



Australian Dental Association Inc.

## **“Dental Access” Proposal**

PROPOSAL TO THE AUSTRALIAN GOVERNMENT FOR A  
SCHEME TO ASSIST DISADVANTAGED AUSTRALIANS  
OBTAIN IMPROVED ACCESS TO DENTAL CARE

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Authorised by

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## Australian Dental Association Inc.

### ABOUT THE AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Association Inc. (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 oral and general health of the public and to advance and promote the ethics, art and science of dentistry, and
- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health care.

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 [ADA] has long argued for more resources to be applied to the oral health care of disadvantaged Australians and it has been pleasing to see the National Health and Hospitals Reform Commission [NHHRC] give the matter of oral health serious consideration. The ADA believes equitable access to dental care is an essential requirement of the Australian health system. This document sets out how such access can be most effectively achieved without the collateral damage likely to occur to the delivery of high quality effective dental care by going down the uncharted path of "Denticare Australia".

#### Evolution not Revolution

The ADA concurs entirely with the NHHRC's argument that there should be equitable access for all Australians but disagrees with its approach to achieving this. The ADA contends that the present method of dental care delivery in Australia, a combination of private and public, is generally a very good one but that the public sector has long been severely under-resourced and this has led to lack of access to dental care for disadvantaged Australians. In fact, 65% to 70% of the population can readily access dental care without Government assistance so that, if the remaining 30% to 35% of the population, who believe they are unable to afford dental care, were to receive appropriate and proper access, this would achieve universal availability of dental care regardless of people's ability to pay.<sup>1</sup> Complete abandonment of the current method of dental care delivery is unnecessary; evolution, not revolution, should be the way forward. In other words, fix the problems which exist and do not invent another system. The relative success of the previous Commonwealth Dental Health Program and the increased funding by some State Governments in the past has clearly confirmed that the current inequity problems in dentistry are not structural but resource based.

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<sup>1</sup> 70% and 30% estimates derived from ARCPDH's telephone survey data where 31.2% of all Australian dentate adults indicated that they avoided or delayed visiting a dentist due to costs. The accuracy of such a survey method is questionable in determining actual inability to afford as opposed to perceived inability.

## Targeting, the Solution to Equitable Access

Proponents and supporters of a universal dental scheme argue that such a scheme is the fairest way to provide dental care and, at first glance, it may appear so. However, in all the universal dental schemes throughout Europe, studies show that oral health inequalities continue to exist - with the disadvantaged still worse off.<sup>2</sup> In Australia, the universal Medicare Safety Net and the Enhanced Primary Care Scheme have clearly demonstrated the Inverse Care Law<sup>3</sup>, which would apply even more strongly in the case of dentistry.

The NHHRC correctly links oral health to general health but does not recognise that delivery of general dental care is different to general medical care. Whilst the aim in dentistry is to prevent disease, and much has been achieved in this area, there is still much repair required to restore dentitions marred by dental decay and periodontal disease. Thus, at present, the delivery of dental treatment requires highly sophisticated dental clinics akin to mini-hospitals in their operation. The prevalence of dental decay from the very young to the dentate elderly means that attempts to liken dental treatment with, for example, hip replacement or treatment of lung cancer, fail to recognise the huge potential for massive dental repair bills unless prevention, particularly of dental decay, is the first and foremost priority. Consider if each Australian had an examination, two dental radiographs and just two teeth to be restored each year, and these were just simple fillings, there would be an outlay of at least \$7 billion per annum. If there are no mechanisms to control dental decay then, as past-Finance Minister Peter Walsh said some 14 years ago, "dental treatment has the potential to be a bottomless fiscal pit which no Commonwealth Government should go near".<sup>4</sup> Further, the belief or proposition that health insurance will cover the costs of dental care for the whole population does not take into account the basic uninsurability of dental decay and periodontal disease. These are not random unlikely events but chronic and largely predictable processes unsuited to an insurance concept.

A properly constructed scheme targeted specifically at disadvantaged Australians would achieve the aims of provision of care to this sector without the complications and expenses and likelihood of continued inequality which a universal scheme would bring.

## Wind up Current Commonwealth Plans

There are two recently introduced dental schemes presently funded by the Commonwealth Government – the Enhanced Primary Care [EPC] - Medicare chronic disease dental scheme and the Medicare Teen Dental Program.

The EPC program utilises medical practitioners as the gate-keepers, is not means-tested and has high annual monetary limits [AMLs] which have led to high usage of expensive dental treatments. It is incongruous that the Government is funding crowns for people under this scheme yet it is not able to provide even basic treatment such as fillings for many disadvantaged people.

The Medicare Teen Dental Program has some means-testing but only provides for an examination, cleaning and some limited diagnostic and preventive treatments. Thus, if a family cannot afford actual remedial treatment, there is no assistance available other than the public sector waiting lists. To date, less than 35% of eligible teenagers have accessed

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<sup>2</sup> Coverage of publicly-funded dental services – an international perspective. Commissioned by the UK Department of Health and prepared by the London School of Hygiene & Tropical Medicine, June 2009, Stefanie Ettelt, Ellen Nolte and Nicholas Mays.

<sup>3</sup> "The availability of good medical care tends to vary inversely with the need for it in the population served." Julian Hart 1971.

<sup>4</sup> Peter Walsh, Confessions of a Failed Finance Minister. Milsons Point, N.S.W., Random House, 1996

this scheme.<sup>5</sup> It is recommended that both the EPC dental scheme and the Medicare Teen Dental Program be closed down and the moneys saved be used in the following proposal.

