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Wait No More: The Use of Private Dental Services By Welfare Recipients In Australia

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Abstract

Dental services in Australia are available both privately and publicly. However, access to public dental services, like access to public hospital services for non-urgent treatment, is subject to a considerable waiting period. Moreover, access to public dental services is restricted to certain categories of welfare beneficiaries who qualify for a health care card. Because of the waiting time for public treatment, there is a frequent call for more public dental resources. This paper addresses the issue of what the waiting time for public dental services represents. One view largely confirmed by our research is that state governments are using the waiting time as a way of trying to push more and more people into the private sector. We find that more and more health care card holders are using the private sector for dental services.

Introduction

The evidence that those on low incomes have poorer oral health is irrefutable (Spencer, 2004). Research from the Australian Institute of Health and Welfare indicates that government health care card (HCC) holders, the so-called socioeconomically disadvantaged, are experiencing an increased incidence of dental problems such as toothache, discomfort with dental appearance, and avoidance of particular foods than before (AIHW Dental Statistics and Research Unit, 2001). Access to dental services and affordability are the major issues as the socioeconomically disadvantaged are unlikely to have dental insurance to help cover costs. Moreover, oral health is an important component of general health.

Dental services in Australia are available both privately and publicly. However, access to public dental services, like access to public hospital services for non-urgent treatment, is subject to a considerable waiting time. Moreover, access to public dental services is restricted to certain categories of

welfare beneficiaries who qualify for a HCC. Because of the waiting time for public treatment, there is a frequent call for more public dental resources.

This paper addresses the issue of what the waiting time for public dental services represents. One possibility for the low funding priority is that dental care is generally considered to not be life threatening. Another possibility is that state governments are using the waiting time as a way of trying to push more and more people into the private sector.

Dental Policy in Australia

In Australia, Medicare or a public insurance subsidy is not available for routine privately provided dental care. A visit to the dentist entails a number of choices. First, an overwhelming majority of dental care, approximately ninety percent, is provided through private clinics with or without the assistance of private health insurance (Lavelle, 2004). Private dental treatment costs on average A\$295 per hour (National Advisory Committee on Oral Health, 2004). Although some low income households do have private health insurance, most insurance policies are held by middle and high income households in Australia.

Secondly, access to public dental services is available for a small co-payment, for a limited number of services, for adults who receive welfare payments and thus hold a HCC. Co-payments range from A\$20 to A\$80 for treatment and up to A\$100 for dentures (Lavelle, 2004). Public dental services are funded by the state and territory governments. However, restrictions in funding have resulted in considerable waiting times for services. The determinants of waiting times and, specifically the role of government expenditure per capita will be discussed in the next section. The accessibility problems associated with public dental services means that many people eligible for public care will instead access private care or receive no care.

The waiting list for public dental care in Australia is affected by two major policy changes in the 1990s. The first change was the abolition of the Commonwealth Dental Health Program at the end of 1996. This program was introduced in January 1994 to provide dental treatment for adult HCC holders and their adult dependents. Prior to January 1994, public dental treatment was financed by State and Territory governments. The stated target of the Commonwealth funding was to treat 1.5m patients. By the time of its abolition at the end of 1996, the Commonwealth Dental Health Program had injected A\$245m over 3 years of extra funding into public dental services. The funding was additional as one of the conditions of the Commonwealth Dental

Health Program funding was that the State and Territory governments did not reduce their funding at the same time. There are a number of indicators that point to the success of the Commonwealth Dental Health Program. 'The Commonwealth Dental Health Program increased the number of eligible cardholders who received public funded dental care in any year, reduced their waiting time, increased their satisfaction with care and moved the provision of services in the direction of less extractions and more fillings' (Brennan, Carter, Stewart, & Spencer, 1997).

On the 1st January 1997, the State and Territory governments resumed full responsibility for adult public dental services. The stated reason for the abolition was that the waiting times for public dental services had been reduced to a satisfactory level (Lewis, 2000). However, the waiting list quickly increased after 1996. At the time of the termination of the Commonwealth Dental Health Program in December 1996, there were approximately 380,000 HCC holders on public waiting lists across Australia, representing an average waiting time of 6 months for non-emergency dental treatment. Within a year of the end of the program, there were approximately 500,000 people nationally on waiting lists, representing waiting times ranging from 8 months to 5 years (Parliament of Australia Senate, 2002). The increase in the waiting time was most likely a reflection of the decline in funding after 1996. There was clearly an increase in Commonwealth funding from 1992-93 through to 1996-97 and although the States did increase their funding contribution in the fiscal year 1996/1997, it was insufficient to compensate for the decline in Commonwealth funding. The shortfall nationally between 1996-97 and 1997-98 was approximately A\$22m (AIHW, 2004).

