



AUSTRALIAN DENTAL  
ASSOCIATION INC.

**Submission to the  
National Health and Hospitals Reform Commission  
on the  
Interim Report:  
*A Healthier Future For All Australians***

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Authorised by  
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## **ABOUT THE ADA**

The Australian Dental Association (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers. The primary objectives of the ADA are to encourage the improvement of the health of the public and to promote the art and science of dentistry. There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at [www.ada.org.au](http://www.ada.org.au)

## **INTRODUCTION**

The Australian Dental Association Inc (ADA) thanks the National Health and Hospitals Reform Commission for the opportunity to comment on the Interim Report: *A Healthier Future For All Australians*.

## **SUMMARY**

### **“Denticare”**

The Australian Dental Association (ADA) is opposed to the universal dental scheme, “Denticare”, as it is too complex, inefficient and impractical, and will not provide quality dental care to those most in need, disadvantaged Australians.

Recent consultation with Commissioners in Canberra only strengthened the ADA’s opposition to “Denticare”, where it was clear that:

- dentistry is not properly recognised as being different to consultative health practices such as general practice medicine and physiotherapy and
- the concept of “Denticare” had not been fully thought through.

The failure to deliver dental care to disadvantaged Australians is not due to a system failure as such but due to under resourcing of dentistry.

“Denticare” is a demographic base care system when what is required is a system that allows patient focused care. What is required is targeted funding to those in greatest financial and oral health need. Further, any proposed scheme should not be offering only limited dental care that won’t be effective. Instead it should offer a well structured, dentally effective scope of treatments to provide patients with long term dental health.

Many Australians are currently accessing dental care and remain capable of caring for themselves and so should continue to do so. Simple, practical and achievable solutions for disadvantaged Australians are required.

The ADA's position is that if the Federal Government is to direct funding to dental health then, amongst many things, the following should apply:

- funding for treatment should be directed to the financially disadvantaged – the one third of Australians who don't receive proper dental care now. Such funding should be immediately increased;
- funding for treatment should not be directed to those who can or are affording it and so dilute benefits to the disadvantaged;
- a wide range of services, with an annual limit will give predictable costs and will provide flexibility to provide better patient focused long term health outcomes;
- funding for dental clinic infrastructure is urgently required for training of the dramatically increased numbers of students and to increase dental public sector capacity;
- increased funding for academic staff to cope with the new dental places created in Australian Dental Schools;
- improve employment conditions for academics and public sector dentists;
- ramping up of funding for treatment for disadvantaged Australians as capacity increases;
- review progress of changes in five years; and
- the initiatives below.

### **Oral Health Promotion**

Given that decay, gum disease and oral cancers are almost entirely preventable investing in oral health promotion has the potential to create massive savings in treatment costs and so is fully supported.

### **Internship**

The ADA has advocated the introduction of an intern or residency year in numerous submissions over recent years. Federal ADA President Dr Neil Hewson gave an undertaking to Minister Roxon in late 2008 to provide a submission which is currently being prepared by an ADA expert committee and will be presented to the Minister in the near future.

### **Child Programs**

The ADA supports the principle of providing more resources for child dental health, though not in the way described in the report.

### **Other Areas**

The ADA has not comprehensively analysed all other areas of the extensive interim report but has made comment on some issues.

## **IMPROVING ORAL HEALTH AND ACCESS TO DENTAL CARE**

### **1. Create a scheme 'Denticare Australia' for universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay.**

ADA Response:

