



Private Healthcare Australia
Better Cover. Better Access. Better Care.



Senate Select Committee into the Provision and Access of Dental Services in Australia - submission

June 2023

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have over 20 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for more than 14 million Australians.

Response

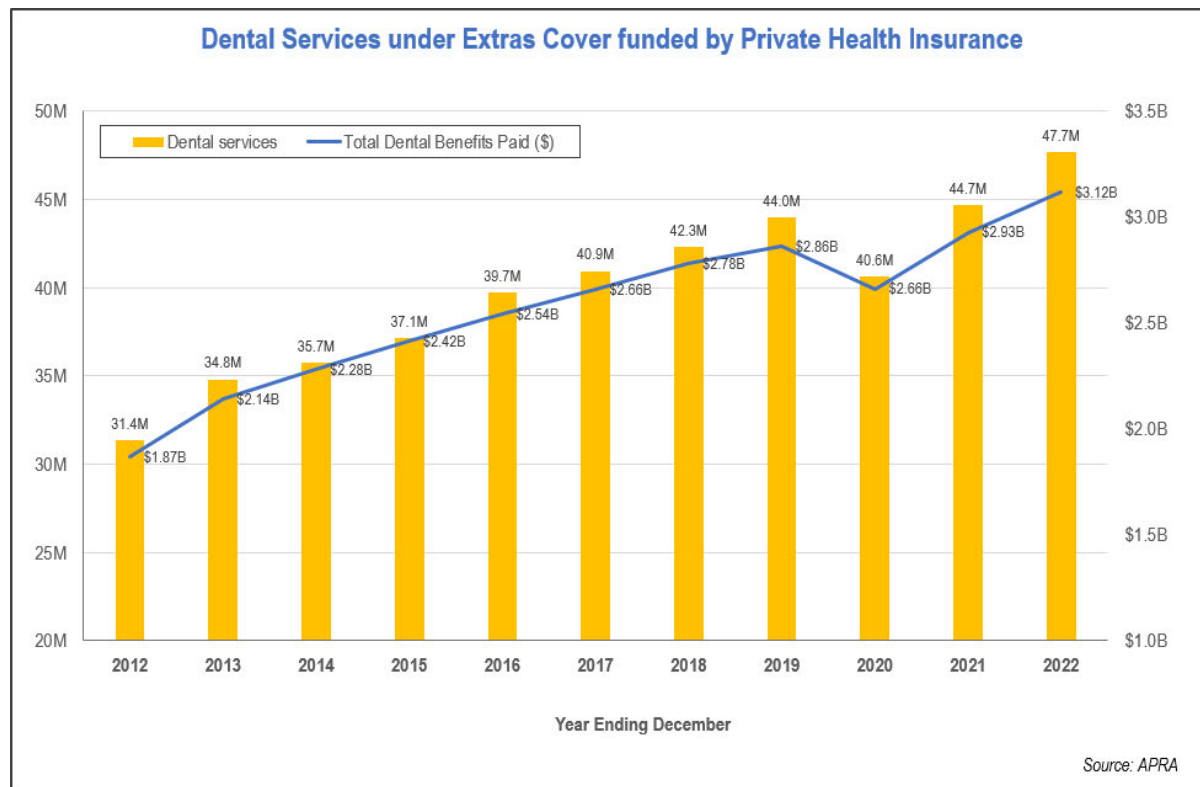
PHA welcomes the opportunity to provide input to the Select Committee into the Provision and Access of Dental Services in Australia.

Access to dental services is a major issue for many people on low incomes and in many parts of the country. Our submission addresses the terms of reference, and highlights the role of health funds in providing support for Australians to access dental care.

PHA can also offer our expertise to government should it choose to expand access to dental services for vulnerable Australians, with the possibility of health funds being directly involved.

The experience of children and adults in accessing and affording dental and related services

Private health insurance is Australia's largest funder of dental services. Half of all Australians claim for dental services through a health fund. As at 31 March 2023, over 14.5 million Australians (55% of the Australian population) were covered by a general treatment policy with dental insurance coverage.