The second important policy change is the introduction from 1999 onwards of a series of measures to encourage higher participation in private health insurance. Three new policies designed to increase the numbers insured were introduced over a three year time period from July 1997 to July 2000. Since the policy changes, the percentage of the population with private insurance has increased markedly. For the purposes of this paper, we concentrate on ancillary insurance as it provides cover for private dental services. In the year ended June 1997, 31.6 percent of the Australian population held ancillary insurance. In the year ended June 2001, after the introduction of the policy changes, this percentage had jumped to 40.5. This is an increase of 28 percent over 4 years. In later figures, for the year ended June 2003, the percentage had increased further to 41.2 (PHIAC, 2003).

Of these measures, the most controversial was the 30 percent rebate on all private health insurance policies which was introduced in January 1999.

Through this rebate, the Commonwealth government subsidises private dental treatment through its private health insurance rebate. As the wealthier are more likely to hold private health insurance, they are also the beneficiaries of this policy. In 2001, 82.5 percent of Australian households in the highest income quintile had private health insurance compared with 29.5 percent in the lowest income quintile (Australian Bureau of Statistics, 2000). The subsidy to private dental practice in Australia associated with this rebate was approximately A\$285 million in 2001-02 (AIHW, 2004).

Factors influencing the waiting list

A waiting list is a response to a situation where demand exceeds supply. If price is below its equilibrium value, it is either because of price controls or because the service is free to consumers. The waiting list thus acts as a rationing device for HCC holders who do not pay the market clearing fee for dental services (Martin & Smith, 1999) in spite of the fact that all the States and Territories governments have introduced small co-payments,

The assessment of a waiting list for dental care crucially hinges on one's conception of dental health. In his seminal paper, Arrow argued that medical care is different to other goods and services because an individual's demand is unpredictable in terms of timing and costs and the demand intensifies when a person is ill (Arrow, 1963).

Sintonen and Linnosmaa (2000), however propose that dental care is different to medical care for a number of reasons. First, the number of dental diseases is relatively few and their occurrence is more predictable than is the case with medical care. Furthermore, individuals experience the same dental procedures several times in their lifetime and therefore can learn from the experiences about the quality and quantity of the services and the cost. Finally, most dental diseases are not contagious. Thus the externality argument often advanced with medical care in general does not apply.

Furthermore in addition to regular dental care, good oral health is a consequence of a complex interaction of biological, social, economics, cultural and environmental factors (National Advisory Committee on Oral Health, 2004). Unlike some health care individuals can put their own time into dental care and improve their dental health status. Conversely, poor oral health can be related to poor diet and nutrition, smoking and excessive alcohol consumption, lack of fluoride in the water during childhood, injury and poor oral health practices (Department of Health, 2005).

Access to dental care may be urgent where there is an accident or infection. But even in the case of an emergency, dental illness is infrequently life-threatening. In Australia, oral infection may be treated quickly either at the GPs surgery or at emergency departments of public hospitals.

What does the waiting list for public dental services reflect? On the demand side, the Australian population who has access to public dental services is restricted to HCC holders. The mix of socioeconomic characteristics in this subpopulation that impact on need for dental services include age and gender. Dental status declines with age in the same way that health status does. Against that trend, the fact that older people are more likely to have dentures, and thus require less frequent dental visits, also has to be taken into account.

Unlike the demand for some medical care, there is no obvious biological explanation of why women should seek more dental care than men. Nonetheless our earlier research indicates that women do use more dental services than men (Hopkins and Kidd, 2005) which is in accordance with the evidence that women are more likely than men to use health services generally (Roberts-Thomson & Stewart, 2003) .

Income also impacts on the demand for dental services but in a complex way. On the one hand, an increase in income may mean that a person no longer qualifies for a HCC. In that case, demand exerted by HCC holders drops, and the waiting list is reduced. Alternatively, the person may use the extra income to purchase ancillary PHI while still qualifying for HCC. . In this case, the person can either choose to continue to wait for public services or use private dental services. Finally, a person with a higher income than previously may choose to self-insure, that is pay directly for the use of private dental services.

