

Fair Dental Care For Low Income Earners

National report on the state of dental care



Executive Summary

Oral health in Australia

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.¹

The impact of oral disease on people's everyday lives is subtle and pervasive, influencing eating, sleeping, work and social roles. The prevalence and recurrences of these impacts constitute a silent epidemic.²

Australia's oral health is characterised by very good but worsening child oral health, high levels of oral disease among adults and major disparities in oral health and access to dental care between high and low income adults.

The social impacts of poor adult oral health are immense. Over a quarter of Australian adults experienced painful aching because of problems with their teeth, mouth or dentures in 2002. A quarter reported avoiding foods and nearly a third reported that they found it uncomfortable to eat. Just under a quarter of Australian adults reported that they felt self-conscious or embarrassed because of oral health problems.³

Those with particularly poor oral health and who are most unlikely to be able to access dental care are low income adults, people living in rural and remote areas, indigenous people, nursing home residents, people with disabilities, young adults on income support payments, and single parent households.

While the problems of access to dental services are most acute for low income and disadvantaged Australians, twenty three per cent of the adults not eligible for public dental care (2.3 million people) report that they delay or avoid treatment because of the cost of dental care.⁴

Government response

A comprehensive national oral health plan, *Healthy Mouths, Healthy Lives, Australia's National Oral Health Plan 2004-2013* was endorsed by Australian Health Ministers on 29 July 2004.⁵

The plan acknowledges that "profound disparities exist across socio-economic groups in Australia with respect to oral and general health. In particular, the incidence of caries and periodontal disease increases as socio-economic status decreases. These two most

¹ AHMAC, p.v

² AHMAC, p.v

³ Spencer (2004), p.18

⁴ Carter and Stewart, p.71. Eligibility of adults for public dental care varies from state to state but generally includes Pensioner Concession Card holders, Commonwealth Senior's Health Card holders, and Health Care Card holders (low income individuals earning less than \$21,840 or families earning less than \$39,936, including people on workforce age benefits or allowances).

⁵ AHMAC, p.ii

common oral diseases lead to poor social and health outcomes in vulnerable populations. Both are amenable to prevention using safe and effective methods.”⁶

Under the Plan, Health Ministers agreed that good oral health for disadvantaged and low income Australians will be achieved through allocating resources equitably and efficiently to achieve maximum health gains across the population, and through improved access to affordable, timely and preventively focussed oral health care.⁷

It is now over two years since the Health Ministers’ endorsement of the National Oral Health Plan. By this time, the agreed short term actions should be implemented and the medium term actions should be under way.

While some progress has been made, the overall achievements have been disappointing. That this is the case reveals what ACOSS believes to be the core problems with oral health and access to dental care in Australia - insufficient government commitment to implementation in all jurisdictions and the lack of a clear role for the Commonwealth Government.

The Commonwealth Government is uniquely placed to exert its leadership in improving the oral health of low income and disadvantaged Australians. The Commonwealth Government’s current Budget surplus is in excess of \$10 billion and the Prime Minister and the Council of Australian Governments recently demonstrated how national leadership can drive implementation in the case of mental health policy and cancer services.

The fact that 40% of adult Australians cannot access dental care when they need it demonstrates the continuing need for the Commonwealth Government to increase its funding commitment and exercise its leadership in planning a more efficient, sustainable and equitable system of oral health promotion, prevention of disease, and treatment.

ACOSS believes that the renewal of adult dental care must be built on the Commonwealth Government taking responsibility for covering the minimum costs of basic dental care for adults who cannot afford the high cost of private fees.

That is, the Commonwealth Government should cover the cost of a comprehensive oral health check⁸ or the cost of a basic course of treatment⁹ every two years for eligible adults. State Governments would be responsible for meeting any other additional treatment costs for eligible adults and for planning and delivering oral health care to eligible adults according to need.

The Commonwealth’s role would be similar to its established role in supporting access to primary general health care through Medicare payments to General Practitioners, but on a means-tested basis. Medicare includes a range of population-level measures (immunisation) and targeted incentives (enhanced primary care health assessment for

⁶ NACOH, p.27

⁷ NACOH, p.3

⁸ Including scale, clean and x-rays

⁹ Eg fillings or treatment for acute gum infection

people over 75 years and in residential aged care) that are practice-based and attach GPs to wider care planning that is not always through individual fees for service arrangements.¹⁰

To better ensure coverage of the 21% of adults who are not eligible for public dental care but who avoid or delay treatment because of the cost of basic dental care, the income limit to qualify for Commonwealth Low Income Health Care Cards should be increased from \$21,840 to \$26,208 for individuals and from \$39,936 to \$47,923 for a couple family with two children. (This would only be for purpose of access to publicly funded dental care). Eligibility for a pensioner or health care card should define the minimum eligible population against which State government performance in addressing needs and meeting performance targets should be measured.

The estimated cost to the Commonwealth of this measure will be \$798 million per annum at the end of five years.¹¹

The money should therefore be provided to the States to use flexibly but with the Commonwealth using its investment to leverage state performance in:

- Undertaking community wide oral health promotion and community education.¹²
- Planning and providing dental services for concession card holders according to need, including provision of general and emergency care and more complex treatments.
- Developing dental health service infrastructure and programs for hard to reach populations.
- Maintaining and/or expanding school dental schemes covering children aged 5-18.
- Extending water fluoridation to all centres with populations of 1000 or above.
- Eliminating co-payments for School Dental Schemes and pensioner and health care card holders.
- Reducing the number of emergency presentations by pensioner and health care card holders and increasing the percentage of card holders receiving regular check-ups and preventive care.

The performance of State and Territory Governments will depend, among other things, on their capacity to incorporate private dentists and other oral health professionals into the provision of public dental care and increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary and maintenance oral health care, including health promotion.

