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The proposed Denticare scheme—an overview

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Introduction

Citing long waiting lists for public dental services and financial barriers to timely dental care, the National Health and Hospitals Reform Commission (NHHRC) proposes the establishment of the Denticare Australia scheme, to provide a ‘universal scheme for access to basic dental services’ in its final report to government.¹ Supplementing this, the NHHRC also proposes an expansion of existing state-based school dental programs, more funding for oral health promotion and an internship scheme for dental graduates. The Denticare scheme and related dental health proposals, were first suggested in the NHHRC’s interim report. These remain essentially unchanged in its final report.²

The Denticare scheme was one of the ‘most welcomed’ of all the reform proposals contained in the Commission’s interim report, issued in November 2008.³ Nevertheless, the response to the Denticare proposal has not been universally positive. Issues that were raised in the wake of the interim report, such as the cost of the scheme, access for disadvantaged groups, and the capacity of the dental workforce, continue to be of concern.⁴

This Background Note provides an outline of the proposed Denticare scheme, including the dental services to be covered, cost estimates and financing arrangements. Responses to the proposal and some key issues for further discussion are highlighted.

What is Denticare Australia?

The final report recommends, among other dental and oral health proposals, the establishment of Denticare Australia, through which all Australians would have access to a ‘basic package’ of dental services. These dental services would be provided through either the public or private sector and be funded by Denticare Australia at no or at subsidised cost to users.

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1. National Health and Hospitals Reform Commission (NHHRC), *A healthier future for all Australians: Final Report*, NHHRC, Canberra, 2009, p. 83, viewed 18 November 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report>
 2. National Health and Hospitals Reform Commission (NHHRC), *A healthier future for all Australians: Interim Report*, NHHRC, Canberra, 2008, p. 266, viewed 11 November 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf). To distinguish between the two reports in the footnotes each will be referred to by its shortened title, ‘Interim Report’ or ‘Final report’.
 3. NHHRC, *Final Report*, op. cit., p. 83.
 4. For an analysis of responses to the proposal as set out in the interim report, see R de Boer, A Boxall, A Biggs, L Buckmaster, J Gardiner-Garden and R Jolly, *The interim report of the National Health and Hospitals Reform Commission—a summary and analysis*, Research Paper no. 24, 2008–09, 19 March 2009, Parliamentary Library, Canberra, 2009, viewed 13 November 2009, <http://www.aph.gov.au/Library/pubs/rp/2008-09/09rp24.pdf>

The basic package of dental services would include preventive work (such as scaling and cleaning of teeth), diagnostic (x-rays), extractions and restorative work (such as fillings of cavities) as well as the provision of dentures. People could choose to have the basic package of dental services provided through a private dental plan or under public dental arrangements.

Full details of what services would be covered are not provided in the report, but it makes clear that certain ‘additional’ services such as orthodontics would not be included under the basic package. Individuals wanting additional dental services, the NHHRC suggests, would have the option of purchasing additional health insurance products.⁵ Purchasing dental services directly, that is, without buying insurance, is not an option canvassed in the final report.

These proposed arrangements are outlined below.

Private dental plans

Those who choose the private option would purchase a health plan from a private health insurer to cover a ‘basic package’ of dental services. Denticare Australia would pay the premium for these plans, which would meet approximately 85 per cent of private dental costs; representing a significant discount.⁶ The remaining costs would be paid by consumers although these co-payment amounts are expected to be lower than currently applies.⁷ Consumers would then access basic dental services through a private dentist where most of their dentist’s fees would be met by the private health plan.

The interim report proposed that the premium paid by Denticare Australia to private health insurers, be ‘risk adjusted’.⁸ This would mean that a person assessed with a higher dental risk would pay a higher premium than someone assessed as having a lower dental risk. However, this proposal is not repeated in the final report, leaving open the question of what sort of premiums would apply.

Public dental services

Those who decline the private health plan option would have access to basic dental services free of charge through state-based public dental services. These services would receive expanded funding from Denticare Australia, although the level of this expanded funding is not detailed in the final report. Those accessing public dental services may still face delays for treatment, but the NHHRC expects waiting times to be less than is currently the case.

5. NHHRC, *Final Report*, op. cit., p. 84.

6. An earlier version of this paper interpreted the proposed payment of premiums by Denticare as constituting an 85 per cent subsidy on premiums instead of a subsidy on dental costs.

7. The NHHRC expects these co-payment amounts to be lower than those currently paid by privately insured patients. NHHRC, *Final Report*, op. cit., p. 84.

