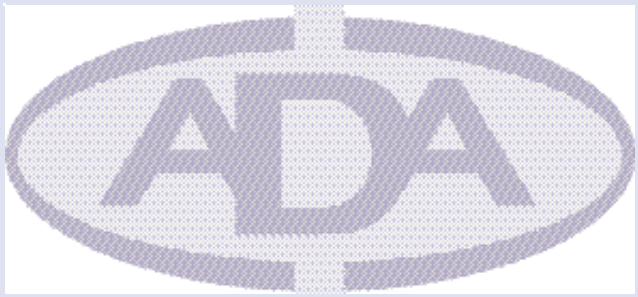

AUSTRALIAN DENTAL ASSOCIATION INC.

# SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

Prepared by the
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Authorized by
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## EXECUTIVE SUMMARY:

This submission addresses the Select Committee's invitation to provide comment upon the issue of whether the extension of Federal funding to allied and dental health services could provide a more cost effective health system - paragraph (d) (i) of the Terms of Reference.

The Australian Dental Association Inc represents approximately 8500 registered dental practitioners within Australia. This constitutes well over 90% of all dental practitioners in this country.

The Association welcomes the opportunity to respond to the Select Committee's invitation to address dental health services within Australia.

The Association recommends the following:

i) Federal funding to dental health services not be provided through the Medicare system as the addition of a comprehensive universal dental scheme would be fiscally irresponsible, and would necessitate a significant increase in the Medicare levy.

ii) Insufficient analysis of the nation's dental health and dental health needs has been undertaken. A national survey of this is required before effective and efficient utilization of government funding can occur. Only then can proper prioritization of objectives and needs be undertaken.

iii) Maintenance of the 30% rebate. The utilization of the 30% rebate enables increasing numbers of the public to have private insurance and thus obtain financial assistance for dental treatment. Removal of the rebate would result in less people being covered and therefore more than 55% of services now covered by private insurance would be met by the individual. The "working poor" would not be covered by private insurance nor would they be eligible for public assistance. Such cost may well result in avoidance of treatment and further deterioration in the oral health of the community. Alternatively, it may increase demand on an already over extended public dental system.

iv) Evaluation of the outcome of the national survey suggested. Re-introduction of a scheme based on the previous "Commonwealth Dental Health Program" should then be considered to provide affordable dental care to a wide sector of the community in such a way as to effectively utilize both private and public dental sectors.

v) Allocation of funding to the Dental Schools to address the chronic shortage of dentists that exists and is increasing.

vi) The development of a significant properly coordinated program to prevent dental disease through fluoridation and oral hygiene, dietary and behavioral modification.

vii) The introduction through the dental schools of a national dental intern or vocational training year for first year dental graduates and graduates of the Australian Dental Council exams. Such system would release approximately 300 dental graduates who could be supervised in appropriate public and private dental facilities.

viii) Effective use of Dental Auxiliaries. Dental auxiliaries have a role in any preventative program and school dental service. Aged care facilities, in particular, have an extremely high need for dental hygienists and effective use of such preventative based auxiliaries is essential within the school dental services if children are to be given the best chance to start life with good oral health.

# Submission to the Senate Select Committee on Medicare

## 1. Background

Recently, significant media attention has been given to the appalling state of public dental services in most, if not all, States and Territories of Australia. ADA Inc does not dispute the general claims made by Channel 9's "A Current Affair" and applauds the Program for highlighting an issue which organized dentistry has been agitating about for years. There are several "solutions" being bandied about which are not ones the Association would agree with as being in the best interests of dental care delivery. The two most common approaches being put forward, which the ADA does not agree with, are "put dentistry under Medicare" and "remove or redirect the 30% Private Health Insurance Rebate from ancillary services, or at least the dental section". A third possibility being canvassed is to "bring back the Commonwealth Dental Health Program" and, on this, the ADA has some sympathy but has qualifying comments to make as outlined in the Addendum.

