Report on the Fifth Review of the *Dental Benefits Act 2008*

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Australian Government
Department of Health and Aged Care

Deputy Chief Medical Officer

The Hon Mark Butler MP
Minister for Health and Aged Care
Parliament House
CANBERRA ACT 2600

Dear Minister

Report on the Fifth Review of the *Dental Benefits Act 2008*

I am pleased to submit the Report on the Fifth Review of the *Dental Benefits Act 2008* (the Act) as required under Section 68 of the Act.

In relation to the Terms of Reference of the Review, it was the Committee's view that the Act and associated *Dental Benefit Rules 2014* provide an appropriate legislative and administrative framework to support the operation of the Child Dental Benefits Schedule (CDBS).

To assist the Committee reach its findings, a public consultation process was undertaken and over 500 submissions were received. The Committee has made 21 recommendations to support the ongoing success and effectiveness of the CDBS. In particular, the Committee notes the ongoing importance of promoting the CDBS to improve awareness and use of the program by eligible children. In addition, the Committee recommends changes to improve access to services for First Nation's children, children with disability and children living in rural and remote locations.

I wish to thank my fellow panel members for their valuable insight, expertise and contribution to this review. I would also like to acknowledge the support of the Department of Health and Aged Care in assisting the Committee with its work.

The report and its findings are tendered to you for your consideration and for tabling in the Parliament.

Yours sincerely

Professor Michael Kidd AM
Chair, Fifth Review of the *Dental Benefits Act 2008*

21 March 2023

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Executive summary

In July 2022, the Minister for Health and Aged Care, the Hon Mark Butler MP, commissioned an independent review of the *Dental Benefits Act 2008* (the Act) pursuant to section 68 of the Act. The Minister approved the Terms of Reference for the review, and appointed members to the independent review panel (the Review Committee), who completed the review.

The Child Dental Benefits Schedule (CDBS) is the only program to operate under the Act and was the focus of the Terms of Reference. The Terms of Reference included specific consideration of the administration and operation of the Act; assessing access to dental services and uptake of the CDBS by vulnerable cohorts; and identifying opportunities to improve the CDBS to allow for the most efficient, effective and sustainable delivery of dental benefits and services.

The Review Committee found that broadly, the Act is achieving its aim of providing a legislative framework for paying dental benefits and supporting the administration of the CDBS. However, the Committee noted that although the program has been operating for nine years, uptake of the CDBS has not reached desired levels and remains below 40 per cent. Furthermore, the review identified marked inequities experienced by children from priority groups – children living in rural and remote locations, First Nations children, and children with disability – and the significant barriers they face in accessing appropriate services under the CDBS.

To further support the deliberations of the Review Committee, the Department of Health and Aged Care (the Department) conducted a public consultation process and received submissions from consumers, dental industry peak organisations, and dental providers. The submissions generally highlighted that the CDBS could better deliver dental services to cohorts of children who are at higher risk of experiencing oral disease, and/or who require specialised models of care, such as access to dental services delivered under general anaesthetic. In alignment with the findings from various data sources, the submissions, too, indicated that children living in rural and remote areas, First Nations children, and children with disability experience disproportionate barriers to accessing dental services under the CDBS compared to the general population of children eligible for the program.

Based on the above findings, the Review Committee provides 21 recommendations to improve access to and utilisation of the CDBS and implement targeted strategies for vulnerable cohorts.

Recommendations

1. To address substantial inequity of access issues, modify the CDBS to improve service access, especially for:
   - children living in rural and remote areas
   - First Nations children
   - children with disability.
2. The Department of Health and Aged Care to work with the National Aboriginal Community Controlled Health Organisation (NACCHO) and other relevant organisations to determine the level of unmet demand for dental services for First Nations children and use this information to inform activities to improve access to services, and support CDBS service delivery to First Nations children.
3. In recognition of the continued under-utilisation of the CDBS, investigate barriers and implement strategies to improve utilisation and service delivery for eligible children.
4. The Department of Health and Aged Care to expand the promotion of the CDBS, including targeting priority groups through culturally appropriate campaigns, and publication of materials for culturally and linguistically diverse groups.
5. Expand the Dental Benefits Schedule to include the following items:
   - 123 *Application of a cariostatic agent – per tooth*
   - 131 *Dietary analysis and advice*
   - 141 *Oral hygiene instruction*
   - 151 *Provision of a mouthguard – indirect*
   - 163 *Resin infiltration – per tooth*
   - 949 *Treatment under general anaesthesia/sedation when provided in a hospital or a day procedure centre.*
6. Allow the claiming of CDBS benefits for in-hospital services, where clinically appropriate.
7. The Australian Government to work with states and territories to improve access to free public sector in-hospital general anaesthetic services for children considered 'high care needs', where clinically appropriate.
8. Amend 88943 *Sedation – inhalation* on the Dental Benefits Schedule to 88493 *Sedation – inhalation of nitrous oxide and oxygen mixture – first 30 minutes or part thereof*, and add a new step-down item 88946 *Sedation – inhalation of nitrous oxide and oxygen mixture – subsequent 30 minutes or part thereof.*
9. Develop a 'CDBS high care needs' definition to support targeted CDBS service delivery to children considered 'high care needs' in relation to dental and oral disease.
10. Remove restrictions on the following CDBS items to support CDBS service delivery to children considered 'high care needs':
    - 88012 *Periodic oral examination*
    - 88013 *Oral examination – limited*
    - 88022 *Intraoral periapical or bitewing radiograph – per exposure*

- 88111 *Removal of plaque and/or stain*
- 88114 *Removal of calculus – first visit*
- 88115 *Removal of calculus – subsequent visit*
- 88121 *Topical application of remineralisation and/or cariostatic agents, one treatment*
- 88161 *Fissure and/or tooth surface sealing – per tooth (first four services on a day)*
- 88162 *Fissure and/or tooth surface sealing – per tooth (subsequent services)*
- 88521 *Adhesive restoration – one surface – anterior tooth – direct*
- 88531 *Adhesive restoration – one surface – posterior tooth – direct*
- 88586 *Crown – metallic – with tooth preparation – preformed*
- 88587 *Crown – metallic – minimal tooth preparation – preformed.*

11. Double the benefit cap for children considered 'high care needs' to ensure they receive adequate oral health care, noting the importance to safeguard against inappropriate treatment.

12. Delete the following items from the Dental Benefits Schedule:
    - 88025 *Intraoral radiograph – occlusal, maxillary, mandibular – per exposure*
    - 88323 *Surgical removal of a tooth or tooth fragment requiring removal of bone – first tooth extracted on a day*
    - 88458 *Interim therapeutic root filling – per tooth*
    - 88511 *Metallic restoration – one surface – direct*
    - 88512 *Metallic restoration – two surfaces – direct*
    - 88513 *Metallic restoration – three surfaces – direct*
    - 88514 *Metallic restoration – four surfaces – direct*
    - 88515 *Metallic restoration – five surfaces – direct*
    - 88575 *Pin retention – per pin.*

13. The Department of Health and Aged Care's Dental Clinical Review Committee[1] to consider:
    - the addition to the Dental Benefits Schedule of 919 *Teleconsultation*, 920 *Extended teleconsultation – 30 minutes or more,* and 921 *Teleconsultation by referral*, and
    - the currency of schedule fees for items listed on the Dental Benefits Schedule.

14. Amend the Dental Benefits Act 2008 to remove 'voucher' terminology.

1 Note regarding the Department of Health and Aged Care's Clinical Review Committee:
- Recommendation 13 of the Fourth Review of the *Dental Benefits Act 2008* sought establishment of a formal process to consider variations to the Act and the Rules.
- The focus was to establish an appropriate formal advisory structure to consider amendments to the CDBS as needed (outside of the triennial legislative reviews) to ensure the program stays current.
- Once established, it will be formally known as the Dental Clinical Advisory Committee.

15. The Department of Health and Aged Care to work with Services Australia to determine if:
    - previous CDBS billing history can be provided to the current dental practitioner, and
    - tooth identification at the point of claim can be captured.
16. Streamline CDBS consent arrangements for state and territory programs with regard to:
    - informed financial consent and out-of-pocket costs
    - financial consent without parental attendance, and
    - removing the requirement for an annual bulk-billing patient consent form.
17. The Department of Health and Aged Care to work with relevant stakeholders to understand foster care and kinship care arrangements, remove access barriers if possible, and determine options for recognising alternative consent arrangements.
18. The Department of Health and Aged Care to work with the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), and other data custodians to:
    - understand what data is available to support provision of information about variations in care under the CDBS, and
    - develop mechanisms for identifying priority cohorts of children, especially children with disability and First Nations children.
19. The Department of Health and Aged Care to identify ways to improve the digital health infrastructure that supports the CDBS to improve patient and research outcomes.
20. The Department of Health and Aged Care to publish an annual data summary of access and utilisation of the CDBS by jurisdiction and priority group, by April of the following calendar year.
21. Acknowledging the existing CDBS data gaps, strengthen research on the CDBS to understand, and address, substantial equity of access issues.

Chapter 1: The Fifth Review

Legislative framework

The Act commenced on 26 June 2008 implementing the commitment by the Australian Government to establish the Medicare Teen Dental Plan (MTDP). The MTDP commenced on 1 July 2008 and operated until 31 December 2013, when it was replaced with the CDBS from 1 January 2014.

Dental Benefits Act 2008

The Act provides the legislative framework for paying dental benefits and is broadly modelled on relevant provisions of the *Health Insurance Act 1973* relating to the payment of Medicare benefits.

The Act:

- establishes an entitlement to dental benefits
- provides for the payment of dental benefits
- provides a framework for issuing vouchers
- establishes provisions for the protection of protected information
- creates general offence provisions relating to assignment of benefit agreements and giving false or misleading information
- allows the Minister for Health and Aged Care to, by legislative instrument, make Dental Benefits Rules
- provides for funds relating to the payment of dental benefits to be appropriated through a new special appropriation.

The Act has been amended from time to time. The *Dental Benefits Amendment Act 2021* amended the Act by removing the lower eligibility age restriction to allow eligible persons aged 0 to 2 years to access the CDBS. The most recent amendment, the *Health Legislation Amendment (Medicare Compliance and Other Measures) Act 2022*, amended the compliance provisions relevant to the CDBS, specifically relating to the Professional Services Review (PSR) program, garnishee arrangements, and harmonising compliance provisions between the *National Health Act 1953*, *Health Insurance Act 1973*, and *Dental Benefits Act 2008*.

Dental Benefits Rules 2014

Section 60(1) of the Act gives the Minister for Health and Aged Care the power to make, by legislative instrument, the Dental Benefits Rules (the Rules). The Rules provide for matters as permitted by the Act, including:

- requirements a person must meet in order to satisfy the means test
- requirements dental practitioners must meet in order to provide services under the CDBS as 'dental providers'
- requirements that eligible divisions of dental practitioners must meet in order to 'render services on behalf of dental providers'
- particulars that must be recorded on the patient's receipt, account, or assignment of benefit form before a dental benefit may be paid

- a Dental Benefits Schedule which contains items that may attract a dental benefit
- a benefit cap for eligible dental patients
- conditions that must be satisfied, including for public sector dental providers, and other item-based conditions that limit when a dental benefit is payable in respect of a particular service
- requirements for dental providers to obtain consent to treatment, and informed financial consent to the cost of dental treatment
- requirement for dental providers to keep clinical records for four years
- provisional access for state and territory governments to provide services as public sector dental providers.

Independent reviews of the Act

Section 68 of the Act outlines that the Minister must cause an independent review of the operation of the Act as soon as possible after the first anniversary of the commencement of the Act; and further independent reviews as soon as practicable after the Act's third anniversary, and at three-yearly intervals thereafter. Section 68 of the Act also outlines the minimum composition of the review panel and provides specific requirements for a copy of each report to be tabled by the Minister in Parliament.

1. The Minister must cause an independent review of the operation of this Act to be undertaken as soon as possible after the first anniversary of the commencement of this Act.
2. Further independent reviews of the operation of this Act must be made as soon as practicable after the third anniversary of the commencement of this Act and at three yearly intervals thereafter.
3. The Minister must cause a copy of the report of each review mentioned in subsection (1) and (2) to be tabled in each House of the Parliament within 15 sitting days of the day on which the report is given to the Minister.
4. The review must be conducted by a panel which must comprise not less than five persons, including:
    a. a person occupying the position of Commonwealth Chief Medical Officer;
    b. a person nominated by the Australian Dental Association;
    c. a person nominated by the Consumers' Health Forum of Australia;
    d. two other persons nominated by the Minister, at least one of whom must have qualifications in medicine or dentistry.

