Policy Statement 2.5.1 – Delivery of Oral Health Care: Funding

Position Summary

The ADA's Australian Dental Health Plan outlines the role that Government-funding should play in the delivery of Australia's Oral Health Care. The essential features are public funding of oral health services focused on community-based prevention such as water fluoridation and oral health education, with additional funding to be targeted towards providing care for those at high risk of oral disease, that are disadvantaged or have special needs.

Background

1.1. Dental services in Australia account for 5.6 percent of total health expenditure in 2016-17 despite dental decay being Australia's most prevalent health problem. Most dental care in Australia is provided by private practitioners and financed by individuals and families either directly or through subsidisation. Federal, State and Territory Government sources provide a small percentage of services, mainly to patients eligible for assistance, both directly and by funding private practitioners to provide the services.

1.2. Although there are Federal, State and Territory Government Dental Schemes, they are not coordinated and are underfunded. There are unmet needs for the treatment of individuals within disadvantaged groups in Australia.

1.3. Internationally, comprehensive oral health care and satisfactory oral health outcomes have been difficult to achieve with universal dental schemes.

1.4. Several countries use "insurance" schemes to fund health care and the rebates vary. The support by dentists varies accordingly. Often these schemes are legislated to be non-profit.

1.5. Capitation schemes have been used more widely in consultative health practice such as general medical practice services under the National Health Service in the United Kingdom.

1.6. Improving oral health assists in maintaining good general health.

1.7. Treatment costs are considerably higher than the costs of prevention.

1.8. 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, and that Governments have a vital role in providing oral health services for individuals within these groups.

1.9. Governments have particular responsibilities in an overall national oral health policy (oral health promotion, research and provision of workforce), which will have an impact on disadvantaged, and special needs groups.

1.10. Oral diseases, unlike medical diseases, are largely predictable and, as such, do not have the essential characteristics of an insurable risk.

Definitions

1.11. DISADVANTAGED is a term used to describe individuals or groups of people who have a physical or mental disability, residents of remote and very remote regions, Aboriginal and Torres Straight Islanders and those that are experiencing poverty.

1.12. SPECIAL NEEDS PATIENTS are patients whose intellectual disability, medical, physical or psychiatric condition require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special oral health treatment plans.

1.13. UNIVERSAL DENTAL SCHEMES are those where provision of publicly funded dental care is available for all persons regardless of their means

1.14. CAPITATION DENTAL SCHEME is a dental benefits program in which a dental practitioner is contracted to provide specified dental services for a set fee per person for a given period.

2. Position

2.1. Government oral health care funding must include community-based preventive activities such as water fluoridation, oral health promotion and encouraging and supporting the cessation of smoking.

2.2. In funding oral health care delivery programs for eligible groups and individuals, governments should apply the following:

2.2.1. Eligibility for treatment, for both child and adult dental care, should be directed preferentially or restricted to disadvantaged and special needs groups as determined by Government.

2.2.2. Eligibility of individuals should not be decided by dentists or other health providers.

2.2.3. If any existing State and Territory schemes are to be replaced, there should be no loss of benefits to patients.

2.2.4. The range of oral health treatment items provided for recipients of Government assistance should be comprehensive to allow patients to achieve long term oral health and should use the ADA Schedule of Dental Services and Glossary without alteration.

2.2.5. The treatment complexities of medically compromised individuals and the range of care which needs to be provided, require that the prime provider of oral health services must be a dentist.

2.2.6. The provision of oral health care should utilize the well-developed network of private practice in conjunction with public health service facilities.

2.2.7. Schemes involving private practitioners should be open to voluntary participation by all registered dentists who elect to be included.

2.2.8. All schemes should use the same rebate schedule, which should be based on reasonable fees and updated annually and monetary annual limits claimable may apply.

2.2.9. Co-payments or gaps may apply and should be claimable on private health cover.

2.2.10. Participation in Government schemes should not create excessive administrative burden.

2.2.11. The ADA should be involved in the development and evaluation of any oral health program.

2.3. Given the special contribution of Australian veterans, the Veteran Affairs Scheme is accepted, although it does not comply with the requirements of 2.2 above.

2.4. Medicare benefits that apply to the Cleft Lip & Cleft Palate Scheme and oral and maxillofacial surgery should be retained.

2.5. The Federal Government should implement ADA's solution for providing oral health care to disadvantaged groups, named Australian Dental Health Plan.

2.6. Universal Dental Schemes must not be introduced in Australia.

2.7. Capitation Dental Schemes in Australia are not supported for funding dental care.

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