CHAPTER 10

Allied and Dental Health Care

[Health care] is not done just by these people called doctors. … we have to broaden our view of what we want a health service to do in a country where the government has a legitimate role of custodianship.[1]

Introduction

10.1 Term of Reference (d)(i) directs the Committee to consider:

> whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system.

10.2 This chapter therefore examines the role that allied and dental services play in the overall health care system; the adequacy of current arrangements in providing appropriate levels of care in these services, and the extent to which the Commonwealth's policy could be improved.

Dental Heath Care

10.3 This section discusses the importance of dental care, details current arrangements for the provision of public dental services and their adequacy, and considers several proposals for improving access to services.

10.4 Under current arrangements, dental health care in Australia is largely performed by privately billing dentists,[2] with relatively small public dental programs provided by the state and territory governments. These programs are targeted at school children and the less well off. The Commonwealth government is indirectly involved in dental funding via the Private Health Insurance rebate and through the VA, which is discussed in greater detail below. According to Dr Madden from the Australian Institute of Health and Welfare, the total national spending on dental services is estimated at about $3 billion, of which a little over $600 million, or 20%, derives from government (including the PHI rebate).[3] Analysis provided by the Australian Dental Association suggests that, reduced to a per capita figure, this amounts to an allocation of public funds equivalent to $57.50 per eligible person (i.e. concession card holders), or $14.31 per capita across the whole Australian population.[4]

---

1 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 69

2 Department of Health and Ageing, Submission 138, p. 41

3 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

4 Australian Dental Association, Submission 184, p. 3. The ADA's calculations are based on total public expenditure figure of $270m, excluding the impact of the Private Health Insurance Rebate.

10.5 In practice this means, as Dr Madden observes, that about two-thirds of expenditure on dental services in Australia is directly from patients' pockets. This fact must be considered in the context of steeply rising costs, outstripping inflation, of dentistry in Australia.[5]

The importance of dental health

10.6 Evidence to the Inquiry has stressed the importance of dental health, and its relationship to a person's general health. A report prepared for the Australian Health Ministers' Conference, *Oral Health of Australians: National Planning for Oral Health Improvement* (2001), stated that:

> As a consequence of shared determinants, general disease and oral disease often occur together. Co-morbidity is most notable in older people.
>
> An oral disease is occasionally the first clinical sign of a wider systemic disease. The oral cavity can act as a window to the body and has diagnostic advantages through direct observation of affected tissues.
>
> Oral diseases and disorders are increasingly being conceptually and empirically associated with general diseases.[6]

10.7 The Queensland Government quoted from a recent paper prepared by Professor John Spencer for the Australian Health Policy Institute:

> Medically necessary dental care has been suggested to be integral to comprehensive treatment to ensure optimum health outcomes for patients undergoing chemotherapy; having heart valve and other heart surgery; transplantation; suffering from diabetes; hepatitis C and HIV infection; and living with long term renal dialysis and haemophilia.'[7]

10.8 Professor Spencer concluded that 'oral health should be seen as an integral aspect of general health and dental care as a component of health care'.[8]

10.9 It is evident that access to dental care is particularly important to certain groups with higher health care needs who often having high levels of chronic illness. These groups include Aboriginal and Torres Strait Islander peoples, recent arrivals (particularly refugees), low income earners, dependent elderly and people in rural and remote areas.[9] The Northern Territory government noted that:

---

5 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 76

6 Quoted in WA Government, Submission 177, p. 13

7 Queensland Government, Submission 32, p. 9, quoting Spencer, J., *What options for organising, providing, and funding better public dental care?*, Australian Health Policy Institute.

8 Queensland Government, Submission 32, p. 9

9 Public Health Association of Australia, Submission 213, p. 1

> Oral health is particularly important in Aboriginal health because of the extremely high prevalence of chronic disease. In their strategic framework, the National Aboriginal and Torres Strait Islander Health Council has identified oral health as one of the top 10 priority areas requiring urgent government attention.[10]

10.10 Professor Wilson also described the link between economic status and oral health:

> This is a condition which is probably, of all the conditions in Australia, the most strongly socio-economically related. The people who have the worst oral health are the most disadvantaged in the community. … there is a large amount of dental disease in the community, and we need a strategy to deal with it.[11]

Access to dental services in Australia

10.11 Given the importance of oral health, the Committee is concerned at the evidence of major deficiencies in access to dental care for many communities and, in particular, certain disadvantaged groups. It is also disappointing to see that little has changed in the five years since the Senate Community Affairs References Committee examined the issue of public dental health.[12] According to the National Dental Health Alliance:

> Recent research show there are 500,000 adult Australians on low incomes who are now waiting for access to the very limited dental care services currently provided by state and territory health services.
>
> The waiting lists for these limited public dental services are so long that some people are waiting up to four years before they receive treatment.[13]

10.12 In their submission, the Combined Pensioners and Superannuants Association explained that:

> Because of the expense of even basic dental procedures such as root canal therapy and fillings, people on pensions are not encouraged to visit dentists regularly. This means they must put up with considerable pain and distress for long periods before they are attended to by a NSW public dental service provider. By then, a simple procedure invariably has turned out to be a more complicated procedure with more difficult treatment.[14]

---

10 NT Government, Submission 82, p. 5

11 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 73

12 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, Parliamentary Paper No.88 of 1998.

