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AUSTRALIAN DENTAL
ASSOCIATION INC.

SUBMISSION TO HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

'Inquiry into Health Funding'

13 May 2005

Authorised by
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EXECUTIVE SUMMARY

Like the health system generally, the organisation and delivery of dental care in Australia is characterised by the involvement of Commonwealth, State and Territory, and Local Governments. Unlike the health system though, dental care in Australia is largely financed by individual out-of-pocket expenses, with direct payments and subsidies by various levels of government making up the balance of expenditure.

The oral health of Australians is mixed. Child oral health ranks second best among all OECD countries while adult oral health ranks second worst.[1] Dental caries and periodontal diseases are the first and fifth most prevalent health problems among Australians respectively. Significantly, 90% of tooth loss can be attributed to these two problems, meaning that the majority of tooth loss in Australia is avoidable.[2]

Based on the latest figures from the Australian Institute of Health and Welfare (2002-03), the financing of Australia's dental system can be summarised as follows:

- Expenditure on oral health ranks seventh highest among the disease groups that account for the greatest level of health expenditure in Australia.

- Total expenditure on dental services in Australia in 2002-03 was $4.37 billion, the equivalent of 6.06% of total health expenditure. This has grown from $1.71 billion 1992-93 when dental services expenditure was the equivalent of 4.90% of total health expenditure.

- As a proportion of total expenditure on dental care, the Commonwealth Government's share has fallen from 2.22% in 1992-93 to 1.78% in 2002-03. (Total expenditure by the Commonwealth has risen from $38 million to $78

[1] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference, p. 7.
[2] Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement*, Final Report, Steering Committee for National Planning for Oral Health, p. i.

million in this period.) Direct expenditure by the Commonwealth Government peaked at $152 million in 1995-96 (the equivalent of 7.31% of total dental expenditure), the year before the Commonwealth Dental Health Program ceased.

- Indirect expenditure by the Commonwealth Government on dental care, through the 30% rebate for private health insurance, was $298 million in 2002-03, the equivalent of 6.81% of total dental expenditure.

- Expenditure by State and Territory and Local Governments was $342 million in 2002-03, the equivalent of 7.82% of total dental expenditure. This is a fall from its peak in 1999-00, when expenditure on dental services was $373 million, the equivalent of 12.94% of total dental expenditure. (State and Territory Governments are responsible for public dental services and school dental programs.)

- Expenditure by private health insurance funds was $680 million in 2002-03, the equivalent of 15.54% of total dental services expenditure. This proportion has halved since 1992-93 when expenditure was $535 million, the equivalent of 31.30% of total dental services expenditure.

- Expenditure by individuals has grown significantly in the period from 1992-93 to 2002-03, rising from $984 million (the equivalent of 57.58% of total dental expenditure), to $2.96 billion (the equivalent of 67.73% of total dental services expenditure).

As a general point of principle, the ADA believes that all levels of government should strive for open, transparent and detailed reporting of oral health expenditure and oral health program performance. Such information should provide sufficient detail to allow policy makers and interested stakeholders to analyse and benchmark the performance of governments.

Recommendations

The ADA makes the following recommendations to the House of Representatives Standing Committee on Health and Ageing:

1. That the Commonwealth Government adopt a leadership role to ensure that recommendations made in *Australia's National Oral Health Plan 2004-2013*[3] are implemented.

2. That governments work together to identify those sections of the community who are in greatest need for oral health care and funding be directed through targeted initiatives to meet those needs. (The current National Oral Health Survey will be a valuable source of information to inform and guide these initiatives.)

3. That all governments must recognise dentistry as an essential element of a nation's health service, and as such, oral health care should be available to every section of the community. Governments must also recognise that there are disadvantaged and special needs groups who will be unable to access reasonable levels of oral health care without assistance, and that they have a vital role in providing oral health services for individuals within these groups.

4. That the Commonwealth Government takes a leadership role in the provision of oral health care in Australia. One of the most cost-effective ways of dealing with large waiting lists is to introduce a scheme coordinated by the Commonwealth and delivered by State and Territory Governments. The Commonwealth Government should re-introduce a plan, akin to, but without the shortcomings of the previous Commonwealth Dental Health Plan, to reduce waiting times for people on public dental waiting lists throughout Australia. The ADA would be happy to offer its expertise and advise to work with the Government to formulate such a plan.

5. That all levels of government increase their financial contribution to the provision of dental care to the Australian community.

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[3] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference.

6. That the problems and initiatives identified in *Australia's National Oral Health Plan 2004-2013* are accepted and common agreement be reached between governments as to the level of dental care that will be provided by governments universally across the country.

7. That all governments work together to create parity between States and Territories with respect to the level of funding made available for the delivery of dental care. The disparities that exist have no logic to them and an equal commitment must be made by all governments.

8. That all State and Territory Governments adopt a uniform approach to reporting the following:

   - Funding for adult public dental services
   - Funding for childhood dental services
   - Number of adults receiving public dental care
   - Number of children receiving care through the school dental program
   - Number of adults on public dental waiting lists
   - Average waiting time for adult public dental care

9. That the Commonwealth Government create further scholarships for dental students from rural and remote parts of Australia as one measure to address the unequal distribution of dentists. Research suggests that dental students from rural and regional areas are more likely to work in these areas following their graduation.

10. That the Commonwealth Government create a moratorium or debt forgiveness on fee indebtedness for all dental graduates who in turn agree to provide their services in rural and remote areas or in the public sector. The extent of the moratorium or debt forgiveness could reflect the period of time the dental graduate undertakes practice in those particular areas. The longer the period of guaranteed service in rural or remote areas, the greater the moratorium or debt forgiveness.

11. That the Commonwealth Government plays a leadership role to ensure consistent planning across all states and territories with respect to dental workforce planning and development. This view is expressed in *Australia's National Oral Health Plan 2004-2013.*

12. That the Commonwealth Government continues to ensure a rigorous process of approval before private health insurance funds increase premiums.

13. In the review process of premiums, health insurers are required to undertake that benefits paid remain commensurate with the increased premium.

14. That in ensuring that adequate benefits are paid, health insurers not participate in practices that impact adversely on the quality of care provided in return for those benefits.

15. That private health insurance funds be prevented from changing the benefits and conditions that apply to an insurance product at any time. Benefits and conditions should only be altered on an annual basis following an approval process similar to that which apples to premium changes.

INTRODUCTION

The Australian Dental Association's submission responds to the House of Representatives Standing Committee on Health and Ageing's 'Inquiry into Health Funding', announced on 16 March 2005. Announcing the inquiry, the Chairman, the Hon. Alex Somlyay MP[4] said:

> *"The Commonwealth spends $41 billion a year on health funding and ageing and over the past 18 months we have committed an extra $11 billion to health spending to improve things like bulk-billing rates, nursing home standards and access to private health insurance. In spite of these improvements, the public perception is that the health system is not providing what Australians need and we need to look at why that is."*

The Australian Dental Association

The Australian Dental Association Inc. (ADA) represents approximately 9,000 registered dental practitioners in Australia, the equivalent of over 90% of all dental practitioners in this country. The primary objective of the ADA is to encourage the improvement of the health of the public and to promote the art and science of dentistry.

