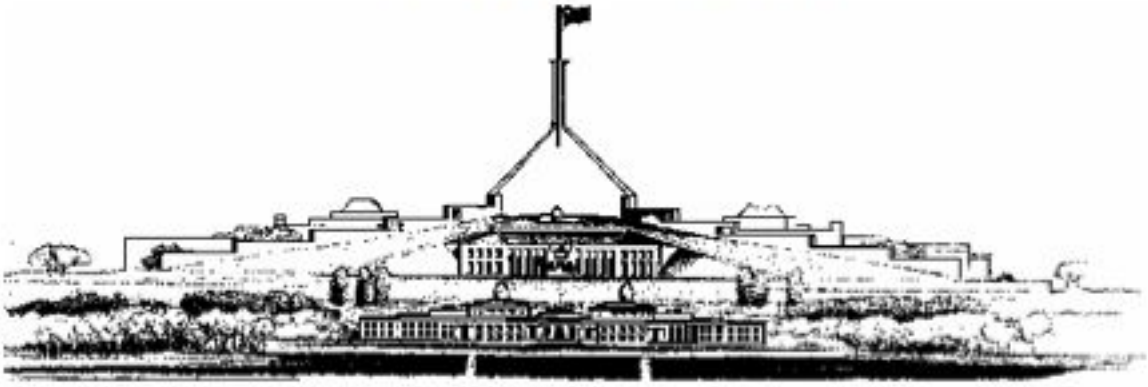
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



HOUSE OF REPRESENTATIVES

COMMITTEES

Health and Ageing Committee

Report

SPEECH

Monday, 17 June 2013

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

SPEECH

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Questioner		**Responder**	
Speaker	Irons, Steve, MP	**Question No.**	

Mr IRONS (Swan) (10:35): I rise to join with the House of Representatives Standing Committee chair on the tabling of the report *Bridging the dental gap: report on the inquiry into adult dental services*. I also note that some of the secretariat are here and congratulate them for the work and effort they put into the report as well.

The terms of reference for the inquiry were to identify priorities and inform the NPA such that it can be framed to meet the particular and localised needs of each state and territory, specifically: demand for dental services across Australia and issues associated with waiting lists; the mix in coverage of dental services supported by state and territory governments and the Australian government; availability and affordability of dental services for people with special dental health needs; availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations; the coordination of dental services between the two tiers of government and privately funded dental services; and workforce issues relevant to the provision of dental services.

The report states that although there have been substantial improvements in dental and oral health in Australia over the last century, the Australian Institute of Health and Welfare's publication, *Australia's health 2012*, reports that almost everyone will experience an oral health problem at some time in their lives and that over 90 per cent of adults show signs of treated or untreated dental decay.

There are many factors that contribute to poor dental and oral health, and the interaction of factors associated with this is complex. The report states that as well as individual factors there is a complex interplay of structural, social and economic factors. Some of these factors associated with poor dental and oral health in adults include possession of a concession card. Concession card holders are more likely to have poorer oral health compared to non-cardholders. This is linked to unfavourable dental-visiting patterns, which include not visiting the same dentist, not visiting yearly and seeking treatment for a problem rather than getting a check-up.

Access to public sector dental services' limited funding and workforce shortages within the public sector have been identified as contributing to poorer oral health status of eligible patients. Remote, rural and regional residents have a higher rate of unfavourable visiting patterns at 38 per cent, which increases the risk of poor oral health as compared to urban residents at 27 per cent.

Also, individual behaviour, and diet and oral health behaviours contribute to oral health—for example, the consumption of sugary and acidic foods can lead to an increased risk of dental decay. The discipline of brushing your teeth at least daily is a personal responsibility that parents need to encourage.

I want to touch on the closure of the Chronic Disease Dental Scheme, which was raised as an issue by some submitters who were concerned about the provision of dental services to people with special needs. The CDDS was closed to new patients on 8 September 2012 and to all patients on 30 November 2012. The Commonwealth Department of Health and Ageing noted that 76.7 per cent of CDDS patients are also eligible for public dental services and so are expected to be able to receive treatment by state and territory services. The Department of Health and Ageing advised the committee that those not eligible for public dental services are expected to access services in the private system.

The Dental Hygienists' Association of Australia would like to see a replacement for the recently abandoned CDDS. The Australian government has not outlined any viable replacement for this scheme. As a result, many chronically ill patients are without a scheme focused on their needs.

The committee visited Charles Sturt University at Dubbo and saw a fantastic clinic that would be a good model for regional areas, and this report goes into many facets of what a good system could be and how it should be structured. As with all health issues, the remote, rural and regional areas have fewer resources, and so we see more long-term problems with health in those areas. In finishing, the report states that the AHHA also expressed concern about the inefficiencies and the potential for duplication observing. After many years of minimal involvement by the Australian government in the funding of dental programs, there are now myriad of

programs being administered by a range of departments and agencies. There is a significant risk of inefficiency, duplication and waste as a result of an uncoordinated approach to the planning and implementation of new initiatives and integration with existing programs.

This report, hopefully, goes some way to assisting the government of the day to achieve better dental and oral health outcomes for all Australians. I also thank my colleagues who attended all the hearings and the committee get-togethers to go through the report. The recommendations are noncontroversial, except maybe for recommendation 3, about which I am sure we will hear back from the industry sometime once the report has been tabled. Again, thanks to the secretariat and also, I commend this report to the House.

The DEPUTY SPEAKER: The time allotted for statements on this report has expired. Does the honourable member for Shortland wish to move a motion in connection with the report to enable it to be debated on a later occasion?