13 The National Dental Health Alliance, Media Release, 17 September 2001

14 Combined Pensioners and Superannuants, Submission 50, p. 7; see also NCOSS, Submission 84, p. 5

10.13 A similar situation exists in Tasmania, where:

> [A] state funded dental service – Oral Health Services, Tasmania – will provide care for school children and welfare recipients, but the demand upon this service effectively means that only emergency treatment is available. Waiting lists for anything other than an emergency are so long that some people report having waited for many years without being called in for treatment. …
>
> The present waiting list with Oral Health Services Tasmania for the fitting of a full set of dentures is three years – with a consultation for partial dentures requiring a wait of between five and six years.[15]

10.14 In the city of Darebin:

> [T]he publicly funded dental services are in crisis. With the closure of the federally funded national dental health program, state funded local Community Health Services are faced with extremely long waiting lists. People in Darebin, for example, must wait for approximately two years to see a dentist unless they have an acute dental issue.[16]

10.15 It is frustrating to note that while Australian children have excellent levels of oral health, in part due to extensive school programs, these gains are lost later in life.[17] Australia now has comparatively higher levels of dental problems among those in the 35-44 year age group, while Australians 65 years old and over have the fourth highest rate of total loss of teeth among OECD countries.[18] Professor Spencer also reported that Commonwealth concession card holders are nearly 20 per cent less likely than non-cardholders to visit for a check up and 2.2 times more likely to have a tooth extracted.[19]

10.16 Even those with private health insurance face significant out-of-pocket costs of almost fifty percent of the total fee.[20]

Options for a wider Commonwealth role in dental services

10.17 The Committee acknowledges the importance of dental care, the relationship between socio-economic status and dental health, and the extent of current problems in accessing dental services. It therefore sees a strong need to introduce measures to improve Australians' access to dental care. The best way to meet this need can be

---

15 TOES, Submission 139, p. 9; see also Tasmanian Government., Submission 148, p. 5

16 City of Darebin, Submission 39, p. 3

17 The National Dental Health Alliance, Media Release, 17 September 2001; see also Australian Research Centre for Population Oral Health, Submission 212, p. 1

18 Public Health Association of Australia, Submission 213, p. 1

19 Australian Research Centre for Population Oral Health, Submission 212, p. 1

20 Australian Research Centre for Population Oral Health, Submission 212, pp. 1-2

determined by studying the answers to two questions. First, what is the appropriate role for the Commonwealth in dental care? Second, (as required by the term of reference) would increased Commonwealth funding for dental care provide a more cost effective health care system?

The role of the Commonwealth

10.18 There is ongoing debate over the appropriate role of the Commonwealth in dental care. While it is clear that the Commonwealth has Constitutional power to become involved in dental care,[21] it is the view of the Government that dental care is, and has always been, the responsibility of the state governments.[22] As the Department of Health and Ageing submission to the Inquiry stated:

> The Commonwealth and the States play different roles in supporting Australia's mixed system of public and private dental and allied health care.
>
> The Commonwealth government has no direct role in the provision of public dental and allied health services. …
>
> The States are best placed to identify and resolve structural, management or financial problems affecting the quality and accessibility of public health care. If more funding is needed for the public dental and allied health network, States can choose whether to use their own revenue sources or commit some of the additional $10,000 million offered in the next round of the Australian Health Care Agreements.[23]

10.19 This view reflects the sentiments of the Government's response to the 1998 Senate Community Affairs References Committee Report on Public Dental Services:

> Notwithstanding the Committee's finding that some low income earners currently have difficulty accessing public dental services, the Government's position continues to be that the provision of public dental services is a State responsibility and that the States must resolve the structural, management and financial problems in their dental services. …
>
> With the introduction of the GST, States will be better off than they would be under existing Commonwealth/State financial arrangements. The additional revenue that will accrue to the States through the GST will be at the disposal of the States to augment the range of health services available to the public, including public dental services.[24]

---

21 See chapter 2. See also: Senate Community Affairs References Committee, *Report on public dental services*, May 1998, chapter 4.

22 See for example, Senator Knowles, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 70

23 Department of Health and Ageing, Submission 138, p. 41

24 Government response to the Senate Community Affairs References Committee Report on Public Dental Services, February 1999, p. 1

10.20 Critics of this view argue that (in addition to the private health insurance rebate, discussed below) the Commonwealth already has an ongoing role in providing dental health for veterans and their dependents, members of the Australian Defence Force, and refugees.[25] According to the Australian Consumers Association:

> The 1946 constitutional amendment specifically enabled the Commonwealth to pay benefits for dental as well as medical services and, incidentally, said nothing about the civil conscription of dentists. The only cogent reason that Medibank and Medicare did not cover dental services was that governments believed the bottom-line cost for their own budgets would be too great.[26]

10.21 The Victorian Minister for Health, the Hon Bronwyn Pike, argued that dental care is a shared responsibility:

> The state of course recognises that we are not wanting to shift the cost to the Commonwealth at all. We understand that we have an obligation in the provision of all sorts of health care …. So we are really asking the Commonwealth to be part of the dental health system as it was in the past so that the state does not have the full burden of that responsibility, because we recognise that dental health is as much a part of people's health as mental health and health within the hospital system.[27]

10.22 Mr Gregory of the National Rural Health Alliance concluded:

> [I]t is far too serious an issue not to have the Commonwealth exercise leadership. Whether or not that leadership comes down to spending money is a later question.[28]

Dental care and private health insurance

10.23 Many view the government's disavowal of responsibility for dental care as being irreconcilable with the operation of the private health insurance rebate. Dental care accounts for 48% of ancillary benefits paid out under private health insurance, amounting to an indirect subsidy in the order of $325 million.[29] As the WA Government stated in its submission:

---

25 Australian Research Centre for Population Oral Health, Submission 212, p. 1

26 Australian Consumers Association, Submission 72, p. 11

27 The Hon Ms Pike, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 75

28 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 72. see also; Uniting Care, Submission 70, p. 6

29 The exact figure is difficult to calculate. The submission from the Department of Health and Ageing states that total ancillary benefits amount to $1500 million, of which 48% is dental. Thirty percent of that figure is $216m. (DoHA, Submission 138, p. 41). In contrast, an Australian Health Policy Institute paper estimates the figure to be in the range of $316-$345m. Prof J. Spencer, *What options do we have for organising, providing and funding better public*

