AUSTRALIAN DENTAL ASSOCIATION

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The Hon. Michael McCormack MP
Minister for Small Business
Department of Treasury
Langton Crescent
Parkes ACT 2600

Dear Minister,

Thank you for providing the Australian Dental Association (ADA) with the opportunity to offer its views regarding priorities for the 2017-18 Federal Budget.

The ADA has as one of its objectives, the improvement of the oral and general health of the public. It is this objective that underpins all of the ADA's efforts in advocating for better oral health care for Australians.

There are approximately 7 million, or 30%, of Australians who have less than optimal oral health, the reasons for this disparity is multifaceted. Relying on a strained and under-resourced state based public dental system means that many spend excessive periods – sometimes years – waiting to receive basic dental care, often by which time their disease has progressed much further than was necessary and potentially compromising their overall general health wellbeing. It is the view of the ADA that it is these members of the community to whom the Federal Government should prioritise its attention. Groups within the population whose oral health is particularly poor include:

- the financially disadvantaged;
- people with special needs e.g. Aboriginal and Torres Strait Islander peoples, residential aged care and nursing home residents and those with mental, intellectual and/or physical disabilities; and
- people living in rural and remote communities.

The ADA has been vocal in its support for the design of targeted dental funding to these groups utilising schemes such as the Child Dental Benefits Schedule (CDBS). In 2016, the ADA developed the Australian Dental Health Plan (ADHP) (Attachment A) which it believes offers the Government with a sustainable funding model for dental care which can build on the CDBS model and aligns the government's efforts with the National Oral Health Plan.

Furthermore, it allows for appropriate utilisation of the available dental workforce.

ADA believes that implementing the ADHP will also result in reduced utilisation of medical services under Medicare and a reduction in potentially preventable hospitalisations for dental care.

Should you seek any further information in relation to this submission, please contact Mr Damian Mitsch, Chief Executive Officer on ceo@ada.org.au or 02 9914 6602

Dr P. Hugo Sachs
President

Enc.

AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Health Plan

Achieving Optimal Oral Health

Objectives

The Australian Dental Health Plan outlined in this paper is the Australian Dental Association (ADA)'s vision for the Commonwealth Government's involvement in the delivery and funding of dental care in Australia.

The ADA is an organisation of dentists which has as its aims the encouragement of the health of the public and the promotion of the art and science of dentistry.

Background

Australia's Oral Health

Oral health is fundamental to overall health and all Australians should be able to achieve optimal oral health. However, despite improvements in the last 20 – 30 years, there is still evidence that many in the community have less than optimal oral health. Many are reported to spend excessive periods – sometimes years – waiting to receive only basic dental care in our public health system.

According to the Australian Institute of Health and Welfare (AIHW) report, *Oral health and dental care in Australia: Key facts, figures trends 2014:*

- Half of six year old children and 12 year olds have experienced some tooth decay;
- Around three in ten Australian adults have untreated tooth decay;
- Over 50% of Australians over the age of 65 years have gum disease or periodontitis; and
- Over 20% of Australians over the age of 65 years have complete tooth loss.

Compared to younger Australians, older people have higher rates of tooth decay and tooth wear.

Common risk factors affecting general health such as high sugar diets, poor oral hygiene, smoking and excessive alcohol intake also apply to dental health. These same risk factors are associated with obesity, diabetes, cancer, heart disease and respiratory diseases.[1]

The correlation between lifestyle and behavioural factors and increased risk of tooth decay, periodontal disease, oral infections, oral cancer and other oral conditions are well known and indicate the need to adopt an integrated approach to the promotion of both oral and general health.[2]

Australia needs a dental healthcare system that is able to ensure all Australians can have access to equitable, timely and appropriate oral healthcare.

Dentists understand the oral health needs of the population and what is required to meet existing gaps in service delivery.

