



## Overview of Commonwealth involvement in funding dental care

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### Executive summary

- The history of Commonwealth funding of dental services is mixed, with different programs and funding approaches being favoured by governments of different political persuasions.
- Most dental care is currently funded directly by individuals rather than by governments or private health insurance.
- The Coalition has favoured state responsibility for public dental services and support for individual's purchase of dental services through private health insurance incentives and rebates; only recently introducing limited Medicare benefits for patients with chronic conditions.
- Labor has preferred funding state-based public dental services that target the financially or socially disadvantaged; although it has recently introduced means-tested Medicare benefits for a preventative health check for teens. This also favours the financially disadvantaged.
- However, dental workforce shortages and funding delays may constrict the effectiveness of the two new Commonwealth programs proposed by Labor to replace the former Coalition Government's benefits for the chronically ill.
- Meanwhile, the introduction of means-tested Medicare benefits for dental services challenges the principle of universality that has traditionally underpinned Medicare.

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## Introduction

Recent calls for increased Commonwealth funding for dental services have been made in the midst of reports of long waiting lists and emerging evidence that poorer dental health is associated with lower socioeconomic status.<sup>1</sup> Although the National Oral Health Plan calls for action on dental health from all levels of government, the issue of responsibility for funding remains contentious. In particular, the role of the Commonwealth government in dental health provision has been the subject of considerable debate.

Under Australia's health system funding for dental health services has been treated differently to other health services. Along with other allied health services, such as podiatry, they are categorised as ancillary services and consequently, most dental services have not been covered under the national health insurance scheme, Medicare. The vast majority of expenditure on dental services in Australia is therefore borne by individuals, while government funding for dental services remains low in comparison. In 2005–06 the combined expenditure of all levels of Australian Government on dental services totalled \$995 million while individuals spent \$3.5 billion on dental services, the second most costly individual health expense (behind medications).<sup>2</sup>

Meanwhile, access to affordable private dental care remains elusive for many. Private dental fees have increased at rates substantially higher than the Consumer Price Index and other health services. Between 1989–90 and 1998–99 dental service prices increased by 50.8 per cent, while the increase in health prices over the same period was only 22 per cent.<sup>3</sup>

Although Australians primarily meet the cost of their own dental health services, it is becoming increasingly accepted that there is a public benefit to be derived from some level of public funding to support them in meeting these costs. Poor dental health is associated with a range of serious health conditions such as poor nutrition, cardiovascular disease, stroke and diabetes that can place other burdens on the health system. In addition, some argue that treating the funding of basic dental services differently to other medical services is contrary to the view, expressed by the World Health Organisation, that oral health is integral to overall health and an important part of primary health care.<sup>4</sup>

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1. Australian Institute of Health and Welfare (AIHW), *Oral health status of middle-aged adults*, AIHW Dental Statistics and Research Unit, Research Report no. 31, Adelaide, February 2007.
  2. Australian Institute of Health and Welfare, *Health expenditure Australia 2005-06*, AIHW, Canberra, 2007, Table A3.
  3. Australian Health Ministers Conference, *Oral health of Australians: National planning for oral health improvement Final Report* Australian Health Ministers Advisory Council Steering Committee, Adelaide, 2001, p. 51.
  4. Senate Community Affairs References Committee, *Report on public dental services*, Senate Community Affairs References Committee, Canberra, 1998, p. 53. WHO regards oral health as

This paper outlines the Commonwealth Government's role in funding dental health services in the past and prospects for future involvement in light of recent policy announcements.

## Australia's health system

An examination of the Commonwealth's role in assisting individuals with access to dental health services requires an understanding of the Australian health system and how dental services are conceived within that system.