The ADA has a strong track record in responding to government inquiries into health, ageing, oral health, and workforce issues. Some of our recent submissions include:

- Department of Education, Science and Training in relation to the 'Building University Diversity: Future approval and accreditation processes for Australian higher education (Issues Paper)', April 2005
- Industry Skills Council in Relation to the HLT02 Discussion Paper, January 2005
- Pre Federal Budget Submission, November 2004
- Productivity Commission on the Economic Implications of an Ageing Australia, August 2004

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[4] Somlyay, A. (2005) *Somlyay Launches New Inquiry Into Health Funding,* Media Release, 16 March, Hon. Alex Somlyay MP, Standing Committee on Health and Ageing, House of Representatives, Canberra.

- Medicare Senate Select Committee, December 2003
- Pre Federal Budget Submission, October 2003
- Submission to the Department of Veterans' Affairs, September 2003
- Submission to the Senate Employment, Workplace Relations and Education References Committee, August 2003
- Submission to the Senate Select Committee on Medicare, July 2003.

Terms of reference

The terms of reference for the House of Representatives Standing Committee on Health and Ageing's 'Inquiry into Health Funding' are:

a. Examine the roles and responsibilities of the different levels of government (including local government) for health and related services;
b. Simplify funding arrangements, and better define roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;
c. Consider how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;
d. How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between health funding, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and
e. While accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

This submission

While the ADA's submission will pay some attention to the broader issues of health financing, the focus of this submission will be to examine the issues raised in the terms of reference in the context of how they impact on Australians access to dental care, dentistry, and the oral health of the Australian population.

(a) Examine the roles and responsibilities of the different levels of government (including local government) for health and related services

Like a number of health programs, the three levels of government – Commonwealth, State and Territory, and Local – all assume some degree of responsibility for the organisation and delivery of dental care in Australia.

Historically, the Commonwealth Government has funded a mix of dental services (see below), while State and Territory Governments have assumed responsibility for adult public dental services and school dental programs.

From a legislative sense, each State and Territory in Australia has a Dental Act or its equivalent. In New South Wales, for example, the object of the Dental Practice Act 2001[5] is:

> *"To protect the health and safety of members of the public by providing mechanisms to ensure that:*
>
> *(a) dentists are fit to practise dentistry, and*
> *(b) dental auxiliaries are fit to carry out dental auxiliary activities, and*
> *(c) dental students are fit to undertake dental studies and clinical placements."*

In Victoria, the main purposes of the Dental Practice Act 1999[6] are:

> *(a) "to provide for the registration of dental care providers and investigations into the professional conduct and fitness to practice of registered dental care providers; and*
> *(b) to regulate the provision of dental care services; and*

[5] Accessed from http://www.legislation.nsw.gov.au/maintop/scanact/inforce/NONE/0 on 19 April 2005.
[6] Accessed from http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/2184e627479f8392ca256da50082bf3e/e7204f38e7a4a469ca256fd9001bb05d/$FILE/99-26a015.pdf on 19 April 2005.

(c) to establish the Dental Practice Board of Victoria and the Dental Practice Board Fund; and

*(d) to repeal the **Dentists Act 1972** and the **Dental Technicians Act 1972** [emphasis in original]; and*

(e) to provide for other related matters."

Although the Commonwealth Government has traditionally played a small role in the provision of dental services in Australia, this is due more to historical custom rather than a formal separation of powers. According to Harford and Spencer,[7] "the Commonwealth Government has exactly the same constitutional powers [S. 51, xxiiiA] to fund dental services as it has for medical services since 1948". The same authors argue that despite playing a relatively small role in the provision of dental care, the Commonwealth Government has nonetheless provided a variety of services over the past 35 years. These include:

- State-based School Dental Service in the early 1970s (In 1981, funds for this program were rolled into block funding for community health services provided by State and Territory Governments.[8])
- Commonwealth Dental Health Program in the mid 1990s
- 30% rebate for private health insurance (covering ancillary services)
- Funding for specific populations such as the Department of Veterans' Affairs, Department of Defence, in-hospital oral care services and outpatient radiological services through Medicare.

As part of its MedicarePlus package, the Commonwealth Government introduced an additional MBS item in 2004 to fund "dental treatment plans ... for ... patients [with chronic conditions and complex needs] where they have significant dental problems that exacerbate their condition."[9]

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[7] Harford, J and Spencer AJ. (2004) 'Government subsidies for dental care in Australia', *Australian and New Zealand Journal of Public Health*, Vol. 28, No. 4, pp 363-368.

[8] Auditor General Victoria (2002) *Community Dental Services*, p. 30

[9] Source: MedicarePlus: Update March 2004, Accessed from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-policy_history-2004-glance.htm/$FILE/glance.pdf on 20 April 2005.

The separation of responsibility for oral health in Australia has led to a lack of coordination in the provision of oral health services. This point was highlighted by the Australian Health Ministers' Advisory Council[10] which argued:

> *"Dental services in Australia have developed in a piecemeal fashion without overarching planning to address the needs of the community. Their separation from general health services and the fact that they are largely financed from private sources has resulted in the development of a set of independent services without any systematic coordination and with minimal formal linkages to general health services."*

Australia's oral health

The oral health of Australians is mixed. On the positive side, the oral health of Australian children ranks second among all OECD countries. On the negative side, the oral health of adults ranks second worst among OECD countries.[11]

Despite the good oral health of Australian children, research by Armfield, Roberts-Thompson and Spencer[12] shows that after many years of improvement, the oral health of Australian children is beginning to show signs of decline. According to the authors, deciduous decay across children of all age groups increased during the period from 1996-1999. (This increase followed a fall in rates of decay from 1991-1996.) The trend since 1996 was most significant for five year old year old children, who experienced a 21.7% increase in deciduous decay during this period.

The most recent burden of disease study (1999) showed that in 1996, oral health disease for all Australians ranked 11th for years of life lost due to disability (YLD).[13] The incidence and prevalence of dental caries and

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[10] Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement*, Final Report, Steering Committee for National Planning for Oral Health, p. 66.

[11] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013,* A Committee Established by the Australian Health Minister's Conference, p. 7.

[12] Armfield, JM., Roberts-Thompson, KF. and Spencer, AJ. (2003) *The Child Dental Health Survey, Australia 1999: Trends Across the 1990s,* AIHW Cat. No. DEN 95, The University of Adelaide, AIHW, Dental Statistics and Research Series No. 27, p. 27.