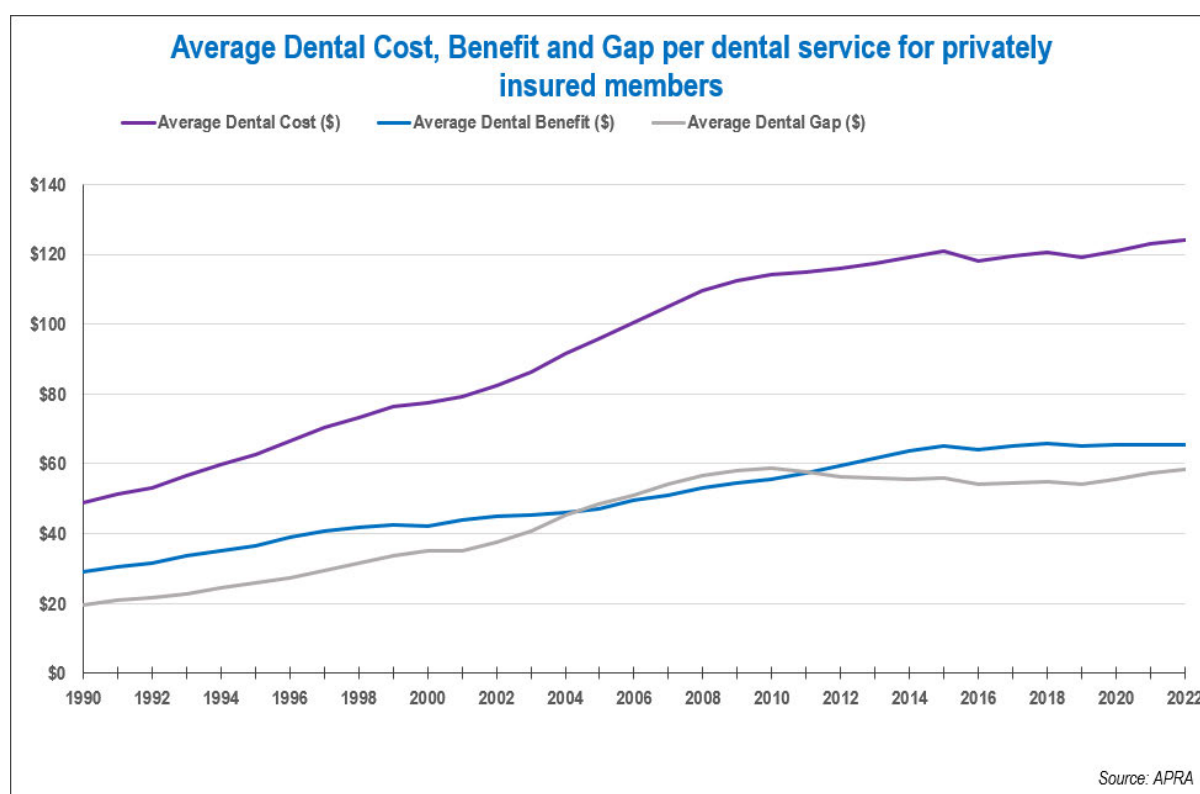


Dental is the largest area of expenditure by private health insurance under general treatment; nearly 55% of extras claims funded by private health insurance is for dental care. In 2022, health funds collectively paid an annual record of \$3.1 billion (including premium rebates) for members' dental treatments, covering over 47.6 million dental services (a 6.4% expenditure increase from 2021 and an 8.9% expenditure increase from pre-COVID 2019). One dollar in every seven (14.6%) of total annual health expenditure by private health insurance funds is for dental services.

Private health insurance has helped keep downward pressure on service costs. Dental benefit returns to members are currently at increased levels compared to 10 years ago. Over the past decade, average dental fund benefits paid per service has increased by 10%, compared to average dental costs per service which has increased by 7%.

Out of pocket costs

Out-of-pocket costs for dental services provided through health funds have been static from 2010-11 to 2021-22, with no increase over that period.



Health funds use contracted billing arrangements with dental practitioners to sustainably pay higher rebates for treatment in exchange for no or known out of pocket costs. This allows health funds to manage premium inflation and affordability concerns for their customers.

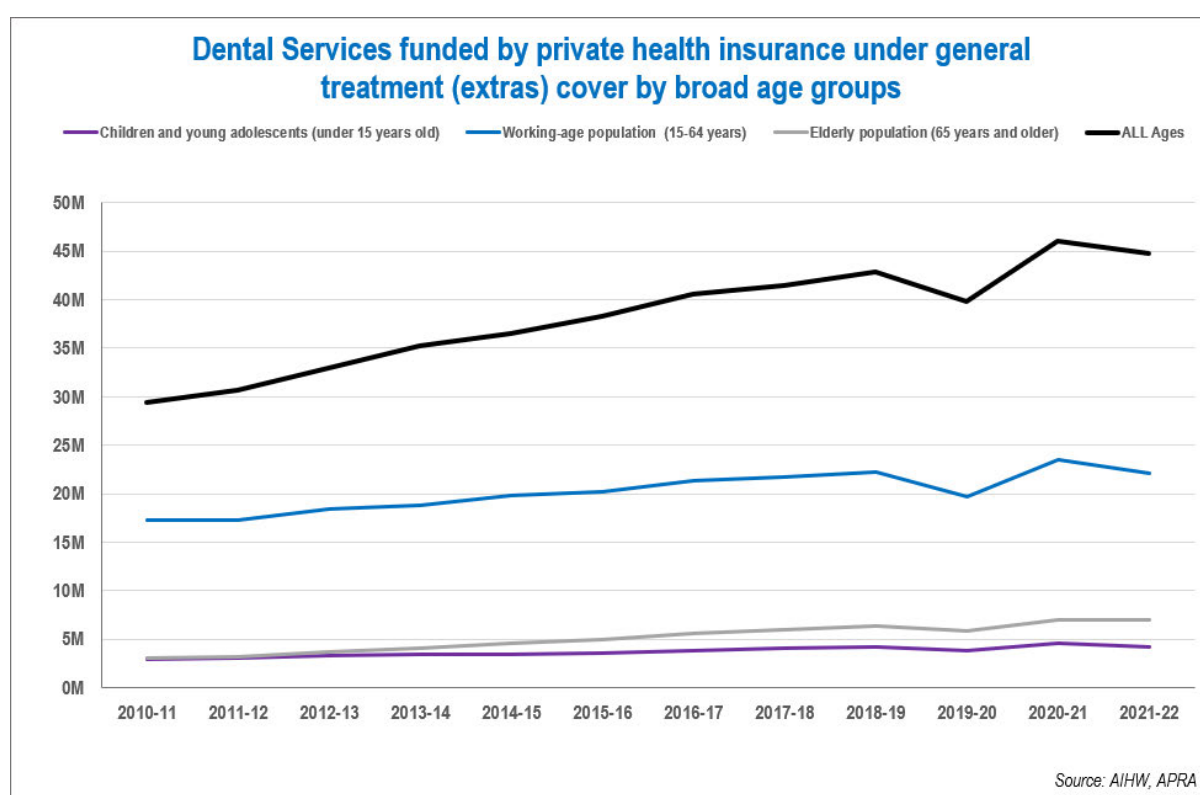
The lack of increases in out-of-pocket costs for dental services covered by health funds contrasts sharply with government-run programs over the same period. Services covered by the Medicare Benefits Scheme have experienced sharp increases in out-of-pocket expenses from 2010-11 to 2021-

