As director of the Grattan Institute's Health Program, Dr Stephen Duckett is one of Australia's most respected health economists and policy reformers. ADA NSW Media Advisor **Stuart Turner** discovered more about his views on the present and future shape of Australian dentistry.

A QUESTION OF EQUALITY

Addressing the 'tragedy' of inaccessible oral health

Q. It's about 16 months since the Grattan Institute's report called for the establishment of a Medicare-funded universal dental health care scheme in Australia. Is this still relevant in the post-COVID world?

I certainly believe there's a need for universal dental care in Australia, especially post-pandemic.

Our report was part of an overall look at out-of-pocket costs in healthcare. The area these were having the most impact was dentistry which prompted us to look at how we address the barriers to accessing service.

Dental out-of-pocket costs are not simply a 'social gradient'. They're a problem for people on various income levels – low, middle and high. That was an eye-opener for us. The more we examined this issue, the more we saw the 'tragedy' in Australia that the mouth is not seen as part of the body, even though it's pretty clear that poor oral health is associated with other poor health outcomes. This situation isn't unique to Australia – in Canada for example, paying for most dental care comes out of the patient's pocket – but it is regrettable.

Q. How does the perception that oral health is determined by individual behaviours rather than linked to social determinants of health affect the argument for a universal scheme?

I don't believe anything is down to individual behaviour alone. If that's the case why do companies continue to spend huge amounts on advertising? We're all influenced by things we see and hear, friends and family and so on. Our health is down to individual choice but shaped by our environment, advertising, impact of economics and our social situation.

Dental health policy should involve provision for universal treatment but dental health education must also be part of any policy going forward. Making sure people understand the importance of oral health is crucial. Each dentist visit should have a preventative component but it's the government's job to enact effective change through legislation – for example, a sugar tax.

Q. The Grattan Institute report estimated that implementing a universal dental scheme would cost about $5.6bn in extra spending per year. How could a universal scheme be funded and how would it be effective?

In the overall picture a universal scheme is not THAT expensive. We believe a tax on sugary drinks would help raise about half a billion dollars a year and would go a long way. There are also many savings to be made across the healthcare sector.

This is a moral issue – why is the mouth treated differently from the body when it comes to providing healthcare?

Q. How would you address workforce issues while implementing the universal dental health scheme?

We know that not every dentist is working to the extent they could be in terms of hours so there is scope in the workforce for additional numbers.

A universal scheme will create additional demand for dentists and oral health therapists. Universities will need to expand places in their courses and programs. Funding for student enrolment should come from ordinary tertiary education funding, but universities may seek capital funding for expansion.

The government would have to say to the universities, 'we expect we would need this number of practitioners to cover a universal scheme' and then we need to think about expanding intakes. It would need a coordinated discussion about workforce numbers.

Q. How can private dentists play a role in a universal scheme and best be utilised to help reduce overall waiting lists for dental treatment?

Private dentists would absolutely play a role in a universal scheme, just as they do in assisting schemes such as the Child Dental Benefits Schedule (CDBS). We recommended a phased model with an initial 'public only' transition period, during which Commonwealth public funding could be equalised across the states and territories. This could be limited to about two years. Total funding would then be expanded, eliminating out-of-pocket costs for state schemes. A public-only expansion phase could help manage the backlog of people who have been on public dental waiting lists for some time.

After two years, the scheme should be expanded to participating private practices. Private practices currently participating in the Commonwealth CDBS, for example, should be allowed to continue to participate on their current terms until the new arrangements for their participation are in place.

In phase two the scheme would be expanded to cover groups such as Pensioner Concession Card holders. The aim would be ensuring those struggling to access treatment get it first – so for example seniors. Then phase three would expand to cover children. The overall aim to ensure those who currently endure the most barriers to treatment get it first.

Our report didn't cover all areas of dentistry and we never said we would expect every dental practice to participate. There would still be areas of dentistry – for example orthodontics – where private dentists could work and therefore charge accordingly.

Q. Is there political will in Australia to introduce universal dental health?

Labor committed to introducing a universal scheme in the run-up to last year's Federal election. I think the Liberals would be more likely to go to a 'targeted' scheme rather than universality but certainly every step forward helps.

Q. The Grattan Institute has – like ADA NSW – advocated for a tax on Sugar Sweetened Beverages. How would your plan work?

