



# **A growing cavity: Why expanding dental coverage is increasingly urgent**

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## Overview

In 2019, Grattan Institute published a report call *Filling the gap: A universal dental scheme for Australia*.<sup>1</sup> The report outlined the problems plaguing dental care in Australia: primarily that the cost of dental care comes straight out of patients' pockets, causing those who can't afford it to miss out. The result is skipped care, and poor oral health, especially for poorer people.

This submission shows that little has changed since *Filling the gap* was published in 2019. In fact, on many measures, Australians' oral health has declined.

The main problem with dental care in Australia – that cost is a big barrier to care – remains the same. Millions of Australians still skip or delay needed dental care because of the cost, and poorer Australians still see the dentist less often than wealthier Australians. Where people are eligible for state dental schemes, waiting times are too long, and getting longer, with many patients waiting more than a year for the care they need.

Because the problems remain the same, the policies proposed in *Filling the gap* are still the best solutions.

The federal government should declare its intention to introduce a universal primary dental care scheme. The National Health Reform Agreement (NHRA), due to be updated in 2025, should be the mechanism used to negotiate a deal between the federal government and the states.

Because the jump from the current incoherent patchwork of inadequate schemes to a national, systematic approach is significant, it would be impractical to move to a universal scheme overnight. The cost would

be large – about \$5.6 billion in extra spending per year – and the oral health workforce would need to grow. So, the federal government should announce a roadmap to a universal scheme, including plans to expand the workforce, followed by incremental steps towards a universal scheme. The recently commissioned review of health practitioner regulatory settings should encompass dental care, to make sure dental clinicians are not restricted in delivering care they are trained to provide.<sup>2</sup>

The first step is for the federal government to takeover funding of existing public dental schemes, fund them properly, and enable private-sector providers to deliver publicly-funded care. Coverage should then be expanded – first to people on Centrelink payments, then all children. After that, the federal government should take the final step to a universal scheme, ideally within a decade.

Removing financial barriers to dental care would improve Australians' oral health. This submission and *Filling the gap*<sup>3</sup> explain why this change is needed, and details how the transition should be staged.

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1. Duckett et al (2019).

2. Department of Health and Aged Care (2023).

3. Grattan's previous report, *Filling the gap*, can be found here: <https://grattan.edu.au/report/filling-the-gap/>

## 1 Many Australians miss out on dental care, with big health consequences

Grattan’s 2019 report, *Filling the gap*, showed that many Australians miss out on dental care because Australia’s dental healthcare system relies on most patients footing the bill for care. The result is worse oral health, particularly for Australians who can least afford dental care.

This chapter updates some of the analysis published in *Filling the gap* with more recent data, and shows that little has changed. Each of the problems outlined in 2019 remain today, and on most measures, Australians’ access to dental care and our oral health has got worse (Table 1.1 on the following page).

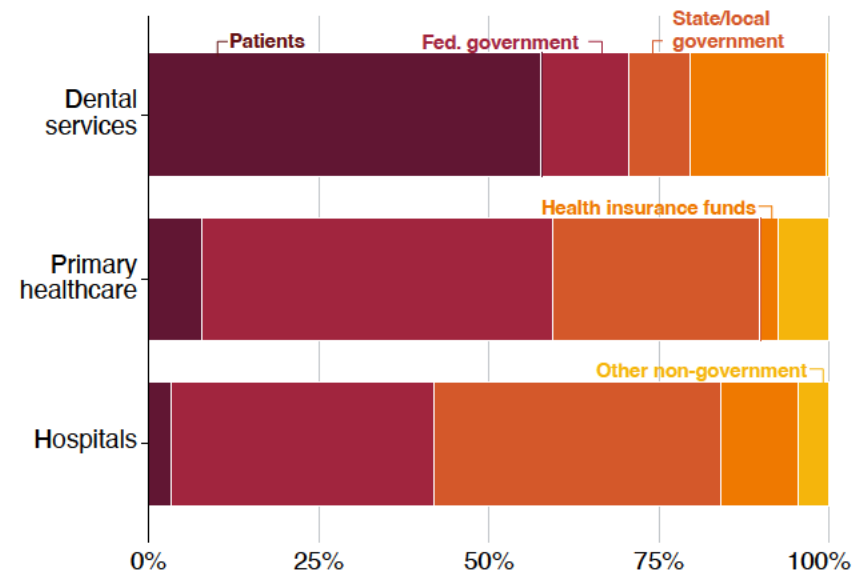
### 1.1 Australians still skip dental care because of cost