[13] Mathers, C., Voss, T. and Stevenson, C. (1999) *The Burden of Disease and Injury in Australia,* Australian Institute of Health and Welfare, AIHW Cat. No. PHE 17, Canberra, p. 41.

periodontal diseases are particularly high in Australia, as highlighted in Table 1. According to the Australian Health Minister's Advisory Council:[14]

> *"Dental caries is the most prevalent health problem in Australia accounting for 19 million existing and 11 million newly decayed teeth each year. Periodontal diseases are the fifth most prevalent health problem among Australians. This establishes these oral diseases as silent epidemics in Australia. About 90 per cent of all tooth loss can be attributed to these two health problems, and because they are preventable and treatable, most of that tooth loss is avoidable".*

Table 1: Dental caries, periodontal disease and edentulism

	Incidence per 1,000		Prevalence per 1,000		Total	
	Male	**Female**	**Male**	**Female**	**Incidence**	**Prevalence**
Dental caries*	596.4	591.7	1,050.4	1,026.6	10,877,803	19,014,040
Periodontal disease	21.4	22.2	54.3	57.9	399,688	1,027,180
Edentulism	1.5	3.5	43.1	109.1	45,212	1,396,740

Source: Mathers, C., Vos, T. and Stevenson, C. (1999) *The Burden of Disease and Injury in Australia,* AIHW Cat. No. PHE 17, Australian Institute of Health and Welfare, Canberra, p. 209.
* Prevalence estimates relate to total decayed teeth (excluding missing and filled teeth), not to people with decayed teeth.

The effect of such a high rate of preventable disease being left untreated has the potential to impact negatively on individual's general health. Research suggests there is a link between oral disease (such as periodontal disease) and systemic disease (such as cardiovascular disease).[15]

When left untreated, oral disease can lead to increased rates of hospitalisation. The Productivity Commission's[16] *Report on Government Services 2005* highlights that in 2002-03 there were 223 hospitalisations per 100,000 people for dental conditions that were potentially preventable.

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[14] Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement,* Final Report, Steering Committee for National Planning for Oral Health, p. i.
[15] Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement,* Final Report, Steering Committee for National Planning for Oral Health, p. ii.
[16] SCRGSP (Steering Committee for the Review of Government Service Provision) (2005) *Report on Government Services 2005,* Productivity Commission, Canberra, p. 10.43

Indigenous Australians are a significant population group with poor oral health. According to the Australian Institute of Health and Welfare's (AIHW) Dental Statistics and Research Unit:[17]

> *"Aboriginal and Torres Strait Islander children have more than twice the caries rates of non-Indigenous children in the deciduous dentition. Dental caries in the permanent dentition among 12-year-old Indigenous children is almost twice that of non-Indigenous children. Dental caries rates in Indigenous children seem to be increasing."*

The Australian Health Ministers' Advisory Council[18] has reported that "some 16.3 per cent of Australia's Indigenous population is edentulous compared to 10 per cent of the non-Indigenous population".

National Oral Health Plan

While the oral health of the Australian population is mixed, the release of *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*[19] in 2004 has the potential – if fully implemented – to act as an important step forward to improve the oral health of the Australian population.

Australia's National Oral Health Plan 2004-2013 identifies seven areas – promoting oral health across the population; children and adolescents; older people; low income and social disadvantage; people with special needs; Aboriginal and Torres Strait Islander Peoples; and workforce – that are regarded as being of high priority in improving the oral health of the Australian population.[20]

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[17] Australian Institute of Health and Welfare (2003) *Oral Health of Aboriginal and Torres Strait Islander Persons*, AIHW Dental Statistics Research Unit, Australian Research Centre for Population Oral Health, Research Report No. 14, The University of Adelaide.

[18] Australian Health Ministers' Advisory Council (2001) *Oral Health of Australians: National Planning for Oral Health Improvement,* Final Report, Steering Committee for National Planning for Oral Health, p. iii.

[19] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference.

[20] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference, p. vii.

What is missing, following the release of the national oral health plan, is the necessary leadership of the Commonwealth Government to ensure its key objectives are met. When commenting on the national oral health plan, the ADA[21] has previously argued:

> *"The recognition of a relationship between oral and general health clearly identifies the need for the Commonwealth to undertake a leadership role in the delivery of dental services as an investment in dental care will not only alleviate dental disease but will have the flow-on effect of reducing later general health expenditure."*

National Oral Health Survey

The current National Oral Health Survey, being conducted by the Australian Research Centre for Population Oral Health at The University of Adelaide, will provide much needed data on the oral health of the Australian population. The ADA has acknowledged the significant support this survey has received from the Commonwealth Government.

The ADA has made the following contributions to advance the survey:

- $60,000 donated to the Australian Research Centre for Population Oral Health
- All ADA members notified that the survey has commenced
- ADA members have indicated a willingness to participate in the survey's assessment process.

The survey is well overdue as the last such survey was conducted in 1987-88. This means that comprehensive data about the oral health of the Australian population is considerably out of date. The completion of the National Oral Health Survey will provide governments with the necessary data to make informed decisions about future directions of the delivery of oral health care in Australia. Despite the benefit of the new survey, there is currently strong evidence to show that the oral health of the Australian population is deteriorating, highlighting the urgent need for immediate action.

[21] Australian Dental Association (2004) 'Australia's National Oral Health Plan 2004-2013 Part One', *National Dental Update*, August.

Recommendations

1. That the Commonwealth Government adopt a leadership role to ensure that recommendations made in *Australia's National Oral Health Plan 2004-2013* are implemented.

2. That governments work together to identify those sections of the community who are in greatest need for oral health care and funding be directed through targeted initiatives to meet those needs. (The current National Oral Health Survey will be a valuable source of information to inform and guide these initiatives.)

(b) Simplify funding arrangements, and better define roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals.

Health expenditure in Australia has risen considerably over the past decade, as shown in Table 2. Recent reports by the Productivity Commission have highlighted the impact of medical technology[22] and an ageing population[23] as key drivers for increases in health expenditure in future years.

Just as overall health expenditure has risen over the past decade, so has expenditure on dental care. Expenditure on oral health ranks seventh highest among the disease groups that account for the greatest level of health expenditure in Australia.[24] Figures from the Australian Institute of Health and Welfare[25] show that as a proportion of total health expenditure, dental services expenditure has risen from 4.90% to 6.06% during the period from 1992-93 to 2002-03.