- The Interim Report has suggested the creation of universal access to basic dental services. Nothing in the report provides justification for the need for the creation of such a universal scheme. No case has been put forward as to how or why the creation of a universal scheme will improve dental delivery in an effective and economic way for Australians.
- The ADA has been consistently opposed to the provision of a universal dental care system, arguing that the most effective utilisation of funds would be to target the available funds to deliver a worthwhile range of dental services to the financially disadvantaged – the one third of Australians who currently do not receive proper dental care. There is little to be achieved by the introduction of a tax scheme that will provide all Australians with very basic dental services that will often give patients poor options when many are able to receive comprehensive treatment now. Rather, funding should be directed to the provision of a wide range of dental services that will properly meet the needs of that group of the community that cannot access dental services now due to their financially disadvantaged circumstances and an inadequate public sector that cannot meet their needs.
- The provision of universal access for preventive and restorative dental care together with dentures provides only very basic dental treatment, and would create two tiers of dental care:
  - a. Provision of very basic dental services universally - under the Scheme,
  - b. A more comprehensive suite of dental services available to those that can afford to access them (basically those that access such services more cost effectively now) - not under the Scheme.
- Targeting funding to provide a comprehensive suite of dental services to the financially disadvantaged with an annual entitlement limit imposed would be a more effective utilisation of funds. Poor dentistry to the poor should not be an option. All funding should be provided on a means tested basis and the level of funding and suite of services available be customised to ensure all the community receive a satisfactory patient focused dental care - not just bare-basic services.

Two Federal Parliamentary enquiries and *Australia's National Oral Health Plan* saw no sense in attempting to deliver a universal dental health scheme such as that proposed in the Commission's report. The architect of Medicare, Professor John Deeble, recognised that dentistry was not suitable for such schemes. He has said: *"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."*

- Government funding should be increased and directed to disadvantaged Australians and not be diluted by paying benefits to all Australians.

**2. Provision of 'Dentcare Australia' pursuant to a mixed approach of public and private cover. Additional costs would be funded by an increase in the Medicare Levy of 0.75% of taxable income, with people opting either to become a member of a dental health plan (with a private health insurer), or to use public dental services.**

ADA Response:

*Private Dental Health Plan Option*

- In the past, private health insurers have not proven to be an effective medium through which dental services are provided. Health funds have to date:
  - attempted to impose treatment regimes on practitioners which are not necessarily in the patient's best interests;
  - created "business rules" that have resulted in creation of a restrictive impact upon the delivery of services;
  - moved from mutuals to companies and so need to return profits to shareholders. Creation of profit for dental plan managers from tax generated funds is inconsistent with the whole tenor of improved dental care delivery.

These are not attributes that are suitable for a scheme funded through taxation and render the proposed scheme totally unsuitable for the achieving of an improvement of the dental health of Australians. This is particularly the case where it is suggested that risk adjustments will be made for those opting for a dental scheme.

- While the ability to access the private dental sector is supported, the ADA has serious concerns as to whether the proposed scheme will have the capacity to deliver the additional demand for services created by the scheme. A resourcing issue will ensue where the flow on effect will be increased demand on an already under-resourced public sector.
- The report refers to a private dental health plan covering "85% of current costs of private dental services". This cannot be achieved as there cannot be control of all dental fees. The ADA would like clarification as to who or what would be the determinant of the costs?

*Public sector option*

- The ADA is gravely concerned about how an already under-resourced public sector will accommodate the increased demand. A dental workforce shortage already exists in the public sector. According to a new Report conducted on behalf of the NSW Oral Health Alliance, (to be launched 1 April 2009) waiting times for access to public dental services were the single biggest issue confronting this sector. In NSW, almost 60% of NGOs surveyed estimated that the average waiting time for their clients to access public dental services was six months or longer. Public dental waiting lists will surely lengthen with the increased demand created only worsening the predicament that exists now.
- Given the inadequacies of the public sector, those who opt to access that sector would be certain to receive a lesser range of services than those that may access the private sector, thus creating a further differential in the quality of care delivered. "Universality" will be non-existent.

- Access to a public sector dental scheme will not help service rural and remote communities - which are markedly under resourced.
- 3. Support for an equitable approach to financing a universal dental scheme.**
- **Many people will pay more no than they currently pay for dental care – the increase in Medicare Levy of 0.75% of taxable income will be smaller than existing out of pocket costs for dental services for many people.**
  - **People on low incomes will pay considerably less and have much better access to dental health services.**

ADA Response:

- The ADA reiterates that if funding available was targeted to where it was most needed, i.e. the financially disadvantaged, this would be a more equitable, realistic and feasible approach to adopt. Also a simpler administrative model not involving health funds would save costs and so allow more funding for disadvantaged Australians.