Current Commonwealth Government involvement

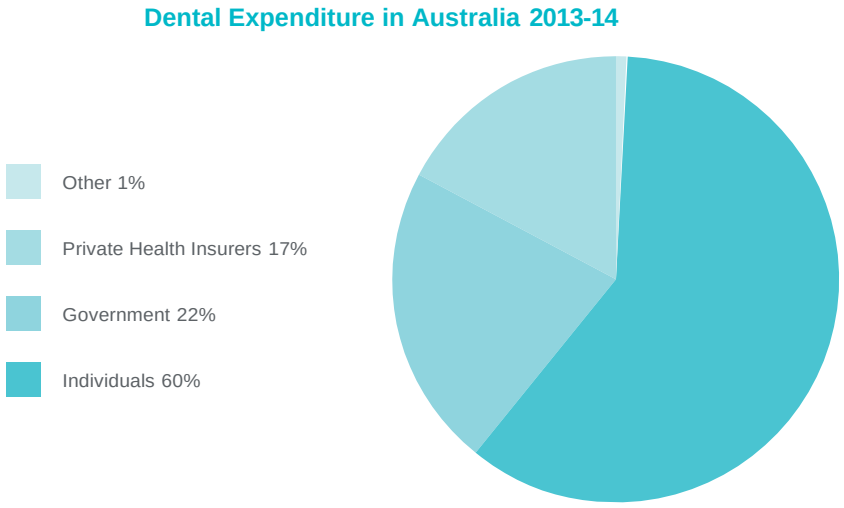
At the Commonwealth level, there are a number of Australian Government dental schemes in operation. These include the Commonwealth's Child Dental Benefits Schedule (CDBS), Cleft Lip and Palate Scheme and the Department of Veterans Affairs Scheme. This paper primarily seeks to modify the CDBS to aid in the delivery of care to wider in need sectors of the community.

[1] Travis P., Bennett et al., 'Overcoming health-systems constraints to achieve the Millennium Development Goals', *Lancet*, September 4 2004, Vol 364, 900 – 906.

[2] Sheiham A., Watt RG, 'The common risk factor approach: a rational basis for promoting oral health', *Community Dent Oral Epidemiol*, Dec 2000, Vol 28, 6, 399 – 406; and Rogers, J.G, *Evidence–based oral health promotion resource,* Prevention and Population Health Branch, Department of Health, Government of Victoria, 2011, 42.

Current national dental expenditure

According to the latest AIHW report, *Health Expenditure in Australia 2013-14*, in 2013-14, total expenditure on dental health care was estimated at $8.706b. Governments at all levels contributed $2.2b of this amount. After medication expenses, dental care costs are an individual's next largest health expense.



The Australian Dental Health Plan (ADHP)

Australia needs a dental healthcare system that is able to ensure all Australians can have access to equitable, timely and appropriate oral healthcare. The model that will be outlined closely reflects the CDBS but provides for some modifications that will create a uniform effective model for all schemes that are implemented.

The ADA has designed an Australian Dental Health Plan (ADHP) which will deliver this by:

1. Providing a system that utilises programmes that are based on a universal set of administrative rules and regulations;
2. Allowing for the gradual development of programmes that provide assistance to access dental care for targeted eligible populations that have demonstrated dental needs;
3. Providing quality care to these target populations on an equitable, efficient and sustainable basis;
4. Addressing the risk factors that lead to poor oral and general health; and
5. Bringing Australia into alignment with World Health Organisation (WHO) global oral health targets and ensures the goals of the National Oral Health Plan are met.[3]

Whereas existing and previous Australian Government dental schemes in Australia varied from scheme to scheme in the type of services offered, administrative and eligibility requirements as well as funding, the ADHP will have:

- A common schedule and set of treatment descriptors for eligible dental services;
- A specified and manageable budget with the imposition of Annual Monetary Limits (AML);

[3] At the time of publishing the National Oral Health Plan 2015-2024 has not been released however this is expected to occur in the near future see also Rogers, J.G, *Evidence–based oral health promotion resource,* Prevention and Population Health Branch, Department of Health, Government of Victoria, 2011, 42.