## **ADA PROPOSAL FOR PROVIDING IMPROVED ACCESS TO DENTAL CARE**

### **Oral Health Promotion is Fundamental**

The ADA has indicated in its responses to the NHHRC Report that it gives 'in principle' support to recommendations 84-86, but is opposed to recommendation 83, the proposed universal dental scheme, for many reasons. This Proposal from the ADA outlines our concerns about the wisdom of introduction of the proposed "Denticare Australia" scheme in Australia whilst suggesting an alternative targeted approach which will deliver equitable access in a more straightforward and effective manner. The ADA contends this would be more consistent with the Government's focus on population health and priority groups.

If oral health is to be improved and costs are to be kept at an affordable level, prevention of oral disease has to be at the forefront of oral health policy in Australia. Fluoridation of reticulated water supplies has long been championed by the Australian Dental Association as a major initiative to reduce dental decay. Apart from recent moves to fluoridate Queensland's water supplies, water fluoridation still has to be implemented for smaller populations of 800 to 1000 given that this is now feasible and cost-effective. Thus, some 24% of the Australian population, including many Indigenous communities, do not have access to this proven health measure.<sup>6</sup> The ADA contends that water fluoridation should be a Commonwealth responsibility consistent with the National Preventative Health Strategy.

Oral health promotion, in all of its forms including education and fluoridation, needs to be an integral part of Australia's health plans. The optimum use of prevention programs and preventive auxiliary personnel, such as hygienists, are an essential pre-requisite. Any dental scheme, targeted or universal, must have requirements for behaviour change where dental decay and periodontal disease are proven risks. Ultimately a person's oral health is in their own hands. This cannot be stressed strongly enough.

### **"Denticare Australia" - Not the Answer**

There are many factors defining disadvantage but there is a general acceptance that the largest disadvantaged sector is that of financial disadvantage. If Concession Card Holders are taken as the measure of disadvantage then there are about 4.2 million people eligible. If telephone surveys are taken as accurate and 30% is accepted as a broad measure of the number of disadvantaged people who require some help to gain access to dental care then there will be about 7 million people who will require assistance in accessing dental care.<sup>7</sup>

To deliver a scheme which provides a satisfactory level of dental care requires a significant outlay on the part of governments in infrastructure, workforce, training and workforce distribution as well as on-going operating expenses. It is particularly in the areas of

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<sup>5</sup> Number derived from Medicare Statistics data. Medicare item number for Teen Dental Plan, 88000, shows that during the year July 2008-June 2009 only 459,691 teenagers accessed the Teen Dental Plan. On the Department of Health and Ageing website it says "Around 1.3 million teenagers are eligible for the Medicare Teen Dental Plan each year." <http://www.nhhrc.org.au/internet/main/publishing.nsf/Content/dental-teen> Medicare Statistics report for item number 88000, please see Appendix 1.

<sup>6</sup> Australian Government, National Health and Medical Research Council, A systematic review of the efficacy and safety of fluoridation, Part A: Review Methodology and Results, December 2007.

<sup>7</sup> Estimate derived from Australian Bureau of Statistics population clock approximately 22,000,000 (as at October 2009).

infrastructure and workforce where the "Denticare Australia" proposal becomes unworkable.

As a result of these structural issues and some questionable costing assumptions, "Denticare Australia" will fail to deliver adequate care to the sector of the community it categorically states is the very reason it was proposed. The majority of disadvantaged people are used to accessing dental care, when they can get it, via the public dental services and it is this area where serious deficiencies are most apparent and where most attention should be directed as discussed later.

The NHHRC rightly identifies the disadvantaged as needing assistance in access, citing an unverifiable, but certainly unacceptably high, figure of the number of people on public sector waiting lists, but then concludes that people who wish to use the public sector will have to contend with waiting lists; one of the very things which the NHHRC says "Denticare Australia" is designed to overcome.

The ADA, along with some health insurers<sup>8</sup>, has major concerns with the costing assumptions made in the Price Waterhouse Cooper [PWC] financial analysis used by the NHHRC and maintains the cost will be significantly higher than the estimate.<sup>9</sup> Thus, in order to provide the universal dental scheme, the following would have to happen:

- (a) income earners would be required to pay a higher dental levy or tax, or
- (b) people would obtain more restricted dental services, or
- (c) people would have to be further subsidised by the Government.

It has to be realised that, unlike medical services under Medicare, "Denticare Australia" will not deliver unlimited dental care within the proposed basic services, as there will need to be annual monetary limits imposed to conserve the funds raised by the income tax levy [understood from PWC figures to average about \$400 per person per annum].

PWC assume there will not be a significant rise in usage of dental services by the middle and higher income groups but very few analysts accept this will be the likely scenario. These groups will continue to utilise private dental services but almost certainly at a higher rate which, in turn, will lead to the disadvantaged sectors being unable to access the care the NHHRC proposes they will get via the private sector. A second assumption is that there will be no change in service mix but, as seen with the EPC dental scheme, if costs are taken out of the equation, then people will opt for the high end treatment items.

### **No Role for Health Funds in Administering Scheme**

A further area of concern is the proposal that, under "Denticare Australia", dental treatment would be administered via private health funds. Whilst there are many health funds which operate as not-for-profit, the large for-profit funds hold about 70% of the market.<sup>10</sup> At present, only one fund, NIB, is listed on the stock exchange but Medibank Private also pays dividends to the Commonwealth Government. Administrative costs for health funds are estimated to be about 15% whereas the administrative costs for Medicare are only about 4%.<sup>11</sup> The best option for administering any dental scheme has to be with a single payer run by the Commonwealth Government via a Dental Benefits Act.

