Filling the Gap: A Universal Dental Scheme for Australia  
Grattan Institute. 2019  

ADA NSW Summary

Overview

Unlike GP visits where Medicare picks up all or most of the bill, most spending on dental care in Australia is funded privately. There is no compelling medical, economic, or legal reason that the mouth is treated differently from the rest of the body. The Grattan report recommends that Australia should move towards a universal primary dental care scheme, funded by the Commonwealth Government.

People who can’t afford to pay private dental fees often can’t access dental care, unless they go on long (often multi-year) waiting lists for public care. About 2 million people who needed dental care in the past year either didn’t get it or delayed getting it, because of the cost. Low-income people are most likely to miss out on care leading to widespread poor oral health. Overall, about a quarter of Australian adults say they avoid some foods because of the condition of their teeth but for low-income people, it’s about a third. Low-income people are more likely to have periodontal disease, untreated tooth decay or missing teeth.

Poor oral health is painful and costly and evidence suggests oral health conditions can contribute to other health problems, including diabetes and heart disease. Most oral health conditions are preventable but get worse if left untreated. GP’s or hospital emergency departments are often accessed for oral conditions that could have been avoided with earlier care.

Existing public dental schemes are inadequate, uncoordinated and inequitable across states with most having waiting lists of well over a year for adult public dental care. The Commonwealth should take responsibility for funding primary dental care as it does for primary medical care. Under a universal dental scheme, Australians could get the care they need, when they need it, without financial barriers.

The Grattan institute recommends that the scheme should be implemented progressively as the cost would be large (around $5.6 billion in extra spending per year) and the oral health workforce would need to be expanded. So, it recommends that the Commonwealth should announce a roadmap to a universal scheme, including plans to expand the workforce, followed by incremental steps towards a universal scheme. The first step should be for the Commonwealth to take over the funding for existing public dental schemes and should fund them adequately (estimated to be an extra $1.1 billion per year). In addition, private-sector providers should be able to deliver publicly-funded care. Eligibility for dental schemes should then be expanded, first to people on Centrelink payments, then to all children and then finally extending to a universal scheme, ideally within a decade.

Grattan Institute argues that removing the financial barriers to dental care would improve Australians’ oral health and “fill the dental gap” in our health system.
Recommendations from the Grattan report:

Commit to a universal dental care scheme

- The Commonwealth Government should declare its intention to introduce a universal primary dental care scheme

  Every Australian should have access to publicly-funded, high-quality, primary dental care when they need it. The Commonwealth Government should set out this goal clearly and legislate a time frame to achieve it.

- The universal scheme should cover primary dental care and emphasise early intervention

  The scheme should cover primary dental care services but not orthodontic and cosmetic procedures. Participating dental practices should be encouraged to practice 'minimum intervention dentistry'.

  **Note:** ADA NSW requests clarity on specific exclusions from the universal scheme. For example, orthodontic treatment for the correction of functional malocclusions should not be excluded. Generalised inclusion using terms such as “primary dental care services” should be avoided.

- Services delivered under the scheme should have no out-of-pocket costs

  A principal goal of the scheme is to eliminate financial barriers to dental care for all Australians. This is best achieved by requiring participating dental practices to charge fees according to an agreed schedule, without additional payments by patients.

  **Note:** This is not a recommendation that ADA NSW concurs with. The medical profession operates within a Medicare scheme that allows co-payment. There is no reason that Dentistry should be treated differently.

- Publicly-funded dental care should be delivered by a mix of public and private providers

  Patients should have choice of dental care providers under the scheme. Both public and private providers should be eligible to participate in the scheme.

- Dental hygienists and oral health therapists should have a greater role

  A range of dental care services can be delivered by non-dentist dental professionals. The payment structure to dental practices should encourage the most appropriate professional to deliver each service.

  **Note:** ADA NSW agrees that all registered dental practitioners should be fully engaged, working as part of a dental team and within their scope of practice.
The Commonwealth and states should enhance prevention programs, including water fluoridation. The universal scheme should fund oral health promotion activities. The emphasis should be on population-wide schemes to reduce the incidence of dental disease.

Steps towards a universal scheme

- The Commonwealth should assume responsibility for funding public dental care
  
The current system is inequitable across states and territories. Only the Commonwealth can adequately fund dental services and ensure equal access for citizens across Australia.

- The Commonwealth should increase total funding for dental care for people currently covered by state dental schemes
  
  Waiting lists for public dental services are far too long. Most states have median waiting times well above one year. The Commonwealth should increase funding, to better meet the needs of people who currently use public dental schemes.