The supply of dental services is a function of financial, incentives and physical and human resources. While available econometric evidence for Australia is lacking with regard to supply, reduced form estimates suggest that higher capacity, in terms of increased numbers of beds and doctors, is associated with lower waiting times (Hurst & Siciliani, 2003; Martin & Smith, 1999). Thus one would expect that the waiting time for dental services would decline with more public dental facilities including dental personnel.

Financial resources are generally used as a proxy for all resources. The productivity or efficiency with which these resources are used also impacts on the supply of dental services. Productivity is influenced by many things but an important issue is the type of remuneration for health specialists. For example, there is considerable evidence that different types of payments should cause different types of work patterns by professionals. Up to this point, it has been

implicitly assumed that demand and supply jointly determine waiting time and waiting lists not vice versa. However, waiting time constitutes an imperfect nonfinancial barrier against the use of dental services. The direct constraining effect on dental demand has not been studied in the case of Australia. Its indirect effect is to encourage purchase of PHI in order to avoid the waiting time for public services. In the case of medical services, this response has been examined using NHS public hospital data where it was found that people are more likely to purchase PHI when the waiting list increases (Besley, Hall, & Preston, 1999).

Waiting time is also likely to have an impact on the supply side. On the one hand, it is conceivable that professional ethics induce practitioners to work longer hours in an attempt to relieve their patients from suffering. On the other hand, there is again an indirect effect as political decision makers are likely to devote more resources to a service characterised by a lengthy waiting time. This tendency for 'money to follow the queue' certainly appears to hold in the case of hospital services (Hurst & Siciliani, 2003). It seems unlikely however, that dental services would have the same electoral appeal.

The determinants of waiting

In this section we examine the factors on both the demand and the supply side that are hypothesised to influence the waiting list for public dental services in Australia.

Table 1 presents evidence on the time dimension of waiting from the five largest Australian States [New South Wales (NSW), Victoria (Vic), Queensland (Qld), South Australia (SA) and Western Australia (WA)]. The data were collected by the various State departments of health using their own criteria, and thus creating the risk of inconsistency. Since public dental services in Australia are a State rather than Federal responsibility, there is no national data on waiting times for public dental services.

The data presented in Table 1 roughly aligns with the National Health Surveys (NHS) of 1995/96 and 2001 (Australian Bureau of Statistics, 1995, 2001). The NHS are used for further data analysis below. The two time periods neatly straddle the policy changes. Thus, 1995/96 is around the time that the Commonwealth Dental Health Program was abolished but before the increase in the proportion of the population with PHI. As mentioned earlier, 31.6 percent of the population had PHI in June 1997. By June 2001, this had jumped to 40.5.

Table 1: Waiting time per Australian State, 1995/96 and 2001/02

	1995/96	2001/02
	Waiting time¹	Waiting time²
NSW	58 months	54 months
Vic	16 months	22 months
Qld	10 months	17 months
SA	22 months	43 months
WA	8 months	10 months

1. Waiting lists and times for public dental care source report to Ministers for Health 2000 data for mid 1996 and 2000

2. Waiting list for public dental care ('Healthy mouths, healthy lives') June 2002

Source: National Advisory Committee on Oral Health 'Health Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013, July 2004, Australian Health Ministers' Conference

There is clearly a considerable wait for public dental services in some States with NSW exhibiting maximum values of 58 and 54 months respectively. In all States except NSW, the waiting time increased between 1995/96 and 2001/02 and even doubled from 22 to 43 months in SA.

Following the hypothesis laid out above, public expenditure on dental care is a crucial determinant of supply and hence should be inversely related to the average waiting time. In Table 1, Vic and Qld consistently are among the States with comparatively short waiting periods. In the case of Qld, the likely explanation is its dental expenditure of A\$27 per capita average over 1995 to 2003 (Table 2). The situation in Vic presents somewhat of a puzzle; its waiting being not much higher than in Qld (22 months compared to 17 months in 2001/2) although the per capita dental expenditure is a mere one-half of that pertaining to Qld. On the other hand, NSW expenditure figures are the lowest and it does have the longest waiting time for HCC holders.