Table 2: Dental services expenditure as percentage of total health expenditure: Australia, 1992-93 to 2002-03

	Total health expenditure ($ million)	Dental services expenditure ($ million)	Dental services expenditure as % of total health expenditure
1992-93	34,910	1,709	4.90%
1993-94	36,495	1,831	5.02%
1994-95	38,898	1,943	5.00%
1995-96	41,308	2,373	5.74%
1996-97	44,279	2,551	5.76%
1997-98	47,030	2,591	5.51%
1998-99	44,279	2,566	5.03%
1999-00	51,011	2,882	5.20%
2000-01	55,427	3,448	5.59%
2001-02	61,660	4,085	6.14%
2002-03	72,182	4,374	6.06%

Source: Australian Institute of Health and Welfare, 'Health Expenditure Australia', Various Years.

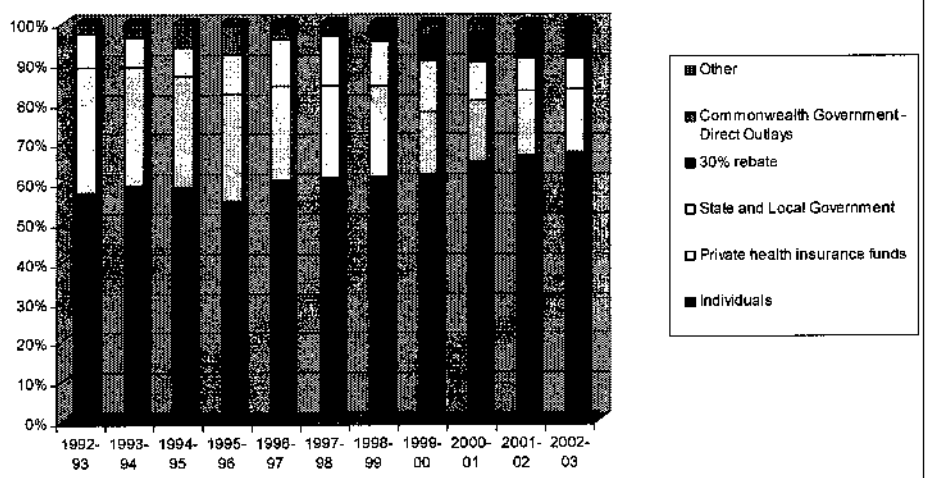
While expenditure on dental services has risen sharply in the decade from 1992-93 to 2002-03, the most significant aspect of this rise has been the change in composition of expenditure. Key aspects of the changing compositing in dental services expenditure, as highlighted in Figure 1, are:

[22] Productivity Commission (2005) *Impacts of Medical Technology in Australia*, Progress Report, Melbourne.
[23] Productivity Commission (2005) *Economic Implications of an Ageing Australia*, Research Report, Canberra.
[24] Australian Institute of Health and Welfare (2005) *Health System Expenditure on Disease and Injury in Australia, 2000-01*, Second Edition, AIHW Cat. No. HWE 28, p. vii.
[25] Source: Australian Institute of Health and Welfare, 'Health Expenditure Australia', Various years.

- Total expenditure on dental services in Australia in 2002-03 was $4.37 billion, the equivalent of 6.06% of total health expenditure. This has grown from $1.71 billion 1992-93 when dental services expenditure was the equivalent of 4.90% of total health expenditure.
- As a proportion of total expenditure on dental care, the Commonwealth Government's share has fallen from 2.22% in 1992-93 to 1.78% in 2002-03. (Total expenditure by the Commonwealth has risen from $38 million to $78 million in this period.) Direct expenditure by the Commonwealth Government peaked at $152 million in 1995-96 (the equivalent of 7.31% of total dental expenditure), the year before the Commonwealth Dental Health Program ceased.
- Indirect expenditure by the Commonwealth Government on dental care, through the 30% rebate for private health insurance, was $298 million in 2002-03, the equivalent of 6.81% of total dental expenditure.
- Expenditure by State and Territory and Local Governments was $342 million in 2002-03, the equivalent of 7.82% of total dental expenditure. This is a fall from its peak in 1999-00, when expenditure on dental services was $373 million, the equivalent of 12.94% of total dental expenditure. (State and Territory Governments are responsible for public dental services and school dental programs.)
- Expenditure by private health insurance funds was $680 million in 2002-03, the equivalent of 15.54% of total dental services expenditure. This proportion has halved since 1992-93 when expenditure was $535 million, the equivalent of 31.30% of total dental services expenditure.
- Expenditure by individuals has grown significantly in the period from 1992-93 to 2002-03, rising from $984 million (the equivalent of 57.58% of total dental expenditure), to $2.96 billion (the equivalent of 67.73% of total dental services expenditure).

The decline in expenditure on dental care by all levels of government as a proportion of total dental expenditure has come at a time when the oral health of the Australian population, particularly those on public dental waiting lists, has declined.

Figure 1: Dental Expenditure by Source as % of Total Dental Expenditure: 1992-93 to 2002-03



Source: Australian Institute of Health and Welfare, 'Health Expenditure Australia', Various Years.

Expenditure by State and Territory Governments

As Figure 1 shows, expenditure on dental services by State and Territory Governments has remained relatively steady in the decade from 1992-93 to 2002-03, growing from $146 million (the equivalent of 8.54% of total expenditure) to $342 million (the equivalent of 7.82% of total expenditure).

Despite the total amount of expenditure on dental services by State and Territories remaining relatively consistent over the past 10 years, there is significant difference in the amount spent on dental services by each State and Territory, including total expenditure, per capita expenditure and expenditure per concession card holder.

As Table 3[26] highlights, total dental services expenditure by Queensland is the highest in the country and third highest on a per capita basis and per concession card holder. By contrast, expenditure by New South Wales is lowest on a per capita basis and per concession card holder.

[26] Note: 2001-02 expenditure figures are based on latest data from the Australian Institute of Health and Welfare and therefore do not necessarily reflect the most up-to-date information. Victoria, for example, has considerably increased funding for public adult dental services in recent years.

Table 3: State and Territory Governments: total dental expenditure, per capita dental expenditure and expenditure per concession card holder

	2001-02 dental expenditure	Per capita dental expenditure ($)	Expenditure ($) per concession card holder*
NSW	78,000,000	11.76	50.40
TAS	10,000,000	21.16	69.36
VIC	95,000,000	19.56	78.73
SA	35,027,000	23.06	84.18
WA	45,166,048	23.47	105.04
QLD	111,000,000	29.91	121.51
ACT	7,000,000	21.77	143.78
NT	7,000,000	35.23	160.16

Source: AIHW 'Health Expenditure Australia', Various Years; ABS; Centrelink.
* Based on the most recent figures from Centrelink then discounted for population growth.

The relatively low level of expenditure by New South Wales and Victoria has meant both states have struggled to keep up with rising demand for public dental care, leading to extensive waiting lists. This difficulty has been exacerbated since the cessation of the Commonwealth Dental Health Program (discussed below). As Table 4 highlights, there were 619,704 people on public dental waiting lists throughout Australia in June 2002, a significant rise from 458,000 people in June 1997.