### Origins of the Commonwealth's health powers

Until 1946, the Commonwealth did not have the constitutional authority to provide health, pharmaceutical or dental services and benefits. Commonwealth involvement in health services was restricted to activities under the *Quarantine Act 1908* and coordinating responses to infectious diseases and epidemics. The exception to this was its responsibility for the health of war service veterans.<sup>5</sup>

A constitutional amendment in 1946 expanded the powers of the Commonwealth to allow it to legislate in a variety of areas, most particularly social security and health care. Section 51 xxiiiA of the Australian Constitution empowered the Commonwealth to legislate for:

'The provision of ... pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription)'.<sup>6</sup>

The 1946 amendment provided the Commonwealth with the powers to provide and fund a wide range of health services and benefits. However, the amendment did not alter the powers of the states in relation to health; thus creating the current situation, where two levels of government have overlapping responsibilities in this area.

Despite these new powers, Commonwealth involvement in funding health benefits beyond those provided to defence force personnel and veterans, did not progress until the election of

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"integral to general health", see, P E Petersen, [World Oral Health Report 2003](#), World Health Organisation, Geneva, 2003, p. 26.

5. Since Federation the Commonwealth has had responsibility for the provision of hospital and medical services to eligible veterans, their dependents and widows. The Department of Veterans Affairs (DVA) administers these functions. During the 1990s the DVA moved away from direct provision of these services to a purchasing role. The DVA now funds treatment by medical personnel, public and private hospitals and allied health providers. Repatriation (Veterans) hospitals were closed, integrated into the public hospital systems of each state and territory or privatised between 1992 and 1995. The Department of Defence provides for the health care of defence personnel.
6. Section 51 xxiiiA of the Australian Constitution

the Whitlam Labor Government. The Commonwealth's involvement in funding dental services began soon after.

## Government responsibilities for health and dental health

The Australian health system has evolved into a complex mix of private/public service provision and funding, involving the three tiers of government and the private sector. The system receives public funding, but the costs are also borne in part by private individuals supported via the private health insurance sector. In some instances, the roles and responsibilities of the different levels of government overlap or are shared. This diverse mix of health funding and service provision has created an environment where there are many potential opportunities for 'blame shifting'. While this most notably occurs in the area of public hospitals, it has also been a significant feature of the debate over the provision and funding of dental health services.<sup>7</sup>

Despite increased Commonwealth involvement in health since 1974, responsibility for the delivery of health services has remained primarily with the state and local governments. This includes responsibility for publicly provided services as well as regulation of those provided privately. The states have responsibility for: the management as well as the shared funding of public hospitals; the funding and management of community health services, mental health, and home and community care services, and ambulance services and for the licensing and registration of private hospitals, medical practitioners and other health professionals. Local governments have a more limited role, delivering community health services, such as immunisation and aged care, water and air pollution abatement, enforcing food standards and quality and the provision of recreational and sporting facilities.<sup>8</sup>

All Australian states and territories provide public dental services, largely through publicly employed dentists in government clinics (although some jurisdictions also contract out services to private dentists). Public dental clinics are usually located in major regional centres often associated with a public hospital and provide access to a limited range of dental treatment. Most jurisdictions have now introduced patient co-payments for these services and there is considerable variation in expenditure by the states and territories.<sup>9</sup>

The kinds of services available, the fees and subsidies that apply and the waiting times for treatment vary between the states and territories, although generally public dental services are

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7. L. Buckmaster, A. Pratt, *Not on my account! Cost-shifting in the Australian health system*, Research Note no. 6, Parliamentary Library, Canberra 2005–06,
  8. House of Representatives Standing Committee on Health and Ageing, *The Blame Game: report on the inquiry into health funding*, House of Representatives Standing Committee on Health and Ageing, Canberra, 2006, p. 11.
  9. Australian Health Minister's Conference, National Advisory Committee on Oral health, *Healthy mounts, healthy lives: Australia's National Oral Health Plan 2004–2013*, Australian Health Ministers' Conference, Adelaide, 2004, p. 9.

available to concession card holders or other financially or geographically disadvantaged people.