## 2. The problems with dentistry in Australia today

Apart from the short-lived Commonwealth Dental Health Program (CDHP), the state of Australian's oral health has not been of major concern to Governments. This is a short sighted view, particularly given the research into links between oral health and general well-being, especially related to periodontal disease. Similarly, with an increased life-span, the ramifications for health expenditure on an ageing population with poor oral health are huge.

The number of persons eligible for public dental treatment is estimated to be 4.69m but the actual distribution of those in need and the extent of their need for treatment is not completely known. A national oral health survey has not been conducted since 1987 despite requests from the dental profession for at least the last 8 years. This lack of monitoring of the nation's dental health is, in itself, a major disgrace as it leads to many ad hoc and ineffective decisions being made about the delivery of public dental treatment.

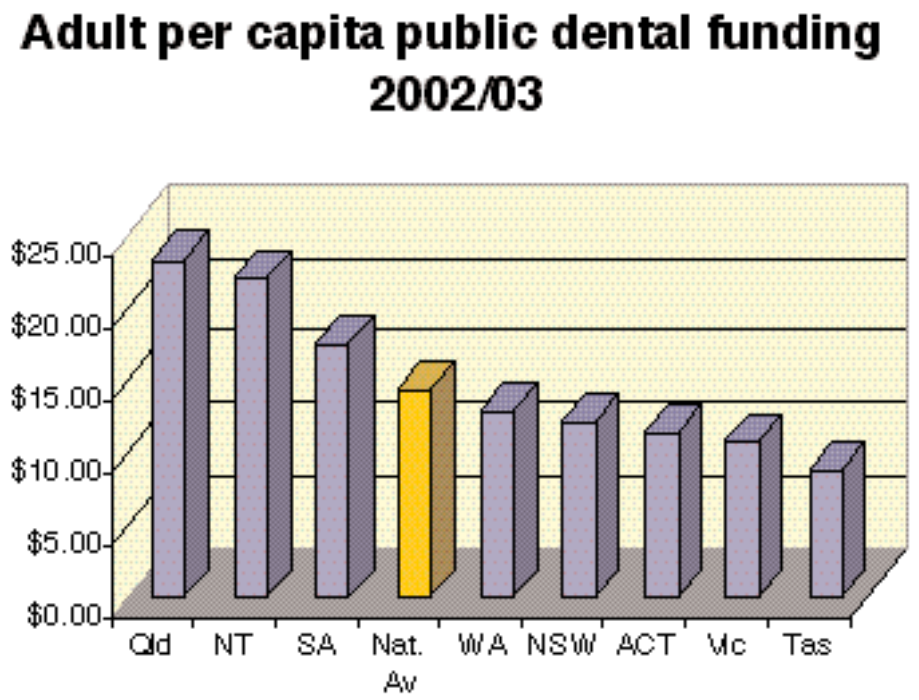
The Australian Dental Association has, for many years, warned of major problems in the delivery of dental services in this country particularly in the public sector but also in rural and remote areas. The scope of the problem starts with insufficient dentists in these arenas and extends to insufficient funds being made available for treatment of people disadvantaged by economics or geography.

Waiting lists for public dental treatment in most, if not all, States and Territories are unacceptably long with many areas within each State and Territory having waiting periods varying from 3 to 4.5 years. Some outlying areas do not really have a waiting period, as it seems no dental services will ever be made available to them.

Dental Schools throughout Australia are grossly under-funded and the consequent lack of academic staff requires members of the dental profession to teach at these institutions gratis. The Faculty of Dentistry at the University of Sydney has estimated that this volunteer teaching amounts to over $650,000 per annum, an amount which would be similar at the other Dental Schools in Australia. In addition, in order to remain solvent, the Schools have to take in many

full-fee paying students from overseas with the eventual outcome that there are fewer dentists being produced for Australian needs.

The Commonwealth Government maintains that dental care is a State and Territory responsibility and consequently does not have any apparent involvement in the allocation of its funds by the States for health expenditure, including dentistry. The combined State and Territory expenditure on public dental care in 2002/03 is $270m, which given an eligible population of approximately 4.7m people, means an allocation equivalent to $57.50 per eligible person p.a. Expressed as a per capita allocation in relation to the entire Australian population however, the average is $14.31 per person. A graph showing the widely varying contributions of the States using this broad per capita measure follows:




Source: SADS 2003

In addition to not being involved in the actual expenditure of money for public dental services, the Commonwealth Government does not appear to take any direct interest in the actual state of the dental health of the nation as there is no accountability requirement of the State and Territory Governments for the Commonwealth funds being used.