**Table 2: Public dental expenditure per capita, 1995-2003
(average annual)**

	Dental expenditure per capita, A\$
NSW	10.82
Vic	13.48
Qld	27.03
SA	18.50
WA	19.34

Source: Australian Health Expenditure (AIHW, 2004)

At this point, an attempt is made at refining the analysis with regard to the demand side by first distinguishing HCC holders from the rest of the population and then differentiating between HCC holders with and without PHI. The data in Tables 3 and 4 (covering the years 1995 and 2001 respectively) have been extracted from the NHS. The 1995 survey consists of 53,828 unit records of individuals who form 23,800 households. The 2001 survey comprises observations on 26,900 individuals. The figures discussed here relate to aged 18 and over.

Table 3: Time since last dental visit, age, gender and income by insurance and health care card status, 1995

	(1) All sample aged 18 & over	(2) All HCC holders	(3) HCC holders without PHI	(4) HCC holders with PHI
Australia				
No.	35101	11051	4270	968
Female (percent)	51.8	60.4	58.4	65.4
Age (mean)	40.75	50.26	48.14	52.69
Annual income (mean A\$)	18416	7435	7047	8676
Months since last dental visit (mean)	9.20	10.50	11.11	7.942
NSW				
No.	5413	1688	700	127
Female (percent)	52.4	58.0	58.8	61.9
Age (mean)	42.15	53.05	51.15	57.94
Annual income (mean A\$)	18824	7297	7089	8095
Months since last dental visit (mean)	8.87	10.12	10.63	6.60
Victoria				
No.	9001	2894	1065	198
Female (percent)	52.4	61.4	57.5	69.2
Age (mean)	41.13	50.45	47.5	52.05
Annual income (mean A\$)	17603	7123	7000	8081
Months since last dental visit (mean)	9.40	11.0	11.65	9.09
Queensland				
No.	4329	1472	551	87
Female (percent)	51.7	60.7	60.4	65.5
Age (mean)	41.0	51.0	49.58	54.37
Annual income (mean A\$)	16967	7160	7078	5977
Months since last dental visit (mean)	9.44	10.77	11.50	6.69
South Australia				
No.	5949	2201	845	241
Female (percent)	51.6	59.9	58.5	64.7
Age (mean)	42.3	52.0	49.15	55.10
Annual income (mean A\$)	15922	6774	6550	7241
Months since last dental visit (mean)	8.87	9.84	10.62	7.92
Western Australia				
No.	3379	1046	400	139
Female (percent)	51.6	60.8	57.0	65.5
Age (mean)	40.4	50.3	48.45	54.88
Annual income (mean A\$)	18096	7892	7675	9281
Months since last dental visit (mean)	9.46	10.43	10.70	8.42

Source: ABS NHS 1995

First, comparing the full sample with the sample of HCC holders shows the latter are older by approximately 10 years, more likely to be female and to have considerably lower incomes. In 1995, the income of HCC holders is A\$7,400 compared with A\$18,000 for all adults. The relative gap is the same magnitude in 2001. The indicator of dental care consumed is the mean time elapsed since the last dental visit. The theoretical considerations expanded above result in ambiguous predictions. While HCC holders have lower incomes, their demand for dental care is boosted by their higher age, and most importantly, the reduced unit price of care they face. A comparison of columns 1 and 2 of Tables 3 and 4 suggests that the income (and age) effect prevails over the price effect, in that the time elapsed since the last dental contact is consistently higher for HCC holders than the general population. For example in 2001, the last dental visit was 10.2 months ago among HCC holders but only 9.01 months ago in the general adult population of Australia. The question now arises of whether income or insurance coverage is the decisive determinant of demand for dental care. Income and PHI are strongly correlated. In order to keep income constant (roughly), the comparison between those with and without PHI is limited to HCC holders (see columns 3 and 4 of Tables 3 and 4). The data show that the time elapsed is consistently lower among HCC holders who have PHI coverage, pointing to more frequent utilisation of dental care. In 1995, the value for those with PHI was 7.94 for Australia as a whole, compared to 11.11 months among HCC holders without PHI. Note that these 7.94 months even compare favourably with the 9.20 months characterising the adult population overall. Interestingly, the differential increased between 1995 and 2001, again consistently in all states. Among HCC holders with PHI coverage, the time since last dental visit dropped from 7.94 to 6.75 months, while it increased slightly from 11.11 to 11.19 in the general population. While several factors may be responsible for this divergent development over time, it cannot be public care of the poor, since the cuts at the Federal level were not counterbalanced by extra funds at the state level. Therefore, the decisive determinant may again be insurance coverage. In 1995, only 8.8 percent of HCC holders had PHI. This percentage had jumped to 20.9 percent by 2001 (Table 5). This sizeable increase in the proportion of the HCC holders with PHI occurred in all states; therefore it likely constitutes a response to the government policy changes including a 30 percent premium subsidy.

