SARRAH
Services for Australian Rural and Remote Allied Health

25 August 2022

Secretariat
Fifth Review of the Dental Benefits Act 2008 Committee
Allied Health and Service Integration Branch
Primary Care Division
Australian Government Department of Health and Aged Care
GPO Box 9848, Canberra ACT 2601

Email: DAHM@health.gov.au

Dear Secretariat,

Consultation on the Fifth Review of the *Dental Benefits Act 2008* Panel – the Child Dental Benefits Schedule (CDBS)

Thank you for the opportunity to provide comment on the Fifth Review of the *Dental Benefits Act 2008* Panel – the Child Dental Benefits Schedule (CDBS).

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by and as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians. Access must include dental and oral health care services.

In line with SARRAH's objectives and priorities, our comments in this submission primarily on the following excerpt of the Fifth Review's Terms of Reference:

> *The Review Panel will assess the practical operation of the Act regarding the accessibility and delivery of services, and uptake (including barriers to uptake) of the CDBS by vulnerable cohorts, including an assessment of: …Service delivery to Indigenous children and children in rural and/ or remote communities, ….*

As to the importance of the CDBS and other efforts to improve access to dental and oral health services, we note the AIHW states that:

> *As well as visits to dental professionals, there were close to 67,000 hospitalisations for dental conditions that could have been prevented with earlier treatment in 2019–20. The rate of potentially preventable hospitalisations for dental conditions was highest in those aged 5–9 years (8.6 per 1,000 population). For more information refer to chapter on*

Hospitalisations. https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary – (accessed 24 August 2022).

In 2019–20, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) was higher for Indigenous Australians (4.4 per 1,000 population) than for Other Australians (2.5 per 1,000 population).

- *In 2019–20, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) was highest in those aged 5–9 years (8.6 per 1,000 population).*
- *In 2019–20, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) generally increased as remoteness increased, ranging from 2.4 per 1,000 population in Major cities to 4.2 per 1,000 population in Very remote areas.*

https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations – *(accessed 24 August 2022).*

We also note ***The National Oral Health Plan 2015-2024*** - Foundation Area 5 – is a Workforce Development Goal: *The workforce for oral health is of an appropriate composition and size and is appropriately trained and distributed.*

SARRAH encourages the Review Group to consider the areas for proposed action in the NOHP and assess whether performance in those areas has contributed to and/or continues to constrain utilisation / access in the CDBS. For example (from page 44) - Strategy F5.2:

> *Build more equity in (i) Geographic distribution of the oral health See page 42 Long the distribution of the workforce workforce to improve (ii) Sector distribution of oral health workforce accessibility to oral health care (iii) Proportion of oral health training programs that develop skills and competence specific to Priority Populations*

Questions for Dental Care Providers and Stakeholder Organisations

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

SARRAH notes that CDBS exists to improve access to dental services, prompt diagnosis and early treatment are key to limiting the impact of children's poor oral health and reducing social inequalities. These are important objectives and the CDBS is contributing to that.

SARRAH also strongly supports the demand driven nature of the CDBS but note this does not actually facilitate access in more than half of the potentially eligible population.

In short, SARRAH strongly supports the CDBS and any improvement of the Scheme especially with regard to utilisation, potentially through expansion of eligibility to other groups as may be warranted (e.g., younger infants).

We hope and assume that the statement from the Fourth Review Report (page 6) continues to apply.

> *The Review Committee 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.*

On this basis, SARRAH believes the available and access of the dental and oral health workforce may be a substantial issue impacting access and utilisation rates for the CDBS, especially in rural and remote Australia.

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

Without criticising the Scheme, itself or the improvements in access (utilisation rates) that are being achieved (e.g. reported on page 93 of the Department's Annual Report 2020-21), overall utilisation as a proportion of the estimated eligible population remains low – reported as 42.1% in the Annual Report. SARRAH would encourage the Review to look specifically into workforce issues which may be inhibiting greater access to the Scheme.

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

The previous review Report of the CDBS showed there were considerable gaps - page 15 (Fourth Review Report) – …*the Committee did acknowledge that limited general public knowledge of the CDBS and program restrictions may hinder the utilisation in both the public and private sector.*

Noting the workforce issues referred to elsewhere, SARRAH also believes it is critical that any effort to improve public knowledge and understanding about the CDBS be progressed together with measures which provide a reasonable level of assurance to families and communities that the services provided through the CDBS can actually be accessed within a reasonable time and that sufficient workforce/service capacity exists to facilitate this access. It is important that the CDBS is not a hollow promise for substantial portions of the population.

4) Do you think the Child Dental Benefits Schedule is useful and accessible for First Nations children, children with Intellectual Disability, and/ or children in rural or remote Australia?

Potentially, yes. SARRAH would defer to the advice provided to the Review by organisations such as NACCHO and Aboriginal and Torres Strait Islander Health Professional Organisations.

Nonetheless, to reinforce other points in this Submission, it is broadly accepted that increasing the representation of Aboriginal and Torres Strait Islander people among the health workforce will improve access, cultural safety and responsiveness, quality, and outcomes of care. The latest available Ahpra data shows Aboriginal and Torres Strait Islander people make up 0.5% of the dental practitioner workforce – far short of population parity. The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 attempts aims to address these issues, including achieving broad parity (over 3%). Obviously, this will require very substantial and continuing commitment, which is needed to improve access and outcomes, including in the CDBS.