¹⁰ Some forms of primary health care, such as physiotherapy, podiatry and psychological services are to be supported through new private health insurance arrangements and are also available through restricted public programs in community health and outpatients' services administered by state governments.

¹¹ Based on an average cost of \$280 for oral exam, clean, scale and x-ray or two fillings or equivalent per eligible card holder (5.7 million people) every two years. Costs based on Department of Veteran Affairs Fee Schedule of Dental Services.

¹² The Healthy Weight National Action Agenda provides a model for Commonwealth/State Cooperation on health promotion, as well as a logical platform on which to incorporate oral health promotion given that oral disease is diet related and there are many common risk factors between obesity, dental caries and gum disease.

State and Territory governments would receive funding on the basis of the number of adults eligible for Commonwealth Pensioner Cards and Health Care Cards, but it would be a condition of funding that State and Territory expenditure on oral health services for children and adults at least matches Australian Government expenditure under this proposal. At an aggregate State and Territory level, this would mean that new State and Territory spending of \$295 million per annum is required.¹³

With Commonwealth Government funding driving the reorientation of dental care to prevention and early treatment, it is likely that the need for State government expenditure on expensive emergency treatment will decline in the longer term. This would free resources for furthering oral health promotion and prevention as well as creating capacity to treat more complex but less urgent cases among health card holders.

Continued provision of Commonwealth funding would be contingent on States making satisfactory progress towards achieving the following minimum standards:

- All children should receive at least one course of general oral health care including appropriate oral health promotion every two years. Children with greater dental needs should be recalled more frequently.
- All eligible adults should receive at least one course of general oral health care every two years on average. Adults with greater dental needs should be recalled more frequently.
- All eligible adults who require denture services should have access to a set of dentures once every eight years on average, with dentures being approved more frequently where clinically indicated.
- No one should have to wait longer than 24 hours to receive emergency dental care for swelling, infection and bleeding, or serious and persistent pain.

The provision of oral health services obviously relies on there being real resources (human resources and infrastructure) available at the right time and place.

Demand for dentists and other oral health professionals has been outstripping supply, and there is both an overall shortage and a mal-distribution in the dental workforce. This means that access to services is highly restricted in some areas, particularly in rural and regional areas.

It has been estimated that by 2010 there will be a shortage of 1,500 dentists, which is equivalent to 3.8 million dental visits.¹⁴

A proportion of the Commonwealth's funding (10% in the first year) should be reserved for measures to ensure appropriate supply and distribution of oral health professionals, including dentists, to meet future needs. The Commonwealth's specific responsibilities should be the development of a national dental labour force plan and funding for the training of oral health professionals in universities.

¹³ State and Territory Government expenditure in 2004-5 was \$503 million. See AIHW (2006) *Health Expenditure Australia 2004-5*, Table A3, p105.

¹⁴ Spencer (2004), p.55

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Oral health in Australia

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.¹⁵

The impact of oral disease on people's everyday lives is subtle and pervasive, influencing eating, sleeping, work and social roles. The prevalence and recurrences of these impacts constitute a silent epidemic.¹⁶

There are persistent high levels of oral disease among adult Australians with one in every two teeth of 35-44 year olds having experienced decay. Australia compares poorly with most other OECD countries in terms of adult oral health, ranking in the bottom third (See Table 1).

The social impacts of this problem are immense. Over a quarter of Australian adults experienced painful aching because of problems with their teeth, mouth or dentures in 2002. A quarter reported avoiding foods and nearly a third reported that they found it uncomfortable to eat. Just under a quarter of Australian adults reported that they felt self-conscious or embarrassed because of oral health problems.¹⁷

While Australia compares well with other OECD countries on child oral health, there has been a marked decline in the oral health of Australian children since 1996.¹⁸

Most striking in the Australian context are the deep and institutionalised inequities in oral health and access to dental care for adult Australians. Those with particularly poor oral health and who are most unlikely to be able to access dental care are low income adults, people living in rural and remote areas, indigenous people, nursing home residents, people with disabilities, young adults on income support payments and single parent households.

The problems of access to dental services are most acute for low income and disadvantaged Australians. However, twenty three per cent of adults not eligible for public dental care (2.3 million people) report that they delay or avoid treatment because of the cost of general dental care.

ACOSS estimates that overall, 40% of adult Australians cannot get the dental treatment they require when they need it.

There are new and agreed policy directions under the National Oral Health Plan which could turn around the inequalities in oral health and access to dental care and greatly improve the oral health of the Australian population. There is no disagreement about what needs to be done, but serious problems with government commitment to implementation in all jurisdictions.

¹⁵ NACOH, p.v

¹⁶ NACOH, p.v

¹⁷ Spencer (2004), p18

¹⁸ Armfield

Children

Australian children enjoy high levels of oral health by world standards but since 1996 the level of tooth decay in both baby and permanent teeth has increased.¹⁹

For example, between 1996 and 2000, the percentage of 6 year old Australian children with no decay in their baby teeth decreased from 61.0% to 56.6%. That is, there was an increase in the percentage of 6 year olds with some decay in their baby teeth over this four year period. Over that period, the average (mean) number of baby teeth with decay among 6 year olds increased from 1.45 to 1.65 teeth.

A decrease in exposure to decay protective factors appears to be the most plausible explanation for this trend and is supported by empirical evidence.

There are a number of potential protective factors that may have changed:

- exposure to fluoride from water supplies;
- exposure to discretionary fluorides; and
- a decrease in oral health promotion activities within the school dental services (e.g., school tuckshop offerings may have become more likely to induce decay and increased vending machine activity, or a decrease in individual and group dental education activities).

