

Co-Payments for Public Oral Health Care Issues Paper



March 2006

Council of Social Service of NSW (NCOSS), 66 Albion Street, Surry Hills, 2010
Ph: 02 9211 2599, Fax: 9281 1968, email: samantha@ncoss.org.au

About NCOSS

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation and is the peak body for the non-government human services sector in NSW. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales.

It was established in 1935 and is part of a national network of Councils of Social Service, which operate in each State and Territory and at Commonwealth level.

NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

Member organisations are diverse; including unfunded self-help groups, children's services, youth services emergency relief agencies, chronic illness and community care organisations, family support agencies, housing and homeless services, mental health, alcohol and other drug organisations, local indigenous community organisations, church groups, and a range of population-specific consumer advocacy agencies

Introduction

It has been suggested that co-payments made by patients for public dental services might provide much needed additional resources for the public dental system. A precedent has been established for this in other States, however research from Victoria and Tasmania, as examples of this model, show that co-payments have a detrimental impact on people's access to oral health care.

Introducing co-payments without a corresponding increase in funding to public dental services would appear to be an effort by NSW Health/Government to shift costs onto those that are least able to afford it. NSW, in comparison to all other States and Territories, spends the least amount per capita on public dental services. It is less than half that spent by Queensland and the Northern Territory.

It has been argued that if people have a financial investment in their treatment, they will develop a stronger commitment to preventing further dental disease by improving their oral hygiene. This presumes that the person is able to afford to purchase items to care for their teeth and purchase healthy food. It also ignores the place of preventative dental care, provided by an oral health practitioner. It must also be noted that patient adherence to preventive measures appears largely independent of the money spent by patients. This is particularly evident in private dental practice, where patients often fail to respond to preventive dental educational advice despite bearing the full cost of treatment and being able to afford to care for their teeth.

The principles and practice of treating dental disease are in every respect identical to those for treatment of other parts of the body. It cannot be accepted that public patients with infection, trauma, deformity or other disorders of the mouth should be uniquely financially disadvantaged in comparison to patients with disorders of other body parts. This is particularly so for patients with complex medical problems and other special needs who require regular and high quality dental services.

Principles of social equity must be considered with regard to co-payments especially for the most socio-economically disadvantaged who are seeking dental services in the public system. Although a \$25 co-payment per service may at first glance not seem substantial, for many of those seeking public dental services this may constitute a large portion of their available funds. It seems likely, that one effect of the introduction of co-payments would be that the most disadvantaged will avoid treatment, and instead the slightly better off will become the principal users of public dental services.

Experience elsewhere show that co-payments reduce the up-take of services by patients on waiting lists. This is accompanied by increased dental disease due to a reduction in prevention and maintenance. Co-payments thus appear to represent a false economy, with the advantage of increased income and reduced initial costs being later overwhelmed by the disadvantage of higher emergency and management expenses.

Victoria

In Victoria co-payments apply to all adult concession cardholders and their adult dependents. Co-payments range from 9 – 25% of the scheduled fee.

However they do not apply to general and emergency care provided to people under the age of 18 who are either concession card holders or dependents of concession card holders. Co-payments apply to care provided to undergraduate students in any community clinic. People with special needs, intellectual disability or a mental illness are also exempt.

In an article in Health Issues (No.61, 1999) Martin Dooland comments on the impact of co-payments on people accessing the Victorian School Dental Service and Community Dental Program for low-income adults.

Co-payments were introduced in Victoria in March 1997 for the School Dental Service; however treatment remained free for children of concession cardholders. A course of care cost \$25 (to a maximum of \$100 per year), which applied to all children whose parents did not have a concession card. This covered a check up and general dental care. The proportion of children receiving dental care through the School Dental Service decreased from 67% in 1996 to 49% in 1997 and the overall participation rate fell from 66% to 37% during the same time.

Participation, amongst people with a concession card, dropped from 83% to 66%. Dooland commented that some of this was due to people's confusion about the co-payment scheme and the belief that they would have to pay the full amount. Further education of parents about co-payments within the school dental service was carried out resulting in a slight increase in the number of children participating in the scheme from 37% in 1997 to 49% in 1999. Dooland also noted that there was a 17% increase in the rate of fillings, reflecting an increase in the number of children from disadvantaged backgrounds participating in the scheme.