<sup>8</sup> Medibank Private and BUPA submissions to the NHHRC 2008/9.

<sup>9</sup> NHHRC: Costing a social insurance scheme for dental care: supplementary report. Page 16-17. Services in scope 5.2bn, Direct govt outlays including expansion programs 4.9bn

<sup>10</sup> State of Health Fund Report 2008, page 23 data was used to compute percentage of market share by for-profit health funds. See Appendix 2.

<sup>11</sup> Kenneth Davidson, The Age, The poor pay so the rich can stay healthy, September 14, 2009.

It has been argued that some health funds run cost-effective dental clinics and this somehow qualifies them for a role in administering "Denticare Australia". Apart from the egregious conflict of interest with such a proposal there is no evidence that this activity qualifies health funds to effectively administer a universal dental scheme. Further, health fund clinics are designed to return a profit to the funds and will not be placed in non-profitable areas of need such as rural and remote, leading to a concentration in urban areas. Health funds could be expected to compete with each other for members and so increased advertising costs would be added to the high administrative costs already apparent.

The ADA remains concerned that health funds, especially the for-profit ones, are designated as the administration vehicle and contends that their lack of transparent administrative arrangements, obvious higher administrative costs and requirement to make a profit is a contra-indication for involvement.<sup>12</sup> As of January 2009 there were 37 health insurers,<sup>13</sup> each offering medical and dental services according to different rules and thus highly inefficient administrative arrangements could be imposed on dental practices (as has been the complaint against HMOs in the USA). A single Government payer would be the only efficient, effective, transparent and non-conflicted option.

### **Constructive Role for ADA**

The ADA wishes to play a constructive role in delivering a successful dental scheme or system for disadvantaged Australians and suggests that the following proposal be used as a basis for that process. While increased funding is required, significant dental care for the disadvantaged should be able to be implemented relatively quickly as part of a staged process at the same time as public dental infrastructure and workforce are augmented. The public infrastructure would include dental hospitals, university clinical teaching facilities and community health centres. By introduction of these measures all Australians will have improved access to a high standard of dental care without the need to introduce a scheme which will enhance 'middle class welfare' whilst doing little to assist the disadvantaged.

#### ***1. ADA strongly supports the proposal that the Commonwealth Government take over the funding of State and Territory public dental facilities.***

The ADA believes the public sector is a critical component in any plan to deliver dental services to the disadvantaged in a cost-effective and efficient manner. Thus, rather than directing all funding and assistance to the delivery of individual treatments, the ADA is suggesting that capital and resource investment in the public sector be undertaken to provide those sectors of the Australian community, including the "working poor" who genuinely struggle to access care, with a solid and resource rich dental asset base. Investment in the public sector will deliver to those eligible Australians, be they disadvantaged financially, geographical or otherwise, a well-structured public sector that will deliver to them a high standard of dental care. The public sector is also an essential component in the dental treatment of special needs patients who require the services of special facilities and staff.

Properly resourced, the public dental sector would then be able to provide high quality, ongoing comprehensive dental care, attracting capable dental professionals whilst acting as a foundation to practice for new graduates in a post-graduate clinical placement year

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<sup>12</sup>See ADA Submission to Submission to the Australian Competition and Consumer Commission (ACCC) - Report to the Australian Senate on Anti-Competitive and Other Practices by Health Funds and Providers in Relation to Private Health Insurance. At: <http://www.ada.org.au/newsroom/articles.category.submissions.aspx>

<sup>13</sup> State of Health Funds Report 2008, page 7.

system. Experienced dental professionals including dental specialists and other members of the dental team from the private sector should be encouraged to work within appropriate areas of the public sector on a sessional basis and mechanisms constructed to achieve that.<sup>14</sup> Further, the public dental services must be sufficiently resourced to be able to look after the dental needs of the majority of those identified as disadvantaged.

The key to this is proper resourcing which requires adequate and equitable funding to raise the public dental services to an acceptable standard both in infrastructure and workforce. Funding for treatment needs to be raised to an equitable and sustainable level per eligible person across all States and Territories.<sup>15</sup> A significant increase in funding will be required to achieve these necessary improvements in the public sector together with appropriate policy objectives.<sup>16</sup>

A further requirement should be satisfactory performance in delivery of services, which would presumably be a condition of the Commonwealth Government funding of these services. Attention will also need to be paid to attracting and retaining a long term public sector dental workforce, and the currently high turnover of public dentists needs to be addressed by rectifying the factors which lead to their departure from the sector. Analysis of those factors will reveal that remuneration is only one of the issues requiring attention.<sup>17</sup>

## ***2. Introduction of a Dental Assistance Program [DAP] for disadvantaged Australians.***

A previous targeted plan, the Commonwealth Dental Health Program [CDHP], was introduced some years ago and, by utilising both public and private dentists, reportedly reduced public sector waiting lists by half within a 12 month period. The CDHP had some faults; the major one being a too-limited scope of dental services. Evidence was also presented to the ADA that many persons eligible for assistance were, in fact, not disadvantaged.<sup>18</sup> These issues could have been overcome or reduced had it survived. The ADA advocates there be a comprehensive range of treatment items in order to allow complete clinical freedom to treat according to a patient's needs. Eligibility requirements should be made more stringent. It is recognised that costs would need to be predictable and rebates at a Treasury scale of fees and annual monetary limits [AMLs] would be appropriate.