There is evidence that any one or more of these factors may have contributed to an increase in tooth decay in children.

While the percentage of the Australian population covered by water fluoridation has increased slightly in the late 1990s, there has been also a dramatic increase in bottled water consumption and a steady penetration of home water filters, some of which do remove fluoride, into Australian households.

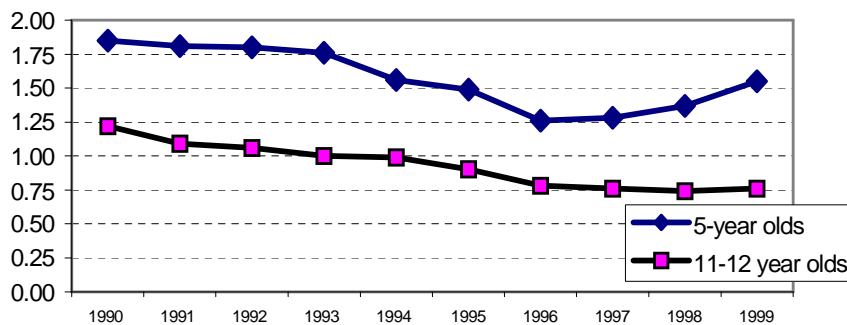
General concerns over water conservation and quality are also leading to a new emphasis on household capture and consumption of tank water. There is also circumstantial evidence that exposure to discretionary fluorides (i.e. fluoride in infant formula powder, drops or tablets; and the early commencement of tooth brushing with a standard fluoride containing toothpaste) has also diminished.²⁰

¹⁹ Armfield (2003)

²⁰ Spencer (2004), p.6

A small disadvantaged group of children experiences a disproportionate share of early childhood caries and decay in primary and secondary teeth.²¹ For example, among 12 year olds, about 12% of children had 66 per cent of all teeth with decay.²² Higher levels of decay have been found among children in lower socio-economic position families, with less of their lifetime in a fluoridated area and with less frequent preventive dental behaviours.²³

Figure 1.



Dental caries experience of children aged 5 and 12 years, 1990-1999.²⁴

²¹ NACOH, p.20

²² Spencer (2004) p.4

²³ Spencer (2004), p.4

²⁴ AHMAC, p.21

Adults

One in every two teeth of Australian adults aged 35-44 have some decay. The incidence of caries among 35 to 44 year olds places Australia in the bottom third of the ranking of oral health among comparable OECD countries. (See Table 1.)

Table 1. Adult oral health: caries experience of 35–44 year olds among OECD countries²⁵

Country	Year	DMFT*	Rank
Korea	1991	4.5	1
Italy	1995	9.4	2
Portugal	1984	10.9	3
Spain	1993	10.9	4
Turkey	1987	11.6	5
USA	1991	13.3	6
Japan	1993	13.7	7
France	1994	14.6	8
Austria	2000	14.7	9
Hungary	1991	15.0	10
Ireland	1990	15.4	11
Greece	1985	15.8	12
Germany	1997	16.0	13
UK	1998	16.6	14
Denmark	2000	16.7	15
Australia	1987-88	17.3	16
Netherlands	1986	17.4	17
Czech Republic	1987	17.7	18
Switzerland	1988	18.8	19
Poland	1993	19.3	20
Canada	1994-5	20.0	21
Norway	1990	20.5	22
New Zealand	1989	20.9	23
No comparable data			
Belgium			
Finland			
Iceland			
Luxembourg			
Mexico			
Slovak Republic			
Sweden			

*DMFT stands for Decayed Missing and Filled Teeth and is a measure of dental health.

²⁵ WHO 2006

Recent evidence indicates that the oral health of at least a sizeable minority of adults may be deteriorating. The Adult Dental Programs Survey monitors the health of eligible adults who use public dental services in Australia. Between 1995-6 and 2001-2 the mean number of teeth with decay experience increased, decayed but untreated teeth increased, teeth extracted because of disease increased and filled teeth decreased. These trends were evident in most age groups, but appear to be more marked in younger adults.

Table 2. Caries experience of patients attending public dental services in Australia²⁶

Decayed		Missing		Filled		DMFT	
1995-6	2001-2	1995-6	2001-2	1995-6	2001-2	1995-6	2001-2
1.97	2.65	5.50	6.35	6.62	6.20	14.09	15.02

Bad though these figures are, the adults captured in these surveys are at least receiving some dental care. Other disadvantaged groups with poor oral health exist in the adult population but with less likelihood of receiving dental care: Indigenous people; people with disabilities; frail older adults; and people living in rural and remote areas.²⁷

Edentulism, or complete loss of teeth, shows a very marked social gradient with a four fold difference in total tooth loss between the lowest and highest income categories.²⁸

Access to Dental Services

Children

In 2002 93% of children aged 5-11 years had visited a dentist in the last two years and among children aged 12-17 years, 89% had visited the dentist within the previous two years.

Since 1975 the School Dental Service (SDS) has provided free or subsidised dental care to children of primary school age and varying grades of secondary school age. Due to different eligibility criteria and resource levels, the proportion of children enrolled in this service varies significantly among states and territories.

