstrated that un-fluoridated communities in rural New South Wales had significantly higher caries experience compared to neighbouring fluoridated areas, despite the universal use of fluoride toothpaste.

In August 2004, in further recognition of the importance of fluoridation as a public health measure, the department increased its capital works funding for fluoridation from 50 per cent of incurred capital costs by council to 100 per cent. Letters advising this were sent to all un-fluoridated councils by the chief health officer, informing them of this change. The Brewarrina Shire Council has now accepted the offer and at least another 10 councils are currently expressing interest in fluoridation and have requested assistance from New South Wales Health with information and programs and community consultation.

Approximately 90 per cent of the residents of New South Wales currently have access to fluoridated water, but it is 100 per cent of the population in Sydney and it falls to 59 per cent outside. These fluoridation initiatives are extremely important. We are committed to the introduction of fluoridation in all communities with a population of over 1,000 in accordance with the National Oral Health Plan for those where fluoridation of the water supplies is possible, and other fluoridation strategies in smaller communities. This has the potential to avoid millions of dollars in dental disease and cost to the New South Wales community and also will impact on diseases with the risk-related factors.

The estimated benefits to cost ratio for fluoridation is 80:1. For every dollar spent there is $80 in benefit in reduction in oral health care needs. The third component of the New South Wales oral health reforms was the introduction of a priority oral health program in July 2001. This provides a more equitable system to assist in assessing patients on the basis of medical and dental needs as well as socioeconomic and other risk factors. This triage protocol commences from the first contact by the client, requesting access to priority oral health care, and enables the completion of the specifically designed questionnaire that is administered by staff either face-to-face or by telephone.

It is our standard that patients in need of emergency care should be seen within 24 hours, while patients reporting less urgent needs are prioritised following a standardised procedure and are registered to have their health condition assessed, in the same way as when people seek a medical appointment.

The Hon. ROBYN PARKER: Madam Chair, may I ask how long Dr Robinson's opening statement will be? I am aware we have not received a submission from the department. This seems to be like a submission that is taking up our time for questions.

Dr ROBINSON: I have another page, but I am happy to defer to the Committee. A submission is in preparation and we have been given an extension to 31 July. We aim to have it to you before that time.

The Hon. ROBYN PARKER: Why is it so late?

CHAIR: If there is another page, perhaps we will let Dr Robinson go on. I assume it is no coincidence that you are in many ways addressing the questions that we have prepared, but there is a lot more detail and so on that we will want to raise with you outside the questions. You are on to other sections of the area, but nevertheless I looked at my watch too, and we do need time for questions.

Dr ROBINSON: Perhaps I will very briefly touch on oral health work force issues which are clearly a national issue in Australia and we accept that there is a co-ordinated effort required by each jurisdiction. We are currently involved in several initiatives to address recruitment and retention issues in the medium and long term, including career pathways and remuneration. To attract dentists to the rural areas, we are looking at incentive packages, scholarships and clinical placements and a streamlined process for the entry of overseas trained dentists, aligned with the processes already in existence for overseas trained doctors. That is an interim measure in terms of addressing the work force issues.

The key strategies under way as part of our oral health or operational plan are to focus on children, older adults and Aboriginal and Torres Strait Islanders using evidence-based programs for children 0 to 8 and their families and progressive fluoridation of community water supplies. Associated elements would be work force, education and training, and partnerships with other health professionals. I thank the Committee very much for your time.

CHAIR: As I said, quite a lot of the issues that we have raised you have taken up at least in general terms. I might begin the questioning and then the Hon. Robyn Parker and others may want to take over. You gave us a broad picture of the dental services provided by the public health system and to whom in terms of the cards and so on. How exactly do people access these services? I know later on in the opening statement you talked about a standard of 24 hours for emergencies. Can you tell us roughly how the system works?

Dr ROBINSON: Yes. People can either attend the clinics or the community health centres where the services are being provided, or through the area health service they can contact a call number and they can make an appointment that way.

CHAIR: And what sort of waiting time do they normally then find they have?

Dr ROBINSON: As I indicated, for those requiring emergency care, our objective is to see those clients within 24 hours. With those who have less urgent conditions, there are alternative standards that apply. If you have a situation where you have some complaints or pain, it may take perhaps two to five days for your appointment to come, perhaps. For people who are wishing to access the service in terms of routine assessment and preventive care, the waiting time could be considerably longer.

CHAIR: Such as, for example?

Dr ROBINSON: It may be several weeks, or it may be several months.

CHAIR: Would it be true to say that the system is pretty much focused at the crisis end?

Dr ROBINSON: The system is pretty much focused at the delivery of the acute care that is required so that emergency needs are met and the more acute conditions are handled, rather than looking at a longer term preventive program.

CHAIR: Obviously some of these issues will come up with some of our other questions—for instance, the fee for service scheme. You may have covered most of our questions about what New South Wales has done since the Commonwealth program ceased. You certainly said something about that. What services, other than the card system that you mentioned, are available through the Commonwealth or through Medicare? Are any things covered that relate to oral health under Medicare?

Dr ROBINSON: The Commonwealth Government does not provide any general oral health services at this point of time. That program ceased in 1996. There are some Medicare services that are available. In recent times the Commonwealth has introduced access for patients who have chronic conditions who receive certification from their general practitioners that oral care is a necessary part of the management of the condition. My understanding is that they have an entitlement to up to three attendances to a private practitioner as part of that scheme. I also understand that there has been very limited take-up of that new initiative to this point of time.

CHAIR: Is there a definitional problem? The mouth, oral health, is dealt with over here, and the rest of the body is dealt with over there, and yet already in the limited evidence we have taken it seems fairly clear that that can be a very artificial distinction.

Dr ROBINSON: I think it is true to say that historically oral health has been treated differently to general health. I mean, general health has been eligible for Medicare rebates and Medicare services for a long period of time now and oral health has not been managed in the same way. I agree with you, though: Oral health is absolutely integral to good general health and there is a growing realisation, I believe, that it is necessary to look at oral health and the same way as we do general health. Certainly the same risk factors that indicate a problem with respect to oral health are those that are responsible for much of our chronic care.

CHAIR: Does that have implications for the training of the medical work force as well as for the training of the dental work force?

Dr ROBINSON: I can only speak from my time as a medical trainee. I am not aware of the components that now exist in the medical program with respect to developing doctors' awareness of oral health and oral disease. It was not something that was well covered many decades ago when I went through. It was seen at that time very much as the province of the dental professions.

Mr CLOUT: Would you be happy for me to add to that?

CHAIR: Yes.

Mr CLOUT: I think the answer to your question is that it increasingly is, and it should be. If I can give you an example of that: I think a couple of the programs that are now being run by the University of Sydney and the University of Newcastle are recognising the need for there to be a much more general education for all health professionals in respect of the interrelationship between dental disease or oral health and general health, and that is gradually, but probably too slowly from my point of view, being incorporated into those programs.

At an area health service level, there is a clear recognition that at the preventive end, the education end of the services that we provide—and I think we have to remember that the acute treatment end is only one component of probably a four-pronged component for oral health—there is an initiative we are looking at for oral health clinicians to work very much more closely with the Families First clinicians who are a range of clinicians, including doctors, nurses and allied health staff who actually go out and work with at-risk families. There is a very high correlation between at-risk families, socioeconomic disadvantage and multiple diseases, including oral health. We should look at programs with our dental clinicians and the general health clinicians in providing that education health promotion and information to people at the preventive and promotion end of dental care, and also identification of families that need to then be referred particularly and specifically to the services.

CHAIR: For instance, in Hunter New England do you have the staff or the resources to provide the services? Do you have the workers to do the assessments that you are talking about?

Mr CLOUT: Hunter New England is part of the northern New South Wales oral health network and we have a strategic plan that looks at doing that. In the Hunter New England Area Health Service we have 14,000 employees who work directly for us. Our objective is to look at every one of those clinical staff—who probably make up about 10,000 of those—and have as part of their service a component and awareness of oral health. That is our objective. Are we doing that at the moment? We are doing it gradually, and in some cases invariably, across the area. But that is certainly what we have to do. There has been a massive increase in the funding, as Dr Robinson talked about, but the funding increase itself and the increase in dental staff will not solve the problem because the demand is increasing very much more rapidly than we are capable of doing it just through the dental staff. So we must look to all of those other clinicians to be oral health advocates at the front end of where they present. Will that solve it all? We will still have demand that is greater than the supply and the capacity to deal with it, but we will improve it enormously if we take that four-pronged approach, in my view.

CHAIR: Is the demand coming from children and young people, from an ageing population or is it across the board?

Mr CLOUT: Dr Hill is probably better placed to answer that but I will give it a run first and he can add to it. My answer is: yes, all of those and a few more. The facts are that fluoridation of water supply systems has been significantly successful for those who have it. The end result of that is people like me still have all their teeth in their head—all bar one, in my case—and my children will have all of them. As they get older obviously there will be more people with teeth and, just as other medical complications occur, there will be complications relating to the provision of oral health for them. That is one.

In my view, we are fighting a great battle and war in relation to diet and the community advertising that goes with fast foods and bad diet. The increased intake of fizzy drinks, for example—particularly those that are acidic—is a major demon for us in terms of increased disease requiring treatment. I do not know how we will address that one over time. We also have the socio-economically disadvantaged, particularly Aboriginal communities in rural areas, whose health status is very much worse than that of anyone in a non-rural area. I think the rate of that is increasing and fluoridation must be part of the solution.

CHAIR: Dr Hill, did you want to add anything?

Dr HILL: I would add that a lot of the work, especially John Spencer's work, talks about polarity and the fact that we know that 80 per cent of people have very good teeth and 20 per cent of

people have very poor teeth. This 20 per cent invariably fall within the patients who are seen in the public dental sector. This gap seems to be widening. In answer to your first question, the demand seems to come across the board—children are represented by their parents obviously—and the demand is normally for fairly urgent access because there is some degree of pain.

The Hon. ROBYN PARKER: Dr Robinson, can you explain why we do not have a submission from the department?

Dr ROBINSON: A submission is nearing finalisation. It is our intention to get it to you as soon as possible. We did seek an extension sometime back and we were advised that it would be acceptable to have a submission to you by 31 July.

The Hon. ROBYN PARKER: Why did you need an extension of time? Why was the department not able to present a submission to this inquiry on time?

Dr ROBINSON: We were originally advised that the inquiry was going to be held somewhat later in the year so we had not commenced our preparation. But, as I said, it is nearing finalisation and will be with you very shortly.

The Hon. ROBYN PARKER: Who advised you that the inquiry was going to be later in the year?

Dr ROBINSON: I am sorry, I cannot give you the specifics on that. That was just my understanding.

CHAIR: I should perhaps say that I think there has been a certain amount of confusion about this. I think it arose originally from the fact that this inquiry has a reporting date of March next year and the funeral industry inquiry—

The Hon. ROBYN PARKER: Nevertheless, other groups have been able to put—

CHAIR: —has a reporting date of November.

The Hon. ROBYN PARKER: —submissions in on time—

CHAIR: So there was a view that this one—

The Hon. ROBYN PARKER: —and the department has not been able to—

CHAIR: —would start later.

The Hon. ROBYN PARKER: —which is pretty poor, I would have thought—

CHAIR: But that was not necessarily our plan.

The Hon. ROBYN PARKER: —from a department that is leading on health and funds health in New South Wales, and dental health in particular. I want to unpack some of your comments about funding. You said that funding was available generously in New South Wales. How does funding for dental health in New South Wales compare with funding in other States?

Dr ROBINSON: I will have to take that question on notice. I am not aware of the specifics. I noted that certain of the submissions that were put before you recognise the fact that, if you look at the eligible population, the amount per capita in New South Wales is considered to be less than in other States. But I do not have the particular quantum amounts. I am happy to provide those, should you wish.

The Hon. ROBYN PARKER: Yes, please. A number of submissions have pointed out that we are the poorest State in terms of funding per capita for dental health.

Dr ROBINSON: I will also take the opportunity to present it on an apples-and-apples basis too because, as I mentioned, the criteria that we have in New South Wales are more generous than exist in any of the other States. So I will make sure that you get an accurate representation.

The Hon. ROBYN PARKER: Granted, but if you can provide the per capita then we will be comparing apples with apples.

CHAIR: Although you will need to add the co-payment in there, I guess.

The Hon. ROBYN PARKER: Yes. Thank you, Chair. Why is no co-payment offered in New South Wales when it is offered in other States?

Dr ROBINSON: Again, this was a matter of policy and I am not party to the establishment of that policy. But we have seen in other times and other places that the addition of a co-payment actually means that fewer people will access the service and fewer people will seek the care that they need. That is a situation that we have seen previously with Medicare: the introduction of a co-payment—even a small co-payment—actually does deter people from seeking care.

The Hon. ROBYN PARKER: You mentioned the Commonwealth program ceasing. Can you outline the Commonwealth program? Was it not a short-term program?

Dr ROBINSON: It ran for a short period of time. My understanding is that it commenced in 1994 and there were two components, with each receiving, as far as New South Wales was concerned, $30 million. One component of that care—the general services component—was increased the following year and then the program ceased the next year. So it ran for approximately 2½ years.

The Hon. ROBYN PARKER: That was a planned period of time for it to run.

Dr ROBINSON: I am not aware that it was planned to cease. However, I am not party to the Commonwealth's decision making in respect of that program.

The Hon. ROBYN PARKER: Are you not? Is it not a fact that it was introduced in order to assist the States, which were falling well behind in public dental provision?

Dr ROBINSON: I would have assumed that, in fact, it was the Commonwealth recognising that oral health was being managed in a completely different way to general health and recognising the need for support at a Commonwealth level to ensure greater equity and access for those who had dental disease.

The Hon. ROBYN PARKER: Perhaps we will ask the Commonwealth what their view was. You said that there is no provision for public dental health in Medicare. Is that a position you are advocating?

Dr ROBINSON: If dental services were provided under the Medicare arrangements people would have the same access to dental services as they have to general medical services. That obviously would have benefits in ensuring greater access for people to the care that they require.

The Hon. ROBYN PARKER: What is your understanding of why it has not been included in Medicare historically?

Dr ROBINSON: I think you would have to go back to the conception of Medicare when the Commonwealth Government was considering whether they would include medical and dental services, and perhaps even allied health professional services. But, again, I was not party to that. But dental services have not been treated in the same way as medical services, and dental professionals have not traditionally had access through Medicare.

The Hon. ROBYN PARKER: Have you made representations to the Federal Government to the effect that you would like that included as part of Medicare?

Dr ROBINSON: No, I am not aware of any submission to that effect, but neither do I consider that is my place to take that particular action. I am appreciative, however, of the fact that there is now an opportunity for some access via Medicare for patients whose GPs conceive that they need to have oral health care of a certain type during any particular year as part of the management of the chronic health condition.

The Hon. ROBYN PARKER: What about veterans? Are they given dental care through Medicare?

Dr ROBINSON: I understand that the Department of Veterans Affairs [DVA] makes alternative arrangements for Veterans Affairs clients.

The Hon. ROBYN PARKER: So they are covered.

Dr ROBINSON: They have access to private dentists through arrangements through DVA.

CHAIR: Do we have any idea what sort of percentage of the population the DVA group covers, because that is much more generous than other provision?

Dr ROBINSON: No, I am afraid I do not.

CHAIR: It is presumably relatively small.

Dr HILL: It is a relatively small amount, and of course it is decreasing all the time. If I may add, you asked about Medicare and you will probably have an opportunity to talk to the Australian Dental Association, New South Wales branch. I think that when Medicare came along they did not support dentistry being included.

Mr CLOUT: If I could just add to that—not on what happened from 1994 to now but what is happening now—I think it is to be encouraged. I think there is a recognition at joint Commonwealth and States level that there is definitely a major issue in relation to how governments collectively need to address the issue of oral health for the community, given the major issues that are arising in terms of the need for that care. I think that is to be commended. It is on the agenda of the Health Ministers Conference, which of course includes health Ministers from the Commonwealth and the States. That is to be commended. The fact that there is now a national plan that is being worked on collectively across the States and the Commonwealth to look at how we can address some of these issues is to be commended. I think that is the forum in which issues of policy relating to those matters have to be forged and have to be sorted out. I am encouraged, as the person who chairs the Northern New South Wales Oral Health Network and a member of the rural health task force, that those things are happening in a collaborative fashion. I think the solutions will come only from that collaborative approach across governments.

The Hon. ROBYN PARKER: Have you made submissions—this is an open question that anyone may answer—to the New South Wales Government requesting increased funding for oral and dental public health?

Dr ROBINSON: The budget process for NSW Health incorporates an assessment of the need for the services and the application of funds in accordance with that need. Obviously there is a large acute care service that needs to be provided as part of Health and the budget that is allocated to dental services is a component of that. It is under ongoing review in accordance with any enhancements that we gain, and certainly we look at every opportunity to see whether there are additional resources that can be put into oral health.

Mr CLOUT: From my point of view, I have been in the public health system in New South Wales for more than 20 years, for the last seven of those as a chief executive and an advocate for oral health services and funding. Yes, I have made numerous submissions and a large number of those have been responded to. I am part of the rural health task force—I am sure you received a submission from them. I agree with that submission very strongly. The Government's response to the rural health task force included additional funding for oral health services in rural communities. In addition to that, there has been an increase in funding for every area health service every year for the last four years—I

am only going back for years because I cannot accurately remember beyond that; obviously the stages of early dementia on my part!

In addition, there was an important program that Dr Robinson referred to. As chair of the Northern Rural Health Network I made a submission for the fluoridation of the water supply. It is not just the fluoridation of the water supply; it is actually an integrated public health promotion and prevention program that includes fluoridation as one of its core components. We sought additional funding from the Government, through the department, to support that program. We were granted an additional $100,000 a year for two years to run that program, which we matched from our mainstream health funding, other than oral health funding, within the area.

The Hon. ROBYN PARKER: Are other States providing better public dental services? Obviously they are funding them all, but are better processes in place in other States to meet the increased demand to which we might look at adopting as a benchmark in New South Wales?

Dr HILL: Yes. One of the other States that comes to mind is Queensland. We are aware that Queensland is better funded. It has had in place a comprehensive service for a number of years. South Australia also has a very comprehensive service. Over the last 10 years Victoria has gone to what it calls the Dental Health Services Victoria model, which is an autonomous public dental service. So all those services have been examined at some point during the past couple of years. In line with the development of the oral health branch we looked at various models in other States.

The Hon. ROBYN PARKER: In an ideal world what would you like New South Wales to adopt from those other States?

Dr HILL: I certainly believe that on an area basis we need to have a streamed oral health service. One of the things to come out of this is that a wide range of services in different areas around the State does things differently. I think we are keen to stream our oral health services, and that is a much better model.

Dr ROBINSON: I think it is fair to say that if we continue to focus on the delivery of acute care services and on fixing up the disease after it has occurred, we are constantly going to have to battle to keep up with demand. We really need to look at a different approach. We need to look at addressing the factors that are causing the problem. It is not much good having your ambulance down the bottom of the cliff when people are just falling over it. So you have to put your barricades up at the top. We need to address, firstly, the issue of fluoridation because we know that gives us a very quick win. It gives us a big decrease in the rate of caries, it makes teeth tougher and it is much more difficult then to get the caries.

We need to get that education to the mothers and babies, to link in with the maternal and child health services. We need to have oral health partnerships so that maternal and child health nurses can look at the mothers, see what their teeth are like and give them the treatment so they do not then pass on the bugs to the babies which in turn gives the babies the problems and they have bad teeth by the time they get to school. We must look at the issue of diet and nutrition, in particular, the sugars that our kids are consuming—Coca-Cola, Pepsi, carbonated drinks and acidic drinks in particular. We are creating an environment in their mouths which means that their teeth are going to be subject to decay. We need to change our orientation.

Mr CLOUT: I wish to add to that. I think we look very broadly for best practice and for things that will work. We do not just look in other States; we look internationally. We are picking up and doing things that are being done in other States and other places. We are looking at them and saying, "We are not doing that. We need to pick it up." A good example of that is the Oral Health Fee for Service Program. We said, "There are work force shortages. We have 83 per cent of dentists and dental services being provided in the private sector. We have problems in rural areas. How do we overcome it?" So we have a mixed model where there is fee for service.

We ask private practitioners to pick up work to complement the work that we are doing specifically in the public sector. Having said that, there are things that we are doing that other States are picking up. The Information System for Oral Health Program has been picked up by quite a number of other places. Queensland is picking up that program and it is running with it. Your question

referred to what I would like in an ideal world. I think the program we have at the moment is the right program. I support it strongly. I have no problem with saying to 50 per cent of the population of New South Wales who are eligible under our open criteria—I could be wrong on that percentage, but it is pretty close to that—that the triaging and prioritising system we have in place means that people who have an urgent need get it first.

We put money into prevention, assessment, health promotion and education. We see that as the main longer-term solution. It is strongly supported and the only way to go. We then say to others who are covered by that criterion, "For less urgent work there is a waiting time." I strongly support that model. I think it is the right model. It is no different from the model that we use anywhere else. Issues of policy above and beyond that are different issues. I think they are issues for people like you to deal with rather than for people like us. But the general strategy that is being put together by looking interstate and internationally, picking the eyes out of it and seeing what will work, I think is the right strategy.

