

Toward more equitable access to dental services

AJ Spencer, ARCPOH, The University of Adelaide, December 2009

Australian's access to dental services is highly inequitable. The frequency of making dental visits and whether the visit is prompted by symptoms are socially patterned. But inequalities don't just exist in how people make visits, they are also extended into what services people receive at any visit. While receipt of routine fillings doesn't vary greatly by social group, preventive services are positively and extractions negatively associated with higher social position. This systematic inequality in the nature of dental services provided for similar oral disease is repeated on many occasions across the life-course, leading to strong social gradients in oral health outcomes like having an adequate dentition or acceptable self-rated oral health.

Inequality in access to dental services has been repeatedly documented over the last two decades. Early reports tended to focus more on the gap between disadvantaged adults and the rest of the population. As a consequence, policy analysis focused on targeted programs for government concession cardholders. However, more recent exploration of inequalities in access have demonstrated the gradient across the full range of social circumstance. Inequality in access to dental services extends into the middle and even upper social position in our community. This reflects a systemic problem and supports a universal rather than a targeted policy response.

Access and affordability of dental services are strongly associated. Dental services are dominated by providers raising direct out-of-pocket fees. While other factors like dental anxiety, dental health literacy and availability of dental services also shape access, affordability at the point-of-service delivery seems the primary factor driving variation in access to dental services.

Affordability can be changed by policy on the financing of dental services. This is seen in the mediating role that current private dental insurance plays in dental services in Australia. Those with private dental insurance have better access to dental services across all household income levels.

Positively re-shaping the association between affordability and access to dental services is the dental health policy challenge firmly grasped by the National Health and Hospitals Reform Commission (NHHRC) and to which its Denticare Australia proposal is addressed.

Denticare Australia is a social insurance scheme to finance dental services for all Australians. Contributions are to be raised by a flat levy against taxable income. A flat levy against taxable income would create a fairer mechanism for paying for dental services than exists at present where people on low incomes contribute twice the percentage of their taxable income to expenditure on dental services than those on high incomes. Denticare Australia would build an element of income transfer from people on high to low incomes establishing a flatter gradient of taxable income spent on dental services. The total funds available to Denticare would be transparent and the identified funding establishes a public interest and accountability in how those funds are used for the benefit of the population. The transparency and accountability that accompany an identified contributions scheme are arguments in favour of a separate financing scheme for dental services rather than extending the Medicare levy or obtaining funding out of general taxation.

The contributions from Australian taxpayers are to be used to fund a universally available benefits package. Denticare Australia places a premium on choice which it seeks to deliver by allowing people to either choose a private dental insurance plan to cover dental services from private dentists, in which case 100% of the insurance premium would be paid by Denticare Australia, or to seek dental services from public dental providers, in which case dental services would be free at the point-of-service delivery. This might seem a Clayton's choice, until the complementary policy recommendations alongside Denticare Australia are acknowledged. The dental residency and to a lesser extent the extension of pre-school and school dental services and the boost to oral health promotion recommendations of the NHHRC would contribute to a substantial re-shaping of public dental services. Extending school-aged dental services would return to

parents a real choice and the increased resources for adult public dental services would satisfy those who would prefer such services and others whom the private practice fee-for-services environment is less willing and able to serve. Despite the complementary policy, the private dental insurance aspect of Denticare Australia, hereafter called Denticare, would likely serve the vast majority of the population, especially adults. Therefore most attention has been directed to it.

Health insurers offering a dental plan under Denticare would be operating in a 'managed competition' environment. Managed competition has been advocated in Australia by Scottan as a cost containment strategy. As people can move insurers annually, health insurers are anticipated to compete in terms of the attractiveness of the benefit package they can negotiate with dental providers. The counter-argument is that health insurers will not bring about substantial variation in the benefit package, but rather compete through marketing. Together with the administrative costs of multiple, some very small and some for-profit, health insurers, the outcome may be considerably higher costs outside the rebates on dental services. Without the presence of a large government health insurer in the mix, as is the case with the Medicare Select recommendations, the private health insurers may end up in only limited competition.

Denticare seems a rational extension of the current private dental insurance arrangements. In this sense it is not radical. However, the motivation for Denticare is more likely the use of dental services as a pilot test for the managed competition approach also shaping Medicare Select. Pursuing Denticare through managed competition would represent a triumph for the ideology of the market. Given the 200 plus different dental plans currently available from just less than 40 health insurers and the inability of consumers to understand their differences, the suggestion that consumers will make informed decisions seems doubtful. It is for all of the above reasons that there is reasonable support for a single government insurer. While this has generally been captured in the notion that dental services simply be included under Medicare, transparency and accountability support a financing scheme run parallel to, even administered by Medicare Australia, but in a separate identifiable scheme.