## 3. Australian Dental Association recommendations

### 3.1 Urgently carry out a national oral health survey

Waiting lists for public dental treatment are unacceptably long but it is essential that the extent of the problem and the areas of need are accurately identified so that expenditure of money is effective. Such a survey result would also guide preventive strategies to reduce the incidence of poor oral health, and hence the subsequent need for expensive treatment.

**3.2 Call on the Minister for Health and Ageing, Senator Patterson, to bring together all State and Territory Health Ministers to jointly decide and agree on a national approach to deal with this problem.**

The Commonwealth claims to have allowed the States to keep an additional $2.5 billion from the growth in the number of private health insurance contributors, and that it puts billions into the health systems of the States and Territories. However, there is no actual requirement of the States or Territories to spend any of the Commonwealth money on dental treatment. The ADA calls on the Commonwealth, State and Territory Governments to come together to agree on common outcomes for public dental treatment which are equitable for all parts of Australia. There needs to be agreement on the amount of money to be spent on public dental treatment and for that money to be properly targeted to those genuinely in need.

The State and Territory Governments should agree to match tied Commonwealth funding on a dollar for dollar basis, so that a clearly identifiable amount of money is guaranteed for public sector dental treatment. This would also require the various levels of Government to cease accusing each other of being the cause of the waiting list problem.

The aim of any public expenditure on dental treatment, at the least, has to ensure that public sector waiting lists are less than 12 months and that any emergency dental treatment is delivered either on the day of presentation or, at the worst, within 48 hours. Nobody should have to suffer pain and discomfort for longer than that period. These targets should be set so that they are reached within 2 years, and further improved thereafter.

**3.3 Utilize the private dental sector where necessary to overcome the shortage of dentists in the public sector.**

The public sector is critically short of dentists in most, if not all, States. There is no quick solution to this structural problem so there is a need to utilize the private sector via such schemes as vouchers for emergency and standard dental care. Rural and remote areas will always remain a problem and a mix of public and private sector dentists will be required. The ADA Branches in most States and Territories are working with their respective Governments on ways to attract and retain dentists in country regions and to assist with issues in the public sector in those areas. Career structures and remuneration aspects for dentists in the public sector need urgent attention if retention rates are to be improved.

**3.4. Urgently address the shortage of dentists in Australia**

**3.4.1** Dental Schools are critically short of money. Consequently, they are resorting to training overseas students as full-fee paying entities so that the Schools can survive. In turn, this leads to less dentists being trained for Australia's needs. It is estimated by Professor Spencer, at the Dental Statistics and Research Unit (DSRU) within the Australian Institute of Health and Welfare in Adelaide, that Australia needs at least an additional 120 dentists per annum just to maintain the status quo. This figure is in addition to the approximately 250 dentists who graduate each year from the five Dental Schools plus an additional 50 overseas-trained dentists who pass the Australian Dental Council (ADC) exams. The

shortage is worsening as Australia's population increases and DSRU estimates that there could be a shortfall of somewhere between 700 and 2200 dentists by 2010.

If Australia is to have a viable dental workforce, the existing Dental Schools have to be given additional funds to enable some expansion in their output. This is mainly a Commonwealth Government responsibility but, again, there is some State Government involvement via their health departments and public sector teaching units. Additional funds are required for infrastructure, staffing and student fee support, and the ADA estimates that the five dental schools would need around $25m extra spent on facilities to accommodate the additional students and staff. Additional teaching costs are estimated at $1m and the extra fee subsidies for 120 dental students per annum is estimated to total approximately $3m.