It is envisaged that a DAP would be able to be put into operation relatively quickly and initially could address the excessive public sector waiting lists. Utilisation of the private sector, especially whilst public sector facilities are being built up, would be essential. With time, reliance on the private sector would be expected to be reduced as the public facilities reached their potential. It must be realised that some geographical locations will, however, always require the use of private dental practices.

Any funds devoted to a DAP must be solely directed to the program and costs involved, with workforce and infrastructure funded separately.

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<sup>14</sup> Possible attractors could be appropriate honorariums and recognition titles.

<sup>15</sup> ADANSW State and Territory Funding computed data, please see Appendix 3.

<sup>16</sup> A soon-to-be published study in Victoria on recruitment and retention of dentists in the public sector shows dentists join the public sector mainly to work in a community-based setting in a supportive and mentored environment with remuneration not a high priority. Subsequently, many leave because of poor remuneration, lack of clinical choice and frustration with administrative policies.

<sup>17</sup> Refer to Page 5ff of ADA 2009-2010 Pre Budget Submission to Federal Government. At:

[http://www.ada.org.au/App\\_CmsLib/Media/Lib/0903/M159499\\_v1\\_633730764418092500.pdf](http://www.ada.org.au/App_CmsLib/Media/Lib/0903/M159499_v1_633730764418092500.pdf)

<sup>18</sup> Internal ADA correspondence.

**The ADA recommends that the following principles be built into a DAP:**

**(a) that eligibility be determined by Government but must be targeted at disadvantaged Australians;**

As discussed earlier, the NHHRC cites ARCPOH data revealing that 31.2% of all Australian dentate adults indicated they avoided or delayed visiting a dentist due to costs. If that figure is accurate, then there will be approximately 7 million people categorised as disadvantaged. It has to be stressed that income is not the only measure of disadvantage and a DAP together with improved public sector facilities would be required to deal with this number.

**(b) there be a comprehensive scope of treatments as defined in the ADA Schedule of Services and Glossary;**

Offering only basic services [up to 88% of the ADA Schedule] will prove prejudicial to good treatment outcomes for many needy patients. Practitioners must be able to offer the most appropriate care to their patients or the restricted range of treatments will bring about second-class dental care for the disadvantaged. Some items, such as crowns, bridges and implants can be costly but are nonetheless sometimes necessary to provide appropriate and acceptable treatment. In these cases such treatments should be available via the public sector and/or be part-paid by the patient using funds available to them from the DAP and/or via PHI and/or out-of-pocket expenses.

It is essential the ADA Schedule of Services and Glossary© continues to be the reference source to describe all dental treatment.

**(c) there be annual monetary limits [AMLs] set by Government;**

It needs to be realised that, according to the PWC analysis, AMLs of around \$400 would apply with a Denticare Australia scheme although people would be able to fund further treatment via out-of-pocket expenses or utilising private health insurance. Likewise, under a DAP, people would be able to access more complex treatments either via the public sector, by part-contribution from their DAP amount, by out-of-pocket expenses, by use of private health insurance or a combination of these funding methods.

The Annual Report of Dental Health Services Victoria shows an average expenditure of \$416 per patient treated in 2009<sup>19</sup> whilst the 2007 ADA dental practice survey, essentially of the private sector, showed average annual spend per patient was \$385.<sup>20</sup> However, a 2008 survey of a section of the public sector in Victoria showed average costs of treatment-needs for a group of eligible patients was \$924.<sup>21</sup> There would be much pent-up demand in these public sector figures and initial AMLs would need to take such figures into account.

In addition, consideration could be given to the AMLs being available over a two year period thus enabling more comprehensive treatment to be completed.

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<sup>19</sup> DHSV Annual Report 2009.

<sup>20</sup> ADA Dental Practice Survey 2007; PD Barnard.

<sup>21</sup> Horey, D., Naksook, C., McBride, T. and Calache, H., 2008, Why is He not Smiling: the Dental Costs Study Final Report. Health Issues Centre, Melbourne.

**(d) that co-payments be applicable;**

As with most dental schemes, it also seems appropriate that there be co-payments or user charges, where applicable, as a means to have people appreciate that there are significant costs associated with their treatment. Such co-payments also assist with the amount of money available for eligible persons.<sup>22</sup>

**(e) that private health insurance may be used to cover any gap between the Treasury scale of fees and dentists' fees;**

Discussed in (b) and (c) above.

**(f) there be fee rebates based on a Treasury scale of dental fees;**

There is nothing markedly different in this approach to that which would occur with a "Denticare Australia" scheme, except which body sets the scale of fees. These fees must be reviewed annually in line with an objective assessment of the costs of delivering dental treatment rather than based on CPI, which does not reflect the changes in the costs of dental materials and provision of dental treatment. Involvement of the ADA in establishment of such a scale of fees should be a requirement as a means to ensure a realistic and fair scale.

The rebates for the private sector must be set at the new Treasury scale of dental fees. Some discounting may apply to the public sector where coverage of practice overheads is not a factor, as these have already been paid for.

**(g) that private sector dentists be able to choose between bulk-billing or their usual and customary scale of fees;**

The true cost of providing dental services cannot be ignored. The delivery of dental care is not cheap and dental practice surveys of ADA members consistently show overheads in private practice to be around 65% of gross fees.<sup>23</sup> Some dentists in private practice would elect to bulk-bill but dentists cannot be compelled to work at a loss, or the service would cease to exist.