The Commonwealth has responsibility for the two national health schemes—Medicare and the Pharmaceutical Benefits Scheme. Medicare provides free access to public hospital treatment and Medicare rebates (or ‘benefits’) for a range of out-of-hospital medical services, such as GP and specialist services. It is founded on the principle of ‘universality’, that is, access to Medicare benefits is available to all Australians based on clinical need not income or other socio-economic attributes and is part-funded through a universal levy on income tax.<sup>10</sup> While Medicare’s coverage of medical services is broad, for example it covers some optometry services, benefits for dental services have been restricted to the specialised clinical treatment of certain dental conditions, such as treatment for cleft palate.

It is a requirement under the *Health Insurance Act 1973* that Medicare benefits are only available for ‘clinically relevant’ services.<sup>11</sup> This has been generally accepted as excluding non-clinical services such as health screening programs. However, in recent years there has been an expansion of the scope of services for which benefits are payable, so that Medicare now provides benefits for preventative health services, such as health checks for 45 year olds at risk of chronic disease.<sup>12</sup> This is in line with an increasing focus on the importance of preventative health to achieve better health outcomes and constrain future health costs.

Other Commonwealth responsibilities for health include: shared funding with the states for public hospital services; the subsidisation of private health insurance; the funding of public health programs (for example immunisation) and of programs for specific population groups; the administration of residential aged care and programs; training the health workforce; funding research and the regulation of various aspects of the health system, including the safety and quality of therapeutic goods and the private health insurance sector.

Commonwealth supported measures for dental services have included:

- some limited support through Medicare to meet specified clinical oral health needs
- subsidised drugs prescribed by dentists under the Pharmaceutical Benefits Scheme (PBS)

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10. Medicare does not guarantee universal access to general practitioners, but it does guarantee universal access to the Medicare rebate. The universal principles that underpin Medicare is discussed further in A. Elliot, [‘Is Medicare universal?’](#), Research Note no. 37, Parliamentary Library, Canberra, 2002–03.

11. *Health Insurance Act 1973* section 3: ‘clinically relevant service means a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered’.

12. Other examples include: health checks for indigenous people and health assessments for residents of aged care facilities.

- the Armed Forces and Army Reserve Dental Scheme. Under this scheme members of the Australian Defence Force (ADF) and the Army Reserve are provided with free dental services as part of their access to a range of health services. A full range of dental services are provided to ADF personnel at no charge
- Veterans' dental scheme—the Department of Veterans' Affairs provides a full range of dental services to eligible beneficiaries. Entitlements vary between White Health Care Card holders (who are eligible for treatment of war-caused conditions only) and Gold Health Care Card holders (who are entitled to treatment for all conditions)
- university training of dentists and dental auxiliaries is partly funded through the Higher Education Contribution Scheme (HECS)
- the 30 per cent private health insurance rebate which subsidises privately insured patients to access private dentistry services. Around 44.6 per cent of the Australian population has some form of health insurance, and insurers paid around \$1.2 billion in benefits for dental services in 2006–07<sup>13</sup>
- dental services provided through Community Controlled Aboriginal Medical Services
- dental services in the Christmas and Cocos Islands and
- other programs targeted to particular population groups.

Successive Labor and Coalition federal governments have had different views about the Commonwealth's role in funding dental health and this has been reflected in the different policies and programs that they have adopted. These approaches have included a direct role in the public funding of targeted dental health programmes to specific groups. Other strategies have involved a less direct role. Providing assistance within the clinical limits of Medicare and encouraging private health insurance are examples of these. The following sections outline the changes in emphasis that have occurred since 1973.

## **Australian School Dental Program**

The Commonwealth's first major involvement in the provision of dental benefits was the Australian School Dental Program introduced by the Whitlam Labor Government.

In 1973 representatives of the states, territories and the Commonwealth agreed to establish an Australian School Dental scheme to be funded by the Commonwealth. Under the scheme the Commonwealth provided the majority of funding, leadership and coordination, while the states

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13. Private Health Insurance Administration Council (PHIAC) 'Membership Statistics' Quarter ended 30 March 2008, at: <http://www.phiac.gov.au/statistics/membershipcoverage/table1.htm>, accessed on 28 July 2008; also see PHIAC, *Operations of the private health insurers annual report 2006-07*, PHIAC, Canberra, 2007, p. 64.

and territories were responsible for the implementation, delivery and administration of the dental services.