- Measurable outcomes;
- Consistent eligibility criteria and terminology; and
- A common fee schedule.

The creation of a universal model will reduce administration levels and improve the efficiency of all schemes that operate under the model.

Eligibility for treatment under the various schedules will be determined by the factors that address the particular group to be targeted.

Determination of eligibility could be recorded through an encryption process on the Medicare Card or a stand-alone ADHP card. Patient eligibility and the balance of any AML entitlement will be available to the patient and health care provider by swiping the card through processes such as Eclipse PKI technology or web claims.

Australian Dental Health Plan Principles

The ADHP will adopt the following principles for each Scheme that is created under the model:

- Eligibility criteria will be determined by the Australian Government and encrypted onto an ADHP Card;
- Administration will be through the Department of Health/Department of Human Services with funding provided by an amendment to the *Dental Benefits Act 2008* to suit each programme;
- Utilisation of the full dental team within their scope of practice;
- Utilisation of both private dental practitioners through their clinics and public sector clinics;
- Utilisation of a common schedule and glossary of dental terms using the ADA Schedule of Dental Services and Glossary;[4]
- Rebate levels to be set at the Treasury scale of fees (such as those used for the DVA Scheme) which will be known as the Dental Benefit Schedule (DBS);
- Opportunity for participating private dentists to be able to bulk bill or charge usual and customary fees with a co-payment through a rebate system that parallels Medicare;
- Public clinics must bulk bill;
- Prior approval to be obtained by the treating dentist for complex treatments;
- AML to be applied;
- Annual DBS review of scale of fees commensurate with the Health CPI as calculated by the Australian Bureau Statistics;
- Differential Fees for GP and Specialist Dentists; and
- Covers dental services delivered in private and public clinics as well as dental services delivered in hospitals.

[4] The Australian Dental Association (ADA) has developed this publication in conjunction with all sectors of the profession, private health insurers and all levels of government. It is The Australian Schedule of Dental Services and Glossary (ADA Schedule), currently in its 10th Edition. This document was first created in 1986 and serves as the definitive and universally accepted coding system of dental treatment and is endorsed by the National Centre for Classification in Health (NCCH). Similar to the Medicare Benefits Schedule it lists dental treatments and allocates a number for each service.

Eligibility for the ADHP

Eligibility for each facet of the ADHP will be determined by the Australian Government. Each segment will focus on a demographic identified by the Australian Government which it considers in need of assistance to access dental care.

As of June 2013, there were approximately 4.5 million health care concession cards issued to Australians.

The ADHP envisages that the eligible population for each scheme developed would primarily be all concession card holders and their dependents. Most health care cards are issued for a period of 12 months which allows for continual re-assessment of eligibility for dental care under the ADHP. Additionally each scheme as detailed later in this paper would have its own specific eligibility requirements that will identify a targeted group in need of assistance to be addressed by that particular scheme.

These targeted schemes could be introduced incrementally as need or demand may determine.

Examples of such additional requirements for eligibility may be adults in a particular age group, or certain sectors of the community such as Aboriginal and Torres Strait Islanders, or patients with complex special needs or Australians from remote and very remote communities.

Targeted Schedules

What follows are some recommendations for modifying the CDBS and some recommendations as to similarly targeted schemes for other sectors of the community.

1 - Child Dental Benefits Schedule (CDBS)

The existing CBDS is the foundation model upon which the ADHP is based. The CDBS's wide adoption and reasonably high uptake, for such schemes, by the community and the dentist profession demonstrates the need for governments to provide assistance for dental care to this cohort of the population, children. Its introduction has laid a strong framework that can be further built upon. Directing a focus to this age group was and will continue to be a sound investment in Australia's long term dental health. Early intervention and education provides a sound base for the future.