> It is ironic that the most financially disadvantaged people who cannot afford insurance, are not able to access any Commonwealth subsidy towards these types of services.[30]

10.24 Professor Sainsbury told the Committee:

> To me, it was ludicrous when the Commonwealth dental health program, which was costing I think $100 million a year, was abolished – a program that did provide some form of dental care for poor, disadvantaged people who often had bad oral health. What we have now with the rebate is the government spending $300 million to $350 million a year subsidising dental care for people who have health insurance.[31]

10.25 This view was shared by Professor Spencer:

> The combined effect of the cessation of the Commonwealth Dental Health Program and the introduction of the 30% rebate on private dental insurance has been to shift public funding from those with the poorest oral health, where significant gains in health status can be made, to those with the best oral health, where the gains are likely to be small.[32]

10.26 The net result is that higher income adults using private dental insurance and dental care receive nearly five times the subsidy received by aged pensioners seeking public dental care.[33] Critics point to the opportunity cost of the funds used for the private health insurance rebate, and suggest a range of public dental health programs that could be funded by reallocating some or all or the rebate.[34]

10.27 The Australian Dental Association, however, supported the use of the rebate, arguing that it helps fund members to access 20 million dental services a year worth $1 billion:

> If these benefits are removed, then many of the families who could no longer afford private insurance would, if eligible, be forced to seek their dental treatment in the public arena… .[35]

A cost effective Commonwealth role

10.28 Controversy surrounds the question of whether Commonwealth intervention in dental care would help in the provision of a cost effective health care system.

---

dental care?, APHI, Commissioned Paper Series 2001/2002, p. 39. See also Prof Deeble, Submission 85, p. 8

30 WA Government, Submission 177, p. 12

31 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 69

32 Australian Research Centre for Population Oral Health, Submission 212, p. 1

33 Mr Webber, Submission 3, p. 7; see also NSW Government, Submission 154, p. 21

34 Australian Research Centre for Population Oral Health, Submission 212, p. 2

35 Australian Dental Association, Submission 184, p. 6

Supporters argue that a relatively small scale but well-targeted Commonwealth dental program could produce significant gains in other aspects of the health care system, through prevention of more serious general illnesses. Professor Richardson concludes that selected services would be highly cost effective.[36] Similarly, the NSW Retired Teachers Association suggested that:

> Under present arrangements many people go without dental care and suffer ill health. There is evidence that bad teeth cause long term health problems. The inclusion of dental care in Medicare would increase the over-all cost of the health care system. The benefits would be less call on the services of hospitals and doctors, less worktime lost and a happier healthier population.[37]

Extending Medicare to cover dental services

10.29 Given the apparent incongruity of treating oral and general health under separate systems, one method for integrating Commonwealth involvement is the extension of the existing Medicare Benefits Schedule to cover dental services: the so-called 'Denticare' option. As the Doctors Reform Society stated:

> Medicare is a very cost effective way of providing hospital services, drugs, and medical primary care. Extension to dental and other health care would provide an opportunity to greatly improve access to such care for those who are currently denied it because of costs. It would also help to control the escalating costs of these services.[38]

10.30 Estimates of the cost of such a program vary. The ACA suggest that extending public dental cover to 100% of the population could cost about $2.5 billion (assuming the continuance of the 45% gap) or $4.5 billion (assuming no gap and not including any of the likely cost efficiencies associated with such a scheme). However, these figures would be affected by the scope of cover and the agreements that it could negotiate with service providers.[39] In this respect, the ACA notes these cost estimates might in practice be reduced:

> [T]he massive buying power of a single public authority could produce substantially improved price discipline and far better cost-effectiveness than the nation enjoys at the moment.[40]

10.31 However, as the Queensland government comments, any proposal to include dental cover in Medicare 'would, in all likelihood, be resisted by the Commonwealth

---

36 Professor Richardson, *Proof Committee Hansard,* Melbourne, 24 July 2003, p. 80

37 NSW Retired Teachers Association, Submission 23, p. 2

38 DRS, Submission 25, p. 6

39 ACA, Submission 72, p. 11. This estimate accords with that of Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

40 ACA, Submission 72, p. 11

government as it would involve extending an already uncapped program.'[41] This concern was also put by the Australian Dental Association:

> Medicare is already under severe financial strain and the addition of a comprehensive universal dental scheme would simply lead to total collapse… .[42]

10.32 Costs aside, Professor Deeble also questioned the suitability of applying a universal insurance scheme such as Medicare, to dental care:

> The main problem with Medicare covering the [dental] industry is its basic uninsurability.
>
> … 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 should not be treated within an insurance approach.[43]

A new Commonwealth dental health program

10.33 A second option, which received wider support, is the reintroduction of a Commonwealth dental health program along similar lines to the program that operated between 1994 and 1996.

10.34 The Commonwealth dental health program aimed to improve the dental health of financially disadvantaged people in Australia, and to direct the dental care received by adult Health Card holders from emergency to general dental care; from extraction to restoration; and from treatment to prevention.[44] The program had funding of $245 million over four years, and operated via agreements with the states and territories.

10.35 Holders of Commonwealth Health Cards were eligible for basic dental care under the program, although certain procedures, such as dentures and some specialist services, were excluded.