Australia funds dental care very differently to most other types of health care, with patients paying for most care themselves. By contrast, patients play only a minor role in funding most major areas of health spending such as hospitals and primary care (Figure 1.1).<sup>4</sup>

Because dental care fees come out of patients’ pockets, people who can’t afford to pay often miss out on care. Almost 4 million people, 32 per cent of Australians who needed dental care, skipped or delayed getting care at least once in 2021-22.<sup>5</sup> About half of the time, people skipped or delayed care because of the cost (Figure 1.2 on the following page).<sup>6</sup>

Dental costs pose the biggest problem for people aged between 25 and 44. They are the most likely to skip or defer care due to the cost.<sup>7</sup>

Figure 1.1: Dental services rely far more heavily than other types of care on patients to pay  
Proportion of total expenditure, by payer and service (2019-20)



Note: Medications and dental services are excluded from the primary care category.  
Source: Grattan analysis of AIHW (2022).

4. Duckett et al (2019).  
5. ABS (2022, Table 15.1).  
6. Ibid (Table 15.1).  
7. Ibid (Table 14.3).

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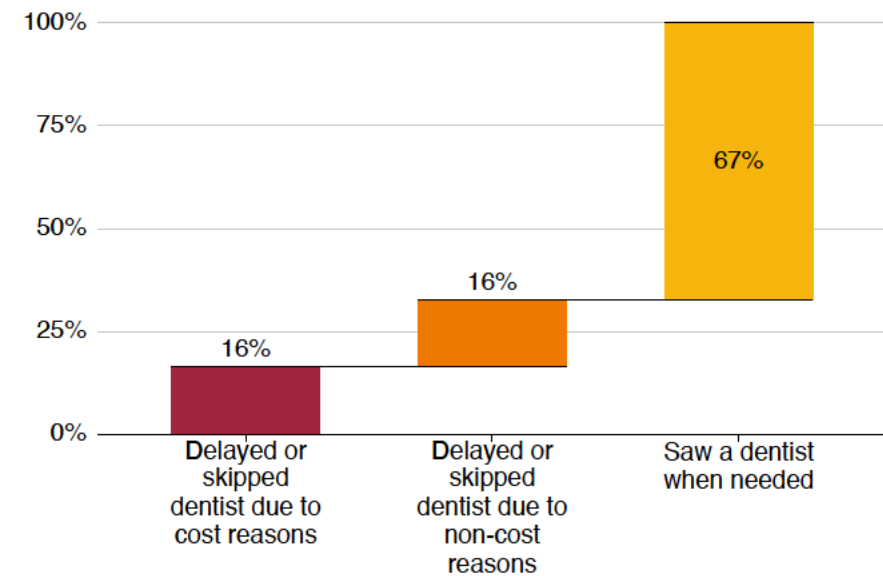
Table 1.1: Most problems have got worse since Grattan Institute’s *Filling the gap* report was published in 2019

Measure	<i>Filling the gap</i> report	Most recent evidence	
<b>Funding and access</b>			
Total government expenditure on dental care, per person	\$89 (2017-18)	\$89 (2020-21)	→
Proportion of total dental care funding provided by patients	58 per cent (2016-17)	58 per cent (2019-20)	→
Proportion of people who skipped or delayed needed dental care	30 per cent (2016-17)	32 per cent (2021-22)	↓
Proportion of people who skipped or delayed needed dental care because of the cost	18 per cent (2016-17)	16 per cent (2021-22)	↑
Waiting times (years, median) for public dental care	Vic: 1.6, Qld: 1.4, WA: 0.2 (2017-18)	Vic: 2.2, Qld: 1.8, WA: 0.9 (2021-22)	↓
<b>Oral health problems</b>			
Proportion of Australians with untreated dental decay	26 per cent (2004-2006)	33 per cent (2017-18)	↓
Proportion of Australians concerned about their dental appearance	27 per cent (2012-13)	35 per cent (2017-18)	↓
Proportion of Australians who avoided some food due to teeth	21 per cent (2012-13)	24 per cent (2017-18)	↓
Proportion of Australians who suffer toothache	16 per cent (2012-13)	20 per cent (2017-18)	↓