In a best possible world I would like us to put a little more effort into finding solutions to the inexorably difficult issue of how one provides health services in general and, specifically, oral health services, to rural and remote communities. I have worked in those communities in senior positions for a long time now. I am loath to be critical because I have not been able to find solutions to some of those issues. They are longer term, significant and social issues for which we have to continue to strive to find solutions. But I think the model is the right model. In an ideal world I would like to see it continued for a long period.

The Hon. ROBYN PARKER: In your preventive strategy would you then support having dental therapists and hygienists as part of the public dental system?

Dr ROBINSON: Yes. I think we have to recognise that we are not going to have sufficient dentists available to do all the things that we traditionally have expected dentists to do. I see no good reason why we cannot extend our dental professional work force. We have dental therapists. That group is undertaking most of our schools-based program at present. It would be appropriate to see whether its role and its numbers could be extended. Currently, we do not have home grown dental hygienists in New South Wales. That is certainly something we can do. I also believe that beyond those dental professional groups we can have effective partnerships with other health professionals. As I mentioned before, the issue is using those who are front-line staff. Terry mentioned earlier that front-line members of staff are learning to lift the lip. As part of their primary care services they are putting oral health into consideration. That is a way in which we can extend our region and our work force overall. I agree that we need to go down that path.

The Hon. KAYEE GRIFFIN: You mentioned in your opening statement that local government areas in rural and regional New South Wales were taking up the offer of fluoridation of their water supply. Has there been a marked difference? I think you also said that there was a change in the funding regime from 50 per cent to 100 per cent in the provision of that program?

Dr ROBINSON: That is correct.

The Hon. KAYEE GRIFFIN: Has there been a marked change in the number of local government areas outside what is deemed to be the metropolitan area—other large local government areas that have fluoridated their water since that change in funding?

Dr ROBINSON: Yes. I mentioned in my opening speech that a number of local councils had already referred to the director-general. Under the Fluoridation of Public Water Supplies Act, councils refer the matter to the director-general, who then directs that fluoridation should occur within a particular time frame. As part of this preventive approach we took the position that we had to be much more proactive in working with councils to persuade their communities that fluoridation was a good thing. We set down the path towards doing that. Over the past 12 months we have effectively moved the position of a number of councils. A number have already been directed to fluoridate. They were the ones that I mentioned earlier. Another 10 are now currently considering the situation with respect to fluoridation.

We have been quite successful in working with communities and councils to demonstrate the difference between one community and a community next door where fluoridation has occurred. So it is quite clear that the number of caries you are seeing in children is higher than it needs to be. There has been a garnering of support. At present about 12 communities are currently moving down this path. We changed the funding regime, which previously was that we would reimburse councils 50 per cent of the cost of their capital works program to install fluoridation equipment. We are now reimbursing them 100 per cent. So the only cost to the councils now relates to the ongoing maintenance of their program. Depending on the size of the community that can work out from, say, 35¢ to 40¢ per head per year to somewhere between $2 and $3, depending on the size of the water supply and the community. But it is a relatively low cost with huge benefits to the population.

The Hon. KAYEE GRIFFIN: Up until now local government areas have been reluctant to move to fluoridation. Has it been because of the capital works cost of introducing it, or have councils come up with other issues relating to whether or not there are benefits from the fluoridation of water?

Dr ROBINSON: Obviously, if you reimburse capital costs in full, it makes it easier for councils to persuade their communities that this is where they need to go. That has certainly been a factor. But I think people perpetuate a lot of myths and legends and they have a number of philosophical positions. They talk about whether or not it is the right of government to place fluoride in the water. We have had to counteract those philosophies as much as anything else. So we are working with communities to give them proper information—scientific, evidence-based data to show them that there are no risks with fluoridation at the level that is proposed. We are working with them to show them the level of caries that exists within their populations. We are convincing communities that this is something that will be of great benefit to their children in particular.

Mr CLOUT: Councils perceive that they have been in an invidious position in relation to this issue for a long time. First, they had the capital works component cost of it, which they always felt should not have been their cost. We have taken away that barrier, which is a major issue. The other issue is that a small proportion of community groups believe that this is the beginning of the end—it is poisoning water. Therefore, councils have been in a difficult position. One of the strategies put clearly to councils and communities is that this not local government issue; clearly, it is a health issue. The administration of the water supply is a local government issue, but the oral health issue is a health issue.

In the 1988 Act are two provisions. One provides that a council that decides to fluoridate the water should seek the approval of the director-general. Section 6A of the Act enables councils to refer the matter to the director-general. So the strategy of the education of councils and communities is about saying, "It is a health issue, therefore, you do not have to make the decision. Refer it off to the health experts." A fluoridation water supply advisory committee advises the director-general. So most of those councils, not all of them, as well as having the barrier of capital works costs taken away, have determined that this matter is a health issue. They have referred the matter for consideration and decision by the director-general. I think it has been helpful for them to realise that they could do that as well.

The only other comment I make is that no-one has gone to councils or communities and said, "Fluoridate the water", because it would be wrong. It has to be a total package that talks about education, regular dental care with brushing of teeth, going to your dentist regularly if you can, looking at those prevention and education programs, and fluoridating the water. If you did not do it with that package those smaller communities that have populations of fewer than 1,000 would not be getting what they need. Where you have been able to move communities to agree or to refer the matter and have fluoridation of the water, you can then concentrate your resources into those parts of your area health services that will not get the fluoridated water supply and concentrate most of your other health staff on schools and those components of that community. That is the best bank for the buck.

The Hon. KAYEE GRIFFIN: Can the Families First Scheme and the groups that operate through that service move into smaller communities?

Mr CLOUT: Absolutely. I must say clearly that that is a strategy that we are looking to put in place. It is one that came up in the Northern Oral Health Network's strategy planning exercise less

than two months ago but we think that is the way to go to target those families who have the most disadvantage and therefore are most at risk.

The Hon. KAYEE GRIFFIN: In the Port Macquarie region a number of Families First services operate fairly co-operatively. Is that happening in such areas at the moment?

Mr CLOUT: Thank you for picking one that I know well, having been the chief executive officer of the mid-North Coast. Yes, we think it would work superbly there because you have got the co-operation across agencies—the Education sector, the Department of Community Services, police, Aboriginal communities, the Aboriginal Medical Services [AMS]. Having said that, we have got to put it in place, see if it works, test it, evaluate it and not assume that it is going to be a solution until we have tried and proved it.

The Hon. KAYEE GRIFFIN: The committee has only conducted a half day hearing when comments were made about the differences within the area health services in the way dental services and so on operated. Do you have any comments about dental services in rural and regional areas would be services if every area health service was doing it the same way?

Dr ROBINSON: There is a commonality in terms of the eligibility criteria and the information systems, and a commonality in terms of the way in which people can access the services, but there is a difference between area health services, and indeed within area health services, in the work force capability and, therefore, the ability to supply. There is also a differential need within parts of area health services because of the level of fluoridation or non-fluoridation, so that those areas that obviously are not fluoridated are more at risk and therefore have a greater need for access to services. The issues of work force, socio-economic status within the area health service and whether there are other preventative strategies in play does impact on how services might be provided.

Mr CLOUT: I agree absolutely with Dr Robinson. I think you should have policy at a national-State level; you should have principles and frameworks at a State level; you should have a performance agreement between Dr Robinson and the chief executive in relation to the range of services that have to be provided and the number of occasions of services, if you like, which have been significantly increasing that have to be achieved with the budget that you have got, but then you must leave to each area health service or oral health network the decision about working out how that is going to be done.

There is no point in trying to get a square box that will work for Northern Sydney-Central Coast or metropolitan Sydney where you can drive from one side of an area health service to another in less than hour and have a large population base and have big clinics to try to put that model in place in an area such as mine that is the size of England and goes from a large metropolitan area in metropolitan Newcastle out to remote areas that have populations of 15-20 people. You cannot do that. What you have got to do is you have got to have performance indicators within the policy framework and within the systems, and then you must allow for the clinicians who are on the ground to work out where is the greatest need and to put those in place in a way that will work. I am a great believer in national and State policies and principles, State policies, frameworks and performance agreements but then allowing the local customisation of that so that it will work at that place.

CHAIR: The committee has been given the impression that the variation between areas, or even smaller units, is greater than would be explained by the variation, for instance, in the demographics. We have asked a question about the lack of uniformity across them. You are suggesting a model that makes sense that there is policy and direction and room for variation. But we have the impression that the variation is much greater than would be explained by the philosophy you have just articulated.

Mr CLOUT: That may be valid but should not be expected.

CHAIR: Why does that variation exist?

Mr CLOUT: Within each area health service you will have different priorities that are picked up within the strategic plans, and the implementation of those will vary sometimes upon the capacity to engage with clinicians and the work force capacity and capability that exists at the

particular time. If I can give an example of that: There is very little difficulty in the northern part of the northern New South Wales oral health network—what used to be the old Northern Rivers Area Health Service—close to the Queensland border in terms of recruitment of dentists. Why? It is a pretty attractive place to live in the world, you can access a major capital city coming across the border, you can access both States, it is a great place to live, it is where people want to live and so you can attract and retain clinicians into that area. That is reasonably true of coastal New South Wales rural. You then say to someone "What we want you to do is to spend six months in Lismore or Port Macquarie and then we want you to spend six months in Moree." They will say "Thank you very much. I will go to Sydney." The diversity comes from diversity of geography, diversity of attractiveness in terms of that geography, diversity of need.

CHAIR: Would that variation be comparable to the same problem that affects other areas of health and public service provision of all kinds—certain regions are popular and certain regions are less popular—so the variation is explained mostly by work force?

Mr CLOUT: I will confine myself to health—that is certainly true of general health.

Dr ROBINSON: Certainly when I was chief executive officer in the Southern Area Health Service recruiting dentists was my most significant issue. I advertised for nearly 18 months and was unsuccessful in gaining any suitable applicants to that position.

CHAIR: To be based where?

Dr ROBINSON: To be based in Moruya and Bega, so that was difficult. The solution ended up being forming a relationship with the Westmead Centre for Oral Health and arranging a secondment of new graduate dentists on rotation to Moruya, in particular, to actually provide the service there because otherwise we had no capacity to service at all.

CHAIR: Is that arrangement still in place for the southern area or other areas?

Dr ROBINSON: That arrangement is in place and it has actually been extended and will be further extended in the future because this is one mechanism whereby you can actually provide support and direction to new graduates who were, perhaps, working out of their comfort zone by having them on a secondment arrangement from a major centre so that they can actually rotate. You get the centres to actually recruit more people as they complete their university courses and to actually employ them as the primary authority and then send them out to the areas. That is only one of a number of strategies but that certainly was the one that I needed to implement when I was in the Southern Area Health Service.

The Hon. KAYEE GRIFFIN: What was the timing of the rotation?

Dr ROBINSON: For Moruya the arrangement was that they would be on for every three weeks. We would have two—I call them baby dentists—dental interns effectively who would actually go and live in Moruya for three weeks and then they would be replaced by another two on a three week basis again. So they did not lose that connection with the Centre for Oral Health; they still had that professional supervision and direction; and working out there in the communities there were arrangements with private dentists to provide peer support and direction, should the need arise at a local level.

CHAIR: Were they in their final year of study?

Dr ROBINSON: They had completed their degree but it was their first year post-graduation.

CHAIR: Some people have suggested that the dental service should have an internship built into it. Doctors have a series of things they must do after graduation whereas recently someone said that dentists just go out fully fledged dentists from the day they graduate.

Dr ROBINSON: Yes, there is a difference. When doctors graduate they only have provisional registration and are not fully registered to work outside the teaching hospital and the

public health system until they have completed at least 12 months satisfactory performance whereas we turn out a fully fledged professional dentist at the end of the course.

CHAIR: Do you have a view whether dentists need a period of internship or whatever it is called?

Dr ROBINSON: It would certainly be very interesting to see whether a voluntary internship was attractive to the graduates but it would be something that would be very difficult to implement in a mandatory sense because it is not an expectation of the course, nor of the individuals at the present time. If we were to move down that path it would be something that would have to be there in the future. But to see how attractive it was to the new graduates would be quite interesting, but it would have to be voluntary.

Dr HILL: As far as that is concerned, in New South Wales the University of Sydney has a graduate entry dental program. The remainder of the States have an entry program straight from school so it is a bit different there. Certainly the feeling is that obviously if someone has already done a degree and then they have done a dental degree, that is seven years. I suppose, the other thing is that everything has to be done within the States because each State recognises the graduates from the other States. If you get one that falls out of line with an internship, it is just a matter of the person moving to the other State, getting registered there, and then coming back. That is an Australia-wide issue. It is certainly being looked at through the Australian Dental Council [ADC] and the Australian Health Ministers as well.

CHAIR: Looking at internship or the rules for training and recognition?

Dr HILL: Looking at training and the rules for overseas-trained dentists which has also been one of the strategies for the lack of dentists in rural New South Wales.

CHAIR: Are overseas-trained dentists an increasing part of the profession?

Dr HILL: In New South Wales dentists from Great Britain, Ireland and New Zealand can get automatic registration. The remainder of the dentists have to sit a qualifying theory and practical exam from the Australian Dental Council. What is being proposed is that certain dentists from schools which are recognised by the General Dental Council in England can actually work in the country under a three-year program before they have to take their mandatory ADC program. That is fairly new. It is in the Dental Practise Act that the Minister can give limited registration and at this moment there are three our four limited registration dentists working in New South Wales under supervision.

Mr CLOUT: Not wishing to suggest that more dentists is the solution, because I do not think it is, all the other things we have talked about I think are essential as well. But if we are just talking about dentists my view is very simple, that is, we need and will increasingly need more dentists trained in this country and for this State.

CHAIR: Why is there a shortage of dentists?

Mr CLOUT: Because demand is increasing.

CHAIR: We seemed to go in a slightly circular fashion the other day when talking to the Dean from the University of Sydney as to why the number of students studying dentistry has dropped over the years. We did not get to the bottom of why that is the case and why, therefore, the number of dentists in training is actually dropping in New South Wales, although the picture may be different in South Australia, and yet everyone seems to agree that we need more dentists and para-professionals.

Dr ROBINSON: In the 1970s and 1980s, as I understand it, there were a larger number of dental graduates than there are at the present time. My understanding is about 45 HECS-funded places are currently in existence at the faculty here. That is certainly not going to be adequate to meet the needs of the population. As a rule of thumb, I was told by the Centre for Oral Health at Westmead when I was seeking support in Southern that I needed to understand if people retain their teeth into old age we need approximately twice as many dentists to provide the services than if everybody lost their teeth and moved into denture land. That was just a rule of thumb. We are seeing with people retaining

their teeth longer they need to have more services and more preventative services. Technology can do more things; the population is growing and ageing. It is all of those factors.

CHAIR: Why is the only university in New South Wales that trains dentists training fewer dentists than it used to?

Dr ROBINSON: I am afraid that is not a question that I am in a position to an answer.

CHAIR: We do not seem to be able to find anyone who can answer that question.

Mr CLOUT: I could probably give you an hypothesis, if that is of assistance. My hypothesis is that there is a growing need and demand in our society for all manner of university courses and programs. Our population is increasing at a rate and with a demographic which means that across all of those courses—I wonder about surfing degrees but we will not go there—particularly the health ones we would need increases in all of them. The Commonwealth is in an invidious position of having to determine which places it is going to make available in each university. It has to do that as best it can and it determines how many places are going to be available, if we exclude the privately funded ones. It has to make that decision; it is a tough decision. I do not think we have got it right. As I said, the national group that is looking at it needs to determine that issue.

CHAIR: Does it come down to the fact it is much more expensive to train a dentist than, for instance, a primary school teacher? From another inquiry we are conducting we know that the universities are training more primary school teachers, with the same Commonwealth Government funding, than are needed.

Mr CLOUT: I am absolutely certain that is part of the equation. If it costs twice as much to train a science-based professional, and it does, if it takes more to train a medical, dental or allied health professional, then obviously it is a harder consideration in terms of numbers versus available dollars. I think that has to be in the equation. Dr Robinson is right that I should not enter into those debates about how those decisions are made. Can I comment on the issue about internships and so forth? I do not know whether internships are the answer. I think there is an absolute need in oral health for us to be looking at mechanisms or models of training that recognise the principles that have been recognised universally in Australia at all government levels, State and Commonwealth, in terms of medical training.

There is a recognition that if we need to address the retention and recruitment of the rural workforce, then we need to create a genuine experience in the training regime, however put together—and I do not enter into that—that gives a significant exposure to a greater proportion of people who are going through that training in a rural and regional setting. That is based on the hypothesis that if we do that then a proportion of those, a higher proportion than now, will see the attractiveness of rural work and not see it as a negative and may, therefore, return to practise in a rural setting. In addition to that, you will have some service delivery benefit while that is occurring—although it is a trade-off because you have to supervise and therefore you lose some but gain some.

My point of view, speaking on behalf of the rural components of New South Wales, is that is essential. In the medical profession, the medical area, it has been recognised that there are rural schools and that for each medical faculty 25 per cent of training placements had to be in a rural setting for a period of time. I think three weeks is too little for people to have that experience. So my very strong view in terms of the need to address work force issues in rural and remote areas is that we must look at ways of doing it. I am not exactly sure whether internships are right or something else. But if we do not do that, then we are going to have problems in metropolitan areas. We will not have any problems in rural areas because we will not have an appropriate work force to provide the care.

The Hon. ROBYN PARKER: In terms of differences between various area health services and rural and regional provision of health care in general but specifically in dental health care and attracting dentists to those areas, do area health services provide the sort of facilities and equipment that will make it an attractive option? Are dental professionals working with state-of-the-art equipment in, for example, Maitland hospital or are they operating with clapped-out old drills and substandard equipment which makes the work less attractive because they are able to do only emergency care rather than more high-tech treatment?

Dr HILL: The facilities in our area health services are normally first-class. The argument that is put to us by new dentists is that they are treating patients who are normally in pain. The majority of the work is done with pain-relief patients, which is fairly restricted to temporary fillings, starting root canals, extractions. The training for dentists often revolves around far more complex work, such as implants and crowns. This work is not normally available through the public dental system. Certainly that is an item put forward by some new dentists about why they do not want to go into the public system.

Mr CLOUT: There is a need to continually upgrade equipment and facilities. That is true as much in metropolitan areas as it is in rural areas. There is quite an amount of capital funding in the northern New South Wales rural health network that we have been able to leverage. One of the advantages of being a network is that we have been able to put our funding together and look at our priorities. We have been able to pool funding to be able to say, "We want to do this in terms of capital works or equipment". I can give you an example of that. There are significant issues in some places about getting vans to places. We have looked at how we can improve the vans, make sure they have got things in place. In others we have taken the decision, which we have been able to do by pooling our funds across area health services, to set up and provide the capital works for fixed sites to replace the vans where it is appropriate so to do. That improves the environment.

We go out of our way when we are trying to attract and retain dentists to say to them, "What equipment do you want?" I think we do a pretty good job at the moment in northern New South Wales in any event of meeting those needs. Having said that, I have never met a clinician ever anywhere who cannot give you a list of things that they would like to have, who has not got a list of equipment that they would like replaced every 12 months rather than making it last for 2 years. It is an insatiable desire to have more and other things. We are in a public health system and we have to make sensible decisions. But I do not accept that in the northern part of New South Wales that is one of the major factors inhibiting our ability to attract or retain dentists.

The Hon. ROBYN PARKER: I cited Maitland as an example because that is where I live. You would not have difficulty attracting dentists there because of the state of the equipment?

Mr CLOUT: Newcastle is relative to metropolitan Sydney regional, though I would never when sitting in my Newcastle office indicate that it was other than metropolitan, for reasons which you would understand. However, it is harder to attract and retain dentists to Greater Newcastle-Maitland than it is to where we sit now. But it is nowhere near as hard as it is in Taree or Tamworth and they are easy compared to Moree, Tenterfield or Boggabilla.

CHAIR: We have heard comments about the perception of the quality of public dental services and what New South Wales Health does to promote the services. Picking up the comment that you made, Dr Hill, you say the public dental services focus on acute work, which is not as interesting or challenging and the equipment needed for such work is not as high-tech. Therefore, is it a circular argument in terms of the perception of the quality of and interest in public dental health as compared to private dental health?

Dr HILL: I think you have to be brutally honest and say that if you are going to work in private practice then you are going to have a far greater range of dentistry than if you work in the public system. That was partly addressed with the Dental Officers Rural Incentives Scheme, which came into being in the mid-1990s, where a proportion of the time dentists were allowed to work in private practice. They could do the various treatments they would not normally do in public health. That initiative has been picked up by other States. It is basically a cash initiative but also includes 10 per cent of the time that can be allocated to private practice.

CHAIR: Your answer to my question, which is a circular question as well, is broadly yes. If the work in public dentistry is, in a sense, less challenging in variety and in using the skills dentists are trained in, then there is a problem in attracting perhaps the best graduates and keeping them, which in turn affects the perception of public dental services?

Dr HILL: I think the other thing that has been pointed out before is that in private practice new graduates are able to get a far better wage. That is often something they have to think about. They

have been at university for seven years. I suppose the other thing is that last year there was a double graduation of dentists from the University of Sydney. The old program, the five-year program, and the new program had a double graduation. There are a number of initiatives that the Department of Health put out to the regional areas to try to get dentists to work in the country. We are in July now and there are still a number of vacancies in country area health services. So these people are moving into private practice in Sydney. It is an issue that a number of bodies—the ADA, the Dental Board—are concerned about that there really are too many dentists in some areas of Sydney.

CHAIR: To the point of over-servicing?