10.36 It is estimated that 1.5 million services were provided under the scheme, which is generally assessed as being successful in increasing access to, and quality of, dental care among disadvantaged groups, and reducing waiting times in public dental programs. In particular, a review found that an additional 200,000 concession-card holding patients per year received treatment under the program, while the proportion of card holders waiting less than a month for a check up increased from 47.5 percent

---

41 Queensland Government, Submission 32, p. 9

42 ADA, Submission 184, p. 6

43 Professor Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 71

44 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, p. 27

to 61.5 percent. It was also found that the proportion of card holders who had visited a dentist in the preceding twelve months increased from 58.6 to 67.4 percent.[45]

10.37 A number of submissions supported the reintroduction of a Commonwealth dental scheme,[46] even if the reintroduced scheme were to be only of limited duration, and intended as a 'catch-up' program, to enable the overloaded public dental programs around the country to reduce the current backlog:

> I believe that even if there were a short-term five-year program, you could make the public dental program work much better in Australia if we had some catch-up phase to do that work.[47]

10.38 Alternatives for a Commonwealth scheme include a targeted oral health program for indigenous people and older adults in residential care, both groups for whom there are direct Commonwealth responsibilities,[48] or an extended school dental service for children up to about 18 years of age. This would be a preventive service covering the period of puberty and adolescence where most dental conditions are likely to emerge:

> The problem is that dental disease gets established in childhood and never gets remediated properly. … So the problems are established and, once they reach adulthood, you have to do something about it early.[49]

10.39 Others have also suggested that the Commonwealth needs to take a leadership role in addressing a national shortage of dentists, noting a requirement for an additional 120 dentists per year.[50]

10.40 The Committee sees a need for a more collaborative relationship between Commonwealth and state governments on the issue of dental health. As Professor Spencer commented: 'a constructive dialogue between the Commonwealth and State or Territory governments needs to begin'. This dialogue would detail an agreement on

---

45 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, pages 30-31. For a detailed description and assessment of the CDHP, see generally chapter 3.

46 For example: Darebin Community Health, Submission 40, p. 2; Queensland Government, Submission 32, p. 9; and Australian Dental Association, Submission 184, p. 7

47 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 73

48 Public Health Association of Australia, Submission 213, p. 2

49 See the discussion of Professors Wilson and Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

50 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 76; ADA, Submission 184, p. 4. Note also references to the shortage of dentists in South Australia (South Australian Dental Service, Submission to the Generational Health Review, p. 11), NSW ('Fears shortage to put bite on dental service', ABC News, 11 August 03), and the Northern Territory (Jane Aagaard, NT Minister for Health and community Services, 'Aagaard calls for action on national dentist shortages', Media Release, 28 July 2003). For a general review of dental numbers, see Australian Institute of Health and Welfare, *Dental labour force, Australia 2000*, University of Adelaide.

the objectives for public dental care, the allocation of roles, and the associated financial arrangements.[51] While state and territory cooperation is essential to achieving these objectives, it requires leadership by the Commonwealth to initiate and carry through such an agreement.

Conclusion

10.41 The Committee agrees that dental health plays a crucial role in overall health, and is concerned at the evidence which demonstrates that many Australians experience significant problems in accessing timely and effective dental care. This has both unfortunate consequences for the individuals concerned, and implications for society as a whole, as it triggers declining population health, increases pressure on public hospitals and potentially counteracts the success of other Commonwealth programs aimed at preventive care.

10.42 For these reasons, the Committee does not accept the simple assertion that dental care is a matter of state and territory responsibility. Adequate access to dental care is too interrelated with other aspects of Commonwealth health care responsibility for any neat jurisdictional lines to be drawn. Furthermore, the social justice implications of the current problems are too great for the Commonwealth to ignore.

10.43 The Committee sees public dental care as a responsibility that is shared with the states and territories, and one in which the Commonwealth should take an active leadership role – a role that is clearly within the Commonwealth's constitutional powers. The key question is what form this role should take.

10.44 Currently, the principle form of Commonwealth involvement in dental care is via the private health insurance rebate. The issue of this rebate and whether the funds could be more effectively allocated to other public purposes is discussed in a later chapter. However, the Committee is concerned that in practice, current Commonwealth involvement is generally limited to the more affluent of Australian society, while providing no targeted assistance to those most in need. In the Committee's view, if the Commonwealth's involvement is to be limited, it should encompass measures that target those groups that have the greatest need.

10.45 However, the Committee considers that for Commonwealth intervention to take the form of incorporating dental care into Medicare is undesirable, both by reason of the enormous budget implications of such a move, and because it would represent a virtual Commonwealth takeover of dentistry that does not fit easily with the shared responsibility with the states.

10.46 The Committee believes the evidence points overwhelmingly to the restoration of the earlier, and successful, Commonwealth Dental Health Scheme. This represents a targeted measure of limited cost that has already been shown to achieve

---

51 Professor Spencer, *What options do we have for organising, providing and funding better public dental care?*, AHPI, 2000, p. 50

significant increases in access to dental care among those most in need. As with the original scheme, such a program needs to be developed in close consultation with the state and territory governments to ensure that it does not simply substitute for current dental funds.

Recommendation 10.1

The Committee recommends that the Commonwealth immediately recommit to a Commonwealth contribution towards public dental health services and negotiate targets with the states and territories, particularly for high need groups.

Allied Health Services

10.47 Allied health services cover a wide range of disciplines including, but not limited to, physiotherapy, occupational therapy, psychiatry, social work, speech therapy, pathology, midwifery, dietetics and nutrition, optometry and podiatry. It should be noted that practice nurses are not considered to fall within the definition of allied health professionals, and are considered in chapter 8.[52]

10.48 Allied health services play an important role in overall health care, a role that can be overlooked in a system which tends to focus on doctors. Allied health professionals can provide both primary care services and a wide range of specialist diagnostic and treatment services for both referred and unreferred patients. These services are employed in a widespread effort to create a more integrated and prevention-focused health care system.

10.49 This section examines current arrangements for the use of allied health services, problems with access under these arrangements, and some of the suggested methods to enhance the effectiveness of allied health services in overall health care.

