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Budget Policy Division
The Treasury
Langton Crescent
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Via email: prebudgetsubs@treasury.gov.au

RE: Australian Dental Association 2020–21 Pre-Budget Submission

The Australian Dental Association (ADA) welcomes the opportunity to provide a submission regarding priorities for the 2020–21 Budget.

In its 2016-17, 2017-18 and 2019-20 pre-budget submissions, the ADA has called for the Australian Government to provide additional targeted and sustainable funding to address the unmet oral and dental health care needs of Australians identified in reports of both the National Advisory Council on Dental Health (2012)[1] and the COAG Health Council (2004 and 2014) as 'priority' groups because they experience 'the greatest burden of poor oral health' and 'the most significant barriers to accessing oral health care'.[2]

The *National Oral Health Plan 2005-2014*[3] specifically suggested the extension of the existing *Child Dental Benefits Schedule* scheme to address the needs of 'priority' sections of the Australian *adult* population *who* face a range of cost and non-cost related barriers to good oral health and accessing regular and timely preventive (and remedial) oral and dental health care. These priority populations included low-income or socially disadvantaged adults, and other predominantly low-income populations that experience additional barriers to accessing oral health care—namely, Aboriginal and Torres Strait Islanders, people living outside major population centres, and people with additional or specialised health care needs, such as the frail aged, and people with disabilities.

However, in recent years, little has been done by the Australian government to implement the National Oral Health Plan, or to address the unmet oral and dental health care needs of the adult populations identified by the Plan as priority populations. Instead, it continues to provide almost as much financial support for dental care through the Private health insurance rebate (which disproportionately benefits middle and higher income earners and the private health insurers themselves) as it provides to low-income households through the CDBS and the National Partnership Agreement on Public Dental Services for Adults.[4]

While the CDBS scheme is working well, funding for adult public dental care under the National Partnership model is not, given the very modest funding contribution made by the Australian Government. Other funding options need to be considered, and the ADA would be happy to be involved in discussions on this in the lead-up to the expiry of the current National Partnership Agreement in 2020.

[1] NACDH (2012). *Final report of the National Advisory Council on Dental Health,* Department of Health, Canberra.
[2] COAG Health Council. (2004). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2005-2014*, and COAG Health Council. (2015), *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2015-2024.*
[3] COAG Health Council (2015). op cit.
[4] Duckett, S., Cowgill, M., & Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia*. Grattan Institute, Canberra.

The government would be well aware that although more than one-third of the Australian population (and a higher proportion of children) is eligible for public dental services, inadequate funding of these services means that the public sector only has capacity to see 20% of those eligible.[5] The result is that adults seeking public dental services generally face lengthy waiting times for treatment of 12 months or more, suffering unnecessary pain or discomfort while their oral health worsens, with concomitant negative impacts on their general health and well-being.

Many who seek simple restorative treatment such as fillings from public dental services must wait until decay progresses to a serious dental abscess before they receive treatment. Often, this means a tooth extraction may be the only clinically appropriate option. Some public dental services are not funded to replace the tooth, while others charge significant co-payments for prosthetic treatment that may be beyond the means of patients reliant on Centrelink allowances. These delays in treatment can raise the costs of service provision to the public dental services and their clients, compromise their oral health, or leave patients with unsightly gaps in their smile that can reduce their self-esteem and social confidence, and in the case of jobseekers, reduce their job prospects.

The results of the National Study of Adult Oral Health (NSAOH) 2017–18[6] published this year confirm the extent of unmet need for oral and dental health care amongst the 'priority' adult populations identified earlier. The study also confirms that on some indicators, oral health and access to oral and dental health care in Australia is declining.

For example, the NSAOH 2017-18 revealed that the prevalence of untreated coronal decay in Australians aged over 15 has increased from 25.5% in 2004-06 to 32.3% in 2017-18. Notably, those on the lowest incomes, and Aboriginal and Torres Strait Islanders have around twice as many tooth surfaces with untreated decay as other Australian adults. The proportion of Australians with moderate to severe periodontitis increased to a similar extent over the period, from 22.9% in 2004-06 to 30.1% in 2017-18. However, adults in the aforementioned 'priority populations' are significantly more likely than other Australian adults to have moderate or severe periodontitis, and the disease tends to affect more sites.

Given the increased prevalence of these oral diseases amongst Australian adults, it is not surprising that the proportion aged between 25 and 74 who self-rate their oral health as poor, or only "fair" has also increased from 16.4% in 2004–06 to 23.9% in 2017–18.[7]

The Australian Charter of Healthcare Rights endorsed by Australian Health Ministers in 2008 states that Australians have a fundamental right to adequate and timely healthcare that addresses their healthcare needs.[8] Clearly, many Australians are denied these rights in relation to oral and dental health care.