Table 4: Time since last dental visit, age, gender and income by insurance and health care card status, 2001

	(1) All sample aged 18 & over	(2) All HCC holders	(3) HCC holders without PHI	(4) HCC holders with PHI
Australia				
No.	16646	6510	5147	1363
Female (percent)	54.09	61.83	61.61	62.66
Age (mean)	46.40	55.3	54.27	59.07
Annual income (mean A\$)	20915	10863	10403	12601
Months since last dental visit (mean)	9.01	10.2	11.19	6.75
NSW				
No.	3417	1397	1149	248
Female (percent)	55.87	60.92	60.84	61.29
Age (mean)	46.82	57.34	56.79	59.85
Annual income (mean A\$)	20117	10426	10286	11868
Months since last dental visit (mean)	9.08	10.05	10.88	6.22
Victoria				
No.	3207	1287	1092	195
Female (percent)	58.59	63.56	62.64	68.72
Age (mean)	46.29	56.11	55.51	59.43
Annual income (mean A\$)	19408	10218	10133	12933
Months since last dental visit (mean)	9.24	10.78	11.53	6.55
Queensland				
No.	2806	1249	1016	233
Female (percent)	55.42	62.45	62.7	61.37
Age (mean)	46.02	53.81	52.60	59.09
Annual income (mean A\$)	19286	10767	10392	12453
Months since last dental visit (mean)	9.33	10.04	10.8	6.72
South Australia				
No.	1849	896	666	230
Female (percent)	54.14	62.61	61.11	66.96
Age (mean)	47.58	55.22	53.66	59.74
Annual income (mean A\$)	19532	10945	10603	11938
Months since last dental visit (mean)	8.82	9.80	11.01	6.31
Western Australia				
No.	1906	759	517	242
Female (percent)	55.5	59.68	58.61	61.98
Age (mean)	45.27	54.23	52.08	58.81
Annual income (mean A\$)	19512	10982	10812	11345
Months since last dental visit (mean)	8.81	9.78	10.97	7.24

Source: ABS NHS 2001

The fact that a rather high percentage of HCC holders have PHI in 2001 reflects, amongst other things, their heterogeneity. They range from people who are young and welfare dependent to those who are old and low income but asset rich. HCC holders in the NHS also includes Veterans who have more immediate access to dental care (Spencer, 2004). These two observations serve to confirm the assertion stated in a earlier paper that letting HCC holders benefit from public dental services fails to achieve much redistribution in favour of the indigent (Hopkins & Kidd, 2005). It would be more effective to target directly lower socioeconomic groups regardless of HCC status.

What we cannot tell from the data in Tables 3 and 4 is whether HCC holders obtain dental care publicly or privately. Spencer (2004) notes that approximately one third of the adult population is eligible for public dental care, yet only 30 percent of those eligible actually obtain care publicly. Finally, we hypothesised that longer waiting may encourage people into PHI and thus into the private sector. On the basis of the long waiting times for public dental services in NSW (Table 1), one would anticipate that in that state, more HCC holders would hold PHI than elsewhere in Australia. According to Table 5, however, proportion of HCC holders with PHI in NSW is smaller than the national average. The fact that NSW, while having a share of HCC holders of about 40 percent (which is close to the average) has so few with PHI indicates that few HCC holders are able to leave the queue thanks to PHI, causing waiting times to be high. In accordance with this interpretation of the causal link, WA with its highest share of HCC holders having PHI also exhibits the shortest waiting time (see Tables 1 and 5). However only a fully specified econometric model and much better data could possibly solve the identification problem plaguing this discussion.