It is worthy to note that in the last review of the CDBS it was reported that approximately 96% of patients serviced under the Scheme were charged at the rebate level or bulk billed.

Continued and increased support to disadvantaged children is essential if demand for dental care in the future is to be reduced.

To ensure consistency across the CDBS and future schemes based upon the ADHP, a number of additional conditions should be introduced to improve the effectiveness of this Scheme and each new programme.

The recommended improvements to the existing CDBS are:

- Access to a full range of services with a greater emphasis on prevention to be incorporated;
- The AML remain at a figure to be determined but reflect the current costs of dental services and the needs of the sector being targeted;
- An incentive payment of a 50% increase in rebate payable for specified items for prevention (e.g. application of topical fluoride to all school age children in non-fluoridated water region;
- As oral health levels vary markedly across Australia with dental health need being more pronounced for disadvantaged groups, a 50% increase in the AML should be introduced where needed to meet the exceptional special needs of some sectors of the population such as:
    a. Children of Aboriginal and Torres Island descent;
    b. Children residing in remote and very remote regions (ABS Remote Area Classification RA4 & RA5); and
    c. Children with disability and special needs.

[5] *Interim report of the Reference Group on Welfare Reform to the Minister for Social Services*, June 2014.

- No AML for children eligible under Cleft Lip and Palate Scheme;
- Treatment under general anaesthetic be permitted with prior approval;
- Prior approval required to be obtained for certain identified schedule items;
- Eligibility be from 0-18 years of age; and
- Implementation of the scheme through a voucher or encrypted card system.

2 – Pensioner/Elderly Dental Benefits Schedule (PEDBS)

It is expected that by 2056 there will be one in four people living in Australia over the age of 65 years and 1.8 million people will be over the age of 85 years. Increasing numbers of older people are retaining their natural teeth and by 2021 only 3% of the population will have complete tooth loss. This will result in high demand for recurrent dental care by the elderly.

The PEDBS will have:

- AML to be set at specific limit;
- Eligibility confined to a specific age group. E.g. 65+ years, and/or those in receipt of the aged pension or other criteria;
- Access to all services based upon the current edition of the ADA Schedule;
- Care under general anaesthetic permitted with prior approval;
- Due to specific issues that impact on the dental health of this cohort, increase by 50% the AML for groups such as:
  - Elderly adults of Aboriginal and Torres Islander backgrounds;
  - Elderly adults in Remote and Very Remote regions as per ABS Remote Area Classification RA4 & RA5;
  - Elderly with disabled and special needs; and
  - Elderly residents of aged care facilities.
- Prior approval be required for certain identified schedule items; and
- No co-payments for DVA eligible patients, i.e. mandatory bulk billing.

3 - Adult Dental Benefits Schedule (ADBS)

There are many adults who suffer from disadvantage as a result of low income, unemployment or poor health. Low socioeconomic status is strongly correlated with poor oral health. People in this group rarely visit a dentist for preventive care and when they do attend, it is often only when a serious problem has developed.

On average Aboriginal and Torres Strait Islander people experience poor oral health earlier in their lifespan and in greater severity and prevalence than the rest of the population. Adults living in regional or remote areas have higher levels of tooth loss and more untreated decay.

All States and Territories offer some form of public dental care to eligible adults, however, infrastructure and the size of the dedicated dental workforce in these facilities vary considerably resulting in discrepancies in services provided and long waiting times for treatment. Considerable impact was made on waiting lists when additional funds were available for dental care under the National Partnership Agreements (NPAs) between the Commonwealth and the States and Territories. Most jurisdictions used the additional monies provided under the NPAs to purchase services from private sector dentists that are in oversupply and will continue to be in oversupply for many years as confirmed by Health Workforce Australia. This is a long term sustainable model for dental service provision.

NPA funding should be made available for use under an Adult Dental Benefits Schedule (ADBS), which would adopt the key elements of the CDBS.