22, including general practice (up 63%), medical specialists (up 98%), and allied health (up 95%).¹ The mental health Better Access Program has also experienced significant increases in out-of-pocket expenses, although the time period is not comparable.

Early data from 2022-23, not yet complete, suggests that out-of-pocket expenses are beginning to increase for people covered by health funds. The impacts of inflation across the economy will affect dental services for insured Australians by increasing the costs of providing dental care, but health funds' arrangements with dental providers have dampened and delayed that effect for consumers.

Children, young adults, adults and older adults

Dental care is important at all ages, and the table below highlights the provision of dental services funded through private health insurance.



The data show that it is younger adults who are least likely to go the dentist. Private health insurance is vital for this undertreated group. About one in nine dental services funded by PHI annually are for young adult members aged 18 to 29 (over 4.32 million dental treatment services),

¹ Derived from Medicare Quarterly Statistics, At <https://www.health.gov.au/resources/publications/medicare-annual-statistics-state-and-territory-2009-10-to-2021-22?language=en>. Comparison is on 'Avg Patient Contribution Per Service: Out of Hospital Patient Billed' from 2010-11 to 2021-22.
Total GP Non-Referred Attendances: \$25.88 in 2010-11 to \$42.25 in 2021-22
Specialist Attendances: \$49.56 to \$98.39
Other Allied Health: \$31.02 to \$60.51
The PHI data on out-of-pocket costs are not available to the cent, it is rounded to the nearest dollar (\$58 in both 2010-11 and 2021-22)

with benefit payments on dental claims totalling \$247 million. Importantly, a third of dental services performed on young members have no out-of-pocket payment.

The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas

Public dental services are inadequate in most parts of Australia. Other submissions will be able to provide greater guidance on gaps by state and by region. This submission will concentrate on the overall funding of dental care.

Both Australian Institute of Health and Welfare (AIHW) and Australian Prudential Regulatory Authority (APRA) data conclusively show that there has been a significant cost shift to private health insurance funding more dental services year on year. The AIHW shows in its latest health expenditure report that the proportion of total expenditure on dental services by health insurance funds has increased significantly from 14.4% in 2009-10 to 20.2% in 2020-21.

Over this period, government funding has declined as a proportion of overall costs. The proportion of total expenditure (including PHI premium rebates for dental) on dental services by the Australian Government has dropped from 12.8% in 2009-10 to 12.2% in 2020-21, and the proportion of total expenditure on dental services by State and Local Governments has also dropped from 10.0% in 2009-10 to 8.5% in 2020-21.

The proportion of total expenditure on dental services by individuals has remained steady from 58.0% in 2009-10 to 58.6% in 2020-21.

Overall, individuals who use dental services are increasingly funding their treatment through private health insurance, with less support from governments.

The interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services

Private health insurance is an important, and currently the most effective, funding mechanism for dental services in Australia. More than half of Australians are covered by private health insurance, and out-of-pocket costs are relatively low and stable. The greatest support for dental care from the Australian Government is the Private Health Insurance Rebate, which contributes up to a quarter of the cost of private health insurance (slightly higher for older Australians).

For the most part, people with private health insurance are not rich - 42% have a taxable income of \$50,000 per year or less and for 10% of these the aged pension is their only income. However, they are all trying to do the right thing by making a direct contribution to the cost of their health care. Without this contribution access to dental care would be severely compromised.

Removing the rebate on extras cover has been raised by some commentators as a way of partially paying for public dental services. The health funds provide similar dental benefits to Commonwealth, State and Local governments combined, and have been able to exercise some market power to put downward pressure on costs in what is essentially a purely private cottage industry. Removing the rebate would just look like a premium increase for lower income earners, and would cause the existing system to unravel. This would likely include significant increases in out-of-pocket costs for consumers.

The provision of dental services under Medicare, including the Child Dental Benefits Schedule

The Commonwealth Government was first involved in funding dental schemes in the 1970s and still funds the Child Dental Benefits Scheme (CDBS), the Cleft Lip and Palate Scheme and the dental scheme supported by the Department of Veterans' Affairs. It also provides limited support via Medical and the Pharmaceutical Benefits Scheme for specific oral health needs or some medicines prescribed by dentists.

