Submission No. 77
AUTHORISED:
13-10-05 MC

AUSTRALIAN DENTAL ASSOCIATION INC.

75 Lithgow Street St Leonards NSW 2065
Postal Address
PO Box 520 St Leonards NSW 1590
Telephone (02) 9906 4412
Facsimile Executive (02) 9906 4736
Administration (02) 9906 4676
Publications (02) 9906 4917
E-mail adainc@ada.org.au
Website www.ada.org.au

8 September 2005

The Hon. Alex Somlyay MP
Chair, Standing Committee on Health and Ageing
House of Representatives
Parliament House
Canberra ACT 2600

Dear Mr Somlyay,

I am writing to provide you with a written response to five questions I took 'on notice' when presenting evidence to the Standing Committee on Health and Ageing's Inquiry into Health Funding on 5 July 2005

I apologise for the length of time it has taken me to respond to you. I have been waiting to receive the latest Australian Dental School enrolment figures to assist my response to the first two questions (see below). Unfortunately, I have yet to receive this information, however, I will provide it to you when it becomes available. In the meantime, my response to the first question is based on 2000 data collected by the Australian Research Centre for Population Oral Health at the University of Adelaide.

Yours sincerely,

Dr William O'Reilly
Federal President
Australian Dental Association

1. Australian Dental Schools – Male v Female Enrolments

As the Table 1 highlights, the period from 1989 to 1999 saw a fall in the number of males graduating from Australian dental schools and an increase in the number of female graduates. During this period, the proportion of male graduates fell from 62% to 56% while the proportion of female graduates grew from 37% to 44%.

Table 1: Australian University Dentistry Course Completion by Gender, 1989-1999

	1989	1991	1993	1995	1997	1999
	Males					
University of Adelaide	15	20	24	24	18	17
University Melbourne	24	32	29	24	25	26
University of Queensland	36	30	30	26	29	30
University of Sydney	55	44	43	52	47	37
University of Western Australia	16	19	19	20	12	15
Total	**146**	**145**	**145**	**146**	**131**	**125**
	Females					
University of Adelaide	11	13	16	21	20	23
University Melbourne	23	20	12	20	24	18
University of Queensland	17	11	16	14	18	18
University of Sydney	27	18	25	33	21	24
University of Western Australia	7	11	13	9	13	15
Total	**85**	**73**	**82**	**97**	**96**	**98**

Source: Teusner, D.N. and Spencer, A.J. (2003) *Dental Labour Force, Australia 2000,* AIWH Cat. No. 116, Australian Institute of Health and Welfare, Dental Statistics and Research Series No. 28, p. 59.

2. Number of fee paying students in Australian Dental Schools

The ADA does not have information available on the number of fee paying students at this stage. I will pass this information onto the Committee when it becomes available.

3. Status of dental plans in United States of America

Private insurance is a significant component of expenditure on dental care in the United States. According to Birch and Anderson,[1] only five per cent of dental expenditure in the United States comes from public sources, while the remainder comes from private insurance.

A 2002 analysis of private dental coverage in the United States indicated that the number of people with dental insurance in that country grew from 4.5 million in 1967 to over 100 million by 1990. The same paper argued that dental insurance is an important factor in influencing whether people seek dental care.[2]

According to the American Dental Association:[3]

> "Dental plans are typically business arrangements between an insurance company and an employer. Most plans are designed to pay only a portion of your dental expenses. However, dental plans may exclude or discourage certain treatments, such as dental sealants, which can prevent tooth decay and save you money later on."

The American Dental Association[4] adds that there are three types of dental plans in the United States. These are summarised below:

- Dental Health Maintenance Organisations (DHMOs) – "pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless or utilisation. In return, the dentists agree to provide specific types of treatment to the patient at no charge (for other treatments, a co-payment is

required). Theoretically, DHMOs reward dentists who keep patients in good health, thereby keeping costs low. DHMO models typically offer the least expensive dental plans".

- Preferred Provider Organisation (PPO) – "are plans under which patients select a dentist from a network or list of providers who have agreed, by contract, to discount their fees. In PPOs that allow patients to receive treatment from a non-participating dentist, patients will be penalised with higher deductibles and co-payments. PPOs can be fully insured or self-insured. PPOs are usually less expensive than comparable indemnity plans and are regulated under the appropriate insurance statutes in the company's state or domicile and operation."
- Direct Reimbursement (DR) – "self-funded dental benefits plan that reimburses patients according to *dollars spent* [emphasis in original], not type of treatment received. It allows the patients complete freedom to choose any dentist. Instead of paying monthly insurance premiums, even for employees who don't use the dentist, employers pay a percentage of actual treatments received. Moreover, employers are removed from the potential responsibility of influencing treatment decisions due to plan selection or sponsorship. DR is the (American Dental Association's) preferred method of financing dental treatment."

4. 20% increase in waiting lists in first year after the Commonwealth Dental Health Program ceased

The Australian Dental Association's[5] argument on page 20 of its submission that "waiting lists grew nationally by 20% within 12 months" of the cessation of the Commonwealth Dental Health Program is based on a conservative interpretation of the available literature. The ADA examined the following three sources, and cited the first in its submission:

- Firstly, an article written by Zigarus[6] for the Brotherhood of St Laurence which argued:

  > "The impact of axing the Commonwealth Dental Health Program was severe and immediate. Waiting lists grew by 20 per cent nationally in just over 12 months."