**3.4.2** ADA policy is to establish a national dental intern or vocational training year for first year dental graduates and graduates of the Australian Dental Council exams. Such a scheme would need supervising dentists and so does not completely release the 300 or so new dentists for the public sector alone, but would need to be in combination of the public and private sectors. Introduction of an intern scheme requires legislation to ensure uniformity across all States and Territories and so will involve Commonwealth and State Government agreement.

**3.4.3** The States need to examine their funding formulae to ensure that teaching, mentoring and professional development activities are encouraged rather than being penalized.

### 3.5 Effective use of Dental Auxiliaries

**3.5.1** Aged Care facilities urgently require dental assistance for their clients, which is mainly of a preventive nature. Dental Hygienists are the appropriate dental auxiliary for this purpose and more need to be trained and employed in this sector of our health and welfare system.

**3.5.2** The use of Dental Therapists is of limited value beyond the school dental services and extension of their duties to treat adults requires additional training which still does not equip them to perform the range of, often complex, duties a dentist is called upon to perform. School age children are particularly vulnerable to dental disease and it is essential that they are placed on a sound footing by an effective school dental service. The moves to extend the duties of dental auxiliaries in some States, supposedly in the interests of creating a more cost effective workforce, are all ironically making these auxiliaries far more attractive to private sector employers, so that many dental auxiliaries are not remaining in the school dental services. The drain of cost-effective talent from the public sector, and the undermining of effective child dental services, is a direct consequence of the shortsighted policies of various State Governments that have sought to promote "mini-dentists' by progressive expansion of the scope of duties of these auxiliary personnel. Expensive moves to increase the number of training places for these auxiliaries will only be frustrated by the failure to lock them into public service upon completion of their training.

**3.5.3** Pre-school children and their parents are in need of sound preventive dental care and advice. Use of the preventive expertise of dental auxiliaries is most appropriate in this age group.

### 3.6 Prevention should be the cornerstone of any dental program, public and private

Much dental disease is of a preventable nature and all available evidence shows fluoridation of reticulated water supplies has had a very significant effect in reduction of dental caries in this country. There remain many towns and cities which have not introduced this cost-effective preventive measure and Governments should take whatever measures are necessary to introduce or extend water fluoridation as soon as possible.

Other preventive measures include oral hygiene, dietary and behavioural modification and need to be included in any scheme involving dental treatment, especially when public money is being expended.

If prevention is not an integral part of all dental programs then ultimately there will be no amount of money nor sufficient dental workforce available to solve the dental problems of Australia.

## 4. ADA comment on some of the solutions being put forward in the media and elsewhere

### 4.1 "Place Dentistry under Medicare"

This is a superficially attractive solution which is neither fiscally responsible nor is it likely to deliver quality dental care. Peter Walsh, Finance Minister in successive Labor Governments in the 1980s and 1990s, wrote in 1995 that "dental treatment (for health card holders) has the potential to be a bottomless fiscal pit which no Commonwealth Government should go near." Medicare is already under severe financial strain and the addition of a comprehensive universal dental scheme would simply lead to total collapse unless significant increases in the Medicare levy were to be introduced. In the UK, which had a nationalized dental scheme for many years, the standard of dental treatment became unacceptably low by Australian standards and the massive costs incurred in its maintenance have led to its gradual winding down. A similar path ought to be avoided as it would be detrimental to the oral health of the nation.

### 4.2 "Remove or redirect the 30% Private Health Insurance Rebate (from dental services)"

Senator Patterson, Minister for Health and Ageing, in a recent press release, says that this rebate is helping to provide 20 million dental services a year with an annual payout of $1 billion to fund members. Many people who took out private health insurance with the ancillary benefits did so because they needed the assistance from health fund insurance for dental treatment for their families. It is flawed logic to remove that rebate for dental services and then place that money into public sector dental services. 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 and so the result

will not be to assist the public sector but rather to increase its load. The remainder, the "working poor", would simply be deprived of any dental care as they would not be able to afford private care and would be ineligible for any assistance from the Government. The aim of private health insurance surely is to assist people to obtain the optimum health care and also to keep people out of the already over-burdened public sector.