We recommend an excise tax of 40 cents per 100 grams of sugar on non-alcoholic, water-based beverages that contain added sugar. This tax would raise about $500 million a year, generate a drop of about 15 per cent in consumption of SSBs and likely result in a small decrease in obesity rates, as

Continued overleaf

Dr Stephen Duckett is Director of Grattan's Health Program. He has held top operational and policy leadership positions in health care in Australia and Canada, including as Secretary of what is now the Commonwealth Department of Health. An economist, he is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Academy of Health and Medical Sciences. He co-authored last year's Grattan Institute report *Filling the Gap: A Universal Dental Health Scheme for Australia.*

people switch to water and other drinks not subject to the tax. The revenue raised by the new tax could go to promoting healthier eating, preventing obesity, reducing the budget deficit or a variety of other purposes, including phasing in a universal dental scheme. Most importantly, a tax on SSBs would help to ensure that the producers and consumers of those drinks start paying closer to the full costs of this consumption – including costs that until now have been passed on to other taxpayers.

Q. What do you say to manufacturers and lobby groups who argue that a sugar tax is ineffective for improving health outcomes?

They're making that up. No-one has said that if you tax sugary drinks then it will fix issues such as obesity, but it will help reduce sugar consumption and address the third-party costs of obesity by reducing sugar intake from SSBs.

We know that for example in the UK the government didn't raise as much money as they envisaged through their sugar tax but manufacturers reduced the sugar content of sugary drinks so it achieved the objective of reducing sugar consumption.

We're seeing many countries introducing sugar taxes – including Conservative countries – so it's not a 'Left/Right' issue politically. Most of Australia's sugar is also exported, so it wouldn't hurt our domestic sugar industry. The data shows that it's feasible and effective and we believe it should be implemented.

Q. How do we 'connect' dentists with the wider health system and would this achieve improved health outcomes for the wider population?

I think one possibility is creating more integrated services such as 'one-stop shops' where there are dentists and other healthcare practitioners in the same building then that could help. By creating those multi-disciplinary services then dentistry would be seen as part of the coordinated approach to healthcare.

Q. Should dentists be given a bigger voice when it comes to shaping Australian healthcare policy?

The evidence is clear that what you put in your mouth is critical to overall health so I think it's important we hear the voice of dentists, especially in the policy debates around things like obesity and health care generally. The more we have them participating, the better.

Q. Telehealth has been important for GPs throughout the COVID-19 crisis. Some dentists embraced teledentistry – for example, using social media and messaging services to contact patients during pandemic-enforced restrictions. Is this an essential part of dentistry going forward?

Telehealth should become a permanent fixture of healthcare in Australia. In the case of GPs, Grattan's view is that we should see telehealth as part of the GP-Patient relationship. If GPs know the patient and are able to use telehealth appropriately then it can help further better their relationship.

Obviously in dentistry with interventional procedures such as oral surgery then face-to-face treatment remains essential. We'd like to see practices become more prevention-orientated and that's where teledentistry can play a role as part of the balanced approach to patient care.

Q. A lack of PPE was a big issue for dentists in the pandemic's early stages. How could this be addressed for future crises?

We didn't have appropriate supply chains prior to the pandemic and we have to think about how we ensure who has responsibility for these chains. In New Zealand, for example, they took steps to purchase PPE from different sources than they did previously and established a national distribution model. It may be that we look at improving manufacturing of PPE here in Australia and establishing a guaranteed supply here so we're not just reliant on China for our future supplies.

Q. What are the positives dentistry can take from the COVID-19 pandemic?

Among the pandemic's downsides has been people neglecting areas of their health, including putting off visits to dentists. The challenge of ensuring that dentistry is seen as an 'essential service' is still there. We have, however, seen rapid innovations across healthcare such as the implementation of telehealth. I hope we continue these when the situation improves.

What the Grattan Institute's *Filling The Gap: A Universal Dental Health Scheme For Australia* Recommended

The Commonwealth Government should take responsibility for funding primary dental care – just as it takes responsibility for primary medical care.

The Commonwealth should announce a roadmap to a universal dental health scheme, including plans to expand the dental health workforce, followed by incremental steps towards a universal scheme.

A universal scheme would cost about $5.6bn in extra spending every year and more dentists and oral health professionals would need to be recruited or trained overseas.

The Commonwealth should take over funding of services for people eligible for existing public dental schemes, fund them properly, and enable private-sector providers to deliver publicly-funded care. Then the scheme should be expanded – first to people on Centrelink payments, then all children. Within a decade, the Commonwealth should take the final step to a universal scheme.

More information: www.grattan.edu.au/report/filling-the-gap

To view the Australian Dental Association NSW's response to the scheme, see: https://www.adansw.com.au/News/Public/Filling-the-Gap-A-Universal-Dental-Scheme-for-Aus

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