Many dentists perform a significant amount of either direct pro bono work or heavily discounted involvement either directly to patients or via teaching at dental schools. This involvement of dentists should neither be disregarded nor jeopardised by overly excessive concentration on dental fees. If dental services could be delivered at significantly lower cost then State and Territory governments would have been able to do this and therefore not have the present excessive waiting lists and limited resources.<sup>24</sup>

**(h) that participation by private dentists be voluntary;**

The involvement of participating dental providers should be voluntary. Large numbers of dentists participated in the CDHP and continue to do so in State and Territory schemes. It is expected that this would occur with a DAP although it has to be realised that some practitioners may not be willing to be involved and that is their democratic right.

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<sup>22</sup> Currently 68% of dental expenditures are paid by individuals. AIHW Health Expenditures Australia 2006-2007. Please see Appendix 4.

<sup>23</sup> ADA Dental Practice Survey 2007: Financial Aspects of Private Practice.

<sup>24</sup> See Appendix 5 for discussion on dental costs.

Compelling participation would have the effect of conscription which would be in breach of S.51 of the Australian Constitution.

**(i) that the scheme be administered centrally via a single Commonwealth Government agency;**

The on-going problems with variable and usually inadequate State and Territory funding of dental care with constant blame shifting between the States/Territories and the Commonwealth Government would be overcome if this scheme were administered solely by the Commonwealth Government. This approach, by reducing duplication, should lead to savings in administration costs. A single Commonwealth Government agency is therefore recommended to administer the scheme.

**(j) that there be an annual assessment of a DAP and its effectiveness utilising a Panel which includes dental experts from the private and public sectors.**

The processes which have been suggested require regular assessment from both financial and oral health view points so that identified problems can be attended to in a timely fashion. It would also be necessary to assess both the effectiveness of a DAP and improvements within the public sector over a period of perhaps five years, to decide if the arrangements should continue or if major modifications were necessary to achieve the required access to dental care. In other words, assess if the proposed changes have delivered, or are likely to deliver, the intended equitable access to dental care.

### **Costing a DAP**

Eligibility for access to the DAP will have to be decided by the Commonwealth Government and will have to be based on the funds available. The numbers involved will determine the AMLs which will apply. It is anticipated there will be an initial high take-up by eligible people although it would be expected that the numbers would decline to the level now experienced in England, where only about 50% of the population utilised the NHS dental services over a 2 year period.<sup>25</sup>

Significant amounts of money need to be spent in upgrading the dental facilities and workforce in the public sector, including dental academia.

In order for the Government to raise the money required, consideration should be given to raising funds for dental care by using a tax on sugar and/or sugar-containing confectionery and soft-drinks, a tax which would also be appropriate in assisting the anti-obesity and diabetes campaigns. The correlation between periodontal disease, oral dysplasia and cancers and smoking would also warrant some use of funds raised from tobacco excise to be used in oral health promotion. A similar argument can be made about the correlation between oral dysplasia and cancers and excessive alcohol consumption, would justify use of funds from alcohol excise for oral health promotion.

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<sup>25</sup> NHS Dental Services in England, Professor Jimmy Steele for Department of Health, June 2009.

### **Other NHHRC Recommendations**

Fluoridation of small community water supplies, investment in oral health promotion, and upgrading pre-school and school dental programmes are further areas in need of urgent attention and will, along with comments on other NHHRC recommendations, be part of another submission. The ADA has already provided a detailed proposal regarding a Dental Foundation (intern) Program.

Thank you for the opportunity to comment.

A handwritten signature in black ink, appearing to read "Neil Hewson", with a horizontal line extending from the end of the signature.