The ADBS scheme would have:

- Eligibility limited to 18-65 years of age;
- Means testing or targeting criteria to apply;
- Access to all services based upon the current edition of the ADA Schedule and Glossary;
- AML be imposed as determined appropriate;
- Care under general anaesthetic be permitted with prior approval;
- Increase by 50% the AML for adults:
    a. Of Aboriginal and Torres Island background;
    b. In Remote and Very Remote regions as per ABS Remote Area Classification RA4 & RA5; and
    c. With significant disability and special needs.
- Prior approval for certain schedule items; and
- No co-payments for DVA eligible patients.

Funding the ADHP

The extent of funding available under one or more of these schemes will be determined solely by the Australian Government, as it will be determining the eligibility criteria for benefits and the level of AML under the scheme.

Proposed funding options for the introduction of the ADHP components could include one or more of:

1. A 0.5% increase to the Compulsory Medicare Levy. The current 2% levy raises $14.16 billion.[6] A 0.5% increase would raise an additional $3.54 billion;
2. Modification to the 30% private health insurance rebate. In 2014-15 the rebate cost Government $5.8 billion.[7] Allocation of a component of the savings achieved to the ADHP is suggested.
3. Allowing Private Health Insurance General Treatment cover to offset costs;
4. Introduction of a tax on the consumption of sugar. Taxes on soft drinks containing sugar have been introduced in other countries with success; and
5. Increase taxation of tobacco products.

Adjunct Initiatives

To be fully effective, funding of dental care must be supported by immediate action to the following foundational areas of good oral health:

Foundation Area 1: Fluoridation

The therapeutic benefits of water fluoridation are unquestionable. Further supporting the scientific consensus, the National Health and Medical Research Council (NHMRC) has recently affirmed that the body of evidence proves that fluoridation is beneficial for reducing dental caries.[8] ADA will commit to the ADHP by assisting all governments to promote the fluoridation of water supplies and will ensure experts in fluoridation are made available for government consultation.

For each $1 invested in water fluoridation, estimates of the savings in future dental treatment costs alone is $67; with the greatest health benefits accruing to those who are most disadvantaged.[9]

With priority, the ADA through the ADHP will support all government initiatives to ensure all localities with 1,000 or more residents that have mains supplied (reticulated) water are fluoridated.

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[6] The Commonwealth of Australia, *Budget Paper No. 1 2014-15*, section 9-20.

[7] The Commonwealth of Australia, *2014-15 Department of Health Portfolio Budget Statements – Outcome 6* .

[8] National Health and Medical Research Council, *NHMRC Public Statement: The Efficacy and Safety of Fluoridation* 2007, https://www.nhmrc.gov.au/_files_nhmrc/_publications/attachments/eh41_statement_efficacy_safety_fluoride.pdf accessed 24-8-2015 11:00 AM.

Non-mains supplied localities should have subsidised alternative forms of fluoride made available to them. There should be an incentivised payment for topical fluoride application in non-fluoridated areas.

Foundation Area 2: Tobacco control

The detrimental effects of tobacco on general and oral health are well documented. Tobacco use harms nearly every organ of the body. Tobacco causes many diseases and reduces the health of smokers in general. It is the single most preventable cause of premature mortality and morbidity.

From the dental perspective, tobacco:

- Is an aetiological factor in the development of oral cancer, leukoplakia, erythroplakia and keratosis;
- Is an important risk factor in the development of periodontal disease;
- Contributes to greater levels of tooth loss;
- Contributes to development of acute ulcerative gingivitis;
- Contributes to xerostomia, abrasion and erosion;
- Causes increased staining of teeth;
- Delays wound healing; and
- Causes increased risk of failure in osseointegrated implants.

All of these factors add substantially to the cost of dental care and, if avoided, will achieve substantial savings. Timely cessation of smoking will usually allow the return toward relative good health.