Notes: A previous version of this submission incorrectly stated that total government expenditure per person declined. For brevity, waiting times are included only for the three largest states where data is available for both time periods. In all cases, expenditure is as 2020-21 dollars. Sources: Grattan analysis, and Duckett et al (2019).

Figure 1.2: Many Australians skip needed dental care because of the cost

Proportion of the people who needed to see a dentist (2021-22)



Note: Percentages do not add to 100 due to rounding.

Source: ABS (2022, Table 15.1).

But in every age group, Australians are more likely to avoid or delay dental care than other types of care, such as GP or specialist visits (Figure 1.3 on the next page).

Dental costs also pose a bigger problem for Australians who do not have dental insurance, those who earn less, or are of lower socio-economic status (Figure 1.4 on page 6). Compared to people with dental insurance, Australians without dental insurance are almost twice as likely to have not seen the dentist at some point in the past

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year, and are more than three times as likely to have not paid a visit to the dentist at any point in the past five years.<sup>8</sup>

Compared to the highest earning third of Australians, the lowest earning third are about 20 per cent more likely to have not seen the dentist in the past 12 months, and are almost three times as likely to have not seen the dentist at any point in the past five years (Figure 1.4 on the next page).

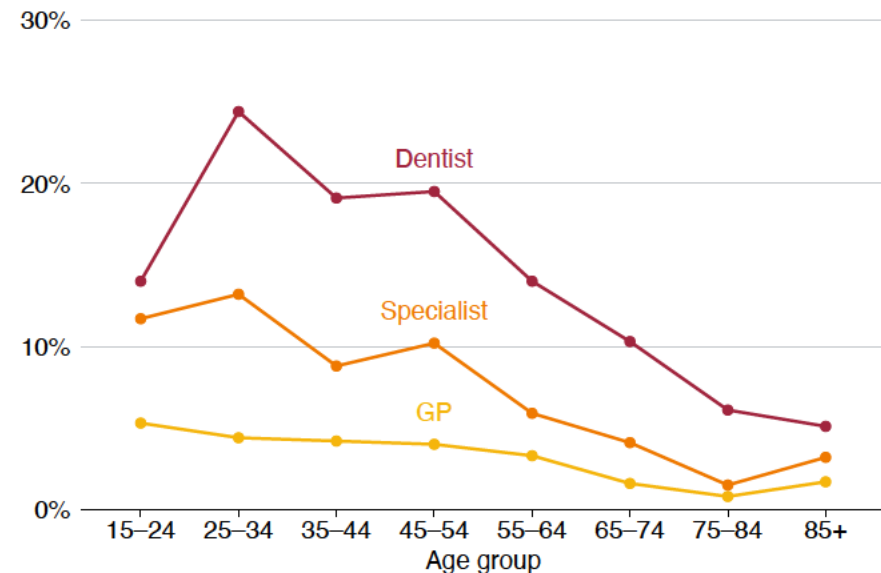
**1.2 Those who can't pay as easily have worse dental health**

People who delay or skip dental care have worse dental health.

Oral health problems are widespread among Australian adults and, on some measures, are becoming more common (Figure 1.5 on the following page). So, it is more important than ever for Australians to be getting regular dental care.