8. NHHRC, *Interim report*, op. cit., p. 268.

Access to public dental services would not attract a co-payment, even where services are contracted out to private dentists. Nor would public dental services only be restricted to those on concession cards as is currently the case.⁹ Anyone opting not to purchase a private dental plan could access public dental services. However, it is not clear how someone who had already purchased a private plan, but who then elects to be treated in a public dental clinic, would be prevented from doing so.

The final report notes that some specialised services such as those provided to people with an intellectual disability may only be available through public dental clinics.¹⁰

Cost and financing

The final report estimates that the cost of the Denticare scheme including the related dental proposals, would be around \$5.5 billion annually (this costing includes funding for the proposed dental internship program, expansion of the school dental program and the oral health promotion program). Of this amount, the NHHRC proposes that the government allocation would be \$4.9 billion, to be funded mainly through an increase in the Medicare levy and the pooling of existing government dental expenditure.¹¹

The Medicare levy—currently set at 1.5 per cent of taxable income—would be raised by 0.75 to 2.25 per cent of taxable income. This would raise some \$4.1 billion in additional revenue for the scheme.¹² This amount would be combined with the \$1 billion it is estimated that the Commonwealth Government currently spends on dental health; this includes funding for the Teen Dental Plan, the medical expenses tax offset and the Commonwealth Dental Plan. Allowing for some limited expansion of the scheme, this funding is expected to be sufficient to cover the government component of the scheme.¹³

9. Under current arrangements the states and territories fund and manage all public dental services, although small co-payments often apply. Access to these services is usually based on eligibility criteria, such as concession card status, or membership of a disadvantaged or vulnerable group, such as children or Aboriginal and Torres Strait Islanders.

10. NHHRC *Final Report*, op. cit., p. 84.

11. NHHRC, *Final Report*, op. cit., p. 273.

12. Currently, the Medicare levy raises \$8.6 billion in revenue. Although the Medicare levy is notionally hypothecated, it covers only a proportion of the Commonwealth's outlays on Medicare which currently costs around \$15 billion a year. See Australian Government, *Budget strategy and outlook: budget paper no. 1, 2009–10*, the Commonwealth of Australia, Canberra, 2009, p. 5-37; and Australian Government, *Budget strategy and outlook: budget paper no. 1 2009–10*, Commonwealth of Australia, Canberra, 2009, p. 6–22.

13. NHHRC, *Final Report*, op. cit., p. 274. The estimates allow for 5 per cent growth in private dental services and 50 per cent growth in public dental services.

The final report does not specify how the outstanding balance of the scheme—around \$600 million—would be funded. But a separate costings paper suggests the balance of the scheme would be funded mainly from individual out-of-pocket expenditure.¹⁴

The NHHRC claims that under the Denticare scheme, many people would pay ‘no more than they currently pay for dental care’ and for those on lower incomes dental costs would be ‘considerably less’ while their access to dental care would improve. But those on higher incomes may face higher costs as a result of the increased Medicare levy which would be only partially offset by lower out-of-pocket costs.¹⁵

The final report does not include detailed costings for the scheme, but such costings are contained in a commissioned paper prepared by consultants Price Waterhouse Coopers (PwC).¹⁶ This paper was commissioned to assist the NHHRC to ‘shape its reform directions’ and so its cost estimates inform those in the final report.

The PwC paper shows that the imposition of the increased Medicare levy is expected to shift the burden of dental funding away from a reliance on out-of-pocket spending to funding via the increased levy on taxable income. Shifting funding of dental services to the taxation system, the NHHRC argues, would achieve greater equity in spending on dental services, as those on lower incomes would experience greater savings than those on higher incomes.¹⁷ The PwC estimates show that those on higher incomes would experience some declines in their out-of-pocket dental spending, but would face additional expenditure mainly due to the increase in the Medicare levy. Overall, PwC calculate that higher income earners would spend more per week than they currently do on dental care, whilst those on the lowest incomes would spend less.¹⁸

The future viability of direct out-of-pocket purchasing of dental services—currently 35 per cent of Australians choose to purchase dental services directly from private dentists on an as-needs basis—is not addressed in the final report.¹⁹ The final report only refers to two

14. K Armstrong, M Campbell, *National Health and Hospital Reform Commission: costing a social insurance scheme for dental care*, Price Waterhouse Coopers, November 2008, p. 18, viewed 18 November 2009,

[http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/\\$File/Costing%20a%20Social%20Insurance%20Scheme%20for%20Dental%20Care%20-%20November%202008.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/Costing%20a%20Social%20Insurance%20Scheme%20for%20Dental%20Care%20-%20November%202008.pdf). This report was specially commissioned by the NHHRC to assist it to shape its reform directions. See: NHHRC, *Interim Report*, op. cit., p. 266.