As part of the ADHP, dentists would:

1. Educate the public on the adverse health implications of smoking and how to quit;
2. Implement suitable smoking cessation programmes to be integrated into dental practices; and
3. Support public awareness campaigns on the health issues related to smoking and other tobacco use.

Foundation Area 3: Dietary and sugar control

The role of dietary carbohydrates (especially monosaccharides and disaccharides) in the causation of dental caries is well established. The process of caries initiation consists of the uptake of simple carbohydrates by bacteria in the dental plaque to produce acids. The production of these acids causes the pH of dental plaque to fall below the critical level leading to demineralisation of tooth structure and subsequently to dental caries in susceptible individuals. The form, frequency and timing of sugar intake are significant in the initiation of the caries process.

While severe malnutrition is extremely rare in Australia, it can be associated with damage to the structure of teeth and their supporting tissues.

Causes of non-carious tooth structure loss include the exposure to acid from the consumption of soft drinks, sport drinks, fruit and fruit juices, wine, vinegar and chewable vitamin tablets. Consumption of foods that combine simple carbohydrates and food acid can be particularly destructive to teeth.

[9] Expressed in Australian dollars. American Dental Association, *Fluoridation Facts*, http://www.ada.org/~/media/ADA /Member%20Center/FIles/fluoridation_facts.ashx, 2005; accessed on 9 November 2015. This source estimated the cost savings to be $US 38 in 2005. We have applied the impact of inflation to reflect the cost savings in 2014 dollars.

As part of the ADHP, dentists would:

- Encourage the Australian dental workforce to educate the public to follow the NHMRC's dietary guidelines particularly in relation to the oral health risks from sugar and acidic foods.[10] Special emphasis should be placed on the form, frequency, and timing of sugar consumption; particularly snacking on sugar-containing drinks and foods;
- Promote the drinking of water rather than acidic and sugary drinks including fruit juice;
- Promote the use of some sugar-free confectionery, including chewing gums as dentally safe alternatives to caries-producing confectionery containing sugar; and
- Provide oral health education to encourage individuals to consume simple carbohydrate foodstuffs less frequently and thus reduce the need for sugar and sugar substitutes.

Foundation Area 4: Promote awareness of the importance of good oral health

The prevalence of poor oral health across the community indicates that Australians do not give their oral health adequate attention and priority. As a consequence poor oral health abounds. Immediate steps need to be taken to address this. If the overall population could be made to recognise the importance of good oral health and its relationship to good general health, overall health levels will improve. Health expenditure would reduce.

All too often cost is a factor identified in the public avoiding care. It is worth repeating that under the CDBS more than 96% of all services were provided to patients at no cost-being either bulk-billed or charged at the rebate level. Notwithstanding this only 30% of those eligible to access the Scheme did so. Here we have seen 70% of eligible patients not accessing a free service.

Education of the population as to the importance of oral health and its impact on general health is essential. As part of the ADHP, dentists and the ADA would:

- Provide the expert advice to support an education campaign;
- Support the creation of oral health promotion materials to support the campaign; and
- Promote the messages surrounding the campaign through dental surgeries and facilities.

Conclusion

What has been outlined here is a method by which the Australian Government can improve the oral health of the Australian community in a way where:

- The nature of the Schemes will be identical and as such achieve economies of scale when it comes to administrative costs;
- The utilisation of a consistent model that will provide certainty and clarity in delivery;
- The target populations of these programmes can be determined by the Australian Government to meet areas of special need;
- The costing of the programmes will be able to be determined by the Australian Government and in so doing provide the fiscal certainty required; and
- The overall dental and general health of the community will be improved, resulting in reductions in preventable hospitalisations and general health care expenses.

[10] See NHMRC, Australian Dietary Guidelines 2013, https://www.nhmrc.gov.au/_files_nhmrc /publications/attachments/n55_australian_dietary_guidelines_130530.pdf accessed 24 August 2015 at 11:16 AM.