Table 4: Waiting lists for public dental care, State and Territories

	Number of people		Waiting time (months)	
	June 1997	June 2002	June 1997	June 2002
NSW	114,000	162,303*	Up to 58	n.a.
VIC	143,000	218,952	16	27
QLD	69,000	114,742	10	17
WA	11,000	26,090	8	13
SA	78,000	91,053	22	49
TAS	13,400	n.a.	30	n.a.
NT	n.a.	3,920	n.a.	32
ACT	3,600	2,644	15-30	25
TOTAL	**458,000**	**619,704**		

Source: National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013,* A Committee Established by the Australian Health Minister's Conference, p. 10.
* Figures for NSW are based on a report in the *Sydney Morning Herald*[27] in February 2005 as they are not cited in the original source.

Commonwealth Dental Health Program

The cessation of the Commonwealth Dental Health Program (CDHP) proved to be an issue that generated considerable debate about the role of the Commonwealth Government in funding public dental services.

[27] Pearlman, J. and Ryan, G. (2005) 'Dental crisis exposes great divide', *Sydney Morning Herald,* 15 February.

Introduced by the Keating Government in 1994, the purpose of the CDHP was to improve access to dental care for adult health card holders by utilising private dental practitioners in the delivery of oral care to those on public waiting lists. The CDHP provided funds to State and Territory Governments for their emergency dental scheme and general dental scheme. Care was provided to an additional 200,000 patients per year, costing $30 million for both schemes in 1994. In 1995, funding for the general dental scheme was increased to $70 million. [28] Budget papers show that by 1999-00, expenditure on the CDHP was projected to be $116.5 million.[29]

An evaluation[30] of the CDHP showed it lead to the following benefits for patients:

- Less perceived need for extractions
- Less experience of toothache
- More frequent dental care
- Shorter waiting periods for care
- Fewer extractions
- More fillings
- Increased satisfaction.

While these were significant achievements of the program, the evaluation[31] found that there was only a small shift away from emergency to general dental care, despite this being a key intention of the program.

The evaluation of the CDHP concluded by saying:[32]

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[28] Brennan, D., Carter, K., Stewart, J. and Spencer, A. (1997) *Commonwealth Dental Health Program Evaluation Report 1994-1996,* Australian Institute of Health and Welfare Dental Statistics and Research Unit, The University of Adelaide, Adelaide, p. 1.
[29] Commonwealth Department of Treasury and Finance (1996) *1996-97 Budget Statement 3,* p. 3-16.
[30] Brennan, D., Carter, K., Stewart, J. and Spencer, A. (1997) *Commonwealth Dental Health Program Evaluation Report 1994-1996,* Australian Institute of Health and Welfare Dental Statistics and Research Unit, The University of Adelaide, Adelaide, p. 1.
[31] Brennan, D., Carter, K., Stewart, J. and Spencer, A. (1997) *Commonwealth Dental Health Program Evaluation Report 1994-1996,* Australian Institute of Health and Welfare Dental Statistics and Research Unit, The University of Adelaide, Adelaide, p. 1.
[32] Brennan, D., Carter, K., Stewart, J. and Spencer, A. (1997) *Commonwealth Dental Health Program Evaluation Report 1994-1996,* Australian Institute of Health and Welfare Dental Statistics and Research Unit, The University of Adelaide, Adelaide, p. 84.

"In the comparatively short time that it operated, the CDHP achieved improved public-funded dental care for more card-holders. However, card-holders are still disadvantaged in terms of their oral health and access to dental care. Future initiatives to improve access to care and the oral health of disadvantaged Australian adults can benefit from more restricted targeting of eligibility, and altered procedures for the provision of care so as to give more emphasis to general dental care."

The axing of the CDHP had an immediate impact on access to public dental care. Waiting lists grew nationally by 20% within 12 months and Victoria and Western Australia introduced co-payments for public dental services.[33] The growth in waiting lists is significant when the relationship between social inequality and oral health status is considered. According to Sanders and Spencer,[34] socio-economically disadvantaged groups rate their oral health poorer than more advantaged groups. Disadvantaged groups report more tooth loss and more problems with their teeth, mouth or dentures than advantaged groups.

Dental services and Medicare

The question of whether dentistry should be included under Medicare was a point of discussion in 2003 by the Senate Select Committee on Medicare. Evidence presented to the Committee by Professor John Deeble[35] made the point that due to its nature, dentistry was never intended to be included under Medicare when it was first conceived:

"The main problem with Medicare covering the (dental) industry is its basic uninsurability. It does not come randomly ... It has to be said that insurance works for best for things that are episodic and unpredictable. Dental illness is slow: it is not episodic and it is not unpredictable, because you know you have it for quite a long time. You do not suddenly discover that you have a dental problem. It should be treated, but it

[33] Zigarus, S. (2001) 'Time for a new national dental health scheme', *Brotherhood Comment,* August, Brotherhood of St Laurence, Fitzroy, pp. 12-13.
[34] Sanders, A. and Spencer AJ. (2004) 'Social inequality in perceived oral health among adults in Australia', *Australian and New Zeeland Journal of Public Health,* Vol. 28, No. 2, pp. 159-166.
[35] Evidence presented by John Deeble to the Senate Select Committee on Medicare. Source: Commonwealth of Australia (2003) *Official Committee Hansard,* Senate, Senate Select Committee on Medicare, 21 July, Canberra, p. 71.

should not be treated within an insurance approach. It should be a program that is different from an insurance concept, because it just does not work that way. That is why it was never added."

The ADA holds the view that dental services should not be funded under Medicare, a view expressed by the former Finance Minister, Peter Walsh in 1985.[36] The ADA believes that in funding oral health care delivery programs for eligible groups and individuals, government assistance should be directed preferentially to those in greatest financial and oral health need. There is a need to target money and resources to those who currently have very poor or restricted access to dental care.

Recommendations

3. That all governments must recognise dentistry as an essential element of a nation's health service, and as such, oral health care should be available to every section of the community. Governments must also recognise that there are disadvantaged and special needs groups who will be unable to access reasonable levels of oral health care without assistance, and that they have a vital role in providing oral health services for individuals within these groups.

4. That the Commonwealth Government takes a leadership role in the provision of oral health care in Australia. One of the most cost-effective ways of dealing with large waiting lists is to introduce a scheme coordinated by the Commonwealth and delivered by State and Territory Governments. The Commonwealth Government should re-introduce a plan, akin to, but without the shortcomings of the previous Commonwealth Dental Health Plan, to reduce waiting times for people on public dental waiting lists throughout Australia. The ADA would be happy to offer its expertise and advise to work with the Government to formulate such a plan.

5. That all levels of government increase their financial contribution to the provision of dental care to the Australian community.

[36] Source: ADA (2004) 'Election Edition', *National Dental Update*, September.

