A Proposal to Extend Universal Insurance to Dental Care in Australia

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Abstract

The debate over universal dental insurance in Australia has persisted since the mid-1970s, as dental care was excluded from Medibank (the predecessor of Medicare) for political and economic reasons. Importantly, dental care expenses are often more predictable than other types of medical care, making insurance design more challenging. We provide an overview of proposals for public dental insurance in Australia, arguing that income-contingent loans to fund higher dental costs may provide a mechanism for expanding insurance while limiting government expenditure. Finally, we argue that a randomised controlled experiment could offer insights into the effectiveness and sustainability of various insurance models for dental care.

1. Background

Whether to provide universal dental insurance in Australia has been debated before the introduction of Medibank in 1975. This issue has again come to the policy forefront, with a 2023 Senate Select Committee inquiry report recommending that the Australian Government provide more equitable access to dental care services, for example, by adding oral health assessments onto the Medicare Benefits Schedule (The Senate 2023).

The Senate report comes on top of several calls from leaders of Australia’s major political parties to extend public funding for dental care (Drape 2012; Karp 2019; Crowe 2022). Initiatives have focused on specific population groups deemed most in need, such as the Child Dental Benefits Scheme that provides a capped level of benefit for those under the age of 18 years. The Senate Report also recommends the same type of coverage be extended to the entire population (The Senate 2023).

The purpose of this article is to provide an historical context on why dental insurance was not included when Medicare was established in 1984, review recent proposals for extending dental coverage that focus on capped benefits, propose a way to further expand coverage through the use of income contingent loans, and suggest a means of testing the potential impact of extending dental insurance on service demand via an experiment similar to the famous RAND Health Insurance Experiment conducted in the United States (Bailit et al. 1985).

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2. Universal Dental Coverage was ‘Too Hard’

The origin of Medicare is Medibank, which was based on proposals of Scotton and Deeble (1968) in an article published in this journal. Their article set out the rationale for a universal public insurance scheme that covered both hospital and medical care. It suggested compulsory insurance was ‘the most efficient and rational way of combining both the insurance and subsidy functions of health cost pooling’.

Importantly, dental insurance was not suggested by Scotton and Deeble (1968) and while the Whitlam Government considered including dental insurance in the Medibank Scheme, it was decided that it was too difficult politically (Menadue 2023). John Deeble later reflected on this, indicating that the success of Medibank:

depended on convincing critics, interest groups and the Australian public that the new scheme was viable … [and] including dental treatment in the basic package of free services for the national scheme would have encountered obstacles: … [as the] public was not yet used to the idea that services could be provided ‘for nothing’ through taxes; there was little knowledge about the demand (and therefore the cost) of free dental treatment; and, compared with other health inequalities at the time, dental care was lower on the list of priorities. (Wilson and Meagher 2007)

After nearly 50 years since Australia developed a universal insurance scheme to improve access to medical and hospital care, it is important to learn from history to successfully design and implement a universal dental insurance scheme in Australia.

3. Is Dental Care Different from Health Care?

On the face of it, dental care shares similar characteristics to general health care. Dentists provide a spectrum of services including dental check-ups, emergency treatment and major costly procedures. Like general health care, services range from necessary to cosmetic, emergency to elective, while other services combine prevention and cosmetic characteristics. Aligning teeth using braces provides a nicer smile and prevents dental wear, reducing the likelihood of expensive dental treatment later in life.

It is, therefore, somewhat surprising that universal public dental insurance is not ubiquitous within many developed countries that have long-established universal schemes for medical and hospital care. Instead, governments around the world treat dental care mostly as an individual responsibility (Wang, Mathur and Schmidt 2020). Even countries such as England, which initially covered dental services as part of the NHS, have largely eroded coverage over time (Lant 2023). Less than one third of dental care costs are now covered by public or compulsory insurance across OECD countries (OECD 2023). While the World Health Organization has recommended countries push for dental care as part of universal health coverage (World Health Organisation 2023), the question remains as to why dental and medical care is treated differently in most countries.

As Scotton and Deeble (1968) eloquently describe, universal tax-financed coverage of health-related services has two functions. First, it insures against unpredictable events that are expensive for individuals. Second, it creates a mechanism for cross-subsiding health care financing. Those on lower incomes are likely to be in poorer health, and so if ‘pooling is to be extended to low-income people, and [so] some of their costs must be borne by higher-income earners’. They also note, ‘The case for pooling is strongest for the most expensive and unpredictable services, less strong for those which are cheap and relatively regular and does not exist at all for services which are in the nature of amenities’. These broad insights are relevant to dental care, as Guay (2006) notes dental care is more predictable than medical care and generally has lower financial consequences for most individuals if they are uninsured. Hence the rationale for pooling risk is not as strong compared to some types of medical care.

These characteristics also make it difficult for private health insurance markets to adequately cover dental care. Dental insurance suffers the classic problems of adverse selection (Godfried, Oosterbeek and van Tulder 2001) and moral hazard (Nguyen and Worthington 2023). Genetic
testing, which may inform the risk of requiring orthodontic procedures, is likely to pose additional challenges for private dental insurance markets in the future (Bardey and De Donder 2024). All these factors mean that private dental insurance coverage is subject to large co-payments, exclusions and delays in access to benefits, which limits the degree to which private insurance can cover high dental costs. Compulsory insurance is a way to overcome adverse selection (see Dahlby 1981), and, as Kenneth Arrow noted, economies of scale also provide a rationale for universal coverage of insurance (Dubra 2005).