The program aimed to provide comprehensive dental treatment for all Australian school children up to the age of 15 years. Services were provided by trained dental therapists working under the direction and control of dentists. Funding of \$7.9 million was provided in the 1973 Budget, with the Commonwealth meeting 75 per cent of the capital and operating costs of the training facilities for dental therapists, 75 per cent of the capital costs and 50 per cent of the operating costs of the school dental clinics. Funding was initially through specific purpose grants to the states, but levels of funding were gradually subsumed into general purpose grants to the states by the Fraser Coalition Government in the early 1980s, effectively ending direct Commonwealth funding and responsibility for the scheme from this time.<sup>14</sup>

Most of the states and territories still maintain dedicated school dental programs although to varying degrees. For example, in NSW the former Child Oral Health program was integrated into the community dental health program in 1999.<sup>15</sup>

## Commonwealth Dental Health Program

Under the Keating Labor Government the Commonwealth returned to a more substantial role in direct funding for dental services with the introduction of the Commonwealth Dental Health Program (CDHP). The origins of the CDHP can be traced back to a National Health Strategy Background Paper in 1992, which reported on the status of dental health in Australia and recommended the establishment of a national dental program specifically directed at low income earners.<sup>16</sup>

The 1993–94 Budget provided funding for the CDHP to 1996–97, with commencement in January 1994. The stated aims for introducing the CDHP were to improve the dental health of financially disadvantaged adults, reduce barriers to dental care, ensure equitable access and improve prevention and early intervention.<sup>17</sup>

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14. Senate Community Affairs References Committee, *Report on public dental services*, op. cit., p. 48.

15. Children up to the age of 18 years are eligible for public dental services delivered through Area Health Services and dental therapists are employed to provide general treatment in designated schools. New South Wales Parliament, Standing Committee on Social Issues, [Dental services in NSW](#), [Report], Sydney, NSW, Standing Committee on Social Issues, 2006, pp. 111–112.

16. National Health Strategy, *Improving dental health in Australia* National Health Strategy Background Paper no. 9, Department of Health, Housing and Community Services, 1992.

17. D.S. Brennan, K.D. Carter, J.F. Stewart, A. J. Spencer, *Commonwealth Dental Health Program Evaluation Report 1994–1996*, AIHW, Dental Statistics and Research Unit, AIHW, Adelaide, 1997, p. 6.



The Commonwealth allocated \$278 million to the states and territories to provide dental services to 1996–97. The program was directed at adults (and their dependents aged over 18 years) covered by the various health concession cards (Pensioner Concession Card, Commonwealth Seniors Health Card, and Health Care Card) and had two components: emergency dental services (EDS) and general dental services (GDS). A separate schedule of fees for each component was established. State and territory governments were responsible for the management and operation of the scheme. Agreements with the Commonwealth specified that the states were to maintain their baseline level of recurrent funding to adult dental services under the program.<sup>18</sup>

Dental services were delivered by both public community dental clinics and private dentists. Fees paid to private dentists were based on those paid under the Department of Veterans' Affairs (DVA) scheme for veterans. Treatment was limited to the services set out in the schedules but excluded dentures, orthodontics, crowns and bridges. Annual caps—\$100 for an emergency episode and \$400 for general treatment—were introduced.<sup>19</sup>

After the election of the Howard Government in 1996, the program was terminated, from 1 January 1997. The reasons given for the early termination of the CDHP were that the target of 1.5 million services had been met and the backlog in public dental services had been reduced.<sup>20</sup> In total, \$245 million was spent and around 1.5 million services provided, with 200 000 patients accessing the program in any one year.<sup>21</sup>

With the cessation of the CDHP sole government responsibility for funding public dental services returned to the states and territories. Evidence provided to a Senate committee soon after indicated that public dental waiting lists increased dramatically following the termination of the CDHP.<sup>22</sup>

Direct Commonwealth involvement in dental health funding shrank substantially after the cessation of the CDHP with direct Commonwealth expenditure on dental services falling from a high of \$105 million in 1995–96 to \$6 million in 1998–99.<sup>23</sup> In response to calls for

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18. Senate Community Affairs References Committee, [\*Report on Public Dental Services\*](#), op. cit., p. 28.