Dr HILL: That is an issue you would have to take up with the Dental Board. It seems harder and harder to get dentists into the rural areas. That is why I think the rotation policy, which we have come up with, is a real good stopgap in that we are providing services to country areas. Those services are presently provided to Nowra and Moruya, the Aboriginal medical service at Kempsey and to Wagga Wagga. Certainly I, and everyone else, would like to see that expanded inland to areas like the Aboriginal medical service at Walgett. Goulburn, which I have been visiting, has not had a permanent dentist for over a year. That is just two hours down the road from Sydney.

Mr CLOUT: With a population of 20,000 people.

CHAIR: Does Queensland, which has a fairly dispersed regional population, manage to address the problems of recruitment, attraction and remuneration better than New South Wales or does it have the same difficulties?

Dr HILL: Queensland has, in fact, a different pay scale. They do offer a higher starting salary. They do tend to get a number of new graduates, more new graduates into the scheme.

CHAIR: Can they direct them to centres outside Brisbane?

Dr HILL: They have a dental officers rural incentive scheme just like New South Wales, however, they have scaled it so that if you go to Hervey Bay you might only get a thousand but if you go out to Mount Isa you get 20,000. That is something we have never done in New South Wales because it has always been a problem outside the greater Sydney area.

Mr CLOUT: Could I just draw a distinction in your question? The range of services that can be provided by our dental officers in our dental services is clearly limited because of the weighting of emergency services that we provide. I would argue very strongly, however, that the quality of the services that are provided in the public health services are second to none. So it is not an issue about quality; the services that are provided are first-class services—as good as you will get anywhere. There is a clear difference between that.

CHAIR: We should talk about a narrow range perhaps rather than quality?

Mr CLOUT: Absolutely. And that is a disincentive to recruitment and retention. It is not an issue about the quality of services that can be or are provided.

CHAIR: I think it is important to make that distinction. I was not meaning to imply poor services but in terms of incentives the range may make a difference.

Dr ROBINSON: There was a survey that was conducted in 2004 of clients who had attended the public health services in the last 12 months and 26.2 per cent rated their care as excellent, 35.2 per cent as very good, 23.2 per cent as good and 7.9 per cent as fair. So I think that we would certainly propose that people are satisfied with the level of care that they are receiving and the quality and safety of the care that is being provided.

CHAIR: We are right on our scheduled finishing time. There are a couple of things that we have not specifically dealt with in our questions but perhaps you could make sure that your submission includes some of those. For example, we would like a little bit more factual details about the oral health fee-for-service scheme and how it works, but I am sure that is something you could do in your submission. We have not at all got into the area of the primary school dental checks, but again,

I think that is something that you can explain to us. I think you were asked a question on notice from Robyn about New South Wales funding and how it compares in various ways with that in other States.

Motion agreed to:

That the question of the Hon. Robyn Parker be taken on notice.

We look forward to receiving your submission as soon as possible. Thank you very much for coming.

(The witnesses withdrew)

GARY MOORE, Director, Council of Social Service of NSW, 66 Albion Street, Surry Hills, and

SAMANTHA RUTH EDMUNDS, Senior Policy Officer (Health), Council of Social Service of NSW, affirmed and examined:

CHAIR: We have received your submission. Do you want to begin by making some sort of statement?

Mr MOORE: Just a brief statement. The lack of adequate dental services in New South Wales, especially for low-income households and in several rural areas, has become a tragic feature of health care. In our submission to this inquiry we are proposing measures that would address both the critical short-term problems faced by consumers and also some of the longer-term sustainability issues that must be resolved if we are to have adequate and quality dental services available to all in the future. Oral health has got to become a core ingredient of mainstream health considerations. It cannot remain a second-11 parallel system of add-ons. The evidence pointing to links between poor oral health and other key health outcomes demands this, let alone the shabby access to service that many now experience.

Both the Commonwealth and New South Wales governments must get much more involved. In the Commonwealth's case there is no excuse for it not to implement a more public dental program immediately that targets reducing the massive waiting lists for services. In the longer term, dental health as a primary health care service must be funded by Medicare. The New South Wales Government must firmly grapple with providing better opportunities and incentives for dentists to practise in disadvantaged and rural communities and both levels of government, in our view, must tackle the skills shortage and looming crisis in dental practitioners.

CHAIR: Sam, did you want to say anything before we start?

Ms EDMUNDS: No.

CHAIR: Did you receive the questions, probably late yesterday—for which we apologise?

Mr MOORE: Yes.

CHAIR: As an indication of what you see as the crisis, or whatever word you would use, you are talking about people being prescribed antibiotics and pain relief by general practitioners as a temporary additive in lieu of dental treatment. Would you like to expand a bit for us on why it is happening in terms of where the problems originate and what you think might be some solutions for getting more appropriate dental treatment for people who are less able to pay?

Ms EDMUNDS: I guess the most obvious is that there is a lack of public dentists in the dental system. If you do not have the dentists providing the treatment people cannot access them, they cannot get that sort of basic first care that they need. This is especially so in rural and remote areas, obviously. There are also issues around access: you may have a dentists but, as I think we said in our submission, that dentists may be 400 kilometres away. How do you actually get there and get the treatment, especially if there is something a little bit more complex? There are also issues around eligibility in that while there has to be some guidance as to who can access public dental services, and the focus has been on concession card holders of one kind or another, there is also that whole sort of broad group of the working poor who are not eligible for public but cannot afford private, so therefore they fall into that gap and try and get whatever service they can to deal with their dental health issues.

Balancing that, you have private dentists practising but their books are full and they are not always affordable for the key groups of people that we are talking about. There is also, I guess, an underutilisation of other parts of the health work force. If you better utilise therapists and hygienists to do some of that first stage, early intervention then that would free up dentists to do much more complex care. Obviously, as a result of the lack of dentists there are long waiting times and long waiting lists. I guess the big one is sort of an undervaluing of oral health; it is not considered part of the main health system; it is not funded on an equivalent basis as other health issues are; it is very rarely addressed in general health planning; and an accompaniment with that is that the general population does not really see oral health as a major issue either, there is sort of a lack of

understanding and education among the general population that it is as important as their general health.

In terms of improving access, the obvious ones are: increasing the workforce; reviewing some of the eligibility criteria to try and tap into those groups that miss out at this point in time; to look at where services are provided and would there need to be something like a mobile treatment team, especially for the really remote communities where it is much harder to get in to see somebody or there is a lack of transport so they cannot make the main town centres; the necessity to have that early intervention and prevention kind of model so that there is some form of check up to deal with the problem before it becomes too complicated and makes a person even more unwell; issues around better funding, obviously; and integration within the whole health system so it is a holistic response to the person's health.

In our submission we have also talked about the training of other people to assist with that: the training of childcare workers just to basically identify early oral health issues with young people and aged care workers in how to clean teeth and things like that for older people. And to deal with the population—I guess, education of the general population about the importance of oral health and needing to intervene early.

CHAIR: Would you say that a very large part of the problem is that oral health has not been integrated with other areas of health in people thinking about health or in education programs or in departmental funding? That in every possible respect it sort of sits out there—

Ms EDMUNDS: Definitely.

CHAIR: So for the people you are talking about, such as childcare workers or aged care workers, they are not attuned to it in the way they are attuned to broader health issues?

Mr MOORE: It would have been very interesting reflecting back 25, 30 years ago, had oral health been part of the original Medibank and then part of Medicare on a broad basis, whether we would be having this sort of discussion and in fact whether people would have seen oral health as a second or third 11 issue.

CHAIR: And as an organisation you strongly call for Medicare to include oral health?

Mr MOORE: Yes.

CHAIR: Do you see an anomaly with the growing amount of money? I think the New South Wales health people said $350 million is going out of private health insurance ancillary benefits for dental care and yet dental care is not included in Medicare. Do you see that as an anomaly in the funding system or in the attitude to oral health?

Ms EDMUNDS: I think certainly, and if you look—this is just anecdotal information being shared with us—that money tends to be spent on, I guess, wealthier people having more cosmetic dental interventions as opposed to socioeconomically disadvantaged people actually getting just basic oral health treatment. So it is really splitting that divide even more.

The Hon. ROBYN PARKER: One of the things you have recommended in one of your submissions—and congratulations on your submission, it is very comprehensive—is taking away the 30 per cent rebate from the Commonwealth and putting that money into public community health services. Surely that will mean a lot of people would drop out of private health care and then put more pressure on the public system? Are there not lots of people who take out private insurance primarily because of the dental provisions within that?

Ms EDMUNDS: Yes and no. People were in private health insurance previously to the 30 per cent rebate, and there was an increased take-up when the 30 per cent rebate was introduced. However, that is now showing to be dropping, regardless of the 30 per cent rebate. Is it being that effective and is it providing the services that it needed? And, as I said, would that money be better spent if you addressed the oral health problems early? That stops the need for these long-term ongoing issues, and also impacts on the health system in general. If you treat the oral health issue before it

becomes a general health issue, it is obviously better all round. So I do not think necessarily that removing the rebate will stop people from having private health insurance or from getting treatment.

The Hon. ROBYN PARKER: When you talk about the Commonwealth funding—and a number of people have made the same comment that funding public oral health would improve the situation—how does that sit with a lack of funding provided by the New South Wales Government compared to other States in Australia?

Ms EDMUNDS: We do not want to see it become, well, the Commonwealth should deal with it, therefore it is not a State responsibility. We still argue and believe that the State should take better responsibility and put more funding into oral health and recognise its importance in the general health. However, at the same time there used to be a Commonwealth Dental Health Program. It was reasonably effective when it was implemented, so there is a requirement for the Commonwealth to have that responsibility as well. I guess our ultimate goal would be to see Commonwealth responsibility. However, that does not mean that the State does not have a responsibility at this point in time.

The Hon. ROBYN PARKER: Does the Constitution of Australia put dental health care as the Federal responsibility?

Ms EDMUNDS: It does. It is in the constitution.

The Hon. ROBYN PARKER: Was that Commonwealth program designed as a long-term program or was it a short-term program to alleviate the fact that the States in Australia had failed to deliver public dental care and the waiting lists were enormous?

Ms EDMUNDS: I cannot tell you. I do not know if Garry has an understanding of where it actually started from. I know that it was successful while it was implemented. I know the attitude seemed to be, well, we have dropped the waiting lists, we do not need it anymore, which ignores the ongoing oral health needs and changing oral health needs. I guess it would be saying, "Okay, we have treated everybody with measles so we don't need to run a measles program anymore." That ignores the fact that all these illnesses will continue to crop up.

The Hon. ROBYN PARKER: Was it because once the GST was introduced the States got increased funding and therefore should be able to provide better care?

Mr MOORE: Can I say to you that the Commonwealth knocked over this program in 1996-97, the GST deal was 2000 plus—

The Hon. ROBYN PARKER: Was the program designed to finish at that point though?

Mr MOORE: I think the argument was that it was about to see what impact it would have on the existing level of waiting lists or not, and the decision about whether or not it was to be continued was to be taken in light of that. It never reduced the total waiting lists. As Sam said, it certainly made a difference. I guess the point I would come back to is: had Medicare been paying for this as a general primary health care provision we would not be having this discussion.

The Hon. ROBYN PARKER: Would we not—

Mr MOORE: No.

The Hon. ROBYN PARKER: —because Medicare pays for public health care generally and we are still having discussions about shortages of doctors in rural and regional areas, the lack of availability of public health care and the New South Wales Government failing to provide adequate public health care?

Mr MOORE: But we are not having discussions about four months to 18 months waiting lists in front of GPs, are we?

The Hon. ROBYN PARKER: Well, aspects of public health, are we not having discussions about that?

Mr MOORE: Sure, about aspects, but we are talking about basic primary health care. We are not having those discussions.

The Hon. ROBYN PARKER: What about waiting lists for elective surgery?

Mr MOORE: Different deal. We are talking here about basic primary health care.

The Hon. ROBYN PARKER: Still Medicare funded things.

Mr MOORE: You have to make a comparison, in our view, between a dentist in private practice working with his or her clients in that community and a GP in private practice doing the same things. The problem is that at the end of the day the dental work force or the dental profession and others way back then won the battle to keep out of their perception of socialised medicine.

The Hon. ROBYN PARKER: Are they willing to come in under the Medicare umbrella now?

Mr MOORE: Well, there is a question about carrots and sticks about making that happen. However, I have to tell you that if the sort of scale of desperation amongst people in this State and the other States, particularly outside Sydney, for basic care is not taken on board by the Commonwealth Government and bettered by the State governments, there is something seriously wrong. It is a carrots and sticks sort of deal in this regard. Unfortunately, governments abrogate their responsibility in terms of the stick side.

CHAIR: You are talking as if dental services or the lack of them has become a more serious problem over the past two or three decades, whatever period we are looking at. Is that what you are meaning to suggest—that it has become a more serious problem in the community? If so, can you clarify for us why it has?

Mr MOORE: There is some evidence in terms of the linking of lower socioeconomic status and poorer health outcomes across a range of areas, this being one. Simply the scale of growth of more lower income households over the past 15 years, the growth in inequality that is occurring in our society. Sure, I acknowledge that the poorest people are in fact doing a bit better, but by comparison with the middle and the top they are doing worse still. In fact, the gap is widening—

CHAIR: And in absolute numbers there are more of them.

Mr MOORE: In absolute numbers as well. We have simply not kept pace, and I guess running a system that has been based around a very marginal safety net approach in public dental health has led us to this issue.

CHAIR: So it is a cumulative thing.

Mr MOORE: It has a cumulative effect over time.

The Hon. IAN WEST: And in this particular area the definition of "poor" is very fluid and flexible in the sense that the price of dental care is rather further up the food chain that people—

CHAIR: Are you suggesting that the price of dental care has gone up absolutely?

The Hon. IAN WEST: I am suggesting that the price of dental care is fairly exorbitant, and that the situation of people being able to have their teeth looked after is such that the definition of "poor" becomes a little fluid.

The Hon. ROBYN PARKER: Have you made submissions to the New South Wales Government about the level of funding for public dental care?

Mr MOORE: We have in each year in our prebudget submission.

The Hon. ROBYN PARKER: What has the response been?

Mr MOORE: I think it would be fair to say, "It's the Commonwealth's responsibility."

The Hon. ROBYN PARKER: That has been the response from the State Government—that it is the Commonwealth's responsibility?

Mr MOORE: Yes.

The Hon. ROBYN PARKER: What is their response when you write submissions about the level of funding for other health care provisions?

Mr MOORE: I am trying to think in other areas, no, we haven't got enough money.

The Hon. ROBYN PARKER: Have you had a written response from the New South Wales Government stating that it is a Commonwealth responsibility?

Mr MOORE: I think we did originally a couple of years ago when we were first raising this issue. NCOSS has been raising this for a very long time as others appearing before you have said.

CHAIR: There has been some increase in the money that New South Wales has put aside. For example, there was an increase in the recent budget, but I assume that you would say it is not enough.

Mr MOORE: In our view.

CHAIR: And certainly nowhere near the scale of what you have called for in your budget submissions.

Mr MOORE: Yes.

The Hon. IAN WEST: I am interested in the issue of fluoridation and your support for the mandating of that across New South Wales.

Ms EDMUNDS: When I was looking at this question, I just sort of wrote two words—access and equity. That is what it is all about. At the end of the day it is about having something available that everybody can have access to, regardless of their socioeconomic status. It is about something that people do not have to pay for. They have to pay for their water but they do not have to pay for it because it is in the water supply. It is about, I guess, equalisation of addressing oral health needs. There are numerous international studies that show that it is actually beneficial. It reduces dental caries and improves oral health. As I said, at the end of the day, our support is basically around those access and equity issues.

CHAIR: Were you here when the Hon. Kayee Griffin was asking New South Wales Health representatives some questions about the changes that were made recently in relation to fluoridation?

Ms EDMUNDS: Just previously?

CHAIR: Yes.

Ms EDMUNDS: No, I think we only came in at the end.

CHAIR: It does not go to mandating, but we are being more active in getting councils to refer decisions to them and also they have shifted the funding from 50 per cent of capital costs to 100 per cent of capital costs for the local government areas that decide to fluoridate. I think that has only occurred in the last 12 months. Presumably that should move a long way down the path of picking up those communities that do not have it. But you would still call for the legislative change to make it mandatory?

Ms EDMUNDS: We only need to look at other States that do not have fluoridation and do comparisons, or even do comparisons between towns. From personal information I know that people in Victoria where there is not fluoridation are buying fluoride drops every week. That is expensive at the end of the day, but people will try to get it in some way, if it is not provided.

The Hon. KAYEE GRIFFIN: Recommendation 21 is funding to assist the New South Wales Oral Health Branch to implement the New South Wales Oral Health Promotion Framework for action plan 2010 which would enable broad strategies to be implemented in relation to oral health. Would you go through some of those strategies that you are referring to there?

Ms EDMUNDS: I cannot remember the whole oral health plan. I guess it is basic health promotion and health problem prevention kinds of activities which we know are the affordable way of addressing oral health issues. It is looking at strategies across the whole spectrum of age and socioeconomic status with those key groups, like people with mental illness and intellectual disability who have high oral health needs and Aboriginal communities. I guess it is getting a range of strategies in that will address oral health and hopefully then reduce the demand on the public system. If you can get in those prevention strategies early on, it is that long-term approach. It is sort of like if you do it now, you are saving that long-term demand on the public health system.

The Hon. KAYEE GRIFFIN: Basically I think the department also said this morning about your recommendation, and a number of your other recommendations related to prevention strategy, that a lot of the issues that we are now facing hopefully will not occur and that work could be done with a range of groups that you are seeing as the vulnerable groups in terms of not having access to oral health and good advice and good information at the moment.

Ms EDMUNDS: Yes, definitely.

CHAIR: Do you have a comment on the National Advisory Committee on Oral Health Plan 2004 to 2014?

Ms EDMUNDS: It is a good, guiding document. Certainly we were involved in the implementation and monitoring group. We have only just had one meeting of that to see how it is rolling out across the States and Territories. I know that the New South Wales plan is linked quite closely to the national plan in terms of recommendations so I guess it is a really good, broad strategic document. But what it needs is far more detail of how you do it on the ground and I guess the funding behind it.

CHAIR: You are involved in the implementation of that?

Ms EDMUNDS: The group that monitors the implementation, yes.

CHAIR: Presumably in terms of what you said earlier about the need for funding and the work force issues, that is something that you will be pushing throughout the next seven or eight years of the program?

Ms EDMUNDS: Yes.

The Hon. KAYEE GRIFFIN: I think you also had in your recommendations a reference to setting up clinics in either hospitals or base hospitals and so on. I wish to follow that through a little bit further. If that occurred and you had at least base hospitals in rural and regional New South Wales, how would you take it further to the more remote communities?

Ms EDMUNDS: I guess that could come in line with what I was suggesting earlier—a mobile type of unit. There used to be buses that used to travel around, providing dental services to schools. The reality is that we know they will not be able to set up a dental unit or a public dental system in every single town.

CHAIR: Mr Clout spoke before about the vans that are operating in the Hunter and the New England areas.

Ms EDMUNDS: Yes. It is thinking outside the square a bit and saying, okay, if you have these communities, you know that they cannot necessarily come to us, so is there better utilisation of the resources we have? Can we use a little travelling mobile unit that can do the dental checks and the easy caries treatment or the base fillings? Is there a way of linking in with the doctor service that flies around, or the nurse service that drops around to the outlying and remote farmhouses and communities? Can we stick a dental therapist on that plane so that they could go out and actually ensure that general health has been checked? The therapist could do a general teeth check and if there are more complex issues, then there might need to be someone travelling to those base hospitals to address that need. But I think it is looking at what is already going on in the general health system and seeing that we can link into that and then we can look at whether that can be expanded into the public oral health system.

CHAIR: Why do you specifically suggest dental units in public hospitals?

Ms EDMUNDS: It came up during consultations that there was a large incidence of people turning up to emergency departments with oral health issues. The general health work force is not trained in how to address those oral health issues. Actually putting a small unit of some therapists in there with a dental backup would help. Some of the early intervention and prevention—not prevention, but early intervention activities—would maybe cut off the problems before they become even worse or more costly and complicated. If someone is turning up with an initial issue, that can actually be addressed, as you would with any other health issue when you turn up to an emergency department.

CHAIR: Does this mean that you are pushing for more integration between dental and political and hospital services, or is it is a more pragmatic sort of approach? People are turning up to emergency sections, and if they are doing that, there may as well be a dental unit on site to help them?

Ms EDMUNDS: It is a mix of both. I was sort of thinking that if you had dental therapists working there, working alongside some of the general practitioners and nurses, that would then skill other health professionals around some of the basic treatments. In the submission we talked about general practitioners treating abscesses on the foot or the arm or whatever, but they will not treat an abscess in the mouth. There is no difference in the abscess; it is just that it is in the mouth and they are a bit nervous and have not had any training. If you can actually start to make them feel confident to deal with that kind of thing, that skills them in some general oral health kind of treatment, but it also reduces public demand because you have a broader skilling base. It may also be a pragmatic issue of people turning up.

The Hon. IAN WEST: However, it is clearly not preventive. Actually, it can be very counterproductive to do that. If you are trying to promote preventive strategies, people gather at public hospitals because they want the painkillers. They cannot afford to go to the dentist, and the public hospital will give them a few painkillers for the abscess. But treating the problem at that stage in a public hospital, putting the money into that area, would be counterproductive, would it not?

