Report on the Third Review of the *Dental Benefits Act 2008*
December 2015

The Hon Sussan Ley MP
Minister for Health
Minister for Aged Care
Minister for Sport
Parliament House
CANBERRA ACT 2600

Dear Minister


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

In relation to the Terms of Reference for the Review, it was the Panel’s view that the Act and its associated Rules attains its legislative and administrative purpose in supporting the establishment and operation of the Child Dental Benefits Schedule (CDBS), and the Medicare Teen Dental Plan before it.

The Panel is pleased that the CDBS is targeting the oral health of young Australians at an age where preventive measures can be most effective. The Panel has made recommendations to the Government to ensure the ongoing success and effectiveness of the CDBS.

I wish to thank my fellow Panel members for their valuable expertise and contribution to the Review. I would also like to acknowledge the support of the Department of Health in assisting the Panel with its work.

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

Yours sincerely

[Signature]

Professor Chris Braggole AO
Chief Medical Officer
Review Panel Chair

GPO Box 9848 Canberra ACT 2601
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Executive Summary

The Dental Benefits Act 2008 (the Act) is the mechanism under which the Australian Government pays benefits for dental services to eligible dental patients.

This Review of the Act has been undertaken as a requirement of section 68 of the Act. Section 68 stipulates that the Minister for Health must cause an independent review of the operation of the Act to be undertaken 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.

To undertake the third review of the Act, the Minister for Health, the Hon Sussan Ley MP, appointed a Review Panel on 22 June 2015. The Review Panel comprised the following persons, as stipulated under section 68 of the Act:

> person occupying the position of Commonwealth Chief Medical Officer;
> a person nominated by the Australian Dental Association;
> a person nominated by the Consumers’ Health Forum of Australia; and
> two other persons nominated by the Minister, at least one of whom must have qualifications in medicine or dentistry.
TERMS OF REFERENCE

The Review Panel will undertake the third independent review of the Dental Benefits Act 2008 (the Act) having regard to the following Terms of Reference:

The Review Panel will report on the administration of the Act and the extent to which it attains its purposes, including supporting the establishment and operation of the Child Dental Benefits Schedule from 1 January 2014, and the operation and closure of the Medicare Teen Dental Plan up to 31 December 2013.

The Review Panel will assess the practical operation of the Act in regard to access and delivery of services, including an assessment of:

> eligibility notification and confirmation processes;
> claiming processes; and
> the Informed Financial Consent regime.

The Review Panel may consider opportunities to improve the operation and administration of the Child Dental Benefits Schedule to allow for the most efficient, effective and sustainable delivery of dental benefits and services.

PANEL MEMBERS

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<tr>
<th>Name</th>
<th>Title/Organisation</th>
<th>Nature of Appointment</th>
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<tr>
<td><strong>Professor Chris Baggoley</strong> (Chair)</td>
<td>Commonwealth Chief Medical Officer</td>
<td>Required by legislation</td>
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<tr>
<td>Dr Angela M Pierce</td>
<td>Federal Councillor, Australian Dental Association Inc.</td>
<td>Nominee of the Australian Dental Association, required by legislation</td>
</tr>
<tr>
<td>Ms Margaret Brown</td>
<td>Consumers’ Health Forum of Australia</td>
<td>Nominee of the Consumers’ Health Forum of Australia, required by legislation</td>
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<tr>
<td>Dr Geoff Franklin</td>
<td>Executive Director, South Australia Dental Service</td>
<td>Appointed by the Minister for Health</td>
</tr>
<tr>
<td>Dr Mark Bowman</td>
<td>Private dental practitioner and Dental Adviser, Department of Veterans’ Affairs.</td>
<td>Appointed by the Minister for Health</td>
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CONDUCT OF THE REVIEW

The Review Panel undertook the Review with secretariat support from the Department of Health.

The Panel met for the first time on 12 August 2015. A second meeting was held on 27 August 2015, and the final meeting on 23 November 2015.

FINDINGS

In relation to the Terms of Reference for the Review, it was the Panel’s view that the Act and its associated Rules (the Dental Benefits Rules 2014) attains its legislative and administrative purpose, in supporting the establishment and operation of the Child Dental Benefits Schedule (CDBS) from 1 January 2014, and the operation and closure of the Medicare Teen Dental Plan up to 31 December 2013.

In particular, the Panel noted the success of the CDBS in targeting the oral health of young Australians at an age where preventative measures can be most effective. It supported the right of every child to access dental treatment from both the private and the public sectors. The Panel agreed that it would make clear recommendations to Government to ensure the ongoing success and effectiveness of the CDBS.

UTILISATION

In the first year of implementation (2014), 3,062,309 children were notified of their eligibility for the CDBS. Of these, 898,797 (29.4 per cent) accessed the programme.

As at 30 June 2015, a total of 2,944,413 children had become eligible for the CDBS and been notified of their eligibility. Of these children, 568,997 (19.3 per cent) had accessed the programme. If this rate continues for the remainder of the year, the annual utilisation rate in 2015 is projected to be higher than in 2014.

The Panel noted that this utilisation rate was considerably lower than originally projected, but was of the view that this may reflect an unrealistic original target, rather than significant underutilisation. However the Panel acknowledged that the current time limited access to the CDBS by the states and territories may impact on some jurisdictions’ engagement with it, and be affecting the programme’s overall utilisation rate.

RECOMMENDATION 1

> Provide greater clarity and certainty for the public sector on continuing access to the Child Dental Benefits Schedule.
ELIGIBILITY NOTIFICATIONS AND PROMOTION

The Panel agreed that the CDBS has been poorly promoted, and noted that the current eligibility notification did not provide readily recognisable advice of an entitlement. The Panel noted that the voucher issued to eligible teenagers under the Medicare Teen Dental Plan was obviously an entitlement to dental benefits, and was of the view that professional advice should be sought to review current promotion of the programme.

In recommending that the eligibility notification be more readily identifiable as a benefit entitlement, the Panel was mindful of the need to ensure that the conditions attached to this benefit were understood.

RECOMMENDATION 2

> Make the eligibility notification letter attractive and recognisable as a ‘voucher’ for services.

RECOMMENDATION 3

> Engage experts in marketing and communication to better target efforts on programme promotion including, for example, utilising communication channels other than the eligibility notifications.

In considering the processes through which families are advised of children’s eligibility, the Panel noted that notification through myGov alone may not generate sufficient interest to guarantee uptake. While there may be efficiencies associated with this means of notification, the Panel was of the view that it may not necessarily support families in accessing the CDBS.

RECOMMENDATION 4

> Ensure hard copy notifications are sent to families who receive notification through myGov, unless they have specifically opted out of hard copy communications.

The Panel supported further promotional opportunities to increase awareness of the CDBS among targeted groups within the eligible population, such as those in regional and rural communities and Aboriginal and Torres Strait Islander families. The Panel identified that there may be opportunities through existing Family Tax Benefit Part A communication channels, and also saw value in communicating by letter with eligible families who had not previously used the programme.

RECOMMENDATION 5

> Provide hard copy follow up notifications to eligible families who have not accessed services.
SCOPE OF SERVICES
The Panel noted the consultation process through which the schedule of services was developed, and the range of services provided. In keeping with the programme’s intent, almost half of the services provided were preventative. There remains some contention about the services for which benefits should be payable. In recommending that the scope of services be expanded, the Panel was cognisant of the challenges of defining ‘basic dental services’.

RECOMMENDATION 6
> Expand the Child Dental Benefits Schedule within the scope of ‘basic dental services’.

In addition, the Panel noted that CDBS utilisation was particularly sensitive to school holidays, and that this was disadvantageous when families were accessing services which were subject to time-related item restrictions. The Panel noted the intention of the restrictions identified in Rules 17 to 29 of the Dental Benefits Rules 2014, but was concerned that a number of these restrictions were applied to the detriment of some families.

RECOMMENDATION 7
> Amend the Rules to provide flexibility for time-based restrictions.

While recognising the complexities of the interaction between Commonwealth and state/territory hospital funding arrangements, the Panel was firmly of the view that there is a cohort of children for whom ‘basic dental services’ can only be provided in a hospital setting. The Panel considered that the intentions of the Act cannot be fully expressed while hospital services are excluded.

RECOMMENDATION 8
> Allow benefits for in-hospital dental services when clinically appropriate.

FEES AND BILLING
The Panel noted the high bulk billing rate under the CDBS and schedule fee observance.

In discussing the CDBS Dental Benefits Schedule, the Panel noted a number of discrepancies between it and the Department of Veterans’ Affairs benefit schedule. Of particular concern was the provision of ‘step-down’ fees, where a significantly reduced benefit is payable for a service repeated on a single day. The Panel recognised that such services do not necessarily reflect clinical efficiencies, and that a benefit regime more reflective of the clinical services provided was required. The Panel also considered that it would be appropriate to review the full CDBS Dental Benefits Schedule in relation to Department of Veterans’ Affairs benefit schedule.
RECOMMENDATION 9
> Adopt the Department of Veterans’ Affairs ‘step-down fees’ model for the Child Dental Benefits Schedule.

RECOMMENDATION 10
> At the next opportunity, align the fee levels of the CDBS Dental Benefits Schedule with those of the Department of Veterans’ Affairs benefit schedule.

