



## DENTISTRY AND MEDICARE

The recent series of articles in the *Sydney Morning Herald* (February 2005) examining public dental care in NSW has focused attention on the often debated question about whether dentistry should be included under Medicare. Articles highlighted long waiting lists for public dental treatment and cited examples of “homemade remedies”, including people using super glue on their dentures, removing teeth with pliers and “(risking) burns to gums by placing aspirin on their teeth”.<sup>1</sup> The question is, would universal dental coverage address these problems?

There are two issues to be considered:

1. The long waiting lists and the difficulty faced by many people – particularly those on low incomes – to access timely dental treatment.
2. The significant cost if universal coverage was provided.

There is a strong case for a targeted increase in funding for public dental services for some sectors of the community. Data collected by the 2002 National Dental Survey, and illustrated in Table 1, reveals people’s self-rated oral health is lower for those on low incomes than those on higher incomes. Similarly, tooth loss is highest for people on low incomes. According to Professor John Spencer<sup>2</sup> there is a “polarisation of the burden of disease, with middle and upper income Australians experiencing better oral health than lower income and disadvantaged Australians”.

**Table 1: Social Inequality in Tooth Loss and Self-Rated Oral Health Among Dentate Adults, Australia 2002**

Household income	Tooth loss (mean)	Self-rated oral health % Average, Poor, Very poor
\$12,000	9.07	34.2
\$12-20,000	8.67	32.8
\$20-30,000	6.19	22.9
\$30-40,000	4.86	24.1
\$40-50,000	3.80	20.1
\$50-60,000	3.58	20.0
\$60-70,000	4.20	15.4
\$70-80,000	3.63	18.3
\$80,000 +	3.49	14.6
<b>All</b>	<b>5.08</b>	<b>21.8</b>

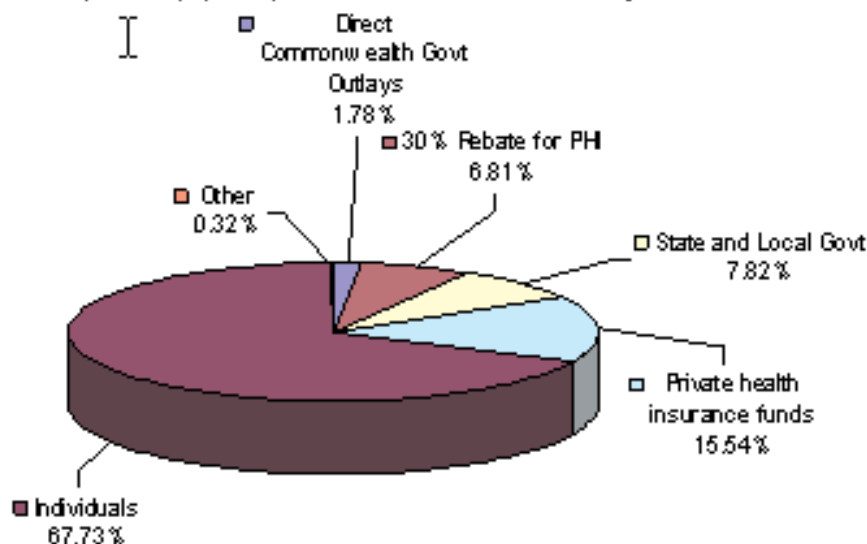
Source: Carter and Stewart (2003), Cited in Spencer, AJ. (2004) *Narrowing the Inequality Gap in Oral Health and Dental Care in Australia*, Australian Health Policy Institute, The University of Sydney, p. 15.

The other side of the argument highlights the significant cost if universal dental coverage was provided. In 2002-2003, total dental services expenditure was \$4.4 billion - the equivalent of 6.06% of total health expenditure in Australia.<sup>3</sup> In the period from 1996-1997 to 2001-2002, expenditure on dental services grew by an average of 5%.<sup>4</sup> As Figure 1 shows, direct expenditure by individuals accounts for the majority of this dental expenditure (67%), followed by benefits from private health funds (15.54%).

Expenditure by State and Local Governments accounts for 7.82% of dental expenditure while subsidies by the Commonwealth Government through the 30% rebate for private health insurance accounts for 6.81%. Direct outlays by the Commonwealth account for only 1.78% of total dental expenditure.

**Contacts: Dr Bill O’Reilly, President Mr Robert Boyd-Boland, Chief Executive Officer**

Figure 1: Proportion (%) of Expenditure on Dental Services by Source



Source: Australian Institute of Health and Welfare (2004) *Health Expenditure Australia 2002-03*, Health and Expenditure Series, Number 20, Australian Institute of Health and Welfare, AIHW Cat. No. HWE 27, Canberra.

The question of whether dentistry should be included under Medicare was discussed in 2003 by the Senate Select Committee on Medicare. Evidence presented to the Committee by Professor John Deeble<sup>5</sup> indicates that by its nature, dentistry was never intended to be included under Medicare:

*“The main problem with Medicare covering the (dental) industry is its basic uninsurability. It does not come randomly ... It has to be said that insurance works for best for things that are episodic and unpredictable. Dental illness is slow: it is not episodic and it is not unpredictable, because you know you have it for quite a long time. You do not suddenly discover that you have a dental problem. It should be treated, but it should not be treated within an insurance approach. It should be a program that is different from an insurance concept, because it just does not work that way. That is why it was never added.”*

## The ADA Position

The ADA holds the view that dental services should not be funded under Medicare. “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.”<sup>6</sup> The ADA policy is that in funding oral health care delivery programs for eligible groups and individuals, Government assistance should be directed preferentially to those in greatest financial and oral health need. There is a need to target money and resources to those that currently have very poor or restricted access to dental care. To make dentistry universally available to the community through Medicare would be “fiscally irresponsible” and unlikely “to deliver quality dental care”.<sup>7</sup> Responding to the recent series of articles in the *Sydney Morning Herald*, ADA President Dr William O’Reilly said:

*“One of the most cost-effective ways of dealing with the large waiting lists is to introduce a scheme coordinated by the Commonwealth and delivered by State and Territory Health Services ... Prevention, including fluoridation of water supplies, is the cornerstone of any oral health care plan. Priority has to be given to this, as without it, no amount of government expenditure will be sufficient to improve the oral health of this country.”<sup>8</sup>*

<sup>1</sup> Pearlman, J. (2005) ‘Glue and pliers for those who can’t bear to wait’, *Sydney Morning Herald*, February 15.

<sup>2</sup> Spencer, A.J. (2004) *Narrowing the Inequality Gap in Oral Health and Dental Care in Australia*, Australian Health Policy Institute, The University of Sydney, p. 11.

<sup>3</sup> Australian Institute of Health and Welfare (2004) *Health Expenditure Australia 2002-03*, Health and Welfare Expenditure Series, Number 20, AIHW Cat. No. HWE 27, Canberra, p. 84.

<sup>4</sup> *Ibid.*, p. 15.

<sup>5</sup> Evidence presented by John Deeble to the Senate Select Committee on Medicare. Source: Commonwealth of Australia (2003) *Official Committee Hansard*, Senate, Senate Select Committee on Medicare, 21 July, Canberra, p. 71.

<sup>6</sup> Australian Dental Association (2003) *Submission to the Senate Select Committee on Medicare*, St. Leonards, p. 6.

<sup>7</sup> *Ibid.*

<sup>8</sup> Australian Dental Association (2005) *Crisis in Dental Care Delivery*, Media Release, 15 February.