It could be inferred from this that there was a corresponding decrease in participation from those without concession cards resulting in a detrimental impact on the oral health of children from families classified as the 'working poor' who are ineligible for concession cards.

The article continues with a consideration of the impact of co-payments on the Community Dental Program. Co-payments ranged from \$20 for emergency treatment, between \$20 - \$80 for non-emergency restorative care (based on the amount of treatment needed) and \$200 for a full set of dentures (this is approximately 20% of the dental fee schedule of the Department of Veteran Affairs). It was noted that co-payments did not reduce the demand for emergency care but, *"this result is not surprising as people in pain only have the option of full private fees or the public sector's highly subsidised fee"* (Dooland, 1999:13).

However fewer concession cardholders who were on waiting lists accepted an offer of treatment when they got to the top of the list. In 1996 60% of those offered treatment accepted it compared to 38% in 1997. By 1999 those that did accept required significantly more treatment and had more teeth extracted than had previously been the case. Dooland comments the *"more likely interpretation is that co-payments are acting as a disincentive to attend for a dental check up and can be expected to lead to higher extraction rates in the future."* This happened in the UK when user charges were introduced. This trend would not align with the desire to reduce costs through better preventative care.

Tasmania

In Tasmania there is a minimum co-payment of \$25 for a course of care, including a course of emergency treatment, which is based on 25% of the Department of Veteran Affairs dental fee schedule. Children aged 0 – 18 receive free dental examinations however treatment following the examination is:

- Free if the child is covered by a health care card; is eligible under the Department of Education Assistance Scheme; attending Kindergarten or is under 5 years of age.
- Requires a \$50 co-payment for all other children for general dental treatment for a month

However all children receiving treatment that is outside the general treatment guidelines, including orthodontic extractions incur a co-payment.

According to Anglicare's Tasmanian Community Survey 2005 more than a quarter of low income Tasmanians have not visited a dentist in the past five years, citing costs as the major reason for this. Further in a Discussion Paper by Prue Cameron (2001: 10) it states, *"Anglicare researchers have found that participants in the focus group discussions and client case studies identify cost as a major barrier. Departmental policy on dental co-payments does acknowledge the financial impost of treatment by capping fees for a course of treatment at \$100. However they continue to maintain an upfront fee of \$20 per visit. As indicated in previous sections of this submission, the extremely low income of concession cardholders means that the \$20 fee for a dental visit is often beyond their capacity. In a situation where the limited budget has to be so tightly managed, even urgent dental treatment cannot be considered a high priority. As one focus group participant stated: "When you are living on the breadline the only thing you can cut back on is the food. I couldn't afford to go to the dentist."*

Dental Health Needs of the Socio-Economically Disadvantaged

National research demonstrates that the oral health problems experienced by people living on low incomes are worsening. In an analysis of the National Dental Telephone Survey data, the Australian Institute of Health and Welfare Dental Statistics and Research Unit argue that the gap between the 'deprived' and the 'privileged' in Australia in oral health outcomes and the use of dental services is growing. The DSRU found that people who are uninsured and living on a low income have:

- Higher rates of complete tooth loss
- Problem oriented dental visiting
- Higher rates of extractions and lower rates of fillings
- Longer periods since the last visit
- Greater likelihood of avoiding or delaying care due to cost; and
- More self-reported treatment needs (AIHW DSRU, 2001b).

The Impact of Poverty

According to the Community Affairs Reference Committee Report "A Hand Up, Not a Hand Out" (2004) between 2000 and 2001 20% of the population in the 2nd and 3rd income deciles received 10.5% of household income, with only minor increases experienced since 1995-96. The income shares of this group "*declined from 10.8% to 10.5% of income over the period 1994-95 to 2000-01, whereas the income share of the high income group increased from 37.8% to 38.5% over the same period.*" (2004:49)

Since 1995-96 critical expenditure on a range of necessities has been increasing at a faster rate than the level of inflation. For example since 1989-90 education costs have increased by 173%, health by 98%, hospital and medical care by 137%, dental by 113.5% and urban transport by 134%. Low income households "*devoted proportionally more of their total budget to the necessities of life than high income households. More than half of the weekly budget of low income households is devoted to three spending categories – food, housing and transport.*" (2004:27) However low income sole parents and singles under 30 spend almost half their weekly budget on food and housing alone.