19. G. Richardson (Minister for Health), *Commonwealth Dental Health Program Fact sheet*, press release, Parliament House, 21 December 1993.

20. *Portfolio Budget Statements 1996–97: Health and Family Services Portfolio*, p. 149. The Coalition Government argued that the program was not 'scrapped'; funding 'expired' as it had achieved its aims. See T. Worth, 'Where are the facts?' press release, 28 April 1998

21. Senate Community Affairs References Committee, op. cit., pp. 28–30.

22. *ibid*, p. 34.

23. Australian Institute of Health and Welfare, *Health expenditure Australia 2000–01*, and *Health expenditure Australia 200–02*, Canberra, AIHW, 2002 and 2003, various Appendix A tables. Excludes dental expenditure for veterans.

greater Commonwealth involvement and spending on dental services, the government argued that the provision of public dental services was primarily the responsibility of the states and territories.<sup>24</sup>

Despite the decline in direct Commonwealth assistance, as a result of the private health insurance incentives introduced by the Coalition government from July 1997, indirect Commonwealth expenditure on dental services increased. Through the Commonwealth's subsidy of private health insurance premiums, indirect expenditure on dental services increased from \$32 million in 1997–98 to \$119 million in 1998–99.<sup>25</sup> Critics argued that the net result of the health insurance rebates was that those on higher incomes using private dental insurance received a significantly greater subsidy than those on low incomes seeking public dental care through public clinics.<sup>26</sup>

## Medicare benefits for dental services

The debate over Commonwealth funding for dental services has also included calls for dental benefits to be made available through Medicare. A number of inquiries have explored extending Australia's universal health care system to include dental treatment.

Inquiries that have discussed a Medicare model of funding include the Layton inquiry into Medicare in 1986, two Senate inquiries—one on public dental services in 1998 and another on Medicare in 2003—and a House of Representatives inquiry into health funding in 2006.<sup>27</sup> Notably, none of these inquiries recommended a Medicare model for funding dental care. Much of the debate about using Medicare has focused on the potentially high cost in providing universal dental benefits; estimates have ranged from \$600 million, up to \$7.5 billion.<sup>28</sup>

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24. See for example, Michael Wooldridge, Minister for Health and Aged Care, 'Commonwealth Dental Health Program: Question on Notice', House of Representatives *Debates*, 30 August, 2000, p. 19 799.

25. AIHW, *Health expenditure Australia 2000-01* and *Health expenditure Australia 2001-02*, op. cit.

26. See Senate Select Committee on Medicare, [Medicare – health care or welfare?](#) Senate Select Committee on Medicare, Canberra, 2003, p. 127.

27. *Medicare benefits review committee: second report*, Robyn Layton (Chair), Australian Government Printing Service, Canberra 1986; Senate Community Affairs References Committee, [Report on public dental services](#), op. cit.; Senate Select Committee on Medicare, [Medicare – healthcare or welfare?](#) op. cit., House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, House of Representatives Standing Committee on Health and Ageing, Canberra, 2006.

28. *Medicare benefits review committee: second report*, op. cit. p. 374; and J. Matthews (ADA) quoted in J. Spencer's paper, [Narrowing the inequality gap in oral health and dental care in](#)

However, although universal dental benefits have been rejected, for some time Medicare has funded certain clinical dental services for specific population groups with special oral health needs. From 1981, benefits have been paid for orthodontic services for young patients with cleft lip or cleft palate conditions.<sup>29</sup> In addition, certain surgical procedures performed by dental surgeons to treat diseases of the oral cavity and jaw have been funded under Medicare since its introduction in 1984.<sup>30</sup>