However, the history of Commonwealth-funded schemes has been plagued with criticisms. These have included that services are restricted; the level of incentives offered to dentists to participate in these schemes are inadequate; and minimal outcomes impacts from the schemes themselves. These programs have also been subject to allegations of significant levels of over-servicing, fraud and inappropriate practice.

In 2019, PHA commissioned a report from Evaluate on the possible role of private health insurance in a publicly funded dental scheme. Evaluate provided a draft report which examined the role of the Commonwealth Government in dental care, which is reproduced at Attachment one.

The social and economic impact of improved dental healthcare

Good dental care provides significant benefits to the individual, to the community and to economic growth. While others may be better placed to articulate the benefits of improved dental care, health funds have acknowledged these for some time. The value of preventive dental care is particularly well recognised – most health funds offer no-gap dental check-ups annually.

Good oral health is critical for people's overall health and wellbeing. Oral health is considered to encompass a person's teeth and gums, as well as the state of the bones and muscles in their mouth. Oral health usually worsens over a person's lifespan and poor oral health – tooth decay, gum disease and tooth loss – affects many Australian children and adults. [Australia's Oral Health Tracker 2020](#) provides a solid source of data and is recommended to the Select Committee.

Dental disease often affects an individual's opportunities for education, social interaction and employment and can impair a person's appearance and speech. This in turn can undermine self-esteem, which further restricts participation in school, work and other social environments.

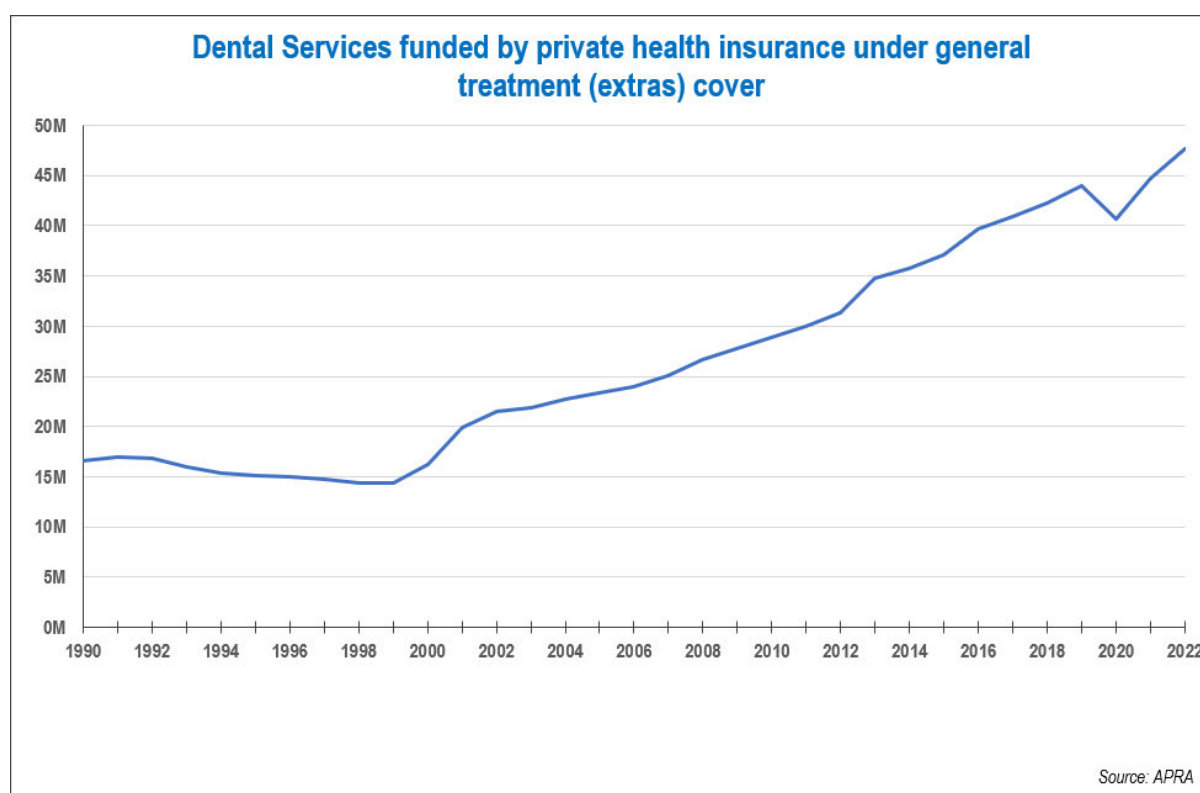
Eating can be negatively impacted by the pain, infection and tooth loss that result from untreated oral disease. Losing teeth can make chewing and swallowing more difficult, leading to poor nutrition and consequently poorer general health.

Poor oral health is also associated with a variety of chronic diseases. Key amongst these are stroke, cardiovascular disease, diabetes and lung conditions. Adverse pregnancy outcomes are also associated with poor oral health.

People's sleep and productivity can be affected by their oral health, and disability and death can be the consequence of soft tissue destruction in the mouth.

The impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services

Access to dental care was severely compromised in the first months of the pandemic in 2020, with a very large reduction in the number of services funded by private health insurance in April 2020 as restrictions were put in place in each state and territory. Across the 2020 calendar year, there were around 10% fewer dental services provided than the year before. The numbers recovered in 2021, and service numbers were back to the long-term trend in 2022. In the second half of 2022 and the first few months of 2023, there is some evidence of 'catch up' services, but overall it is clear that many people failed to receive their regular check-ups in 2020. This is likely to have resulted in people needing more substantial dental work as problems were not identified earlier. The national figures are also likely to disguise localised issues with access to care.



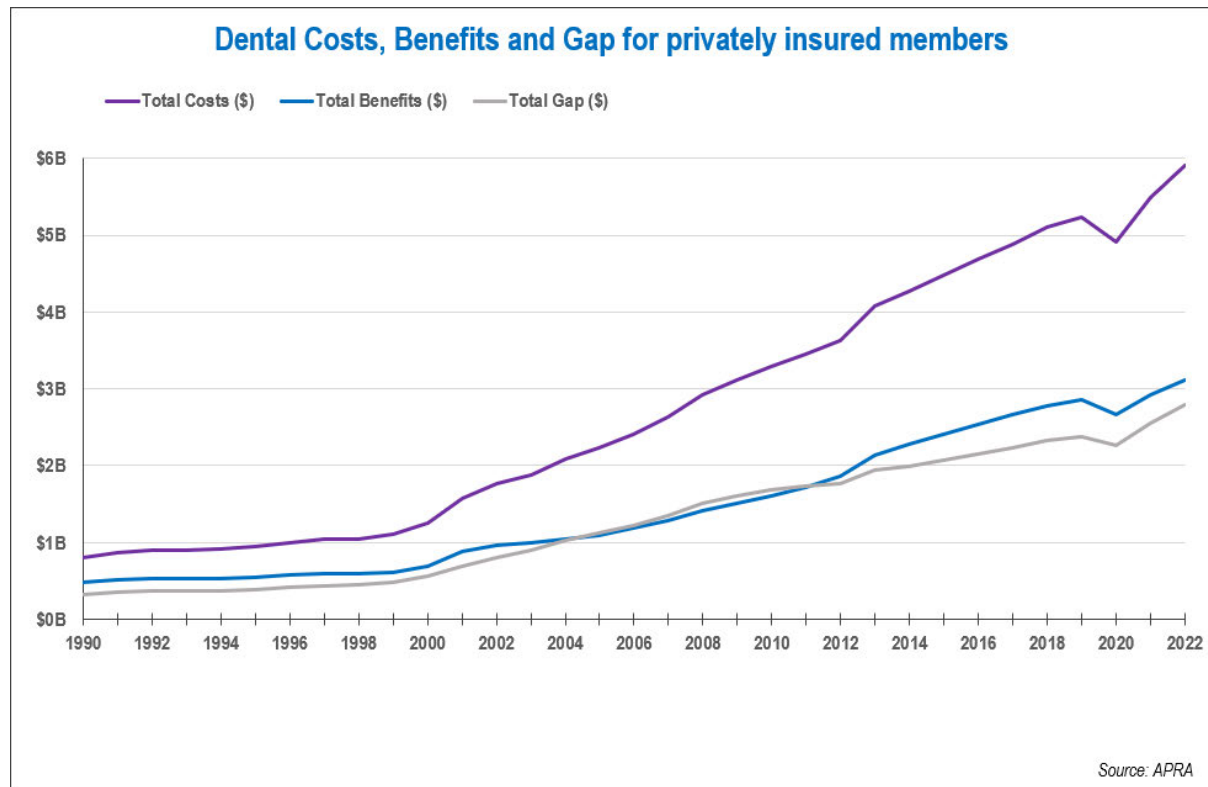
The cost-of-living crisis has not yet significantly affected the total number of insured persons accessing dental treatment. However, health funds are concerned that increased financial pressure on households will affect people's capacity to afford premiums and for those insured, may also affect capacity to access services with out-of-pocket costs. Health funds are working hard to maintain access to annual dental check-ups with no out-of-pocket costs for their customers.

PHA has recommended that government increase the Private Health Insurance (PHI) Rebate for people on very low incomes. Increasing the PHI rebate for singles earning under \$50,000 and families under \$100,000 by one percentage point would cost the Budget around \$70 million directly (with lower net costs), saving families with a 'Silver' policy an average \$27 on their premiums each year.

Cost-of-living pressures are biting hard amongst this group, and more support is needed for them to maintain their private health insurance.

Second order savings to Commonwealth and States and Territories Budgets from increasing the PHI rebate have a combined positive return on investment, as low-income earners leaving private health insurance will then create greater pressure on the public system.

Supporting private health insurance is the best way to ensure more access to dental care in the short term.



Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services

PHA recommends the Select Committee consider paths to improved access to dental services that do not include universal subsidies for dental care. In particular, PHA recommends that the Select Committee reject the inclusion of dental care into Medicare.

Medicare - a universal health system - is not necessarily a fair health system. Millionaires in the eastern suburbs of Sydney and Melbourne get the same rebate from Medicare as people living below the poverty line, those who are homeless, and Australians living in areas where access to care is severely limited.

To illustrate some stark examples, people living in New South Wales get 20% more in Medicare rebates than people in Western Australia per head of population. The suburbs north of Bondi in Sydney's east get the most in specialist rebates. Allied health rebates are concentrated in more affluent regions. People living in remote parts of Australia receive about half the Medicare rebates as the average Australian.