Use of the SDS by children aged 5-11 years varied significantly among states and territories. Children from the Northern Territory (87%), Western Australia (78%) and Queensland (72%) South Australia (69%) and Tasmania (60%) were more likely to have attended an SDS at their last visit than New South Wales (38%), Victoria (45%) and ACT (44%) where the majority of children attended a private clinic.²⁹

Only 5% of Australian children aged 5-17 years were prevented from receiving recommended dental treatment due to cost.³⁰

²⁶ Spencer (2004), p.8

²⁷ Spencer (2004), p.9

²⁸ Spencer (2004), p.16

²⁹ AIHW (2006), p.2

³⁰ AIHW (2006), pp 1-2, 5

Adults

Financial affordability acts as a barrier to access and influences patterns of dental service use in Australia. For example, people who usually visit for a problem are more likely to report difficulty in paying for dental care than people who usually visit a dentist for a check-up. Low affordability and higher levels of financial hardship, leading to problem visits rather than check-up visits, were associated with higher rates of tooth extraction.³¹

Even among more affluent Australians, there has been an increase from 1994-96 and 2002 in the percentage of people who:

- visited a dentist more than 5 years ago
- last visited for a problem rather than a general check-up
- avoided or delayed treatment because of cost
- received extractions in the last twelve months (with a corresponding decrease in the number of fillings received suggesting inadequate access to preventive and restorative treatment).

However, the situation is far worse for concession card holders. They have experienced further declines in access and the gap between higher income groups and concession card holders has grown.

People living on low incomes visit dentists less frequently than the rest of the community, are likely to have teeth extracted rather than filled, and are less likely to get preventive care.

Card holders whose last dental visit was to a public dental hospital were increasingly more likely than non-card holders to:

- perceive need for dental treatment
- have experienced toothache in the last twelve months
- have avoided or delayed visiting because of cost
- have waited more than six months for an appointment.
- have received extractions in the last twelve months.³²

On the assumption that all Australians should be able to access a comprehensive oral health check or a course of basic dental treatment every two years, ACOSS estimates that about 40% of Australian adults face barriers to the kind of basic dental care that should be available to all in a developed country like Australia.

While three quarters (73%) of all Australian adults and 70% of concession card holders visited a dentist in the last two years, nearly half of all adults (47%) and 60% of all concession card holders visited for a problem rather than a check up.³³

There are approximately 5 million concession card holders in Australia, of whom 30% (1.5 million) did not visit a dentist in the last two years.³⁴

³¹ AHMAC, p.61

³² Spencer (2004), p.27

³³ AIHW DSRU Report No 26, p2, Carter and Stewart, p38

³⁴ Carter and Stewart, p.33

Among concession card holders who did visit a dentist in the last two years, 60% (2.1 million people) did so for a problem³⁵, indicating sub-optimal access to regular check ups and early treatment. While concession card holders are generally eligible for public dental care in all States and Territories, only 20% attend a public dental clinic in any one year.³⁶

Restrictions in funding for State and Territory public dental services mean that waiting lists and waiting times are unacceptably long, often exceeding 2 years and may be as long as 10 years for less urgent services (eg dentures).³⁷ About 500,000 people are on waiting lists around Australia for general dental care from public dental services of whom only 11% receive treatment each year.³⁸ (See Table 3 for public general dental service waiting times).

On top of concession card holders who cannot access basic dental care is another group who struggle to afford the cost of private dental care. Among adults who do not hold concession cards and are not therefore eligible for public dental care, 23% (2.3 million) delay or avoid treatment because of the cost of dental care.³⁹ While this figure probably includes people who had problems meeting the cost of very expensive treatments, the majority (90%) of dental care is required for tooth decay and gum disease. We therefore assume that the majority of those reporting problems with the cost of dental care are struggling with the costs of more basic treatments (2.1 million people).

When the number of concession card holders who did not see a dentist in the past two years or who attended for a problem in the last two years is added to the number of non-concession card holders who avoided or delayed treatment because of the cost of routine treatment, the total number of adult Australians who face barriers to basic dental care is 5.7 million people (or 38% of the adult population of 15 million).

³⁵ Carter and Stewart p.38

³⁶ AIHW (2001), p.2

³⁷ NSW Parliament, p96

³⁸ NSW Parliament, p.96

³⁹ Carter and Stewart, p.71. While this figure probably includes people who had problems meeting the cost of very expensive treatments, the vast majority (90%) of dental care is required for tooth decay and gum disease. We therefore assume that the majority of those reporting problems with the cost of dental care are struggling with the costs of more basic treatments.

Table 3. Visits for publicly funded general dental care⁴⁰

	Number of people		Waiting time	
	June 1997	June 2002	June 1997	June 2002
NSW	140,000	n.a.	to 58 months	n.a.
Victoria	143,000	218,952	16 months	27 months
Queensland	69,000	114,742	10 months	17 months
Western Australia	11,000	26,090	8 months	13 months
South Australia	78,000	91,053	22 months	49 months
Tasmania	13,400	n.a.	30 months	n.a.
Northern Territory	n.a.	3,920	n.a.	32 months
ACT	3,600	2,644	15-30 months	25 months
Total /National Average	458,000	457,200	24 months	27 months

Table 4. Visits for publicly funded “emergency” dental care⁴¹

	1997/98	2001/2002
New South Wales	239,224	319,045
Victoria	92,471	132,219
Queensland	226,066	274,174
Western Australia	37,015	60,570
South Australia	70,714	82,705
Tasmania	n.a.	13,123
Northern Territory	Not recorded	7,061
ACT	n.a.	n.a.
Total	665,300	888,800

Cost of dental care

Of all household health service expenditure, dental charges have consistently accounted for the highest average weekly expenditure.⁴²

In 2006, the cost of a check-up, x-ray, scale and clean at a private dentist is around \$280. Treatment for acute gum infection costs \$62 on average with the cost of a simple filling between \$120 and \$140. Since 1999 there has been a 45-50% increase in the price of basic dental services compared to the increase in CPI over the same period of 26.5%.⁴³

⁴⁰ Source: State/Territory dental services, NSW Parliament (2006)

⁴¹ Source: State/Territory dental services, NSW Parliament (2006)

⁴² AHMAC, p.51

⁴³ Calculations based on Department of Veteran's Affairs Fee Schedule of Dental Services, AHMAC, p52, and ABS (2006).