In general terms, the purpose of the review is to evaluate the operation of the Act, including identifying mechanisms within the Act that can be modified or enhanced to optimise the delivery and policy objectives of the CDBS. Four previous reviews were completed in 2009, 2011, 2015 and 2019.

Terms of Reference

The Review Committee has reviewed the Act having regard to the following Terms of Reference:

- The Review Committee will report on the administration of the Act and the extent to which it attains its purposes, including the operation of the CDBS.
- The Review Committee will assess the practical operation of the Act regarding the accessibility and delivery of services, and uptake (including barriers to uptake) of the CDBS by vulnerable cohorts, including an assessment of
  - service delivery to First Nations children and children in rural or remote communities
  - children with intellectual disability as identified in the *National Roadmap for Improving the Health of People with Intellectual Disability*.
- The Review Committee may consider other opportunities to improve the operation and administration of the CDBS to allow for the most efficient, effective and sustainable delivery of dental benefits and services.

Meetings

The Review Committee met a total of four times via teleconference on 18 July 2022, 15 August 2022, 31 October 2022, and 5 December 2022. Secretariat support to the Review Committee was provided by the Dental Section in the Department.

Review Committee membership

The Minister for Health and Aged Care appointed the Review Committee on 5 July 2022. Members are:

Professor Paul Kelly

Commonwealth Chief Medical Officer, Department of Health and Aged Care

Professor Michael Kidd AM (Chair)

Deputy Chief Medical Officer, Department of Health and Aged Care

Dr Andrew Barnes

Representing private dental practitioners
Private Dental Practitioner

Dr Heather Cameron

Representing public dental practitioners
Clinical Director, Oral Health Service, Western NSW Local Health District

Dr Martin Hall

Representing public dental practitioners
Chief Oral Health Officer, Dental Health Services Victoria

Dr Peter King

Special needs dentistry representative
Private Practice
Australian Society of Special Care in Dentistry

Dr Jessica Manuela

First Nations representative
Private Practice
Director, Indigenous Dental Association of Australia

Mr Tan Nguyen

Nominated by the Consumers Health Forum of Australia
Oral Health Therapist
Spokesperson, National Oral Health Alliance

Dr Mihiri Silva

Nominated by the Australian Dental Association
Senior Lecturer, Paediatric Dentistry, Melbourne Dental School
Consultant Paediatric Dentist, Royal Children's Hospital

Chapter 2: Background

Child Dental Benefits Schedule (CDBS)

The CDBS commenced operation on 1 January 2014. The program provides eligible children aged between 0 and 17 years[2] access to-up-to $1,052[3] in benefits for basic dental services, with benefits capped over two consecutive calendar years. The program aims to:

- address declining child oral health, with a longer-term strategy to deliver improved population-wide oral health into the future
- target Commonwealth expenditure on dental services to children in greater financial need
- build a unified national system for patient eligibility and service delivery for children across states and territories.

The CDBS is administered by the Department in conjunction with Services Australia.

Eligible dental services

The Dental Benefits Schedule in Schedule 1 of the Rules sets out 76 items that may be claimed under the CDBS, with their associated descriptors, claiming restrictions, and benefit amounts. The schedule lists general dental services that sit across eight groups:

- Group U0 – Diagnostic Services
- Group U1 – Preventive Services
- Group U2 – Periodontics
- Group U3 – Oral Surgery
- Group U4 – Endodontics
- Group U5 – Restorative Services
- Group U7 – Prosthodontics
- Group U9 – General Services.

The current Dental Benefits Schedule is based on the Australian Dental Association (ADA) *Australian Schedule of Dental Services and Glossary, 12th Edition*. The ADA Schedule is a description of dental services commonly used by the dental profession and does not provide guidance on billing arrangements. Not all ADA Schedule items are included in the Dental Benefits Schedule, as the intent of the CDBS is to support access to basic dental care for eligible children. Some Dental Benefits Schedule items also have specific limitations and/or restrictions on the number of times that they can be claimed. There are also a small number of step-down items specific to the CDBS.

Where possible, items listed on the Dental Benefits Schedule use a five-digit item code which contains the equivalent three-digit ADA Schedule item code with an additional two-digit prefix of 88. For example, CDBS item 88011 corresponds to ADA item 011. The exception is where the CDBS has specific step-down items as there are no corresponding items in the ADA Schedule.

2 The *Dental Benefits Amendment Act 2021* expanded the age eligible criterion to include children aged 0–2 years. Prior to 1 January 2022, the age eligible criterion was 2–17 years.

3 The benefit cap is indexed annually; the benefit cap for the 2023 to 2024 relevant two-year period is $1,052. The benefit cap for the 2022 to 2023 relevant two-year period is $1,026.

Under the CDBS, benefits are not payable for orthodontics, cosmetic dental work, or complex restorative services. Benefits are also not payable for services provided to an admitted patient in hospital or where a private health insurance benefit has been paid.

Eligible dental practitioners

A dental practitioner's registration division, as determined by the Dental Board of Australia, delineates the services that may be rendered to an eligible patient under the CDBS, and the claiming arrangements for individual services.

Dentists

Dentists who hold general or specialist registration with the Dental Board of Australia and have a Medicare provider number are a class of dental provider. In addition to providing services directly, a dentist who is a dental provider may have registered dental hygienists, dental therapists, oral health therapists and dental prosthetists render services on their behalf.

Dental prosthetists

Dental prosthetists who hold general registration with the Dental Board of Australia may only render services on behalf of a dentist who is a dental provider, in accordance with accepted dental practice and under the supervision of the dentist. In other words, dental prosthetists are not eligible to directly claim for services they provide under the CDBS.

Dental hygienists, dental therapists, and oral health therapists

From 1 July 2022, dental hygienists, dental therapists, and oral health therapists who hold general registration with the Dental Board of Australia and have a Medicare provider number are eligible to opt in to directly claim for some services under the CDBS. These arrangements are flexible, meaning this class may become independent dental providers or render services on behalf of a dentist who is a dental provider; however, they are not eligible to claim for services provided by other dental practitioners.

This change came into effect in response to the Dental Board of Australia introducing a new Scope of Practice Registration Standard for dental practitioners following approval by the then Council of Australian Governments Health Council on 1 July 2020. The decision was taken after an independent review by the Australian Commission on Safety and Quality in Health Care assessed the patient safety implications and consumer benefit of the proposed change. The review found no evidence that removing the structured professional relationship between a dentist and a dental hygienist, dental therapist or oral health therapist will have an adverse effect on patient safety and quality. Rather it may increase the capacity of the dental workforce and provide greater access to services and reduced wait times for services in rural and remote communities.

Table 1: Summary of CDBS dental provider requirements

Division with general or specialist registration	Eligible to provide services to children eligible for CDBS	Eligible to directly claim for CDBS services they provide	Eligible to claim for services provided by other dental practitioners
Dentist	Yes	Yes – all items	Yes
Dental Hygienist	Yes	Opt in – limited items	No
Dental Therapist	Yes	Opt in – limited items	No
Dental Prosthetist	Yes	No	No
Oral Health Therapist	Yes	Opt in – limited items	No

Student registration

Dental practitioners who hold other types of registration, including student registration, cannot provide services under the CDBS, either directly or on behalf of a dental provider.

Patient eligibility requirements

To satisfy the eligibility requirements for the CDBS, a child must at some point in the calendar year be:

- entitled to Medicare
- aged between 0 and 17 years, and
- satisfy the means test for the program by receiving an eligible Australian Government payment.

Once a child is assessed as eligible, they will remain eligible for that full calendar year and will need to meet the eligibility requirements in subsequent calendar years to maintain CDBS access. Most eligible children satisfy the means test because their parent/guardian receives Family Tax Benefit Part A.

Table 2: Eligible Australian Government Payments

Recipient of payment	Payment
Child, parent, or guardian	Family Tax Benefit Part A
	Parenting Payment
	Double Orphan Pension Payment
	ABSTUDY
Child	Family Tax Benefit Part A
	Carer Payment
	Disability Support Pension
	Parenting Payment
	Special Benefit
	Youth Allowance
	Department of Veterans' Affairs education allowances under the Veterans' Children Education Scheme (if aged 16–17)
	Military Rehabilitation and Compensation Act Education and Training Scheme (if aged 16–17)

Recipient of payment	Payment
Teenager's partner	Family Tax Benefit Part A
	Parenting Payment

Notifications

Services Australia assesses eligibility by cross-matching relevant data provided by Centrelink with Medicare records. Once eligibility is determined, Services Australia sends out a notification letter via post or digitally via MyGov. Depending on the child's circumstances, notification letters are sent to parents, guardians, eligible teenagers, and Approved Care Organisations, providing an overview of the CDBS and benefit cap.

Services Australia undertakes a bulk mail-out of letters at the start of each calendar year. Over the rest of the year, Services Australia sends letters to newly eligible children at fortnightly intervals.

Since 2022, Services Australia has included a CDBS brochure (at Appendix A) when sending hard copy versions of the notification later. From 2023, Services Australia will also include a link to the CDBS brochure when sending electronic notifications to those eligible.

Eligible children are not required to present letters during their dental visit. Instead, dental practitioners can check a child's eligibility and benefit cap balance by phoning Services Australia, or via Health Professional Online Services (HPOS). Patients can also obtain this information by phoning Services Australia, or through their Medicare online account.

Chapter 3: CDBS utilisation trends

Service delivery

Since its commencement on 1 January 2014, the CDBS has provided $2.8 billion in benefits and delivered 45.8 million services to 3.3 million Australian children (to 31 January 2023).

Utilisation rates

Around 2.7 million children are eligible for the CDBS at any point within a given calendar year. The number of eligible children has been decreasing over time, likely due to changes in means testing arrangements[4] linked to Australian Government payments.

Table 3 shows that since the beginning of the program, utilisation rates have ranged from a low of 29.5 per cent in 2014 to a high of 39.6 per cent in 2019, but in general, utilisation represents just over one third of the eligible population.

Table 3: CDBS utilisation rates (2014 to 2021)

Year	Eligible notified children	Patients using CDBS[5]	Utilisation rate (%)
2014	3,062,309	904,896	29.5
2015	3,086,278	1,022,085	33.1
2016	2,997,794	1,037,901	34.6
2017	2,934,221	1,068,597	36.4
2018	2,840,001	1,092,953	38.5
2019	2,717,458	1,075,303	39.6
2020	2,677,848	911,619	34.0
2021	2,607,949	959,517	36.8

Australian research on trends regarding CDBS utilisation rates has identified:

- mental health conditions and poor health behaviours (such as smoking) of mothers were found to be predictors of non-utilisation of the schedule in the Longitudinal Study of Australian Children[6]
- an increase in reported access to dental services and favourable visiting patterns in low-income households provides some evidence that the CDBS program is improving access to dental care.[7]

National distribution of CDBS eligibility and utilisation

In 2021, across states and territories, the proportion of the population aged 18 and under who were eligible for the CDBS ranged from 58 per cent in Tasmania to 28.6 per cent in the Australian Capital Territory.

4 To be eligible for the CDBS, a person must at one point in the calendar year i) be eligible for Medicare, ii) be aged between 0 and 17 years, and iii) satisfy the program's means test.

5 Patient data reflects individual patients who have claimed for at least one service within the relevant year as identified by the date of service recorded in the claim. This data is correct as of 31 January 2023; however, figures may increase as late claims are processed.

6 Nguyen, H, Le, H and Connelly, L (2021). 'Who's declining the "free lunch"? New evidence from the uptake of public child dental benefits'. Health Economics, [online] 30(2), pp. 270–288. doi: https://doi.org/10.1002/hec.4200.

7 Stormon, N, Do, L and Sexton, C (2022). 'Has the Child Dental Benefits Schedule improved access to dental care for Australian children?'. Health Social Care in the Community, [online] 30, pp. e4095-e4102. doi: https://doi.org/10.1111/hsc.13803.

Table 4: CDBS eligible children as a proportion of estimated residential population by jurisdiction (2021)

State	Est. residential population[8]	Eligible notified children	Eligible for CDBS (%)
NSW	1,769,550	802,801	45.4
VIC	1,411,324	649,304	46.0
QLD	1,195,406	625,101	52.3
WA	627,666	271,951	43.3
SA	373,284	194,982	52.2
TAS	114,909	66,668	58.0
NT	61,297	33,726	55.0
ACT	98,065	28,074	28.6
National[9]	5,651,501	2,607,949	46.1

Utilisation differs by jurisdiction, with the Northern Territory, Western Australia and the Australian Capital Territory consistently demonstrating lower utilisation rates compared to the national average between 2018 and 2021. South Australia, Tasmania and Victoria are the jurisdictions with the highest rates of utilisation.

Active dental providers

Until 1 July 2022, only dentists with general or specialist registration and a Medicare provider number were eligible to be dental providers. Table 5 shows the number of dentists claiming CDBS services per year since the program commenced.