As noted in the National Oral Health Plan, national leadership and additional Australian Government funding will be required to ensure that timely, quality oral and dental health care and better oral health can be equally enjoyed by Australians in all states and territories. The ADA submits that the Australian Government should use the upcoming 2020-21 Budget to make a start on providing this leadership and addressing these areas of dental need.

[5] Australian Institute of Health and Welfare (AIHW) (2018b). *Patient Experiences in Australia: Summary of Findings, 2017-18,* Cat. No. 4839.0, Canberra.
[6] Australian Research Centre for Population Oral Health. (2019). *Australia's Oral Health: National Study of Adult Oral Health 2017–18*, The University of Adelaide, South Australia.
[7] Ibid.
[8] https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Charter-PDf.pdf;
https://www.safetyandquality.gov.au/wp-content/uploads/2009/01/A-guide-for-patients-consumers-carers-and-families-v3.pdf

The Australian Dental Health Plan

The ADA has recently reviewed and updated its *Australian Dental Health Plan* (ADHP), which is attached to this covering letter and was first presented to the Australian Government for consideration in 2016. The ADHP is aligned with the National Oral Health Plan and proposes measures to build on the existing success of the Child Dental Benefits Scheme (CBDS) to address the oral and dental health care needs of adults in the 'priority populations' discussed above.

The ADHP proposes a model that would retain the CDBS (with some modifications) and use it as a template for two additional targeted dental benefits schemes to meet these needs. The schemes proposed, which would have clear eligibility criteria, minimal capital costs, cover a broad spectrum of dental services, and could be implemented in stages, are:

- an Adult Dental Benefits Schedule targeted towards low-income adults aged 18-64 who hold any type of Australian government-issued Health Care Card (including the Low Income Health Care Card) or Pensioner Concession Card, plus their eligible dependents, and

- a Seniors Dental Benefits Schedule for those aged 65 and over who hold a Pensioner Concession Card, a Commonwealth Seniors Card, or a Health Care Card issued by the Australian Government (and, in a small number of cases, any eligible dependents).

The ADA envisages that these schemes would be based on the following principles:

- the utilisation of a common schedule and glossary of dental terms – the ADA's *The Australian Schedule of Dental Services and Glossary*;[9]

- access to all services based upon the current edition of the ADA Schedule;

- benefit levels to be set at DVA Schedule for Dentists and Dental Specialties[10] levels and indexed annually, with differential benefits for GP and specialist dentists;

- Annual Monetary Limits (AML) set at a level that reflects the current costs of dental services and the dental needs of the eligible population to be applied;

- coverage of dental services delivered in private and public clinics as well as under general anaesthetic/sedation in day procedure and hospital facilities;

- 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;

- bulk billing by public clinics; and

- prior approval to be obtained by the treating dentist for complex treatments.

[9] 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. Currently in its 12th edition, it 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). Like the Medicare Benefits Schedule, it lists dental treatments and allocates a number for each service.

[10] Department of Veteran's Affairs. (2019). *Fee schedule of dental services for dentists and dental specialists*, https://www.dva.gov.au/providers/fees-schedules/dental-and-allied-health-fee-schedules

In keeping with the government's intention to develop a *National Preventive Health Strategy* during 2020, the ADHP also proposes that the government take immediate action on a range of prevention-oriented initiatives designed to reduce the incidence of oral disease. These include:

- the funding of a national oral health promotion strategy;
- introduction of a health levy on sugary drinks to raise the price by 20%;
- changes to food labelling laws to require that added sugars are clearly listed on all packaged food and drink products; and
- increased taxation on the sale of tobacco products.

To improve the oral health of Australians living in remote locations, it is also crucial that the Australian Government honour the commitment made in the National Oral Health Plan 2015 – 2024 to work with the States and Territories to ensure fluoridation of reticulated water supplies in all localities with 1,000 or more residents across Australia. This is the most cost-effective way to reduce the incidence of dental caries, with benefits outweighing costs even in small remote communities with as few as 600 people.[11]

Possible ways in which the ADHP could be funded include phasing out the Private Health Insurance rebate for General Treatment policies, the introduction of a tax on sugary drinks, increased taxation of tobacco products, and/or increasing the compulsory Medicare Levy by 0.5%.