The Social Policy Research Centre developed a series of 'low cost budgets' for various classifications of people on either pensions or an unemployment allowance. This was based on the assessment of the minimum cost of essential budget items people needed. The following table shows that pension and unemployment benefits fall well short of the cost of living for these groups as, on average, the payments only just cover 75% of the budget.

	Low Cost Budget	Pension	Unemployment Allowance
Single adult	\$341	\$256	\$230
Couple, no kids	\$443	\$395	\$376
Sole parent, 2 kids	\$564	\$428	\$428
Couple, 2 kids	\$698	\$531	\$512

The Report (41:2004) also lists the groups that are at a high risk of poverty:

- Aboriginal people
- People who are unemployed
- People dependent on government cash benefits
- Sole parent families and their children
- People earning low wages
- People with disabilities or those experiencing a long term illness
- Aged people, especially those renting privately
- Young people, especially in low income households
- Single people on low incomes
- People who are homeless
- Migrants and refugees

The working poor are also addressed in the Report noting that since the 1990s being employed is no longer a guarantee of avoiding poverty. ACOSS states that 365,000 Australians live in working poor households – those with incomes below the poverty line. A Smith family study “*found that one in five poor Australians live in a family where wages and salaries are the main source of income*” (2004:74) Female workers and workers aged under 30 are the most highly represented in this group. Evidence from low paid workers shows that finances are always tight, expenditure is overwhelmingly on necessities and there is a requirement to carry a level of debt to make ends meet as well as going without “*things and activities associated with full and active participation in society.*” (2004:61) An ACTU study backs this showing that more than 75% of households in the lowest income quintile are either only just breaking even in terms of income and expenditure or are spending in excess of their income.

There are broader concerns related to the impact of co-payments. While the economic argument suggests that co-payments are generally desirable to help ensure efficient resource allocation, McAuley (1996:11) highlights problems with this way of thinking, “*the economists view ... ignores the unequal distribution of consumer resources (wealth and income) and ... the unequal distribution of health care needs.*”¹ Hill (1999:117) also notes that the two key equity considerations in relation to co-payments are that firstly, co-payments “*may deter people from seeking health care that they need*”, and secondly, that “*if health care bills become too burdensome, people’s standard of living will be adversely affected.*”

A submission by Anglicare to the Tasmanian Government State Budget Consultative Process 2006 – 07 supports these findings stating “*The imposition of fees has a similar effect to the waiting list in stopping access to the dental service. In many cases it results in low income earners using dental services only for emergency treatment, rather than for preventative or restorative procedures. Research has found that one of the negative outcomes of this fee schedule or co-payment policy is the net increase in the total cost of dental care by increasing the number of more expensive emergency treatments (Ziguras and Moore, 2001). Again, the suggested explanation for the increase in surgical procedures is the declining access to general dental care and an escalation of oral health problems to the point where a surgical procedure was required (Cameron, 2002).*”

¹ Carolyn Atkins, VCOSS (2003)

Conclusion

It is often argued that introducing a co-payment reduces unnecessary use of services which were previously provided free of charge. There is, however, no evidence that consumers of free care are using dental services which they do not need. On the contrary, the extremely long wait times mean that people often have advanced dental disease before they receive services.

It is also argued that if the income from co-payments is retained in dental services, these funds could increase the number of people who receive dental services. At best, a 20% co-payment would increase services in NSW from 50% of that provided during the life of the CDHP, to 60%. This assumes that these funds are retained in dental services rather than consolidated revenue, and it ignores the transaction costs of introducing a fee for previously fee-free services. This increase in service provision is insufficient to stop the escalation in waiting lists and waiting times.

Co-payments have been observed to result in extractions rather than restorative work as people avoid early treatment because of the cost. There is evidence that while many low income parents may go without to find money for their children's dental care, they often do not have funds for their own care and therefore receive no dental care. Where States provide services with discretion to waive fees or to accept payment over time, there is evidence that consumers are not informed of this.

This is a disturbing picture of increasing inequity, and NCOSS does not consider that the small gains in service provision outweigh these disadvantages.