As *Filling the gap* explained, there is a strong link between the amount of dental care people receive, and their oral health. It makes sense that more frequent dental care leads to better oral health, particularly because many dental conditions are preventable. If people visit a dentist at least once a year, they are more likely to receive preventive or arrestive care and less likely to require extractions.<sup>9</sup>

**Figure 1.3: More people skip visits to the dentist than to a specialist or GP because of the cost**  
Proportion of people who needed to see a health professional, but skipped or delayed care because of the cost (2021-22)



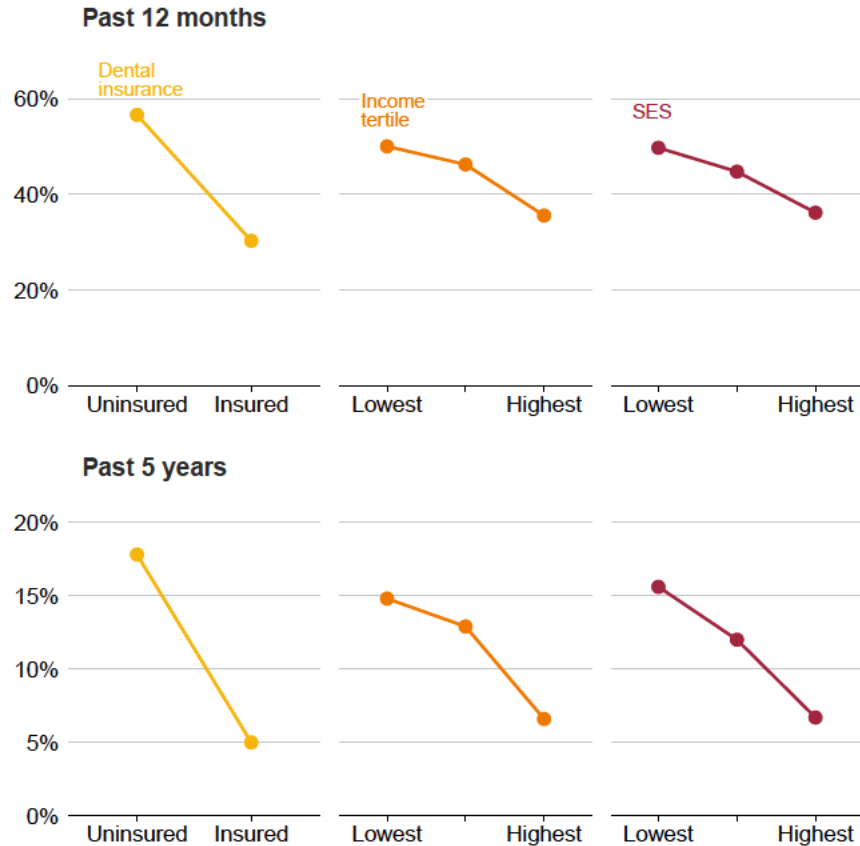
Source: ABS (2022, Table 5.3, Table 11.3, Table 14.3).

8. Brennan et al (2020).  
9. Ellershaw and Spencer (2011).

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**Figure 1.4: Poorer Australians and people without dental insurance are less likely to visit the dentist**