The AHIA submission to the Select Committee addresses the potential impact removal of the rebate may have on the provision of ancillary services and the Committee's attention is drawn to paragraphs 34-46 of their submission. Based on that analysis the obvious consequence of the removal of the rebate would be a further deterioration in oral health.

### 4.3 "Bring back the CDHP"

There is no question that this program, which was funded to the extent of about $250 million, had a positive effect with about 1.5 million people being afforded some dental treatment and reducing waiting lists to nearly acceptable limits. It necessarily involved both public and private dental sectors and eventually operated with reasonable efficiency, although there were significant problems such as:

- It did not properly target the genuinely needy. Any public dental program, given that there are limited resources, should aim at including those most in need and strategies should include specific targeting using criteria such as duration of hardship, permanent disability and severity of unmet dental needs.
- There were significant anomalies in the actual services which could be delivered and inconsistencies with regard to availability of certain dental services to the disadvantage of the patient. For example, an abscessed upper front tooth could only be extracted from an otherwise healthy mouth as there was no allowance for pulp extirpation which would have saved the tooth.
- Administrative problems were frequent because of the lack of dental expertise of personnel directing patients for treatment. Proper triage arrangements are necessary for any such scheme.
- Fee levels for private dentists were unreasonably low and resulted in less than optimum participation.

These problems are surmountable and the ADA would be willing to use its resources, expertise and knowledge to assist in designing a program of effective services should such a scheme be contemplated. Some States are now using similar approaches for restricted, largely emergency-based treatment using State revenue, which admittedly may have had its origins as Commonwealth money.

# Australian Dental Association Inc. Policy Statement: Principles of Government Funding of Oral Health Care

## 1 Introduction

**1.1** 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.

**1.2** Governments must recognise that there are disadvantaged and special needs groups who will be unable to access reasonable levels of oral health care without assistance.

**1.3** Governments must recognise they have a vital role in providing oral health services for these groups of individuals.

## 2 Principles of Involvement

**2.1** The Australian Dental Association [ADA] recognises that a Government's general responsibilities in an overall national oral health policy [oral health promotion, research and provision of workforce] will have an impact on disadvantaged and special needs groups.

**2.2** In funding oral health care delivery programs for eligible groups and individuals, the ADA believes that the following underlying principles should apply to Government involvement.

**2.2.1** Government assistance should be directed preferentially to those in greatest financial and oral health need.

**2.2.2** Governments may choose to encourage the community to take out private health insurance [including ancillary cover] through taxation rebates or other financial incentives. The financing of these incentive programmes should not diminish the Government's obligation to fund reasonable levels of oral health care preferentially for those disadvantaged and special needs groups who are unable to access care without that assistance.

**2.2.3** The complexities of the medically compromised and the range of care which needs to be provided require that the prime provider of these services must be a fully qualified dentist.

**2.2.4** Eligibility for treatment in the school dental service should be restricted to disadvantaged children.

**2.2.5** ADA supports the principle of patient co-payment for oral health services.

**2.2.6** Government funding for the provision of oral health care should utilise the well-developed network of private practice in conjunction with public health service facilities.

**2.2.7** Fees for service should utilise the usual and customary fee of the provider with patient co-payment supplementing the Government fee component.

**2.2.8** The range of dental treatment items provided for recipients of Government assistance should be comprehensive and of a high standard.

**2.2.9** The services provided should be directed towards allowing the recipient to achieve long term oral health.

**2.2.10** Any Government scheme involving private practitioners should be open to participation by all registered dentists who elect to be included.

**2.2.11** Private practitioners should not be subject to inordinate administrative tasks in the provision of these services and their time is best directed towards the required clinical care.

**2.2.12** As the organisation representing the dentist workforce, the ADA should be involved in the development and evaluation of any dental health programme.

## 3 Universal Dental Health Programmes

**3.1** Where Governments might choose to provide the entire community with dental care, they must involve professional organisations in the planning and must clearly identify any limitations of such a programme. In general, the ADA opposes such programmes.

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**Policy Statement 1.5**
Adopted by ADA Federal Council, November 21/22, 2002.
Amended by ADA Federal Council, April 10/11, 2003.