Table 5: Active private CDBS dental providers (2014 to 2021)

Year	Active private CDBS dental providers[10]
2014	10,604
2015	11,058
2016	11,306
2017	11,765
2018	12,182
2019	12,597
2020	12,842
2021	13,240

8 This refers to the estimated residential population aged 18 and under by jurisdiction as of quarter 4 of 2021. Source: Australian Bureau of Statistics.

9 The totals of individual states and territories will not equal the national total as some patients have received treatment in more than one state or territory.

10 Data based on date of service as of 31 January 2022. These figures exclude dental practitioners who render services on behalf of dental providers, representative public dentists, dental hygienists, dental therapists and oral health therapists.

Table 6: CDBS utilisation by jurisdiction (2018 to 2021)

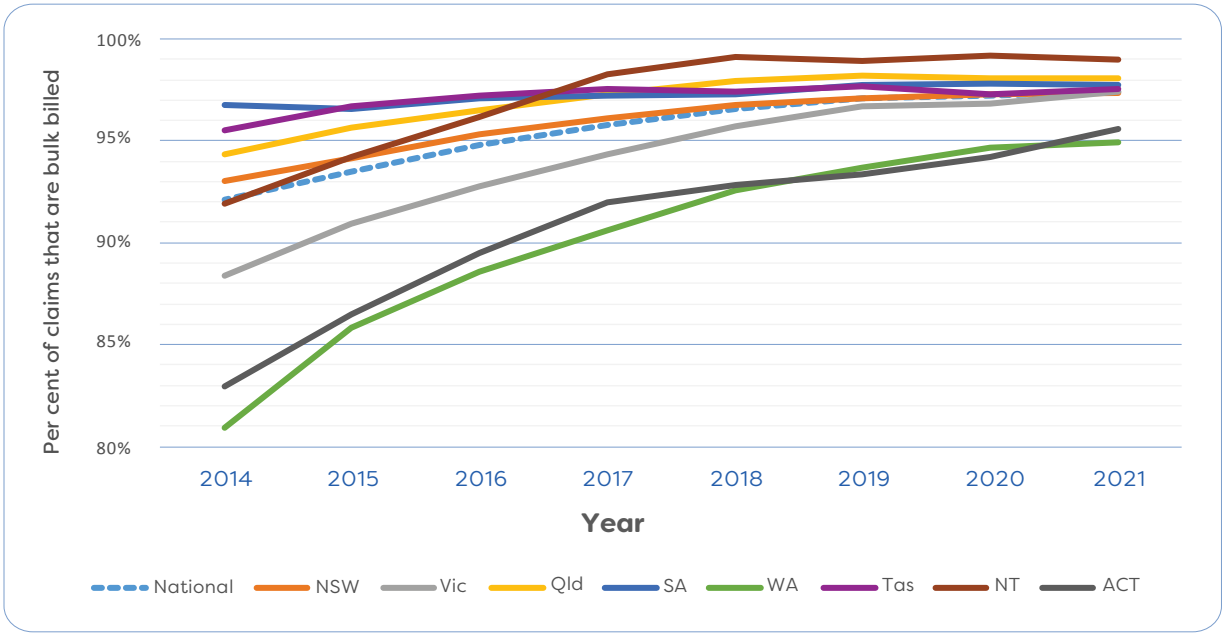
	2018			2019			2020			2021		
	Notified eligible children	**Patients using CDBS**	**Utilisation rate**	**Notified eligible children**	**Patients using CDBS**	**Utilisation rate**	**Notified eligible children**	**Patients using CDBS**	**Utilisation rate**	**Notified eligible children**	**Patients using CDBS**	**Utilisation rate**
ACT	31,307	9,331	29.8%	29,698	8,827	29.7%	29,007	8,620	29.7%	28,074	8,586	30.6%
NSW	882,046	338,488	38.4%	839,348	327,251	39.0%	828,263	294,589	35.6%	802,801	282,797	35.2%
NT	35,924	7,033	19.6%	34,709	5,992	17.3%	34,831	4,595	13.2%	33,726	5,519	16.4%
QLD	662,566	251,606	38.0%	641,130	250,360	39.0%	640,115	221,220	34.6%	625,101	236,783	37.9%
SA	212,277	90,757	42.8%	203,128	93,950	46.3%	200,604	80,256	40.0%	194,982	85,514	43.9%
TAS	74,319	32,509	43.7%	70,872	31,583	44.6%	68,926	23,171	33.6%	66,668	26,129	39.2%
VIC	710,221	298,240	42.0%	678,405	289,624	42.7%	667,987	215,964	32.3%	649,304	249,278	38.4%
WA	287,128	67,496	23.5%	278,930	70,146	25.1%	278,769	64,991	23.3%	271,951	67,371	24.8%
National[11]	2,896,525	1,092,953	37.7%	2,777,358	1,075,303	38.7%	2,749,095	911,619	33.2%	2,673,377	959,517	35.9%

11 The totals of individual states and territories will not equal the national total as some patients have received treatment in more than one state or territory.

Public and private service delivery

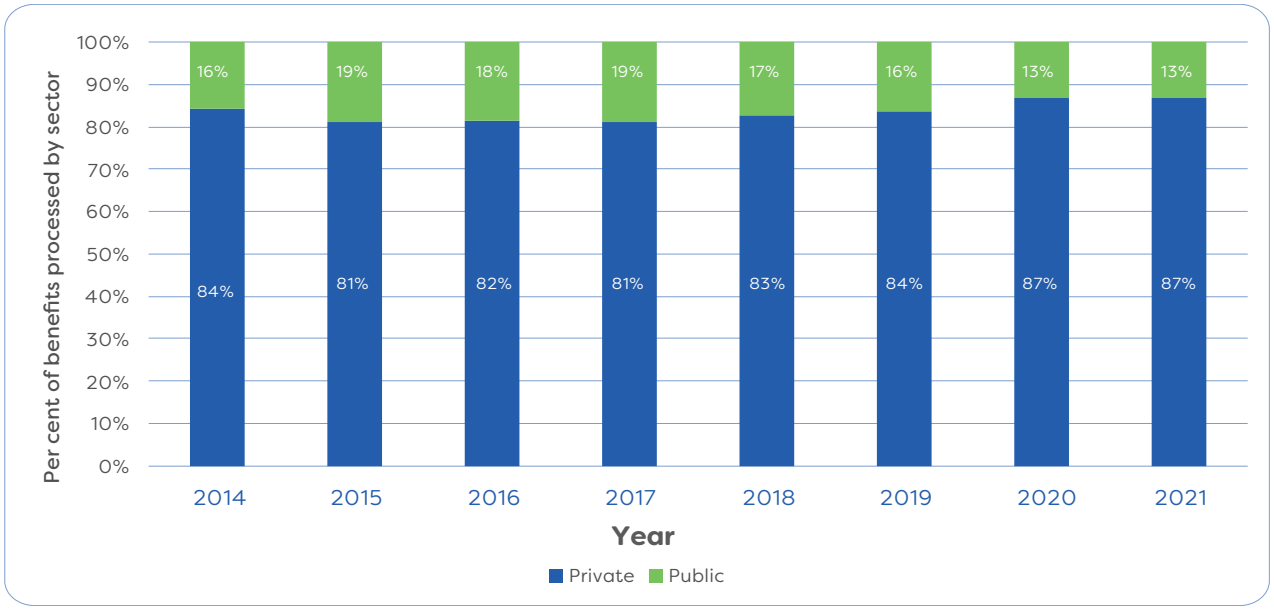
CDBS services can be provided by both public and private sector dental providers. Public sector dental providers are required to bulk bill for services delivered under the CDBS. Private dental providers may charge a co-payment, but currently approximately 95 per cent of all CDBS services are provided without any additional charges.

Figure 1: Bulk-billing rates by jurisdiction (2014 to 2021)[12]



Over the life of the program, 83 per cent of all services have been delivered by the private sector, while 17 per cent have been delivered by the public sector. There has been a noticeable decline in public sector service delivery as a total proportion of CDBS service delivery since the COVID-19 pandemic.

Figure 2: CDBS benefits paid by provider sector (2014 to 2021)[13]



12 Based on date of service as of 31 January 2023. The totals of individual states and territories will not equal the national total as some patients have received treatment in more than one state or territory. State/territory is based on patient residence.

13 Based on date of processing as of 31 January 2023.

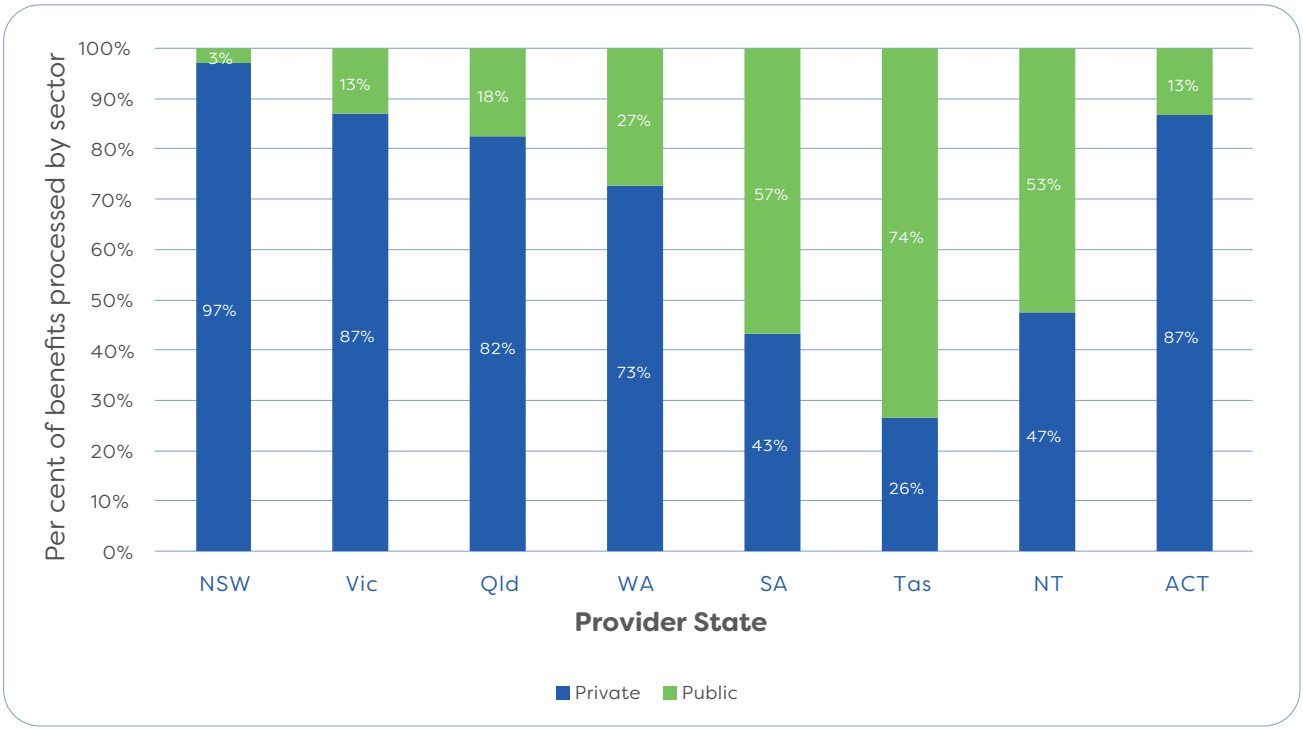
Public dental services

While around 5.2 per cent of dentists are employed in public dental clinics[14] the public sector delivers a significant number of services to CDBS patients. Since the CDBS commenced on 1 January 2014, public sector dental providers have received around $449 million in benefits – delivering over 7.7 million services to 892,000 Australian children (to 31 January 2023).[15] This equates to public sector providers:

- providing services to 24 per cent of CDBS patients
- delivering 17 per cent of all CDBS services
- receiving 16 per cent of all benefits paid under the CDBS (see Figure 2 above).