(c) Considers how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved

As previous sections of this submission have shown, there is a significant disparity between the level of funding provided by State and Territory Governments in Australia. The ADA believes that States and Territories should strive to ensure uniformity in the provision of dental care and levels of funding.

Furthermore, the ADA believes that all levels of government should strive for open, transparent and detailed reporting of oral health expenditure and oral health program performance. Such information should provide sufficient detail to allow policy makers and interested stakeholders to analyse and benchmark the performance of governments.

Recommendations

6. That the problems and initiatives identified in *Australia's National Oral Health Plan 2004-2013* are accepted and common agreement be reached between governments as to the level of dental care that will be provided by governments universally across the country.

7. That all governments work together to create parity between States and Territories with respect to the level of funding made available for the delivery of dental care. The disparities that exist have no logic to them and an equal commitment must be made by all governments.

8. That all State and Territory Governments adopt a uniform approach to reporting the following:

   - Funding for adult public dental services
   - Funding for childhood dental services
   - Number of adults receiving public dental care
   - Number of children receiving care through the school dental program
   - Number of adults on public dental waiting lists
   - Average waiting time for adult public dental care

(d) How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between health funding, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government

The provision of dental care in Australia is largely by private providers, supplemented by a mix of publicly provided care. The ADA believes there are two significant issues (firstly, future dental workforce and secondly, higher education changes) that have the potential to impact on the supply of dentists, and therefore the provision of oral health care to the Australian population in future years.

Current dental workforce

Before examining future pressures on the dental workforce, it is worth examining the current situation. A review of the Australian dental labour force in 2000 by Teusner and Spencer[37] showed that 82.6% of all practising dentists worked in the private sector, while 16.2% worked in the public sector and 1.2% worked in other areas of industry.

Other key points of the dental labour force are: [38]

- The number of dentists has risen from 43 dentists per 100,000 population in 1994 to 46.9 dentists per 100,000 population in 2000. (During this same period the dental labour force increased by 17.3% compared to a population increase of 7.4%).
- Despite this rise, Australia ranks nineteenth out of 29 OECD countries for numbers of practising dentists per 100,000 population.
- The dental labour force is ageing. In 1994, 43% of practising dentists were aged 40 years or under. By 2000, this figure had fallen to 36.2%. In 1994, 28.6% of practising dentists were aged 50 years and over. This figure had increased to 31.9% by 2000.

[37] Teusner, D. and Spencer, A. J. (2003) *Dental Labour Force, Australia 2000,* Dental Statistics and Research Unit, Australian Institute of Health and Welfare, AIHW Cat. No. DEN 116, p. 8.
[38] Teusner, D. and Spencer, A. J. (2003) *Dental Labour Force, Australia 2000,* Dental Statistics and Research Unit, Australian Institute of Health and Welfare, AIHW Cat. No. DEN 116, p. 5-12.

- Female practitioners comprise 22.9% of all dental practitioners.
- 82.6% of dentists work in private sector. 16.2% work in public sector and 1.2% work in other types of practice including industry.
- Of dentists working in public practice, 30.5% work in a dental hospital and 27.4% work in general dental services.

Dental workforce demand

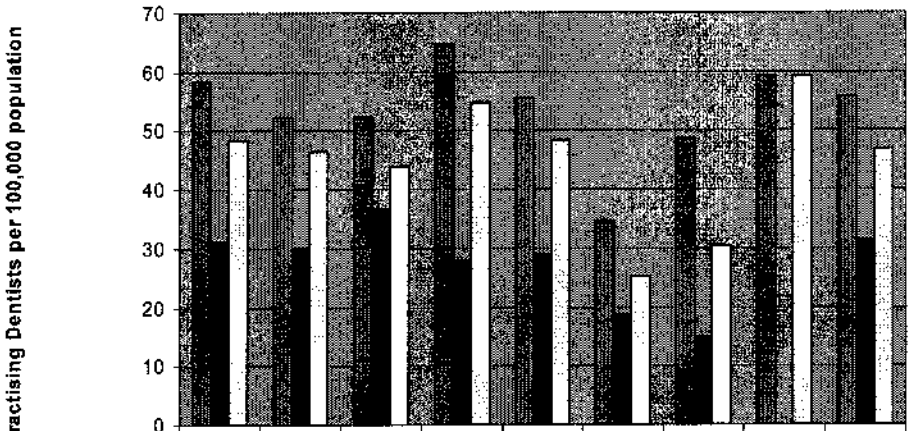
Although there has been a growth in the dental labour force in recent years, this may not be enough to meet the future demand. According to Spencer et al:[39]

> *"The capacity to supply visits is projected to fall well short of the Australian population's demand for dental visits ... If trends in demand continue, even at half the pace observed during 1983-1998, Australians' demand for dental visits will increase from 23.8 million visits in 1995 to 33.2 million visits in 2010. The increase in demand is projected to be predominantly among middle-aged and older Australians, and for diagnostic, preventive, endodontic and crown and bridge services. The aggregate projected shortage in supply in 2010 is about 3.8 million visits, which equates to approximately 1,500 dental providers.*

Another key aspect of the dental labour force demand is the unequal distribution of dentists in metropolitan areas compared to rural and regional areas. As Figure 3 highlights, there are 55.7 practising dentists per 100,000 population in metropolitan areas compared to 31.4 practising dentists per 100,000 population in rural and regional areas. **The ADA believes this is creating an unreasonable burden on rural dentists. More importantly, the ability of people living in rural communities to obtain dental care is made increasingly difficult and in too many cases impossible without travelling to major cities. This only adds to the cost of care which, with some simple action, could be avoided.**

[39] Spencer, A.J., Teusner, D.N., Carter, K.D. and Brennan, D.S (2003) *The Dental Labour Force in Australia: The Position and Policy Directions,* Population Oral Health Series No. 2, AIHW cat. No. POH 2, Australian Institute of Health and Welfare, Canberra, p. 2.

Figure 3: Practising Dentists per 100,000 Population: 2000



	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
Capital city	58.4	52.4	52.3	64.6	55.6	34.6	48.7	59.2	55.7
Rest of state	31.2	29.9	36.7	28.1	29	18.7	15		31.4
All	48.4	46.3	43.9	54.8	48.5	25.3	30.5	59.3	46.9

Source: Source: Teusner, D. and Spencer, J. (2003) *Dental Labour Force, Australia 2000*, Dental Statistics and Research Unit, Australian Institute of Health and Welfare, AIHW Cat. No. DEN 116, Figure 7, p. 10.

One way to address the shortage of dentists in rural and regional areas is to encourage students from those areas to study dentistry. Research suggests that upon graduation, such students are more likely to return to practice in rural and regional areas.[40] This view is supported by a study published in 2001 in the *Australian Journal of Rural Health*[41] which surveyed 100 first-year medical students at The University of Melbourne's Faculty of Medicine, Dentistry and Health Sciences. A key finding of the study was that 86% of students from a rural background intended to undertake internship training in a rural hospital compared to 30% of students from an urban background.