The Albanese Government has recognised the principles of Medicare require greater support for the more vulnerable across the community. Earlier this year, the government took steps to ensure fairer access to mental health care, removing excessive benefits for additional psychology consultations – benefits which were overwhelmingly paid to people in well-off areas, with good access to services, many of whom were amongst the wealthiest in our society. The Better Access evaluation noted, “The profile of use of Better Access treatment services across income groups is not consistent with the profile of their levels of psychological distress. Those on the lowest incomes are least likely to access services.”

The 2023-24 Federal Budget included a tripling of the bulk billing incentive for general practice as the central health measure, rather than an increase in Medicare benefits available to all Australians. This approach is more targeted, fairer, and will do much more to improve access to primary care than a blunt increase in benefits for all Australians regardless of wealth, location and health status.

Adding dentistry to Medicare would simply subsidise the wealthy and exacerbate the existing workforce distribution problems. The income gaps are now too wide, and the inequalities in opportunity too vast to be able to afford to subsidise the wealthiest in the community to access the basic dental care with first dollar health insurance. This comes at a cost to the vulnerable, the economically and geographically disadvantaged, and the sickest in our community.

Health funds support a more targeted approach to assist the vulnerable. We acknowledge this is desperately needed and are happy to work with government to share our extensive knowledge of the sector to help develop a financially sustainable and effective policy proposal.

Health funds may be able to play a role in delivering a publicly funded dental service, given the past problems experienced in Commonwealth-funded schemes and health funds’ long experience in managing issues such as over-servicing, potential fraud, eligibility, complaints handling and administrative burdens (both in the broader health system and with dental care specifically).

In addition, any new dental care model needs to look at how the competing incentives in the area might be better aligned. Health funds are more exposed to the challenges in managing public dental care; that is, the need to balance the technical efficiency of maximising the outcomes achieved for the monies expended, the reputation of delivering good quality care and the longer-term goal of continuing to deliver effective and profitable programs. Exploring a model where consumers can choose between providers of dental services, thus encouraging competition and better management of individual consumers’ dental programs, is recommended.

In establishing any new model, a ruleset for dental care would need to be developed and would likely incorporate means testing, an annual check-up for eligible patients, funding for certain limited treatments (likely to exclude major work, such as crowns, and cosmetic work) and clinical requirements for additional services or work during a single calendar year.

Health funds have the expertise to deliver a future Commonwealth-funded scheme that avoids the challenges faced by previous government dental programs. We would be happy to work with the Government should it decide to address access to dental services.

The adequacy of data collection, including access to dental care and oral health outcomes

Data collection for oral health care, including outcome measures, is patchy and should be improved. This weakness is clearly outlined in [Australia's Oral Health Tracker 2020](#), which highlights several indicators had no data collected between 2017 and 2020.

The data collections held by APRA, AIHW and the health funds are sound, but are not representative of the whole population. Despite their limitations, however, these data are underutilised given that they represent the largest dataset available in Australia.

Workforce and training matters relevant to the provision of dental services international best practice for, and consideration of the economic benefit of, access to dental services

Since 1 July 2022, health funds have been able to cover the services of Dental Hygienists, Dental Therapists and Oral Health Therapists operating independently. Several funds have taken up this opportunity, but there has been limited uptake by providers to date. Scope of practice for these dental professions is ideally suited to preventative and dental maintenance. PHA supports the government's intent to encourage health professionals to work to the limit of their scope of practice, recognising this provides the best options for patients in a supported, team-based environment.

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Attachment one: Extracts from draft Evaluate Report on dental care

The Commonwealth was first involved in funding dental schemes in the 1970s despite the Commonwealth/State split on this issue and the general exclusion of dental services from Medicare. Currently, the Commonwealth still funds the Child Dental Benefits Scheme (CDBS), the Cleft Lip and Palate Scheme and the dental scheme supported by the Department of Veterans' Affairs.

The Commonwealth also provides funding for dental services to current service personnel as well as limited support via Medicare and the Pharmaceutical Benefits Scheme for specific oral health needs or some medicines prescribed by dentists.

Australian School Dental Program

The Commonwealth's first "major involvement" in providing dental benefits was introduced by the Whitlam Labor Government – the Australian School Dental Program.² Under this program, the Commonwealth Government provided funding, coordination and leadership, while states and territories delivered and administered the program. The intent of the program was to deliver comprehensive dental treatment to all Australian school children to 15 years old.

The 1973 Federal Budget saw \$7.9 million provided to the states through special purpose grants. The Commonwealth Government was responsible for 75% of the capital and 50% of the operating costs of school dental clinics, as well as 75% of the operating and capital costs for training facilities for the dental therapists employed by the scheme. Services were delivered by dental therapists under the direction of dentists.³

Funding for the program was transferred from special to general purpose grants in the 1980s by the Fraser Coalition Government, which ended the Commonwealth's direct responsibility and funding of the scheme⁴ although, as highlighted above, most of the states and territories continued their delivery of various school dental programs.

Commonwealth Dental Health Program (CDHP)

In 1993-94 Budget, the Keating Labor Government announced Commonwealth funding for dental services – the Commonwealth Dental Health Program (CDHP). This program, which began in 1994, was specifically intended to target people on low incomes and its goals were "to improve the dental health of financially disadvantaged adults, reduce barriers to dental care, ensure equitable access and improve prevention and early intervention".⁵

² Amanda Biggs, *Overview of Commonwealth involvement in funding dental care*, 2008.

