Public Health Association of Australia submission on Fifth Review of the Dental Benefits Act 2008

Contact for recipient:
Department of Health and Aged Care
A: GPO Box 9848, Canberra ACT 2601
E: DAHM@health.gov.au
T: (02) 6289 3800

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: policy@phaa.net.au **T:** (02) 6285 2373

25th August 2022

Contents

Public Health Association
AUSTRALIA

The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction

PHAA welcomes the opportunity to provide input to Fifth Review of the Dental Benefits Act 2008. The PHAA Oral Health Policy notes that:

> 'Oral health is fundamental to overall health. Population and targeted prevention strategies are essential to reduce the burden of oral diseases and oral health inequities in Australia. All Australians should have access to person-centred and value-based, culturally appropriate, safe, affordable, timely and cost-effective oral health care. Oral health literacy should be enhanced to promote the understanding of oral conditions and the options for appropriate oral health care and health promoting lifestyles. Disadvantaged population groups have a higher burden of oral disease and should be given priority in publicly funded oral health care programs.'

Issues

Our comments on the questions posed by the consultation are set out below.

1. What do you like about the Child Dental Benefits Schedule?

The Child Dental Benefits Schedule has increased access to affordable oral healthcare, particularly for children from low household incomes, who are at great risk for oral diseases. Long-term retention of the dental program and ensured that there is ongoing oral disease management, which can be accessed in either the public or private sector.

2. What don't you like about the Child Dental Benefits Schedule?

The Child Dental Benefits Schedule is restricted and can only be billed by a registered dental practitioner provider. Thus, it does not allow for non-dental health professionals' access to the program to provide preventive oral healthcare services, for which they may be trained and competent to do so. It also does not have a strong focus on prevention, and there is little oversight in whether the dental services provided are having value to clients or are clinically relevant and appropriate to the clients' oral health needs. The Child Dental Benefits Schedule, in its current form, is at-risk for overservicing treatments including restorative, endodontic and oral surgery (especially wisdom teeth). Regarding restorative treatments, it is clear that standard care dentistry is inappropriate, as indicated by the systematic review and meta-analysis by Innes and Schwendicke (2017):

> For proximal lesions extending up to the enamel-dentin junction, 48% (95% CI, 40%–56%) of dentists/therapists would intervene restoratively. For occlusal lesions with enamel discoloration/cavitation but no clinical/ radiographic dentin involvement, 12% (95% CI, 6%–22%) of dentists/therapists stated they would intervene, increasing to 74% (95% CI, 56%–86%) with dentin involvement."
>
> *Innes NPT, Schwendicke F. Restorative Thresholds for Carious Lesions: Systematic Review and Meta-analysis. Journal of Dental Research. 2017;96(5):501-508. doi:10.1177/0022034517693605*

Many restorative treatments are being provided when they are unnecessary, or when alternative non-invasive preventive treatment options are appropriate. This finding is supported by research in Australia by Keys et al. (2019), which demonstrates overservicing for restorative treatments and concluded:

> "In this study, 887 responses were received. In 'enamel-limited' carious lesions, dentists intervened most frequently in primary tooth approximal (365, 41.1%), followed by permanent tooth occlusal (295, 33.3%) and approximal (244, 27.5%), and primary tooth occlusal (203, 22.9%) surface carious lesions.'…. 'Australian dentists reported significant variation in their management of approximal and occlusal carious lesions in both primary and permanent teeth. A substantial proportion of respondents would intervene surgically on non-cavitated enamel-limited lesions."
>
> *Keys T, Burrow MF, Rajan S, Rompre P, Doméjean S, Muller-Bolla M, Manton DJ. Carious lesion management in children and adolescents by Australian dentists. Aust Dent J. 2019;64(3):282-292. doi: 10.1111/adj.12710.*

Some administrative requirements present themselves as potential barriers to accessing the dental program, such as the written consent arrangements, regular monetary value benefit checking at each dental appointment, and inability to cross reference any previous history of billing by another dental provider. It would be helpful to align the billing requirements consistent with the Medicare Benefits Schedule (MBS), reviewing whether a 'capped' benefit is required (this is largely absent from the MBS), and enable functionality to review client information on previous billing history to understand what item codes may be restricted if dental services are provided recently and externally to the public or private practice entity. Consent timelines and validity are particularly challenging for state and territory government school dental programs.