## Howard Government's Allied Health and Dental Care Initiative

During the last three years of the Howard Coalition Government, Medicare benefits for certain dental services to treat patients with chronic conditions were introduced. In July 2004, as part of a suite of reforms to Medicare known as *MedicarePlus*, the government announced the introduction of limited Medicare benefits for patients whose chronic conditions (for example, diabetes), were significantly exacerbated by dental problems. This was consistent with the application of Medicare benefits based on an identified clinical need. At the time the government emphasised that the scheme was 'a health measure not a dental care scheme'.<sup>31</sup>

The dental component of the initiative known as the Allied Health and Dental Health Care Initiative (AHDCI) allowed a patient with an Enhanced Primary Care (EPC) plan on referral from a general practitioner, to access Medicare benefits for up to three dental treatments a year from a private dentist, with a maximum rebate of \$220 per year. The supply of prostheses such as dentures, bridges, crowns or implants was not covered.<sup>32</sup>

However, the initial uptake of the dental services available under the AHDCI was low. Many patients reportedly faced high out-of-pocket costs for dental services; on average an additional \$61 in out-of-pocket costs were incurred by patients per service. In some instances patients paid up to \$692 as a co-payment for a single dental service.<sup>33</sup> Over its first three years of operation, from July 2004 to June 2007, only \$1.8 million in Medicare benefits were

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[Australia](#), *Australian Health Policy Institute Commissioned Paper Series* Sydney University, 2004, p. 67.

29. Benefits were first introduced in 1981 for those aged under 22 years with these conditions. The arrangements continued following the introduction of Medicare in 1984. For more information on benefits see Medicare Australia, '[Cleft Lip and Cleft Palate Scheme](#)', accessed on 21 April 2008.

30. *Medicare benefits review committee: second report*, op. cit., p. 20.

31. T. Abbott (Minister for Health and Ageing), [MedicarePlus](#), media release, Parliament House, Canberra, 10 March 2004.

32. *ibid.*

33. For the period 2005–06. Senate Community Affairs Committee, Answers to Estimates Questions on Notice, Health and Ageing Portfolio, Supplementary Budget Estimates, 2006–07, 1 November 2006, Question no. E06-142.

paid to provide around 16 000 dental services.<sup>34</sup> This was well-short of budget estimates that around 70 000 dental care plans would be supported.<sup>35</sup>

The provisions for dental benefits were consequently expanded in the 2007–08 Budget, with additional funding of \$377.6 million over four years. Benefits for diagnostic and treatment services were added and the benefits cap was set at the higher rate of \$2000 per year. Eligibility was extended to include residents of aged care facilities who were being managed by a general practitioner. The government estimated that this expanded measure would assist 200 000 patients with chronic conditions to access Medicare funded dental care.<sup>36</sup> Further changes were introduced in August 2007; the monetary cap was increased to \$4250 over two calendar years (and included benefits paid under the Extended Medicare Safety Net) and benefits for dentures were included. These new arrangements came into effect on 1 November 2007.

These expanded arrangements resulted in a significantly higher uptake of services and payment of benefits. For the first three months of the revised scheme, some 171 000 dental services were accessed and around \$21.8 million in Medicare benefits paid. From March to June 2008 the number of services more than doubled to nearly 480 000, with benefits more than tripling to just over \$79 million.<sup>37</sup> Most services were provided in New South Wales (400 235) and Victoria (103 950); only 184 services have been provided in the Northern Territory.<sup>38</sup>

## The Rudd Government's programmes

During the 2007 election campaign Labor announced it would replace the dental component of the AHDCI with two new initiatives: a revived Commonwealth dental health program

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34. For the period July 2004 to June 2007. A. Biggs, 'Health Insurance Amendment (Medicare Dental Services) Bill 2007', Bills Digest no. 35, Parliamentary Library, Canberra, 2007–08, p. 3.

35. T. Abbott, Minister for Health and Ageing, 'Budget 2004-2005: Health 2', Budget Fact Sheet, 11 May 2004. Total funding for the entire initiative, including the allied health components was \$121.2 million over four years.

36. T. Abbott (Minister for Health and Ageing), *Improving Medicare and hearing services* media release, Parliament House, Canberra, 8 May 2007.