INFORMED FINANCIAL CONSENT
The requirement for informed financial consent provides a mechanism whereby providers and patients can discuss both treatment options and likely costs prior to commencement of any treatment. The Panel noted the value of the informed financial consent requirement and did not consider it to be onerous. However, the Panel recognised the particular complexities of administering the requirement in cases where benefits were claimed through the application of retrospective eligibility. The Panel was also of the view that the Ministerial Guidelines for Child Dental Benefits Schedule: Extenuating Circumstances for Informed Financial Consent (Ministerial Guidelines) are not clear on the issue of retrospective eligibility.

RECOMMENDATION 11
> Streamline administrative processes, and if necessary revise the Ministerial Guidelines, to enable the policy intent of retrospective eligibility to be met with clarity and without undue administrative imposition on dental practices.
Chapter 1: Background

The Dental Benefits Act 2008 (the Act) commenced on 26 June 2008 and establishes a legislative framework for the payment of dental benefits.

From 1 July 2008 until 31 December 2013, the Act provided the legislative framework for the Medicare Teen Dental Plan (MTDP). From 1 January 2014, the MTDP was replaced by the Child Dental Benefits Schedule (CDBS). The Department of Health (Health) and the Department of Human Services (Human Services) are responsible for administering the MTDP and CDBS.

Under section 68 of the Act, the Minister for Health must cause an independent review of the operation of the Act to be undertaken 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.

In accordance with section 68 of the Act, the Minister has caused the third statutory review to be undertaken as soon as practicable after the sixth anniversary of the Act.

THE DENTAL BENEFITS ACT 2008

The Act is modelled on the provisions of the Health Insurance Act 1973 which provides a legislative framework for the payment of benefits for medical services through the Medicare Benefits Schedule (MBS).

Broadly, the Act:

> establishes an entitlement to dental benefits;
> provides a framework for the issuing of ‘vouchers’ for dental benefits;
> provides for the payment of dental benefits;
> establishes provisions for the protection of information and the circumstances in which disclosure of such protected information is authorised;
> creates general offence provisions relating to assignment of benefit agreements and the giving of false or misleading information;
> gives the Minister for Health power to make, by legislative instrument, the Dental Benefits Rules (the Rules); and
> provides for funds relating to the payment of dental benefits to be appropriated through a special appropriation.

An amendment to the Act came into effect on 4 November 2014 which introduced penalties to enforce disclosure activities by disqualified dental practitioners and new powers to require dental practitioners to participate in compliance audits. These provisions mirror those of the *Health Insurance Act 1973*, to ensure broadly consistent compliance regimes between the two acts.

**THE DENTAL BENEFITS RULES**

The Rules provide for matters that the Act requires or permits or are necessary or convenient for carrying out or giving effect to the Act. In providing for such matters, the Rules establish the operational framework for the payment of dental benefits under the Act.

Broadly, the Rules:
> define classes of persons who satisfy the means test;
> define ‘dental providers’ and specify the persons eligible to render services on behalf of dental providers;
> specify the particulars that must be recorded on accounts/invoices for dental benefits to be payable;
> specify details in relation to issuing ‘vouchers’; and
> establish the Dental Benefits Schedule and rules restricting when a dental benefit is payable in respect of a particular service.

To support the operation of the CDBS, additional provisions were added to the Rules from 2014 to:
> specify that services provided by a state or territory are eligible for dental benefits only if the service was provided on or before a date specified in the Rules;
> require dental providers to obtain consent to treatment and informed financial consent to the cost of treatment; and
> require clinical records to be kept for four years.

Copies of the Act and Rules can be found at [http://www.comlaw.gov.au](http://www.comlaw.gov.au)
PAYMENT OF DENTAL BENEFITS

Under the Act, the person who incurs the dental expense has the right to payment of dental benefits in respect of a dental service. The Act provides for three methods for claiming dental benefits.

Section 12 of the Act outlines the assignment of benefit process, whereby:
> the person assigns his or her right to the payment of the dental benefit to the dental provider, in accordance with the approved form; and
> the dental provider accepts the assignment in full payment of the dental expenses incurred by the person.

This process is commonly known as bulk billing and the patient does not pay any costs for dental expenses incurred. In the public dental sector, this is the only method of claiming.

Where the service is not bulk billed, a dental benefit may be claimed in two different ways:
> the dental provider bills the patient for the dental expenses and the patient provides payment to the dental provider in full. The receipt is then supplied to Medicare to claim the dental benefits.
> the dental provider gives the patient an account or invoice for the services provided. The patient supplies Medicare with the unpaid account and a cheque for the total benefit payable is issued in the dentist’s name. The patient then provides the cheque to the dental provider and pays any outstanding amount for the dental services (section 14 of the Act).

Services claimed in this way are known as patient billed services. While patients will not incur any costs for bulk billed services, patient billed services may lead to an out-of-pocket cost.

Section 15 of the Act provides for the process to claim for both bulk billed and non-bulk billed dental benefits. It further stipulates a time limit of two years from the date of service to make a claim for bulk billed services.

Subsection 17(2) of the Act stipulates that the particulars specified in the Rules must be complied with in order for dental benefits to be payable. These particulars are defined in rule 8 of the Rules:
> patient’s name;
> date of service;
> item number in the Dental Benefits Schedule that corresponds to the service; and
> dental provider’s name and provider number.
If the dental provider bulk bills, the amount of the dental benefit being assigned must be indicated on the assignment of benefit (bulk billing) form. For patient billed services, the account or receipt must indicate the amount charged for the service, total amount paid, and any amount outstanding for the service.

**QUALIFICATION FOR DENTAL BENEFITS ‘VOUCHERS’**

The Act provides a framework for issuing ‘vouchers’ for dental benefits to eligible patients for both the MTDP and the CDBS. In accordance with this framework, an individual qualifies for a voucher if he or she:

- meets the age test set out in section 23 of the Act;
- qualifies for Medicare under the *Health Insurance Act 1973*; and
- satisfies the means test set out in section 24 of the Act and rule 9 of the Rules.

A person satisfies the means test where:

- the person receives either Family Tax Benefit (FTB) Part A, ABSTUDY, Carer Payment, Disability Support Pension, Parenting Payment, Special Benefit, or Youth Allowance; or
- the person’s family/carer/guardian receives either FTB Part A, Parenting Payment, or the Double Orphan Pension in respect of the person; or
- the person’s partner receives FTB Part A or Parenting Payment; or
- the person receives financial assistance under VCES or MRCAETS and cannot be included as a dependent child for the purposes of FTB because they are 16 years or older.
Chapter 2: 
Medicare Teen Dental Plan

The MTDP commenced on 1 July 2008 and operated until 31 December 2013. The purpose of the MTDP was to provide financial assistance to families to help assess the health of their teenagers’ teeth and encourage good lifelong oral health habits in teenagers.

Approximately 1.2 million eligible teenagers aged 12 to 17 received a voucher for the MTDP each calendar year to assist with the cost of a preventative dental check provided in that year. The preventative dental check consisted of an oral examination as a minimum requirement and, where necessary, x-rays, a scale and clean, fluoride treatment, oral hygiene instruction, dietary advice and/or fissure sealing.

Preventative dental checks could be provided under the MTDP by dentists and dental specialists who had a Medicare provider number. Dental therapists, dental hygienists and oral health therapists were also eligible to provide preventative dental checks on behalf of dentists.

MTDP vouchers could be used at private dental surgeries and public dental clinics participating in the programme. When introduced in 2008, the MTDP voucher provided a dental benefit of up to $150 towards the cost of an annual preventative dental check. The benefit was indexed on 1 January each subsequent year (Table 1). As such, the dental benefit payable under the voucher in the final year of the MTDP was $166.15.

TABLE 1: BENEFIT PAYABLE UNDER THE MTDP—2008–2013

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
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<tbody>
<tr>
<td>Amount</td>
<td>$150.00</td>
<td>$153.45</td>
<td>$157.00</td>
<td>$159.85</td>
<td>$163.05</td>
<td>$166.15</td>
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</table>

Source: Dental Benefits Rules
While the MTDP did not prevent dentists from setting their own fees for services, the government encouraged dentists to bulk bill preventative dental checks for eligible teenagers. Over the life of the MTDP, 68.8 per cent of preventative dental checks were bulk billed. However, the schedule fee observance rate was much higher, with dental providers charging at or below the schedule fee for 95.4 per cent of services. The majority of MTDP services were provided with no out-of-pocket costs to the patient.

**ELIGIBILITY REQUIREMENTS**

The MTDP was available to teenagers who were eligible for Medicare, and who, at some time in the calendar year:

- were aged between 12 and 17 years; and
- satisfied the means test for the programme\(^1\).

**ARRANGEMENTS FOR PUBLIC SECTOR SERVICES**

State and territory governments’ public dental providers could provide MTDP services. Preventative dental checks provided in public dental clinics were bulk billed with the income paid to the state/territory or public health service rather than the individual dentist.

As Medicare provider numbers can only be issued to individual dentists (ie not to an organisation), special Medicare provider numbers were issued to one or more representative public dentists nominated in each state and territory under whose name the preventative dental checks were billed. All of the benefits assigned to representative public dentists were paid directly into a state/territory or public health service controlled bank account.

The Commissioner for Taxation ruled that income derived by representative public dentists from benefits bulk billed under the MTDP is taxable income. However, the amount paid by Medicare\(^2\) to a state or territory bank account in respect of these benefits is an allowable deduction to the representative public dentist (class ruling CR 2009/16).

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1 Details of the means test are on page 11 (Table 4)
2 Medicare became part of the Department of Human Services from 1 July 2011.
PROMOTION

Information and resources about the MTDP were available on both Health’s website and the Medicare website.