15. NHHRC, *Final Report*, op. cit., p. 84.

16. K Armstrong, M Campbell, op. cit., p. 18.

17. NHHRC, *Interim Report*, op. cit., p. 267.

18. K Armstrong, M Campbell, op. cit., p. 24. Highest income earners will face additional expenditure of \$1.43 per week and lowest income earners will see savings of \$0.71.

19. NHHRC, *Interim Report*, op. cit., p. 267.

possible funding options: either through the purchase of a private dental plan or relying on free public dental services.

Responses to the Denticare proposal

As noted, when the Denticare proposal was first raised by the NHHRC in its interim report, response to it was mixed. While the proposals for the internship scheme, school dental program expansion and funding for oral health promotion were all broadly welcomed, the proposed Denticare scheme garnered criticisms, as well as plaudits. The Government is currently undertaking an extended consultation process; the Prime Minister has so far only commented that the proposal is ‘bold’.²⁰

Not surprisingly, as the Denticare proposal outlined in the final report remains largely unchanged from the interim report, recent comments about the proposal tend to mirror the earlier ones. Some of the main issues raised in responses are summarised below.

Criticisms

Cost

A concern raised by some is the impact the scheme would have on dental fees. Increased demand for services without a simultaneous increase in workforce capacity would lead to price increases in the short term at least. This risk is identified in the PwC costings paper:

The Scheme is intended to broaden the range of people who seek dental services, increasing demand considerably. Given that the workforce supply will take some time to respond, price increases seem a reasonable likelihood in response to increased demand.²¹

As Nick Miller of *The Age* has noted, because the government as insurer will bear most of the cost of increased fees, ‘dentists will be able to bump up their fees with a clear-ish conscience without slugging their patients’.²² Dr Chris Bourke from the Indigenous Dentists Association, argues that over time, the ‘gap’ between what Denticare covers and what dentists charge will widen.²³ Others, including Professor Hans Zoellner from the Association for the Promotion

20. K Rudd (Prime Minister), *Transcript of Address John Curtin School of Medical Research, ANU ‘Reforming Australian Health Care*, media release, 27 July 2009, viewed 17 November 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2FWN9U6%22>

21. K Armstrong, M Campbell, op. cit., p. 33.

22. N Miller, ‘Time to stop the rot’ *The Age*, 1 August 2009, viewed 13 November 2009, <http://www.theage.com.au/national/time-to-stop-the-rot-20090731-e4iu.html>

23. E Kretowicz, ‘Denticare leaves hole for many who need help’, *Canberra Times*, 28 July 2009, p. 1.

of Oral Health (APOH) also point to the potential inflationary effects of the scheme.²⁴ The health insurer's peak body the Australian Health Insurance Association (AHIA) had warned that the Denticare proposal could cost up to \$11 billion annually.²⁵

Some such as Tony McBride of the Australian Health Care Reform Alliance and John Menadue from the Centre for Policy Development question funding being directed to private health insurers to provide coverage for basic dental care. They argue it would be 'cheaper' to fund dental services through the 'more efficient Medicare' where administrative costs are estimated to be up to three times lower.²⁶

Equity

Another major concern raised by a number of groups relates to equity.

APOH in a detailed submission to the NHHRC suggests the Denticare proposal as it stands, risks entrenching a 'two tiered' dental health system. They argue that patients accessing Denticare services through the public system would be disadvantaged compared to those in the private sector. Public patients would be subject to exclusions—such as orthodontics—which those who could afford dental care through the private sector would be able to access. Also, 'medically fragile patients' who rely solely on the public sector to provide for their complex needs, would be 'limited' in the range of treatments they could receive. In addition, those in the public sector would be subject to 'extended waiting lists' while those in the private sector would not.²⁷

Others expressing concerns over equity include the Australian Dental Association (ADA) which is concerned that Denticare will fail to deliver dental care to the most disadvantaged.²⁸ The Public Health Association of Australia has also warned that unless a 'phased

24. Reported in A Cresswell, 'Opposite sides unite to slam dental scheme' *The Australian*, 29 July 2009, p. 8; also A Sharp, 'Medicare rise may fund dental plan', *The Age*, 28 July 2009, p. 5.

