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Access to oral health care – an Australian perspective*

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Abstract – The objectives of this paper are to give a brief description of the Australian context for its dental care services and to discuss some of the nationally recognized issues in access to dental care with special reference to the situation in the most populous state, New South Wales. Australia is the size of continental USA but with only around 21 million people, 85% of whom reside within 50 km of the coastline. Thus, access to health care has a strong urban–rural dimension. The universal healthcare coverage excludes dental care, 80–90% of which is delivered through traditional fee-for-service private dental care. A public dental care system exists with varying eligibility criteria from state to state, mostly directed at children, low-income individuals, pensioners, and defined disadvantaged groups. Thus, access to dental care also has a strong socioeconomic dimension with disadvantaged people having serious access problems and extensive waiting times. Government and other reports have documented considerable polarization issues both in oral health and in access to dental care. Suggested change strategies have ranged from broad political changes in the dental care system to local oral health promotion initiatives, but overall, dental care remains a pawn in state–commonwealth political squabbles. In response to strong public reactions documented shortcomings of the public dental care system the government of New South Wales has recently initiated a political inquiry into dental care. Unless new resources are injected and policy adjustments made, serious changes are unlikely.

Key words: access; Australia; children; dental care; dental care; inequality; polarization; public dental care

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Access to oral health care in Australia is intimately linked to its special geographic and demographic features. This immense country is approximately of the same size as continental USA, but has only the population of Texas, i.e. around 20 million people. Over 25% of them reside in the state of New South Wales (NSW), which includes the city of Sydney and surrounds the Australian Capital Territory and Canberra, the federal capital. The population centers are major cities along the coastline: Sydney, Melbourne, Adelaide, Perth, Darwin, Cairns, and Brisbane. Around 85% of the population resides within 50 km of the coast, leaving a very minor part of the population to the rural vicinity of the cities and the inner part of the continent.

Despite being an ancient continent, colonial and independent development is relatively recent. Aboriginal settlers arrived on the Australian continent from Southeast Asia about 40 000 years before the first Europeans began exploration in the 17th century. No formal territorial claims were made until 1770, when Capt. James Cook took possession in the name of Great Britain. Six colonies were created in the late 18th and 19th centuries; they federated and became the Commonwealth of Australia in 1901 (1). An active immigration policy has insured a constant population growth for more than 200 years. In the 2001 Census of Population and Housing, 22% of all Australian residents were born overseas, and almost half of them were born in one of four countries: UK, New Zealand, Italy, and Vietnam. At present, the Aboriginal/Torres Strait indigenous population constitutes only around 2% of the population, with Northern Territory the only state with a considerable proportion of indigenous people. Today, the Commonwealth comprises six states and two territories, one of which is the

Australian Capital Territory. The directly elected Commonwealth government, which has been in power for over 10 years, is a conservative–liberal coalition in contrast to the seven local state governments, which are all led by the Labor Party. This dichotomy has important implications for the tensions between state and federal policymaking with immense impact on the dental and other healthcare services.

The objective of this paper is to consider and discuss some of the nationally recognized issues in access to dental care within the Australian context with some special reference to the situation in the most populous state, New South Wales, because of recent developments in this state.

Dental care in the context of health care

Australians have access to universal health care coverage (Medicare), which insures access to free or low-cost medical, optometrist, and hospital care while leaving people free to choose private health services and, in special circumstances, allied health services.

Australia's public hospital system is jointly funded by the Australian Government and state and territory governments and is administered by state and territory health departments. The individual's contribution to the healthcare system is based on income and is made through taxes and the Medicare levy. In addition, the Government promotes membership of private health funds through a 30% rebate of the premium for extending individual coverage to additional health services, such as dental care and eye care.

However, Medicare itself excludes dental services. Unlike general health, dental health has generally not been seen as the province of government responsibility by politicians – neither have dentists encouraged government intervention (2). The Commonwealth government has intermittently used specific purpose grants to influence a certain development, such as to support the states' establishment of school dental services in 1973, which were transferred to state funding by 1981, and the establishment of the Commonwealth Dental Health Program for adults in 1994, which lasted <2 years. One of the purposes of this program was to address serious waiting times in the public dental sector by specific Commonwealth subventions to the states. These were to be used for providing improved dental care for the poor through public dental clinics or from private dental practitioners. A thorough analysis of the politics involved in the establishment and the abolition of this program is provided by Lewis (2). The cessation of the Commonwealth Dental Health Program in late 1996 had a major impact on all states, with waiting times for dental care increasing dramatically. In the first year following the cessation of the Commonwealth Dental Health Program, there was a 62% decrease in the number of adults treated in New South Wales. In 1995–1996 there had been 440 000 adult patients who received care; in 1997–1998, this figure fell to 172 000. In response to the withdrawal of the program, most states have introduced a variety of demand reduction or demand management techniques and all states except Queensland and New South Wales have introduced a co-payment scheme whereby patients pay their contribution toward the cost of the service (3). The different reactions in the states to this devolution and the degree to which they took up the financial challenge left behind by the Commonwealth to a large extent also reflect present-day problems in the dental care situation. Thus, there are presently considerable differences between the per capita public expenditure for dental care among states with Queensland allocating around A$35 per capita and New South Wales allocating around A$15 (2002–2003 figures). Presently, the predominant part of dental care is provided by private dental practitioners, covering around 80–90% of dental services in a traditional fee-for-service system. Whereas around 80% of the expenditure in general health care is paid by Commonwealth or state governments, 84% of expenditure to dental care is paid as individual out-of-pocket expense and private insurance (in 2002–2003, dental expenditure amounted to A$4.4 billion, 6.5% of health expenditure) (4).

State-based public dental services are provided in dental teaching hospitals, community health centres, and school-based clinics, with clinical care provided by dentists and dental therapists. Access to public dental services is defined by special eligibility criteria administered by the Commonwealth Department of Human Services agency, Centrelink. This agency delivers a range of services to the community, among them a Health Care Card, a Pensioner Concession Card, and a Commonwealth Seniors Health Card for low-income earners and pensioners, which assist cardholders with the cost of medicines and other subsidies

including health, transport, and education. These concessions may vary from state to state. In New South Wales, the eligibility criteria for public dental services are the most generous of all states. It extends to adults with health care cards, pensioner concession cards and to the Commonwealth seniors health card holders and dependents. It also covers preschool and full-time school students up to the age of 18 years. In New South Wales, approximately 50% of the population is estimated to be technically eligible for care compared with approximately 30% in Victoria or Queensland. Limited public dental care is referred to the private sector through a fee-for-service scheme (vouchers).

The strong relationship between cardholder eligibility and low socioeconomic status, plus the documented relationships between low socioeconomic status and dental diseases, imply that public dental patients are the more disadvantaged components of the population. They are likely to experience more and more severe dental disease, as well as have problems with access to dental services, than do those in higher socioeconomic groups. Indeed, such data exist in abundance from the Australian Institute of Health and Welfare Dental Statistics and Research Unit at the University of Adelaide (5).

Workforce and access to dental care

Nationally, the number of oral health practitioners (general and specialist dentists, dental therapists, dental hygienists, oral health therapists and dental prosthetists) across Australia falls short of the numbers required to meet current need. The ability of the dental workforce to meet demand for dental services in both the private and public dental sectors is also deteriorating and will seriously worsen over the next 10 years. Australia was ranked 19th in terms of practicing dentists per 100 000 population out of 29 OECD countries for which data were available (6, 7).

There is a marked variation in the supply of dentists per 100 000 population between urban and rural areas. Over 70% of practicing dentists in 1992 had their main practice located in a capital city. The supply of practicing dentists per 100 000 population was 51.0 for capital cities and 28.6 outside of capital cities (Dental Statistics Research Unit, Australian Institute of Health and Welfare, unpubl. data). The acuity of this situation has very recently been highlighted in a series of newspaper articles about the oral health situation and the workforce shortage in rural areas of New South Wales (8), among other things pointing out that Central Sydney enjoys a dentist:population ratio of 1:1000, whereas it is around 1:4000 in mid-north New South Wales and 1:9500 in the far west of the state. As an extreme illustration, around 50% of the 6 million population in New South Wales are eligible to receive oral health care through the public dental care system. However, whereas the private dental sector in New South Wales consists of 3500 dentists, 420 dental specialists, 400 prosthetists, and 60 dental hygienists, the public dental care system comprises 250 dentists, 30 specialists (most of whom are in the two teaching hospitals), and 190 dental therapists, whose work is limited to children and young adults. Indeed, of 1.7 million children eligible for public and school dental care in 2003 only 7.3% received care from the system (Center for Oral Health Strategy, New South Wales Health Department, Sydney, pers. comm.). According to the New South Wales Child Health Survey, 65% of the eligible children reportedly accessed dental services with private dental practitioners in 2001 (9).

The dental manpower supply shortage is similarly challenging in each Australian state/territory. In all states and territories, it is more keenly felt in rural/remote areas and the public sector. There is ample published evidence that the supply maldistribution is associated with reduced access to dental care, and with patterns of service provision that are less beneficial to improving oral health or quality of life, in such subgroups of the Australian population (10).

As a result, many Australians access dental care, if it is available at all, only in emergencies or when advanced oral disease is present. This leaves little opportunity for preventive care and oral health promotion, and treatment tends to focus on extraction rather than restoration of teeth (11). In 2001, the Australian Health Ministers Advisory Council (AHMAC) among other things stated that '…despite the reduction in decay experience in children and tooth loss in adults, oral diseases and disorders remain prevalent and a substantial burden on the Australian population. There is a continuing need for a robust service system that supports access across the community to basic preventive and treatment services, and specialist care for population sub-groups with particular needs.' It also pointed out that the poor health outcomes of this pattern of care are not equally distributed in the population. Poor oral health is evident in the

indigenous community, Australians on low incomes, rural and remote area dwellers and the dependent elderly. They all experience a worse oral health status than the population as a whole, or have specific oral health service needs (12).

The rural connection

Access patterns in Australia are uneven across the population. Geographic inequalities in access to dental care among residents of rural and remote areas of Australia are shown by their greater problem-oriented dental visiting pattern. Rural and remote dwellers have 15% more tooth extractions than the rest of the population when they visit a dentist for a check-up, although the extraction rates among those who usually visit for a problem were similar to that of the total population. A visit to a dentist for a problem rather than a check-up is usually an indicator of inadequate access and is associated with a lack of comprehensive dental services. As summarized by the Chief New South Wales Health Officer (13), oral health is worse in rural or remote areas. Compared with residents of urban areas, residents of rural areas have more tooth decay (children); are more likely to have no natural teeth (adults); have less frequent dental check-ups; have fewer preventive dental treatments. A dramatic example of how the oral health situation has been polarized is illustrated in Fig. 1. On the backdrop of the overall average improvement in children oral health in Australia an increasing minority does not partake in this improvement. Thus, the rates per 100 000 0- to 4-year-old and 5- to 14-year-old children who are admitted to hospital for removal and restoration of teeth (under general anesthesia) have been increasing during the last 14 years (13). Additional statistics from council areas in the North Coast region of New South Wales indicate that these rates are three to five times higher in councils without water fluoridation compared with councils that have fluoridated drinking water.

These data and trends have been amplified and supported by a range of recent conferences and publications focusing on both rural and remote oral health conditions in general and the oral health situation in indigenous population groups in particular (14–17).

Issues and challenges in dental care

The oral health report (12) gave the AHMAC the impetus to further establish a National Oral Health Advisory Committee (NOHAC), which developed Australia's National Oral Health Plan, *Healthy Mouths Healthy Lives*, a couple of years later (11). Among other things, it recognized that 'the majority of dental services in Australia are funded on a private basis with or without the assistance of private dental insurance' and 'while the Commonwealth continues to play a direct and indirect role

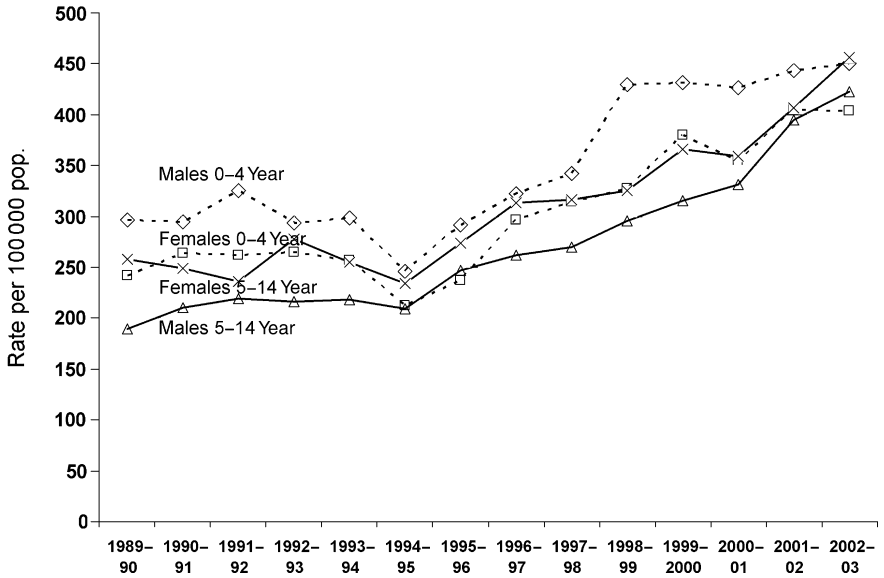

Fig. 1. Hospital separations for removal and restoration of teeth by sex, children aged 0–4 and 5–14 years, New South Wales, Australia, 1989–1990 to 2002–2003 (after 13).

in the provision and financing of dental services, responsibility for the delivery of the major public programs for children and disadvantaged adults is managed by the states and territories. Demand from concession card holders for dental care far outstrips state and territory dental services' capacity to supply treatment, and waiting lists are 5 years and more in some areas, despite significant increases in expenditure. The ability of the public and private dental sectors to provide the dental services demanded by Australians is severely threatened by a worsening national shortage of dental providers. By 2010, there will be 1500 fewer oral health providers (general and specialist dentists, dental therapists, dental hygienists, oral health therapists, prosthetists and dental assistants) than will be needed just to maintain current levels of access' (10). The oral health plan was published and distributed without any national endorsement or budgetary priorities. In spite of the principal support by the state health ministers, no commitments were made to implement any of the recommendations or change any specific policies keeping the dental care in the force field between state and commonwealth political squabbles. This is in contrast to the recent and parallel development in the USA, where the Surgeon-General's report on Oral Health (18) was supported by a nationwide range of advocacy groups, and was followed by the *National Call To Action To Promote Oral Health*. This publication was addressed to professional organizations and individuals concerned with the health of their fellow Americans. It was presented as an invitation to expand plans, activities, and programs designed to promote oral health and prevent disease, especially to reduce the health disparities that affect members of racial and ethnic groups, poor people, many who are geographically isolated, and others who are vulnerable because of special oral health care needs (19). In addition, a variety of specific purpose grants were released through several federal agencies for competitive bids by organizations and educational institutions.

In one initiative that could be seen as a supportive activity to further the oral health plan priorities, the Australian Health Policy Institute commissioned a more detailed review in 2004, focusing on some of the serious shortcomings that were pointed out in the previous reports (20). In this report, Spencer presented detailed analyses of the increasing inequalities in oral health and access to dental care in Australia that had developed over time because of some of the political developments previously described. These are shown in Table 1, which contrasts aspects of access to dental care between affluent and disadvantaged Australians. Spencer points out that 'it is clearly a chasm, one that cannot be jumped without a substantial commitment to policy change. This commitment seems lacking at all levels of government, especially at the level of the Commonwealth government.' Spencer suggested a number of policy action steps that would diminish the increasing disparities and help to improve oral health and access to dental care. These steps were proposed so as to stimulate a better balance between the prevention and the treatment of oral disease, and are relevant to all levels of government and jurisdictions. Figure 2 is a diagrammatic representation of these action steps, taking into consideration where they would most likely be activated in relation to the tripartite administrative structure that dental care is part of.