- Secondly, citing figures from Dental Health Services Victoria, the Senate Community Affairs Reference Committee[7] *Report on Public Dental Services* in May 1998 highlighted the growth in the number of people on public dental waiting lists from the time the CDHP ceased. These figures are outlined in Table 2. A comparison of the growth in public dental waiting lists for New South Wales, South Australia, Australian Capital Territory and Victoria (as comparative data is not available for the other state and territories) shows that public dental waiting lists grew from 234,200 in mid-1996 to 364,000 in mid 1997. The average increase for those states where comparative data was available is 55.42%.

Table 2: Public dental waiting lists

State/Territory	Number of people mid-1996	Number of people mid-1997	Increase in waiting lists (%)
NSW	78,000	140,000	79.49%
SA	53,800	78,000	44.98
ACT	1,400	3,600	157.14
TAS	Not available	13,400	-
VIC	101,000	143,000	41.58
QLD	Not available	69,000	-
WA	Not available	11,000	-

Source: Dental Health Services Victoria, cited in Senate Community Affairs Reference Committee[8] *Report on Public Dental Services* in May 1998.

- Thirdly, the AMA[9] has argued that in the period from the cessation of the CDHP to May 1998, public dental waiting lists grew from 380,000 to 500,000, a rise of 31.57%.

In addition, an evaluation of the CDHP by the AIHW Dental Statistics and Research Unit[10] at the University of Adelaide found that the introduction of the CDHP significantly reduced waiting lists for publicly funded dental care. According to the evaluation:

> "Prior to the CDHP less than half (47.5 per cent) of card holders who last received public-funded dental care for a check-up waited less than a month for that visit and over one-fifth (21.1 per cent) waited 12 months or more. The percentage of card-holders who last received public-funded dental care waiting less than one month for a check-up increased substantially (61.5 per cent) and the percentage waiting 12 months or more almost halved (11.3 per cent) over the 24 months of the CDHP. However, waiting times were still in marked contrast to non-card holders who last visited a private dentist, who nearly all waited less than one month (94.9 per cent), with nobody reporting waiting 12 months or more."

With this additional point in mind, it is logical that waiting lists and the length of time people spend on those waiting lists grew following the cessation of the CDHP.

5. Commonwealth spend on dental care

The Australian Dental Association was asked to provide a breakdown of 'Figure 1: Dental Expenditure by Source as % of Total Dental Expenditure: 1992-93 to 2002-03', which appears on page 17 of its submission. This breakdown is highlighted in Table 3.

Table 3: Dental Expenditure by Source of Funds: 1992-93 to 2002-03 ($m)

	GOVERNMENT			NON-GOVERNMENT SOURCES			
	Australian Government						
	Commonwealth Government – Direct Outlays	30% rebate	State and Local Government	Private health insurance funds	Individuals	Other	Total
1992-93	38	-	146	535	984	6	1,709
1993-94	58	-	139	539	1,089	6	1,831
1994-95	105	-	141	546	1,143	8	1,943
1995-96	152	-	205	564	1,149	10	2,080
1996-97	97	-	297	596	1,151	9	2,550
1997-98	44	32	328	600	1,611	8	2,623
1998-99	6	37	305	603	1,640	11	2,662
1999-00	69	193	373	442	1,794	11	2,882
2000-01	68	254	341	520	2,255	10	3,448
2001-02	71	280	329	666	2,727	12	4,085
2002-03	78	298	342	680	2,963	14	4,375

Source: Australian Institute of Health and Welfare (AIHW), 'Health Expenditure Australia', Various Years.

References

[1] Birch, S. and Anderson, R. (2005) 'Financing and delivering oral health care: What can we learn from other countries?, *Journal of the Canadian Dental Association,* Vol. 71, No. 4, pp. 243-243d.

[2] Manski, R.J., Macek, M.D. and Moeller, J.F. (2002) 'Private dental coverage: Who has it and how does it influence dental visits and expenditures?, *JADA,* Vol. 1333, pp. 1551-1559.

[3] Accessed from www.ada.org/public/manage/insurance/index.asp on 10 August 2005.

[4] Accessed from http://www.ada.org/public/manage/insurance/index.asp on 10 August 2005.

[5] Australian Dental Association (2005) *Submission to House of Representatives Standing Committee on Health and Ageing: Inquiry into Health Funding,* p. 20.

[6] Zigarus, S. (2001) 'Time for a new national dental health scheme', *Brotherhood Comment,* August, Brotherhood of St Laurence, Fitzroy, pp. 12-13.

[7] Accessed from http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1996-99/dental/report/c03.htm on 5 July 2005.

[8] Accessed from http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1996-99/dental/report/c03.htm on 5 July 2005.

[9] Australian Medical Association (2000) *Commonwealth Dental Scheme Essential: AMA,* Media Release, 3 August.

[10] Brennan, D.S., Carter, K.D., Stewart, J.F., Spencer, A.J. (1997) *Commonwealth Dental Health Program Evaluation Report 1994-1996,* AIHW Dental Statistics and Research Unit, The University of Adelaide, Adelaide, p. 73.