Measures contained in the ADHP may require significant investment, but they also represent sound fiscal policy geared towards realisation of significant savings through reductions in the massive direct and indirect cost burden imposed by oral and dental disease, including its effects on productivity, and its deleterious effects on general health which significantly increase costs elsewhere in the health system.[12]

An increasing body of evidence implicates tooth decay, oral cancer and/or periodontal disease in the onset or worsening of other chronic health conditions like cardiovascular, cerebrovascular and respiratory diseases, diabetes and Alzheimer's disease.[13] In 2017-18, there were 73,000 potentially preventable hospitalisations for treatment of dental conditions,[14] and many more potentially preventable hospitalisations to treat other conditions (e.g. aspiration pneumonia in the elderly) which are commonly caused or exacerbated by untreated oral health conditions.[15]

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[11] Gray, N. et al. (2008). *Water fluoridation in remote communities in the Northern Territory: A cost-benefit analysis*, Department of Health and Families, Darwin.

[12] Listl, S. et al. (2015). Global Economic Impact of Dental Diseases. *Journal of Dental Research*, 94(10), 1355–1361; Richardson, B and Richardson, J. (2011). *End the decay: the cost of poor dental health and what should be done about it*, Brotherhood of St Laurence, Melbourne.

[13] Dietrich, T. et al. (2017). 'Evidence summary: The relationship between oral and cardiovascular disease', *British Dental Journal,* 222, pp.381-5; Pillai, R. S. et al. (2018). 'Oral health and brain injury: causal or casual relation?' *Cerebrovascular diseases extra*, 8(1), pp. 1–15. doi:10.1159/000484989. Lewis A, Wallace J, Deutsch A & King P. (2015). 'Improving the oral health of frail and functionally dependent elderly', *Australian Dental Journal*, 60 (1 – Supplement), p.97; Mydel, P. et al. (2019) Porphyromonas gingivalis in Alzheimer's disease brains: Evidence for disease causation and treatment with small-molecule inhibitors. *Science Advances*. doi.org/10.1126/sciadv.aau3333.

[14] Australian Institute of Health and Welfare. (2019). *Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017-18,* Cat No. HPF 36, AIHW, Canberra.

[15] Hopcraft, M S. (2015). 'Dental demographics and metrics of oral diseases in the ageing Australian population', *Australian Dental Journal*, 60 (1 – *Special Supplement on Dentistry for the Ageing Population*), p.3; Lewis et al., op cot; Maarel-Wierink C. D. et al. (2011). 'Risk factors for aspiration pneumonia in frail older people: a systematic literature review', *Journal of the American Medical Directors Association*,12, pp.344–354; Tada, A & Miura, H. (2012). 'Prevention of aspiration pneumonia with oral care', *Archives of Gerontology and Geriatrics*, 55 (1) 16-21.

Other hidden costs borne by taxpayers as a result of inadequate government funding for oral health care include the costs to Medicare and the Pharmaceutical Benefits Scheme associated with the 7-10% of GP visits[16] that are from patients seeking pain relief, antibiotics and/or time off work or school for untreated oral infections.

Finally, it is also important to take the substantial indirect costs to the economy and individuals that result from associated days lost from school and work into account.

Australian studies undertaken in 2007 and 2011 that attempted to quantify the collective magnitude of these costs estimated that they could amount to up to AUD $2 billion per annum.[17] When inflation is taken into account, that amounts to $2.7 billion in 2019 dollars. However, as many of the associated costs (e.g. episodes of hospital care) have risen faster than the rate of inflation, the figure of $2.7 billion is likely to underestimate the present-day cost of inaction considerably.

In a context marked by declining access to timely and affordable oral and dental health care, and significant deteriorations in several indices of adult oral health, the ADA strongly encourages the Australian Government to begin staged implementation of measures set out in the ADHP in the upcoming 2020-2021 Budget.

Should you wish to discuss any matters raised in this submission further, please contact Mr Damian Mitsch, Chief Executive Officer of the ADA, at ceo@ada.org.au.

Dr Carmelo Bonanno
Federal President
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[16] Leeder, SL & Russell, L. (2007). *Dental and oral health policy issue paper*, The Menzies Centre for Health Policy, Sydney.
[17] Econtech Pty Ltd. (2007). *Economic analysis of the dental health for older Australians*, final report for COTA Over 50s and the Australian Dental Industry Association, Canberra; Leeder and Russell, op cit; Richardson, B and Richardson, J. (2011). *End the decay: The cost of poor dental health and what should be done about it,* Brotherhood of St Laurence, Melbourne.