Under Denticare health insurers would provide a service rebate to providers for all in-scope services. The service rebate is recommended at 85% of a scheduled fee. This is at odds with existing small-scale reimbursements of private dentists under schemes like that for military veterans and their dependents. These reimburse at 100% of the scheduled fee, with the fee set by an independent tribunal. It has been suggested that the discount against the scheduled fee will work against 'bulk-billing', creating a gap that potentially allows affordability to once again drive use of dental services. Alternative approaches of reimbursement at, or even with a loading above, the scheduled fee when servicing particular people (government concession cardholders) or in particular regions (dental workforce shortage areas) would provide an incentive to private dentists to compete without a gap or to respond in what would be an targeted manner. Such competition among private dentists could be encouraged by making known their pricing behaviour to consumers ahead of a dental visit. All private dentists could require a provider number with Denticare. Private dentists would declare their willingness to accept the scheduled fee with no gaps, or gaps of different magnitudes on their fees so that people can shop around on the basics of price and perceived quality.

The fundamental task of Denticare is to attract and retain people in regular use of preventively-oriented and more comprehensive dental services. Cost at the point-of-service is to be lowered so that people previously deterred by affordability make greater demands for dental services. However, out-of-pocket cost at the point-of-service will be lowered for all Australians. Demand for dental services is likely to increase from previous high users as well as low users of dental services. Controlling overall demand and creating incentives for growth in 'beneficial' new demand are key challenges. This is especially so in an environment of a constrained supply of private dentists. While Australia's recruitment of dentists and other oral health providers is increasing, growth is expected to only modestly outpace population growth through to 2020.

Overall cost control would be best achieved by limiting included dental services to those that are cost-effective in producing oral health gains. However, the evidence-base for this approach is limited. Therefore, the starting point is inevitably a mix of the philosophical and practical, leaving plenty of room for debate.

Past small schemes have included diagnostic, preventive and conservative restorative, endodontic and periodontal services, as well as many prosthodontic and dento-alveolar oral surgical endodontic services. These services constitute just under 90% of all dental services and 67% of estimated expenditure for dental services provided by private general practitioners.

These have been labeled routine dental services. Services and costs outside these are dominated by crown and bridge services and some special prosthetic services, such as lower arch metal partial dentures.

In addition to recognizing in-scope dental services there should be limits on the frequency with which particular services can be provided to people under Denticare (some of which might be age-related) and a cap or maximum annual expenditure. It is suggested the frequency should be initially focused on one 'course of care' provided a year and the cap should be set at a high percentile eg 90th of existing annual costs of dental services. These measures are to give budgeting certainty and also extend the benefit package as widely as possible so as to achieve greater equity in access to dental services.

Out-of-scope services could still be available for private purchase, possibly under private dental insurance. Those that argue that they should be included need to recognise that they will be more affordable as a result of the elimination of two-thirds of costs at the point-of-service. In addition, varying mechanisms have been mooted to cater for exceptional circumstances. These might include authorization for out-of-scope services for management of a limited number of clinical situations, eg dento-facial trauma, or for people whose financial circumstances rule out private purchases who might receive such dental services via the residency program in the public dental services.

The implementation of Denticare Australia would be a major undertaking, especially in an environment of constrained supply. This has led to suggestions of a phased implementation. Priority could be given to particular population sub-groups in the initial phase. Younger people or lower income Australians have been identified. However, any phased approach needs to have a logical way of expanding coverage over time. Early experience could also inform policy adjustments.

Restricting coverage in initial phases creates a lack of symmetry between contributions and access to the benefit package. Although it is possible to rationalize this situation, it creates a potentially unattractive political issue. An alternative is to further limit the in-scope services, frequencies and annual cap, but maintain universality from the beginning of a phase implementation. The benefit package could then be extended in phases across time.

Any phased implementation built around income could lead initially to a situation resembling the preferred option of the peak dental professional body, the Australian Dental Association. It favours a highly targeted scheme for the financially disadvantaged, ie government concession cardholders. This reflects the ADA's stance that the problem of access is limited to a quarter to a third of the adult population with the lowest incomes. Whilst there may be some initial similarity, the ADA's position is that this should be the full scope of the scheme, while a phased implementation is still consistent with the goal of universality in access to the benefit package.

Denticare is a major dental reform proposal. It gives long-term direction for addressing inequalities in Australia's dental services. It moves beyond bit measures and the blame game which have characterized much of the last decade long discussion on dental services. Its implementation needs to be matched by a substantial scaling-up in the importance and level of activity in governance of dental practice. There needs to be strong national leadership and a capacity for policy advice. Public oversight, with clear lines of accountability, professional standards and oral disease/condition management strategies need to be developed. Program evaluation must be built into Denticare Australia with appropriate information captured, analysed and interpreted against the sort of goals that it is tasked with achieving. Such evaluation must be in the public domain and linked to review and refinement of the detail within the financing scheme.

The Denticare Australia recommendation is bold enough to tackle a systemic problem in accessing dental services. It takes dental services where no previous Australian health policy has been brave enough to go. It is significant reform that would be welcomed by the community. The detail will be debated, but there should be optimism that progress can be made through negotiation and compromise within a realistic envelope of what is achievable.