Benefit cap

Figure 3: CDBS benefits paid to public and private providers by jurisdiction (2014 to 2021)[16]



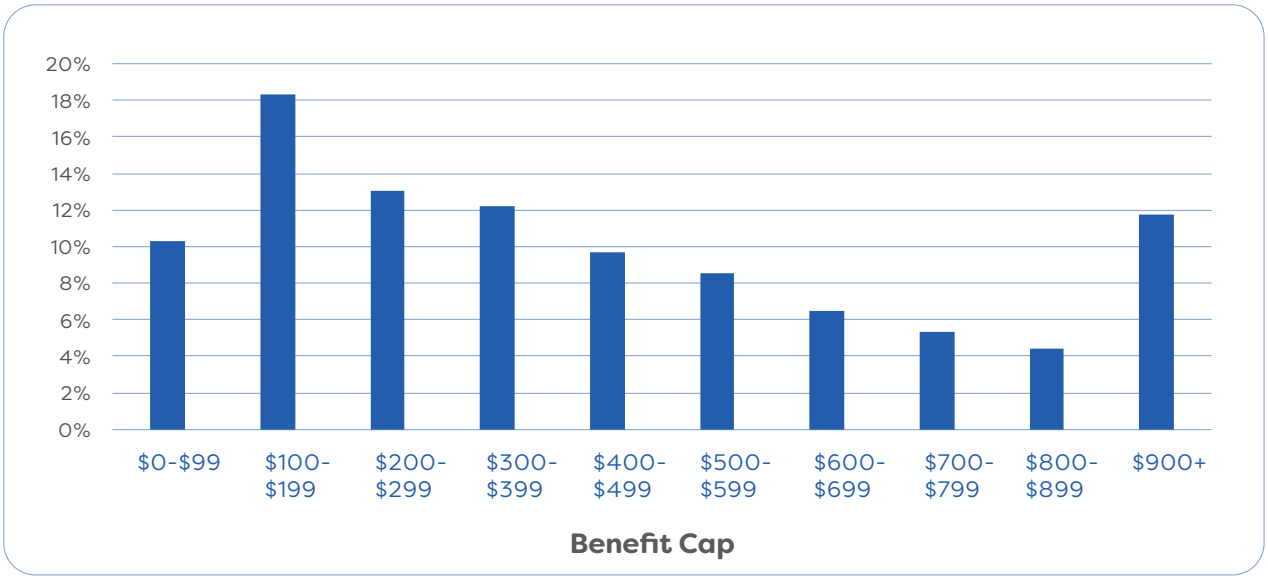
As of 1 January 2023, the benefit cap was indexed to $1,052 for the relevant two-year period. Analysis of cohort years (the first of the two-year eligibility period) indicates that historically around 88 per cent of children spend less than $900 of their benefit cap, with approximately 12 per cent spending $900 or over of their benefit cap (refer to Figure 4).

14 Australian Institute of Health and Welfare (2022). Oral health and dental care in Australia – Dental workforce. [online] Australian Institute of Health and Welfare. Available at: www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce [Accessed 22 February 2023].

15 Data as of 31 January 2023. The totals of patients will not equal totals described earlier as some patients may have received services from both public and private providers.

16 Data is based on date of processing as of 31 January 2023. State/territory is based on provider principal practice.

Figure 4: Distribution of benefit cap balance, since CDBS commenced[17]



COVID-19 impact

The COVID-19 pandemic has had an impact on the delivery of dental care services in Australia. Australian research shows that the COVID-19 pandemic significantly impacted the provision of dental services to children of lower socioeconomic backgrounds.[18] The pattern of decline in dental service provision broadly coincided with the restrictions imposed on dental practice in Australia.

In the three months from March to May 2020, there was a 52 per cent decrease in the number of dental services provided to eligible children. This trend was repeated in Victoria between July and September 2020. Delayed dental care because of the COVID-19 pandemic is likely to have a significant impact on the oral health of these children. CDBS utilisation rates improved in 2022.[19]

A rapid review of national and international evidence[20] concluded that the COVID-19 pandemic has had pronounced negative effects on the provision of primary and secondary dental care for children, with:

- reductions in service availability and utilisation, including patient and parent-driven demand
- changes to the configuration of services provided, particularly greater rates of emergency treatment, reduction in aerosol-generating procedures and more use of tele-dentistry, self-management and prevention approaches
- delays to routine dental care, leading to more dental problems and ongoing need, especially dental caries
- disproportionate impact on socio-economically disadvantaged children and families.

17 Data as of 30 June 2022.
18 Hopcraft, M and Farmer, G (2021). 'Impact of COVID-19 on the provision of paediatric dental care: analysis of the Australian Child Dental Benefits Schedule'. Community Dentistry and Oral Epidemiology, [online] 49(5), pp. 369–376. doi: https://doi.org/10.1111/cdoe.12611.
19 Ibid.
20 Hall Dykgraaf, S, James, D and Kidd, M (2022). 'The impact of COVID-19 on access to dental services among children: a rapid review of national and international evidence'. BMJ Open (under review).

Chapter 4: CDBS uptake for priority groups

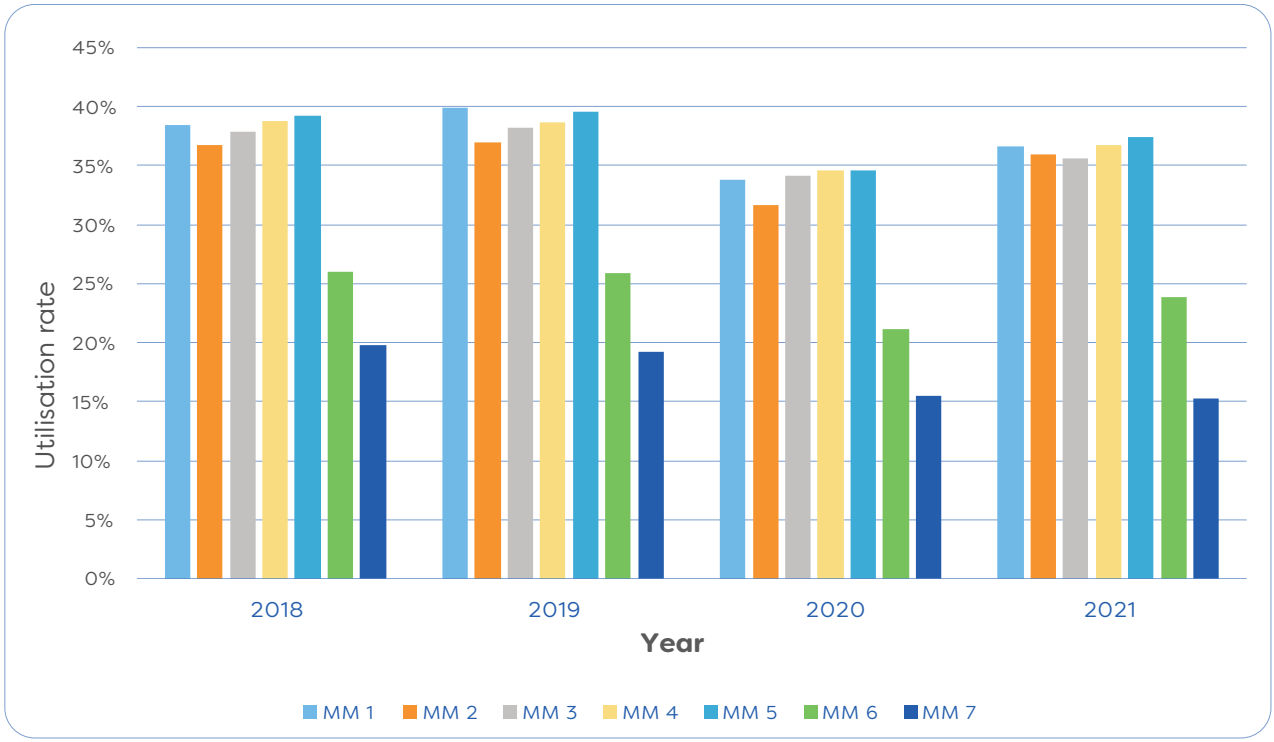
Children living in rural and remote areas

The Modified Monash Model (MMM) is a methodology used to classify areas from metropolitan areas (Modified Monash (MM) 1) through to very remote communities (MM 7).[21]

Analysis indicates CDBS utilisation is comparable between MM 1 and MM 5 but is notably lower for MM 6 and MM 7. Since 2018, there has been a steady decline in utilisation rates for children living in MM 6 and even more so for children living in MM 7.

Children living in MM 6 and MM 7 represent less than 2.7 per cent of total notified eligible children under the CDBS and are more likely to be First Nations children.

Figure 5: CDBS utilisation by MM classification (2018 to 2021)[22]



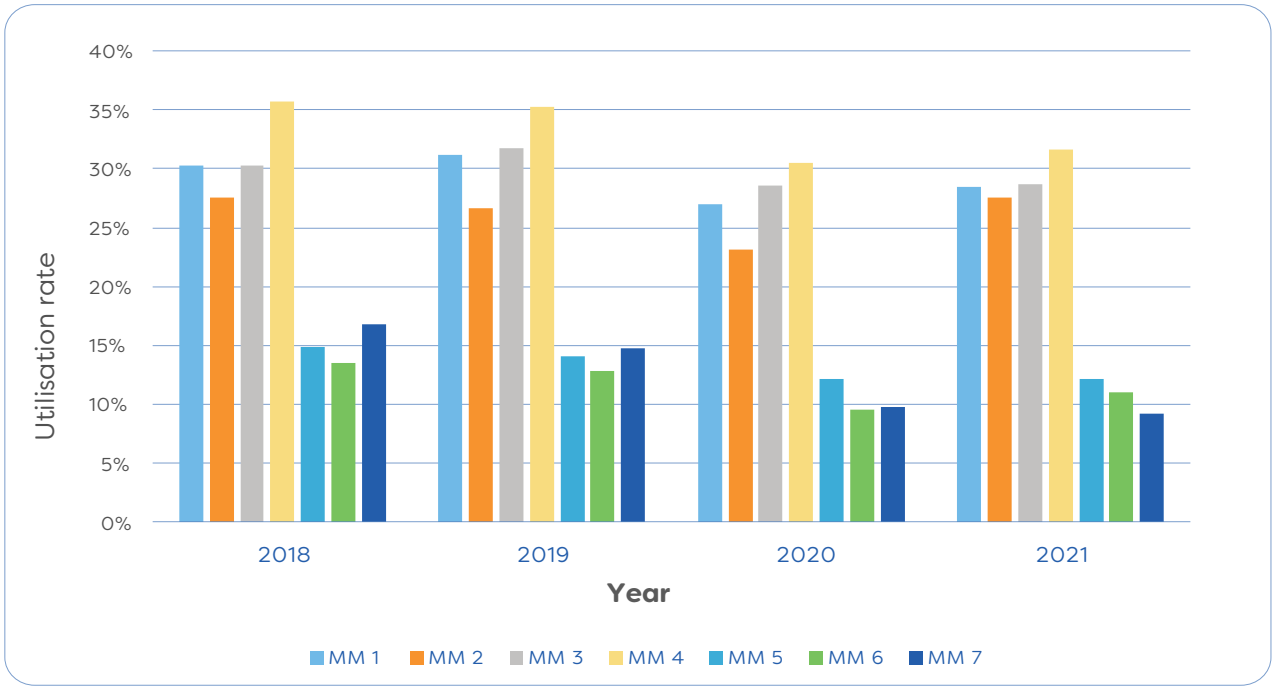
21 MM 1 is a metropolitan area and includes approximately 71.3% of the total population (e.g., cities such as Geelong, Gold Coast, Newcastle, and all capital cities except Darwin and Hobart).
MM 2 is a regional centre and includes 9% of the total population (e.g., Ballarat, Bunbury, Cairns, Hobart, Darwin).
MM 3 is a large rural town and includes 6.5% of the total population (e.g., Coffs Harbour, Dubbo, Shepparton, Whyalla).
MM 4 is a medium rural town and includes 4% of the total population (e.g., Batemans Bay, Lithgow, Port Pirie, Phillip Island).
MM 5 is a small rural town and includes 7.3% of the total population (e.g., Renmark, Port Douglas, Walpole).
MM 6 is a remote community and includes 1.2% of the total population (e.g., Alice Springs, Broome, Fraser Island, Mallacoota).
MM 7 is a very remote community and includes 0.8% of the total population (e.g., Arnhem, Birdsville, Hopetoun, Nullarbor).
Above total population distribution by MM classification is based on Versace, VL, Skinner, TC, Bourke, L, Harvey, P and Barnett, T (2021). 'National analysis of the Modified Monash Model, population distribution and a socio-economic index to inform rural health workforce planning'. Australian Journal of Rural Health, [online] 29(5), pp. 801–810. doi: https://doi.org/10.1111/ajr.12805.

22 Based on date of service as at 31 January 2023. MM classification is based on patient residence.

First Nations children

First Nations children who are eligible for the CDBS are identified in the data below using the Voluntary Indigenous Identifier (VII). As of June 2022, individuals choosing to identify using the VII are estimated to represent 79 per cent of the ABS-estimated total First Nations population (2016). Therefore, the data presented below is likely to be under-representative.