Dr Neil Hewson  
Federal President  
November 2009

## APPENDICES

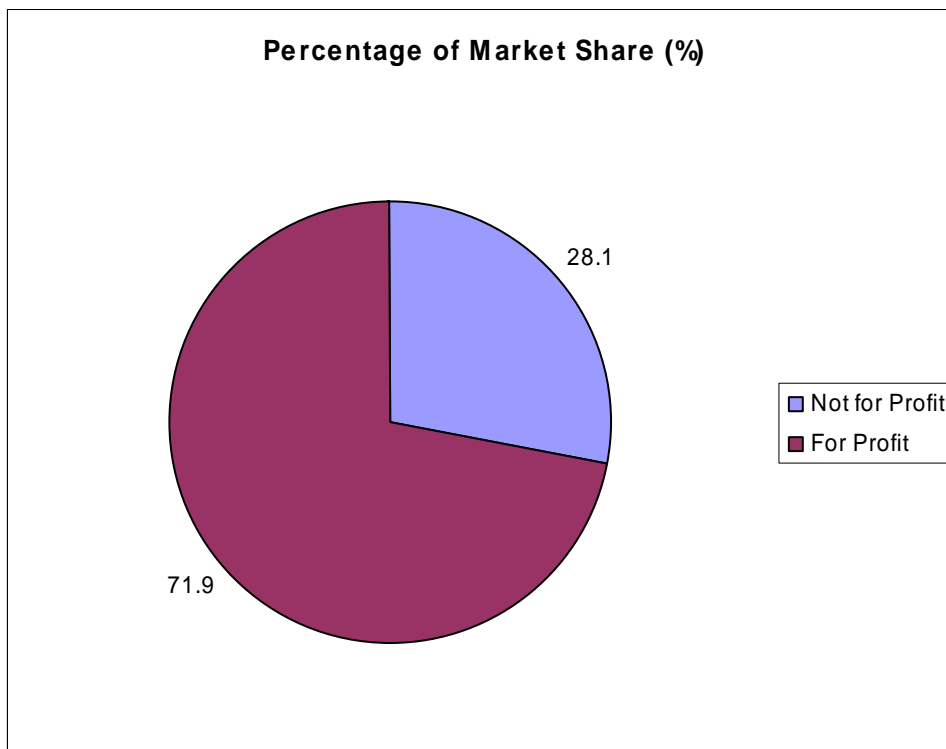
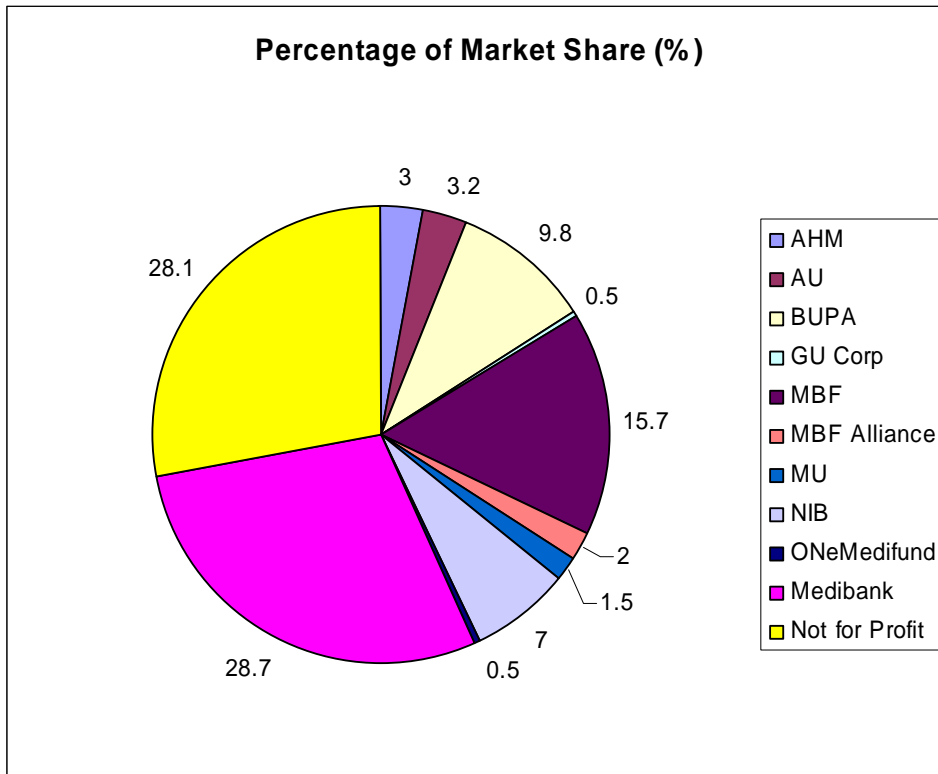
### Appendix 1:

Medicare Statistics for Item Number 88000, Teen Dental Plan Uptake  
Obtained online from Medicare Statistics, Item Report

Medicare Item 88000 processed from July 2008 to June 2009											
Item 88000	State										Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT			
	Services	Services	Services	Services	Services	Services	Services	Services	Services	Services	Services
Female	0-4	0	0	0	0	0	0	0	0	0	0
	41760	44564	34879	22317	7267	6225	1512	1241	381	118386	
	15-24	40292	32335	22072	6821	7535	1634	1254	339	112282	
	25-34	0	0	0	0	0	0	0	0	0	
	35-44	0	0	0	0	0	0	0	0	0	
	45-54	0	0	0	0	0	0	0	0	0	
	55-64	0	0	0	0	0	0	0	0	0	
	65-74	0	0	0	0	0	0	0	0	0	
	75-84	0	0	0	0	0	0	0	0	0	
	>=85	0	0	0	0	0	0	0	0	0	
	Unknown	0	0	0	0	0	0	0	0	0	
	Total	84856	67214	44389	14088	13760	3146	2495	720	230668	
Male	0-4	0	0	0	0	0	0	0	0	0	
	41760	44994	36039	22965	7355	6587	1607	1214	415	121176	
	15-24	38730	31746	20826	6536	6920	1533	1273	283	107847	
	25-34	0	0	0	0	0	0	0	0	0	
	35-44	0	0	0	0	0	0	0	0	0	
	45-54	0	0	0	0	0	0	0	0	0	
	55-64	0	0	0	0	0	0	0	0	0	
	65-74	0	0	0	0	0	0	0	0	0	
	75-84	0	0	0	0	0	0	0	0	0	
	>=85	0	0	0	0	0	0	0	0	0	
	Unknown	0	0	0	0	0	0	0	0	0	
	Total	83724	67785	43791	13891	13507	3140	2487	698	229023	
Total	0-4	0	0	0	0	0	0	0	0	0	
	41760	89558	70918	45282	14622	12812	3119	2455	796	239562	
	15-24	79022	64081	42898	13357	14455	3167	2527	622	220129	
	25-34	0	0	0	0	0	0	0	0	0	
	35-44	0	0	0	0	0	0	0	0	0	
	45-54	0	0	0	0	0	0	0	0	0	
	55-64	0	0	0	0	0	0	0	0	0	
	65-74	0	0	0	0	0	0	0	0	0	
	75-84	0	0	0	0	0	0	0	0	0	
	>=85	0	0	0	0	0	0	0	0	0	
	Unknown	0	0	0	0	0	0	0	0	0	
	Total	168580	134999	88180	27979	27267	6286	4982	1418	459691	
Disclaimer											
The information and data contained in the reports and tables have been provided by Medicare Australia for general information purposes only.											
While Medicare Australia takes care in the compilation and provision of the information and data, it does not assume or accept any liability											
for the accuracy, quality, suitability and currency of the information or data, or for any reliance on the information or data.											
Medicare Australia recommends that users exercise their own care, skill and diligence with respect to the use and interpretation of the information and data.											

