Overview
On 29 August the Australian Government and the Greens announced an agreement to a major reform of access to dental services in Australia: establishing an entitlement to dental services for 2/3 of children in Australia; and increasing investment to dental services for adults on low incomes. ACOSS applauded this announcement, which incorporated many of the policies ACOSS has been advocating for well over a decade, most recently through our appointment to the National Advisory Council on Dental Health. This briefing analyses the origins of this reform and its implications for the policy priorities ACOSS has advocated.

Background: ACOSS advocacy for dental reform
In 2001, the National Dental Health Alliance emerged out of a think tank convened by ACOSS and our member organisation Brotherhood of St Laurence. The Alliance formed the ‘Stop The Rot’ campaign, calling for dental health reform during the Federal election. An advocacy day to Canberra as part of this campaign presented tins of baby food to parliamentarians, reflecting the lived experience of poor oral health and its particular impact on people experiencing poverty. The media release called for a national strategy for oral health and substantial ongoing federal funding to address (what numbered at that time) 500,000 adults on low incomes in Australia who were going without access to dental care services.

Since founding this Alliance, ACOSS has worked consistently and in partnership with dental and oral health service providers and with health and community organisations towards improved access to dental services and oral health outcomes. Through its various iterations, the Alliance has been a critical platform to bring together diverse voices calling for dental reform at key periods, including elections and the Commonwealth Budget cycle.

In 2010, ACOSS renewed the National Oral Health Alliance to reassert the importance of dental reform in that year’s election. By this time, the National Health and Hospitals Reform Commission had recommended ‘Denticare’ and related proposals, with an estimated cost of around $5.5 billion annually. The NHHRC proposed a government allocation of $4.9 billion, to be funded mainly through an increase in the Medicare levy and the pooling of existing governments’ dental expenditures.

While the Denticare proposal was welcomed by many, it was rejected by Cabinet on the basis of cost. Differing views then emerged as to the most appropriate, effective and achievable ways to improve access to dental services and oral health outcomes. While ACOSS, like several other Alliance members, maintained a strong position for universal health care including in oral health, this had become harder to advocate through the broad strategic alliances that had to be formed in the interests of positive dental reform.

Through this advocacy, the network of Councils of Social Service (COSSES) have highlighted the inequalities based on differences in state and territory dental services. COSSES have coordinated and supported efforts to improve the effectiveness of existing expenditure on dental health by all governments, and to increase investment to improve access and
effectiveness in those States and Territories with particularly inadequate programs. ACOSS has also supported the evidence base for population-based policy reform through our longstanding membership of the Expert Advisory Committee of the Australian Research Centre for Population Oral Health.

Key policy positions
Since founding the National Dental Health Alliance and the 2001 'stop the rot' campaign, the following positions have guided ACOSS' work on dental reform:

- Establishing a National Strategy for Oral Health;
- Adequate and ongoing funding from Commonwealth and State/Territory governments;
- Adequate public dental care for those unable to afford private services;
- Recognition that an annual check-up did not constitute an adequate response for low income groups that had long been missing out on routine and preventive dental care;
- Reform of public subsidies for high income earners, many of whom obtained benefits for dental care from the private health insurance rebate.

ACOSS has maintained core positions on dental health in successive Budget Priorities Statements and has undertaken detailed policy analysis and advocacy on major dental policies including: the National Oral Health Plan; the 2007 Commonwealth Dental Health Program introduced under the Labor Government; the Medicare Chronic Diseases Dental Scheme (MCDDS) introduced by the former Coalition Government (also in 2007); and the introduction of the Medicare Teen Dental Program (MTDP) under the current Labor Government.

Our concerns have focused in particular on poorly targeted programs like MCDDS and MTDP, both of which had failed to demonstrate effectiveness in improving oral health outcomes or arresting the growing gap between the oral health of people on low incomes and other people living in Australia. For instance, the MTDP provided for a check-up but did not enable treatment or preventive services. Nevertheless the 80% of people accessing the MCDDS were health care card-holders who constituted a significant proportion of the adult population suffering the most significant levels of oral health disadvantage. Over successive Budget submissions ACOSS advocated strongly for the abolition of these schemes on the condition that their current expenditure be redirected into more effective and equitable oral health programs.

Throughout our advocacy, ACOSS has maintained the central importance of universal access to health care. In recent years, as the inequalities grew between people on low incomes and those who could afford access to dental care, we have argued that those who have been most disadvantaged in terms of access to services need to be supported first in order to address their chronic and acute oral health problems. Other critical issues have included the poor distribution of dental practitioners beyond urban centres; the ongoing unaffordability of private services; the implications of significant co-payments for those who can’t afford treatment; the failure to ensure adequate preventive care to individuals reliant on public
dental services; and the failure to establish effective, national population-based oral health promotion strategies.