Allied Health Spending

10.50 The exact levels of total allied health spending in Australia are unclear due to an absence of data.[53] However, the Australian Health Insurance Association's CEO Mr Russell Schneider estimated total national expenditure on allied health at between $5 billion and $7 billion (including dentistry, estimated at $3 billion).[54]

10.51 The Department of Health and Ageing's Submission to the Inquiry stated that the distribution of funds to allied health services is a responsibility of the states through the state-federal Australian Health Care Agreements (AHCA), with states funding and administering free but limited access to allied health professionals through the public hospital system and Community Health Centres. However, the Department also submitted that core allied health services are Commonwealth-funded to the extent of $1.5bn (including dentistry) through the PHI rebate for private health ancillary cover.[55]

10.52 The remaining expenditure on allied health services in Australia is incurred through out-of-pocket costs to patients and state and territory programs including workers' compensation schemes.

10.53 As discussed above in relation to dentistry, there are concerns that the focus of Commonwealth involvement in allied health is via subsidies to private health

---

52 This distinction was pointed out by Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, pp. 76-77 and Ms Mickel, *Proof Committee Hansard*, Melbourne, 24 July, p. 6

53 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

54 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

55 Department of Health and Ageing, Submission 138, p. 41

insurance. The University of Sydney Faculty of Medicine submission referred to this arrangement as an 'inside out safety net: the rich are reimbursed with public money while the poor miss out'.[56]

Current Provision for Allied Health under Medicare

10.54 Allied health services presently included on the MBS are limited to prescribed psychiatry and optometry services. No other allied health services are funded under Medicare. This section also considers pathology services, although it is recognised that they are not traditionally categorised as an 'allied health service'.

10.55 Pathology represents a substantial cost to Medicare despite funding being capped by the Commonwealth through agreements with the two peak pathology bodies.[57] The number of pathology services provided in 2002-03 was 70,482,000, at a cost to the Commonwealth in excess of $1.3 billion. Of these, 84% were bulk-billed. Pathology services have been growing at a considerable rate over the past decade; per capita the number provided for 2002-03 was 3.5, up from 2.2 a decade ago.[58]

10.56 Despite the relatively high rate of bulk-billing, the pathology industry argues that it faces increasing difficulty in continuing to provide equitable access to pathology services in the context of expanding demand pressures and capped Medicare funding. According to the Australian Association of Pathology Practices, costs in the industry over the life of the existing agreement have risen 14% against a notional cost escalation of less than 6% allowed for in the agreement. The Association submitted that cost increases associated with providing pathology services have been hitherto absorbed by the industry through efficiency gains, but that the situation is no longer sustainable and that bulk-billing rates are likely to fall.[59]

10.57 Given the importance of diagnostic services, any significant fall in bulk-billing by pathologists has significant implications for both gap payments and the overall costs of accessing health care. However, the Committee is also mindful of the view that mergers and consolidation in the sector has resulted in major economies of scale and reduced overheads.[60]

---

56 University of Sydney Faculty of Medicine, Submission 148, p. 6; see also WA Government, Submission 177, p. 12

57 Australian Association of Pathology Practices, Submission 108, p. 1

58 Department of Health and Ageing, *Medicare Statistics 1984/85 to June Quarter 2003*, pp. 33-39

59 Australian Association of Pathology Practices, Submission 108, p. 1 – Attachment: David Kindon, *Pathology feels the pinch*, Australian Doctor 30 May 2003, p. 28. See also Morgan Melish, *Bulk-billed pathology at risk*, Australian Financial Review, 25 August 2003, p. 4; and Mark Metherell, *Pathologists face loss of bulk-billing*, Sydney Morning Herald, 25 August 2003, p. 7

60 *Keep a lid on pathology fees*, Sydney Morning Herald, 26 August 2003, p. 12

10.58 Optometry services in 2002-03 numbered 4,573,000 at a total cost to Medicare of $182 million. Services were bulk-billed at a high rate, 96.5 per cent of the time.[61] This can be explained by the dual role of medical practitioner and retailer, which has historically enabled optometrists to subsidise the former activity with the latter.[62]

10.59 Optometrists are also reporting increasing difficulties with continued high rates of bulk-billing. In arguments closely reminiscent of those of general practitioners, optometrists claim that cross subsidisation of consultations by sales of spectacles reflects the declining real value of the Medicare rebate for consultations. They contend that the value of the rebate has not kept up with a significantly more complex and expensive diagnostic environment, including imaging equipment, direct opthalmoscopy, slit lamp biomicroscopes, and tonometers for the detection of glaucoma.[63] Over time, they argued, cross subsidies cannot be sustained:

> Consumers will tend to go to optometrists for a good quality professional service (which they are getting cheaper than is optimal, due to caps on optometrists fees) and then take their prescriptions to optical dispensing companies (which do not have to increase its prices to make up for lost income elsewhere). High quality providers cannot survive in this climate.[64]

Difficulties providing Allied Health Services under Medicare

10.60 A number of issues arise from the exclusion of all the other categories of allied health care from the Medicare schedule.

10.61 First, although in many cases an allied health professional rather than a doctor may be the most appropriate provider of treatment, only the service provided by the doctor is supported by Medicare. This means that many (poorer people and/or those not having Private Health Insurance Ancillary cover) who cannot afford the costs of allied health services simply go to the doctor instead. As the Health Consumers' Forum argued, cost represents the main deterrent to patients' accessing appropriate allied health care services:

> Despite improving public awareness of illness prevention and health promotion there are few options for consumers to use General Practitioners more appropriately as part of the health care team. Consumers who might benefit from using allied health services such as counsellors, dieticians or complementary health care providers may currently choose to visit a General Practitioner because it is the least expensive option.