Ms EDMUNDS: I think you need a balance. You can have preventive strategies, but you will always have those who, for whatever reason, the strategies that do not work or they do not reach, and what have you. I think you will always have, as you do in the general health system, people turning up to the emergency department. So if you can provide some of those services in there and get them early on, that would be good. We also have the ageing population who are keeping their teeth for far longer, so that is creating greater oral health problems. You have all your other key groups—your people on methadone programs, people with HIV-AIDS and people with hepatitis C—and all of these impact on the mouth. They would quite likely turn up if there was an issue and they could not get in to see a dentist. The prevention strategies would only go so far, but there still needs to be treatment.

The Hon. IAN WEST: I also noticed that you referred to a recommendation regarding residential aged care facilities which seem to be housing fewer and fewer people. The push is clearly on for living in the community and living at home. We are all going to be living happily ever after at home. That seems to be counter to the concept of institutionalised care.

Ms EDMUNDS: I guess again it is looking at those two issues. I mean, we would like to see that your home and community care workers or your workers who are supporting people within their home would also be skilled, but there will always be a group of aging people who will need more intensive residential care and who will get to that stage where they need to actually be in a residential facility because of dementia or because of other more complex or chronic conditions that cannot be handled in a home environment.

The Hon. IAN WEST: However, I suggest that most people—and I may be so bold as to say 95 per cent plus—who have dementia are not in institutions.

Mr MOORE: Yes, it is a problem. Once again it is a balancing sort of act.

CHAIR: The Ministerial Advisory Committee on Ageing are our next witnesses, so they may be able to give us the details.

Mr MOORE: While I think about this—it is not in our submission but it comes up quite frequently—the whole issue of dealing with dual diagnosis people who are either homeless or people who are perhaps long-term poverty stricken in public housing. In trying to put aside some things about family support and mental health issues or drug and alcohol issues, one of the issues that often comes up is poor oral health and having the capacity to have a dental practitioner as part of a case management team in that approach. We simply do not have that. Once again, we have struggled enormously to do that. When we talk a little bit about interdisciplinary or multidisciplinary things, I guess that is one of the examples that has been pointed out to us quite frequently. There are significant numbers of people, particularly homeless people, who are in and out of the refuge, et cetera, systems in inner Sydney and around Parramatta and other places. We need to be thinking much more smartly about the linkages of practitioners, and in that, dental practitioners as well.

CHAIR: Your submission is valuable for us in going through those various groups because you have dealt with particular problems. We prepared a question about a much bigger group and those different ones you have itemised—people from non-English speaking backgrounds. Can you suggest that the statistical evidence is that poor oral health is disproportionately high among those people. Can you expand on why people from non-English-speaking backgrounds, leaving out the particular groups such as the refugees to which you refer, have a problem and whether the problem is even the services reaching out to them or being accessible to them?

Ms EDMUNDS: I guess it is a mix of things. It is a mix of culture and attitudes from their own cultures and coming to Australia. I do not know if we mentioned it in our submission but I know during consultations that in some cultures milk teeth are not considered important so there is no thought—or, not really no thought—but getting caries treated in milk teeth is not considered to be an essentially important thing because they will fall out and the person will get there. There are some of those cultural aspects and attitudes which may be different from ours. It might be about simple access or language barriers. The local dentist may not speak the language that the people speak.

I know that in the submission we referred to not necessarily problems of the dentist but getting through the receptionist to get through to the dentist to get the appointment happening, and where the receptionist would not organise interpreters. The dentist was happy to work with an interpreter, but the administrative staff would not actually make the phone calls to get the interpreters in, which can be a problem. I do not know enough detail and you probably need to speak to groups that are far better representative of culturally and linguistically diverse [CALD] communities. Sometimes there areas in which they may need a family member as the interpreter, but it might not be something that they want to talk about with their family member and that might prevent the person from going in to the dentist.

CHAIR: Can you expand for us a little bit on the oral health fee-for-service scheme and how it should be improved? This is an area in which we actually had a number of questions for the New South Wales Health representatives. In effect, they are going to include them in their written submissions and we did not really explore them at all. What is your opinion of the scheme? Should it be expanded in general? In what specific ways do you suggest it should be improved?

Ms EDMUNDS: It is a mix of everything. Looking at the questions that you asked initially, it needs to be expanded to some extent but I guess there are also cost constraints. So you need to look at whether you expand it to more eligible people—extend the eligibility—or keep it to the group that are currently eligible and provide a more cost-effective scheme in terms of reimbursement for dentists. What came up during consultations was very much that the amount that is paid to a dentist for treatment is quite significantly below the cost of the treatment. While there are a number of dentists who are willing to drop the cost so it matches the fee for service reimbursement or to provide extra treatments on top of what they are being paid for, they are running a business and it is not something they can continually provide on an indefinite basis. It also gets down to how do they determine who should get these extra treatments and who should not?

There also seems to be quite a bit of frustration around. Dentists were doing some basic stuff but they knew that once the person left, the problems would get worse and they could not provide the full range of treatments that the person needed to deal with their oral health issues. They might do the basic intervention strategies but they know that a year down the track it will be even worse. There is a lack of satisfaction because they cannot feel that they are doing their job.

CHAIR: The fee is based on doing a particular procedure, which is usually an acute procedure. So the dentist does that but then the person goes away and the underlying problems remain.

Ms EDMUNDS: Yes. There are also issues around the Department of Veterans Affairs reimbursements. They are considered much higher so dentists much prefer to receive that and take on those clients.

CHAIR: So you basically recommend that the DVA rate should apply under this scheme.

Ms EDMUNDS: Yes. There were also issues during the consultation that the fee has not increased over the years. It has not matched the consumer price index or treatment cost increases. So you have just got a standard cost and that is it. But all the other costs will be increasing for dentists. Sometimes a dentist has to travel and that is not included within those costs. The dentist has to cover a very large area and a large number of people. They have their private practices, which are fairly full and they are trying to run, and then they are taking public patients in addition. I guess they must weigh up at the end of the day how many people they will take and how much time they will put into that if the fee is not commensurate with what it costs them.

CHAIR: Would it be true to say that a relatively small percentage of dentists participate in the scheme and that most of them are in rural and regional areas or perhaps in parts of Sydney and other places that are less well served by dentists?

Ms EDMUNDS: I could not tell you where they were based but certainly there seems to be only a small number, and that number seems to be decreasing. Talking to people in regional areas, the dentists there are slowly dropping out because it is just not keeping up with their costs and they say, "Why should we continue to do this? We have a huge waiting list of private patients who will pay full fee".

CHAIR: So, on the whole, I guess the dentists who are participating in the scheme are in areas where there is a lack of dentists in the public dental service. That is mainly in rural and regional areas. How would you encourage dentists, particularly new dentists, to participate—other than by offering more money?

Ms EDMUNDS: I was going to say more money. One of the suggestions we had that was made to us during consultations was having a kind of tender proposal, where there is this amount of money for this area and this number of people so that the dentist could see exactly what they were getting. That could be used as a training area for new dentists who are just coming into the field before they go off to do private practice. Perhaps, if they decide to go into the public dental work force, it might be an addition—a way to supplement their income—to their public dental work. It could look at associated costs such as travel and some of those other things.

CHAIR: Would you have the tender include a broad range of services—instead of the one-off "I'm in pain and need an acute service now" and then they go away? Would you limit it to where it is at the moment or would you include a more holistic approach?

Ms EDMUNDS: I think you would need a more holistic approach to address the whole problem so it does not come down to tooth extraction, which unfortunately seems to be the state at the moment. It is about treating the caries or the disease and providing that ongoing care. It is about the root canal and all those long-term kinds of treatments that will enable people to maintain health.

CHAIR: Turning to quite a different question—I think we discussed this before you came in—the NSW Health people talked about using organisations or programs such as Families First as a way in to fairly active prevention strategies that involve having dental therapists and hygienists training child care people. Have you given much thought to that sort of co-operative program amongst not only health people but people from other agencies as well?

Ms EDMUNDS: Yes, we do touch on it. I think we have always argued for a multidisciplinary approach to health, whatever that may be and whatever that team may consist of, to meet that group of people's needs. That would probably be another effective way of getting into some of those really disadvantaged groups that you need to get into. It would be a way of skilling other people in some of the basic oral health treatments. As we said before, it is about linking into programs that are in existence so it is not costing more money to set up new programs—you are actually linking into something that is funded, active and happening and you can see whether it is being effective. It is part of that team approach that needs to happen, and which is happening in other aspects of health. It just means linking oral health into that approach.

Mr MOORE: It is interesting, given that an evaluation of Families First is taking place at the moment, to look at things such as home visiting services—which are now a universal commitment in New South Wales to all families with children—and see exactly who in fact has jumped onto this approach and added in dental health or oral health issues and to ask that question. I suppose I am suggesting that it is quite timely. It is also interesting in terms of child care provision to the extent that, particularly with fees increasing significantly, the range of what you expect out of a child care centre, early childhood development and related things whether or not there is something more to be thinking about in terms of health prevention and promotion.

The Hon. ROBYN PARKER: Do you support the notion of a co-payment system?

Ms EDMUNDS: I know we have not in the past and I would suggest that we would not into the future. For those that are most disadvantaged, even a co-payment is beyond their means. I think you then have the possibility of making access even less for those groups of people.

The Hon. ROBYN PARKER: So you do not think it would have any impact on the waiting list.

Ms EDMUNDS: No, I do not think so.

CHAIR: I assume that in dental services there is no problem of overservicing by the client.

Ms EDMUNDS: No.

Mr MOORE: Not by comparison.

CHAIR: The co-payment argument is sometimes used to stop overservicing of general medical services but I do not know whether anyone is suggesting that there is massive overservicing here.

Ms EDMUNDS: The majority of treatments are basic oral health treatments; they are not cosmetic.

CHAIR: You started to talk a bit about one aspect of internship. Do you want to tell us more about your more radical proposal for a 12- to 18-month internship in the public dental system?

Ms EDMUNDS: It is already on the drawing board to some extent. Our thoughts around it are that dentists leave the dental training system and are expected to be fully qualified and capable of going out and instantly providing dental treatment. Yet in the medical profession there is an internship period, when a person gets supported, supervision and guidance and develops their skills while practising under the supervision of someone with greater experience. It seems strange that there is that process for one health or medical profession but for another that can be dealing with some quite complicated and invasive treatments there is the expectation that they are able to just go out there and do it. So we see the internship as making better quality dentists. I am not saying that they are poor quality now, but it is about improving on that. You could look at things such as rural rotations, as they are considering with GPs. You could get them out to remote rural and regional areas to practice in the public dental work force. It would help to address some of the public dental work force issues because you would know that you would have this ongoing pool of people. You may get more dentists—but not necessarily—staying in the public sector rather than going to the private sector if they have had some good experiences in practice in the public sector.

CHAIR: Do we have any models of a good internship system?

Ms EDMUNDS: I know that some are being discussed by the Association for the Promotion of Oral Health and some other groups. We have not gone into that whole model side of things but we will certainly discuss with them what they are proposing. I know that the oral health branch has some as well.

CHAIR: When we asked a related question of the NSW Health people they pointed out that dentistry at the University of Sydney is graduate entry so you are not talking about the very youngest and most raw graduates. The system of recognition and accreditation Australia wide would potentially creates problems unless all States agreed—you could go and register somewhere else, for instance. I guess the implication was that it would need to be discussed and planned on a national basis.

Mr MOORE: We have often had breakthroughs in terms of mutual recognition across the jurisdictions in vocational training.

CHAIR: So it could be a good thing.

Mr MOORE: Yes.

The Hon. IAN WEST: Have there previously been internships in this area?

Ms EDMUNDS: Not that I am aware of. I could not tell you historically.

The Hon. KAYEE GRIFFIN: The NSW Health officers talked about a short-term internship as a way of filling vacancies in the southern region of New South Wales. That occurred on a three-week rotational basis, using two people each rotation, when they had difficulty getting someone to fill the position permanently. They thought that was reasonably successful and could be used in other remote and rural areas. But obviously it involved people who were already at the hospital.

CHAIR: It was an arrangement with the dental hospital.

The Hon. IAN WEST: Do you have any views—from memory, there is nothing in your submission about this—about the vexed issue of where basic oral health ends and cosmetic oral health starts?

Ms EDMUNDS: We have not gone there. I guess basic oral health is the treatment of dental caries and dental disease, such as periodontitis. It is the saving of the tooth—whether it is a root canal or something to maintain the integrity of the tooth. Cosmetic I guess we see more as—it is a hard division—whitening the teeth, but that might be important for certain groups. We have not really got into that whole division.

The Hon. IAN WEST: I am thinking about the bureaucratic issue of determining, if it was part of Medicare, where the funding would start and finish. It seems to be a fairly complex area.

Ms EDMUNDS: Yes. It needs careful consideration.

The Hon. IAN WEST: Have you addressed that? The first step is obviously to get it there. I suppose it is about crossing your bridges.

Ms EDMUNDS: Yes.

The Hon. KAYEE GRIFFIN: Recommendation No. 17 refers to dental therapists. You talk about the benefits of employing dental therapists in private practice as well as in public practice. The extension of the question is: What other models for the employment of dental therapists might be appropriate in New South Wales?

Ms EDMUNDS: In relation to dental therapists our understanding is that 500 plus dental therapists qualified, but that only 200 might be working. So that sort of suggests that the system might not be particularly attractive to work in, for whatever reason. It is about fairness to bring therapists in line with hygienists and dentists who can work privately, but they cannot. Private practise would enable them to earn their own income and perhaps supplement it by working in the public sector as well. It might encourage some of those who have left to return to work if they know that they can do some private treatment and be part of that. The other arguments are that they can provide cheaper services than dentists. They can do some of the early check ups and assessment.

We might have to extend some of their training, but they can attend to the basic caries, small and easy fillings, and that would then free up dentists to take on more complicated and invasive kinds of treatments. We talked earlier about having oral health teams. If you have an oral health team in the public health sector perhaps you should then consider having oral health teams in the private sector. Again you could have therapists providing basic treatment and the dentists would be freed up to provide more intensive and invasive treatments. So again we would be freeing up the dental work force and reducing the lists.

The Hon. KAYEE GRIFFIN: In your submission you state:

> A more flexible work force would mean that dental therapists would keep working as dental therapists doing assorted and preventive dentistry part time in the private sector or full time in the public sector instead of working for specialist orthodontists or periodontists in the private sector only.

You said earlier that 200 of the 500 qualified dentists are working in the profession. Are you saying that perhaps the other 300 are working in orthodontics and so on?

Ms EDMUNDS: I do not know. You would need to talk to dental therapists to obtain greater detail about where that group is and why it is there. It is quite possible that that is where it is. However, as I said, you would need to talk to the therapy association to find out. When we do the consultations and get the information we are not necessarily getting all the finer details of where people are.

CHAIR: We can take up that issue later.

Ms EDMUNDS: I would certainly talk to them about it. It is down to that team approach. If we are to have team approaches—we are looking at trying to reduce demand and better utilise the resources we have—we have to look at those resources and say, "How can that be improved? How can we get a team approach happening? Allowing therapists to work privately would do that. It also brings us in line with every State and Territory.

The Hon. KAYEE GRIFFIN: Does that fit in with the concern that everyone has expressed, that is, not as many people are becoming dentists now as there were a number of years ago? To use a phrase that we heard in evidence the other day, there are more teeth in the community now than there were before. Do you see that as relieving some of these issues? Do we need more oral health professionals coming through the system in the future to service the ageing population and to address the complex oral problems that they will have? Why are fewer dentists coming through university

now? Why are fewer people involved in the services that are being provided? How can that problem be fixed in future, given the fact that the workload is obviously growing rather than diminishing? In saying that I am excluding the suggestion that people should be given more information to prevent some of these oral problems.

Ms EDMUNDS: Some of it is historic in relation to the number of positions that were available in universities, which were then cut back. So maybe the answer in part is to increase the places available for dentists to train within universities. I do not have a full answer to that because I do not know why people are not training as dentists. In the public system it is not as attractive as the private system. The reasons why people might not coming into the public system might be salary, hours and things like that. That would impact on people becoming public dentists or working in the public dental work force. In relation to why people are not becoming dentists, I could not answer that. I do not know. All I can think of is that there is not the accessibility to get in. There are not the places to get in to train. Perhaps the costs associated with training and establishing a clinic when you first leave could be quite prohibitive for some people.

The Hon. KAYEE GRIFFIN: If that is an issue some of these proposals might resolve some of the problems that exist today. Obviously it is a big concern. All things being equal, you might resolve these other problems as a result of some of the recommendations that you have made. However, that still does not necessarily mean that people are on the ground to provide health services.

Ms EDMUNDS: Yes. It is a bit like the chicken and the egg. You need the dental work force to get the things happening, but you need to get things happening to get the dental work force.

CHAIR: One solution is to have more dental therapists and hygienists and so on.

Ms EDMUNDS: And a better utilisation of their roles.

CHAIR: Would the course at the University of Newcastle help in that respect?

Ms EDMUNDS: Yes.

CHAIR: We have covered most of our questions. If we have other questions I hope we are able to get back to you. Thank you for assisting the Committee with its inquiry.

(**The witnesses withdrew**)

FELICITY MARGARET BARR, Chair, Ministerial Advisory Committee on Ageing, New South Wales, affirmed and examined:

CHAIR: We have your submission. I hope you received from us late yesterday some questions that we wanted to raise with you. Obviously there will be other questions as well. Would you like to say anything by way of an opening statement before we commence?

Mrs BARR: Briefly, I would like to thank the Committee for the opportunity to appear on behalf of the Ministerial Advisory Committee on Ageing and to explain that I do so because the issue of dental services has been raised with us on a number of occasions in the consultations that we regularly conduct with older people around New South Wales. It is an issue of great concern to older people. When we are out and about talking with people we undertake to relay their concerns to levels of government as and when the opportunity presents itself. So we are grateful for this opportunity.

CHAIR: You do not want to make any broad statement about the problems as you see them? You are happy to have it all come out as we go through questions?

Mrs BARR: I think we covered the issues that we wanted to raise in the submission. We are happy to respond further to your inquiry.

CHAIR: What are the main barriers or problems that older people face in relation to dental services in New South Wales?

Mrs BARR: The things that have been raised with us are the cost of private dentistry and the availability of public dental services, both in relation to waiting lists, distance and transport difficulties. So particularly in rural areas, transport difficulties exacerbate the problems. As we understand it the problems that exist across the State—and they have been raised with us in the places that we have been—are long waiting times and the difficulty of getting dental treatment, in particular, emergency dental treatment. Some of the consequences of that are that older people, and particularly low income older people, choose not to pursue dental treatment. That exacerbates their oral health problems. Oral health being one of the key determinants of primary general health, the consequences of poor oral health show up in the general health of an older person. So there can be quite serious complications and flow-on effects.

CHAIR: So you are not talking about things being linked, like a syndrome of conditions? You are talking about poor oral health causing other health problems?

Mrs BARR: It is a complex issue. I am certainly not an expert. However, my understanding is that poor oral health can lead to poor nutrition. That, of course, is a significant factor in general health. Some research is emerging to link inflammation of various parts of the body, and obviously gum inflammation is a significant one from which we all suffer at various stages during our lives.

CHAIR: We heard evidence recently from a cardiovascular specialist.

Mrs BARR: Excellent. I do not know enough about it. I understand from my readings of gerontology that significant evidence is emerging of a link between inflammation and cardiovascular health, but also possibly dementia, which is an interesting development. As yet it has not yet been proven scientifically.

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

Mrs BARR: They certainly have a Seniors Card, yes. I understand from the Chief Dental Officer's presentation to the Committee that from the New South Wales Older Persons Health Survey in 1999 the majority of respondents, 71.1 per cent, held a card that made them eligible for publicly funded oral health care services. So, yes, in New South Wales the bulk of older people are eligible because of the high rate of pension entitlement.

CHAIR: Are the people with whom you consult mostly in that group?

Mrs BARR: Either in that group themselves, or representative of organisations caring for, serving or co-ordinating older people's groups in one way or another.

CHAIR: The first barrier you mentioned was the cost of private services. Are you talking about people who are eligible for public services but because of access problems, long waiting lists or whatever, seek private dental services instead and that is when the cost becomes an issue?

Mrs BARR: Particularly in emergency circumstances often the issue is one of cost.

CHAIR: How might that be addressed is the $64 million question.

Mrs BARR: I understand that when the Commonwealth had its Commonwealth Dental Scheme the access issue was significantly reduced. However, I understand from readings from the Australian Dental Association that there is mixed evidence as to whether it really had a major impact on the oral health of the older population as such. That is something that the committee might like to take up with them. Again, it is not an area in which I am particularly expert. I would not say that the committee was in a position to make a strong recommendation one way or the other about the nature of a publicly funded dental service but, given that cost is a barrier, given that poor oral health leads to increased cost in the health system through poor general health, it would seem to me that there may be some cost effective solutions for government in funding basic oral health services. In particular, we would like to see preventative dental education programs but backed up by greater education programs.

Certainly at the seminar that we ran that we mentioned in our submission to you, I was personally surprised at how much I learnt myself about dental issues in later life, but I was also very surprised at the amount of ignorance amongst the audience and the number of people who were expressing surprise at the information that was being presented about the loss of teeth, about the receding of gums, about the way in which teeth could be and should be protected later in life, about the particular phenomenon of dry mouth and the consequential effects of dry mouth on general health and on nutrition, and the fact that dry mouth is often caused by many medications. People in the audience who were taking particular medications that were mentioned said "I didn't know that that was because of that" and linking the two, and obviously things had not been adequately explained. So one of your other questions was how could we get better information out to people.