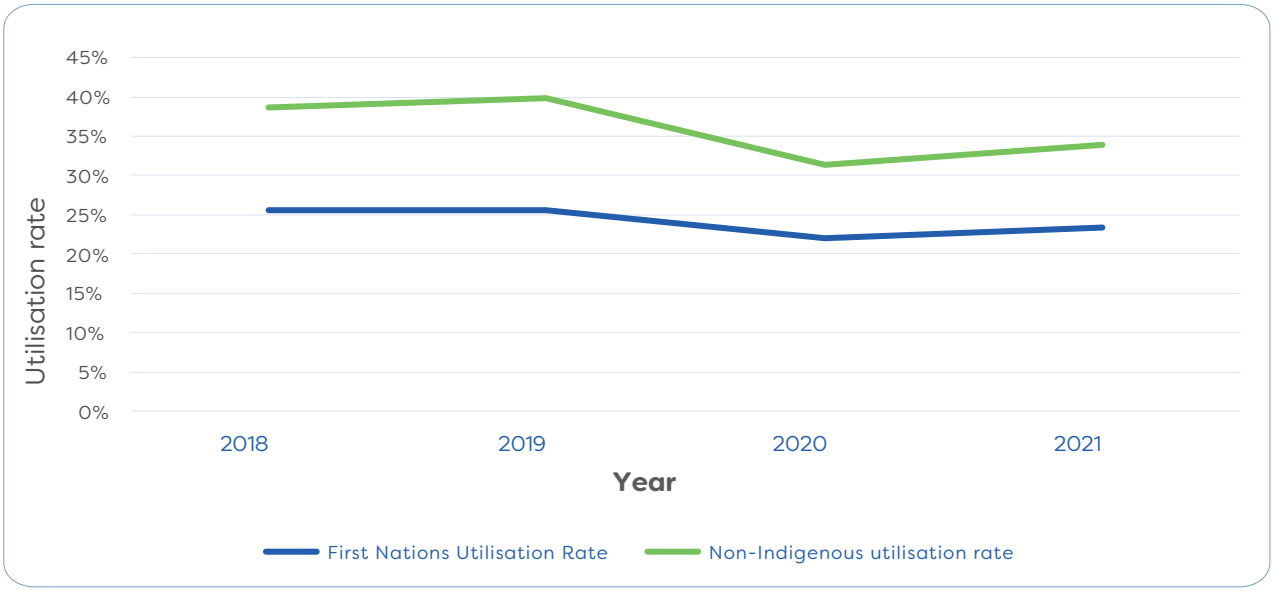
Figure 6: CDBS utilisation for First Nations children by MM classification (2018 to 2021)[23]



First Nations children are consistently less likely to receive services under the CDBS compared to non-Indigenous children. On average between 2018 and 2022, there has been a 14 per cent difference in utilisation rates between First Nations and non-Indigenous children.

23 Based on date of service as at 31 January 2023. MM classification is based on patient residence.

Figure 7: CDBS utilisation for First Nations and non-Indigenous children (2018 TO 2021)[24]



The difference in utilisation is far greater in MM 6 and MM 7 classifications.

Table 7: CDBS utilisation for First Nations and non-Indigenous children by MM classification (2018 to 2021)[25]

Non-Indigenous	**2018**	**2019**	**2020**	**2021**
MM 1	38.8%	40.3%	34.1%	37.0%
MM 2	38.0%	38.4%	33.0%	37.3%
MM 3	38.9%	39.1%	35.1%	36.8%
MM 4	39.2%	39.2%	35.2%	37.6%
MM 5	41.6%	42.3%	37.1%	40.5%
MM 6	34.3%	35.0%	29.7%	32.6%
MM 7	25.3%	28.4%	27.7%	31.0%
First Nations	**2018**	**2019**	**2020**	**2021**
MM 1	30.2%	31.2%	26.9%	28.5%
MM 2	27.6%	26.6%	23.1%	27.6%
MM 3	30.3%	31.8%	28.5%	28.7%
MM 4	35.7%	35.2%	30.5%	31.6%
MM 5	14.9%	14.1%	12.1%	12.2%
MM 6	13.5%	12.8%	9.6%	11.0%
MM 7	16.8%	14.7%	9.8%	9.2%

24 Based on date of service as at 31 January 2023. MM classification is based on patient residence. First Nations status is identified using VII, which may not capture all First Nations people.

25 Based on date of service as at 25 September 2022.

Children with disability

Indicators of disability, or confirmation that a Medicare customer is accessing a disability support payment through Centrelink, do not exist within the health data environment. There is no disability identifier immediately available that will allow disability-specific CDBS eligibility or utilisation to be identified.

It is a medium-term action under the *National Roadmap for Improving the Health of People with Intellectual Disability*[26] to improve oral health data collection to better identify people with intellectual disability and service provision both within the CDBS and between state/territory/Commonwealth data-sharing arrangements.

26 Department of Health and Aged Care (2021). National Roadmap for Improving the Health of People with Intellectual Disability. [online] Canberra: Department of Health and Aged Care. Available at: www.health.gov.au/resources/publications/national-roadmap-for-improving-the-health-of-people-with-intellectual-disability.

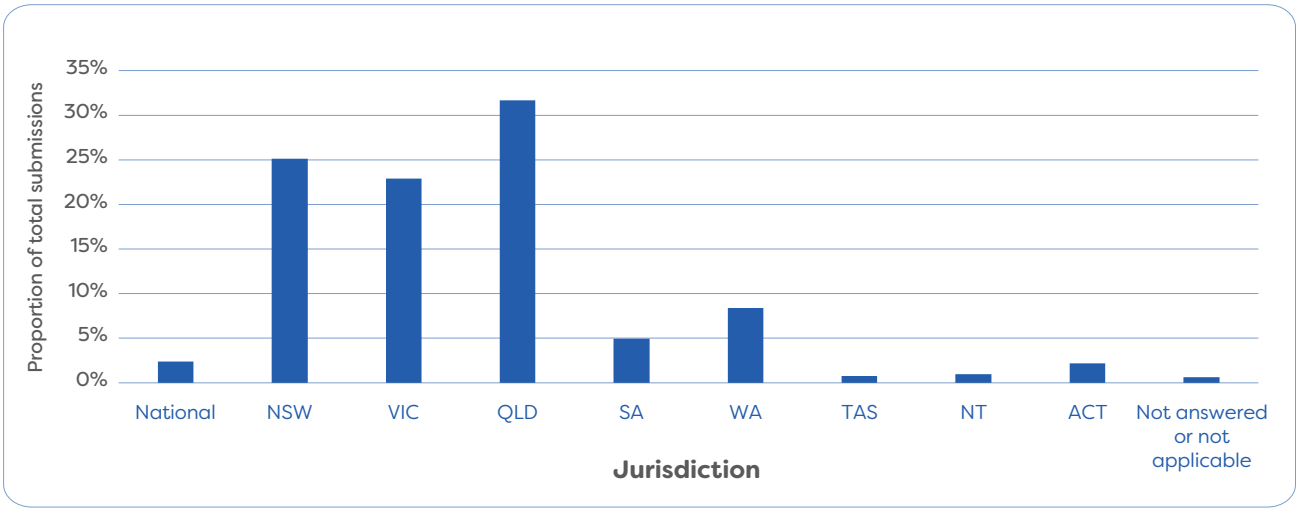
Chapter 5: Stakeholder consultation

To support the deliberations of the Review Committee, the Department conducted a stakeholder survey via a public consultation process to seek views on the CDBS (refer to Appendix 2). This is the first time this approach has been undertaken as part of a review of the Act.

General information about survey respondents

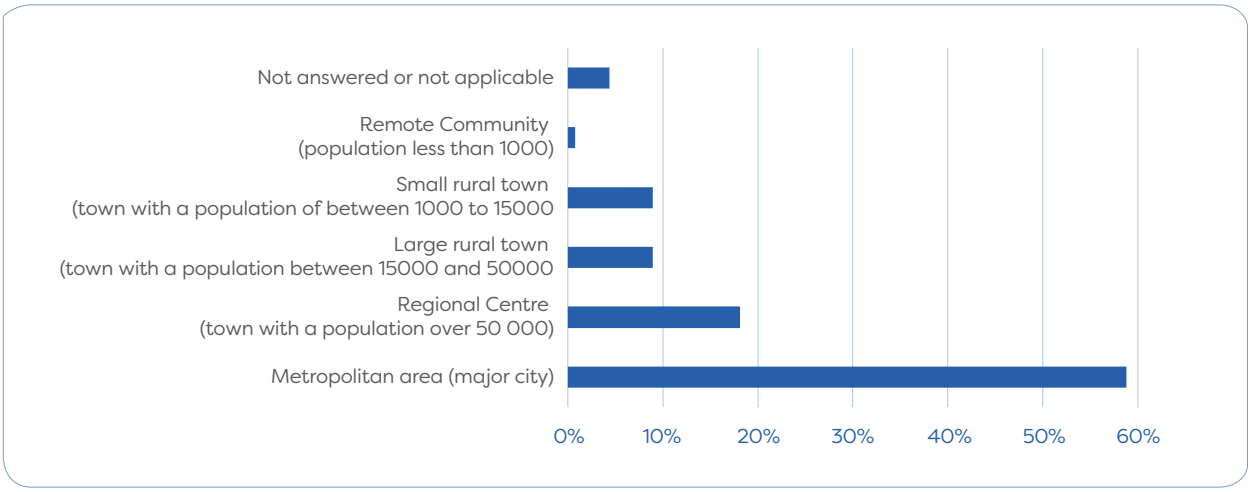
At the close of the stakeholder consultation process, 502 submissions were received in total, with 90.4 per cent of submissions made by individuals, and 9.6 per cent of submissions made by organisations. Responses were received from respondents across all states and territories, with 2.2 per cent providing national views.

Figure 8: Breakdown of survey responses by jurisdiction (% of total responses)



Responses were received across all geographic locations, with 58.8 per cent received from respondents living in metropolitan areas; 36.9 per cent from respondents in regional, rural, and remote communities; and 4.4 per cent from respondents who did not answer this question or indicated the question was not applicable.

Figure 9: Breakdown of survey responses by location (% of total responses)



Respondents like the CDBS

Overall, respondents stated that the CDBS is an important government program that enables access to dental care for children whose families may otherwise not be able to afford it. People like that both public and private dentists are involved in the CDBS. Examples of responses are:

> *"Dental care for kids, what's not to like."*
>
> *"Children who could otherwise not access dental care are able to use CDBS at private clinics."*
>
> *"It's important to have a good working relationship with the private sector to allow for improved dental care access for these eligible children."*
>
> *"The Scheme is highly beneficial to the families of children who simply cannot afford the sorts of expensive dentistry."*
>
> *"Removes part of the financial burden of dental care. It provides reasonable preventive care and intervention for children that have mild to moderate dental needs."*
>
> *"Brings kids into the system and sets them up for a healthy life."*
>
> *"Subsidised treatment for my 3 children that we would struggle to afford otherwise."*
>
> *"Allows access to care."*
>
> *"It is a great scheme; with some more adjustments it will deliver the care we need."*

Respondents' views on what could be improved

Respondents noted that the CDBS is operating reasonably effectively as a standardised program; however, it could be improved to better deliver dental services to cohorts of children who have a higher risk of oral disease, have high care needs and/or require specialised models of service delivery, including services delivered under general anaesthetic. Submissions highlighted that First Nations children, children with disability, and children living in rural and remote areas experience disproportionate barriers in accessing

dental services under the CDBS, compared to the general cohort of children eligible for the program.

While respondents provided a broad range of ideas to improve the CDBS, key themes included:

- The 2022 benefit cap of $1,026 is insufficient for children with extensive and/or high care needs.
- Access to in-hospital services is needed, supported by the inclusion of general anaesthesia on the Dental Benefits Schedule, particularly for children with severe anxiety, for children with disabilities that affect their ability to be treated in a community setting, and where complex extensive dental treatment is required.
- Better promotion of the program is needed, with targeted promotion for priority groups.
- There is a need for more preventive and restorative services on the Dental Benefits Schedule, including mouthguards and silver fluoride.
- Item restrictions should be removed, as they:
  - do not allow suitable balancing of therapeutic risk-benefit and undermine dental practitioners' decision ability to service children appropriately, particularly children with a disability and other high care needs children
  - restrict effective service delivery in rural and remote locations.
- A rural and remote loading is needed for children living in these areas, where extensive travel is often required to access/deliver services.

Chapter 6: Findings

Overview

In presenting its findings, the Review Committee has drawn on available CDBS data, the findings of the stakeholder consultation process, and the experience and knowledge of its members.

The Review Committee agreed that the Act achieves its aim of providing a legislative framework for the payment of dental benefits and supports the administration of the CDBS, which is currently the only program administered under the Act.