**Appendix 2:**

Private Health Insurance Percentage of Market Share  
 Computed from data taken from the State of Health Funds 2008



### **Appendix 3:**

State and Territory Oral Health Budgets  
Computed by ADANSW

## State and Territory Oral Health Budgets 2008-09

	2008/2009 State & Territory Dental Budgets (\$)	Population as at June 2008 <sup>1</sup>	Per capita dental expenditure (\$)
Tasmania	\$23,084,000	498,200	\$46.33
Northern Territory	\$9,480,000	219,900	\$43.11
Queensland	\$150,000,000	4,279,400	\$35.05
South Australia	\$56,000,000	1,601,800	\$34.96
Western Australia	\$63,380,000 <sup>2</sup>	2,163,200	\$29.30
Victoria	\$139,300,000	5,297,600	\$26.29
Australian Capital Territory	\$8,491,599 <sup>3</sup>	344,200	\$24.67
New South Wales	\$150,000,000	6,967,200	\$21.53
<b>Total</b>	<b>\$599,735,599</b>	<b>21,374,000</b>	<b>\$28.06</b>

### **Notes**

- A. Funding in Column 2 is funding allocated by state and territory governments and does not include funding from the Commonwealth Government under the Enhanced Primary Care (EPC) Medicare dental benefits, Commonwealth Dental Health Program (CDHP), or Medicare Teen Dental program.
- B. This information was sourced from publicly available information or by contacting state and territory public dental services.

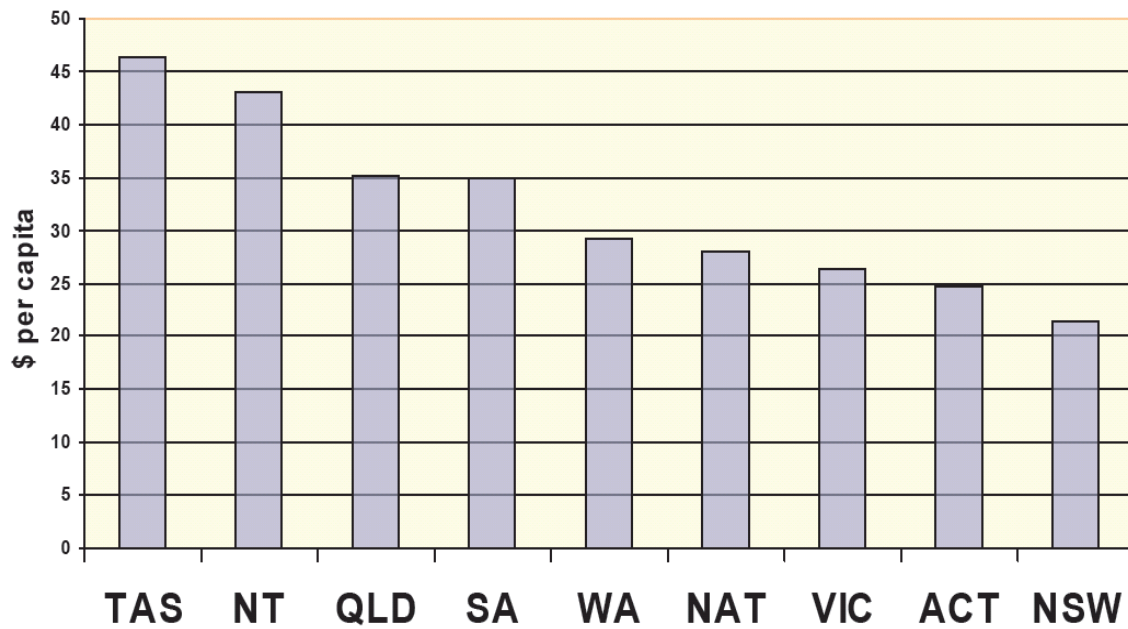
<sup>1</sup> Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, June 2008 (released 2 December 2008) (<http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>).

<sup>2</sup> Includes \$6.2M in income.

<sup>3</sup> Includes \$816,935 miscellaneous user charges.