CHAIR: How could the information be best distributed, and taking up your suggestion that area health services should conduct dental information sessions targeting older people, are you talking about information being available?

Mrs BARR: It is a public education campaign, and they are always difficult to do because people do not absorb information until the moment that they actually need it. Any broad-brush public education campaign will have mixed results: some will and some will not get the information, and often the people who need it most will not. In particular, we would like to see greater co-operation between the medical profession, the dental profession and pharmacists so that the particular relationships between medication and the dry-mouth syndrome, and its consequences for dental health, are properly explained to people. Once again it is an issue of people listening and absorbing the information when it is given to them, but if you say it often enough at the time the particular medication is issued some of the information will be absorbed.

CHAIR: You are the first witness to mention pharmacists, and I am not sure why, because it seems fairly obvious in relation to side effects of individual medications?

Mrs BARR: And combinations of medications. Pharmacists are often in a position to talk about the combination. I understand that dry mouth is often caused by a combination rather than just a single medication.

CHAIR: It sounds like you think the role of the medical and dental professions and pharmacists working together is more important than having a whole series of brochures sitting in a waiting room?

Mrs BARR: It would be particularly helpful. Pharmacies are known to be one of the good information distribution mechanisms for older people. They tend to spend 10 minutes waiting for the prescription to be filled and they read all the brochures and pamphlets around them whilst they are there. I do it myself while I am there too. It is a very effective way to get that kind of information across, particularly having a number of over-the-counter products, a packet of a chewing gum and I think a spray and a little tablet that you can suck to generate saliva, and all of these things are good for you, but very little known. I did not know about it myself until I heard it at that seminar.

CHAIR: If area health services ran the sessions that you are talking about how would you encourage people come?

Mrs BARR: Generally a cup of tea is a really good way to get people to come along to a seminar. Older people find those kinds of seminars very attractive and a worthwhile activity—attractive speakers, attractive venues. It is always difficult to get the right people, but particularly by using community transport to assist those who have no way to get there.

The Hon. IAN WEST: It sound like it would be like drawing teeth.

Mrs BARR: Not as painful as that, I hope.

CHAIR: Is it easier to run that kind of information session in a regional or rural area than in Sydney? Do community networks function better to get people to attend in smaller communities or is that a gross generalisation?

Mrs BARR: I think it is a generalisation. My colleague here, Ms Fogg, has considerable expertise in organising our consultation sessions. We generally have a pretty good turn-up wherever we go. We are quite well networked into local older people's groups and systems. Reaching the ones who are not socially active, who are not participants in existing groups is always a conundrum for us and for anybody organising sessions like that. But again you see if you are targeting particular people who may have dental health problems then again the doctors will often know and advertisements in doctors' surgeries and that sort of thing can be helpful. It is not easy.

CHAIR: You are also trying to get to people before they have dental health problems? It is perhaps a harder group—

Mrs BARR: Yes, I think most older people have some kind of dental health issues. Certainly we are seeing—that fancy word of—edentulism is declining. As the population ages more people are going to have more teeth in the coming older generations, and that is I guess a tribute to modern dentistry, to fluoridation of the water system and to better nutrition all round, but also a bit of social practice too. I can recall when my sister turned 21 they took out her teeth.

CHAIR: As a present—

Mrs BARR: People did, as a present: an extraordinary coming of age thing that was done. Mind you in Tasmania teeth were pretty appalling, and the water system was pretty appalling too. But that is no longer done.

The Hon. IAN WEST: Many a soldier before they went to war had their teeth extracted.

Mrs BARR: Absolutely, in the present older generation that is very true. I think we will see a very difficult picture, that is not to say though that people will not have dental health problems, so higher levels of caries, those kind of things, and receding gums, the possibility of infection.

CHAIR: What are the implications of that for the training of dentists and other members of the dental profession?

Mrs BARR: I do not have any figures but obviously the impact is going to be quite significant. The dental work force has increased, as I understand it, in this State by something like 10

per cent over the past five years, which is good, but it will obviously need to be significantly increased as a higher proportion of the population keep their own teeth.

CHAIR: And as the proportion of older people is increasing and people with their own teeth are living longer?

Mrs BARR: Exactly.

CHAIR: Will we need more people in the dental work force because, as the Hon. Ian West said earlier, there are more teeth in the community than there used to be?

Mrs BARR: Exactly. We need more training programs. So there may be scope for a subsidiary dental work force who are not fully qualified dentists but may be dental educationists if you want to coin a horrible word like that. In America I know dental hygienists and associate practitioners play a very significant role in support, promotion and prevention programs. There may be scope for that.

CHAIR: Are you assuming that it is going to be very difficult to get a much higher number of qualified dentists or do you see that as a good thing?

Mrs BARR: No, I was not, I was seeing dentists being reserved to the profession of dentistry, so doing the actual work, but also needing, as we have said, to create a promotion and education program for the whole community, but particularly for older people. I see that as a subsidiary role that does not necessarily need a dental qualification, but it does need some education and training.

The other issue I want to raise in the training context is particularly in educating the dental work force to deal with dementia. Firstly, to increase their knowledge of dentistry in older people. Because of past practices of removing teeth and so on, and the higher level of dentures, we do not actually have very good research information available yet on the probable conditions, the rate of prevalence, the rate of incidence of certain conditions in older people. I have not yet read a study of centenarians' teeth—I am sure I will be able to in about 20 years' time—but we do not actually have that information yet because we simply do not have enough people who have been studied. So we do need significant education, training and research. We would like to see research funded into older people's dentistry.

Secondly, we would like to see the training, as I mentioned, for dementia. Unfortunately, there are some predictions about the high incidence of dementia. We know at the present time one in four people over 85 years suffer from dementia. With those high rates, we are seeing significant problems related to their oral health. Those problems emerge from a number of factors. One is the difficulty of giving basic normal oral health maintenance and hygiene so it is a really significant issue for carers. Secondly, one of the common physical problems associated with dementia is the loss of the swallowing response so very often food will sit around the mouth for considerable periods of time. If there are teeth still present in the mouth then the rate of caries is very high and there are some studies of dental health in nursing home residents. Of course, in nursing homes these days the preponderance of people in care have dementia. The problems are quite dramatic, quite horrendous and at the moment there is a very small proportion of the dental work force who are capable of dealing with dental care in demented patients.

The Hon. IAN WEST: With the home care visits that take place under the Home and Community Care [HACC] program, those very good field staff undertake a great deal of complex personal care but no dental care. Is that an area where a lot of work could be done under the preventative oral health program?

Mrs BARR: It is a very, very tricky and complex question that you ask. The issue of personal care and training for giving personal care is one where you are invading a person's very private personal space. Assistance with showering is a considerable problem in the private home. The invasion of the mouth by somebody coming to clean your teeth is almost the ultimate indignity, almost. Assistance in toileting is probably the ultimate indignity for most people. For someone with dementia it is very, very threatening to have someone come to your face, force your mouth open and

shove something in it to clean your teeth. It is an extremely difficult problem. The Alzheimer's Association has on its web site some very good information documents which attempt to give home-based carers some information, guidance and support on how to deal with those problems. The training of the paid work force to go in and do it is very complex. Yes, I think there is a solution in there that could be an improvement, but it is not an easy one to solve.

The Hon. IAN WEST: There would be probably 3,000 people in New South Wales go into homes doing not just simple care but complex personal care of all parts of the body other than the mouth. It seems to be an area of scope to look at.

Mrs BARR: Yes, I would not disagree with you. It is not an area that I am expert in. But it is difficult. Again, in hospitals nurses deal with that.

The Hon. IAN WEST: I would be so bold as to suggest that probably 85 to 90 per cent of those doing the complex personal care would be ex-trained nurses.

Mrs BARR: Qualified nurses, indeed.

CHAIR: As far as we know, no-one is looking at training for all those people involved in home care in terms of oral health?

Mrs BARR: I certainly could not categorically say. It is not an area that I have any knowledge of. It is not an area that is discussed very much. That is one of the reasons why we ran that seminar. We found there was very limited information.

The Hon. IAN WEST: The carers do enemas, change colostomy bags, all sorts of complex care.

CHAIR: And look after teeth as well but, as you say, with great difficulties.

Mrs BARR: Yes, it is very difficult. It is very invasive and very personally threatening. It is probably easier to attack from the other end.

The Hon. KAYEE GRIFFIN: Particularly with some types of dementia, the way it manifests itself in individuals.

Mrs BARR: Yes, and very often the perception as to what is happening. It is a common problem.

The Hon. IAN WEST: A field staff person could leave the house with the person being very clean externally.

Mrs BARR: It happens, I am sure. Again, I am not in a position to comment. I am not expert in that field. Also, in residential care there are issues. I recall my own mother spent her last years in care with dementia. She had dentures and they got lost. They went out with the laundry and they were never replaced. She had slops for the remaining three years of her life. It was most appalling. It happens. That was in Canberra and there was no dentist available who could handle a dementia patient at that time.

CHAIR: As far as you know, no specific training for people working in residential care.

Mrs BARR: None whatsoever, not at that time. Things have improved since then. Certainly dental hygiene is one of the issues now listed under the quality management program for residential care. It is one of the things that is checked during inspections of residential care. That is not to say that it happens on a daily basis everywhere.

CHAIR: That gives us areas to follow up. Do you think fluoridation should be mandatory?

Mrs BARR: That is not something that the Committee has discussed. It is not something the committee has taken a position on. I would simply say that there seems to be sufficient evidence that fluoridation of the water supply has significant dental health benefits. Personally I would support it.

CHAIR: You are not speaking on behalf of the Committee.

Mrs BARR: It is not something that the Committee has discussed at all or would be in a position to take a position on.

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

Mrs BARR: Yes, indeed.

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

Mrs BARR: Yes and no. Transport is the number one issue for older people. Whenever we go out for any consultation on any subject—it does not matter what it is, where it is—transport is the big issue that we come back with. It manifests itself in many different ways but particularly for older people who are getting to the stage where they are no longer able to drive themselves and where public transport is not available to take them to the services that they need. We talk glibly about community transport being the solution. It is and it is not. It certainly solves some problems. For medical and dental appointments it can be a boon and a blessing. When combined with the difficulty of getting a dental appointment, the transport issue is a complicating factor. The other point about community transport is that where it is available it is generally in strong demand and it also has a cost factor. In my own neck of the woods—I live at Nelson Bay—to access the public dental service in Newcastle it is $42 to take the community transport down to Newcastle. That is a significant amount of money on top of whatever fee might be charged.

CHAIR: That is $42 return.

Mrs BARR: I actually think that is one way, depending on whether it is a special appointment or whether you can hitch a ride on the bus that happens to be going down at that time anyway.

The Hon. ROBYN PARKER: Do they provide dental services at the polyclinic at Nelson Bay?

Mrs BARR: No, as I understand it, they do not. Again, I am not expert, I do not know. I have not lived there long enough or have had to use the service myself. That figure was quoted to me by someone who was going to medical purposes for a special one-off appointment. The figure did horrify me. Yes, there is a patient contribution requirement. Again, the issue is one of availability and timeliness. The group who falls between the stools are the ones who do not qualify for public services but do not have a high income. They are the ones that have the most difficulty in terms of cost.

CHAIR: The working poor.

Mrs BARR: The working poor, indeed, or the non-working poor in the older age groups: the self-funded retirees on limited incomes.

The Hon. ROBYN PARKER: In terms of those people, are you talking about the group that do not have private health insurance?

Mrs BARR: Many of them cannot afford private health insurance.

The Hon. ROBYN PARKER: How does the dental care provided by the Department of Veterans Affairs compare to the public dental care services offered to other older people?

Mrs BARR: You are tempting me to put on my previous hat of Deputy Commissioner for Veterans Affairs in New South Wales. I will resist the impulse and simply say it would be nice if all older people could have the same quality of dental service that Veterans Affairs makes available to its beneficiaries.

CHAIR: Most of those beneficiaries are fairly old, I would assume.

Mrs BARR: Indeed, they are now. Their average age is well into their eighties.

CHAIR: Therefore, the number of people catered for is dropping and will drop sharply.

The Hon. ROBYN PARKER: What about Vietnam veterans?

Mrs BARR: There are very small numbers of Vietnam veterans.

The Hon. IAN WEST: The difference between my father's dental health care as a veteran and my mother's is significant.

The Hon. ROBYN PARKER: It does not get around rural and regional equity and availability issues.

CHAIR: It does with the Department of Veterans Affairs [DVA] because of the provision of transport.

Mrs BARR: It does. The DVA does provide the transport. Again, that availability is always an issue. We will never solve the problem of rural people having the same easy access as people have in the cities. Let us not kid ourselves about easy access in the cities either.

The Hon. ROBYN PARKER: Has your Committee made representations to the New South Wales Government about the fact that New South Wales funds public oral health care at a lower rate per capita than any other State in Australia?

Mrs BARR: The Ministerial Advisory Committee on Ageing reported the findings. We prepare a report each time we have a consultation. After the seminar we prepared a report which we sent to our Minister and asked that Minister to pass it on to her colleague the Minister for Health.

The Hon. ROBYN PARKER: Did you get any response from the Government?

Mrs BARR: We did get a response which we then followed up by inviting the Chief Dental Officer, Peter Hill, to come and speak to the Committee and to educate us further.

The Hon. ROBYN PARKER: Would you explain the nature of that response? What was its answer to such poor levels of funding?

Mrs BARR: The particular issue that you specifically asked about was not covered in the letter that we sent to the Minister. So there was no response on that particular point. The points that were raised were noted and were taken into account, or we were assured they would be taken into account in the planning. Of course, it was at the time that the area health services were being restructured. We were advised that the dental health services were also part of that restructuring and that the comments that we made would be taken into account in that process.

The Hon. ROBYN PARKER: Are many of the problems as a result of lack of funding and resources?

Mrs BARR: Funding is always a difficulty. As we said in our submission, we do note that the Commonwealth does have constitutional responsibility. Of course, the Commonwealth program was in place for a number of years. Personally, I think it is very sad that things fall between the two levels of government. We have these endless arguments over who should fund what. I would dearly love to see the present discussions that the Council of Australian Governments has initiated about

what I understand is the delineation—it is a lovely word, isn't it—of responsibilities between Commonwealth and State in Health. I would like to see it pick up some of these issues.

CHAIR: As far as you know, dental issues are not included in those discussions?

Mrs BARR: I have not heard it mentioned.

CHAIR: We should check. So if the Commonwealth takes over all the hospitals you would like it to take over the dental services as well?

Mrs BARR: I live in hope that the levels of government in this country will learn to work together for the benefit of the community.

CHAIR: Does local government play any role in terms of the networks of older people or in terms of—

Mrs BARR: Local government is a significant player in the networks of older people.

CHAIR: That might be relevant to dental services or information about dental services?

Mrs BARR: Very much part of the information networks, yes. Local government tends to provide facilities—community health centres, community facilities of various kinds—which are meeting places for older people and good information distribution points. Many local governments also have very good directories of services and again those are useful places to get information out and to help people to find their way through the system when they need the information. So I think there is a significant education, information and co-ordination role for local government in this particular arena.

CHAIR: The final question we included here is probably a difficult one to answer: Is it possible to gauge the impact of private dental insurance and the subsidies of that on older people?

Mrs BARR: I have not seen any real research material about that, but I understand the Australian Health Policy Institute at the University of Sydney did make some comments in one report, I know I am not sure which report that was, it is not one that I am aware of, but we can provide that information to you. The comment there was that higher income adults using private dental insurance and dental care may receive nearly five times the subsidy received by an aged pensioner seeking public dental care because the subsidy for private insurance works only for those who can afford it, obviously.

CHAIR: Presumably the take-up rate is lower amongst older people given their access to various other forms of assistance?

Mrs BARR: Yes, indeed. The number of people who qualify for a pension would indicate that most of those people cannot afford the level of health insurance that would cover dental insurance as well. It is not the basic, it is generally the extras or the top level, or whatever.

CHAIR: We can try and get some statistics on that. But that would lessen the impact compared with younger people who would be more likely to have that high level health insurance?

Mrs BARR: At this stage, given the distribution of income in the older age groups, yes, I would have to say that dental insurance subsidy would not be an effective strategy.

CHAIR: But given the arrangements that the Federal Government has put in place in terms of going in early and in terms of, I guess, income levels amongst ageing people now, with the younger generation you would expect that level of insurance to increase as time goes on?

Mrs BARR: You are way out of my expertise, but my understanding is that the forecasts from the National Centre for Social and Economic Modelling, are that incomes for older people in the baby boomer generation will be nowhere near adequate, certainly not the levels of self-funded superannuation, self-funded retirement. We will see, it is my understanding, an increase in the number

of people who are caught in the poverty trap of not qualifying for a pension but not having abundant income.

The Hon. IAN WEST: Can I add the other side of the equation to that? I would assume that actuarially the insurance industry would price that sort of insurance out of the realm of most people, irrespective of the poverty trap of the baby boomers, because of your susceptibility to use.

Mrs BARR: It is an interesting point, yes. As I made the point earlier, I do not think we have yet adequate information about oral health care and oral health requirements in the older age. So probably the actuarial studies have not yet been done because actuaries tend to base existing information and project it forward. I do not think we have enough existing information yet to have adequate actuarial projections.

The Hon. ROBYN PARKER: There has been a call in some submissions that have been presented to us for the Federal Government to take that subsidy for private health insurance off. Would you have some idea of whether that would tip more people out of private health insurance and then onto the waiting list?

Mrs BARR: That is nothing that I would be able to hazard a guess at.

The Hon. IAN WEST: No doubt there would be more and more people that would end up in the public sector and therefore the waiting list, by its very nature, would have to increase.

CHAIR: That is something we can discuss. Unless Committee members have other questions, we have got to the end of the ones we had written down for you. Thank you very much, not only for dealing with those questions and giving us the submission, but for being very patient and even adventurous with us as we asked all kinds of questions that were probably way outside your field of expertise. You have certainly given us some lines of thinking.

Mrs BARR: Thank you for the opportunity.

(The witness withdrew)

(Luncheon adjournment)

ALEXIS TAYLOR, Caseworker, UnitingCare Burnside, 6-8 Iolanthe Street, Campbelltown,

KEO VORASARN, Intensive Family Support Worker, UnitingCare Burnside, 232 Railway Parade, Cabramatta,

JO ALLEY, Policy Officer, UnitingCare Burnside, 13 Blackwell Place, North Parramatta, and

ANN MAREE DAVIES, Service User, UnitingCare Burnside, 13 Blackwell Place, North Parramatta, affirmed and examined:

CHAIR: We have your submission, and you received some questions from us yesterday. Would you like to make an opening statement?

Ms ALLEY: I will make an opening statement which captures some of the issues that we have highlighted in the submission. UnitingCare Burnside primarily provides programs to people of low socioeconomic status, and obviously they are the main users of public dental services. We have 80 programs across 27 locations in Sydney, and rural and regional areas. We work with a range of groups which are priorities under Australia's national health plan, including Aboriginal and Torres Strait Islanders, people with disabilities, people from culturally and linguistically diverse backgrounds, drug users, children, young people, and rural and remote people.

Our submission was based primarily on consultation with Burnside staff and service users, and we focused our submission on the oral health of disadvantaged groups. From the literature it is evident that the incidence of caries and periodontal diseases increases as socioeconomic status decreases. Compared to the general population, people from disadvantaged backgrounds have longer intervals between dental visits, receive twice as many extractions as the rest of the community and are eight times more likely to have no natural teeth in the 45 to 65 age group. From our consultations we identified some substantial barriers to accessing services. The main ones of those are waiting lists and costs.

We found that waiting times to access public dental services varied across different parts of the State. For adults, in one regional centre the waiting list was seven years; emergencies were being seen more quickly. In Sydney reports of waiting periods varied from four weeks to two years, and the shorter end probably would have been for emergencies. So people who are in pain are at least waiting up to a couple of months in pain before they are being treated. There are long waiting periods for dentures. One regional service centre—the same one with the seven-year waiting period—reported that a service user waited for up to three years without teeth for dentures. There have been similar waiting times reported for dentures in Sydney.

For children we found there generally seems to be shorter waiting periods. One service in Sydney has a 10-day waiting period for children who are in pain. We found in one of our regional centres that the situation is very difficult with children of primary school age only being able to be referred from the school dental visit to the clinical service; that is their only way of accessing the clinical service. School dental visits have been dropped down to one every two years. Costs were identified as a major barrier. The literature shows that there is an average cost of $295 per hour for dental treatment. Only 3 per cent of concession card holders have private insurance, and even then there is a limit to the number of treatments they can receive, which is very problematic if you have not been able to access services for years. Obviously people are showing up at the public dental services with major problems that will not get solved necessarily in one treatment.

Some types of treatment are unavailable in public dental services, including wisdom teeth and braces, and our service users report that the cost of something like wisdom teeth is completely beyond their budget. Money must go on other essential items like the needs of the children. In rural areas transport was raised as a major barrier to accessing services. Particularly for people in outlying towns, there is no public transport to the regional centres. Within regional centres there are also transport difficulties for people on low incomes. They must take at least two buses to get to a dental service. So the implications of this lack of access to services and the lack of prevention results in ever-worsening dental health.