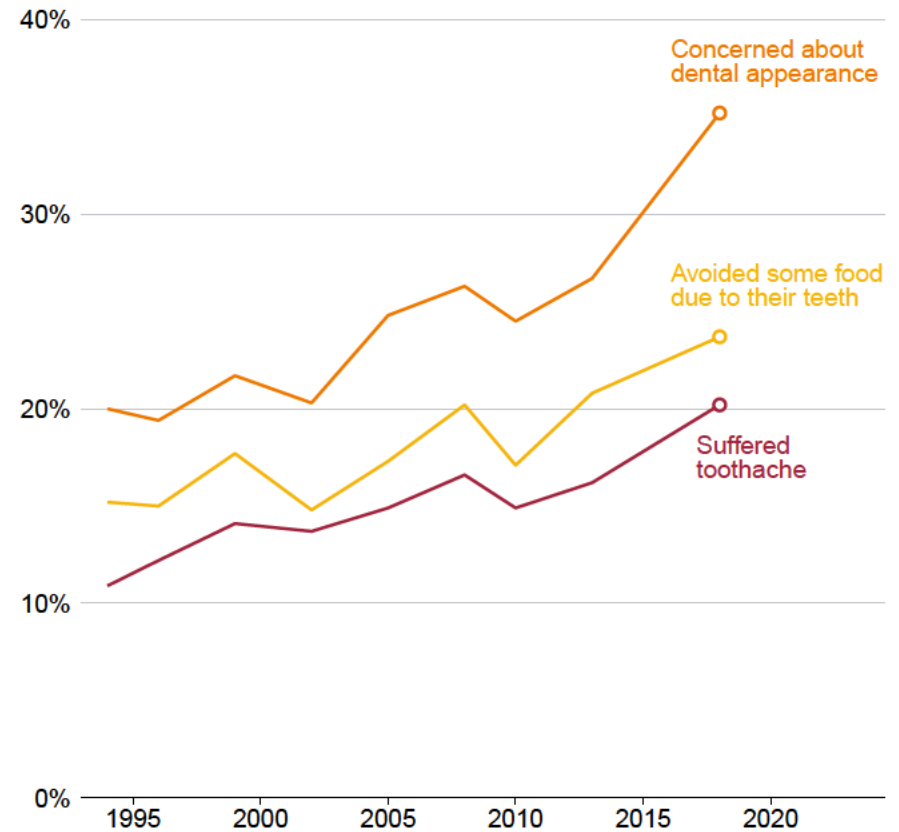
Proportion who have not seen a dentist within the past 12 months, and with the past five years (2017-18)



Note: SES = Socio-economic status.

Source: Brennan et al (2020).

**Figure 1.5: Dental problems are becoming more common**  
Proportion of adults who suffered oral health problems, 1994 to 2018



Sources: Duckett et al (2019) and ARCPOH (2019).



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The spread of conditions such as tooth decay can be arrested if treated early. But if people don't have regular check-ups, their oral health is more likely to degrade to the point where they require more extensive and expensive treatment. Regular care can prevent, arrest, or minimise oral health problems.<sup>10</sup>

Compared to people who have a good record of visiting the dentist, people who have a poor record of visiting the dentist are about 2.25 times more likely to have untreated tooth decay, and have five times the number of average decayed tooth surfaces per person.<sup>11</sup>

In almost all age groups, the lowest-earning third of Australians have the highest rates of untreated dental decay (Figure 1.6). For Australians between the ages of 15 and 34, the most disadvantaged third of people are 30 per cent more likely to have untreated dental decay compared to the most advantaged third.

**1.3 Waiting times for publicly funded schemes are still too long**

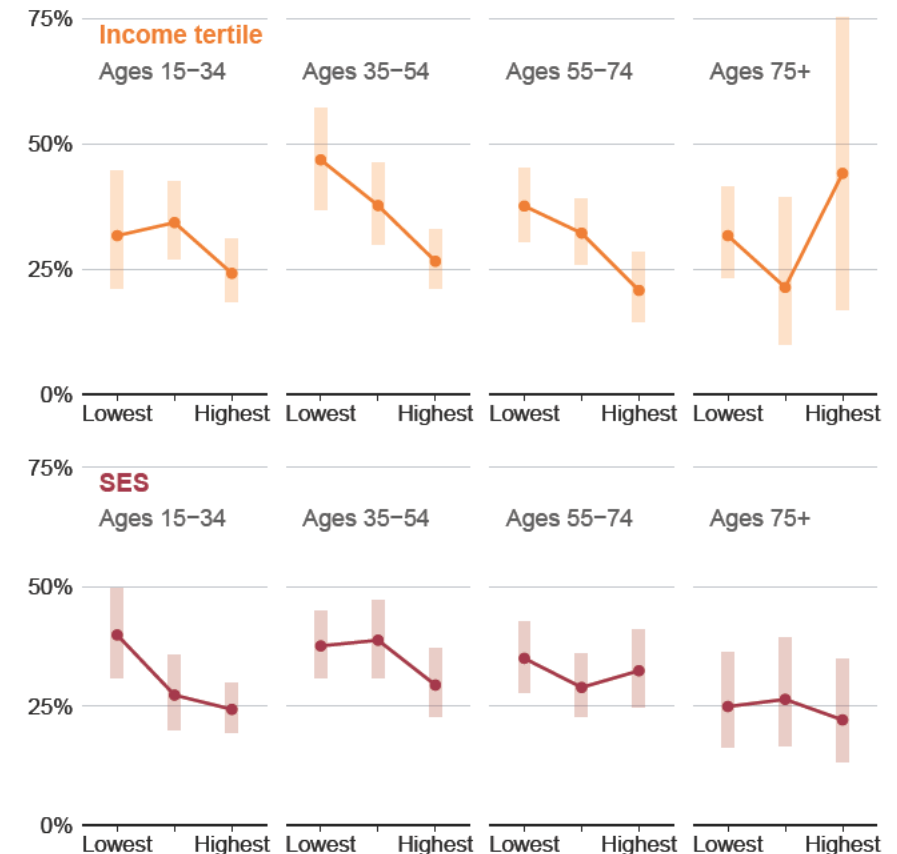
The alternative to private, and often expensive, dental care is public dental care. Public schemes are run by the states and territories, and can take away cost barriers.