Medicare offices also displayed posters and brochures promoting the MTDP and provided dentists with information for display in their surgeries. Furthermore, eligible teenagers and families received a letter and voucher(s) from Medicare each year outlining the programme and explaining how to use the voucher(s).

Most promotional activity occurred in the first two months of the calendar year when the majority of vouchers were posted. Other promotional activities occurred throughout each calendar year through social media, newspaper advertisements, school publications and other teenager-focused or parent-focused communications.

CLOSURE OF THE MEDICARE TEEN DENTAL PLAN

The MTDP was closed on 31 December 2013 and replaced by the CDBS. This was effected through amendments to the Act and the replacement of the Dental Benefits Rules 2009 with the Dental Benefits Rules 2013.

Over the life of the MTDP (1 July 2008 to 31 December 2013):
> $346 million in benefits were paid;
> 2,241,961 preventative dental checks were provided;
> 1,152,814 unique children accessed benefits; and
> 12,171 providers provided services.

The MTDP was funded under a special appropriation\(^3\), whereby spending was driven by demand. Table 2 shows benefits paid and utilisation under the MTDP.

TABLE 2: MTDP BENEFITS PAID—1 JULY 2008 TO 31 DECEMBER 2013

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<tr>
<td>Actual benefits paid ($m)</td>
<td>66.7</td>
<td>63.4</td>
<td>59.80</td>
<td>58.0</td>
<td>59.8</td>
<td>37.8</td>
<td>346.0</td>
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<td>Utilisation Target (%)</td>
<td>55</td>
<td>60</td>
<td>33</td>
<td>36</td>
<td>39</td>
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<td>Actual Utilisation (%)</td>
<td>32</td>
<td>32</td>
<td>30</td>
<td>31</td>
<td>31</td>
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Source: Department of Health and Ageing Annual Reports, various years

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\(^3\) A special appropriation is a provision within an Act that provides authority to spend money for particular purposes, the MTDP being governed by the Dental Benefits Act 2008.
Figure 1 shows an increasing number of patients receiving multiple MTDP services. This repeated usage suggests that some teenagers were beginning to develop good oral health habits through usage of the MTDP, and that its aim was being achieved.

**FIGURE 1: MTDP CUMULATIVE SERVICES RECEIVED PER PATIENT, 2010–2013**

<table>
<thead>
<tr>
<th>Year/Quarter</th>
<th>250,000</th>
<th>500,000</th>
<th>750,000</th>
<th>1,000,000</th>
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**Note:** Services provided since 2008  
**Source:** Health analysis of claiming data

The CDBS expanded the eligibility of the MTDP by increasing the age range of eligible children from 12–17 to 2–17. The means test did not change. Expanding the age cohort from the CDBS increased the notified eligible population by approximately 1.9 million children to almost 3.1 million children.

In designing the CDBS, there was a significant increase in the scope of dental services covered to ensure that the basic dental needs of children aged 2 to 17 years were met.

The Panel acknowledged that the Act provided a legislative framework for the MTDP from 2008 to 2013. The Panel noted that the two statutory reviews that had taken place under the Act in 2009 and 2011 had focused on the MTDP. The Panel noted that suggestions raised by previous Review Panels were taken into consideration in the design of the CDBS, including the introduction of treatment services, the use of specific item numbers for each service, and a higher benefit amount.
Chapter 3: Child Dental Benefits Schedule

The CDBS replaced the MTDP on 1 January 2014. The programme provides eligible children aged between 2–17 years access to up to $1,000 in benefits for basic dental services, with benefits capped over two consecutive calendar years. As previously noted, almost 3.1 million children are eligible for the CDBS each year.

The programme 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 those children in greater financial need; and
> build a unified national system for patient eligibility and service delivery for children.

The range of services covered under the programme includes examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures. Benefits are not available for orthodontics, cosmetic dental work or high level restorative services (crowns, bridges and implants). Benefits are also not payable for services provided to an admitted patient in hospital or where a private health insurance benefit has been paid.

CDBS services can be provided by dentists who hold general or specialist registration with the Dental Board of Australia and who have a Medicare provider number (‘dental providers’). Dental hygienists, dental therapists, oral health therapists and dental prosthetists who hold general registration with the Dental Board of Australia can also provide services under the CDBS on behalf of a dentist or dental specialist. However, dental practitioners who hold student registration cannot provide services under the CDBS.

Consistent with the MTDP, dentists are free to set their own fees for CDBS services. Information on the CDBS is communicated to eligible children and dental providers through direct communications and is available online.
A range of provider education materials is available on the Human Services website, including a quick reference guide on the CDBS, an eLearning module and a fact sheet on using the Health Professional Online Services. The Guide to the Child Dental Benefits Schedule and informed financial consent forms are available on the Health website. Dental practices are also supplied with CDBS programme brochures to display in their practices.

The primary promotional activity undertaken with eligible people is an annual letter to notify them of their eligibility.

**FUNDING AND EXPENDITURE**

The CDBS is funded under a special appropriation\(^4\), whereby spending is driven by demand.

Table 3 shows CDBS expenditure in the first two financial years of operation.

<table>
<thead>
<tr>
<th>TABLE 3: CDBS FUNDING: 2013–14 TO 2015–16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits paid ($m)</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health Annual Reports, various years

\(^*\)The CDBS commenced 1 January 2014 and was only in operation for 6 months of the financial year.

**ARRANGEMENTS FOR PUBLIC SECTOR SERVICES**

Access to the CDBS by the public dental sector is facilitated through the same representative public dentist arrangements as the MTDP. A new class ruling (CR2014/7) was issued by the Commissioner for Taxation to enable representative public dentists to continue to claim a tax deduction for CDBS income derived through their representative public dentist Medicare provider number.

Unlike the MTDP, public sector access to the CDBS is time limited. This is further explained on page 16.

**1. ELIGIBILITY**

The CDBS is available to children who are eligible for Medicare and who, at some point in the calendar year:

> are aged between 2 and 17 years; and
> satisfy the means test for the programme.

\(^4\) A special appropriation is a provision within an Act that provides authority to spend money for particular purposes, the CDBS being governed by the Dental Benefits Act 2008.
The CDBS has the same means test as the MTDP.

Eligibility is determined on a calendar year basis and must be reassessed at the start of each calendar year.

Together, the Act and the Rules identify ten government payments as satisfying the means test for CDBS eligibility. The majority of CDBS eligible children meet the means test though their family receiving FTB Part A. Table 4 shows the breakdown of CDBS eligibility in 2014 through relevant government payments.

**TABLE 4: CDBS ELIGIBILITY IN 2014 BY GOVERNMENT PAYMENT RECEIVED**

<table>
<thead>
<tr>
<th>Government Payment</th>
<th>Eligible children (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTB Part A</td>
<td>96.91</td>
</tr>
<tr>
<td>Youth Allowance</td>
<td>1.52</td>
</tr>
<tr>
<td>ABSTUDY</td>
<td>0.66</td>
</tr>
<tr>
<td>Parenting Payment</td>
<td>0.60</td>
</tr>
<tr>
<td>Disability Support Pension</td>
<td>0.26</td>
</tr>
<tr>
<td>Special Benefit</td>
<td>0.02</td>
</tr>
<tr>
<td>Carer Payment</td>
<td>0.01</td>
</tr>
<tr>
<td>Double Orphan Pension</td>
<td>0.01</td>
</tr>
<tr>
<td>VCES and MRCAETS</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Source: Data provided by Human Services

**VOUCHER TERMINOLOGY**

The ‘voucher’ terminology used in the Act and the Rules pertained to the MTDP, where an actual voucher was sent to eligible teenagers for a preventative dental check. The design of the MTDP lent itself to this voucher due to the programme providing a single dental service each calendar year.

The ‘voucher’ terminology has remained in the legislation, but the term ‘voucher’ is no longer used in CDBS promotional and information materials. The notification of eligibility, in the form of a letter, performs the legislative function of the ‘voucher’.

Panel members were of the view that the ‘voucher’ terminology is still useful within the legislation and does not cause confusion.
RETROSPECTIVE ELIGIBILITY

Section 31 of the Act provides that a voucher for a calendar year takes effect on the day on which it is issued and remains in effect until the end of the calendar year unless the Rules provide for a different period of effect.

Rule 12 of the Rules provides that a voucher takes effect from 1 January and remains in effect until 31 December of that same year.

The effect of this rule is that if, at any point during the calendar year, a person becomes eligible for the CDBS, eligibility can be retrospectively applied for the full calendar year. This provision also applied to the MTDP. Retrospective eligibility means that dental costs incurred earlier in the calendar year, prior to receiving the notification of eligibility, can still be covered under the programme.

The Panel indicated qualified support for retrospective eligibility as an important process by which eligible people were able to access dental benefits, but noted the administrative challenges in processing claims retrospectively. The Panel also noted the challenges that arise when patients discover their eligibility retrospectively and have already claimed from their private health insurer.

These administrative challenges are elaborated further in Chapter 3–6 Informed financial consent requirements.

ADMINISTERING THE ELIGIBILITY REQUIREMENTS

Similar to the MTDP, the CDBS is administered by Human Services through Medicare, using customer eligibility data provided by Centrelink and the Department of Veterans’ Affairs (Veterans’ Affairs). In early January each year, Centrelink provides Medicare with data on children aged 2–17 who satisfy the means test for that year. After the main January data transfer, Centrelink provides Medicare with daily data on children who newly satisfy the means test.