Our service users reported an array of problems, including chronic pain, abscesses, cavities and much more serious problems as well. They highlighted issues of ongoing pain and how they tried to get around ongoing pain, including using antibiotics, through going to a GP to get antibiotics, and pain killers. A couple of people reported trying to pull out their own teeth. A young person talked about trying to pull out teeth with pliers but found that they could not because it was too painful. Service users talked about the impact on diet of not being able to eat certain foods and not being able to bite into an apple. Some of them talked about subsequent weight loss. There was a lot of concern about the impact on people's appearances, such as people missing rows of teeth. This has an impact on people's self-esteem and may lead to stigmatisation as people are perceived to be a certain sort of person because their teeth are not in good repair.

They talked about quality of care. There were concerns about the qualifications and experience of staff, especially in dental hospitals. They also spoke about language barriers and a lack of interpreters and some instances of negative attitudes to service users, particularly those who are on methadone programs. There were issues about, "Oh, you are not looking after your own teeth", but the real issue is that people cannot get access to good dental treatment. Some people reported a reasonable quality of treatment through public dental services whereas quite a few people had stories of poor treatment. There were comments about services needing to be more sensitive to people's circumstances—understanding that people do not have money to access services.

There was a lot of comment about the lack of preventive focus on existing services. There were quite a few people who commented about the trend in public dental services to pull out teeth, to rip out teeth, rather than trying to fix them by putting in fillings or doing major work to retain teeth. They were the sorts of issues that came up in our consultations. Burnside put forward a number of recommendations. We considered that it would be ideal if Medicare was expanded to include oral health and if there was joint State and Commonwealth funding for additional programs. I know at the moment though that this is a State inquiry, but given the dire situation in relation to oral health, we believe that the State has an obligation to take immediate and substantial action. Current funding per capita for oral health in New South Wales is the lowest compared to the other States. We believe it should be brought into line with that of Queensland, which is the highest level.

Our other main recommendations are for funding to be provided to fully implement the recommendations of the Australian National Oral Health Promotion Plan in New South Wales and that funding be provided to implement the New South Wales Oral Health Promotion Framework for action, which is nearing completion, and its companion Aboriginal document.

CHAIR: It is a pretty grim picture that you have painted of what your clients tell you.

Ms ALLEY: That is right. It was not much fun doing the consultations, actually.

CHAIR: Do any other witnesses wish to make any comments at this stage, or will you take a turn when we go around?

Ms ALLEY: Yes, we will do a rotation during questions.

CHAIR: Our first question depends a bit on what you are going to say, but you have probably told us enough about your client groups and the areas your service operates in and where they would access public dental services in your area. In relation to that huge variation in waiting lists and so on that you mentioned, were the ones with the longest waits in the more isolated rural areas?

Ms ALLEY: We did not do a survey of all the dental services but we talked to two regional centres. One had the really long waiting period. With the other service, our consultation was mainly about access for youth. It did not seem to be as difficult because they were homeless and at-risk youth, so they would be prioritised in the existing system, I think. I would imagine there would be worse in rural areas but I did not do a comprehensive study of it, yes.

CHAIR: Again, from what you say, it sounds as though the generality of people are not getting preventive care from public services. It is more the emergency sort of focus.

Ms DAVIES: I have really quite bad teeth. I have had experiences with the dental system. I started off with my back teeth which were rotting. Rather than filling them, they just pulled them straight out. I have since found out—I went with my mother to her dentist who has been her dentist for years. He had a free look at my teeth. They had pulled teeth out that did not need to be filled, that could have been filled, being my back teeth, so I have no longer any back teeth. Two of the teeth they pulled out, they left roots so I still have roots in there and it is still quite painful. The other thing is that I would ring up to make an appointment because I had a hole in my tooth and to get it filled. By the time I got to my appointment in a couple of months, that tooth had deteriorated so much, they had to pull it out. It had fallen out by the time I got my appointment.

I have got to get dentures. I am 25 and I have to get dentures. I have been on that waiting list for two years and it has just come up now. In the meantime my teeth have just been getting worse and worse. Whereas before I just had to get back teeth, now I have to get front teeth. That is to do with the waiting. Because of having to wait so long, my teeth deteriorated in that time and I was a priority. I was in pain for a lot of that time. I would stay up nights. I went through scripts of Panadeine Forte. It is just the worst pain you could imagine.

CHAIR: How old were you where the problems started?

Ms DAVIES: About 19 when I started with the back teeth. I went in and the first thing they did was pull the tooth out, and it could have been filled.

CHAIR: Could it have been filled if you had been treated earlier, or could it have been filled even when it got there?

Ms DAVIES: It could have been filled then. Even when I got there, the original two could have been filled.

CHAIR: So what was the reason for the extraction?

Ms DAVIES: I do not know. They did not say. Like I said, I went to my mother's dentist who has x-rays and stuff of my teeth before I started going to the public clinic, but my mum cannot afford to pay for me any more and I cannot afford to go there.

CHAIR: Have you been in different regions or in one part of Sydney, or outside Sydney?

Ms DAVIES: I have been in Sydney. I have been in Canberra. Yes, I think that is it, and Liverpool.

CHAIR: Each time you had a new tooth giving problems, so you went on a new waiting list basically.

Ms DAVIES: Yes.

CHAIR: And each time, for an individual problem?

Ms DAVIES: Yes.

CHAIR: Was there ever any treatment or any planning to look at what was going on in your mouth in a general way?

Ms DAVIES: No. Just recently, because I am getting the dentures, they have made a plan for me. They have said, "We are going to fill this one, this one, and this one, on the first", so they have given me three visits, "and during this visit we are going to take this one out, and on this visit we are going to take these ones out." But originally, they would just look at the one that was hurting and do that too. Then I would say, "Well, this one is bad", and he or she—the dentist—would say, "Well, you have to leave. Ring up the referral line and make a whole new appointment for that too."

The Hon. ROBYN PARKER: That is ridiculous.

Ms DAVIES: Even he could see that this one needed to be done, right then and there, but they would only do the one tooth. I could not even make the appointment there. I had to leave, ring the referral line and make a whole new appointment, and that could be a couple of months.

Ms TAYLOR: Ann's situation actually is not an exception. I have worked with numerous young people, through the Macarthur Youth Services, who have had exactly that same experience—of teeth being pulled out that did not need to be pulled out, of comments being made like, "We would prefer to pull it out as opposed to putting a filling in because a filling could come out in a couple of years anyway, so you would have to come back. You would be better off if we pulled it out." I have also had comments on those extremely long waiting lists. When you call up that line, they will actually say to you, "How much pain do you feel that you are in?" so that they can work out how long they are going to give you before you receive treatment.

CHAIR: Do you get involved as a worker in perhaps making a judgment or appealing on behalf of someone?

Ms TAYLOR: I have advocated on behalf of young people before. One of the examples is actually in the submission of a young man I worked with who had a brain injury and who had a lot of pus and gunk coming out of an abscess in his mouth. His entire face was swollen. He did not know anything about the community dentist but when I told him, he phoned them up. They said the earliest he could get in, with his level of pain and everything else, was within a month. I advocated for him and was able to get him in there to a place within the next few days, but he had to travel from where he was living in south-west Sydney down to Bowral to access that service. He needed to be there by eight o'clock in the morning, which is a very difficult thing for someone with his level of disability to do. Then they treated it at that time and it was not suggested to him to have any follow-up checkups or anything after the tooth was pulled out.

CHAIR: Again, it is treated as one tooth, one place?

Ms ALLEY: Yes. We found that across-the-board basically with the people we talked with, both service users and staff. The pain is being treated, but nothing else in the mouth.

The Hon. ROBYN PARKER: When you say you were using the public dental service, were you actually going to a public clinic or were you going to a dentist using the voucher system?

Ms DAVIES: No, I was going to the public clinic. Once or twice I turned up when my face has been swollen and I just turned up there and they have given me a voucher to go to a private dentist. I think he was the one that left the root in there. I am not 100 per cent sure. Like I said, I do not know which tooth. Once they gave me a voucher.

CHAIR: Did that meet the expense?

Ms DAVIES: Yes. But every other time they send you—like it is just a 1 300 number and you call that up and they send you to your closest government clinic. I was actually going to one. It was at Liverpool. There was another one in Hoxton Park Road. I went to that one and I found that the dentist was a bit better there. She was looking at my teeth and saying, "Right, when you come next, we will try to do this, and this, and this. But you still have to go away and ring up." She actually looked at all the other teeth as well a bit more.

CHAIR: Did she keep a record so that when you went back, she knew that she had a record of what she had done?

Ms DAVIES: Yes, she did, but she has left now anyway. She did keep a record.

Ms ALLEY: The other issue is turnover of staff, so you may get a different dentist. Is that the case?

Ms DAVIES: Yes. That was the first time. I had her three times running, but every other time I have been, there has been a different dentist.

CHAIR: But would the clinic keep a record so that even if the individual dentist changed, the new dentist would be able to look up a card or a computer record or an x-ray?

Ms DAVIES: I am not sure. I know there are a lot of folders behind the counter. I suppose they would. I have never known them to take a folder out or anything.

The Hon. IAN WEST: Does anyone know how the vouchers work?

Ms ALLEY: Yes. That is one of the later questions. I can talk about that. Do you want it now?

CHAIR: You can do it now.

Ms DAVIES: I talked to staff of one of our services where this voucher system is in operation. From what they said, the reason why it is in place in this particular regional centre is that there is no capacity in the public dental system, so there are young people just automatically going onto the voucher system. The process is that the person has to go to the public dental service to get the voucher and make an appointment with a private dentist. Apparently there are slots. Private dentists usually have a slot allocated for emergencies on a particular slotted day type of thing. They make the appointment and go to the private dentist and have the treatment done. My understanding is that it is the same sort of process though with the public dental. If there are other problems identified, you only get the value of the voucher. Then you have to go back to the public dental service and get another voucher and go through the process again. From my discussions there, the problems that are encountered in this system are that there is a limit on the voucher. They said it was about $120 so that does not necessarily get you very far.

That raises transport issues, particularly in this particular regional centre. The public dental service is not centrally located. It is in a residential area, so that means two buses for most people to be able to get there and then you have to get to the private dentist. From talking to people who work in oral health, they said that one of the problems of the voucher system is actually that not all dentists will want to participate in it because they are not reimbursed at the same rate that they would get for a private practice. There is also additional paperwork associated with it. There is also a bit of an issue about trying to find dentists who are prepared to do it.

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

Ms ALLEY: To be honest, I do not know. From what I have read in the literature, $295 an hour is the average price of a dentist so I would not have thought that $120 would amount to all that much. But I do not know enough about it.

Ms TAYLOR: In my experience advocating for young people, none of the young people that I have worked with or advocated for have ever been offered a voucher of any kind. They have always been put on the waiting list. It has never even been mentioned that it is available.

CHAIR: Presumably that is because there are more public dentists operating in the area where you work and it is used more in areas of great shortage.

Ms TAYLOR: Possibly. But waiting a month for emergency treatment seems like an opportunity when a voucher could be used.

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

Ms ALLEY: You must go to the public dental—

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

Ms ALLEY: Yes.

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

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

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

CHAIR: In terms of preventative care or looking at the client in any holistic way, it is not happening in your experience.

Ms DAVIES: No. Six years ago I had a full mouth of teeth and now I think I have eight teeth.

Ms VORASARN: As to the waiting list, I think Ann was pretty lucky that she was only on the waiting list for dentures for two years.

Ms DAVIES: Yes, I was very lucky.

Ms VORASARN: I have one client who has been on the waiting list to get dentures for five years and she still has not got them. Ann is probably one of the lucky few.

Ms DAVIES: I am pretty sure that the longer you wait, the more your mouth shrinks. I have a friend who has just got her dentures after seven years. Her face is sunken in and the dentures are making her mouth stick right out. I work with children in school holidays and I have just started freelance film-making. You have to get up and talk in front of people. I used to smile a lot. It has been a huge impact on my self-esteem. I have lost heaps and heaps of weight because I cannot eat. There is so much that I cannot eat. I cannot eat hot stuff or cold stuff because of the holes that are left—it hurts. I cannot eat hard stuff—I cannot eat an apple, for example. I do not have the back teeth that everybody uses to chew with. I have to chew with my front teeth. My front teeth are now breaking because they are not designed for chewing everything. Because I am doing that it is now destroying my front teeth.

CHAIR: Keo, did the client you were talking about have a lot of teeth left? Was that person's need for dentures considered greater than another person's? Was there a priority?

Ms VORASARN: She has only been with the organisation for about a month. We run groups and I have only seen her twice. When Jo went to do the consultation with our service users and we were talking about waiting lists she said—she does not talk much or smile much so you do not really see her teeth but you can see that she is having difficulties talking so she would rather not talk—"I've been on the waiting list for five years and I couldn't be bothered chasing it up; I thought I would just wait and when my time is up, it is up".

CHAIR: So you do not know any more about her individual circumstances.

Ms VORASARN: No, because they do not really come to see us about problems with their teeth; we are there to do other things.

Ms DAVIES: I have never noticed that she has any teeth—I know who you are speaking about. I have not seen any teeth so I do not think she would have many.

Ms VORASARN: Even when she speaks, her mouth is really closed.

CHAIR: Do you all deal with people from a variety of cultural and linguistic backgrounds?

Ms VORASARN: Yes.

CHAIR: Can you make any generalisations about the different needs and problems faced by different groups? I know it is a huge area.

Ms ALLEY: It is. What came up in the consultations—although we only did one that was primarily focused around people from culturally and linguistically diverse backgrounds—was issues around people bottle feeding to an older age than is recommended and this having a substantial impact on the mouth. We talk about that in the submission. That seemed to be across quite a few cultural groups. There were issues in relation to access to interpreter services. Interpreters are not always available. When I spoke to someone who works in the area of oral health, basically they said that getting access to interpreter services is an issue. One of the questions is: What should the department do in terms of culturally and linguistically appropriate services? One of the things would be to provide greater funding for the interpreter service. In our submission we give an example of someone who did not have an interpreter and ended up having quite a number of teeth removed because they did not understand what they were saying yes to. It is not appropriate—and it is against the guidelines—to be utilising family members as interpreters.

CHAIR: From what backgrounds are the people who use your service in Cabramatta, Keo?

Ms VORASARN: We have Cambodians and Vietnamese basically. We do get some Middle Eastern people but not often. There are some Lao and probably some Samoan people as well. But that is only in the Cabramatta area.

CHAIR: Do those people come to Australia with pre-existing dental problems or do children who have been born in Australia have problems?

Ms VORASARN: Some of them come to Australia with dental problems but I know that a few people, even my own friends, have children—I do not let my children suck on the bottle or drink juice—whose front teeth have gone black and they had to have them taken out. That is because they do not know. Some of them have language problems. Parents who have grown up here, like me, can see about it in the news and sometimes the school talks about it. When I went to school they had a mobile dental van and they would check our teeth. That is not there any more. Some children are brought up by grandparents because their parents go to work. The grandparents just let the kids do whatever is easy for them—they drink from the bottle or drink juice so their teeth are rotten. They do not know about the emphasis on brushing your teeth morning and night.

Ms ALLEY: In south-west Sydney the area health service nutritionists have been involved in conducting a multilingual bottle feeding multi-strategic health promotion intervention. That is the sort of thing that could be picked up on. There are types of pilot projects that are around, particularly working with people from culturally and linguistically diverse—different ethnic—groups that could be funded more extensively. I was aware of the Cabramatta service, which is not part of the area health service, program. But these programs usually operate on very limited budgets. With something like that NSW Health could put in a little extra money and make it more statewide, utilising the resources that it has developed and using the print media and ethnic radio.

One of the things about doing the preventative end is that we need the clinical end to be fixed up. It is all very well to talk to people about prevention but if they cannot get their teeth treated it is a very difficult situation as service providers. So there is certainly a lot of opportunity for working different types of innovative programs for a whole heap of different communities around prevention but you need to have the treatment stuff happening as well. The other things that came up around that were that you could utilise the voucher system to enable people to access dentists who speak their own language. But I think the voucher system needs to be streamlined because it has its problems, as we have already talked about.

CHAIR: Is there a reasonable mix of dentists from different linguistic backgrounds so that you can match clients to dentists who speak their language?

Ms ALLEY: Again, I have not done a survey of them all but I have seen them around. Keo, you might have more of an idea.

Ms VORASARN: I know that in Cabramatta there are lot of dentists who are Chinese or Vietnamese. I have not seen any Cambodians dentists. I think there is only one Lao-Chinese dentist out there. In Fairfield you get dentists from Middle Eastern backgrounds and a lot of their clients would probably be from their backgrounds because they can speak the language. In Cabramatta a lot of Asian people go there even if they do not speak Vietnamese or whatever. Some of the receptionists or nurses are from that background so they can talk.

CHAIR: Looking at the Cabramatta and Fairfield areas, do you know whether the dentists you are talking about did their training in Australia or overseas?

Ms VORASARN: Yes, they have done their training in Australia. When you go into the surgery you see straight away which university they went to. Some of them are quite young. There is one dentist in Cabramatta right in front of the station who is very popular. He did his study in England, I think. A lot of people go to see him but they have health funds because he is quite expensive. My girlfriend will not go to anyone else because he has done such a great job. If we could have someone like that in the public system it would be great. Records are another issue. We talked previously about keeping records. Every time you make an appointment there is no chance that you will get the same dentist. You get dentists telling you different things. One dentist will tell you to do this and this and this, and then three or four months down the track another dentist will tell you that you do not need to do those things. Who do you believe? That can stuff up your teeth.

CHAIR: So the mix of dentists you talked about from different linguistic backgrounds are all in private practice not the public system.

Ms VORASARN: Yes.

Ms ALLEY: One of the workers I spoke to suggested that a way forward would be to recruit additional bilingual staff to the public system. I know that the recruitment of staff to the public dental system is difficult anyway but I guess that it would not necessarily have to be the dentist, it could be the dental assistant or dental nurse.

CHAIR: Or a therapist or hygienist.

The Hon. IAN WEST: I imagine that in most of the suburbs we are talking about there are probably 120 different languages. You would need to be a bit more than bilingual.

Ms ALLEY: Yes. That gets back to the initial point about additional funding for the interpreter service. That is what the interpreter service is meant to be there for, so that the public health system can access interpreters, given the array of different language groups. That would be my primary suggestion in relation to this, but we are putting up other ideas as well.

CHAIR: Would it help if public dental services were located with other big health services so you could bring a pool of interpreters together to service different needs?

Ms ALLEY: From talking to people in that system there is a centralised booking number. There are just not enough interpreters available. So you might know you are having a client coming in on a certain day who speaks a particular language, but there may be no interpreter available to service that client. I do not think it is necessarily about the co-location of services because the needs will vary, according to who the individual is, unless you were doing a group education session. Even then, if you are trying to match it up with someone else's events needs you are pretty unlikely to be able do it. I know, for example, that the interpreter service of the Illawarra Area Health Service, which is now part of the South Eastern Sydney Area Health Service, works very well, I think partly because it is a smaller city too. Even then, for some of the newer arrivals there is a difficulty just because no interpreters are trained from those countries. Compared to, say, Sydney, Illawarra works a lot better. The issue, from what I can understand it in Sydney, is that there are just not enough interpreters.

CHAIR: I guess that the Illawarra would have a smaller number of languages?

Ms ALLEY: Yes, probably.

CHAIR: Proportionately more people speaking fewer languages?

Ms ALLEY: Travel is also easier in the Illawarra. You can get across the city in less time. There is a better utilisation of people's time as well. The other suggestion that came up was providing education about dental services to general practitioners from particular cultural groups. People from different language groups may have a general practitioner who speaks their own language. If a general practitioner has an understanding about dental issues it might help to facilitate better treatment in the long term.

Ms DAVIES: I have a four-year-old daughter and a one-year-old. Recently I rang up to make an appointment for my four-year-old. I still brush her teeth for her. I do not know whether or not there is a hole in her tooth. I want her to have her teeth; I do not want the same thing to happen to her as happened to me. So I rang up the public clinic to get her in. Apparently she goes onto a waiting list somewhere. That could take from six to 12 months to come up. Once her name comes up they ring me back. I have to go on another waiting list at the clinic closest to me. So there is a base waiting list. When your name finally comes up on that you go onto the waiting list of the clinic that is closest to you. By the time that comes up she could have lost her teeth. They said that if she is in pain or anything I can ring up and they will see her immediately. That is for the children's services rather than for the adult services. It is a long wait as well. It works differently, as far as I can tell from the phone call, from the adult services.

CHAIR: You suggested earlier that the wait for children is shorter than the wait for adults.

Ms DAVIES: That is what I was led to believe. When I rang up the other day they said from six to 12 months.

Ms TAYLOR: That was without any problems.

Ms DAVIES: If she were in pain she said it would be shorter. But just to get her mouth checked it is quite a long wait.

Ms ALLEY: I rang one of the area health service dental clinics and found that the waiting list for children in pain was a lot shorter than for adults in pain.

CHAIR: For safeguard type checking?

Ms ALLEY: Yes. For a preventive check there is a long waiting list.

Ms TAYLOR: That is leading to worried parents ringing up and saying that their children are in pain to try to get them in sooner because they are concerned that within 12 months they might be in pain and then they would still have to go on another waiting list.

The Hon. IAN WEST: Did you indicate earlier that a number of your peers and friends have had similar difficulties?

Ms DAVIES: Yes. I know a lot of people who cannot afford the dental system. I know many people who walk around holding their jaws because they have toothache. Quite a few of my friends have had abscesses and their faces have swollen up. About three weeks ago my friend's eye would not open because the whole side of her face was so swollen. I work a lot with groups of disadvantaged people. The people that I know in those groups cannot afford—as I cannot afford—to go to a private dentist. Once your front teeth start going it really affects yourself esteem. So I know a lot of people who cannot afford it.