However, while the Review Committee agreed that the CDBS can be considered successful as a basic program, the Committee noted the inequities experienced by children from priority groups – children living in rural and remote locations, First Nations children, and children with disability – that prevent access to the CDBS. The Review Committee strongly advocates for changes to the CDBS to improve access and utilisation in these vulnerable cohorts.

Considerations

The data presented to the Review Committee identified that although the program has been operating for nine years, uptake of the CDBS has not reached expected levels and remains below 40 per cent. In addition, some population groups face greater challenges in accessing oral health care and experience a greater burden of poor oral health. These findings are consistent with those reported in the *National Child Oral Health Study 2012–14*.[27]

Children in rural and remote areas

As noted in *Chapter 4: CDBS uptake for priority groups*, there has been a decline in CDBS utilisation in MM 6 and MM 7 classifications. The children living in these classifications are also more likely to be First Nations children. Stakeholder feedback provided several options to promote uptake of CDBS services among eligible children living in these areas, including removing item restrictions – particularly quotas on number of services per day, as they undermine service delivery in rural and remote locations – and addressing workforce maldistribution issues (noting that workforce issues are out of scope of the review).

First Nations children

Data presented in *Chapter 4* shows that eligible First Nations children are consistently less likely to receive services under the CDBS compared to non-Indigenous children. Stakeholder feedback provided several options to improve uptake of CDBS services by eligible First Nations children, such as:

- removing current item restrictions and increasing the number of preventive items, where there is evidence for clinical benefit and cost-effectiveness
- supporting the delivery of culturally safe care

27 University of Adelaide (2016). *Oral health of Australian children: the National Child Oral Health Study 2012–14*. [online] Adelaide: University of Adelaide Press. Available at: www.adelaide.edu.au/press/titles/ncohs.

- acknowledging kinship arrangements and allowing consent forms to be completed by non-parents where kinship relationships exist
- making it possible for First Nations health practitioners to perform preventive dental services for children, including the application of fluoride varnish (as is already in place in several states and territories).

Children with disability

While the Review Committee noted it is currently not possible to identify children with disability in CDBS data, there is strong anecdotal evidence, highlighted through the stakeholder feedback process, that this group also experiences significant access issues.

Stakeholder feedback suggested several options to address access barriers for this priority group, such as:

- increasing the current benefit cap for children with extensive and/or high care needs
- removing item restrictions as they undermine dental practitioners' ability to service children with high needs appropriately
- allowing access to in-hospital services, supported by including general anaesthesia on the Dental Benefits Schedule, particularly for children with severe anxiety and significant treatment needs.

Priority groups

Recommendation 1

To address substantial inequity of access issues, modify the CDBS to improve service access, especially for:

- children living in rural and remote areas
- First Nations children
- children with disability.

The Review Committee considered options to improve service access for identified priority groups, including:

- the need to identify and understand barriers to access
- utilising Aboriginal Medical Services, and training First Nations and other health care workers in preventive oral health care to deliver basic dental services in rural, remote, and First Nations communities
- opportunities for registered health care workers to claim basic dental treatments under the CDBS, recognising the need for training and supervision, particularly around fluoride
- leveraging state and territory delivered school dental programs
- focusing on children before they reach school, such as working with childcare centres and kindergartens, and including oral health check-ups within the 'Blue Book' checklist or equivalent
- reviewing scope of practice and clinical delegations under scope of practice arrangements.

The Review Committee noted the following:

- In relation to CDBS uptake in regional, rural, and remote Australia:
  - the availability of basic dental care in rural and remote communities is limited
  - there is significant under-utilisation of the CDBS, even though other services are available (e.g., the Royal Flying Doctor Service).
- In relation to the service delivery to First Nations children:
  - the need to review how the CDBS is delivered to First Nations communities, to improve uptake and utilisation
  - a greater focus on co-design with First Nations organisations to improve service delivery to First Nations groups
  - the need for health providers to be culturally safe while working in First Nations communities.
- In relation to service delivery to children with intellectual disability:
  - the importance of having a way to record the number of children with disability who have access to CDBS services
  - a move to use of 'children with disability' rather than 'children with intellectual disability', as the latter group does not always include children with autism.

The following recommendations support improved service access to the program for children in priority groups identified in the Terms of Reference.

Priority group	Recommendations
First Nations children	1, 2, 3, 4, 5, 9, 10, 11, 13, 16, 17, 18, 19, 20, 21, 22
Children living in rural and remote locations	1, 3, 4, 5, 9, 10, 11, 13, 16, 17, 18, 19, 20, 21, 22
Children with disability	1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 16, 17, 18, 19, 20, 21

Recommendation 2

The Department of Health and Aged Care to work with the National Aboriginal Community Controlled Health Organisation (NACCHO) and other relevant organisations to determine the level of unmet demand for dental services for First Nations children and use this information to inform activities to improve access to services, and support CDBS service delivery to First Nations children.

The Review Committee notes that despite a larger proportion of First Nations children being eligible for the CDBS, utilisation is lower compared with non-Indigenous children. Low uptake of the CDBS by First Nations children may in part be attributed to a general reluctance to visit the dentist in this population group, and concerns about lack of access to culturally safe care. The Review Committee noted that the First Nations dental professional workforce is currently very small.

Data on CDBS uptake for First Nations children, particularly the delivery of services through Aboriginal Controlled Community Health Organisations (ACCHOs) is limited. The Review Committee identified that understanding the level of unmet demand for dental services is an important step to addressing access barriers and that if demand could be satisfied by supporting ACCHOs – who provide culturally appropriate services and are well suited to provide dental services – this would likely increase CDBS uptake in this cohort.

Program awareness and promotional activity

Recommendation 3

In recognition of the continued under-utilisation of the CDBS, investigate barriers and implement strategies to improve utilisation and service delivery for eligible children.

The Review Committee noted that while under-utilisation of the CDBS is most apparent in priority groups, utilisation continues to be suboptimal and can be improved for all cohorts of eligible children.

Options to improve general utilisation and service delivery form part of an integrated strategy alongside actions listed to improve utilisation and service delivery for priority groups. This includes:

- the need to identify and understand barriers to access
- the need to ensure the CDBS continues to reflect current clinical practice
- the need to ensure information about the CDBS is accessible and in plain English
- leveraging state and territory delivered school dental programs
- focusing on children before they reach school, such as working with childcare centres and kindergartens, and including oral health check-ups within the 'Blue Book' checklist or equivalent
- reviewing scope of practice and clinical delegations under scope of practice arrangements.

Recommendation 4

The Department of Health and Aged Care to expand the promotion of the CDBS, including targeting priority groups through culturally appropriate campaigns, and publication of materials for culturally and linguistically diverse groups.

The stakeholder consultation process findings revealed there was a strong theme around lack of awareness, the need for greater CDBS program promotion, and child oral health promotional messages.

The Review Committee considered that low CDBS utilisation rates may in part be attributable to a general lack of awareness of the program and a lack of understanding of the benefits for children in visiting the dentist regularly from an early age. The Review Committee identified that there is significant value in expanding the scope of the CDBS promotional activities currently undertaken by the Australian Government to address this issue.

Recent activities undertaken by the Department to promote the CDBS through its social media communication channels include:

- a social media campaign run during Dental Health Week (1 August 2022)
- monthly social content posted with a focus on dental care and hygiene on relevant dates, including Easter, Halloween and school holidays
- providing information to state and territory education and health directorates, including promoting the inclusion of CDBS information in the child health 'Blue Book' (or equivalent) distributed by states and territories.

The Review Committee noted that the Department has worked with Services Australia on strategies to further promote the CDBS, including distributing hard and soft copies of the Department's CDBS information brochure with the 2023 annual eligibility notification letters (see Appendix 3).

The Review Committee noted that additional options for promoting the CDBS include:

- paid advertising across digital, social media channels and radio
- making printed copies of the CDBS brochure available to stakeholders to order
- developing targeted First Nations and non-English-speaking background written resources and media strategies using apps such as Facebook, Instagram, myGov, Medicare and state-specific apps such as Service NSW
- distributing written resources through kindergartens and schools, GPs and hospital waiting rooms, Primary Health Networks (PHNs) and child and maternal health care clinics.

The Review Committee recommends the Department of Health and Aged Care expand the promotion of the CDBS, including targeting high-priority groups through culturally appropriate campaigns, and translation of materials for culturally and linguistically diverse groups.

Dental Benefits Schedule

Recommendation 5

Expand the Dental Benefits Schedule to include the following items:

- 123 *Application of a cariostatic agent – per tooth*
- 131 *Dietary analysis and advice*
- 141 *Oral hygiene instruction*
- 151 *Provision of a mouthguard – indirect*
- 163 *Resin infiltration – per tooth*
- 949 *Treatment under general anaesthesia/sedation when provided in a hospital or a day procedure centre.*

The Dental Benefits Schedule was last reviewed and amended with effect from 1 January 2018. These amendments aligned the schedule with the 12th Edition of the ADA's *Australian Schedule of Dental Services and Glossary*. The 13th Edition of the ADA Schedule came into effect on 1 July 2022.

The Review Committee considered the impacts of the 13th Edition of the ADA Schedule. Most of the new items added to the ADA Schedule were considered outside the scope of the CDBS (the remit of which is to deliver basic dental services) and not recommended for inclusion. Several items have also been deleted from the ADA Schedule and these were also considered. Some existing items on the Dental Benefits Schedule were nominated for deletion and/or amendment by members of the Review Committee.

The Review Committee discussed the scope of services included in the CDBS and recommends that it be expanded to align with evolving changes in clinical practice and to strengthen the range of preventive services currently available on the Dental Benefits Schedule. Stakeholder feedback supported this approach.

The inclusion of 123 *Application of a cariostatic agent – per tooth* is recommended as this is a targeted treatment providing a more potent remineralising agent than the whole mouth topical application currently on the Dental Benefits Schedule. In appropriate cases, this could potentially arrest progression of the caries in a tooth. This was strongly supported through stakeholder feedback and was a recommendation from the Fourth Review of the *Dental Benefits Act 2008*.

Providing dietary and fluoride/oral hygiene advice is an important component of preventive care. The inclusion of additional preventive services of 131 *Dietary analysis and advice*, 141 *Oral hygiene instruction*, and 151 *Provision of a mouthguard – indirect* are recommended. Providing guidance on how to keep teeth and gums healthy from an early age helps to prevent children from developing dental problems later in life. Children particularly benefit if newly developing adult teeth come in strong and healthy.

It takes time for a dental provider to explore the causes of any emerging dental issues and explain them thoroughly to a parent during an initial consultation. The Review Committee recommends that item 131 and item 141 both be at least 15 minutes in length. Items 131 and 141 can be billed together in a 30-minute appointment but would be limited to claiming once per year.

Regarding including 151 *Provision of a mouthguard – indirect*, the Review Committee considered that the common causes of dental trauma in children are falls and sports, and that the ADA and Sports Medicine Australia have a mouthguard policy for sports clubs to implement 'no mouthguard, no play'. All Australian sports clubs are encouraged to make wearing mouthguards mandatory for their players. Including this item on the Dental Benefits Schedule is on the proviso that the mouthguard is custom made and properly fitted, and that the patient must have been reviewed by the dentist within the previous six months. The Review Committee recommends a limit of one per year, and a minimum age of 8 years, and for the Department to consider any taxation implications associated with products provided under this item.

Item 163 *Resin infiltration – per tooth* is recommended for inclusion as it is a minimally invasive method for treating very early decay.

Recommendation 6

Allow the claiming of CDBS benefits for in-hospital services, where clinically appropriate.

Section 20 of the Act excludes a dental benefit from being payable if a dental service is rendered as part of an episode of hospital treatment, or as part of a hospital-substitute treatment as prescribed under the *Private Health Insurance Act 2007*. This means CDBS benefits cannot be claimed in both public and private hospital settings.

The Review Committee noted that this restriction operates as a barrier that prevents patients who require in-hospital treatment from accessing basic dental treatment, particularly for children who require general anaesthesia to access dental services that are listed on the Dental Benefits Schedule.

The Committee agreed that eligible children should be able to access CDBS benefits in hospital settings (both public and private), where it is clinically relevant.

Recommendation 7

The Australian Government to work with states and territories to improve access to free public sector in-hospital general anaesthetic services for children considered 'high care needs', where clinically appropriate.

The Review Committee noted that eligibility requirements for access to this service vary between states and territories and that waiting lists are very long. Members agreed that access to general anaesthesia for children with high care needs in public hospitals must be improved, in part because there are substantial cost barriers associated with accessing equivalent treatment in the private hospital sector.

The Review Committee were also strongly of the view that this exclusion creates a significant barrier to dental care for CDBS-eligible children with disabilities and with significant treatment needs requiring a general anaesthetic to access dental care. This issue was also raised extensively by respondents through the stakeholder consultation process.