37. Medicare Australia, Medicare Statistics, Group N1 Dentist Services, Group N2 Dental Specialist services, Group N3, Dental prosthetics services, [https://www.medicareaustralia.gov.au/statistics/dyn\\_mbs/forms/mbsgtab4.shtml](https://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbsgtab4.shtml), accessed on 31 July 2008. The statistics do not provide details of numbers accessing these benefits, only services provided.

38. *ibid.* Age and gender profiles are also available.

targeted at low income earners and means-tested benefits for dental health checks for teenagers.<sup>39</sup>

#### New Commonwealth Dental Program

Labor promised up to \$290 million over three years to fund a dental program to assist approximately one million Australians access public dental treatment. Under the proposal funding will be redirected from the AHDCI and made available to the states and territories to assist them to clear public dental waiting list backlogs (estimated by some commentators at 500 000). Eligibility for public dental services in the states and territories is generally rationed on the basis of socio-economic status, so generally only those on low incomes can access these services. In exchange for additional funding state and territory governments will be required to adhere to new standards of dental care and reporting requirements.<sup>40</sup> However, one significant problem that may be faced in meeting these targets is the shortage in the dentistry workforce, particularly shortages in the public dental workforce. Dental health commentators have estimated that by 2010 there will be 1500 fewer oral health providers than will be needed just to maintain current levels of access.<sup>41</sup>

The new program was scheduled to commence from July 2008, with dental benefits under the current AHDCI program to cease also from that date.<sup>42</sup> Although new patients ceased to be accepted for the dental component of the AHDCI from 30 March 2008, patients who already commenced dental treatment under the AHDCI can only access benefits for services until cessation of the program. But it is not clear, however, how they will be accommodated in the new schemes if they require ongoing treatment.

Some commentators criticised the impending cancellation of dental benefits under the AHDCI, arguing that despite initial problems with uptake, the scheme is now successful and

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39. Details of the legislation are outlined in A. Biggs, 'Dental Benefits Bill 2006' Bills Digest no. 135, Parliamentary Library, Canberra, 2007–08, at: <http://www.aph.gov.au/library/pubs/bd/2007-08/08bd135.pdf>, accessed on 28 July 2008.

40. Full details are yet to emerge. See K. Rudd, 'Federal Labor clear dental health backlog by establishing a Commonwealth Dental Health program' media release, Parliament House, Canberra, 18 September 2007.

41. It is estimated that by 2010 there will be 1500 fewer oral health providers than will be needed just to maintain current levels of access. Australian Health Minister's Conference, National Advisory Committee on Oral Health, op. cit., p. v.

42. N. Roxon (Minister for Health and Ageing), *First steps in implementing new Commonwealth Dental health program*, media release, Parliament House, Canberra, 2 March 2008. See also the 'Health Insurance (Dental Services) Amendment and Repeal Determination 2008', tabled by the Minister for Health and Ageing on 13 May 2008.

should be retained.<sup>43</sup> In June 2008 the Opposition majority in the Senate blocked the cancellation of these dental benefits, by disallowing the Legislative Instrument that would have given effect to the cancellation, effectively passing the decision to cancel the program to the new Senate.<sup>44</sup> Other allied health benefits provided under the AHDCI remain unaffected.

Details of the funding and eligibility requirements for the new Commonwealth Dental Program for the states and territories have yet to be finalised; potentially further delaying timely access to affordable dental care for many people.<sup>45</sup>

#### Medicare Teen Dental Plan

During the 2007 election campaign Labor also promised to assist families meet the cost of an annual dental check-up for teenagers.

Legislation enabling the establishment of the Medicare Teen Dental Plan to give effect to this promise was passed in June 2008.<sup>46</sup> From 1 July 2008, eligible families (those families receiving Family Tax Benefit A or teenagers in receipt of ABSTUDY or Youth Allowance) will receive vouchers (with a value up to \$150 per year) to assist them in meeting the cost of an annual dental check-up for teenagers aged between 12 and 17 years.