Centrelink and Veterans’ Affairs data is matched with Medicare data to confirm Medicare eligibility. Human Services issues a notification of eligibility only when the two sets of data for a child can be matched. In 2014, around 98 per cent of eligibility records were matched with confirmation of Medicare eligibility.

Once CDBS eligibility is determined, Human Services sends out a notification of eligibility to parents, guardians, eligible teenagers and Approved Care Organisations. The bulk of the notifications are sent out during January and February. The bulk mail-out of eligibility letters in January–February 2014 reached approximately 90 per cent of children eligible for the CDBS (Figure 2).

---

5 Data transfer from Veterans’ Affairs operates under a different process due to the small number of children who are eligible for the CDBS through Veterans’ Affairs payments.
For the rest of the year, Human Services sends notifications to newly eligible children at fortnightly intervals. From 1 November each year, Human Services is not required to send notifications of eligibility to eligible children, except on request of the eligible child or their parent/carer (section 27 of the Act).

FIGURE 2: CUMULATIVE NUMBER OF CDBS NOTIFICATIONS ISSUED—JANUARY 2014 TO JUNE 2015

2. UTILISATION

In the first year of implementation (2014), a total of 3,062,309 children were notified of their eligibility for the CDBS. Of these, 898,797 (29.4 per cent) accessed the programme.

As at 30 June 2015, a total of 2,944,413 children had become eligible for the CDBS and been sent a notification of eligibility for the 2015 calendar year. Of these children, 568,997 (19.3 per cent) had accessed the programme. If this rate continues for the remainder of the year, the annual utilisation rate in 2015 is projected to be higher than in 2014.

Of the children eligible in 2015 (to 30 June), 85 per cent were also eligible in 2014. Health’s 2014–15 Portfolio Budget Statement identifies a target of 2.4 million children accessing the CDBS, which would equate to a utilisation rate of 78 per cent.

Source: Health analysis of eligibility data.
In considering this target, the Panel looked to international data to determine the suitability of the target and consideration of the 30 per cent utilisation rate. This proved difficult, as there is no comparable national programme which employs a means test to determine an eligible population for the provision of dental services.

Both Hong Kong and Malaysia provide school based oral health programmes, with participation rates of 95 per cent⁶ and 96 per cent ⁷. Denmark also provides free dental care to children up to the age of 18 through the school system, including free orthodontics. However, given the dearth of comparable data, and the unique elements of the CDBS the Panel concluded that the original target may well be considered optimistic. Nevertheless, the programme would appear to be underutilised, which is possibly a reflection of its under-promotion.

The utilisation rates for each jurisdiction are compared in Table 3. The number of eligible children per jurisdiction is relative to the population in that jurisdiction. However, utilisation of the scheme is highly variable across jurisdictions. In 2014, the three states with the largest CDBS eligible populations (New South Wales, Victoria and Queensland) reached similar utilisation rates of 30.8 per cent, 32.3 per cent and 30.0 per cent respectively. The Northern Territory and Western Australia had the lowest utilisation rates of 6.5 per cent and 10.9 per cent respectively. Utilisation in South Australia was the highest at 38.4 per cent.

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible patients</td>
<td>Patients using CDBS*</td>
<td>% of eligible patients using CDBS</td>
</tr>
<tr>
<td>NSW</td>
<td>970,071</td>
<td>298,721</td>
<td>30.8</td>
</tr>
<tr>
<td>VIC</td>
<td>752,389</td>
<td>243,089</td>
<td>32.3</td>
</tr>
<tr>
<td>QLD</td>
<td>678,656</td>
<td>203,540</td>
<td>30.0</td>
</tr>
<tr>
<td>SA</td>
<td>226,283</td>
<td>86,954</td>
<td>38.4</td>
</tr>
<tr>
<td>WA</td>
<td>283,682</td>
<td>30,862</td>
<td>10.9</td>
</tr>
<tr>
<td>TAS</td>
<td>81,454</td>
<td>26,472</td>
<td>32.5</td>
</tr>
<tr>
<td>NT</td>
<td>35,126</td>
<td>2289</td>
<td>6.5</td>
</tr>
<tr>
<td>ACT</td>
<td>32,927</td>
<td>7,842</td>
<td>23.8</td>
</tr>
<tr>
<td>AUS Total</td>
<td>3,062,309</td>
<td>898,797</td>
<td>29.4</td>
</tr>
</tbody>
</table>

*Patients by state do not sum to total as some patients have received treatment in more than one state.
* based on patient postcode
Source: Health analysis of claiming and eligibility data
The Panel noted the utilisation of CDBS across jurisdictions, especially the particularly low utilisation rates in the Northern Territory and Western Australia. The Panel considered that the Stronger Futures programme\(^8\) may be affecting the utilisation of the CDBS in the Northern Territory. Evidence shows that the delivery of oral health services to Aboriginal and Torres Strait Islander children under the age of 16 living in the Northern Territory has been successful since the commencement of the Stronger Futures programme.

PUBLIC AND PRIVATE DENTAL SECTORS

The variation of CDBS utilisation rates across jurisdictions may be partially attributable to differences between their public dental systems.

As with the MTDP, the states’ and territories’ public dental sectors are able to provide dental services to eligible children under the CDBS. However, access under the CDBS by states and territories is time limited.

Rule 8A of the Rules provides that services provided by a state or territory are eligible for dental benefits only if the service was provided on or before a date specified in the Rules. When the CDBS was implemented, access for the public sector was available to 31 December 2014. Since then, public sector access has been extended twice by the Minister for Health. Public sector access to the CDBS is currently to 30 June 2016.

The Panel discussed the time limit on public sector access and noted it is currently available to 30 June 2016. The Panel noted that the uncertainty around continued access to the CDBS creates difficulties for service and financial planning by the public sector. Further clarity and certainty on the future of public sector access to the CDBS would enable equitable access for children to seek treatment from both public and private sectors.

**Recommendation 1:** Provide greater clarity and certainty for the public sector on continuing access to the CDBS.

Patient utilisation in the public and private dental sectors, by state and territory, is shown in Figure 3. In South Australia and Tasmania, the majority of CDBS patients are treated in the public sector; these two states also have the highest overall CDBS utilisation rates. In comparison, almost all CDBS patients in New South Wales are treated in the private sector. Australia-wide, 78 per cent of services are provided by the private sector (Figure 3).

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\(^8\) The *Stronger Futures in the Northern Territory* programme provides enhanced access to services for Aboriginal and Torres Strait Islander people in remote areas of the Northern Territory. The health component of the programme includes facilitation and delivery of dental services.
FIGURE 3: COMPARISON OF PATIENTS ACCESSING CDBS VIA PRIVATE AND PUBLIC DENTAL SYSTEMS BY JURISDICTION—1 JANUARY 2014–30 JUNE 2015

Notes: Northern Territory—There have been no claims for services provided under a public practitioner number since January 2015. This may be due to the existence of other dental schemes in operation in the Northern Territory and the fact that there is no efficient and straightforward claiming system for the CDBS within the Northern Territory public system.
Australian Capital Territory—Services provided before 28 August 2014 are yet to be processed under a public practitioner number.
Source: Health analysis of claiming data

The Panel noted the high public sector utilisation of South Australia and Tasmania and understands that the South Australian Dental Service is particularly proactive in accessing the CDBS.

SOCIO-ECONOMIC INDEXES FOR AREAS (SEIFA)
As one of the objectives of the CDBS is to target Commonwealth expenditure on dental services to those children in greatest financial need, the Panel applied the SEIFA index of relative socio-economic advantage and disadvantage to examine CDBS eligibility and utilisation data.

The SEIFA index of relative socio-economic advantage and disadvantage summarises information about the economic and social conditions of people and households within a geographic area, including both relative advantage and disadvantage measures. A low score indicates relatively greater disadvantage and lack of general advantage. An area could have a low score if it is, for example, an area with many households with low incomes, or people in unskilled occupations, and few households with high incomes, or people in skilled occupations. A high score indicates a relative
lack of disadvantage and greater general advantage, for example, many households with high incomes, or people in skilled occupations, and few households with low incomes, or people in unskilled occupations. Figure 4 shows the percentage of CDBS eligible population by SEIFA decile in each state and territory.

FIGURE 4: CDBS ELIGIBLE CHILDREN BY SEIFA DECILE IN EACH JURISDICATION: 2014

An analysis of CDBS eligible children by jurisdiction and SEIFA decile in 2014 shows:

> New South Wales, Victoria, Queensland and Western Australia have CDBS eligible children spread over the breadth of the SEIFA deciles;

> a large proportion of CDBS eligible children in the Northern Territory are in areas of high disadvantage (SEIFA 1); and

> South Australia and Tasmania also have high proportions of CDBS eligible children in areas of high disadvantage (SEIFA 1, 2).

A comparative chart of the distribution of CDBS utilisation by SEIFA decile in each jurisdiction (Figure 5) shows that utilisation per SEIFA decile is generally proportional to the eligible population per SEIFA decile in that jurisdiction. The only exception to this is the Northern Territory, where utilisation is predominantly by eligible children from areas of relative advantage, despite having a large portion of the eligible population living in areas of relative greater disadvantage (SEIFA 1).
Figure 5: CDBS patient utilisation by SEIFA decile in each jurisdiction: 2014

Note: Based on patient postcode.
Source: Health analysis of claiming data

Nationwide, patient utilisation across SEIFA deciles is generally evenly distributed (23–33 per cent). However, SEIFA 10 shows a significantly lower utilisation rate of 16.2 per cent (Figure 6).