The increase in prices may be accounted for by increases in the price of individual services, changes in the technology used to provide services (eg more expensive equipment or materials) and increases in costs associated with infection control measures.⁴⁴

As fees for dental services are not regulated in Australia and private dentists are free to set and adjust fees as they wish, these price increases may also be due to a desire among some dentists to increase private earnings in a market of limited supply.

The only brake on price inflation is the consumer's capacity to pay and it is not surprising in this context that so many consumers are effectively excluded from proper treatment due to cost.

If the trend in the price of dental services continues then dental services will become progressively more out of reach for lower and middle income earning Australians.⁴⁵

Funding of oral health services

The funding of oral health services in Australia is highly inequitable and plays a major role in denying access to dental care and creating poorer oral health outcomes for low income and disadvantaged Australians.

The vast majority of funding comes from individual consumers, which means that access is strongly determined by capacity to pay.

Direct patient payment for services discourages people, especially those with the least means, from seeking desirable services. It can also make the cost of using those services so burdensome as to deprive people from other desirable consumption, such as food and heating.

When the direct cost of services is borne by patients, those who struggle to afford services are also discouraged from using routine preventive care and will attend only when a problem becomes apparent. This tends to skew services towards acute rather than restorative and preventive treatment and may ultimately increase the total cost of care. The heavy reliance on direct patient payments is likely to be a significant factor in explaining why 47% of adults who visited a dentist in 2002 did so for a problem rather than a check-up.

As Table 5 shows, individual consumers (children and adults) contributed \$3.4 billion or 67% of funding for dental services in 2004-05 compared to \$953 million from governments (19%) and \$701 million from private health insurance funds (14%).

This is the reverse of the situation of health service funding in general, where governments contribute nearly 70% of total funding, consumers 20% and private health insurance 7%.

⁴⁴ AHMAC, p.51

⁴⁵ AHMAC, p.52

Table 5. Spending on dental services 2004-5⁴⁶ compared with spending on general health services

Source	Amount	Percentage (dental health)	Percentage (general health)
Commonwealth	\$450m	9%	46%
States	\$503m	10%	23%
Individuals	\$3,399m	67%	20%
PHI	\$701m	14%	7%
Other	\$10m	-	4%
TOTAL	\$5,064m	100%	100%

The majority of Commonwealth expenditure (82% or \$368 million) is spent on the Private Health Insurance Rebate for private dental cover, with the remainder covering the Department of Veterans' Affairs Dental Scheme, and Medicare inpatient, oral surgical and radiology services.

State and Territory funding covers adult dental care (50%), school dental services (21%), denture schemes (10%), dental education (7%), and corporate and health promotion (12%).

⁴⁶ AIHW (2006), *Health Expenditure Australia*, Table A3, p.105.

Table 6. Funding by State/Territory⁴⁸

State	Amount 2004-5 (\$ million)	Eligible population ⁴⁹	Amount per eligible person (\$)
NT	7	45,434	\$155.60
ACT	7	50,607	\$137.30
QLD	128	949,566	\$134.75
SA	47	432,513	\$108.50
WA	45	446,959	\$100.70
TAS	15	149,879	\$100.00
VIC	118	1,254,324	\$94.10
NSW	110	1,608,864	\$68.40
Total	477	4,938,146	\$96.60 (Avg)

In 2003-4, dental services accounted for 13% of the expenditure of private health insurance funds, excluding the indirect expenditure from the Australian Governments Private Health Insurance Rebate.

Many health funds have exclusions on expensive dental work as well as annual limits. Plans for orthodontic work, for example, often have to be approved by the fund before treatment starts.

⁴⁸ Source: ADA NSW, p37. AIHW data on individual state and territory expenditure was not available. This explains the difference in total expenditure between tables 5 & 6.

⁴⁹ Total number of people with Commonwealth Seniors Health Care, Pensioner Concession Card and Health Care Card 2004-5. Source: Centrelink administrative data.

Health Insurance extras cover costs between \$250 and \$500 per annum per person covered. The average benefit paid for dental care in 2004-5 was \$46 and generally only 50% of the fees charged are covered. In most cases, contributors only get back 80-90% of what they pay in premiums.^{50 51}

While state public dental services are efficiently targeted at those in need, the low level of funding means that many people with high oral health needs miss out on services altogether.

A number of State governments also charge patients for using public dental care. Direct patient payment for services discourages people, especially those with the least means, from seeking desirable services. It can also make the cost of using those services so burdensome as to deprive people from other desirable consumption, such as food and heating.

When the direct cost of services are borne by patients, those who struggle to afford services are also discouraged from using routine preventive care and will attend only when a problem becomes apparent. This tends to skew services towards acute rather than restorative and preventive treatment and may ultimately increase the total cost of care.

⁵⁰ PHIO, p.35-37

⁵¹ PHIAC, p.45

Government response

A comprehensive national oral health plan, *Healthy Mouths, Healthy Lives, Australia's National Oral Health Plan 2004-13* was endorsed by Australian Health Ministers on 29 July 2004. The plan acknowledges that "profound disparities exist across socio-economic groups in Australia with respect to oral and general health. In particular, the incidence of tooth decay and gum disease increases as socio-economic status decreases. These two most common oral diseases lead to poor social and health outcomes in vulnerable populations. Both are amenable to prevention using safe and effective methods."

Australia's Health Ministers agreed that good oral health for disadvantaged and low income Australians will be achieved through allocating resources equitably and efficiently to achieve maximum health gains across the population and improved access to affordable, timely and preventively focussed oral health care.

Key National Oral Health Plan actions

Short term actions: Extend fluoridation of public water supplies to communities across Australia with populations of 1000 or more.