The Hon. IAN WEST: And they cannot afford health insurance?

Ms DAVIES: No.

The Hon. IAN WEST: It is out of the question?

Ms DAVIES: Yes.

Ms TAYLOR: Most of the young people I work with are either homeless or at risk of soon becoming homeless. So private insurance is certainly not on their list of priorities of things to pay for. Private dentists are totally out of the question in relation to paying for things when all you are really looking at trying to afford is your next meal. So many young people between 12 and 24 walk into the service each day—they are at quite a young age—with brown teeth, lots of teeth missing, and that sort of thing. I really do not think that is okay in Australia.

CHAIR: The only thing we have not done is ask you to enlarge on your comment about new models of service delivery, such as outreach clinics in a methadone unit or a youth service such as the one you were talking about. Do you want to tell us a bit more about that?

Ms ALLEY: Yes. I talked to some people a bit more after we received our list of questions, which was useful. The types of ideas that came up related to rural services. It could even work in Sydney, theoretically. We talked about things like mobile vans going to where people are in rural and regional areas. There is the issue of people in outlying towns not having the transport to get to the service. Even in different parts of a regional centre, as I said, it is difficult for people to be able to easily access such a service. You could have a van moving from disadvantaged areas, often concentrations of public housing, one day a week and moving to towns. I understand that to some extent they used to have that sort of system. That was one of the suggestions. I am aware that the cost of setting up dental clinics in existing organisations is very expensive. But there are examples of that with Aboriginal medical services having dental facilities on the service. Those sorts of things could work really well. It means that people are going to be able to access it where they are getting their other needs met. You might have some thoughts as well.

Ms TAYLOR: Because a lot of our service users are homeless they are transient. It is not really possible for them to say, "Okay, I will make an appointment in Campbelltown in a month's time", because they are not really sure where they will be or in what sort of state they will be in a month. We have talked about some of those barriers for culturally and linguistically diverse groups. A lot of the young people we work with have mental health issues or disabilities. That is a huge core of our group. It is real barrier for them to access a service. They call up a line and then they wait. Then they have to go somewhere to see someone. It can all become a bit too much for someone with a mental illness or someone who is experiencing that disadvantage.

In other services, for example, Centrelink and the Department of Housing, outreach workers come in and consult with young people in our youth service. They say, "We will listen to your situation, then we will advocate for you with that program." So it might not be possible to set up little dental clinics in each youth service, but someone could come out and have a quick look and say, "I can see you have pus coming out of your jaw. You need to see someone straightaway. I am going to call and get you in sooner." We need someone to advocate for those people, or just to talk to them about how to brush their teeth. I have taught a number of young people how to brush their teeth, even though I have no experience in dentistry. I know from my own experience how I brush my teeth. This would be an excellent opportunity for people to access that from a soft entry point.

CHAIR: Does that sort of thing happen in relation to medical services? Do they have visiting doctors?

Ms ALLEY: There are youth services that have that. It is a different model. There are youth services that have doctors who are funded through area health services. They are located there and they work a certain number of hours a week. I am aware of one youth service that has that sort of model, which I guess is a bit different from what you were talking about earlier. It is the same sort of principle. You need someone coming from a particular service who can advocate on behalf of a client and who can provide some education at the same time. Part of the issue is that young people also need a friendly face. They can build a bit of a relationship with the service provider. I think it all helps.

Ms TAYLOR: At the moment we physically take young people there and we sit with them while they are having treatment, if there is an access issue. I guess that is what we would do with

medical services. We often take them up to the medical centre and we wait with them to have that treatment, particularly if there is a mental illness. We are funded to work with people, to get them into accommodation and to deal with drug and alcohol issues. Our time is really limited and we do not have much time to focus on oral health. That is not anywhere in our criteria. It is just what we do because we do not want to see them go without that service.

Ms ALLEY: South Eastern Sydney Area Health Service set up a special needs service in the Mission Australia building for people with drug and alcohol, mental health and homelessness issues. It has a social worker who is also the receptionist. It feeds into a dental clinic there. There are models of services. That would be a more expensive type of service, but there are existing models that can be looked at, expanded or spread across. The oral health plans that are in existence or are in development have a lot of good ideas in them. It is about funding to get them implemented, and also funding just to get the basic service right so that people are not on huge waiting lists.

The Hon. IAN WEST: I am not suggesting that this is in any way ideal, but when you suggest that as part of your objectives oral health is not on the radar, is there a need for Burnside to put forward a submission that you want funding and you want oral health to be part of your objective?

Ms ALLEY: I think the question would be: From whom do you get the funding?

The Hon. IAN WEST: As a starter?

Ms ALLEY: In the process of going around and talking to our different services, service users and people have identified it as a big issue. The senior managers are now very interested to pick up on the issue. Burnside would probably have to seek external funding. The big question would be: Who from? It is not just about non-government organisation services; it is also about the public dental system and getting that sorted out.

The Hon. IAN WEST: Sure.

Ms ALLEY: We are always happy to receive funding.

CHAIR: Essentially, you and other witnesses have told us that oral health is just not on the radar. I guess you have to assume that funding might be more available if more people and organisations gave it a higher priority.

Ms ALLEY: I think the "not on the radar" comment might have meant that sometimes it is not on the client's radar because of different needs. In relation to that, any service tends to focus on the most pressing needs that come to the door. Oral health does not always appear to be the most pressing need.

Ms TAYLOR: Unless they are in an emergency situation, it has reached a crisis point and they cannot think straight about finding accommodation because of the pain.

CHAIR: Are your clients often resistant to any sort of dental work treatment? Do they shy away from it until the pain too much?

Ms TAYLOR: Definitely, probably general statistics would show that people, no matter who they are, do not like to go to the dentist. I know that young people have been quite resistant to treatment and sometimes that is because treatment has not been explained to them. Often times when a young person has accessed the public dentist they have said "You are going to have to have a tooth pulled out" but there is no discussion around why, what it will involve, the alternatives or anything like that. Young people would leave and say "Well, I'm not going back there, that's for sure". So it is that sort of confusion about what that actually might involve.

A lot of young people that I have worked with have never been to the dentist in their life; their family has never taken them there because they have not had that sort of background, so they do not know what happens at a dentist. If you talk about a dentist chair, they do not know what it is or what it looks like, so it can be very intimidating. When they have heard from people that going to the

dentist is horrible, and they have never been, and there is a possibility a tooth might have to come out, that would be enough to stop a lot of young people from going.

(The witnesses withdrew)

CHRISTOPHER STEPHEN WILSON, President, New South Wales Branch, Australian Dental Association, 71-73 Lithgow Street, St Leonards, and a practising dentist in Raymond Terrace, New South Wales, and

MATTHEW FISHER, Chief Executive Officer, New South Wales Branch, Australian Dental Association, 71-73 Lithgow Street, St Leonards, sworn and examined, and

BERNARD RUPASINGHE, Policy Officer, New South Wales Branch, Australian Dental Association, 71-73 Lithgow Street, St Leonards, affirmed and examined.

CHAIR: Do you want to make an opening statement?

Dr FISHER: A point of clarification: my doctor's title is a PhD, not a dentist so I will not be answering questions clinically.

Mr WILSON: We do not have a prepared speech. Bernard put a lot of work into the submission, with input from the rest of us, so we are happy to proceed to questions.

CHAIR: When we ask a question please do not hesitate to say that it is in your submission. Tell us about the New South Wales Branch of the Australian Dental Association [ADA]. What is your role? Who do you represent?

Dr FISHER: ADA, New South Wales Branch, is the professional association representing dentists both in New South Wales and the Australian Capital Territory and forms part of a federation. We do have a national entity that would represent on national issues and a federation structure that then looks at State issues. We have a membership that is 80 per cent of registered dentists, but if you look at a work force participation rate of what we understand of around 78 to 80 per cent that we have a representation both in the public and private sectors, that is above 95 per cent of active practising dentists. I need to reiterate that we do represent dentists in all sectors—public, private and academic. We see ourselves as being able to act apolitically to look after the interests of the public and the profession. Our core statement is about acting in the interests of the public and in the interests of the membership.

CHAIR: Do you have any representation or links of any kind with dental therapists or dental hygienists or any of those ancillary groups?

Dr FISHER: We certainly have links across ancillary groups or auxiliary groups, some are better developed than others. What I think we are aiming to do is to improve where we may have points of difference, or what is perceived as points of difference, whether it is internal or external groups, to look at how issues such as what this inquiry is going through and how they can be addressed. In the end if we take it from the perspective of what are best models of care and where might a government best spend its money, I think that we need to look at unbiased and unambiguous views to try to make recommendations back to those who are controlling from where the monies are coming.

CHAIR: Is there a philosophy of a team approach? How do you see the profession now and developing into the future?

Mr WILSON: The only way you can deliver dental services is with a team: it is not an individual effort; you cannot do without the other participants. I think whether you are talking about a public sector experience or a private delivery service, both of those require several types of team members. A dentist cannot do his or her job without the support of assistants and there are other team members that come into play, particularly in the preventative and educative roles, with a hygienist and then you also have technical support in the way of dental technicians and so on and so forth. That is supplied in both public and private sectors.

Dr FISHER: On page 5 of the submission we have put in some policy statement that talks about a national oral health policy and on page 6 that extends to a dental team which comprises a mix of dentists and appropriate allied dental personnel. On page 9 there is another policy statement that

talks about the dental work force and provides you with some definition of the different members that make up what would be seen as the dental work force and continues to then look at the responsibilities that each of those members would have under legislation.

The Hon. ROBYN PARKER: Doctors have a registration board and a medical tribunal, do dentists have anything like that?

Mr WILSON: Yes, the Dental Board of New South Wales.

Dr FISHER: The Dental Board of New South Wales this year, because of the change to the Dental Practise Act 2001, now requires dental therapists and dental hygienists to be registered as well. There is also a separate Dental Technicians Registration Board.

The Hon. ROBYN PARKER: That is right, we brought in those changes last year.

Dr FISHER: Yes.

CHAIR: Does the board have disciplinary type powers or an over-riding power to deal with problem areas?

Mr WILSON: The Dental Board has some disciplinary powers and can refer things to the Health Care Complaints Commission as well, and vice versa.

Dr FISHER: There is also the extension now with the Consumer, Trader and Tenancy Tribunal that would look at matters from a fair trading perspective. I suppose if I also put the overlay of the association, that a requirement for membership of the association is to abide by our code of conduct and ethics. There certainly have been instances where proven membership has then been removed or sanctions applied as a result of transgressions of the code of conduct and ethics.

CHAIR: Our second question appears to be a master piece of under-statement: there appears to be general agreement that the public Dental Service in New South Wales could be improved. We have not met anyone who does not agree with that—

Mr WILSON: Nobody wants to leave it as it is.

The Hon. ROBYN PARKER: There were a few defensive statements earlier this morning.

CHAIR: Possibly, but I am not sure they were denials.

Mr WILSON: That is understandable.

CHAIR: What are the main problems and options for improvement? I know it is a big question.

Mr WILSON: It certainly is, and you can go down a number of tracks. We see three thrusts. I am sure that all of your witnesses would bring up the issue of funding. Everybody knows that as it stands the system is under funded. It is a very small part of the Health budget. We in New South Wales spend a lot less per head on our public sector dental service than any other State and the Commonwealth, so funding is a really big issue and we could talk about that for the next hour without any problems at all, but I think it is a little bit more than that. You certainly have a work force issue. They have serious problems with recruitment and with retention when it comes to dentists who obviously we know the most about. Perhaps it is all tied up together.

You could say it is all to do with pay rates, and our public sector dentists are paid less than those in Queensland. Our public sector dentists are definitely paid less than even below average salaries in private practise. Our public sector dentists are paid less than other corporate players in the market place, so from a funding perspective that is all an issue. But the professional satisfaction, the range of service that people can provide or are limited to when taking a position in public dentistry is an issue. The load that they are under means that they can really only provide a limited range of services because it is unfair and inequitable to provide some very high-cost labour-intensive services

to a limited number of patients while others are suffering, so we understand that. So we understand that. That means that dentists in the system feel undervalued, they cannot use their full range of skills and they want to go on to something more fulfilling. That is a big issue too.

Dr FISHER: Once again, I draw you to a couple of points in our submission. We have looked at the funding issue, which starts on page 34. As a visual representation, if you look at the graph on page 37 it will give you a sense of the per capita State and Territory dental spend for 2004-05. This has all been sourced, as you will see, from people in positions of authority in each service. Also, given there is a lot of information for you to reflect on, we conducted a survey with our membership. Some of the points that Chris made have been reiterated by the survey results. This starts on page 50 where practitioners, particularly those within the public sector, responded. We have collated those responses. The Oral Health Strategy Group of New South Wales Health has utilised our survey as part of what they want to do within the work force. We have been looking at some co-operative information sharing so we are all trying to be off the same page.

The Hon. ROBYN PARKER: On the funding question, I note that New South Wales is the lowest funded per capita of any State or Territory in Australia. I note also on page 60 you say:

> The budget allocation for oral health was $109.7 million, representing 1 per cent of the total health budget.

Is that the total New South Wales health budget?

Dr FISHER: The total New South Wales health budget.

The Hon. ROBYN PARKER: That is the State health budget?

Dr FISHER: Yes.

Mr WILSON: Morale is a big issue for people in the service. I started my practising career as a public sector dentist. I did 18 months working in the clinic of Royal Newcastle Hospital. I am sure you know where that is, Robyn. Those days the patient load was large but the acute services could be dealt with pretty much the same day or the day after. We had allocated clinic times to deal with courses of treatment. People are getting seen initially as emergency patients and then going on to courses of treatment. Within three to six months they would have their basic problem dealt with. There was a lot of denture provision and so forth. It was a clinic of some 15 dentists. I understand that that clinic now is down to something like 6. The population of Newcastle has not got any less. The eligibility criteria have got wider. As to the demand on that service, I could not imagine what it must be like trying to cope with that on a day-to-day basis.

I did 18 months in that service. We got to help with a lot of things. There was on staff an oral surgeon and we got to help with motor vehicle accident cases. We got a wide range of experience, even though we might not have had a lot of experience on the very high-end type dentistry developments that were going on then. I am talking 25 years ago. You got good solid grounding. Unfortunately, I think the people who have to try to make that service function now really get to deal with only the emergency services and trying to get people out of trouble. That is the most they can do with the resources they have. For me 18 months was a good grounding and I went on to other things. I work in an area that is not what you would call a very rich area. It has a very wide cross-section of people. We do oral health fee-for-service patients and we do Department of Veterans Affairs [DVA] patients. We provide that sort of service to them too, at some cost but by and large it is viable for me. The further you get out it gets harder and harder.

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

Mr WILSON: My patients—the people who are coming to see me because they cannot get in—would say it is not. The service is not available. The amount of vouchers going out to private

dentists in my area means that the service is not able to cope with the demand that is being put on it. Anecdotally the people working in the service are finding it extremely difficult to continue to do so.

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

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

CHAIR: You heard the evidence from the people at Burnside. Do you endorse the bleak picture they paint of very disadvantaged people on waiting lists, the emphasis on extracting one tooth but not looking at anything else, and the various aspects of the service?

Dr FISHER: To give you another example of a similar group in need, we have members who have helped set up a clinic for the homeless in the Exodus Foundation. That is staffed by volunteers who give up their time looking at arrangements to gain equipment from dentists supply companies to try and fulfil that need. Their impressions are that there is a large demand. So there have been initiatives that have commenced as a result of trying to fulfil a role that should exist with another body doing it.

Mr WILSON: I was going to say, yes, I think that there is certainly a very big demand for the emergency services. That means that a disproportionate amount of resources have to be devoted to that aspect of dental care in the public sector at the moment. That appears to be the situation. The amount of resources that I in a private practice situation would devote to emergency care is only maybe a 10 per cent proportion of my resources. I have no doubt that the public clinics I know of have to devote a lot more of their resources to that. That is a multifactorial problem, particularly with the sorts of groups that the Burnside people are talking about.

Dental disease needs the patients to take care of themselves to make any meaningful impact. It will always be a problem for people who have real difficulty living. I understand that a large number of the people Burnside deals with have real problems with the basics of living. It will always be a difficult situation for them and they probably need a lot more help than anybody-else. I am certain the system is not geared up to help them.

The Hon. IAN WEST: This is probably an unfair question in that you represent the Australian Dental Association. Can you give us an opinion as to the possible moral judgements that dentists might make when people attend under the voucher system? Can you give us an indication as to how the voucher system works in terms of dollars?

Mr WILSON: I am not entirely certain what you mean by moral judgements. I will try to answer as best I can. Patients are given a voucher to receive a certain amount of treatment. I think it is up to $130 now, although they sometimes give two vouchers at a time to do it. The way the system works varies a bit from area health service to area health service. In my area the clinic or health centre issuing the voucher on behalf of the area health service rings around and makes the appointment for the patients and the patients turn up and are treated for the acute condition they have. All the dentists that I know who participate in the scheme try and do the best they can for those patients for that acute situation.

They will generally go beyond what the voucher provides for in that there will give uncharged for advice or point out things to the patient that they also need to take care of, which in a normal course of treatment you would charge for right from the beginning. That advice is provided because the voucher does not allow for thorough comprehensive type examination with x-rays and so forth. The acute problem is usually dealt with and some other directional advice is given to the patient as well. Different places I know work differently. Some area health services, I believe—and I am only going anecdotally here, I am not in the system issuing vouchers so I do not know—provide the vouchers to the patients and it is up to the patients to make their own arrangements. For us we choose to do it and we do it in conjunction with the area health service. They ring us and say, "Do you have a spot where you can see this patient within the next couple of days?"

The Hon. IAN WEST: It may be easier for you to give me an answer anecdotally as to the scope of dollars. What does the voucher allow them to do?

Mr WILSON: Generally it will cover the extraction of one tooth, which is what the bulk of the work is. I can tell you in the last two days we have had four vouchers. That has meant six teeth in the bucket. I nearly said on the floor, but I cannot say that. That tends to be the scope of it. You can provide restorative treatment if that can fix the problem without the patient running the risk of having a repeat episode fairly quickly. Most of the people who come to us are already in such a state and in such a situation that you can only fix the problem that way, unless they can spend $500 or $600 trying to fix the problem, which is out of the question.

The Hon. IAN WEST: I think you have answered my question.

Dr FISHER: If I can add to that, in the submission from page 42 onwards you will see some comments and review about the oral health fee-for-service scheme. I suppose the other point to pick up on the moral perspective is that we know through our members the amount of pro bono work they do or waiving of fees. We made the submission when the national competition policy issue was around last year that, conservatively, people in the private sector are waiving at least $30 million with regard to fees, whether it is for people trying to access public services at a State or Federal level. So I do not think there is a moral judgment being made, I think people are trying to provide services when they can.

The Hon. ROBYN PARKER: How does the fee for service compare with the DVA reimbursement?

Mr WILSON: What you would do for $130 on the fee for service is probably about a $150 to $160 return on DVA.

The Hon. ROBYN PARKER: But there is no limit with DVA, I gather?

Mr WILSON: No. There are restricted services on DVA, very mild restrictions: crown work, bridge work, that sort of thing is restricted or needs prior approval or so forth, but all the general dental services right up to root canal work and oral surgery, if necessary, can be done unrestricted, yes.

The Hon. ROBYN PARKER: With the fee for service do dentists have to give an assurance that the course of treatment that they have taken is not likely to reoccur?

Mr WILSON: Not as specifically as that. The assurance is that we will do the best we can for the patient, the same as we do for all our patients.

CHAIR: But the DVA system enables you to use your professional judgement because you know that the person can come back again. You can say, "It would be better for me to do this today and then they will come back later and then I will do that"?

Mr WILSON: It is. It is more a question of whether the patient has the time, the facilities and the resources to be able to undergo a course of treatment of DVA.

CHAIR: But you have got that confidence that DVA will pay?

Mr WILSON: Yes. There is virtually never any question about it. There are issues with that, but that is for another forum. By and large, yes, you are exactly right.

The Hon. ROBYN PARKER: But with fee for service they go back into the pool and back onto the waiting list after the one-off visit?

Mr WILSON: Nine times out of 10 you would never see them again. If the patient is a marginally eligible patient and they have a reasonable experience with the oral health fee for service scheme they might ask you what it will cost to fix something else and they may become some sort of regular patient on a part-time basis.

The Hon. ROBYN PARKER: So there is no ongoing maintenance of their records then? They do not go back to a pool somewhere; you would keep a record of that patient for that one-off visit? The next dentist they go to has a record of their one-off visit, et cetera?

Mr WILSON: Yes, that is right. I do not know what the system is at the area health service but they do not ask us to send in a detailed medical record of the patient. The material that goes back to the area health service nominates what was done by item number. In other words, they know which tooth was taken out or which tooth was repaired and how big the repair was.

CHAIR: So there is a complete lack of any kind of clinical history for most?

Mr WILSON: I would say so, yes.

CHAIR: It is interesting, I think you just said that nine times out of 10 you never see the person again even though practising, as you do, in Raymond Terrace you have got a reasonably easily defined geographical drawing area, have you not?

Mr WILSON: It is a bit more diverse than that. After us there are not too many people pass us; it is quite a bit geographic area, which of course is a problem for the distribution of the work force in New South Wales and in the public sector as well.