---

61 Department of Health and Ageing, *Medicare Statistics 1984/85 to June Quarter 2003*, pp. 33-39

62 Optometrists Association of Australia, Submission 136, p. 3

63 Optometrists Association of Australia, Submission 136, pp. 4 & 6

64 Optometrists Association of Australia, Submission 136, p. 4

> Providing consumers with more affordable and timely access to allied health services may in turn decrease the demand on General Practitioner's services, leading to more appropriate use of other members of the health care team.[65]

10.62 Secondly, different revenue sources for General Practice rebates and most allied health services, creates an inherent difficulty in integrating the two, posing a problem for government programs which seek a multi-disciplinary approach, such as the Enhanced Primary Care (EPC) items (described in chapter 3). Both the AMA[66] and the ADGP noted the disincentive to utilise allied health workers for GPs attempting to operate a financially viable practice.

> Even the most conservative of general practitioners have come to the realisation that good primary health care is about a team approach. It is not only practice nurses but a number of other allied health workers that can assist in providing this to the community. At the moment the pressure on the general practitioners, where remuneration can only be obtained if the practitioner touches or is face to face with the patient, puts a bit of a skew on it and sometimes creates farcical situations.[67]

10.63 The EPC extends the scope of the MBS, to provide an incentive for GPs to incorporate a range of allied health professionals into the realm of GP primary care. The scheme offers additional GP rebates for multidisciplinary care planning and case conferencing.[68] However, while GPs are provided incentives under the EPC program to incorporate allied health professionals as part of a multidisciplinary approach, only the GP is paid for their involvement. Other team members receive no recompense for their time.[69]

10.64 The North West Tasmanian Division of General Practice praised the intention of EPC, but noted its inappropriateness for busy GPs in poorly serviced areas:

> Not only is the average GP very busy but, even if they did want to take up that incentive and even if they had the time in their day to do so, there is very little opportunity to link in an easy way with the allied health workers. They are just not there or, if they are there, they are often not willing to participate … It was a great idea, but it did not take into account the reality of how rural GPs work on the ground and the availability of other services to contribute.[70]

---

65 Health Consumers' Forum, Submission 102, p 3

66 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 48

67 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

68 www.health.gov.au/epc/index.htm, accessed 9 September 2003

69 Australian Physiotherapy Association, Submission 94, p. 13

70 North-west Tasmanian Division of General Practice, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 79

10.65 There is evidence that measures such as the EPC case conferencing are largely underutilised. According to the Productivity Commission's report into *General Practice Administrative and Compliance Costs* case conferences were used by 3,121 participating GPs, who claimed for just 10,727 services in the year 2001-02,[71] and a recent Department of Health and Ageing report into EPC reflects many of the problems discussed above.[72]

Other Commonwealth Funded Allied Health Programs

10.66 Two other Commonwealth programs are relevant to the enhanced provision of allied health services; MAHS and AAHSIMH.

More Allied Health Services Program (MAHS)

10.67 MAHS began in 2000-01 as part of the Commonwealth's *Regional Health Strategy: More Doctors, Better Services* initiative. The program has facilitated links between rural GPs and allied health professionals by allocating targeted funding to employ additional allied health professionals in rural areas. MAHS is a $49.5 million program administered over four years by eligible rural Divisions of General Practice.[73]

10.68 Mental Health Council CEO, Dr Grace Groom, referred positively to MAHS in evidence to this Inquiry, but called for it to be more broadly implemented:

> An interesting phenomenon occurred through the More Allied Health Service Program … What we saw there was a real trend for those rural divisions to use their allied health money primarily for mental health care – there was a much higher percentage – but we were very clear when we were negotiating the better outcomes initiative that the allied health pilot should be both metropolitan and rural. One of the great areas of need in mental health is actually those outer urban areas – and even some of the inner urban areas – where we are seeing a decline in bulk-billing and people not being able to get access to care.[74]

10.69 The Australian Physiotherapy Association criticised the program, however, for inappropriately distributing funds to subsidise practice nurses:

> The MAHS program was very specifically for more allied health services. In our opinion nursing is not allied health, yet in the last year, 30 per cent of the funding in the MAHS program for more allied health services has gone to putting practice nurses into general practices … Only five per cent of that

---

71 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, pp. 24 & 60

72 Department of Health and Ageing, *Evaluation of the Enhanced Primary Care Medicare Benefits Schedule Items, Final Report*, July 2003, p. 5

73 www.ruralhealth.gov.au/services/mahs.htm, 9 September 2003

74 Dr Groom, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 37

> MAHS funding has gone to providing physiotherapy services, yet we are one of the biggest allied health professions in this country.[75]

Access to Allied Health Services in Mental Health

10.70 This program is a component of the Commonwealth's *Better Outcomes in Mental Health Care* initiative. It aims to improve the community's access to primary mental health services by providing GPs with better education and training and more support from allied health professionals via sixteen pilot sites across Australia.[76]

10.71 The South Australian Division of General Practice offered praise for the program but lamented the limited impact it could have due to insufficient funding:

> That is a very good initiative, but it is only half the size of what it needs to be. Even large divisions of general practice would only be able to employ one or two full-time, or perhaps a few more part-time, mental health workers or psychologists under that initiative … It is really not big enough to provide responsive, collaborative mental health workers who will work in conjunction with general practice.[77]

Allied Health under 'A Fairer Medicare'

10.72 As discussed above, the Government's 'A Fairer Medicare' package would enable participating practices in urban areas of workforce shortage to utilise the services of any salaried allied health professional in preference to a practice nurse. The package has earmarked 457 new places for this scheme, an indeterminable proportion of which would be filled by allied health professionals.