25. Quoted in R de Boer, et. al., op. cit., p. 26.

26. T McBride (Chair Australian Health Care Reform Alliance), *Alliance welcomes significant health reform report*, media release, 27 July 2009; J Menadue 'Medicare's future is at stake', *Crikey*, 23 October 2009, viewed 16 November 2009, <http://www.crikey.com.au/2009/10/23/medicare%E2%80%99s-future-is-at-stake-menadue/>

27. Association for the Promotion of Oral Health (APOH), 'Response to the Interim Report of the National Health and Hospitals Reform Commission 'A Healthier Future for All Australians December 2008,' p. 5, viewed 16 November 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/023-interim/\\$FILE/023%20-%20Submission%20-%20Association%20for%20the%20Promotion%20of%20Oral%20Health.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/023-interim/$FILE/023%20-%20Submission%20-%20Association%20for%20the%20Promotion%20of%20Oral%20Health.pdf)

28. N Hewson (Federal President Australian Dental Association), *Final report of the National Health and hospitals Reform commission fails to properly address dental care issues*, media release, 27 July 2009.

implementation’ is adopted which gives priority to the most disadvantaged, then ‘more advantaged groups would be likely to be the immediate beneficiaries, thus increasing inequalities’.²⁹

Dr Tim Woodruff from the Doctors Reform Society is also concerned the scheme puts ‘choice before equity’.³⁰

Range and scope of services

The final report does not specify the range of services to be covered by Denticare Australia, but these are outlined in the PwC paper. Services include diagnostic (examinations and x-rays), preventative (scale and clean, fissure sealing, oral hygiene), periodontic (treatment of gum disease), extraction, endodontic services such as root canal therapy and the provision and maintenance of dentures.³¹

But the scope of dental services to be covered has been questioned by some. The President of the ADA, Dr Neil Hewson argues that the proposed package of basic dental services is too limited, while Professor Hans Zoellner has concerns that a limited range of services will lead to ‘stupid clinical decisions’.³² Echoing the views of Menadue and McBride, he is in favour of a more comprehensive range of dental services being provided under Medicare.³³

Impact on the private health insurance sector

Another issue is the potential impact on the private health insurance sector. The PwC paper notes any change to the way dental services are financed is likely to ‘significantly impact’ on the industry. It identifies a decline in private health insurance coverage as a key risk. Because dental coverage is a large factor in the decision to take up private cover, if health insurers are permitted to offer separate private dental plans this could erode demand for other health

29. Public Health Association of Australia (PHAA), ‘Response to the National Health and Hospitals Reform Commission (NHHRC) Interim Report: Submission to National Health and Hospitals Reform Commission’, p. 4, viewed 18 November 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/240-interim/\\$FILE/240%20-%20Submission%20-%20Public%20Health%20Association%20of%20Australia.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/240-interim/$FILE/240%20-%20Submission%20-%20Public%20Health%20Association%20of%20Australia.pdf).

30. T Woodruff (President Doctors Reform Society), *Equity before choice, patients before vested interests*, media release, 29 July 2009.

31. K Armstrong, M Campbell, op. cit., pp. 36–38.

32. N Hewson, op. cit.; A Cresswell, op. cit.; also A Sharp, op. cit.

33. The idea of funding dental services under Medicare has been proposed previously. For example, two Senate Committees have discussed this model. See: Senate Select Committee on Medicare, *Medicare – health care or welfare?*, The Senate, Canberra, 2003, pp. 128–129; Senate Community Affairs References Committee, *Report on public dental services*, Canberra, The Senate, 1998, pp. 52–54.

insurance products.³⁴ Nick Miller from *The Age* warns ‘there’s a good chance’ that people would drop their private hospital cover in preference for a private dental plan and ‘hit the public hospital waiting lists’.³⁵

In a submission to the NHHRC, the AHIA said it was ‘very concerned’ that under the proposal, consumers might instead purchase private insurance for expensive procedures not covered by Denticare such as orthodontics. Such ‘adverse selection’ would lead over time ‘to increased premiums’ and erode the value of health insurance.³⁶

Mark Fitzgibbon CEO of health insurer NIB argues that rather than establish a new bureaucracy in Denticare Australia and raise taxes, the government should increase support for the private health insurance rebate. He is also opposed to any proposal which results in a ‘Medicare style dental system’.³⁷