Figure 6: CDBS patient utilisation by SEIFA decile: 2014

Source: Health analysis of eligibility data and claiming data
REMOTENESS

Patient eligibility and utilisation can also be analysed by remoteness. Remoteness areas are based on the Accessibility/Remoteness Index of Australia (ARIA+), an index based on the measurement of road distances to service centres.

The remoteness categories based on the Australian Statistical Geography Standard (ASGS) are:

- Major Cities of Australia: Collection Districts (CDs) with an average ARIA+ index value of 0 to 0.2;
- Inner Regional Australia: CDs with an average ARIA+ index value greater than 0.2 and less than or equal to 2.4;
- Outer Regional Australia: CDs with an average ARIA+ index value greater than 2.4 and less than or equal to 5.92;
- Remote Australia: CDs with an average ARIA+ index value greater than 5.92 and less than or equal to 10.53; and
- Very Remote Australia: CDs with an average ARIA+ index value greater than 10.53.

Figure 7 shows the percentage of CDBS eligible population by remoteness category and jurisdiction. The majority of the CDBS eligible population reside in the major cities of Australia. However, a significant proportion of the eligible population also reside in other remoteness areas.

Patient utilisation by ASGS remoteness area is comparable in major cities and inner regional areas, but drops steeply in remote and very remote areas (Figure 8).

The Panel noted that some rural areas still experience workforce shortages. Some funded positions in rural areas are unable to attract dentists.

Panel members noted factors that could be affecting CDBS utilisation in regional and remote areas included workforce maldistribution, lack of transport, economic barriers (including levels of funding available for dental services) and fear of dental treatment. It was also noted that the lack of fluoridated water supply in certain communities is a major contributor to poorer oral health outcomes. The Panel acknowledged that these factors were beyond the scope of the CDBS.
FIGURE 7: CDBS ELIGIBLE CHILDREN BY REMOTENESS CATEGORY AND STATE/TERRITORY: 2014

<table>
<thead>
<tr>
<th>Remoteness Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major City</td>
<td>68.20%</td>
</tr>
<tr>
<td>Inner Regional</td>
<td>23.14%</td>
</tr>
<tr>
<td>Outer Regional</td>
<td>7.91%</td>
</tr>
<tr>
<td>Remote</td>
<td>0.58%</td>
</tr>
<tr>
<td>Very Remote</td>
<td>0.17%</td>
</tr>
</tbody>
</table>

Note: Based on patient postcode.
Source: Health analysis of Human Services eligibility data

FIGURE 8: ELIGIBLE POPULATION UTILISATION BY REMOTENESS AREA: 2014

<table>
<thead>
<tr>
<th>Remoteness Area</th>
<th>Not accessing</th>
<th>Accessing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major City (29.2%)</td>
<td>1,750,000</td>
<td>250,000</td>
</tr>
<tr>
<td>Inner Regional (30.8%)</td>
<td>1,500,000</td>
<td>500,000</td>
</tr>
<tr>
<td>Outer Regional (26.0%)</td>
<td>1,000,000</td>
<td>750,000</td>
</tr>
<tr>
<td>Remote (18.2%)</td>
<td>750,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Very Remote (8.1%)</td>
<td>750,000</td>
<td>1,000,000</td>
</tr>
</tbody>
</table>

Note: Based on patient postcode.
Source: Health analysis of claiming and eligibility data
ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Aboriginal and Torres Strait Islander children are identified under the CDBS through Medicare’s Voluntary Indigenous Identifier. The Voluntary Indigenous Identifier relies on voluntary identification and therefore does not comprehensively capture all Aboriginal and Torres Strait Islander people’s interaction with the Medicare Benefits Schedule and the CDBS. The Voluntary Indigenous Identifier data is only available on a financial year basis.

The CDBS was implemented on 1 January 2014. The financial year of 2014–15 is the first full year where data on the Voluntary Indigenous Identifier is available to compare CDBS eligibility and utilisation between Aboriginal and Torres Strait Islander children and non-Aboriginal and Torres Strait Islander children.

In 2014–15, 225,251 children identifying as Aboriginal and Torres Strait Islander became eligible for the CDBS. This is approximately 70 per cent of the projected number of Aboriginal and Torres Strait Islander children across Australia. In contrast, 2,761,538 children who did not identify as Aboriginal and Torres Strait Islander became eligible for the CDBS, representing approximately 54 per cent of the projected number of these children.

Despite a larger proportion of Aboriginal and Torres Strait Islander children being eligible for the CDBS, utilisation is lower in comparison to non-Aboriginal and Torres Strait Islander children. In 2014–15, 45,396 Aboriginal and Torres Strait Islander children accessed the CDBS, which is an utilisation rate of approximately 20.2 per cent. During this same period, 957,978 non-Aboriginal and Torres Strait Islander children accessed the programme which is an utilisation rate of 34.7 per cent.

The Panel noted the lower utilisation rate of Aboriginal and Torres Strait Islander children despite a higher proportional representation in the CDBS eligible population. Panel members again considered the effects of the Stronger Futures programme and suggested that analysis by jurisdiction will help identify further opportunities for programme promotion.

3. ELIGIBILITY NOTIFICATIONS AND PROMOTION

VOUCHERS AND ELIGIBILITY NOTIFICATIONS

Under the MTDP, a letter with a voucher enclosed was sent to an eligible teenager or family of an eligible teenager. The material distributed in 2012 is representative of annual MTDP notifications (Appendix 1).

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9 Based on the Australian Bureau of Statistics 3238.0 Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021. The projected Aboriginal and Torres Strait Islander population for children is based on 0–19 year olds.
Under the CDBS, an eligibility notification letter is sent to either the eligible person or the person receiving the relevant government payment. Three types of letters are prepared: one for families, one for teenagers and one for Approved Care Organisations (agencies that assist homeless youth, Juvenile Justice Centres, and adoption and foster care agencies).

While 2014 notifications included detailed CDBS programme information, 2015 eligibility notifications are more succinct. Examples of the 2014 (Appendix 2) and 2015 (Appendix 3) CDBS notification letter are attached.

In 2015, eligibility notifications were also made available on myGov for users who have linked their Medicare record to their myGov account. Among the 1,313,290 notification letters issued between 1 January and 30 June 2015, 330,627 (25.1 per cent) were issued through myGov.

The Panel considered the eligibility notification to be an important communication tool for those patients who do not use dental services. The Panel expressed concern that the CDBS eligibility notification did not highlight the advantages of the CDBS. The MTDP voucher and letter were more appealing than the CDBS eligibility notification and highlighted the benefits available to recipients. The Panel recommended the CDBS eligibility notification letter be revised to be more readily recognisable as a ‘voucher’ with a benefit attached.

The Panel considered that information included in the eligibility notification would benefit from a review by a marketing professional to help determine that the notification be appropriately targeted, and promote the programme through communication channels other than the eligibility notification letter.

The Panel also recommended that the CDBS eligibility notification displays the $1,000 cap figure more prominently to catch the reader’s attention. This would need careful consideration to avoid setting false expectations, given the impact of the benefit cap, annual eligibility requirements, scope of service and the possibility of out-of-pocket costs.

**Recommendation 2:** Make the eligibility notification letter more attractive and recognisable as a ‘voucher’ for services.

**Recommendation 3:** Engage experts in marketing and communication to better target efforts on programme promotion including, for example, utilising communication channels other than the eligibility notifications.

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10 myGov is a tool that allows users to access multiple government services online.
The formal notification of eligibility is not required to confirm that a child is eligible. Both patients and dental practitioners can confirm a child’s eligibility by calling Medicare, and online through myGov (patients) or the Health Professional Online Services system (providers).

Dentists are strongly encouraged to check the eligibility of the child before any dental services are provided. In addition, as the CDBS has a benefit cap of $1,000 over two calendar years, dentists are also encouraged to check the remaining benefit balance before providing services.

Panel members found that the dental profession understood that a physical voucher is not required to access the CDBS, and practices have generally adopted routine CDBS eligibility checks as part of their day-to-day administration. Practice managers understood that they risk increased administrative requirements if they choose to not check CDBS eligibility when a patient presents for dental services. The Panel is of the view that dental providers, in practice, should check CDBS eligibility.

Panel members found that there is variability to the ease of checking eligibility through either the website or the telephone hotline.

The Panel noted that web-based and telephone services were also available for eligible patients to check their eligibility. However, it was acknowledged that there is a degree of unreliability as real-time CDBS balances are unavailable owing to a possible delay in submitting and processing CDBS claims. The Panel acknowledged the difficulties of navigating myGov and noted that this system makes it difficult for families to access their child’s cap balance. The Panel also noted that there may be some advantage in Human Services investigating additional user-friendly options for families to access their child’s cap balance, such as SMS or mobile apps.

Recommendation 4: Ensure hard copy notifications are sent to families who received notification through myGov, unless they have specifically opted out of hard copy communications.

PROMOTION

For patients, the eligibility notification is the principal promotional activity undertaken for the CDBS. Human Services also promotes the CDBS to the general public through screensavers on the Self Service Terminals and a front of house video in Service Centres. In 2014, information was broadcasted by 44 community radio stations in three community languages (Chinese, Vietnamese and Arabic), and articles were published in Ethnic Press in 37 language publications in three community languages (Chinese, Vietnamese and Arabic). Human Services, in consultation with the Australian Dental Association, also sends promotional material to dentists to display within their practice.
The Panel agreed with the conclusions of previous Reviews that broad advertising of the programme was required to help increase utilisation of the CDBS. The Panel identified that further promotional opportunities could be utilised to increase the visibility of the CDBS, including messages in school newsletters and local libraries, as well as social media communication channels. The Panel also considered that targeting rural communities and promoting the CDBS through existing FTB Part A communication channels could be beneficial. The Panel also considered targeted communication to Aboriginal and Torres Strait Islander families to increase their utilisation of the programme.