In implementing this recommendation, the National Health Reform Agreement may provide a mechanism to support improved access to public dental services delivered under general anaesthetic.

The Review Committee recommend that the Act be amended to enable access to in-hospital treatment, where clinically appropriate. Furthermore, the Review Committee recommend including item 949 *Treatment under general anaesthesia/sedation when provided in a hospital or a day procedure centre* in the Dental Benefits Schedule to support access to eligible dental services provided under general anaesthesia (Recommendation 5).

A minority of members recommended that 15 per cent of the CDBS budget be appropriated directly to states and territories to specifically fund delivery of dental services to children with high care needs. This recommendation would replace existing state and territory access arrangements for the CDBS and focus public dental services towards children with high care needs. This aims to increase access to dental and associated general anaesthesia services in public settings for eligible children.

Recommendation 8

Amend 88943 *Sedation – inhalation* on the Dental Benefits Schedule to 88493 *Sedation – inhalation of nitrous oxide and oxygen mixture – first 30 minutes or part thereof* and add a new step-down item 88946 *Sedation – inhalation of nitrous oxide and oxygen mixture – subsequent 30 minutes or part thereof*.

The Review Committee recommends amendment of item 88943 to improve alignment with ADA item 943, including alignment with the ADA's name and descriptor, and with how the item is used in practice. It is further recommended that this amendment be supported by the addition of new, related, step-down item 88946. The Review Committee recommends that the step-down item 88946 include the following applicable restrictions: subsequent 30 minutes only; limit of 90 minutes over items 88943 and 88946; and to only be claimed by a dentist.

Recommendation 9

Develop a 'CDBS high care needs' definition to support targeted CDBS service delivery to children considered 'high care needs' in relation to dental and oral disease.

The Review Committee recommends developing a 'CDBS high care needs' definition that identifies classes of CDBS-eligible children who are at higher risk of developing dental and oral care issues, and therefore are likely to require more services rendered as part of a single episode of care.

This definition is required to implement recommendations 10 and 11.

Recommendation 10

Remove restrictions on the following CDBS items to support CDBS service delivery to children considered 'high care needs':

- 88012 *Periodic oral examination*
- 88013 *Oral examination – limited*
- 88022 *Intraoral periapical or bitewing radiograph – per exposure*
- 88111 *Removal of plaque and/or stain*
- 88114 *Removal of calculus – first visit*
- 88115 *Removal of calculus – subsequent visit*
- 88121 *Topical application of remineralisation and/or cariostatic agents, one treatment*
- 88161 *Fissure and/or tooth surface sealing – per tooth (first four services on a day)*
- 88162 *Fissure and/or tooth surface sealing – per tooth (subsequent services)*
- 88521 *Adhesive restoration – one surface – anterior tooth – direct*
- 88531 *Adhesive restoration – one surface – posterior tooth – direct*
- 88586 *Crown – metallic – with tooth preparation – preformed*
- 88587 *Crown – metallic – minimal tooth preparation – preformed.*

The Review Committee notes the importance of being able to increase CDBS service delivery for high care needs children and recommends removal of restrictions and/or limitations for a number of specific CDBS item numbers to allow more clinically relevant services to be rendered during a single episode of care. However, these restrictions should only be removed for children considered to be 'high care needs', not for the general eligible population.

The Review Committee notes that in addition to the items listed in this recommendation, the Department's Dental Clinical Review Committee may identify additional CDBS items for which restrictions should be removed for 'high care needs' children.

Recommendation 11

Double the benefit cap for children considered 'high care needs' to ensure they receive adequate oral health care, noting the importance to safeguard against inappropriate treatment.

The Review Committee also recommends that the benefit cap be doubled for 'high care needs' children, due to the higher burden of oral disease and the need for more frequent and more costly services in this group.

Recommendation 12

Delete the following items from the Dental Benefits Schedule:

- 88025 *Intraoral radiograph – occlusal, maxillary, mandibular – per exposure*
- 88323 *Surgical removal of a tooth or tooth fragment requiring removal of bone – first tooth extracted on a day*
- 88458 *Interim therapeutic root filling – per tooth*
- 88511 *Metallic restoration – one surface – direct*
- 88512 *Metallic restoration – two surfaces – direct*
- 88513 *Metallic restoration – three surfaces – direct*
- 88514 *Metallic restoration – four surfaces – direct*
- 88515 *Metallic restoration – five surfaces – direct*
- 88575 *Pin retention – per pin*.

The 13th Edition of the *Australian Schedule of Dental Services and Glossary*, which came into effect on 1 July 2022, represents the most contemporaneous advice from the ADA. In this edition, the ADA has deleted items 025, 054, 085, 086, 323, 458, 730 and 983, and replaced item 774 with item 781. To align the Dental Benefits Schedule with this advice, the Review Committee recommends deleting equivalent CDBS items 88025, 88323 and 88458.

The use of amalgam items (88511–88515) on the CDBS has been steadily declining for years. In 2021, the total number of services delivered for these items was the lowest since the CDBS commenced on 1 January 2014 (data presented below). The Review Committee also recommends deletion of these items from the Dental Benefits Schedule, noting these changes also align with Australia's commitments under the Minamata Convention on Mercury.

Item	2014	2015	2016	2017	2018	2019	2020	2021
88511	3796	3232	2055	1449	981	774	643	461
88512	4561	3176	2153	1680	1218	918	734	492
88513	885	697	440	363	264	164	142	109
88514	158	118	74	58	41	30	26	30
88515	31	33	24	15	27	13	16	13

Recommendation 13

The Department of Health and Aged Care's Dental Clinical Review Committee[28] to consider:

- the addition to the Dental Benefits Schedule of 919 *Teleconsultation*, 920 *Extended teleconsultation – 30 minutes or more*, and 921 *Teleconsultation by referral*, and
- the currency of the schedule fees for items listed on the Dental Benefits Schedule.

While further evidence is needed, including tele-dentistry in the CDBS was identified as a potential strategy to address barriers to dental services for children in rural and remote areas. The Review Committee noted that tele-dentistry services potentially have a place in the CDBS but should be used with caution as there are some compliance concerns associated with claiming and that the circumstances where a verbal-only consultation in dentistry is satisfactory are far more limited than they are for a medical consultation. The Review Committee recommends that this matter be further considered by the Department's Dental Clinical Review Committee.

Through the stakeholder consultation process, feedback was received that some CDBS item benefit amounts are too low. Examples include pulpotomy (88414) and root canal treatment (88415 to 88421). The Review Committee noted that the last time the CDBS schedule was comprehensively reviewed and updated was in 2018. Therefore, the Review Committee recommends that a comprehensive review of the currency of the CDBS schedule benefit amounts be undertaken by the Dental Clinical Review Committee and provided to Australian Government for consideration.

Administrative arrangements

Recommendation 14

Amend the *Dental Benefits Act 2008* to remove 'voucher' terminology.

Part 4 of the Act outlines the framework for issuing dental benefits vouchers. The requirement for a voucher to be issued under the CDBS is linked to the entitlement for a child to receive dental benefits under the CDBS.

Under current arrangements, a 'notification letter' is issued by Services Australia to eligible children to inform them of their eligibility and the funding they can access under the program. Operationally, this letter (refer to Appendix 3 for the 2022 and 2023 notification letters) is deemed equivalent to the provision of a 'voucher' for the purposes of the Act.

The Review Committee considered the departmental advice noting that the use of the term 'voucher' in the Act is hangover terminology from the Medicare Teen Dental Program. The format and content of the letter is restricted by publication rules determined by Services Australia. The Review Committee noted that there is no policy reason for the 'voucher' term to remain, and recommended that the reference to the voucher mechanism be removed from the Act.

28 Note regarding the Department's Dental Clinical Review Committee:Recommendation 13 of the Fourth Review of the *Dental Benefits Act 2008* sought establishment of a formal process to consider variations to the Act and the Rules. The focus was to establish an appropriate formal advisory structure to consider amendments to the CDBS as needed (outside of the triennial legislative reviews) to ensure the program stays current. Once established, it will be formally known as the Dental Clinical Advisory Committee.

Recommendation 15

The Department of Health and Aged Care to work with Services Australia to determine if:

- previous CDBS billing history can be provided to the current dental practitioner, and
- tooth identification at the point of claim can be captured.

Stakeholder feedback suggested that the CDBS administrative arrangements are burdensome – for example, the requirement to complete annual bulk-billing forms, and the fact that providers cannot cross-reference previous billing history by another dental provider. Access to the previous CDBS billing history by the current dental practitioner would improve the timeliness and quality of care provided to patients and reduce the possibility of claiming limits being inadvertently breached. The need for patient privacy considerations to be considered in any such arrangements was noted.

The Review Committee concluded that CDBS data collection would be significantly enhanced by the capture of tooth identification data at the point of claiming. This would facilitate longitudinal tracking at the 'tooth level' of the oral health of children – for example, identifying if further treatments on the same tooth are required over time. Tooth identification information could be used to support CDBS program compliance monitoring and would support policy development to improve long-term population health outcomes. The Review Committee recommends that if tooth identification is introduced, the World Dental Federation (FDI) two-digit tooth identification number should be employed.

Recommendation 16

Streamline CDBS consent arrangements for state and territory programs with regard to:

- informed financial consent and out-of-pocket costs
- financial consent without parental attendance, and
- removing the requirement for an annual bulk-billing patient consent form.

The Review Committee recommends improvement in CDBS consent arrangements by removing complexity and the need for an annual informed financial consent form for bulk-billed dental services delivered by states and territories. These arrangements are especially burdensome when states and territories are administering school dental programs. Issues with CDBS consent arrangements identified as part of the Fourth Review of the Act and through ongoing discussions with states and territories include:

Issues raised around informed financial consent and out-of-pocket costs

- The current informed financial consent form states parents and carers need to personally meet the costs of any services not covered by the CDBS.
- This causes unnecessary confusion and concern about possible out-of-pocket costs for clients attending public dental services, where clients are always bulk billed for their treatment costs.
- Some states have suggested developing a public sector version of the informed financial consent form, removing information about capped benefits and possible out-of-pocket costs. This would reduce confusion and concern amongst parents and improve the effectiveness of the program's reach to all eligible children.

Issues raised around financial consent without parental attendance

- States and territories argue that consent mechanisms are cumbersome, confusing for parents and not congruent with delivery of services to children in a public sector setting.
- Public oral health services may treat children in fixed or mobile dental clinics on site at schools during school hours when a parent cannot be physically present.

Recommendation 17

The Department of Health and Aged Care to work with relevant stakeholders to understand foster care and kinship care arrangements, remove access barriers if possible, and determine options for recognising alternative consent arrangements.

Through the CDBS public consultation process, stakeholders suggested that children in foster care and kinship care should be eligible for the CDBS and non-parents should be recognised when kinship arrangements exist. The Review Committee noted that children in foster and kinship care generally have higher oral health care needs than other children of the same age due to the disrupted nature of their care arrangements.

The Review Committee also noted that CDBS eligibility and/or consent processes do not cater for foster care and kinship care arrangements, which presents a barrier to CDBS uptake within this cohort.

The Review Committee recommends work be undertaken by the Department to explore how the CDBS could appropriately recognise foster and kinship systems, including removal of barriers (for example, through legislation changes), and pursue options for more flexible consent arrangements.

Data, digital infrastructure and research

The Review Committee noted the importance of available data to underpin their deliberations. However, there are significant data limitations that undermine analysis of the program, particularly for children from priority cohorts. The Review Committee also noted the disparity in state and territory dental service data, which is difficult to capture and coordinate without a centralised data exchange. In addition, stakeholder feedback highlighted a lack of public reporting and analysis of CDBS data and program evaluation.

Recommendation 18

The Department of Health and Aged Care to work with the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), and other data custodians to:

- understand what data is available to support provision of information about variations in care under the CDBS, and
- develop mechanisms for identifying priority cohorts of children, especially children with disability and First Nations children.

The Review Committee recommends the Department work with the ABS, the AIHW, and other data custodians such as Services Australia, to understand the existing data landscape, including gaps, and what can be done to improve the data available. This includes, as noted previously, addressing data gaps in relation to children with disability who are eligible for the CDBS.

Recommendation 19

The Department of Health and Aged Care to identify ways to improve the digital health infrastructure that supports the CDBS to improve patient and research outcomes.

The Review Committee recommends the Department improve the digital health infrastructure that supports the CDBS. The aim of this recommendation is to develop a digital focus for the CDBS that enables translational research to improve service delivery and patient outcomes. This may include initiatives to capture higher quality data, promote centralised data storage and exchange, and better coordinate information between relevant clinicians and researchers.

Recommendation 20

The Department of Health and Aged Care to publish an annual data summary of access and utilisation of the CDBS by jurisdiction and priority group, by April of the following calendar year.