- The Commonwealth should progressively expand the number of people covered by the universal scheme
  
  Publicly-subsidised dental care is currently available for some children and for adults with a Health Care Card or Pensioner Concession Card. Access should be broadened in several incremental steps towards universal coverage.

- The Commonwealth should set out a clear roadmap to a universal scheme
  
  A universal scheme will require significant fiscal investment and expansion of the oral health workforce. It will also have major implications for private health insurers. The Commonwealth should develop a clear roadmap to a universal scheme, including the cost, timing and workforce development.

Note: ADA NSW does not agree with the PHA’s assertion that they are best-placed to be the provider of dental services in this scheme. ADA NSW recommends that all private dental providers are engaged on equal terms.

Note: ADA NSW does not agree that workforce development should be undertaken until the scheme has commenced and a more accurate workforce analysis can be undertaken. The lag in increasing the DH/OHT workforce is only 3 years with Dentists being 4-5 years. Until the current workforce is able to respond to the demand by increasing service provision within its existing practitioner levels (working greater hours) there should not be any consideration in increasing university places or increasing levels of immigration of overseas trained dentist (skilled migration list).
Some interesting facts from the Grattan Report:

- Governments are responsible for most health care spending in Australia, with Commonwealth, State and Local governments accounting for about two-thirds of the $170 billion of health spending in Australia in 2016-17.\(^1\)

- In 2016-17, the $10.2 billion spent on dental care in Australia was largely privately-funded (with state governments contributing $836 million and the Commonwealth contributing $1.5 billion). Nearly half the Commonwealth’s contribution to dental care was delivered via the subsidy for private health insurance (PHI).\(^1\) This is not an effective use of the funding as only about a quarter of the population have PHI Extras cover that includes Dental and this group probably do not represent a large proportion of those with the highest needs.

- Grattan Institute estimates that a universal dental scheme would cost around $5.6 billion in extra health spending per year. (The estimated gross total cost of a fully operational universal scheme would be $6.5 billion a year offset by redirecting existing public dental spending).

- Only 22% of low-income Australian adults have a ‘favourable’ pattern of dental care, meaning that they usually visit a dental professional at least once a year, they have a ‘usual’ dental care provider and they usually visit for a check-up rather than to treat a problem.\(^2\) By contrast, 56% of high-income Australian adults have a ‘favourable’ pattern of dental care.\(^3\) People with a ‘favourable’ dental attendance pattern have better oral health than people who visit the dentist less frequently.\(^3\)

- Each year, 57% of people with PHI see a dental professional compared to only 31% of people without PHI.\(^4\) However, only about 54% of dental costs incurred by people with PHI Extras Dental cover was reimbursed.\(^5\)

- Due to Medicare, only 4% of people report not seeing a GP when they need to due to cost. This rises to 7% for specialist services and similar for not filling prescriptions due to the cost.\(^6\) In comparison 18% of people (2.05 million adults) report that cost caused them to skip or delay dental care.\(^6\) About 8.5% of these are high-income adults but the figure for low-income adults is more than three times higher, at 27.9%.\(^7\) For Indigenous v Non-Indigenous Australians, it is 32% compared to 21% skipping dental care due to the cost.\(^8\)

- Perceptions of “need for dental care” differ across different socio-economic groups, with low income people more likely to perceive it as “absence of symptoms” (no toothache or cavity) compared to high-income people perceiving a need to visit even in the absence of symptoms.\(^9,10\)

- The National Advisory Council on Dental Health estimated that there are more than 750,000 GP consultations each year for dental problems, with the most common treatment being prescriptions
for pain relief medication and antibiotics.11

- ARCPOH (Uni Adelaide) estimates the total economic cost of reduced workforce participation due to dental conditions at $556 million per year, based on a 2010 survey.12

- The CDBS in 2017-18, funded services to about 1.1 million children – about 37.1%13 of those eligible– at a cost of $326 million.14 (Note: this is only $300 per child per year so as well as only 37.1% of those eligible using it – on average they only used 60% of the eligible spend of $1000 per 2 years)

- About a third of the Australian population is eligible for public dental services but there is only capacity to provide services for about 20% of those who are eligible.1

- The proportion of dentists working part-time increased from 48.6% in 2006 to 58.2% in 2016.15,16 This is at a greater rate than GPs and other health professionals. Grattan estimates that there is capacity within the existing dental workforce to see more patients. However, better analysis of the existing workforce needs to be undertaken prior to recommendations on workforce capability are made.
References: