Policy Statement 2.5.2 – Universal Dental Schemes

Position Summary

A 'universal dental scheme' is not a practical solution to improving oral health outcomes for Australians. Government funding should target disadvantaged Australians as set out in the Australian Dental Association's Australian Dental Health Plan.

1. Background

1.1. Dental services in Australia accounted for only 5.6 percent of total health expenditure in 2016-2017 despite dental caries being Australia's most prevalent health problem. Most dental care in Australia is financed by individuals either directly or through subsidisation and is provided by private practitioners. A small percentage of services are provided by Federal, State and Territory Government sources, mainly to patients eligible for assistance both directly through public dental services and by funding private practitioners to provide services.

1.2. Several countries use "insurance" schemes to fund health care and the rebates vary. The support by dentists varies accordingly. Often these insurance schemes are required to be non-profit arrangements by legislation.

1.3. In Australia approximately one third of people have indicated they do not access oral health care in a timely manner because of cost. This is a reflection of both the price sensitivity toward oral health services and priorities given by individuals with their discretionary spending.

1.4. Internationally, comprehensive oral health care and satisfactory oral health outcomes have been difficult to achieve with universal dental schemes. In particular, the national health services in the UK and Germany have resulted in oral health outcomes worse than those of Australia. All countries, including those with universal dental schemes have a disparity in oral health with the disadvantaged having poorer oral health.

1.5. Improving oral health assists in maintaining good general health.

1.6. Governments have responsibility for overall national oral health policy (oral health promotion, research and provision of workforce), which will have a positive impact on the oral health of all Australians including disadvantaged and special needs patients.

1.7. Most oral disease can be prevented through good personal oral hygiene and diet, cessation of smoking, professional dental care and community-based preventive activities such as water fluoridation. Treatment costs are considerably higher than the costs of prevention.

1.8. The rebates and fees of Universal Dental Schemes create cost asymmetries which have an impact upon the quality and mix of services delivered.

1.9. Oral diseases are largely predictable and as such, do not have the essential characteristics of an insurable risk.

1.10. Dentists are protected from civil conscription in the Australian Constitution. Competition law also prevents the Commonwealth from directing or coercing dentists to accept set maximum fees.

1.11. The ADA has proposed a model, *Australian Dental Health Plan*, which targets disadvantaged Australians.

This Policy Statement is linked to other Policy Statement: *2.5.1 Delivery of Oral Health Care: Funding: Government, 5.1 Dentistry and Third Parties & 5.5 Funding Agencies*

Definitions

1.12. DENTAL PRACTITIONER is a person registered by the Board to provide dental care.

1.13. DISADVANTAGED is a term used to describe individuals or groups of people who have a physical or mental disability, residents of remote and very remote regions, Aboriginal and Torres Straight Islanders, those that are experiencing poverty.

1.14. SOCIAL HEALTH INSURANCE is insurance for a population against the costs of health care. It may be administered by the public sector, the private sector, or a combination of both. It is usually established by national legislation.

1.15. SPECIAL NEEDS PATIENTS are patients whose intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special oral health treatment plans.

1.16. UNIVERSAL DENTAL SCHEMES are those where provision of publicly funded dental care is available for all persons regardless of their means.

2. Position

2.1. The first priority for government dental funding must be community-based preventive activities such as water fluoridation, encouraging the cessation of smoking and oral health promotion and education.

2.2. In funding oral health care delivery, government programs should be targeted to eligible groups and individuals as per ADA Policy Statement 2.5.1Delivery of Oral Health Care: Funding: Government

2.3. Dentists must not be conscripted into a universal dental health program, nor coerced into any universal private health insurance-based scheme.

2.4. Funding of dental health care under a Social Health Insurance Scheme should be independent of dental practitioners.

2.5. Funding agencies must comply with ADA Policy Statement 5.5 ‘Funding Agencies’.

Policy Statement 2.5.2

Adopted by ADA Federal Council, April 22/23, 2010.

Amended by ADA Federal Council, April 18/19, 2013.

Amended by ADA Federal Council, November 14/15, 2013.

Amended by ADA Federal Council, November 10/11, 2016.

Editorially amended by Constitution & Policy Committee, October 5/6, 2017.

Amended by ADA Federal Council, August 21,2020