But most Australians, particularly adults, are not eligible for public dental care.<sup>12</sup> Only about 23 per cent of Australians are eligible.<sup>13</sup>

And even for those who are eligible, there is no guarantee that they will receive a timely service. It is estimated that there is only capacity to provide services for about 20 per cent of the people who are eligible.<sup>14</sup>

10. Productivity Commission (2017).  
11. Peres et al (2020).  
12. Duckett et al (2019).  
13. Productivity Commission (2017).  
14. AIHW (2018).

**Figure 1.6: Poorer people tend to have more untreated dental decay**  
Proportion of Australians with untreated coronary dental decay, by income and SES status (2017-18)



Notes: SES = Socio-economic status. Shaded areas represent 95 per cent confidence intervals; we can be 95 per cent sure that the population average falls within this range.  
Source: Peres et al (2020).

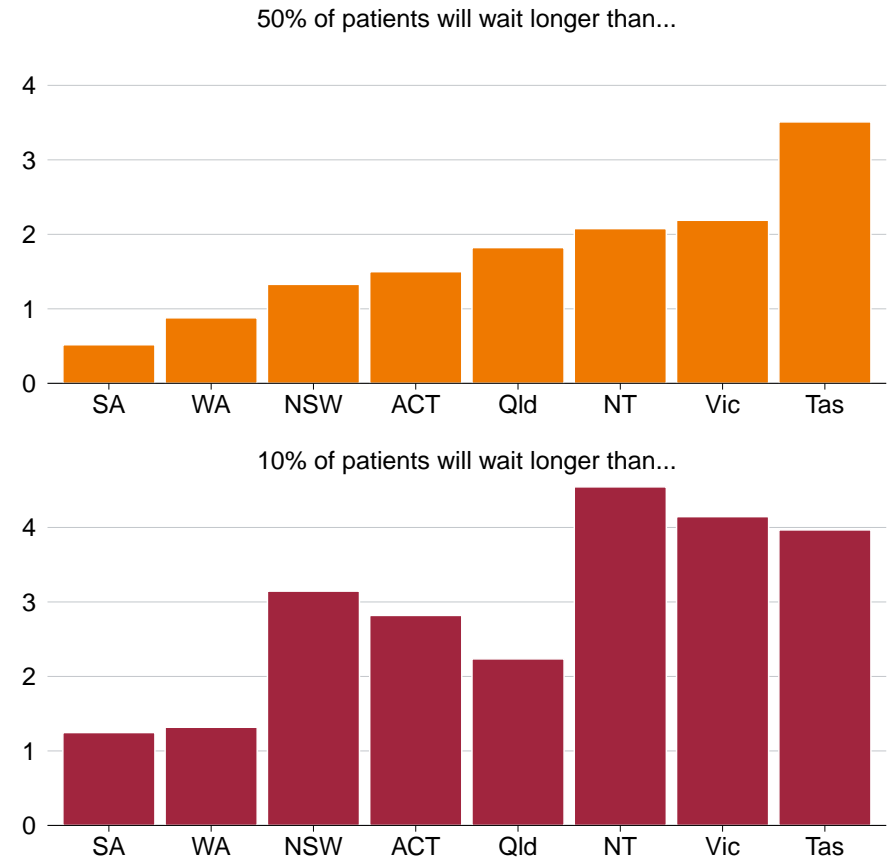
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The result is very long waiting lists in all jurisdictions. In almost every state and territory, most patients wait more than a year for a first appointment (Figure 1.7). In every state and territory except South Australia and Western Australia, half of patients wait more than a year for care, and 10 per cent of patients wait at least two years. In Tasmania, more than half of people on public dental waiting lists wait more than three years for care.