Higher education changes

Recent changes to Australia's higher education system have the potential to add to the unequal distribution of dentists in Australia and reduce incentives for dentists to work in the public dental system.

[40] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference, p. 41.

[41] Azer, S., Simmons, D. and Elliot, S. (2001) 'Rural training and the state of rural health services: effect of rural background on the perception and attitude of first-year medical students at the University of Melbourne', *Australian Journal of Rural Health*, 9: 178-185.

According to *Australia's National Oral Health Plan 2004-2013,*[42] the number of graduates from Australia's dental schools is one-third less than in the 1970s, with graduation levels at their lowest level since the Second World War. Spencer et al.[43] estimate the number of dental graduates in Australia would need to increase by 120 each year for the Australian dental labour force to be sustainable in the medium to long-term.

There is little evidence, at least at this stage, to suggest that reforms to Australia's higher education sector over the past two years have alleviated Australia's dental workforce shortage.

For new students, the Commonwealth Government estimates that the student contribution amount (formally known as HECS) for dental students will rise from $6,136 in 2003 ($30,680 for a five year dental degree) to a range from $0-$8,355 from 2005 onwards ($41,755 for a five year dental degree).[44]

For a student studying dentistry at the University of Melbourne, annual student contribution fees are $8,004 in 2005 ($40,200 for a five year degree).[45] For University of Sydney students, student contribution fees are $8,018 in 2005 ($40,090 over five years).[46]

The cost of dentistry at the University of Melbourne for a full-fee paying local student is $30,000 for 2005 ($150,000 for a five year degree),[47] while full-fee paying students at the University of Sydney will pay $27,024 in 2005 ($135,120 for a five year degree).[48]

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[42] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013,* A Committee Established by the Australian Health Minister's Conference, p. 40.
[43] Spencer, A.J., Teusner, D.N., Carter, K.D. and Brennan, D.S (2003) *The Dental Labour Force in Australia: The Position and Policy Directions,* Population Oral Health Series No. 2, AIHW cat. No. POH 2, Australian Institute of Health and Welfare, Canberra, p. 2.
[44] Nelson, B (2003) *Our Universities: Backing Australia's Future*, The Hon. Dr Brendan Nelson, Minister for Education, Science and Training, Commonwealth of Australia, p. 22.
[45] Accessed from www.services.unimelb.edu.au/admissions/coursefees/australian/hecs.html on 16 March 2005.
[46] Accessed from www.usyd.edu.au/fstudent/undergrad/apply/scm/hecs.shtml on 16 March 2005.
[47] The University of Melbourne (2005) *Australian Student Tuition Fees,* Accessed from http://www.services.unimelb.edu.au/admissions/pdf/fee_schedule/aust_fee_schedule_2005.pdf on 31 March 2005, p. 4.
[48] Accessed from www.usyd.edu.au/fstudent/undergrad/apply/scm/feepaying.shtml on 16 March 2005.

For international students studying dentistry at the University of Melbourne, the cost of dentistry is $36,000 in 2005 ($180,000 for a five year degree).[49] International students studying dentistry at the University of Sydney will pay $33,024 in 2005 ($165,120 for a five year degree).[50] (Refer to Table 5 for a summary of fee changes.)

Table 5: Student Contribution to Dental Degree – University of Melbourne and University of Sydney

		UNIVERSITY OF MELBOURNE		UNIVERSITY OF SYDNEY	
		Year 1	**Total for 5 year degree**	**Year 1**	**Total for 5 year degree**
2003	**Student contribution (HECS)**	6,136	30,680	6,136	30,680
2005 onwards	**Student contribution (HECS)**	8,004	40,200	8,018	40,090
	Full-fee local student	30,000	150,000	27,024	135,120
	International student	36,000	180,000	33,024	165,120

Changes to student contribution fees have the potential to significantly impact on the delivery of dental care in Australia. While the ADA does not believe recent higher education changes will reduce the number of students choosing to study dentistry, it is concerned about the impact these changes will have on the future dental workforce. A Commonwealth-supported (formally HECS) dental student studying at the University of Melbourne will graduate with a student liability of $40,020, while a full-fee paying local student will graduate from the University of Melbourne with a liability of $150,000.

Faced with a high level of debt, the ADA is concerned that students will be more likely to choose to practice in metropolitan areas rather than rural and regional areas. Such an outcome may result in the further unequal distribution of dentists throughout Australia, as highlighted by Figure 3.

Similarly, the ADA is concerned that students graduating with high debts will be less likely to work in the public sector, adding pressure to public dental waiting lists. *Australia's National Oral Health Plan 2004-2013*[51] argues that lower

[49] The University of Melbourne (2005) *International Student Tuition Fees*, Accessed from http://www.services.unimelb.edu.au/admissions/pdf/int_fee_schedule_2005.pdf on 31 March 2005, p. 4.
[50] Accessed from www.usyd.edu.au/fstudent/undergrad/study/inm/faculties.shtml on 16 March 2005.
[51] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, A Committee Established by the Australian Health Minister's Conference, p. 42.

remuneration levels in the public sector compared to the private sector is one of a number of reasons why it was difficult to attract dentists to work in the public sector. The ADA believes that in a society with the level of wealth as Australia, the provision of basic and timely dental care should not be an exception, but rather a fundamental service.

Recommendations

9. That the Commonwealth Government create further scholarships for dental students from rural and remote parts of Australia as one measure to address the unequal distribution of dentists. Research suggests that dental students from rural and regional areas are more likely to work in these areas following their graduation.

10. That the Commonwealth Government create a moratorium or debt forgiveness on fee indebtedness for all dental graduates who in turn agree to provide their services in rural and remote areas or in the public sector. The extent of the moratorium or debt forgiveness could reflect the period of time the dental graduate undertakes practice in those particular areas. The longer the period of guaranteed service in rural or remote areas, the greater the moratorium or debt forgiveness.

11. That the Commonwealth Government plays a leadership role to ensure consistent planning across all states and territories with respect to dental workforce planning and development. This view is expressed in *Australia's National Oral Health Plan 2004-2013.*[52]

[52] National Advisory Committee on Oral Health (2004) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013,* A Committee Established by the Australian Health Minister's Conference, p. 38.

(e) While accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's private health insurance rebates, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Since its introduction in 1999, the 30% rebate for private health insurance has become the Commonwealth Government's key source of expenditure for dental care. As outlined previously, figures from the Australian Institute of Health and Welfare show that the 30% rebate accounted for $298 million in expenditure on dental services in 2002-03, the equivalent of 6.81% of total dental services expenditure.