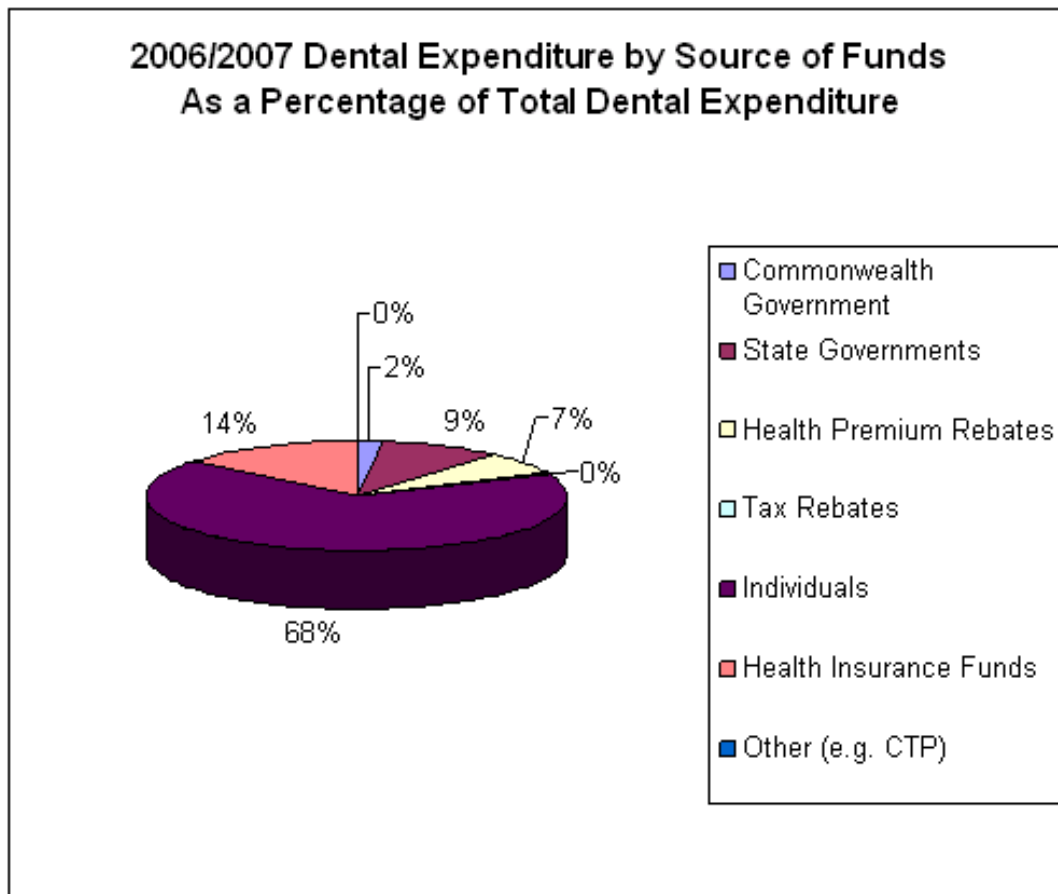
Appendix 3 (contd)

**State and Territory Public Oral Health Budgets  
2008/09**



**Appendix 4:**

Dental Expenditures by Source of Funds  
AIHW Health Expenditures Australia 2006-2007



## Appendix 5:

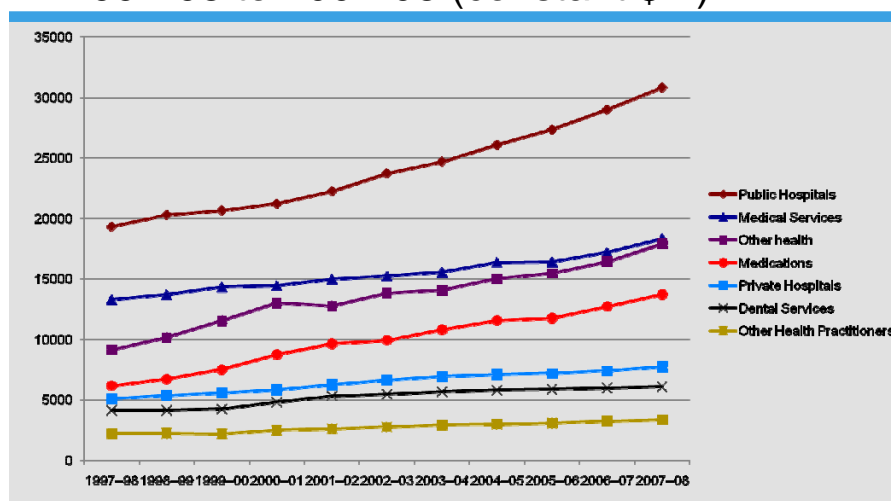
### Costs of dentistry

Some 20+ years ago the Hawke Government commissioned a study into dental fees in private practice in Australia. That study found the fee setting mechanism used by dentists to be fair and reasonable, and the ADA contends there has been no substantial change from that process of fee setting since then. The ADA conducts a fee survey of a range of common dental treatment items each year across all States and Territories and some members use this as a guide for setting their fees. However, the establishment of a fee requires the practitioner to take into account the costs of running a practice which include wages, purchases of materials, laboratory fees, rent, interest and bank fees, depreciation and repairs and maintenance. In addition, costs of continuing education, registration and other licensing costs must also be included. These overheads amount to at least 65% of the gross income of a dental practice per annum.

The health index increases from 2003 to 2008 averaged 5.1% [4.1% to 6.9%] with pharmaceuticals and hospital costs being major contributors.<sup>26</sup> Dental fee increases over that same period averaged 5.6% [5.0% to 6.0%].<sup>27</sup>

Recently, the following graph was part of a presentation to the Australian Healthcare and Hospitals Association and the Australian Institute of Health Policy Studies Congress.<sup>28</sup> Of most interest from a dental perspective, is the very slow rate of increase of dental expenditure over many years, supporting the argument that under the present system there are not inordinate increases occurring in dental costs.

### Australia: Health expenditure by component, 1997-98 to 2007-08 (constant \$m)



<sup>26</sup> Australian Bureau of Statistics data 2003 to 2008.

<sup>27</sup> Australian Dental Association Dental Fees Survey 2008. PD Barnard.

<sup>28</sup> J Stoelwinder, AHHA-AIHPS 2009 Congress, Hobart, 9 Oct 2009.