Turning to the current policy proposal, costing undertaken by the Parliamentary Budget Office (PBO) looked at uncapped versus capped benefits (which limits the amount an individual can receive to around $1,000 over a 2-year period) (see Appendix 6 of The Senate 2023). While the PBO showed that capping public subsidies will reduce public financing costs by around 25 per cent, it would also limit the insurance component. Similarly, restricting public subsidies for dental care to seniors or means-testing access to public subsidies would also reduce government expenditure but provide no subsidy or insurance to a significant proportion of the population, including many taxpayers who would finance the scheme.

The longevity of a publicly funded dental insurance scheme depends on the government being able to cover benefits from tax revenue and for the scheme to receive continuing public support. A critical factor in Medicare's longevity has been its high level of community support (Ellis et al. 2021) despite benefits for medical services being a major driver of growth in health expenditure. Perhaps a key factor behind Medicare's popularity is not only its universal nature, but that it provides all taxpayers with a regular benefit, coupled with an insurance component that subsidises medical services delivered in the community and in private hospitals, and allows all taxpayers to access public hospital services for free.

It is hard to see how dental insurance can achieve similar sustained public support without providing benefits to all taxpayers. The real challenge is that achieving a universal dental scheme akin to Medicare would be costly. The PBO had previously estimated that bringing all routine and therapeutic dental care into Medicare would cost over $9 billion by 2026–27 (The Senate 2023). Such forecasts are based on limited evidence of the potential demand side response, making it a potential underestimate of the true cost. Increased dental care demand and the associated response from private dental care providers will likely also produce an increase in the level of fees charged.

Another aspect to consider is that dental services are also covered by the same constitutional provision, that is Section 51(xxiiiA), that defines the Commonwealth powers in regard to medical care, but which also has a proviso that laws cannot 'authorise any form of civil conscription'. While a recent detailed legal analysis of the relevant High Court cases by McDonald, Duckett and Campbell (2023) argues that this provision is unlikely to prevent a wide range of regulatory policies, any attempts to regulate fees charged for dental services would require further clarification of the Commonwealth's powers under Section 51.

5. Equitable Access to Dental Care Using Subsidies and Income Contingent Loans (ICLs)

A potential solution to increase insurance against high dental care expenses while limiting additional government expenditure is to combine capped public subsidy for routine and therapeutic dental care with an income-contingent loan for more expensive dental care (ICL-D). This scheme could operate alongside private health insurance products and have the advantage of providing a universal scheme with an additional insurance component.

While the limited public insurance would be covered by general tax revenue, the ICL-D would initially be funded by the government and repaid by users through additional tax payments for those exceeding an income threshold. The ICL-D would give users access
to funds to cover unexpectedly high dental expenses. Most income earners would repay the loan through the tax system in subsequent years. Hence, insurance for high dental expenses comes from consumption smoothing rather than risk pooling, while likely also providing a much higher level of insurance than under a government funded capped scheme.

Key issues with the design and implementation of ICL-D would be determining eligibility for the scheme, what services an ICL-D would cover and the terms under which it would be repaid. Given Australia’s use of ICLs for financing higher education, there is already a well-developed and efficient mechanism for repayment of debts through the tax system (Chapman et al. 2014). While ICLs have initially been developed to help finance higher education they have been proposed to increase access to other high-cost goods and services, such as rooftop solar cells (Baldwin, Chapman and Raya 2015).

ICL-D would need to be used in combination with other policies to cover high dental costs (for example, enhancement of state public dental services for those on low incomes), especially if access to an ICL-D was restricted to those with taxable incomes of a sufficient level to enable repayment of debts over time.

6. The Need for a Dental Health Insurance Experiment

While numerous proposals for tax-financed dental insurance exist within Australia, the evidence base on which to make design decisions is scant. For example, the recent costing of dental insurance by the PBO for the Senate is based on assumptions from a Canadian costing of a similar scheme, not robust experimental data.

Given there are many alternative ways of facilitating universal access, there would be great value in conducting a randomised experiment examining different levels and types of insurance, which will provide the best evidence for future policies. Key elements of dental health insurance trial could include:

- understanding the up-take, use and repayment of the ICL-D;
- quantifying the impact of various types of insurance on oral health; and
- assessing the interactions with private health insurance products.

Such a trial, involving randomising several thousand families, would be invaluable in understanding how different policies could impact the quantum and composition of dental care received and potentially the pricing of services, which would be key to designing an efficient and sustainable dental health insurance scheme.

7. Final Reflections

While there have been numerous proposals to provide a universal dental scheme like Medicare in Australia, differences in dental care characteristics compared to medical care create challenges for public and private insurance systems. Policy innovation such as using ICLs and testing alternative approaches through a well-designed randomised controlled experiment should lay the foundations for a universal dental care scheme for all Australians care.

Data Availability Statement

Not applicable.

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Extending Universal Insurance to Dental Care