3. Do you think people know about the Child Dental Benefits Schedule? If so, how could government promote it better?

Broadly, the Child Dental Benefits Schedule is heavily promoted through mainstream media such as TV or radio advertising. The above proposed strategies will help in increasing efficient utilisation of the Child Dental Benefits Schedule. Targeted advertising channels may also be helpful – for example many schools, principals, and parents and carers are unaware of the program. Additionally increasing awareness among priority populations would be helpful such as through ACCOs, Koori Mail etc.

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?

The Child Dental Benefits Schedule was designed with the intention to address affordability to dental services for children from low household incomes, which is largely provided by mainstream healthcare services. This meant that the dental program does not specifically address the needs of First Nations children, children with Intellectual Disability, and/ or children in rural or remote Australia. Additionally, a number of Aboriginal Community Controlled Organisations, which provide oral health services have noted challenges with the administrative processes for claiming. Specific inclusion criteria for inclusion of children from these groups will also help in ensuring the accessibility of this scheme by these priority groups beyond the eligibility solely based on the household income means-test.

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?

In our policy statement, we recommend:

- The Commonwealth government to engage with stakeholders who work with First Nations children, children with intellectual disability and/or children in rural or remote Australia. This would involve consideration to review what other dental services should be included in the Child Dental Benefits Schedule of permitted services, and associated limitations or restrictions for billing.
- Increased engagement with Aboriginal community-controlled health services. The scheme is poorly advertised among these community-controlled health services, and an increased engagement with community and Aboriginal health workers and practitioners will be a positive step towards providing these services for First Nations children. As an example, Victoria has recently approved Aboriginal and Torres Strait Islander Health Practitioners to perform preventive dental services for children, including the application of fluoride varnish to prevent dental caries.

6. Do you have any further comments that you would like to make?

To date, the Child Dental Benefits Schedule has not had formal evaluation on the effectiveness of the dental program. We support the recommendation in Australia's National Oral Health Plan 2015-2024, to 'Promote and evaluate the use of Child Dental Benefits Schedule (CDBS) for children in Priority Populations'. The PHAA Oral Health Policy also articulates the need to 'enhance the effectiveness of the Child Dental Benefits Schedule (CDBS) by:

- introducing evidence-based guidelines,
- introducing risk based preventive dental care pathways, and
- monitoring treatment services and access by vulnerable special needs groups.'

To ensure sustainability and promote evidence-based practice, a national standard set of clinical guidelines should be developed to assure appropriate and safe clinical care. One example includes the American Dental Association Evidence-Based Clinical Practice Guideline on Restorative Treatments for Caries Lesions. In addition, the CDBS fee-for-service model should gradually transition towards value-based health care, which will support better integration of dental services into primary healthcare. Finally, the CDBS should be reviewed for alignment against the World Health Organization Global Oral Health Action Plan.

7. What state or territory do you work in?

Australia-wide.

8. Do you work in a?

None applicable.

9. Are the answers to the questions above your individual views, or do they represent an organisations' views?

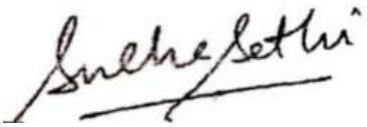
Organisation - Public Health Association of Australia.

Conclusion

PHAA supports the broad directions in increasing access to affordable oral healthcare for children from low household income. However, we are keen to ensure its utilisation is equitable to address unmet oral healthcare needs, are clinically appropriate, and are value for money, in line with this submission.

The PHAA appreciates the opportunity to make this consultation. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia



Dr Sneha Sethi
PHAA Oral Health SIG Co-convenor

25 August 2022