It must be noted that the introduction of co-payments would be in direct contradiction to the NSW Health Equity Statement "In All Fairness – increasing equity in health across NSW." Charging a co-payment to the most disadvantaged in NSW is not an equity measure.

A recent media release from the National Rural Health Alliance (*60 per cent more adults in remote areas missing out on food than four years ago*, 16 March 06) shows that for people living in rural and remote NSW the imposition of a co-payment could have an even more detrimental impact. The media release stated that 18,000 adults in remote and very remote Australia reported running out of food at some time because of a lack of money in the twelve months 2004-05. As a "*proportion of people in remote areas, this was sixty per cent more than in 2001 ... The National Health Survey shows that 759,000 people over 18 ran out of food and could not afford to buy more at some time in the last financial year.*" It is therefore highly unlikely that in these areas, for the most disadvantaged, that oral health will be high on the list of items to spend money on.

Therefore there is a strong argument that co-payments will result in families avoiding or delaying oral health care due to the competing demands of being able to afford an a basic standard of living and pay for essentials such as food. In a Brotherhood of St Laurence report it states that low income people "*... did not dismiss the importance of their own dental health but when it came to competing choices they always placed their own needs last. This is hardly surprising when, as Sarah said, \$20 means bread and milk for two or three days*" (1998:4). Internationally, health economists are now "*recommending the lowering of co-*

payments and user fees as one of three major strategies to improve access to dental care. The other two are increasing the public supply of dental care accompanied by an efficient recall system (see for example Nguyen & Hakkinen, 2005)."

The imposition of fees in many cases results in low income earners accessing dental services only for emergency treatment, rather than for prevention or restoration. One of the negative outcomes of this co-payment policy is the resulting increase in the total cost of public dental care by increasing the number of more expensive emergency treatments that people require.

Recommendations

1. NCOSS strongly recommends against the introduction of co-payments in NSW.
2. That if any consideration is given in the future to the introduction of co-payments that NSW Health will then allocate funding for independent qualitative research, to be conducted in collaboration with the Centre for Oral Health Strategy.

This aim of the research will be to identify the impact of co-payments on people eligible for public dental services. This would cover the financial and social implications for the individual (with a strong focus on equity issues) and the financial implications for NSW Health, including the costs of administering such a strategy and the potential increases in more expensive emergency treatments. The research is to be overseen by a reference group including consumers.

This information is to be reported on publicly and discussions with consumers and consumer representative organisations are to take place prior to any further consideration being given to the introduction of co-payments.

3. That NSW Health develop other models of delivering public dental services, taking into consideration best practice models from internationally, that do not involve additional costs to those that already cannot afford dental care.

References

Anglicare Tasmania, **Sick to the Back Teeth: Oral Health and Access to Dental Care for Low Income Tasmanians**

Anglicare Tasmania, **Submission to State Budget Consultative Process 2006 – 07**, September 2005.

Atkins, C., **Health policy and Governance – Factors relating to inequality for people on low incomes to Community Health Services in Victoria**, November 2003.

Australian Institute of Health and Welfare, Dental Statistics and Research Unit, “Oral Health and Access to Dental Care – the gap between the ‘deprived’ and the ‘privileged’ in Australia” **Research Report**, Adelaide University (2001b)

Cameron, P., Access to Dental Care for Low Income Tasmanians: A Discussion Paper, Anglicare Tasmania and the Social Action Research Centre, February 2002.

Community Affairs References Committee, “A Hand Up not a Hand Out: Renewing the fight against poverty”. **Senate Committee Report**, March 2004.

Department of Health and Human Services, Tasmania, www.dhhs.tas.gov.au

Dooland, M. “Impact of Co-payments on Public Dental Services: the Victorian Experience” in **Health Issues**, No. 61, December 1999.

Leverat, Mandy, **Poverty of Policy: An Oral History of Low Income People**, Brotherhood of St. Laurence, 16 January 1998.

Oral Health of Victorians, www.audit.vic.gov.au

Tasmanian Council of Social Service, **Pre Budget Submission**, 2005.

Ziguras, S. & Moore, C. **Improving the dental health of people on low incomes**, Brotherhood of St Laurence and the Australian Council of Social Service, 2001.