The plan includes the establishment of a new standalone Dental Benefits Schedule (DBS) that includes means-tested, age restricted Medicare benefits for the preventative dental check for teenagers. Bulk billing of services is allowed, although it is unclear how many dentists will choose to bulk bill. The original election commitment was costed at \$510 million over three years. However, this estimate has been revised at least twice; first down to \$360 million, then to \$490.7 million over five years.<sup>47</sup>

The Teen Dental Plan marks a significant departure in the use of Medicare, not only for dental services, but for health services more generally. Previous Medicare benefits for dental services, while limited in clinical scope, were universally applied, that is they were not based

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43. See for example, H. Zoellner, Chairman of the Association for Promotion of Oral Health, reported in S. Ryan, 'Late rush for scheme belies reason for axing', *Weekend Australian*, 17 May 2008, p. 10.

44. Senate Standing Committee on Regulations and Ordinances, 'Disallowance Alert', Senate Standing Committee on Regulations and Ordinances, Canberra, 2008.

45. M. Metherell, 'Dentists warned off Medicare scheme', *Sydney Morning Herald*, 29 July 2008, p. 10.

46. For an analysis of the legislation see the Bills Digest, A. Biggs, 'Dental Benefits Bill 2006', op. cit.

47. N. Roxon (Minister for Health and Ageing), [One million Australian kids to benefit from Teen Dental Plan](#), media release, Parliament House, Canberra, 2 March 2008; and N. Roxon, 'Second Reading Speech: Dental Benefits Bill 2008', House of Representatives, *Debates*, 29 May 2008, p. 61.

on socio-economic status. This means-tested arrangement for dental benefits for teenagers represents a significant change in the application of Medicare, from universal access based on clinical need, to access that is income based. The Plan also continues the trend to expand the clinical scope of Medicare arrangements to include a preventative component. Despite the challenge that implementation of this programme represents to the universal principles underpinning the Medicare system, the issue has yet to attract significant commentary from stakeholder groups or health academics.

## Conclusion

Unlike other health services, dental health services in Australia have not been generally covered by the Medicare system that provides universal coverage for other medical services. Consequently, individual Australians usually finance their own dental health services. While it is increasingly accepted that governments have a role in supporting access to dental services, there is little consensus about how this support should be provided or the extent to which it should be provided. Australia's complex model of shared responsibility for the provision and funding of health services gives rise to debate about the responsibility that should be borne by individuals as well as by the different levels of government and by the Commonwealth government in particular.

While some Commonwealth dental programmes, such as those for veterans, have survived successive changes in government, others have not, and have been dependent on the different policy priorities of subsequent Coalition and Labor governments. Previous Labor government programs that targeted specifically disadvantaged or vulnerable groups, such as children and the financially disadvantaged—namely the School Dental Service and the Commonwealth Dental Health Program—were either absorbed into general purpose grants to the states and territories or abolished, when the Coalition came to office.

Based on the premise that the funding of public dental services was the responsibility of the state and territory governments and not a responsibility of the Commonwealth, the former Coalition government preferred less direct forms of assistance to Labor's targeted programmes. Through the private health insurance rebate it supported an expansion in private health insurance coverage to assist individuals meet the costs of their dental services. The former government did, however, expand Medicare benefits for specific clinical services for specified oral conditions which had been introduced in the 1980s, when it introduced Medicare funded dental benefits for the chronically ill.

The new Labor government's initiatives, the Teen Dental Plan and its proposed financial assistance to state-based public dental services, reintroduce targeted financial assistance for dental care for the young and for those who are socioeconomically disadvantaged. But it remains to be seen how effective this change in Commonwealth direction will be, in light of chronic dental workforce shortages and ongoing delays in implementing the financial assistance package to the states.

Perhaps more significant, but less commented on, is the potential of these initiatives to influence the nature and scope of Medicare. The use of Medicare to deliver means-tested dental health checks to teenagers represents a significant departure from a funding model that has in the past provided universal access based solely on clinical need, not socioeconomic status. This new programme effectively challenges the universal underpinnings of Medicare, while at the same time allowing for the continued expansion of Medicare benefits for preventative care.

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