The Review Committee noted that data on the accessibility and utilisation of the CDBS could be made more available. In order to increase transparency, the Review Committee recommended that at the end of each calendar year, the Department should publish, by April of the following year, a CDBS data report on its website.

Recommendation 21

Acknowledging the existing CDBS data gaps, strengthen research on the CDBS to understand and address substantial inequity of access issues.

The Review Committee recommends strengthening research on the CDBS. This may include supporting research to identify population health and strengthen the understanding around inequity of access.

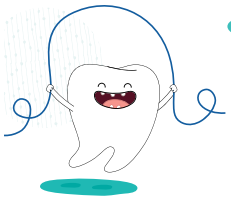
Appendices

Appendix 1: 2022 CDBS brochure

Give your kids a reason to smile!

Child Dental Benefits Schedule

Australian Government
Department of Health

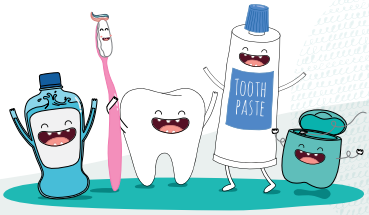


For more information on the Child Dental Benefits Schedule:

- Visit health.gov.au/CDBS or servicesaustralia.gov.au and search for **'child dental benefits schedule'**.
- Call **Services Australia** on **132 011**.
- **Ask your dentist** about the CDBS!

Get up to **$1,026*** towards your kids dental care

Find out if your kids are eligible



* Amount indexed annually, this is the CDBS cap amount for 2022.
Current at October 2021

health.gov.au/CDBS

The Child Dental Benefits Schedule

The **Child Dental Benefits Schedule (CDBS)** covers part or the full cost of some dental services for eligible children.

WHAT IS COVERED

Eligible children can access up to **$1,026*** for basic dental services over 2 calendar years.

The services covered include:

- dental check-ups
- cleaning
- x-rays
- fissure sealing
- fillings
- root canals
- extractions.

At your appointment check what each service will cost and if the CDBS covers the full cost of those services.

The CDBS does not cover:

- orthodontics
- cosmetic dental work
- any dental services in a hospital.

* Amount indexed annually, this is the CDBS cap amount for 2022.

Check if your child is eligible

You don't need to apply or register for the CDBS. If your child is eligible, you will automatically receive a letter to let you know.

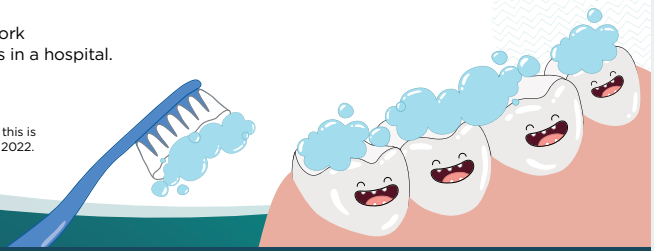
Your child is eligible when:

- they are eligible for Medicare
- they are under 18
- they receive an eligible payment at least once that year, or you receive one as their parent or guardian.

You can find a list of eligible payments when you visit servicesaustralia.gov.au and search **'child dental benefits schedule'**.

If you aren't sure if your child can access the CDBS this year, you can either:

- check your **Medicare online account** through MyGov at my.gov.au
- call **Medicare on 132 011**.



Finding a dentist

You can get child dental benefits for services at most dentists, whether they are public dental services provided by your State or Territory Government or private dental practices.

When you book an appointment:

1. let your dentist know that you want to use the CDBS, and
2. ask how much funding you have available under your CDBS cap.

PUBLIC OR PRIVATE?

A public dentist using the CDBS will bulk bill you and there will be no out-of-pocket expenses. Some private dentists bulk bill CDBS services.

Private dentists who do not bulk bill may charge a gap fee for services.

Ask your dentist when you book your appointment.

To find a dentist who bulk bills, use the **'find a health service'** tool on the healthdirect website at:

healthdirect.gov.au/australia-health-services

Appendix 2: Stakeholder consultation process

STAKEHOLDER CONSULTATION

CHILD DENTAL BENEFITS SCHEDULE

About the Child Dental Benefits Schedule

The Child Dental Benefits Schedule (CDBS) is a national program funded by the Australian Government and managed by the Department of Health and Aged Care and Services Australia. It provides children who are eligible for Medicare and who satisfy a means test up to $1026 in benefits over a two calendar year period for basic dental services (refer to the CDBS Brochure at Attachment A).

The CDBS is legislated under the *Dental Benefits Act 2008* (the Act) and the *Dental Benefit Rules 2014* (the Rules). Under the Act, an independent review of the Act must occur one year after the Act commenced, and once every three years thereafter. Previous reviews were commenced in 2009, 2011, 2015 and 2018.

Since the CDBS commenced on 1 January 2014, more than $2.6 billion in benefits and around 42.7 million services have been delivered to nearly 3.2 million Australian children[1].

Why are we asking questions about the Child Dental Benefits Schedule?

The fifth review of the Act is currently underway. The Fifth Review Panel, appointed by the Minister for Health and Aged Care, is considering how the CDBS program can be improved.

Additional information about the CDBS can be found on the Department's website at https://www.health.gov.au/initiatives-and-programs/child-dental-benefits-schedule. The Terms of Reference and the Fifth Review Panel membership are located at the end of this document (refer to Attachment B).

Consultation Process

The Fifth Review Panel is seeking views from the public on the CDBS.

There are two sets of questions – one for people who use CDBS services (consumers) and one for people who deliver CDBS services (providers). You only need to answer one set of questions. All questions are optional. You can choose to answer some or all questions.

How to make a submission

You can make a submission in several different ways:

- Online on the Department's Consultation Hub at Australian Government Department of Health and Aged Care - Citizen Space
- Via email at DAHM@health.gov.au
- Over the phone by calling the Dental Hotline on 02 6289 3800

Closing date for submissions

The closing date for submissions is Thursday, 25 August 2022.

[1] Data to 30 June 2022

Questions for Consumers

1) What do you like about the Child Dental Benefits Schedule?
2) What don't you like about the Child Dental Benefits Schedule?
3) How did you find out about the Child Dental Benefits Schedule?
    a. Dentist
    b. Website
    c. Government letter
    d. Family or friend
    e. Other (please specify)
4) Do you think people know about the Child Dental Benefits Schedule? How could government promote it better?
5) Do you think the Child Dental Benefits Schedule is useful and accessible for First Nations children, children with Intellectual Disability, and/ or children in rural or remote Australia?
6) If your child identifies as First Nations, do they feel culturally safe seeing non-indigenous dental providers through the Child Dental Benefits Schedule?
7) How could the Child Dental Benefits Schedule be improved?
8) Do you have any further comments that you would like to make?
9) What state or territory do you live in?
    a. Australian Capital Territory
    b. New South Wales
    c. Northern Territory
    d. Queensland
    e. South Australia
    f. Tasmania
    g. Victoria
    h. Western Australia
10) Do you live in a?
    a. Metropolitan area (major city)
    b. Regional Centre (town with a population over 50 000)
    c. Large rural town (town with a population between 15 000 and 50 000)
    d. Small rural town (town with a population of between 1000 to 15 000)
    e. Remote community (population less than 1000)
11) Are the answers to the questions above your individual views, or do they represent an organisations' views?
    a. Individual
    b. Organisation (please specify)

Questions for Dental Care Providers and Stakeholder Organisations

1) What do you like about the Child Dental Benefits Schedule?
2) What don't you like about the Child Dental Benefits Schedule?
3) Do you think people know about the Child Dental Benefits Schedule? If so, how could government promote it better?
4) Do you think the Child Dental Benefits Schedule is useful and accessible for First Nations children, children with Intellectual Disability, and/ or children in rural or remote Australia?
5) How could the Child Dental Benefits Schedule be improved in general, or to deliver effective dental services to First Nations children, children with intellectual disability and/ or children in rural or remote Australia?
6) Do you have any further comments that you would like to make?
7) What state or territory do you work in?
    a. Australian Capital Territory
    b. New South Wales
    c. Northern Territory
    d. Queensland
    e. South Australia
    f. Tasmania
    g. Victoria
    h. Western Australia
8) Do you work in a?
    a. Metropolitan area (major city)
    b. Regional Centre (town with a population over 50 000)
    c. Large rural town (town with a population between 15 000 and 50 000)
    d. Small rural town (town with a population of between 1000 to 15 000)
    e. Remote community (population less than 1000)
9) Are the answers to the questions above your individual views, or do they represent an organisations' views?
    a. Individual
    b. Organisation (please specify)

Appendix 3:
CDBS notification letters for 2022 and 2023

2022 notification letter

If not delivered return to: Child Dental Benefits Schedule
PO Box 1001 TUGGERANONG DC ACT 2901

Australian Government
Services Australia

medicare

11 July 2022

<Title> <First name> <Surname>
<Address Line 1>
<Address Line 2>
<SUBURB> <STATE> <Postcode>

Our reference: <**reference**>

Dear <Title> <First name> <Surname>

Your child/ren's eligibility for dental benefits

Your child/ren listed below are eligible for dental benefits in <YYYY> under the Child Dental Benefits Schedule which covers part or the full cost for a range of basic dental services for eligible children.

You can now access benefits for basic dental services for your child/ren up to $<AMOUNT> per child which can be used over 2 calendar years. If you do not use the full amount in the first year, you can use the remaining amount in the second year, if your child/ren remains eligible.

Your child/ren's eligibility is re-assessed each calendar year and remains valid for that year, even if the payment that made them eligible stops or they turn 18 years of age.

Eligible child's name
<First name>
<First name>
<First name>
<First name>
<First name>
<First name>
<First name>
<First name>

Your next steps

To get dental services for your eligible child/ren:

1. make an appointment with any dentist of your choice and let them know that you will be using the Child Dental Benefits Schedule.
2. discuss costs and any restrictions on the dental items with your child's dentist. Do this before you consent and begin treatment.
3. pay the bill if your child's dentist does not bulk-bill. You can then claim the benefit from us. If the dentist does bulk-bill, you do not need to do anything.

You should confirm your child's available dental benefits balance before you make an appointment by:

- accessing Medicare services through your myGov account. If you do not have a myGov account, go to **my.gov.au** to create one and link it to your Medicare online account.

Z1869.1906

Page 1 of 2

- calling us on 132 011 (call charges may apply).

The dentist can also check your child's available balance by contacting us.

Dental services you can claim

You can claim benefits for a range of basic dental services for your child, including; check-ups, x-rays, cleaning, fissure sealing, fillings, root canal work and extractions. You cannot claim benefits for orthodontic or cosmetic dental work, or any dental services provided in a hospital.

More information

For more information about the Child Dental Benefits Schedule and eligibility, please go to **servicesaustralia.gov.au/childdental**

Yours sincerely

Director
Medicare Consumers

2023 notification letter

If not delivered: Child Dental Benefits Schedule
PO Box 1001 TUGGERANONG DC ACT 2901

Australian Government
Services Australia

medicare

<11 July 2023>

<<recipient barcode>>
<Title> <First name> <Surname>
<Address Line 1>
<Address Line 2>
<SUBURB> <STATE> <Postcode>

Our reference: <**reference**>

Dear <Title> <First name> <Surname>

You may be eligible for dental benefits for your children

You may be eligible for up to $<AMOUNT> for each child listed below to use at the dentist over 2 consecutive calendar years, starting in <YYYY>.

This will cover part or the full cost for a range of basic dental services, including check ups, x-rays, cleaning, fissure sealing, fillings, root canal work and extractions.

What you need to do

Call your dentist to make an appointment for your children listed below and tell them you want to use the Child Dental Benefits Schedule (CDBS).

<Child's first name>
<Child's first name>
<Child's first name>
<Child's first name>
<Child's first name>
<Child's first name>

Ask your dentist what services they provide and if they bulk-bill. If your dentist asks for payment, you can claim dental service costs that are **covered by the CDBS** from us afterwards.

Eligibility and balance

To check your child's eligibility and balance, go to **my.gov.au** sign in and select Medicare to access your online account. View your 'Child Dental Benefits Schedule' under 'History and statements'. You can also ask your dentist or call us on 132 011 (call charges may apply).

The CDBS is available to eligible children up to 17 years of age. Eligibility is checked each year and is valid for that calendar year. If you do not use the full amount in the first year and if your child remains eligible, you can use the remaining amount in the second year. However, if your child turns 18 this year, their eligibility will cease on 31 December this year.

Z1869.2210

More information

For detailed information about eligibility and what dental services are covered, please go to **servicesaustralia.gov.au/childdental** or **health.gov.au/cdbs**

To find a local dentist who will bulk-bill, go to **healthdirect.gov.au/australia-health-services**

Yours sincerely

Director
Medicare Consumers