The ADA has supported the 30% rebate for private health insurance as it has made ancillary cover (through private health insurance) more affordable. Dental cover is a significant aspect of private health insurance as it accounts for over 50% of all ancillary service benefits.[53] Since the 30% rebate for private health insurance was introduced in 1999, the number of dental services provided through private health insurance has grown from 14.4 million in 1999 to 22.7 million in 2004.[54]

Premium increases

While the 30% rebate has meant a large number of people with private health insurance are able to access dental treatment, the ADA notes there are several pressures on the future of private health insurance. Chief amongst these is the growing cost of private health insurance, with premiums rising by 7.96%[55] in 2005, 7.58% in 2004,[56] 7.4% in April 2003[57] and a 6.9% rise in April 2002.[58]

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[53] Private Health Insurance Administration Council (2004), *Operations of the Registered Health Benefits Organisations Annual Report 2003–04*, PHIAC, Canberra, p. 35.
[54] Source: Private Health Insurance Administration Council, 'Statistical Trends in Membership and Benefits', Accessed from www.phiac.gov.au/statistics/trends/index.htm on 13 April 2005.
[55] Abbott, T. (2005) *Private Health Premiums,* Media Release, 2 March, Minister for Health and Ageing, Canberra.
[56] Private Health Insurance Administration Council (2004) *Health Fund Rate Increase 2004,* Media Release, 27 February.
[57] Patterson, K. (2003) *Private Health Insurance Premiums,* Media Release, 14 March, Senator the Hon. Kay Patterson, Minister for Health and Ageing, Canberra.
[58] Patterson, K. (2002) *Health Insurance to Rise by $2.66 a Week for Average Family,* Media Release, 26 February, Senator the Hon. Kay Patterson, Minister for Health and Ageing, Canberra.

The rise in the cost of private health insurance over the past three years contrasts claims in 2000 by the then Health Minister, Michael Wooldridge[59] who said: "Because we've got so many extra people in, that'll keep real downward pressure on premiums". This view was supported by the Australian Health Insurance Association[60] which claimed that the 30% rebate for private health insurance and Lifetime Health Cover and subsequent increase in the number of people with private health insurance would lead to "... long term premium stability."

Unfortunately, there has been little stability in private health insurance premiums over the past three years and the outlook does not appear to be positive. According to a recent analysis of private health insurance funds by the ratings agency, Standard and Poor's:[61]

> *"Benefit costs increasing will always remain a challenge for the industry, as medical CPI generally runs twice as high as normal CPI. So, without seeking premium increases to support benefit levels, the industry risks remaining unprofitable, and the long-term picture remains tenuous."*

Reduced benefits

An examination of benefits paid to private health insurance members for dental services shows benefits are not keeping up with the cost of dental care, as highlighted by Figure 4. Figures from the Private Health Insurance Administration Council[62] show that the total cost of dental services through private health insurance funds has risen from $996.4 million in 1996 to $2,082.4 million in 2004. During this same period, benefits paid have risen from $584.2 million to $1,051.2 million. As a proportion of the cost of services, benefits paid per service have fallen from 58.63% in 1996 to 50.48% in 2004.

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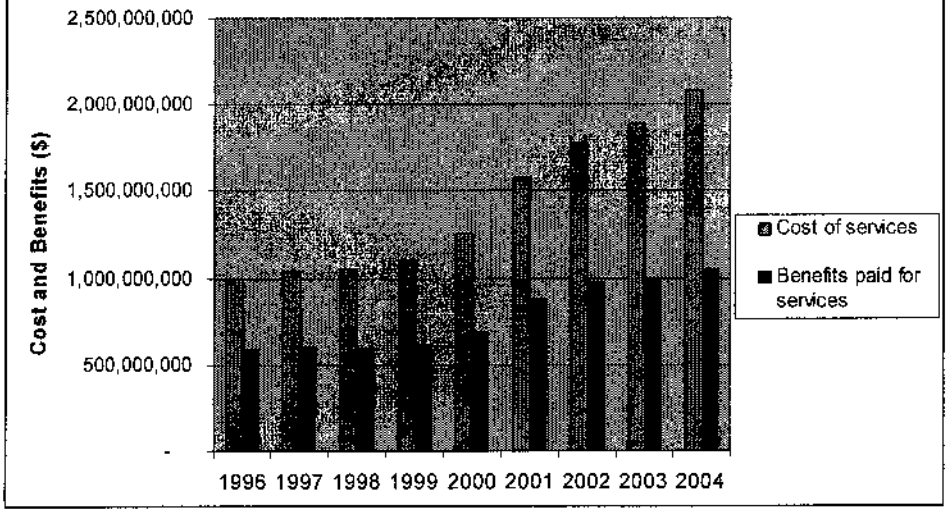
[59] Quoted from July 2000 and reported on *Lateline*, 'Hike in insurance premiums', Broadcast on 26 February 2002.
[60] Australian Health Insurance Association (2000) *Figures Back Government PHI Program*, Media Release, 14 August, Canberra.
[61] Standard and Poor's (2004) *Australian Health Insurance Report: Rising Costs: The Achilles Heel of Stable Credit Quality'*, p. 3.
[62] Source: Private Health Insurance Administration Council, 'Statistical Trends in Membership and Benefits', Ancillaries, Accessed from www.phiac.gov.au/statistics/trends/index.htm on 13 April 2005

Figure 4: Private Health Insurance and Dental Care: Cost of Services and Benefits Paid



Source: Source: Private Health Insurance Administration Council, 'Statistical Trends in Membership and Benefits', Ancillaries, Accessed from www.phiac.gov.au/statistics/trends/index.htm on 13 April 2005

The fall in benefits paid to consumers was recently considered by the Private Health Insurance Ombudsman,[63] who commented:

> *"There are ... signs that, in their efforts to keep premium increases to an acceptable level, some funds are devaluing their health insurance products by reducing benefits or other conditions and allowing more patient gaps. Although health funds may only alter their premiums annually after an approval process, they can change the benefits and conditions applying to a health insurance product at any time. In this regard, health insurance consumers have less protection from such changes than is available in other consumer contracts and insurance policies, where change to contracts cannot be made unilaterally or contracts are renewed annually."*

Recommendations

12. That the Commonwealth Government continues to ensure a rigorous process of approval before private health insurance funds increase premiums.

[63] Private Health Insurance Ombudsman (2004) *The State of the Health Funds Report 2004,* PHIO, Canberra, p. 5.

13. In the review process of premiums, health insurers are required to undertake that benefits paid remain commensurate with the increased premium.

14. That in ensuring that adequate benefits are paid, health insurers not participate in practices that impact adversely on the quality of care provided in return for those benefits.

15. That private health insurance funds be prevented from changing the benefits and conditions that apply to an insurance product at any time. Benefits and conditions should only be altered on an annual basis following an approval process similar to that which apples to premium changes.

Authorised by
W J O'Reilly
Federal President