Alternatives for enhancing the role of Allied Health

10.73 Evidence to the Inquiry suggests there are significant potential benefits to be gained by enhancing the role of allied health professionals in the health care system. These include economic benefits accruing from a reduced burden on overworked GPs, and improveed health outcomes derived from greater access to allied health professionals. These will become critical with the increasing rate of chronic illnesses such as diabetes and mental illness. At the Committee's roundtable discussion, Professor Wilson questioned the existing primary health funding paradigm:

> We have to get around some of the historical issues around public funding flowing only through the doctor. We have to think more creatively about how we fund these services so that people can have access to [allied health] care.[78]

---

75 Ms Mickel, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 6

76 www.gpcare.org/phc/overview.htm, 10 September 2003

77 Dr Wade, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 91

78 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

10.74 Professor Sainsbury emphasised the need for a flexible strategy in treating increasing rates of chronic illness:

> The burden on health services is now not so much from acute illnesses – particularly, infectious diseases – but more from chronic illnesses and complex illnesses. And the population have come to expect a broader range of therapies … So it is appropriate that we think not just about whether we can afford to pay anyone other than doctors and whether they will all just rip us off, but rather about what is the function of a health service in society.[79]

10.75 The ADGP also recommended that allied health services provided in the GP setting fall within the ambit of Medicare funding:

> The problem we have at the moment is that using allied health professionals within practices is an expensive business unless you are in one of the areas where it is subsidised. We think that there should be some consideration of being able to obtain remuneration for services performed by allied health professionals under the direction of the general practitioner – possibly even through the MBS … There is the capability to do that.[80]

10.76 Articulating a different perspective, President of the Australian College of Non-Vocationally Registered GPs Dr James Moxham suggested that a lack of GP knowledge about allied health services was as significant as the availability and access to those services:

> There are private people and there are also dieticians, physios and all of those allied health people associated with public hospitals to whom it is not that difficult to refer people. Sure there are waiting lists, but people can still get in to see a dietician or a physiotherapist in a public hospital. In fact, many doctors do not realise that you can actually refer to those people … I think those resources are available if people choose to take them.[81]

10.77 Four specific areas of allied health were identified as priorities for an expanded role: physiotherapy, dietetics and nutrition, mental health, and midwifery.

Physiotherapy

10.78 There are presently no Medicare rebates available for physiotherapy services. These services are covered by private health ancillary cover or incur out-of-pocket expenses for patients.

10.79 The Australian Physiotherapy Association (APA) submission argued that physiotherapy management of incontinence and knee joint osteoarthritis is the most cost effective treatment for these conditions. They called for the creation of two new

---

79 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

80 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

81 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 11

MBS item numbers and the extension of the EPC to allow broader access to these services:

> In both cases diagnosis is discrete and relatively simple, economies will be gained by applying physiotherapy interventions rather than pharmaceutical or invasive interventions, the physiotherapy interventions required could easily be defined into MBS discrete item numbers, health consumers will be afforded greater choice and pressure will be taken off overworked GP's allowing them to apply skills appropriate to other areas of practice.[82]

10.80 Mr Peterson, a Bundaberg physiotherapist, indicated to the Committee that access to allied health services affected the delivery of optimal treatment methods and ultimately health outcomes:

> We see patients who have been medicated to the point where, had they perhaps received some sort of musculoskeletal intervention previously, they might have had a better outcome.[83]

Dietetics and Nutrition

10.81 The Committee also heard about the potential role of allied health professionals to more effectively manage the community's increasing rates of diabetes. Professor Wilson told the Committee that:

> In Australia somewhere between one in 10 and one in 20 Australians within five to 10 years will be suffering from diabetes. If we are going to provide proper care for them, we need to think about how they can get appropriate access to things like nutritionists, podiatry services and the other services, which we know are essential to providing good care for people with chronic illness.[84]

10.82 Professor Marley also urged strongly for improved access to dieticians for diabetes sufferers:

> The extension to allied health is essential. The biggest prospective study of diabetes, which was conducted in the UK, showed that the thing that made the most difference was access to a dietician. It was not access to hospital clinics or doctors or medication, it was access to a dietician. Given the prediction that within 10 years 50 per cent of the population aged over 50 will have diabetes, then addressing this is essential. I think that the only sustainable model of care is to reduce the dependency on doctors through care delivered by those most appropriate to the role.[85]

---

82 Australian Physiotherapy Association, Submission 94, p. 17

83 Mr Peterson, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 63

84 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

85 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 31

Mental Health Treatment

10.83 Mental illness encompasses a range of psychiatric disorders including unipolar depression, alcohol abuse, bipolar affective depression (manic depression), schizophrenia and obsessive compulsive disorder.[86]

10.84 According to the ABS' *National Survey of Health and Wellbeing* almost one in five adult Australians had suffered from mental illness twelve months prior to the survey and of these only 38% had accessed health services.[87] The Mental Health Council of Australia (MHCA) estimates that over one million Australians suffer from mental illness.[88] This highlights the importance of GPs as the first line of diagnosis and treatment of mental health problems.

10.85 Furthermore, mental health is likely to become an increasingly significant health issue in the coming decades. According to global figures, in 1990, five of the ten leading causes of disability were psychiatric conditions, and projections show that psychiatric and neurological conditions could increase their share of the total global burden by almost half by 2020.[89]

10.86 MHCA called for a reorientation of Medicare towards early intervention in mental illnesses:

> Investment of early intervention and increasing access options to effective treatments is urgently required. The absence of such access will ultimately result in greater costs at both a Commonwealth and State/Territory level becoming evident in other areas of service systems.[90]
>
> The Australian Psychological Society's (APS) submission highlighted current anomalies between the provision of Medicare rebates for patients for psychiatric services, which receive $141.90 per session for up to 50 sessions, with psychological services, which attract no Medicare rebate.[91]

10.87 They also expressed concerns that inadequate access to evidence-based intervention would worsen under the proposed 'A Fairer Medicare' package:

> What concerns the Australian Psychological Society about the current proposed reforms is that they further increase the problems of access for many sufferers of health disorders by exacerbating the gap between services that are currently supported and those that are not. The dilemma is intensified by the fact that there is now substantial scientific evidence that