In addition, the Panel also recommended that a follow up letter be sent to CDBS eligible families who have not used the programme with a view to increasing utilisation.

**Recommendation 5:** Provide hard copy follow up notifications to eligible families who have not accessed services.

### 4. SCOPE OF SERVICES

The then Minister for Health, when announcing the programme, intended for the CDBS to cover for ‘basic dental’ services. Subsequent Health ministers have also implicitly agreed to this scope through their approval of various iterations of the Rules.

The benefits payable under the CDBS are described in the Rules, under the Dental Benefits Schedule (DB Schedule). The DB Schedule is based on the schedule of basic dental services developed by the National Advisory Council on Dental Health, and adapted for a child only programme. Consultation on the CDBS schedule was undertaken with the Australian Dental Association, state and territory dental directors, Health’s clinical advisers, other key stakeholders and the general public.

Item numbers and descriptors for the CDBS are based on, but not identical to, the Australian Dental Association’s *The Australian Schedule of Dental Services and Glossary 10th Edition*. The CDBS items use an additional two-digit prefix of 88. For example, CDBS item 88011 corresponds to the Australian Dental Association item 011.

Additional item numbers, not found within the Australian Dental Association’s Glossary, are created in the Rules to provide for step-down benefits. For example, CDBS item 88316 has been created in the Rules to provide for an additional extraction provided on the same day as a previous extraction.

In 2014, the majority of CDBS services used were preventative and diagnostic services. The top 5 services were:

- fissure and/or tooth surface sealing (item 88161);
- comprehensive oral exam (item 88011);
- intraoral periapical or bitewing radiograph—per exposure (item 88022);
> topical application of remineralisation and/or cariostatic agents (item 88121); and
> removal of calculus—first visit (item 88114).

These diagnostic and preventative services totalled 68 per cent of all services provided under the CDBS. A full breakdown of the service type provided under the CDBS in 2014 is shown in Figure 9.

**FIGURE 9: CDBS SERVICE TYPE: 2014**

Source: Health analysis of claiming data

The Panel noted that the concept of ‘basic dental service’ is contentious and that it may be desirable to allow access to additional items for the promotion of good dental care. The Panel recommended that there should be an opportunity for both the profession and other stakeholders to review the scope of services covered under the CDBS.

**Recommendation 6: Expand the CDBS within the scope of ‘basic dental services’.”**
ITEM RESTRICTIONS

Rules 17 to 29 of the Rules outline item restrictions that apply to certain CDBS schedule item numbers. The item restrictions reinforce dental services that are clinically appropriate, ensure the appropriate expenditure of Commonwealth funds, and contribute to patient benefit entitlements being used to best effect.

Item restrictions include:

> limits on the frequency of certain dental schedule items;
> limits on the quantity of certain dental schedule items;
> limits on like dental schedule items, so as not to be used on the same day;
> limits on some items so that benefits can only be payable if a pre-requisite schedule item has been claimed; and
> limits on multiple services on the same tooth.

Some restrictions are applied automatically through mechanisms which reject claims for benefits. There is some evidence however, that some claims that are not compliant due to time-based restrictions are accepted through bulk billing claims through the HICAPS machine, but practices are later told that the claim had been rejected. On these occasions, practices have had to accept the costs incurred as the patient has left the surgery. Restrictions which require identification of the tooth can only be enforced through compliance audits.

There is a substantial increase in CDBS utilisation during school holidays (Figure 10). Families accessing the CDBS through school holidays may be disadvantaged where services required are linked to items which carry a time restriction. For example, item 88012 (periodic oral examination) is limited to one per six-month period. If a patient returns for a second oral exam during a subsequent school holiday period that falls just inside the six month limit, a CDBS benefit is not payable.

The Panel discussed item restrictions in the CDBS Dental Benefits Schedule and how time based restrictions on dental items are common in private health insurance and dental programmes.

The Panel recommended that changes be made to some of the time based restrictions under the CDBS to allow greater flexibility in providing these services and particularly to address the issues relating to this age cohort such as school holidays.

Recommendation 7: Amend the Rules to provide flexibility for time-based restrictions.
FIGURE 10: CDBS SERVICE TREND OVER THE CALENDAR YEAR IN 2014 & 2015

Source: Health analysis of claiming data

**BENEFITS CAP**

Rule 14 and Schedule 3 of the Rules outline the monetary limit, known as the cap, for dental benefits paid for services listed in the DB Schedule to an eligible patient within a relevant two-year period.

The relevant two-year period is the calendar year in which the eligible patient received their first dental service and the following calendar year. The current cap amount specified in Schedule 3 is $1,000.

A patient’s entire benefit cap can be used in the first year if needed. If the entire benefit cap is not used in the first year, the balance can be used in the following year if the child is still eligible. For example, if a child receives CDBS services and benefits to the value of $550 in 2014, then in 2015 if he or she is still eligible for the CDBS he or she can receive more dental services and benefits to the value of $450. However, if the child reaches the $1,000 benefit cap in the first year of the relevant two year period, they would have to wait until 2016 before they can access a new benefit cap of $1,000.

In 2014, 4 per cent of CDBS patients reached the benefit cap of $1,000, with a further 4 per cent close to reaching the cap with expenditure of between $900 and $999. However, 71 per cent of patients used less than half of their cap. Almost 2 per cent of patients who commenced treatment in 2015 for the first time reached the cap of $1,000 in the first six months of the year, with an additional 2 per cent close to the cap. Around
85 per cent of patients who were eligible in 2014 and accessed the CDBS retained their eligibility in 2015. These patients can continue to access the CDBS in 2015 up to the value of the two-year cap. The distribution of benefits paid per patient is shown in Figure 11.

**FIGURE 11: DISTRIBUTION OF BENEFITS CLAIMED PER CDBS PATIENT, COMMENCING TREATMENT IN 2014 AND 2015**

The impact of the $1,000 benefit cap was discussed in the context of expanding the services under the CDBS, noting that the benefit cap may restrict access to specialists’ services. It was recognised, however, that the cap was a significant element in ensuring the ongoing sustainability of the CDBS.

**THE EXCLUSION OF DENTAL BENEFITS FOR IN-HOSPITAL DENTAL SERVICES**

Section 20 of the Act specifies that a dental benefit is not payable if the 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*.

There are arrangements between the Commonwealth and states and territories for funding public hospitals, which include hospitalisations due to dental conditions. Where a child with special needs requires basic dental care that can only be delivered in a hospital, arrangements can be made by the public hospital or Local Hospital
Network to provide the necessary inpatient or non-admitted patient care for that child. In addition, the public dental sector has received Commonwealth funding through the National Partnership Agreement on Treating More Public Dental Patients (July 2012–June 2015) to provide additional public dental services to eligible patients, which included in-hospital services provided to children under general anaesthetic.

It is the Panel’s view that Australia-wide, the public dental sector’s waiting list for children accessing treatment under general anaesthesia can be unacceptably long.

The Panel recommended that CDBS benefits be available for some services provided in hospital, when clinically appropriate. The Panel agreed that there is a clinical need for some children to access dental care within a hospital setting, noting in particular that rural and remote children often require extensive dental treatment due to irregular visiting patterns\textsuperscript{11}. In addition, the Panel noted the challenges of treating pre-cooperative children in the chair, and that some procedures would be traumatic without general anaesthesia and the use of hospital facilities. The Panel also recognised children with special needs who may require basic dental care to be performed in a hospital. The Panel was of the view that this restriction often penalises patients most in need of financial support and dental care.

The Panel was strongly of the view that the intentions of the Act cannot fully be expressed with the restrictions on hospital services, and that the restriction should be removed, to allow flexibility for the services to be delivered in the most appropriate setting.

**Recommendation 8:** Allow benefits for in-hospital dental services when clinically appropriate.

5. FEES AND BILLING

**CLAIMING PATTERNS FOR THE CDBS**

The availability of bulk billing may have implications for access to CDBS services, as bulk billing does not require an upfront payment and leaves the patient with no out-of-pocket costs. The public dental sector bulk bills all CDBS services.

Patient billing generally requires the patient to pay for the costs of the dental service before claiming any CDBS benefit. This may act as a deterrent for certain patient groups. Nationwide, bulk billing rates for 2014 and 2015 are over 90 per cent. The fee observance rate, where the dental provider charges at or below the schedule fee, is over 95 per cent (Table 6).