Table 1. Inequities in dental care access exemplified by differences in selected indicators between affluent Australians and disadvantaged individuals eligible for healthcare cards (16)

Access Performance Indicator	Affluent[a] (%)	Health Card Holders (%)
Perceived need for treatment	32	53
Experienced a toothache <12 m	8	27
Visited dentist 5+ years ago	5	11
Last visited for a problem	41	74
Avoided/delayed due to cost	17	41
Waited >6 m for appointment	0.4	31
Cost prevented rec. treatment	8	22
Received extractions <12 m	12	43
Received fillings <12 m	40	54

[a]Affluent individuals have been defined as those adults living in households with incomes above $40 000, covered by private dental insurance and residing in a high socioeconomic area. These adults comprised 13.1% of the adult population in 2002.

Development in New South Wales

In addition to the examples given above from New South Wales, a few concrete developments as of late should be pointed out. At the beginning of 2005, one of Australia's major newspapers, the *Sydney Morning Herald*, conducted a month-long investigation of the status of dental care in New South Wales and published a range of unflattering reports in February 2005. These reports highlighted a wide range of the issues mentioned in the

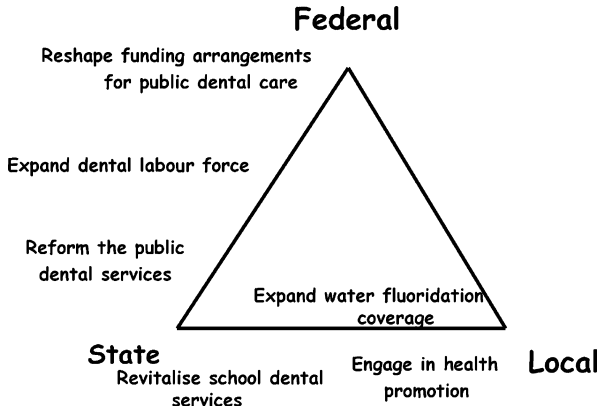

Fig. 2. Narrowing the inequality gap. Diagrammatic representation of policy directions to diminish inequalities and improve oral health and access to dental care in Australia presented in relation to administrative level of action [after Spencer (20)].

previous pages, with e.g. usual press-style dramatic examples of children in pain waiting 12 months for dental care. In response to an unusually strong reaction from the press, the public, and advocacy groups, the New South Wales Parliament initiated an inquiry into dental services with the following terms of reference (21):

1 That the Standing Committee on Social Issues inquire into and report on dental services in New South Wales, and in particular:

(a) the quality of care received in dental services,

(b) the demand for dental services including issues relating to waiting times for treatment in public services,

(c) the funding and availability of dental services, including the impact of private health insurance,

(d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,

(e) the dental services workforce including issues relating to the training of dental clinicians and specialists,

(f) preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and

(g) any other relevant matter.

2 That the committee report by March 31, 2006.

The ongoing inquiry is being documented entirely on the website referred to and thus, it is for the whole world to see both the 230 submissions sent to the Committee and the eventual outcome of this exercise. In the meantime, the Department of Health and its Centre for Oral Health Strategy has been actively preparing strategic directions and frameworks for intensifying oral health promotion and other action steps to improve the state's oral health, including intensifying the push to have water fluoridation in all council areas. The present challenge will be to inject new resources into the flagging dental care system and making necessary policy adjustments. Hopefully, by the time this paper is read, the largest state in Australia will have made serious headway towards improving access to dental care and towards improved oral health for all.

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