³ Amanda Biggs, *Overview of Commonwealth involvement in funding dental care*, 2008.

⁴ Senate Community Affairs References Committee, *Report on Public Dental Services*, Canberra: Senate Community Affairs Reference Committee, May 1998.

https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/1996-99/dental/report/index Accessed 14 April 2019.

⁵ Brennan DS, Carter KD, Stewart JF, Spencer AJ., *Commonwealth Dental Health Program Evaluation Report 1994–1996*. Adelaide: AIHW Dental Statistics and Research Unit and The University of Adelaide, 1997.

<https://www.adelaide.edu.au/arcpoh/downloads/publications/reports/dental-statistics-research-series/1994-1996-cdhp-evaluation.pdf> Accessed 3 June 2019.

The program had two key components – general dental services (GDS) and emergency dental services (EDS) – and these were governed by different fee schedules. Dentures, orthodontics, crowns and bridges were excluded from the GDS and EDS schedules, and other treatments restricted to those services listed on them. Under the program, both public dental clinics and private dentists could deliver services, with private dentists being paid fees based on the scheme operated by the Department of Veterans' Affairs. Caps of \$400 for general treatment and \$100 for an emergency episode per year were introduced.⁶

The two services components also had different aims. The EDS was focused on increasing teeth retention by filling rather than extracting teeth. In contrast, the GDS was intended to support people receiving public care into regular general dental care.⁷

The Commonwealth Government provided \$245 million to the program between 1993-94 and 1996-97. \$240 million was provided to the States for service provision, delivery and administration, while the remainder was used for evaluation and national projects. Under the agreement that governed the program,⁸ the State Governments committed to maintaining their base funding for dental, and this funding was therefore additional to public monies already being spent.

Once full funding of the program was achieved in 1995-96, it was found that an additional 200,000 people received dental care annually. In addition, around 600,000 people benefited from changes in the service mix due to additional resources under the program.⁹

Numerous criticisms of the program existed. These included:

- The restricted range of the services offered;
- The fact that the restricted range of services encouraged the removal of teeth which could be saved;
- The low level of fees contained within the schedule meant that there was insufficient incentive for practitioners to participate in the program, with the Australian Dental Association (ADA) arguing that, in many cases, fees did not even cover costs; and
- A relatively small shift from emergency to general dental care in publicly-funded care.¹⁰

Administrative concerns were also raised. Problems existed in relation to the separation of general and emergency dental care, and the Australian Dental Association noted that some referrals were for items not covered by the program.

⁶ Amanda Biggs, *Overview of Commonwealth involvement in funding dental care*, 2008.

⁷ Senate Community Affairs Committee, *Report on Public Dental Services*, 1998.

⁸ Senate Community Affairs Committee, “, *Report on Public Dental Services*., 1998.

⁹ Brennan DS, Carter KD, Stewart JF, Spencer AJ., *Commonwealth Dental Health Program Evaluation Report 1994–1996*. 1997.

¹⁰ Senate Community Affairs Committee, “Chapter 3 – Commonwealth dental health program”, *Report on Public Dental Services*, 1998.

Chronic Disease Dental Scheme (CDDS)

The Howard Coalition Government discontinued the CDHP when it came into office and introduced in its place the Chronic Disease Dental Scheme, whereby patients with chronic health conditions can be referred to a dentist by their GP and be reimbursed.

The Scheme was introduced in 2004 and then expanded in 2007. The scheme provided capped Medicare dental benefits to patients with a chronic disease, such as diabetes or cardiovascular disease, that was being exacerbated by their problems with their teeth. Patients needed to be referred by their GP to be eligible for the Scheme and initially received \$220 worth of benefits.¹¹ Under the expanded scheme, the benefit cap was increased to \$4,250 over a two-year period. These funds could be spent on a specified list of services which, like the cap, was extended in 2007.¹²

The CDDS provided more than 19 million services at a cost, by 2012-13, of over \$2.6 million, rapidly exceeding its expenditure forecasts after its 2007 expansion.¹³ The Scheme was plagued by allegations of fraud and overservicing, and Medicare Australia sought to reclaim some benefits paid to dentists under the scheme.¹⁴ This caused a backlash from dentists and led to a Senate inquiry.¹⁵ In a submission to the Productivity Commission, Dental Services Victoria argued that two-thirds of increased expenditure on the scheme following its expansion was found “to be attributed to a service that had limited evidence of disease-control benefits”.¹⁶

The Scheme apparently was responsible for more complaints than any other area of Medicare and, following the Senate inquiry, various of the cases raised were sent to Medicare for review. The design of the scheme was criticized, and it was stated that some people were over-serviced, others received no services and yet others received services to which they had not consented.¹⁷ By 2012, the Federal Labor Government was stating that the program, which had initially been estimated to

¹¹ Amanda Biggs, “Calls to waive dentists' debts to Medicare”, *Flagpost*. Canberra: Parliamentary Library, 19 April 2012.

<https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22library/prspub/1585350%22>
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¹³ Commonwealth of Australia, *Dental Benefits Amendment Bill 2012, Bills Digest no. 22 2012–13*, 2012.