Table 5: HCC holders with PHI, 1995 and 2001 (percent)

	1995	2001
Australia	8.8	20.9
NSW	7.5	17.8
Vic	6.8	15.2
Qld	5.9	18.7
SA	10.9	25.7
WA	13.3	31.9

Source: ABS NHS 1995 & 2001

Queensland for example has always had a strong public sector in health care provision and this is reflected in a high per capita public outlay on dental care and a lower proportion of PHI in that state (Tables 2 and 5). On the other hand, the notion that more PHI might help reduce the waiting time is challenged by the noting that the waiting time for public dental services in all States apart from NSW (Table 2) has increased over the same period when the proportion of HCC holders with PHI has increased quite dramatically.

Policy implications

The issue of whether public dental services are funded appropriately or not and thus whether the waiting time for treatment is too long is a complex one.

The issue of the debate is not effectiveness (that is whether public expenditure results in good oral health in spite of waiting for public dental services); it is also about distribution (that is whether public expenditure is sufficient to ensure that the poor have access to dental care). In fact, surveys of the dental health of the aged and HCC holders consistently reveal higher rates of lost teeth and edentulism (Spencer, 2004).

Focusing on the distributional issue is complicated by the fact that some HCC holders have private health insurance (PHI) which frequently enables them to avoid waiting for public services. Their share increased from 6.7 percent in 1995 to 19.6 percent in 2001. As more HCC holders are bypassing the public dental queue by purchasing and accessing private services, they may free up the limited public services for those HCC holders without PHI.

In public dental services, the Australian government thus may have achieved what it tried but failed to achieve in the case of public hospital services. The objective of inducing people to purchase PHI using various policy changes in the period 1999 to 2001 was to enable more citizens to use private hospital services and to thereby reduce the public hospital queue. Most of the available evidence seems to suggest that the objective has not been met (Hopkins & Zweifel, 2006). By way of contrast, the present study finds that time since the last dental visit has decreased among HCC holders with PHI coverage (column 4 of Tables 3 and 4) between 1995 and 2001. This achievement is the more remarkable as the Federal government had cut its spending with the State governments failing to fill the gap. As with many other areas of health and welfare expenditure and service provision in Australia, there is a distributional issue too. It concerns two levels of government, Federal and State, who debate

the responsibility for the service rather than the appropriate level of funding and the funding priorities.

The fact that a group of people, while deemed to qualify for access to public dental services, have such poor access that they feel compelled to purchase PHI for improved access is idiosyncratic. One way to see this is as an unintended lack of precision in the targeting of public dental services, caused by the fact that HCC holding is an imperfect indicator of low income. The other amounts to the ongoing suspicion about the public commitment to oral health of genuinely disadvantaged groups of people.

However, it is worthy of note that the Federal Labor Government elected in 2007 recently announced the first installment of its new dental plan under which it will contribute \$290 million in a Commonwealth Dental Health Program with the aim of providing additional care and reducing public dental waiting lists (Roxon, 2008). Ongoing monitoring of the new program will be necessary to ensure that stated targets are met.

Conclusions

The issues of who gets dental care, who gets access to public dental services and how quickly are critical ones. They bring into focus some broader questions concerning the Australian health and welfare system, viz. the allocation of health care cards (HCC) that grant treatment at low or no charge and the role of the government in the division of health services between the public and private sectors. Whilst the government would in all probability argue that it has no role in private dental services, it does subsidise private practice through its 30 percent rebate on the premiums PHI policies.

There is an ongoing discussion amongst members of the Australian dental profession about the best way to induce more dentists into the public sector, noting financial incentives for practice are not as attractive as in the private sector. Supplier incentives in dental care are a highly contentious issue in many OECD countries. For example, in the UK there has been some discussion of shifting from a curative to preventive model requiring a change in provider payments from fee-for-service to capitation (Robinson, Patel, & Pennycate, 2004).

In most OECD countries, government policy with regard to dental services tends to be piecemeal, reflecting the fact that poor dental health is rarely life threatening. This is in spite of Australian and international evidence

suggesting that widespread incidence of poor dental health imposes considerable costs on individuals by restricting their normal functioning.

Moreover, neglect of teeth now creates a need for more expensive care later and oral diseases are the fourth most expensive diseases to treat (Petersen, Bourgeois, Ogawa, Estupian-Day, & Ndiaye, 2005). Thus, timely access to dental care is important but we find that not all Australians have it.

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