Undertake a National Oral Health Survey and a National Children's Oral Health Survey, each to be repeated every ten years.

Ensure continuation and/or expansion of school dental services to provide regular and timely check ups and preventively focussed oral health care for children and adolescents.

Make affordable portable dental equipment available to public and private oral health providers to enable them to treat older people in their homes and in residential aged care facilities.

Establish affordable and appropriate transport arrangements to enable frail older people to attend oral health clinics.

Develop and implement targeted health promotion and preventive programs for specific socio-economically disadvantaged groups including people in rural and remote areas, the homeless, people in institutions, low income earners and their families, disadvantaged young adults and older people, and disadvantaged people from Indigenous and non-English speaking backgrounds.

Develop and implement mechanisms to identify people with special needs at their first point of contact with health services so that the implications for oral health can be managed.

Support the proposal to include under Medicare a biennial adult health assessment for Indigenous people, which includes an oral examination.

Increase the supply of new Australian-trained oral health practitioners by at least 150 graduates per year.

Fund dental schools and other oral health training programs at a level that better reflects the full cost of training oral health practitioners.

Medium term actions: Increase funding to public oral health services to ensure concession card holders living in the community have timely access to preventively focussed dental care that meets the minimum standard benchmark for oral health service provision

It is now over two years since that endorsement and the time by which the agreed short term actions should be implemented and the medium term actions should be well under way.

Some progress has been made.

Oral examinations are now included in the biennial health checks for Indigenous people under Medicare and the first National Oral Health Survey in 15 years has recently been conducted.

The Commonwealth Government has also recognised the need for dental care among patients with chronic conditions and complex care needs. Approved patients may be referred to a dentist for an assessment and two other services within a 12 months period with Medicare to provide remuneration.⁵² This may in fact meet only part of their costs as often their needs are significantly higher and preventive treatments may need to be continuous.

There has also been modest additional spending on dental services by many State and Territory Governments.

The overall picture on implementation of the National Oral Health Plan however is disappointing.

That this is the case reveals what ACOSS believes to be the core problems with oral health and access to dental care in Australia - insufficient government commitment to implementation and the lack of a clear role for the Commonwealth Government. This can be clearly seen in the lack of any serious mechanism for evaluating and monitoring progress of the Plan.

Evaluation and monitoring of the National Oral Health Plan is the task of the Australian Health Ministers Advisory Council (AHMAC) and the National Oral Health Plan Implementation and Monitoring Committee (NOHPIMC).

The formal role of the NOHPIMC is to report on implementation of the National Oral Health Plan to AHMAC. The informal role of NOHPIMC is to provide a mechanism for State and Territory Governments to report to each other on developments in their state or territory.

Neither AHMAC nor NOHPIMC has the power to drive implementation.

There is no coordination of activity behind the National Oral Health Plan and the Australian Government plays no formal role in holding State or Territory Government responsible for action or inaction. Implementation of the Plan is therefore fragmented and uncoordinated.

⁵² Data suggests a low level of referral under these plans. See Marshall and Spencer.

Solutions

There is no disagreement about the nature and extent of the problem nor that the National Oral Health Plan provides a largely sound framework for action.

However, in ACOSS' view there are two weaknesses in the National Oral Health Plan:

- it does not spell out clear roles for the Commonwealth and State and Territory governments in implementing the Plan
- it does not adequately address the affordability and accessibility of dental care for those that do not have health cards but who nevertheless struggle with the cost of dental care.

A renewed role for the Australian Government

The fact that 40% of Australians cannot access dental care when they need it demands that the Commonwealth step up both its commitment to the funding needed to reverse the situation and its leadership in planning a more efficient, sustainable and equitable system of oral health promotion, prevention of disease, and treatment.

ACOSS believes that the renewal of adult dental care must be built on the Commonwealth Government taking responsibility for covering the minimum costs of basic dental care for adults who cannot afford the high cost of private fees.

That is, the Commonwealth Government should cover the cost of a comprehensive oral health check⁵³ or the cost of a basic course of treatment⁵⁴ every two years for eligible adults. State Governments would be responsible for meeting any other additional treatment costs for eligible adults and for planning and delivering oral health care to eligible adults according to need.

The Commonwealth's role would be similar to its established role in supporting access to primary general health care through Medicare payments to General Practitioners, but on a means-tested basis. Medicare includes a range of population-level measures (immunisation) and targeted incentives (enhanced primary care health assessment for people over 75 years and in residential aged care) that are practice-based and attach GPs to wider care planning that is not always through individual fees for service arrangements.⁵⁵

To better ensure coverage of the 21% of adults who are not eligible for public dental care but who avoid or delay treatment because of the cost of basic dental care, the income limit to qualify for Commonwealth Low Income Health Care Cards should be increased from \$21,840 to \$26,208 for individuals and from \$39,936 to \$47,923 for a couple family with two children. (This would only be for purpose of access to publicly funded dental care). Eligibility

⁵³ Including scale, clean and x-rays

⁵⁴ Eg fillings or treatment for acute gum infection

⁵⁵ Some forms of primary health care, such as physiotherapy, podiatry and psychological services are to be supported through new private health insurance arrangements and are also available through restricted public programs in community health and outpatients' services administered by state governments.

for a pensioner or health care card should define the minimum eligible population against which State government performance in addressing needs and meeting performance targets should be measured.