Waiting too long for care is bad for patients, and governments. If patients are forced to wait for care, their oral health problems will only get worse.<sup>15</sup> When those patients finally receive care, the cost of delivering that care will probably be higher than it would have been if the care had been provided months, or years, earlier.

**Figure 1.7: Most people in most states who are eligible for public dental care have to wait more than a year for it**

Wait times (years) for general dental care under state dental schemes (2021-22)



Note: Measures may not be comparable between states, due to differences in reporting.

Source: Productivity Commission (2023).

15. Productivity Commission (2017).



## 2 The best way to improve dental care in Australia is to introduce a universal system

In 2019, our *Filling the gap* report described each of the problems discussed in this submission in greater detail. Newer data included in this submission shows that the same gaps in access to dental care still exist, and that some problems have got worse.

Because the problems are the same, so are the solutions. Taking steps toward introducing a universal dental scheme, as outlined in *Filling the gap*, is still the best approach.<sup>16</sup>

A universal primary dental scheme would remove financial barriers to dental care and ensure that people can get the care they need, when they need it.

There is no compelling medical or economic reason to have a universal health care system for the rest of the body but not the mouth.<sup>17</sup> The exclusion of dental services from universal health coverage is an anomaly, probably the result of political choices made when Medibank and Medicare were designed and implemented decades ago.<sup>18</sup>

Report after report has recommended ways to close the dental gap. Some dental schemes have been introduced, but they have often been funded on a short-term basis and withdrawn with a change of government, and so the problem has festered.

The jump from the current incoherent patchwork of inadequate schemes to a national, systematic approach is significant. Given the

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16. The World Health Organisation (2010) has identified three dimensions of universal coverage: what services are covered; the extent of cost sharing or co-payments; and which populations are covered. The scheme we propose would cover all 'primary dental' services, with an emphasis on preventive care; would require no co-payments for primary dental care; and would cover the Australian population as per Medicare.

17. Russell (2014).

18. Menadue (2018).

degree of reform, funding, and national coordination needed, the National Health Reform Agreement (NHRA), due to be updated in 2025, should be the mechanism used to negotiate a deal between the federal government and the states. The Agreement should provide the overall direction for dental reform.

It would be impractical to move to a universal scheme overnight. The cost would be large – in 2019 Grattan estimated it to be about \$5.6 billion in extra spending per year – and the oral health workforce would need to be expanded. So, the federal government should announce a roadmap to a universal scheme, including plans to expand the workforce, followed by incremental steps towards a universal scheme.

As part of this, the recently commissioned review of health workforce regulation should encompass dental care. The review should ensure that dental clinicians can use all their skills, which will make it easier and less costly to increase access to dental care.<sup>19</sup>

The first step is for the federal government to takeover funding of existing public dental schemes, fund them properly, and enable private-sector providers to deliver publicly-funded care. Coverage should then be expanded – first to people on Centrelink payments, then all children. After that, the federal government should take the final step to a universal scheme, ideally within a decade.

Grattan's previous report, *Filling the gap*, can be found here: <https://grattan.edu.au/report/filling-the-gap/>. It explains in greater detail how the transition to a universal dental health system should be staged.

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19. Department of Health and Aged Care (2023).

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