<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>2014 Bulk billing (%)</th>
<th>2014 Schedule fee observance (%)</th>
<th>2015 Bulk billing (%)</th>
<th>2015 Schedule fee observance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>93.2</td>
<td>97.2</td>
<td>93.8</td>
<td>97.3</td>
</tr>
<tr>
<td>VIC</td>
<td>88.8</td>
<td>95.3</td>
<td>90.6</td>
<td>96.3</td>
</tr>
<tr>
<td>QLD</td>
<td>94.2</td>
<td>97.4</td>
<td>95.6</td>
<td>98.2</td>
</tr>
<tr>
<td>SA</td>
<td>96.9</td>
<td>97.8</td>
<td>96.7</td>
<td>97.4</td>
</tr>
<tr>
<td>WA</td>
<td>81.0</td>
<td>89.7</td>
<td>84.6</td>
<td>91.8</td>
</tr>
<tr>
<td>TAS</td>
<td>95.4</td>
<td>97.8</td>
<td>96.3</td>
<td>98.1</td>
</tr>
<tr>
<td>NT</td>
<td>92.4</td>
<td>95.3</td>
<td>93.5</td>
<td>96.1</td>
</tr>
<tr>
<td>ACT</td>
<td>83.5</td>
<td>93.5</td>
<td>85.6</td>
<td>94.3</td>
</tr>
<tr>
<td>AUS Total</td>
<td>92.3</td>
<td>96.5</td>
<td>93.3</td>
<td>97.1</td>
</tr>
</tbody>
</table>

Source: Health analysis of claiming data

The high bulk billing rates in South Australia and Tasmania reflect the high utilisation of the CDBS by their public sectors. Figure 12 illustrates bulk billing in the private sector only. It shows a slight reduction in bulk billing rates in South Australia and Tasmania once public sector utilisation is removed.

FIGURE 12: PRIVATE SECTOR SERVICE BILLING PATTERNS BY JURISDICTION (1 JANUARY 2014–30 JUNE 2015)

Source: Health analysis of claiming data

The Panel noted the high bulk billing rate under the CDBS.
STEP-DOWN FEES

The CDBS provides for the payment of reduced (step-down) benefits for certain services where more than one service is provided on the same day. The CDBS structure is modelled on the step-down fee structure used for the Chronic Disease Dental Scheme, where a different item number is used to pay a lower benefit for subsequent similar services on the same day. Table 7 shows the CDBS item and step-down items for extraction services.

The CDBS also has a step-down fee for fissure sealants, with the first four services attracting a benefit of $46.05, and subsequent services a benefit of $23.05 (50 per cent reduction).

TABLE 7: CDBS STEP-DOWN FEES STRUCTURE FOR EXTRACTION ITEMS

<table>
<thead>
<tr>
<th>Item number</th>
<th>Service Description</th>
<th>Fee for first tooth extracted on a day</th>
<th>Subsequent Item and fee</th>
<th>Reduction percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>88311</td>
<td>Removal of a tooth or part(s) thereof</td>
<td>$131.30</td>
<td>Additional extraction item 88316—$82.75</td>
<td>37.0%</td>
</tr>
<tr>
<td>88314</td>
<td>Sectional removal of a tooth or part(s) thereof</td>
<td>$167.80</td>
<td></td>
<td>50.7%</td>
</tr>
<tr>
<td>88322</td>
<td>Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division</td>
<td>$213.10</td>
<td>Additional extraction item 88326—$174.35</td>
<td>18.2%</td>
</tr>
<tr>
<td>88323</td>
<td>Surgical removal of a tooth or tooth fragment requiring removal of bone</td>
<td>$243.35</td>
<td></td>
<td>28.4%</td>
</tr>
<tr>
<td>88324</td>
<td>Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division</td>
<td>$327.35</td>
<td></td>
<td>46.7%</td>
</tr>
</tbody>
</table>

Source: Dental Benefits Rules 2014

Veterans’ Affairs provides benefits for a range of dental services for certain veterans, war widows and eligible dependents. The Fee Schedule of Dental Services for Dentists and Dental Specialists outlines all the dental items covered under the Veterans’ Affairs dental scheme. As with the CDBS, Veterans’ Affairs has a step-down fee for the five extraction items (Table 8). Unlike the CDBS, however, Veterans’ Affairs will pay the higher fee for the first extracted tooth from each quadrant of the mouth, and pay a step-down fee for the second and subsequent extractions from the same quadrant on the same day.

12 The Chronic Disease Dental Scheme was a Commonwealth Dental programme that was in operation from 1 November 2007 to 30 November 2012.
TABLE 8: DEPARTMENT OF VETERANS’ AFFAIRS STEP-DOWN FEES FOR EXTRACTION ITEMS

<table>
<thead>
<tr>
<th>Item number</th>
<th>Service Description</th>
<th>Fee for first service from each quadrant*</th>
<th>Step-down fee for subsequent service from same quadrant*</th>
<th>Reduction percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>D311</td>
<td>Removal of a tooth or part(s) thereof</td>
<td>$133.55</td>
<td>$84.15</td>
<td>37.0%</td>
</tr>
<tr>
<td>D314</td>
<td>Sectional removal of a tooth or part(s) thereof</td>
<td>$170.65</td>
<td>$112.70</td>
<td>34.0%</td>
</tr>
<tr>
<td>D322</td>
<td>Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division</td>
<td>$216.70</td>
<td>$144.15</td>
<td>33.5%</td>
</tr>
<tr>
<td>D323</td>
<td>Surgical removal of a tooth or tooth fragment requiring removal of bone</td>
<td>$247.50</td>
<td>$177.30</td>
<td>28.4%</td>
</tr>
<tr>
<td>D324</td>
<td>Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division</td>
<td>$332.90</td>
<td>$219.45</td>
<td>34.1%</td>
</tr>
</tbody>
</table>

* Veterans’ Affairs pays differential fees for a general dental practitioner and a dental specialist. Only the fees for general dental practitioner are shown, as this is more comparable to CDBS benefits.

Source: Fee Schedule of Dental Services for Dentists and Dental Specialists (1 June 2014), Department of Veterans’ Affairs.

A dental provider claiming under the Veterans’ Affairs dental scheme for items D311–D324 is required to include the relevant tooth number(s) with the claim for payment. The CDBS payment system does not have the capacity to collect tooth numbers.

The Panel discussed the creation of new item numbers under the CDBS with reduced fees set for subsequent items used multiple times. Panel members considered that step-down fees that are linked to multiple services within the same dental quadrant to be a better reflection of the clinical efficiencies of performing more than one of a similar procedure on the same day.

Panel members considered the information provided on step-down fees under the Veterans’ Affairs Dental Schedule showing that CDBS step-down fees are significantly lower in comparison to the Veterans’ Affairs’ fees. Panel members noted that the profession does not support step-down fees; however, should step-down fees continue to be applied, the Veterans’ Affairs ‘per quadrant’ model is preferable to the current CDBS scale.

Panel members also considered that CDBS fee levels should be similar to those found in the Veterans’ Affairs Dental Schedule.
Recommendation 9: Adopt the Department of Veterans’ Affairs ‘step-down fees’ model for the CDBS.

Recommendation 10: At the next opportunity, align the fee levels of the CDBS Dental Benefits Schedule with those of the Department of Veterans’ Affairs benefit schedule.

6. INFORMED FINANCIAL CONSENT REQUIREMENTS

Rule 15 of the Dental Benefits Rules stipulates the informed financial consent requirements for accessing the CDBS. It mandates that a dental provider must:

> obtain consent to provide the dental service from the eligible dental patient or a person able to consent on his/her behalf and informed financial consent from the person who incurs the dental expenses for that dental service before providing any item in the Dental Benefits Schedule;

> record the consent to treatment and costs; and

> obtain the appropriate signature or signatures on a patient consent form.

The rule mandates that if the dental provider bulk bills, a ‘Bulk Billing Patient Consent Form’ only needs to be executed on the day of the first service of the calendar year, and is valid for the rest of the calendar year as long as the provider continues to bulk bill.

If the dental provider does not bulk bill, a ‘Non-Bulk Billing Patient Consent Form’ needs to be executed on the same day as the service, and a new form is required for each subsequent visit during the calendar year.

The informed financial consent requirements aim to facilitate discussion of proposed treatment and costs, and ensure patients are fully informed before undergoing a course of care. If a dental provider fails to satisfy the informed financial consent requirements, the services provided cannot be deemed ‘eligible CDBS services’ and the dental provider will be required to pay back to the Commonwealth all amounts paid purportedly by way of benefit for these services.

The informed financial consent requirements for bulk billing and non-bulk billing claiming reflect the different levels of financial risk borne by the patient. As non-bulk billing results in the patient paying upfront costs, as well as potential out-of-pocket costs, informed financial consent must be completed at each visit.

The Panel noted the importance of informed financial consent and did not consider the requirement to be onerous.
MINISTERIAL GUIDELINES FOR EXTENUATING CIRCUMSTANCES

Subrule 15(6) of the Dental Benefits Rules provides for a dental provider to be relieved of the requirement for informed financial consent if there are extenuating circumstances.

The Ministerial Guidelines for Child Dental Benefits Schedule: Extenuating circumstances for Informed Financial Consent (the Ministerial Guidelines) outline six specific circumstances where CDBS benefits may still be payable when a dental provider has not recorded informed financial consent on the appropriate consent form due to circumstances beyond his/her control:

> emergency services provided outside of normal practice;
> failure of patients to disclose their intention to use CDBS benefits to the provider or practice on the day of service;
> refusal to sign;
> administrative error;
> incapacity/death of patient before signing; and/or
> person executing the patient consent form does not have authority to sign.

The Ministerial Guidelines only exempt the provider from the requirements to record the consent and to obtain a signature on the consent form. All other requirements of the CDBS must be met, including consent to both the services provided and any relevant costs.

The Ministerial Guidelines explain how extenuating circumstances should be recorded to ensure that, when audited, the dental provider will be exempt from any requirement to reimburse assigned dental benefits in relation to the service.

The Panel agreed the Ministerial Guidelines provide clear instructions on most of the extenuating circumstances where a patient consent form had not been signed but a CDBS claim could still be made. However, the Panel noted that the Ministerial Guidelines were not clear regarding retrospective eligibility, as they do not distinguish between a patient who does not disclose his/her eligibility, and a patient who only becomes eligible after a service has been provided.