The estimated cost to the Commonwealth of this measure will be \$798 million per annum at the end of five years.⁵⁶

The money should therefore be provided to the States to use flexibly but with the Commonwealth using its investment to leverage state performance in:

- Undertaking community wide oral health promotion and community education.⁵⁷
- Planning and providing dental services for concession card holders according to need, including provision of general and emergency care and more complex treatments .
- Developing dental health service infrastructure and programs for hard to reach populations.
- Maintaining and/or expanding school dental schemes covering children aged 5-18.
- Extending water fluoridation to all centres with populations of 1000 or above.
- Eliminating co-payments for School Dental Schemes and pensioner and health care card holders.
- Reducing the number of emergency presentations by pensioner and health care card holders and increasing the percentage of card holders receiving regular check-ups and preventive care.

The performance of State and Territory Governments will depend, among other things, on their capacity to incorporate private dentists and other oral health professionals into the provision of public dental care and increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary and maintenance oral health care, including health promotion.

State and Territory governments would receive funding on the basis of the number of adults eligible for Commonwealth Pensioner Cards and Health Care Cards, but it would be a condition of funding that State and Territory expenditure on oral health services for children and adults at least matches Australian Government expenditure under this proposal. At an aggregate State and Territory level, this would mean that new State and Territory spending of \$295 million per annum is required.⁵⁸

With Commonwealth Government funding driving the reorientation of dental care to prevention and early intervention, it is likely that the need for State government expenditure on expensive emergency treatment will decline in the longer term. This would free

⁵⁶ Based on an average cost of \$280 for oral exam, clean, scale and x-ray or two fillings or equivalent per eligible card holder (5.7 million people) every two years. Costs based on Department of Veteran Affairs Fee Schedule of Dental Services.

⁵⁷ The Healthy Weight National Action Agenda provides a model for Commonwealth/State Cooperation on health promotion, as well as a logical platform on which to incorporate oral health promotion given that oral disease is diet related and there are many common risk factors between obesity, dental caries and gum disease.

⁵⁸ State and Territory Governments spent \$503 million on oral health in 2004-5. See AIHW, Health Expenditure Australia, Table A3, p105. To match new Commonwealth funding, State and Territory Governments would be required to spend an additional \$295 million per annum.

resources for furthering oral health promotion and prevention goals as well as creating capacity to treat more complex but less urgent cases among health card holders.

Continued provision of Commonwealth funding would be contingent on States making satisfactory progress towards achieving the following minimum standards:

- All children should receive at least one course of general oral health care including appropriate oral health promotion every two years. Children with greater dental needs should be recalled more frequently.
- All eligible adults should receive at least one course of general oral health care every two years on average. Adults with greater dental needs should be recalled more frequently.
- All adults who require denture services should have access to a set of dentures once every eight years on average, with dentures being approved more frequently where clinically indicated.
- No one should have to wait longer than 24 hours to receive emergency dental care for swelling, infection and bleeding, or serious and persistent pain.

Failure by State and Territory Governments to achieve performance targets against minimum standards should result in financial penalties.

These standards should be underpinned by stronger monitoring and surveillance activities. The Australian Government should establish a National Oral Health Plan Implementation Unit in the Department of Health and Aged Care to lead and oversee the implementation of the actions within the National Oral Health Plan.

The provision of oral health services obviously relies on there being real resources (human resources and infrastructure) available at the right time and place.

Demand for dentists and other oral health professionals has been outstripping supply, and there is both an overall shortage and a mal-distribution in the dental workforce. This means that access to services is highly restricted in some areas, particularly in rural and regional areas.

It has been estimated that by 2010 there will be a shortage of 1,500 dentists and other oral health professionals, which is equivalent to 3.8 million dental visits.⁵⁹

A proportion of the Commonwealth's funding (10% in the first year) should be reserved for measures to ensure appropriate supply and distribution of oral health professionals, including dentists, to meet future needs. The Commonwealth's specific responsibilities should be the development of a national dental labour force plan and funding for the training of oral health professionals in universities.

⁵⁹ Spencer (2004), p.55

Table 7. Summary of Commonwealth and State roles and funding under ACOSS plan.

Action Area	Commonwealth	States/Territories
<p>Dental services for pensioner and health care card holders</p>	<p>Funding for provision of preventive and early intervention treatment for eligible persons, equivalent to either one comprehensive oral health check, scale clean and x-ray every two years or a course of basic treatment every two years.</p> <p>Expansion of entitlement to publicly funded dental care through easing income test limits on Low Income Health Care Card.</p>	<p>Any additional funding required for provision of preventive and early intervention treatment for eligible persons to ensure progress against agreed minimum standards</p> <p>Planning and provision of dental services for concession card holders according to need, including provision of general and emergency care and more complex treatments.</p> <p>Developing dental health service infrastructure and programs for hard to reach populations.</p>
<p>Children</p>	<p>Establish a National Oral Health Plan Implementation Unit to lead and oversee the implementation of the actions within the National Oral Health Plan.</p>	<p>Maintain and/or extend universal free school dental scheme</p>
<p>Public oral health measures</p>	<p>Establish a National Oral Health Plan Implementation Unit to lead and oversee the implementation of the actions within the National Oral Health Plan.</p>	<p>Extend water fluoridation to all centres with a population of 1000 or more</p>

Fair Dental Care for Low Income Earners

ACOSS Info Paper | October 2006

Action Area	Commonwealth	States/Territories
Dental health workforce	<p>Lead development of a national dental labour force plan.</p> <p>Fund training of additional oral health professionals in universities.</p>	<p>Contribute to development of national dental labour force plan.</p> <p>Find ways to incorporate private dentists and other oral health professionals into the provision of public dental care and increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary oral health care and health promotion.</p>
Implementation of National Oral Health Plan	Establish a National Oral Health Plan Implementation Unit to lead and oversee the implementation of the actions within the National Oral Health Plan.	Report on performance against agreed minimum standards
Total cost first year (2007-8)	\$160m	\$59m
Total cost per annum after five years	\$798m	\$295m

Recommendations

Recommendation 1 – A course of free basic dental treatment to concession card holders

The Australian Government should fund the cost of basic dental care for adult health card holders. This would comprise the cost of either an oral health exam, scale, clean and x-ray or basic treatment such as fillings or treatment for acute gum disease. State Governments would be responsible for meeting any other additional treatment costs for eligible adults and for planning and delivering oral health care to eligible adults according to need.