86 Mental Health Council of Australia, Submission 113, p. 3

87 Quoted in Mental Health Council of Australia, Submission 113, p. 5

88 Mental Health Council of Australia, Submission 113, p. 5

89 Mental Health Council of Australia, Submission 113, p. 5

90 Mental Health Council of Australia, Submission 113, p. 11

91 Australian Psychological Society, Submission 49, p. 8

> some of the services currently unsupported by Medicare are in fact the ones as effective, if not more so, in treating these health disorders.[92]

10.88 They added that proposed safety provision for out-of-hospital expenses would further exacerbate this inequity of access to alternate treatments by generating increased demand for psychiatric services.[93]

10.89 The Health Consumers' Council of West Australia also supported improved patient access to psychologists as an alternative to pharmaceutical treatment:

> I would say that in the area of mental health, psychologists providing people with the capacity for talking therapy would be very useful because people see that pharmacology has taken over in psychiatry from engaging with people as human beings. Psychologists are seen as the vanguard in allied health for providing people with that kind of attention.[94]

10.90 APS asserted that 12 to 15 sessions with a clinical psychologist can achieve significant change amongst patients with anxiety and/or depression and further claimed that if supported by Medicare registered psychologists could provide a cost-effective resource to supplement a poorly distributed psychiatric workforce.[95] Views differ on the optimal number of allowable treatments. Professor Martin indicated to the Committee that:

> I do not know of any treatment given by a psychologist or psychiatrist of more than 20 sessions where someone has been able to demonstrate that is the treatment of choice. I have no evidence of that at all. I do not know how anyone can justify funding beyond 20 sessions.[96]

Midwifery

10.91 The Maternity Coalition Inc (MCI) and the Australian Midwives Act Lobby Group (AMALG) stated in their submissions that primary care throughout pregnancy and birth is recognised internationally as best practice. They claim that current Medicare arrangements create a monopoly of prenatal services for GPs, restricting the ability of pregnant women to choose their preferred method of care[97] It should, however, be noted that midwifery services may be insured under private health ancillary cover.[98]

---

92 Australian Psychological Society, Submission 49, p. 3

93 Mr Stokes, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 16

94 Ms Drake, *Proof Committee Hansard*, Perth, 29 July 2003, pp. 71-72

95 Australian Psychological Society, Submission 49, pp. 7-8

96 Professor Martin, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 16

97 Maternity Coalition Inc, Submission 169 and Australian Midwives Act Lobby Group, Submission 200

98 National Medicare Alliance Fact Sheet 2, www.nma.org.au/fact_sheet02.html, 8 September 2003

10.92 Both MCI and AMALG propose the establishment of a funding arrangement operating independently of Medicare to offer rebates for using midwifery services. They reason that funding implications would be minimal as midwives are less expensive and pregnancy terms, unlike chronic illness, are limited.[99]

Conclusion

10.93 As noted above, the Committee received considerable evidence supporting the funding of health promotion, other preventative health strategies and the treatment of chronic illness through complementary allied health services under Medicare.

10.94 While the Committee agrees with this evidence, it recognises that any extension of the MBS to cover allied health services has considerable and complex economic and financial consequences.

10.95 The cost implications are very large, requiring an increase of Commonwealth funding of potentially $3-4 billion, depending on the scope of the additional services covered (although this does not take account of any savings resulting from any reallocation of subsidies to private health insurance ancillary benefits).

10.96 While such measures could in all likelihood result in overall savings from reduced demand for GP and public hospital services, these savings would be difficult to quantify. However, the inclusion of allied health services would be justified where targeted preventative health measures provided by allied health professionals could be shown to generate cost-effective health outcomes.

10.97 A further complication is that savings generated via improved access to primary care and allied health professions, funded by the Commonwealth would potentially emerge in areas of health care currently funded by the states and territories, which might necessitate further renegotiation of the relative responsibilities for health services provision.

10.98 Secondly, the broader cost effects of wide scale additions to the MBS are also difficult to predict. An extensive range of allied health services included on the MBS could trigger an explosion of supply-induced demand for allied health services, with attendant stress on Medicare funding. Conversely, Medicare could impose pricing discipline on the allied health professions, thereby reducing overall costs.

10.99 Thirdly, extending the MBS to cover allied health also raises the important issue of which services would receive priority for Medicare funding and which would not qualify. The decision about which allied health services to include on the MBS is difficult because of, among other things, the varying allied health needs of different

---

99 Maternity Coalition Inc, Submission 169 and Australian Midwives Act Lobby Group, Submission 200. The Committee notes existing funding arrangements under the Alternative Birthing Services Program administered through Commonwealth/State Public Health Outcome Funding Agreements. See Senate Community Affairs Committee Report into Childbirth Procedures, December 1999 and Government Response to Report, August 2000.

regions in the Australia, the choice of allied health services to include on the MBS is difficult. Few areas have identical requirements or priorities and moreover, such a decision could arbitrarily create a financial windfall for certain professions while excluding others.

10.100 Finally, given the problems inherent in the fee-for-service model of payment used by Medicare (and discussed in greater detail in chapter 12), it is not desirable to exacerbate the issue by enlarging the number of MBS rebateable items.

10.101 For these reasons, the Committee does not advocate any broadening of the scope of services covered by the MBS. While recognising that there is a legitimate need to enhance accessibility of allied health professionals, the Committee considers there are more targeted and effective mechanisms for addressing the issue. These include enhancing successful aspects of current initiatives, such as the More Allied Health Services program, the funding of primary health care teams, and providing funding for shared access to resources via groups such as the Divisions of General Practice.

10.102 These options are explored in greater detail in the final chapter that examines options for enhancing integrated primary care models.