Dental workforce capacity

Another significant issue is the capacity of the dental workforce to meet the forecast increased demand for dental services. This is also identified as a key risk in the PwC paper, which notes that the ‘workforce supply’ will take some time to respond to the increased demand.³⁸

Of particular concern to APOH is the capacity of the public dental workforce, given that there is likely to be an increase in demand for public dental services under the proposal. While the proposed dental internships will in time increase the public dental workforce, APOH warns this would ‘still be insufficient to satisfy current demands for public dental service by currently eligible citizens’. Nor is it likely that there would be any shift in the workforce from the private to the public sector.³⁹

34. K Armstrong, M Campbell, op cit, p. 34.

35. Ibid.

36. Australian Health Insurance Association (AHIA), ‘213–Submission–Australian Health Insurance Association’, 20 March 2009, NHHRC website, viewed 16 November 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/213-interim>;

37. NIB, *NIB responds to NHHRC report*, media release, 28 July 2009; and C White, ‘Scrap Denticare, raise private health rebates: NIB’, ABC News Online, 17 February 2009.

38. K Armstrong, M Campbell, op cit, p. 33.

39. APOH, op. cit., p. 3.

Others to express such concerns include the consumer group, the Health Consumers Alliance of SA, which is also worried the scheme ‘does not address the clear shortage of staff in the public dental system’.⁴⁰

Risk adjusted premiums

The Denticare proposal in the interim report was based on the proposition that the private dental health plan premiums would be ‘risk adjusted’. Risk adjusted premiums are where insurers can charge higher premiums to those considered to be at a higher risk. In Australia health insurers are not permitted to vary premiums based on a member’s risk profile. Instead, they are required to adhere to ‘community rating’ principles. Community rating means that premiums cannot be varied according to age, gender, health service usage or health status. It has been a feature of the Australian health insurance landscape for many years and applies to premiums paid for all private health insurance products.

Risk adjusted premiums were proposed in the interim report. However, the final report is silent on whether these remain a feature of the Denticare scheme. Although not likely to affect the overall cost of the scheme, risk adjusted premiums could result in higher premium costs applying to some individuals. Further, the report fails to articulate how premiums for the dental plan would be set and how to ensure that the value of the subsidy offered by Denticare would be maintained in the face of rising premiums or gap amounts.

Direct purchasing of dental services

Under Denticare people would be able to opt to purchase either a private health plan subsidised by Denticare, or instead rely on an expanded public dental service. As already noted, many Australians—some 35 per cent of the population—purchase private dental services directly on an as-needs basis, rather than taking out private health insurance. How these Australians or others such as overseas visitors who wish to purchase on an as-needs basis would access dental care, is not addressed in the final report. It is unclear if the option of direct purchase of dental services would be closed under the Denticare proposal; if it were, there may be legal or other implications of denying people this choice.

Redirection of government dental funding

In recent years, Australian governments have introduced funding for a number of dental programs targeted to specific populations. The Howard Government introduced the Medicare Enhanced Primary Care (EPC) program, under which Medicare funds dental services for

40. Health Consumers Alliance Inc of South Australia, ‘Response to National Health and Hospital Reform Commission Interim Report’, viewed 16 November 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/238--interim/\\$FILE/238%20-%20Submission%20-%20Health%20Consumers%20Alliance%20of%20SA.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/238--interim/$FILE/238%20-%20Submission%20-%20Health%20Consumers%20Alliance%20of%20SA.pdf)

people with chronic conditions where dental problems exacerbate their condition.⁴¹ The Rudd Government introduced the Teen Dental Plan whereby a means-tested voucher is provided to eligible teenagers for an annual dental check-up. It also proposed the introduction of the Commonwealth Dental Health Plan to increase funding for state public dental services.⁴²

Under the Denticare proposal Commonwealth funding for these targeted programs would be diverted to the new Denticare scheme.⁴³ While some of these targeted programs have been criticised for cost blowouts—particularly the EPC scheme—arguably, many patients have benefited from access to timely and affordable dental care. Dismantling these may mean that those who previously relied on these targeted programs but who cannot afford a private plan will instead be forced to rely on public dental clinics, where waiting periods would apply.

Other reform proposals

The NHHRC does not outline how the proposed Denticare scheme would ‘fit in’ with its other options for structural reform of the Australian health system. Its proposal for Medicare Select would seem to share some features.⁴⁴ Both proposals have a reliance on taxation revenue, an emphasis on private health plans and a universal package of services—but there are also important differences. For example, Medicare Select allows for the Commonwealth to separately offer private health plans in competition with health insurers. This is not an option considered under the Denticare proposal. How the various reform proposals would be accommodated would require further consideration.