Cost to Commonwealth: \$160m in 2007-8 (\$320m in 2008-9)

Recommendation 2 – More people to qualify for health cards

To better ensure coverage of the 21% of adults who are not eligible for public dental care but who avoided or delayed treatment because of the cost of basic dental care, the income limit to qualify for Commonwealth Low Income Health Care Cards should be increased from \$21,840 to \$26,208 for individuals and from \$39,936 to \$47,923 for a couple family with two children. (This would only be for the purpose of access to publicly funded dental care). Eligibility for a pensioner or health care card should define the minimum eligible population against which State government performance in addressing needs and meeting performance targets should be measured.

Cost: included in funding for Recommendation 1.

Recommendation 3 – Greater focus on implementation of National Oral Health Plan

The Commonwealth should establish a National Oral Health Plan Implementation Unit in the Department of Health and Aged Care to lead and oversee the implementation of the actions within the National Oral Health Plan.

Cost: within existing resources.

Recommendation 4 – Better supply of oral health professionals

A proportion of the Commonwealth's funding (10% in the first year) should be reserved for measures to ensure appropriate supply and distribution of oral health professionals, including dentists, to meet future needs. The Commonwealth's specific responsibilities should be the development of a national dental labour force plan and funding for the training of oral health professionals in universities.

Cost: included in funding for Recommendation 1.

References

- Australian Dental Association (ADA), *Background briefing on public dental services*, July 2006.
- Australian Dental Association (NSW Branch) (ADA NSW) (2005) *Inquiry into Dental Services in NSW: Submission to the New South Wales Legislative Council Standing Committee on Social Issues*.
- Armfield, J M, Roberts-Thomson K F, and Spencer, A J, *The Child Dental Health Survey, Australia 1999: Trends across the 1990s*, Australian Institute of Health and Welfare Dental Statistics and Research Series No. 27, University of Adelaide, 2003.
- Australian Bureau of Statistics (ABS), *Consumer Price Index Australia 2006*, <http://www.abs.gov.au/ausstats/abs@.nsf/e8ae5488b598839cca25682000131612/938da570a34a8edaca2568a900139350!OpenDocument>, accessed 29 September 2006.
- Australian Health Ministers' Advisory Council (AHMAC), *Oral health of Australians, National planning for oral health improvement: Final Report*. South Australian Department of Human Services on behalf of the Australian Health Ministers' Conference, 2001, Adelaide.
- Australian Institute of Health and Welfare (AIHW), *Australia's Health 2006*, Canberra, 2006.
- Australian Institute of Health and Welfare (AIHW)(2006), *Health Expenditure Australia 2004-05*, <http://www.aihw.gov.au/publications/hwe/hea04-05/hea04-05-x01.pdf>, accessed 18 October 2006
- Australian Institute of Health and Welfare Dental Statistics and Research Unit (AIHW), *Access to dental services among Australian adults and children*, DSRU Research Report No 26, May 2006, Adelaide.
- Australian Institute of Health and Welfare Dental Statistics and Research Unit (AIHW), *Oral Health and access to dental care – 1994-96 and 1999*, DSRU Research Report, March 2001, Adelaide.
- Carter, CD, & Stewart, JF, *National Dental Telephone Interview Survey 2002*, AIHW Dental Statistics and Research Unit, Adelaide 2003.
- Centrelink, Administrative Data (FOI request, Australian Dental Association) 2005
- Marshall, R I and Spencer, A J, "Accessing oral health care in Australia, Why try a doctor when you need a dentist?" *Medical Journal of Australia*, Vol 185, No2, July 2006.
- National Advisory Committee on Oral Health (NACOH), (2004a), *Healthy mouths, healthy lives: Australia's national oral health plan 2004-2013*. Government of South Australia on behalf of the Australian Health Ministers' Conference, 2004, Adelaide.
- National Advisory Committee on Oral Health (NACOH) (2004b), *Financial implications of the National Oral Health Plan 2004*, draft (not published).

New South Wales Parliament, Legislative Council Standing Committee on Social Issues, *Dental Services in NSW*, Report 37, March 2006, Sydney

Private Health Insurance Administration Council (PHIAC), *Operations of the Registered Health Benefits Organisations*, Annual Report 2004–05, 2005.

http://www.phiac.gov.au/publications/ar_registered_health/82pa.pdf accessed 28 September 2006.

Private Health Insurance Ombudsman (PHIO), *State Of The Health Funds Report 2005*, <http://www.phio.org.au/documents/SOHFR2005.pdf#search=%22ancillary%20dental%20exclusions%20mbf%22>. accessed 28 September 2006.

Spencer, A J, *Narrowing the inequality gap in oral health and dental care in Australia*, Australian Health Policy Institute Commissioned Paper Series 2004, Australian Health Policy Institute, 2004, Sydney.

Spencer, A J, *What options do we have for organising, providing and funding better public dental care?* Australian Health Policy Institute Commissioned Paper Series 2001-02, Australian Health Policy Institute, 2001, Sydney.

National Oral Health Alliance (NOHA), *Improving the dental health of people on low incomes*, (unpublished).

World Health Organisation (WHO), WHO Oral Health Country/Area Profile Programme, <http://www.whocollab.od.mah.se/countriesalphab.html>, accessed 5 October 2006.