¹⁴ Amanda Biggs, “Calls to waive dentists' debts to Medicare”, *Flagpost*, 2012.

¹⁵ The inquiry was undertaken by the Senate Finance and Public Administration Committee with its report tabled on May 10 2012.

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¹⁶ Dental Services Victoria, “Reforms to Human Services – Submission to the Productivity Commission Issues Paper”, February 2016. https://www.pc.gov.au/data/assets/pdf_file/0016/214216/sub465-human-services-reform.pdf
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¹⁷ Senator Kim Carr, Minister for Human Services, “Community Affairs Legislation Committee Budget Estimates 2012–13”, *Hansard*. 29 May 2012.

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https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1213a/13bd022#_ftn24 Accessed 3 June 2019.

cost \$90 million a year, was costing \$80 million a month¹⁸ and it was discontinued in December 2012.¹⁹

Teen Dental Plan

In 2008, the Rudd Labor Government introduced a means-tested program to target teenagers aged 12 to 17, including providing annual check-ups. This was the Teen Dental Plan which was introduced in 2008. Eligible teenagers – usually those receiving ABSTUDY or Youth Allowance or whose families were in receipt of Family Tax Benefit A – were entitled to a dental voucher to cover an annual preventive dental check-up. The value of the voucher ranged from \$150 per year at the plan's inception and rose to over \$160 over time.

Services could be provided in either a public or private clinic by an eligible dentist or dental hygienist private practitioner. Services were limited to preventative treatments only, such as an oral examination, x-rays, and scaling and cleaning.²⁰ A separate Dental Benefits Schedule was established that included these benefits.

Various problems were identified with the Teen Dental Plan, including that the voucher did not cover any follow-up work required by the patient. Those in receipt of the vouchers also claimed that often the full amount of the voucher was charged by the practitioner, even when little work seemed to have been undertaken, and that different rates were charged to different recipients.²¹

Uptake of this program was low. 1.3 million teenagers were eligible to use the voucher annually, with uptake being 32% in 2009-10 before it fell to only 30% the following year. This was acknowledged to be “disappointing”.²²

Other problems also existed including administrative issues. Teenagers becoming eligible in November or December of the year were not automatically sent their voucher and instead had to request one. In the event they did not, they then missed out on a year's access.

¹⁸ Ben Packham, “Millions set to benefit from new dental care scheme that will also save \$2.5 bn”, *The Australian*, 29 August 2012. <https://www.theaustralian.com.au/national-affairs/health/labor-to-spend-4bn-on-dental-care-for-low-income-families/news-story/ccd19039117a8365e05b34184b5ccf44> Accessed 14 April 2019.

¹⁹ Henry Francis Akers, Arosha Tania Weerakoon, Michael Anthony Foley and Andrew James McAuliffe, “The Medicare Chronic Disease Dental Scheme: Historical, Scientific, Socio-political Origins”, *Journal of the History of Dentistry*, Vol. 65, No. 2 Summer/Fall 2017. https://www.researchgate.net/profile/Arosha_Weerakoon/publication/318946856_The_Medicare_Chronic_Disease_Dental_Scheme_Historical_Scientific_Socio-political_Origins/links/5b0e74dc4585157f8722b078/The-Medicare-Chronic-Disease-Dental-Scheme-Historical-Scientific-Socio-political-Origins.pdf?origin=publication_detail Accessed 21 August 2019.

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²² Commonwealth of Australia, *Report on the second review of the Dental Benefits Act 2008*, 2012.

In addition, concerns were raised in getting certain at-risk groups to access the scheme. These included Aboriginal and Torres Strait Islanders, teenagers with a disability, homeless and culturally and linguistically diverse people. It was also found that people in rural and remote areas had significantly lower rates of take up compared to those living in inner regional or metropolitan areas.

Further, while bulk-billing of the relevant Medicare items could occur against the voucher, some families were also charged out-of-pocket fees.

Child Dental Benefit Schedule (CDBS)

The Teen Dental Plan was replaced by the Child Benefit Dental Schedule in 2014. To access this Schedule, eligible children need to be aged between 2 and 17 years old and their families, as with the Teen Dental Plan, must be in receipt of Family Tax Benefit A or another relevant Australian Government payment.

The CDBS outlines specific benefits for a variety of services, such as x-rays, examinations, cleaning, fillings, root canals, extractions and fissure sealing. Cosmetic or orthodontic work is not included in the CDBS and benefits cannot be paid for services provided in a hospital. Benefits paid under the CDBS are capped at \$1,000 over two years.²³

The purpose of the CDBS is to address declining oral health in children while also supporting the longer-term goal of improving oral health across the Australian population. This is impacted by the low uptake of the program which remains around 30%.²⁴ Similar concerns exist in relation to the CDBS as with the Teen Dental Scheme, given the CDBS is largely an extension of the earlier program.

²³ The Department of Health, "The Child Dental Benefits Schedule", 1 January 2018.

<https://www.health.gov.au/internet/main/publishing.nsf/content/childdental> Accessed 14 April 2019.

²⁴ The Australian National Audit Office, "Administration of the Child Dental Benefits Schedule", 3 December 2015. <https://www.anao.gov.au/work/performance-audit/administration-child-dental-benefits-schedule> Accessed 5 June 2019.