CHAIR: I was just going to say, the impression we got, talking to the Burnside people from the other side of the equation, is that one of their criticisms is you never get to see the same dentist twice. They are talking more perhaps about Sydney experiences that you do not see people twice, although that is not because of choice, but they do not see people twice either and they think it would be better if they did.

Mr WILSON: That is a criticism that has been levelled at both public sector clinics and health fund clinics for many years because of the turnover of staff, and it goes back to that recruitment and retention issue. When I worked as a public sector dentist, patients used to ask to see the same dentist again, and wherever possible we did it. I could not imagine that would be easy to organise under the current circumstances and from what I see, it is very difficult for them to provide any more than emergency care, so there are not too many return visits.

CHAIR: Would it not be better to scrap the whole system and put dental services under Medicare so that you did not have to have the sort of struggle in the public system and the kind of half-privatised vouchers and then a private system?

Mr WILSON: The problem with that is, I think I mentioned before in answer to an earlier question that part of dental disease is controllable, to a degree, by the patient; it depends on the patient's choices and the patient's lifestyle and so forth and how much they are prepared to take responsibility for looking after themselves. The investigations of putting the industry under Medicare that have been done in the past have certainly come to the conclusion that that would be an extremely expensive thing for any government to do and there would be some question as to whether the taxpayer would be prepared to fund it to that degree.

CHAIR: What about the view of the dental association? In the past dentists have opposed the idea. Is that still your position?

Mr WILSON: Yes, it would be for those reasons more than anything. We just do not think it would be supportable. We put a submission in to the Senate select committee in 2003 about exactly that issue. So it is still policy for it not to be included under Medicare. It would be an administrative nightmare; it would be very difficult to run. Part of the criticism of DVA, for instance, is that the cost of administration is quite significant on both sides of the fence, both from the department's side of things and also from the practising dentists' side of things. The form filling out and submitting and all of that sort of thing is costly for us, it is costly for them to do and a scheme like Medicare will do that, but I think it would be a pretty brave fiscal move for any government to include us under Medicare. And I think you are not going to do that from a State point of view anyway, are you?

CHAIR: No. I think you said earlier that DVA managers have some restrictions, for instance, on crown and bridge work?

Mr WILSON: Yes.

CHAIR: Presumably that is partly because that is the more expensive end of the service, so that would presumably operate if there were a Medicare-type—

Mr WILSON: I imagine the restrictions would be a lot greater.

CHAIR: But is it very hard to draw the lines of needs and wants? Drawing the divisions?

Mr WILSON: Yes. They would be hard lines to draw, and I think the administration, as a result of that, would be more complex and difficult. That would be my assessment of it.

The Hon. IAN WEST: You do not see it is worthwhile investigating?

Mr WILSON: I think that you can investigate it but I think you would spend an awful lot of money investigating it as well. I do not see how it can help you from a State perspective; you would need the Federal Government to do it for you. I just do not see it as being a workable solution.

The Hon. IAN WEST: We are trying to get appropriate finances for people to be able to get decent treatment for their teeth, I would have thought.

Dr FISHER: Just to interject for a moment; in our submission on page 34 you will also see where we have made some statements about the funding and I think we are clear where you are leading to. We are saying both State and Federal funding should be made available for the provision of public dental services. Based on the submissions we are saying the Federal Government should play a leading role in developing and co-ordinating a national approach to oral health planning. All levels of government should ensure that adequate funds are provided to meet public oral health needs. So we do support that it is made available.

The Hon. ROBYN PARKER: In terms of the funding, and specifically State funding, given that New South Wales is the lowest of any State or Territory, what representations has your association made to the State Government about that very issue, if any?

Mr WILSON: I would say up until this year we have had very little effect on getting to talk to the State Government about funding for dental services. We have made several approaches over the years about the problems of the public sector dental scheme but generally no one was interested in listening. So we are really glad to see this inquiry happening.

The Hon. ROBYN PARKER: But you are a peak organisation. You are the dental association for New South Wales. You telling me that the department and the Minister are not in communication with you and are not responding to your concerns?

Mr WILSON: Until recently I think that is probably a fair summation of what has been happening for the last five years.

The Hon. ROBYN PARKER: Your members must be outraged by that.

Mr WILSON: I think their dealings with the Government have generally desensitised them to that.

Dr FISHER: We also did market research of the membership and got a sense of where some of their concerns and issues may have been, and certainly I think they have wanted to see some action in different areas from the Government. I suppose, as one point, when a budget comes out it is very hard to actually find the allocation to oral health in New South Wales—

Mr RUPASINGHE: We still have not found it.

Dr FISHER: We are running off the reports that we can get through NSW Health specifically. And I suppose the other part to that, in the Dental Health Services Victoria they had the Auditor General do an audit of spend within oral health care. It was quite interesting to look at that because then you can look at the distinction that goes to direct services versus what may be directed into support services or whatever else. So if the intention is to try and get best bang for the dollar and those in need being in receipt of the services, one of the first steps would be to make sure the available funding is being directed to where it is going to have that best effect.

CHAIR: There was an increase in this year's budget in New South Wales. Not a huge increase, but have you managed to find that in the budget papers?

Mr RUPASINGHE: We have heard various figures from 113 up to almost 120 million. But one of the things that we would say is particular disappointing is that if you look at the financial year 1996-97 when the Federal Government stopped the Commonwealth dental health program, that year New South Wales—combined Commonwealth and State funds—was spending $103 million. Almost a decade later we are only up to $109.7 million, so less than a $7 million increase in almost a decade. That is a pretty damning indictment really.

CHAIR: They are now up to 120 or 121.

Dr FISHER: I think the extension of that is also saying that might be the global level of funding. But we have certainly received reports from people in area health services where they would say that not all of that is able to be spent, so therefore it gets redirected into general revenues. I think that then leads to—

CHAIR: Do you think that is partly because of unfilled vacancies?

Dr FISHER: That then goes to some of the structural issues. Going back to your first question that was raised about what it is; certainly structure is one of those and I am sure you have heard that from lots of witnesses at the inquiry. I suppose to put that point on that, a lot of discussion and research has gone on but I think that the level of action is something that has not been as apparent—and there are some key points in that as well which are about co-operation and co-ordination too—if we go back to the point of how does a publicly eligible person get the level of care and the quality of care they are wanting, at this stage the structure of that sector would not support that.

CHAIR: Just finishing off on criticising everyone on funding, I note also on page 34 that you are critical of the 30 per cent rebate on private health insurance and the way it works to deliver money to more affluent people. You suggest that more attention needs to be focused the other way.

Mr WILSON: Our problem would be that if you dismantled it would the money get directed to the right people? At the moment that is money being spent directly or indirectly on dental services, and it is providing dental services to a range of the population. It means that in some places practices are viable and being run, and that increases the accessibility of services. If that was taken away, would the Government spend to the effective subsidy on public dentistry or in dental services?

CHAIR: I assume, in terms of making practices viable, it would probably also contribute to the overrepresentation of dentists in Sydney's eastern suburbs and on the North Shore, for instance.

Mr WILSON: I am not sure that that would be particularly different, whether that was there or not. I think that overrepresentation was probably there well before that subsidy was ever placed there.

The Hon. ROBYN PARKER: If you take that off—

Mr WILSON: We have a fairly wide spread of people across the metropolitan area. It is not like it is all clustered.

Dr FISHER: This is showing a representation of where practices are located in the urban Sydney area. I think there is a sense of concentration but I think what you can see, if you do the 15-

kilometre radius around, is that there is quite a spread of practices in Sydney. Certainly, if it would be helpful, we can make a reproduction of this available.

CHAIR: There does not appear to be many west of a line going through Parramatta.

Dr FISHER: There is a concentration in Parramatta and then you start to get a spread. It just goes to show that we are concerned about a distribution perspective but we will make this available to you.

CHAIR: We know that you need to leave. Obviously some of these have been dealt with in your submission. Is the issue of continuing education for dentists addressed in your submission? And the work the association does in making sure that dentists—and we have been told that it is an aging profession—are kept up-to-date?

Mr WILSON: The New South Wales branch of the Australian Dental Association has been very proactive in continuing education. We started a continuing education arm some five or six years ago.

Dr FISHER: Seven in total.

Mr WILSON: Seven years ago and then approximately three years ago the council took the decision to fund and build a dedicated facility at our offices in St Leonards that has four dental chairs and 20 training work stations where we provide and underwrite continuing education courses for our membership. So we have had a very proactive role in that. Prior to that we always encouraged the membership to be involved in continuing their education, and it has been a big part of our focusing budget for many years.

CHAIR: It is not mandatory under the Dental Board.

Mr WILSON: It is not mandatory under the Dental Act but it is certainly encouraged for our membership.

Dr FISHER: To follow on with it, again with the market research we have done on our members and just statistics, we know that more than 2,000 of our members have participated directly in some form of education that we have offered, let alone that six times a year we send an audio CD to all of our membership discussing what is called best practice in dentistry. For example, an upcoming issue of best practice has an interview with the president of the Dental Board to have an hour-long discussion about the Dental Practice Act, it changes, its relationships with health care complaints and other matters so that dentists in practice are doing the best that they can for the public.

The Hon. ROBYN PARKER: When you do those training sessions where do you draw your patients from?

Mr WILSON: At the moment patient participant training is very limited for the reason that you are suggesting. We do not have access to public patients so dentists who want to upskill on a new technique under a mentor would bring their own patient to the centre. By far and away the vast majority of the programs are on demonstration models of some sort or simulation stations, just as they are at the various stages of the course initially before they migrate to patient treatment.

Dr FISHER: There is some discussion with the Australian Capital Territory jurisdiction, for example, where they are moving towards mandatory continuing education that with our facility we will probably have some role in recency of practice and upskilling to enable people to comply with the change in legislation they have had there.

CHAIR: We have not asked about the number of dentists and whether there is a current shortage, a looming shortage.

Mr WILSON: Which one do you want to do first?

CHAIR: It is your call.

Mr WILSON: The situation with dental internship, our preferred model or work force policy is that we are in favour of a system along those lines because we are concerned about the pressures that have been put on the university over the years with clinical time and so on. This made it difficult for it to provide the undergraduate dentists or as it is in Sydney now the post-graduate students or graduate entry students with what a lot of us would consider to be adequate clinical time. They do a very good job with what they can but it would be nice if the more senior students and in your first year or so of graduation you would be able to practice in an environment where there was someone to support you. So from that point of view an internship sounds great and it certainly is well entrenched in medical courses around the country and around the world.

The difficulty for us as we see it at the moment is that there is not a structure out there that could provide this. The public sector dentistry is under extreme strain right now. To ask them to provide support for an intern in various areas would be literally impossible. There would not be the supervision or the support that would be needed to benefit the first year graduate doing that sort of work. The range of procedures that could be done, as I think generally people have agreed, is very limited at the moment because of the pressure that the system is under. So if we can go down an internship route, it cannot happen until the structure to support it can be put in place, and that certainly will not happen overnight.

To ask people to go into an unsupported internship year will not help anyone. I have no doubt that the first year graduates who come and work in private practices like mine with somebody who has been there and done that gained a lot more from that than having to try to work unsupervised in difficult circumstances, which would be the worry in that structure as it is at the moment. So I think there would have to be a lot of rebuilding.

CHAIR: Could it be introduced in stages?

Mr WILSON: Yes but I think the first stage would be to rebuild the system that we have at the moment to the point where it can provide a reasonable range of services to the patients who need them. You would then get benefits to the public and to the profession.

CHAIR: So you would need to increase the number of practitioners before you would have enough people to make an internship program viable.

Mr WILSON: I believe so, yes.

Dr FISHER: I think the other part that will be interesting from the student's perspective where the level of indebtedness that a student graduates with, conservatively close to $100,000 with the HECS load, that in the implementation of any system—and we are on record in supporting vocational training or new graduate experience or whatever title you want to give it; and you will see that in the submission—but unless the experience within the sector is going to be a fulfilling one for them you would not want to necessarily achieve a reluctant work force that is seeing time. I will use an example in terms of a closer competitor to the public sector, and this is as told by people in the public sector—other health fund clinics. We are aware of an example where one final year student at the moment is on a bonded scholarship close to $15,000 with a view that their commencing salary next year will be close to $90,000. That in itself will provide a challenge with regard to award rates and structures. So that is where we go back to that initial part of what is the sustainable structure and career path to get a vibrant public sector which we see as crucial for both the public requiring service, the relationship with the tertiary education sector and the relationship with the private sector.

The Hon. IAN WEST: However, to have any vision of that structure, I find it difficult to envisage yourselves standing alone. Unless you are integrated into the broader health system it seems that you are heading for a situation where your funding will become more stunted.

Dr FISHER: I do not think we have ever made representations that we do not see an integration into general health in terms of the acknowledgement—and you will see that in policy statements as well—that oral health care is part of general health. So it depends on whether you are talking about overlaying models that you see in medicine with regard to internship or is it the acknowledgement that dentistry is part of general health or separate.

The Hon. IAN WEST: No, I was trying to come to grips with how you structure the funding, and if there is not any—

CHAIR: For training or for the whole system?

The Hon. IAN WEST: For the whole system and how you graduate that funding and how it links into the rest of the health system. I am having difficulty visualising the future of standalone funding.

Mr RUPASINGHE: That is the problem.

CHAIR: It has traditionally been.

The Hon. IAN WEST: The funding is traditionally shrinking. It is inadequate, to state the obvious.

Dr FISHER: As everyone agrees.

CHAIR: On the training issue and the HECS debt and all of that, did the association support the University of Sydney's move to the graduate entry program, which means a seven-year training period in total and then any internship would be on top of that?

Mr WILSON: At the time I think it is fair to say that the association was not asked. If you want a retrospective opinion I think at the time probably our membership did not see any great benefit in it. Whether there is a benefit in it or not, I think the jury is still out, and I am sure that the faculty will find that out eventually but we were not part of that process.

Dr FISHER: We have subsequently participated in a recent strategic planning forum with the faculty where we are hopeful that our views will be listened to a bit more, given the interrelationship that occurs between the place that goes to graduate a lot of our members and the reciprocal view that they want to see the faculty, as the ADA does, we want to see the faculty presume a place of prominence and vibrancy.

Mr WILSON: Work force.

CHAIR: Yes. Are there enough being produced in New South Wales, and in Australia in general?

Mr WILSON: The statistics that we have been able to find from the surveys that have been done all point to there being a shortage. Whichever way you cut and dice it, there is a shortage. It is just a question of how big the shortage is. Depending on what the environment is or what point of view you are coming from, that might vary a bit, but essentially there is a shortage. There is probably a worse distribution problem overlaid on that shortage, which means that many geographic areas suffer considerably.

CHAIR: And the public sector suffers?

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

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

Mr WILSON: Our research and statistics says that it will, yes.

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

CHAIR: Because of the age structure?

Mr RUPASINGHE: It corresponds with the big retirement of the baby boomer generation.

Dr FISHER: One of the things that we also did in our market research in trying to project forward is look at things such as intention to relocate, intention to retire, the perception of business within a practice, where are the areas of need. We were able to break that down from metropolitan, regional and rural so we have a sense from our membership's view also of what will be sustainable. At the moment we have commissioned some further research that will look at practice viability with the overlay of demographic projections. With that map, basically you were shown what we will be able to do. We will be able to look at overlays of growth and try and get a sense of where in New South Wales the likely shortages are now and which will be most acute.

CHAIR: We have heard that New South Wales imports dentists from South Australia. Do we also import a growing number perhaps from overseas?

Mr WILSON: I think the overseas registrants per year in New South Wales outnumber the faculty registrants. I think that is the figure, is it not?

Dr FISHER: Yes.

Mr WILSON: You gave a talk to 40—

Dr FISHER: On Saturday, there were the Australian Dental Council preliminary examinations which were being conducted at the Sydney Dental Hospital. We speak to each group twice a year and there were 40 participants on Saturday.

CHAIR: Was that 40 overseas trained?

Dr FISHER: Overseas trained dentists.

CHAIR: And the University of Sydney is producing how many graduates a year? There was a 45 intake.

Mr WILSON: I think its intake this year was up to 80 or 85, but that 40 was sitting the half-year examinations.

Dr FISHER: That is right. In the previous six months, there was closer to 50. What we would see in our pattern of application for membership is that our greatest inflows are Australian Dental Council and internal faculties, which is where students are completing the BDent. We would then have interstate transfers and South Australia tends to be the greatest State where we would be getting the inflows from. It would be about that order—close to equal between the Australian Dental Council and the University of Sydney. Secondary would be interstate, and predominantly the interstate inflow is from South Australia.

CHAIR: When you say the Australian Dental Council, that is the body that certifies the qualifications of overseas trained dentists.

Dr FISHER: Yes, that is correct.

Mr WILSON: Although there are a number of areas that are recognised without having to sit the examination, of course.

CHAIR: That is with New Zealand?

Mr WILSON: The mutual recognition with New Zealand, yes.

CHAIR: In the future, we will be more reliant on overseas-trained dentists?

Mr WILSON: That appears to be the situation, yes. We are reasonably reliant on them right now.

Dr FISHER: We have certainly made our views recently known to the Minister for Health again. On 10 May we wrote to him regarding overseas trained dentists' registration.

CHAIR: Is this the State Minister or the Federal Minister?

Dr FISHER: It is the State Minister. Certainly we could again make that available to you as well, if that is helpful.

CHAIR: Yes. That would be useful. We know we must finish, but to get it on the record, what is the association's position on fluoride?

Mr WILSON: We have supported the fluoride initiative since 1956 or something along those lines. The issue comes up reasonably constantly and cyclically. By far and away the majority of research that we have accessed and looked at is fully supportive of water fluoridation. The most recent thing that we have done actively is provide seed funding for the Save Our Smiles campaign which started in the Northern Rivers area.

Dr FISHER: That was the Teeth For Life campaign.

Mr WILSON: That was on the mid North Coast. That was last year at a cost of $5,000.

CHAIR: Was that in conjunction with the New South Wales Health campaign?

Mr WILSON: Yes, it was.

CHAIR: That seems to be focusing on the mid North Coast to be directed.

Dr FISHER: Yes.

Mr WILSON: There are also areas of focus at Mudgee. I think I read recently that the authorities in Mudgee have decided to fluoridate. They have not quite got that over the wire yet, but that appears to be the direction in which things are going. There is a lot of quite recent information that shows that it is effective quite close to home. With the expansion of Sydney Water into the Penrith and Blue Mountains area, there has been a noticeable change in the dental statistics in that area. That was not by a council deciding to fluoridate; it was just purely because those areas started to receive fluoridated water from Sydney. That same research group, the Spencer's group from Adelaide which was not even a local research group, demonstrated that there has been a change in the dental statistics there. Whatever helps the patient, we are in favour of it.

CHAIR: Would you support making it mandatory for local government areas to fluoridate?

Mr WILSON: I think yes, we would. It is politically difficult for you, but I guess that is not our problem. From our point of view, the benefits are proved and well known. The risks are well understood and are absolutely minimised to the point where I think you would have to say you could ignore them. The safety mechanisms built into the types of fluoridation of the water supply that are done now are very, very good. I think you would have to say that we would be in support of having State legislation to do it.

Mr RUPASINGHE: It is also probably fair to say that if it was taken out of the hands of local councils, the groups that are antifluoride tend to be able to get a lot of traction in those local communities. Very small numbers of them can create quite a big stir because of just throwing in words like "cancer" and "poison" whereas if it was taken out of such a local setting, we do not think they would get anywhere near as much traction as they currently do.

Dr FISHER: You will see in our submission, starting at page 56, where we discuss preventive dental treatment and initiatives and population oral health. Also we have brought in separate copies of both "About Fluoride" and some "Dental WorkForce" monthly updates that would give you a sense. Certainly with the initiative that has been occurring that has been focused on the

Coffs Harbour area, we have supported it actively in terms of funding, and supported it directly by providing all of the kits.

We have assisted the project manager in the lobbying of the councils, the media and in arranging letters of support to water bodies such as Rous Water to try to keep them firmly in their decision to fluoridate the water supply. Picking up on Bernard Rupasinghe's point about cancer, there was a recent media article and the President of the Cancer Council wrote and stated that there is no link, to try and again take away the emotive exploitation that people do have.

CHAIR: The Hon. Robyn Parker has moved that we accept these tabled documents, one of which is a public document.

Documents tabled.

CHAIR: I will ask a question that keeps coming up. Does the fashion for bottled water mean that some of the benefits of fluoridation are being undone?

Mr WILSON: I would say that the jury is still out on that. It would take quite a lot of targeted and detailed research to be sure that that is happening. The indications are that it may be. Part of the reason that it is a little difficult to tell for sure is often that groups who have gone over to bottled water are also participating in other activities that create them some teeth problems. Heavy exercise and rehydrating with sports drinks cause some wear problems and things like that. It all gets put into the mix. To separate out what is causing what takes quite a bit of careful, detailed and targeted research. I would not be prepared to categorically say, yes, it will give us some really big problems, but I would be prepared to categorically say that if we took the fluoride out of reticulated water, we would have a lot more trouble than we do now.

CHAIR: We will have to conclude there. We kept you longer than we anticipated. I thank you very much for coming, for your submission, which is very comprehensive, and also for the other useful documents you have given us.

Mr WILSON: Thank you for giving us a chance.

CHAIR: I think you may have taken one or two matters on notice. The staff will check the transcript to see whether there is something you said you will get for us.

(The witnesses withdrew)

(The Committee adjourned at 4.43 p.m.)