Data

In proposing Denticare Australia, the NHHRC cites that up to 650 000 Australians may be currently waiting for public dental care.⁴⁵ Others have also referred to this figure.⁴⁶ But while

41. Also known as the chronic disease initiative, the scheme was first introduced in 2004, but substantially expanded in 2007. A cap on benefits applies.

42. This was reliant on the EPC scheme being closed down and funding from it being redirected. So far, efforts to close this scheme down have been resisted in the Senate. See A Biggs, *Dental benefits for chronic conditions—an update*, Background Note, 30 October 2008, Parliamentary Library, Canberra, 2008, viewed 18 November 2009, http://www.aph.gov.au/Library/pubs/BN/2008-09/Dental_Benefits.htm

43. NHHRC, *Final Report*, op. cit., p. 274.

44. For a discussion of the Medicare Select proposal see A Boxall, *What is Medicare Select?*, Background Note, Parliamentary Library, Canberra, 2009, viewed 17 November 2009, <http://www.aph.gov.au/Library/pubs/BN/sp/MedicareSelect.htm>

45. NHHRC, *Final Report*, op. cit., p. 82.

46. See for example, J Lewis, ‘The road to oral health policy innovation in Australia’, *Australian Review of Public Affairs*, October 2007, p. 1, viewed 18 November 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjrnart%2FUUUO6%22>; S Leeder, A Dominello, ‘Dental as anything’, *New Matilda*, 30 March

there is a consensus that many Australians are waiting intolerably long periods for dental treatment, the actual number of people waiting for public dental care is not known precisely. While some jurisdictions report on the length of their public dental waiting lists, others do not and what figures are reported are not nationally consistent or always comparable across jurisdictions. Without improved data collection and mandatory publication of such data, it is difficult to see how the impact of Denticare Australia on public waiting times would be assessed.

Positive commentary

Not all commentary about Denticare Australia has been critical. As noted, there has been consistent support for the proposals to increase funding for public dental services, school dental programs, and oral health promotion and for the proposed dental graduate internship scheme. Many commentators have also welcomed the emphasis the report has given to providing universal dental care. The Public Health Association of Australia has voiced its ‘strong but qualified support’ for Denticare,⁴⁷ while the Council of the Ageing has also welcomed the proposal.⁴⁸

In contrast to the criticisms from some commentators outlined above, comments from the public appear largely positive. Postings on the yourHealth website—set up by the government to encourage public consultation over the NHHRC proposals—generally express concern about the high cost of dental care and the pressing need for a scheme like Denticare.⁴⁹

Concluding comments

The Denticare proposal involves the establishment of a new bureaucracy in Denticare Australia, to make a basic range of dental services available to all Australians. These would be provided through either private dental plans or expanded state-based public dental services, and be funded mainly by higher taxes and the redirection of existing government spending.

2007, viewed 18 November 2009,

<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjm-art%2FMNOM6%22>

47. PHAA, op. cit, p. 4.

48. Council on the Ageing (COTA), ‘National Health and Hospitals Reform Commission Interim Report COTA Over 50s response’, viewed 18 November 2009,

[http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/153-interim/\\$FILE/153%20-%20Submission%20-%20Council%20on%20the%20Ageing%20Over%2050s.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/153-interim/$FILE/153%20-%20Submission%20-%20Council%20on%20the%20Ageing%20Over%2050s.pdf)

49. The yourHealth website hosted by the Department of Health and Ageing has been established to allow members of the public to offer their views on the NHHRC proposals. As of 6 November some 35 respondents had commented on the dental proposals, viewed 6 November 2009, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/home>

Denticare is a significant dental reform proposal that has generated a mixed response. This diversity of views makes the task for government even more difficult. Critics of the Denticare proposal have tended to focus on its cost estimates, the range of basic services, equity issues, the impact on the health insurance sector and dental workforce capacity. Other issues remaining to be addressed include the type of premiums to be levied (risk adjusted or community rated), the extent to which direct purchasing of dental services would be permitted, how other reform proposals would be accommodated and data limitations. Supporters of the Denticare proposal point to the current high costs of timely dental care, making it unaffordable for many and to the long public dental waiting lists for those forced to rely on public dental services.

Navigating these diverse views and resolving some of the complex issues raised by stakeholders will ensure that the means of providing affordable dental care remains a challenge for policy makers.

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