**National Advisory Council on Dental Health**
In 2011, Dr Tessa Boyd-Caine, Deputy CEO of ACOSS (and Senior Policy Officer responsible for dental health) was appointed to the National Advisory Council on Dental Health. The Council’s report was a blueprint for achieving universal oral health improvements, through staged reforms using incremental and sustainable investments. A key concern for the Council was how to maintain existing commitment to policy reform, not only by government funders but from those 60% of individuals and families already accessing regular dental services. The Council set out the following options for dental reform in the Federal Budget 2012:

- Option 1: An individual capped benefit entitlement
- Option 2: Enhanced access to public dental services
- Option 3: A means-tested capped benefit entitlement
- Option 4: Enhanced access to public dental services

These options were based on the Council’s identification of priority populations, including children, for preventive oral health, and adults on low incomes who faced the most disadvantages in accessing dental services. The Council also recommended an integrated model for health care card-holder adults and for all children. While the recent announcement on national dental reform by the Government and Greens does not encompass all children, it incorporates the key elements of the Council’s integrated model.

**2012 – the year of dental reform**
On 29 August the Government and the Greens announced they had reached agreement on dental reform. This was a key area of policy for both parties and one which the Greens made central to their support of Labor taking Government in 2010. The six-year plan entailed:

i. An entitlement up to $1000 every two years for the 3.4 million children of families receiving Family Tax Benefit Part A ($2.7 billion)
ii. Increased investment into State and Territory public dental services for approximately 5.4 million adults who hold health care cards, including all adults receiving pensions (e.g. aged care or disability support pensions) or allowances (e.g. Newstart Allowance or job seekers on Youth Allowance) ($1.3 billion)
iii. Grants for infrastructure and workforce development to support expanded services in outer metropolitan, rural, regional and remote areas, at a value of $225 million.

The package built on the oral health commitments in the 2012 Budget, which allocated $515 million to reduce public dental waiting lists and provided additional training and support for the workforce in rural and remote areas.
Analysis of the 2012 reform

ACOSS welcomed the reform as a significant improvement to the policy framework and important steps towards national oral health. It met the core ACOSS aim of timely, affordable and appropriate treatment for people on low incomes. It recognised that those people reliant on the public dental system were only able to access emergency treatment, and were having to wait such long periods of time that they frequently developed acute and chronic oral health problems as a result. It took the long view of building a significant foundation for a preventive model of oral health care, by establishing an entitlement for 2/3 of all children. And it invested in workforce development and improving infrastructure, without which those facing the highest levels of health disadvantage cannot get long term and sustainable improvements to their oral health outcomes.

While the announcement is a major improvement to the policy framework, it contains real risks in the short to medium term. The new policy will not be implemented in full until 2014, but the MCDDS and MTDP will be closed this year. While this year’s funding for waiting lists will assist those with the most acute needs, there will be resulting gaps in access to routine and restorative services for those with chronic conditions and uninsured young people, and this may increase the pressure on the provision of public dental services.

The reliance on FTB (A) as the basis of entitlement to children is also questionable, given that it extends to the children of families earning up to $120,000 pa. A more targeted approach, for instance to people earning up to $80,000, might have enabled the extension of services to those on low incomes but above income support levels. At the same time, the policy should be supported as a crucial first step towards a population and entitlement-based approach to oral health, while maintaining the contributions that higher income earners already make to their own dental care.

Much has been made about the $4 billion financial commitment involved in this announcement. Yet the total package is not actually an increase on what the Commonwealth would have had to spend if the current programs had been maintained; indeed it may result in a slight reduction. Moreover there is some uncertainty about the longevity of this reform, as a 6-year reform (where MCDDS was ongoing) and subject to changes in political as well as policy contexts. From a policy perspective, the important features are that:

- Some of current MCDDS funding is not well-targeted and is providing high levels of service, when others with greater oral health need languish on waiting lists; and
- The new funding arrangements look at the whole system for the first time and establish building blocks that can grow into a fully fledged equitable system over time, something that was unachievable in the current system.
This announcement redefined the policy landscape in which we can work towards universal dental care and improved oral health outcomes for all. But there is more work to be done¹.

i. A key priority is the expansion of adequate dental services for people on low incomes without health care cards, in particular people who may be employed but are still unable to afford either private insurance or basic dental care.

ii. For those with insurance, the problem of co-payments continues to drive health inequalities and for those who continue to make trade-offs between their oral health and the medical and allied health services they need, there is some way to go before they get a wholistic model of care.

iii. It is vital that this reform supports existing services, particularly in terms of adding capacity to public dentistry, rather than replacing existing services and disrupting already functional, but under-resourced, relationships. For example, it should ensure added support to existing services such as Aboriginal community controlled organisations, community health models that integrate oral health care with physical and mental health, and encourage oral health promotion through a range of professionals, and especially provide more resources to established services in rural, remote and regional areas.

iv. The integration of oral health into the primary health agenda should continue to be a policy priority, particularly through Medicare locals.

v. The Opposition’s position on dental policy is as yet unclear, although it was one of the policy areas identified by Leader Tony Abbott in his 2012 National Press Club address. Oral health reform needs to attract bipartisan commitments.

ACOSS would like to extend congratulations to all of our members who worked so hard to secure this important improvement in dental health for Australia. We would like to acknowledge Tessa Boyd-Caine for her excellent contributions on behalf of ACOSS.