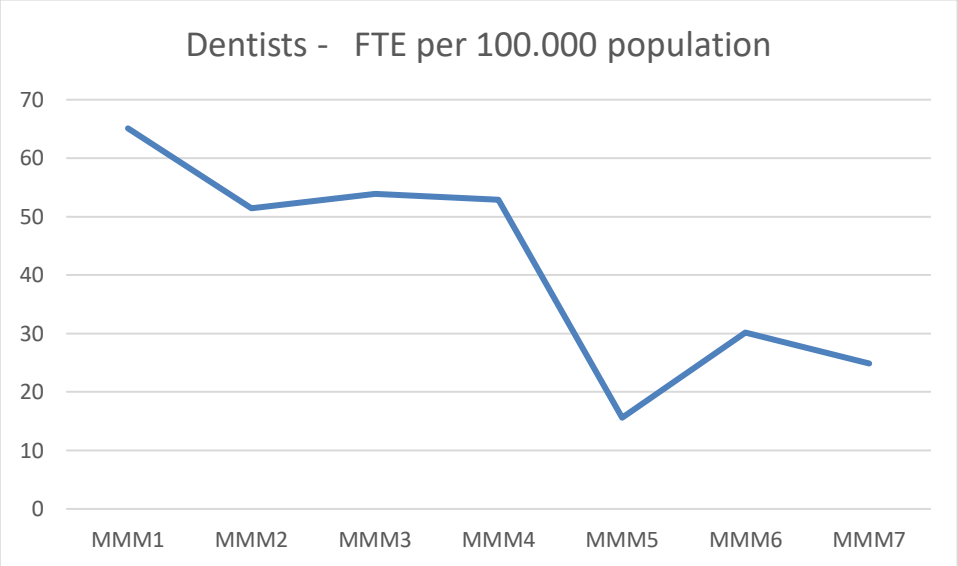
5) How could the Child Dental Benefits Schedule be improved in general, or to deliver effective dental services to First Nations children, children with intellectual disability and/ or children in rural or remote Australia?

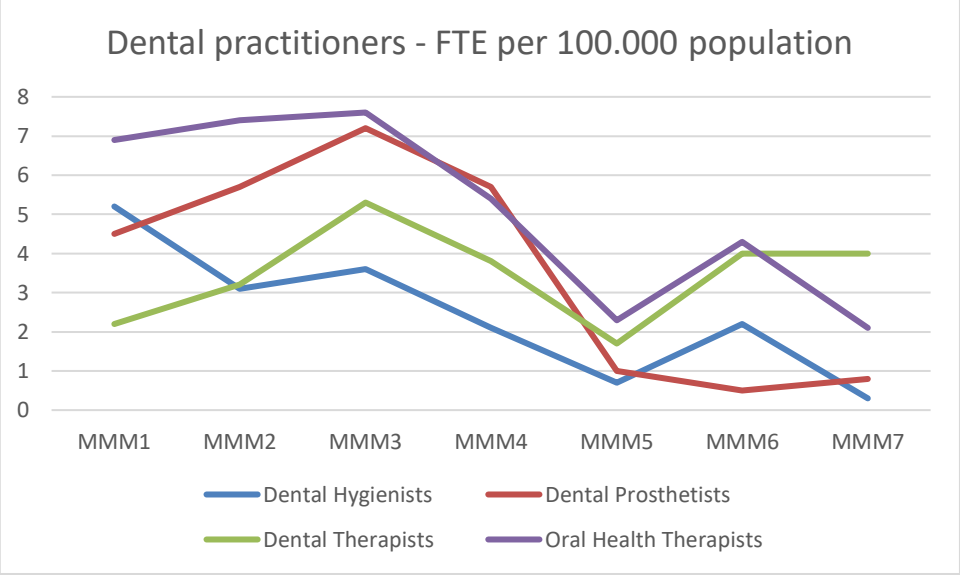
By improving workforce distribution, capacity, and access to all of these and other groups (as discussed elsewhere in this submission).

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

We note and support the situation where CDBS services can be provided by a dental practitioner who holds a general or specialist registration with the Dental Board of Australia and who has a Medicare provider number *as well as* dental hygienists, dental therapists, oral health therapists and dental prosthetists who hold general registration with the Dental Board of Australia are also eligible to provide CDBS services on behalf of a dentist or dental specialist (taken from page 11 of the Report on the Fourth Review of the Dental Benefits Act 2008).

Noting our comments regarding workforce distribution we refer the Review to the maldistribution of relevant professionals on a per head of population basis by remoteness, as represented in the following graphs.





The above material has been drawn from the Department of Health website (24 August): https://hwd.health.gov.au/resources/dashboards/nhwds-alld-factsheets.html. And https://hwd.health.gov.au/resources/publications/factsheet-alld-oral-health-therapists-2019.pdf

7) What state or territory do you work in?

SARRAH is a national rural and remote allied health peak body, with members in every Australian State and Territory.

8) Do you work in a? a. Metropolitan area (major city)

b. Regional Centre (town with a population over 50 000)

c. Large rural town (town with a population between 15 000 and 50 000)

d. Small rural town (town with a population of between 1000 to 15 000)

e. Remote community (population less than 1000)

SARRAH delivers and promotes supports to enable access to, capacity and delivery of allied health services across every allied health service SARRAH in regional, rural and remote Australia.

As a general comment access to those services becomes more difficult with increasing remoteness. However, shortages in some allied health professions, especially, are worsening nationally and shortages are now being felt in some metropolitan areas, adding to the risk of further and more severe shortages in rural and remote settings. Some SARRAH members are located in metropolitan areas, and some provide services and/or education and professional support into more rural areas.

9) Are the answers to the questions above your individual views, or do they represent an organisations' views? a. Individual *b. Organisation (please specify)*

Organisation - Services for Australian Rural and Remote Allied Health.

We hope this submission assists with your work on this important Review. Further information about SARRAH is available at https://sarrah.org.au/

Yours sincerely,

Catherine Maloney
Chief Executive Officer