In addition, the Panel also raised a number of concerns around the process for utilising the extenuating circumstance where the patient’s eligibility was not known at the time of service, particularly in the event where they find out their CDBS eligibility after a claim has been made from a private health insurer.
The Panel found that dentists were concerned about the requirement to reissue an invoice in response to this extenuating circumstance. Dental providers are concerned about the legality of amending invoices and the attendant risk of an adverse audit outcome by private health insurers and/or Medicare. Panel members agreed that it must be made clear that dentists are under no obligation to issue a second invoice.

The Panel recommended that an alternative process be developed to reduce the administrative burden for accessing benefits where a patient’s eligibility was not known at the time of service. Health and Human Services are working together to develop processes which will address the profession’s concerns.

**Recommendation 11:** Streamline administrative processes, and if necessary revise the Ministerial Guidelines, to enable the policy intent of retrospective eligibility to be met with clarity and without undue administrative imposition on dental practices.
Conclusion

The Review of the *Dental Benefits Act 2008* (the Act) has been undertaken as a requirement of section 68 of the Act. Section 68 stipulates that the Minister for Health must cause an independent review of the operation of the Act to be undertaken as soon possible as after the first anniversary of the Act’s commencement and further independent reviews as soon as practicable after the Act’s third anniversary and at three yearly intervals thereafter.

The Review Panel was appointed on 22 June 2015 by the Minister for Health, the Hon Sussan Ley MP, to undertake this task.

The Review Panel found that the Act achieves its aim of providing a legislative framework for the payment of dental benefits, and supports the administration of the Child Dental Benefits Schedule. The Panel noted the utilisation rates across jurisdictions, the public and private dental sectors and population groups such as Aboriginal and Torres Strait Islander children and rural and remote communities.

It is also the Panel’s view that some changes to the Child Dental Benefits Schedule could be made in order to enhance the programme and increase uptake. The Panel has made recommendations to Government that it believes would assist the Child Dental Benefits Schedule in becoming even more effective in improving the oral health of young Australians.
Appendix 1:  
2012 MTDP Voucher

Medicare Teen Dental Plan  
Annual preventative dental check  

Your $163.05 teen dental voucher

This voucher is valid between 1 January and 31 December 2012

This voucher entitles  
to claim a dental benefit from Medicare for one preventative dental check this calendar year,  
as long as all eligibility requirements of the service are met. The service is described below.  
Take this voucher and your Medicare card to your appointment.

Who can provide the preventative dental check?  
• Private dentists  
• dentists in public dental clinics, including school-based clinics, and  
• dental hygienists or dental therapists under supervision or oversight of a dentist.

How do I use the voucher?  
Using the voucher is easy—just make an appointment with a dentist.  
When making a booking, ask:  
• does the dentist accept the voucher  
• will the voucher cover the full cost of the check, and  
• will there be any extra costs?

Claim for your preventative dental check  
After your preventative dental check the dentist will either:  
• bulk bill the service by asking you to sign an assignment of benefit form with no cost to you  
• ask you to pay in full up front—you then claim your benefit (up to $163.05) through Medicare,  
just like other Medicare benefits, or  
• ask you to take your unpaid account to Medicare—you will then be sent a cheque to take back  
to the dentist.

If the dentist charges more than $163.05 for the preventive dental check, you’ll need to pay the  
difference. Other dental treatment services are not covered by the voucher.

For more information go to humanservices.gov.au, call 132 011* or visit your local Service Centre.

Dental Benefits Schedule  
(DBS) item number  
Description of eligible service  
Maximum benefit payable by Medicare

<table>
<thead>
<tr>
<th>Dental Benefits Schedule (DBS) item number</th>
<th>Description of eligible service</th>
<th>Maximum benefit payable by Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>88000</td>
<td>Preventative dental check</td>
<td>$163.05</td>
</tr>
</tbody>
</table>

*Call charges apply

Voucher for a preventative dental check

$163.05

Item number Description Maximum benefit Expiry Voucher number

---

39
Appendix 2:  
2014 CDBS Notification Letter

<XX January 2014>

<Title> <Name> <Surname>  
<Address 1>  
<Address 2>  
<SUBURB> <STATE> <Postcode>  

Dear <Title> <Surname>

Children in your family are eligible for dental benefits under the  
Child Dental Benefits Schedule

Children in your family are eligible throughout 2014 for the Child Dental Benefits Schedule, a new dental program which replaces the Medicare Teen Dental Plan. The Child Dental Benefits Schedule provides up to $1,000 in benefits for basic dental services, capped over two consecutive calendar years.

A child is eligible for the Child Dental Benefits Schedule if he or she is aged between 2-17 years old for at least one day in the calendar year, is eligible for Medicare and is part of a family that receives a relevant Australian government payment such as Family Tax Benefit Part A. The child(ren) remain eligible all year, even if the payment that made them eligible stops this year or if they turn 18 this year.

**Eligible child(ren) and benefit cap amount(s)**  
Listed below is/are the eligible child(ren) in your family and each child’s benefit cap amount.

<table>
<thead>
<tr>
<th>Full name</th>
<th>Benefit cap amount*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;First name&gt; &lt;Surname&gt;</td>
<td>$XXXX.XX</td>
</tr>
<tr>
<td>&lt;First name&gt; &lt;Surname&gt;</td>
<td>$XXXX.XX</td>
</tr>
<tr>
<td>&lt;First name&gt; &lt;Surname&gt;</td>
<td>$XXXX.XX</td>
</tr>
</tbody>
</table>

* A child’s benefit cap amount starts the year they first receive a dental service.

You can use the full benefit cap of $1,000 for each child in the first year. If the child does not use it all, you can use what is left in the second year if the child is still eligible. Any balance remaining at the end of the two year period cannot be used to fund services that are provided outside that two year period. A child’s benefit cap can only be used for eligible services provided to that child.
Eligible services
The Child Dental Benefits Schedule provides individual benefits for a range of services including examinations, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. Benefits are not available for orthodontic or cosmetic dental work and cannot be paid for any services provided in a hospital.

What you need to do
A benefit can only be paid for a dental service if the child has a balance remaining in his or her benefit cap. Before making an appointment, you can easily check your child’s eligibility and remaining benefit cap amount, or view other family Medicare information, by accessing Medicare services through your myGov account at my.gov.au If you do not have a myGov account, you will need to create one first and then link it to Medicare.

Alternatively, you may phone 132 011 (call charges may apply – calls from mobile phones may be charged at a higher rate). You will need to have your child’s Medicare card details with you to access this service. Your dentist can also check your child’s eligibility and remaining benefit cap amount by contacting the Australian Government Department of Human Services.

When you make the appointment with either a private dentist or a state or territory public dental clinic let them know that you will be using the Child Dental Benefits Schedule.

At the appointment, the dentist is required to discuss your child(ren)’s treatment and its costs with the parent/guardian, or your child depending on his or her age, and obtain consent before treatment is provided. This consent will need to be confirmed by signing a form provided by the dentist.

Public dental clinics must bulk bill under the Child Dental Benefits Schedule, which means the benefit available under the Child Dental Benefits Schedule covers the cost of the service.

Private dentists may charge a fee that exceeds the benefit available for a service. If they do, you will have to pay the difference in cost. You cannot claim a benefit from both a private health insurer and the Child Dental Benefits Schedule for the same dental service. More information is at: humanservices.gov.au/childdental

Shared Care arrangements
If your child(ren) is/are in equal shared care arrangements, each parent or carer/guardian will receive a letter. Whilst either parent or carer can organise dental services for each child, that child’s total benefit cap of $1000 cannot be exceeded.

Receiving your Medicare letters online
You can now access some of your Medicare letters online through your myGov Inbox. In future, you will also be able to receive letters about the Child Dental Benefits Schedule from your Inbox.

Updating your family details
If your circumstances have changed and you need to update your family details, you can do this by accessing your Centrelink services through your myGov account at my.gov.au You will need to link your myGov account to Centrelink first.

More information
For more information on the Child Dental Benefits Schedule, go to humanservices.gov.au/childdental
Appendix 3:
2015 CDBS Notification Letter

<<12 January 2015>>

<table>
<thead>
<tr>
<th>First name</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your reference: <reference>

Dear <Title> <Surname>

Your child/ren’s eligibility for dental benefits

We are writing to you about your child/ren’s eligibility for dental benefits under the Child Dental Benefits Schedule. The Child Dental Benefits Schedule pays benefits for basic dental services up to $1000 over two years.

The following child/ren are eligible from 1 January <2015> to 31 December <2015> even if the payment that made them eligible stops or if they turn 18 years of age:

<table>
<thead>
<tr>
<th>Child name</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
</tr>
<tr>
<td>First name</td>
</tr>
<tr>
<td>First name</td>
</tr>
<tr>
<td>First name</td>
</tr>
<tr>
<td>First name</td>
</tr>
<tr>
<td>First name</td>
</tr>
</tbody>
</table>

Available benefit amount

You can check the available benefit amount for your child/ren by:
- accessing Medicare services through your myGov account if you do not have a myGov account, you will need to create one first by going to my.gov.au and then link it to Medicare.
- calling us on 132 011 (call charges may apply).

The dentist can also check the available benefit amount by contacting us.

Dental services you can claim

You can claim benefits for a range of basic dental services for your child/ren including checkups, 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, please go to humanservices.gov.au/childdental

Yours sincerely

Director
Medicare and Veterans Branch