The report's comment that "people on low incomes will pay considerably less and have much better access to dental health services" does not follow. Those on low or no incomes are those currently accessing the public sector. In that case they currently pay nothing. If those on low incomes were to opt to adopt the private cover, then only a reimbursement of "costs" would be received, therefore those persons on low incomes will have to meet costs which they are not required to meet now.

As the Medicare levy would rise by 0.75 percentage points to pay for the scheme, this effectively means that with average ordinary time earnings for full-time workers now at \$1145 a week, that rise represents an average tax increase of about \$442 annually.

- 4. Support the introduction of a one year internship scheme prior to full registration, so that clinical preparation of oral health practitioners operates under a similar model to medical practitioners.**

ADA Response:

- The ADA is supportive of this measure and has already made a commitment to the Federal Minister for Health to supply a paper as to the methodology for the adoption of this scheme.
- Although supportive of an internship scheme the ADA has serious concerns that the limited range of services currently proposed for Denticare would de-skill new graduate dental interns. New dental graduates currently leave university trained to perform a wide range of procedures, however the restricted range of services proposed under the new scheme would be systematically de-skilling interns during their internship period. This undermines a core purpose of internships and additionally would make work as a clinical mentor for interns unattractive for senior clinicians.

## **5. The national expansion of the pre-school and school dental programs.**

ADA Response:

- The ADA supports the principle of providing more resources for child dental health, though not in the way described in the report.

## **6. Provision of additional funding for improved oral health promotion.**

ADA Response:

- The ADA has been a regular advocate of oral health promotion over decades and fully supports this proposal. Given nearly all caries, gum disease and oral cancer is preventable, this measure could potentially be extremely cost effective.
- The ADA recommends the following initiatives:
  - Invest in health promotion programs which focus on risk factors that contribute to poor oral health.
  - Promote the introduction of water fluoridation, which should be adopted as part of a Government's health policy and should be implemented in non-fluoridated communities.
  - Provide supplementary funding to existing promoters of oral health promotion.

## **CREATING STRONG PRIMARY HEALTH CARE SERVICES FOR EVERYONE**

**Reform Direction 2.7 - Proposal that in remote and rural areas some diagnostic and specialist medical services be performed by other registered health professionals according to defined scopes of practice determined by health professional registration bodies.**

The ADA will only comment with relevance to dentistry.

ADA Response:

- The ADA is concerned that a second tier level of care will be provided in remote and rural areas if registered health professionals can carry out tasks with which they are not fully qualified. Safety and quality of all health services must be paramount and there must be no compromise of this in order to meet short term workforce shortages. Workforce shortages must be addressed as such and not addressed by devising methods of compromised care delivery.
- Specific programs are required to encourage health professionals to live and work in remote and rural areas, as proposed in Section 9.
- In remote and rural areas dental practitioners do not have the luxury to refer patients for complex procedures so these areas need dentists who can do all procedures.
- The high capital and ongoing cost of delivering dental care mean workforce substitution will create inefficiencies.

## **DELIVERING BETTER HEALTH OUTCOMES FOR REMOTE AND RURAL COMMUNITIES**

The ADA will only comment with relevance to dentistry.

ADA Response:

### **Reform Directions 9.1 to 9.3**

- The ADA supports many of the initiatives in 9.1 to 9.3.

### **Reform Direction 9.4 - Proposal that a higher proportion of educational places be allocated to remote and regional centres.**

- The ADA still has reservations regarding the viability of rural dental schools especially regarding matters such as attracting adequate teaching staff and having enough patients with a wide range of conditions to provide the necessary advice and experience required. There is already evidence of problems such as these occurring. The hub and spoke model with rural clinics and rural sourced students at city schools may be a better model.

## **WORKING FOR US: A SUSTAINABLE HEALTH WORKFORCE FOR THE FUTURE**

### **Reform Direction 14.3 – Proposed new education framework**

The ADA will only comment with relevance to dentistry.

ADA Response:

- The ADA does not support adopting a competency-based framework.
- The ADA believes there is limited scope for a flexible, multidisciplinary approach.
- The ADA supports extra funding for clinical placements and clinical training infrastructure.

Thank you for the opportunity to comment.



Dr Neil Hewson  
Federal President