Child Dental Health Survey 2009

Identifying and definitional attributes

Metadata item type:	Quality Statement
Synonymous names:	CDHS 2009
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Data quality

Quality statement summary:

• All states and territories provide subsidised dental care to school-aged children.
• The Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit (DSRU) compiles data on a sample of children using information provided by states and territories.
• Data are not provided for New South Wales as children for whom data could be collected are not representative of those who approach the service for care.
• Data are not provided for Victoria.
• Although there are national standards for collecting data, there are some variations in school dental service coverage, level of enrolment, services policy focus, or access to services in rural or remote areas. Therefore, any comparison among states and territories should be made with caution.
• As the child populations of New South Wales and Victoria represent a sizeable proportion of the Australian child population, any comparisons with national estimates from previous years, or with international data, should be made with caution.

Description

All states and territories provide subsidised dental care for school-aged children (usually a school dental service). Each participating jurisdiction provides oral health data annually to AIHW DSRU. Data provided are for a sample of children who visit a service. These data are compiled into a national dataset.

Institutional environment:

The AIHW is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health and Ageing portfolio.
The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.
The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. It works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.
One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national data sets based on data from each jurisdiction, to analyse these data sets and disseminate information and statistics.
The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance with the Privacy Act 1988 (Commonwealth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.
For further information, see the AIHW website at www.aihw.gov.au. The Child Dental Health Survey (CDHS) is conducted on behalf of AIHW by one of AIHW's collaborating units, the DSRU at the University of Adelaide. In this capacity the DSRU is subject to the provisions of the AIHW Act and the Privacy Act.

Timeliness:

The data in the publication relates to the calendar year 2009.
Data are provided annually by state and territory jurisdictions, and published annually.
Data are provided to DSRU as soon as practicable for jurisdictions. For future iterations of this report, steps will be taken to improve the timeliness of reporting.
First release of CDHS 2009 data will be on 30 May 2013 in the report: The dental health of Australia's children by remoteness: Child Dental Health Survey Australia 2009.

Accessibility:

National reports are produced annually and available from the AIHW website. See <http://www.aihw.gov.au/dental-and-oral-health-publications/>.
Individual state and territory reports up to 2002 are available from DSRU via the Australian Research Centre for Population Oral Health website. See <http://www.arcpoh.adelaide.edu.au/publications/report/statistics/>.
Customised tables are available on request (on a fee-for-service basis). Data access policy and data request form can be obtained by contacting arcpoh@adelaide.edu.au.

Interpretability:

Detailed sampling methodology is outlined in the report: The dental health of Australia's children by remoteness: Child Dental Health Survey Australia 2009.
The published report provides estimates of decay experience in both deciduous and permanent teeth for children aged 5–14, as well as fissure sealants present at examination in the permanent teeth of children aged 6–14. The report features a chapter on the oral health of children across remoteness areas of location.

Relevance:

Scope and coverage

The aim of the CDHS is to monitor the health of children attending the school dental services. No data are collected for New South Wales as children attending the service have been triaged and are not representative of children who approached the service for care. Data are not currently provided for Victoria. Sampling ratios vary between jurisdictions (TableB1).

Table B1: Sampling ratios vary between jurisdictions, as follows:

State/territory	Sampling ratio[(a)]	Days of birth
Queensland		
Gold Coast	1:1	Any
Other Queensland	1:15	1st and 6th
Western Australia	1:8.5	28th, 29th, 30th, 31st
South Australia	1:1	Any
Tasmania	1:1	Any
Australian Capital Territory	1:1	Any
Northern Territory	1:1	Any

• (a) Sampling ratios are approximate only.

Reference period

Calendar year 2009.

Geographic detail

Data set includes children's postcode of residence.

Statistical standards

The criteria and procedures for examinations used by school dental services for the Child Dental Health Survey were first developed in 1977 and were redesigned in 2004 by AIHW DSRU, in conjunction with the states and territories. The methodology used follows those published by the World Health Organization (WHO) for oral epidemiological studies (WHO 1997). Written instructions for the survey were provided to clinical staff describing the assessment of caries experience and recording procedures.

Full Indigenous identification is included in the 2009 collection.

Types of estimates available: decay experience in deciduous (dmft) and permanent teeth (DMFT) by age, and fissure sealants in permanent teeth.

Accuracy:

State and territory providers such as Queensland and Western Australia used standard forms to record information from school dental service clinical records that contain these items: Sex; Age; Postcode; School or clinic; Indigenous status; Number of decayed teeth; Number of missing teeth; Number of filled teeth; Number of fissure sealed teeth; and Number of teeth present. In Queensland and Western Australia, children were sampled at random from school dental service (SDS) clinics by selecting those examined during the 2009 calendar year who were born on specific days of the month. In other jurisdictions, a full count was extracted from electronic patient records. The number of children included in the survey from those jurisdictions was considerably larger than for Queensland and Western Australia.
New South Wales was excluded from the data collection as the sample was not representative. Children were seen in the New South Wales public dental service only if they had been through an initial assessment and had been identified as having treatment needs; for example, decay. This meant that the dental health of the children seen in the dental service did not represent the dental health of the entire child population who presented for initial assessment, many of whom did not have treatment needs.
Estimates for Australia (overall estimates) in this report exclude Victoria due to lack of provision of 2009 data.
Differences in administration and local data requirements of each SDS created further variation in the number of children sampled by state and territory. This variation was accounted for in the weighting procedure.
The main outcome of this study is caries experience. Caries experience was measured by the mean count of clinically detectable decayed, missing and filled teeth. The methodology used for diagnosis and reporting of caries experience follows those published by the WHO for oral epidemiological studies.
Although there are national standards for collecting data, there are some variations in SDS coverage, level of enrolment, services policy focus, or access to services in rural or remote areas. Therefore, any comparison among states and territories should be made with caution. As the child populations of New South Wales and Victoria represent a sizeable proportion of the Australian child population, any comparisons with national estimates from previous years, or with international data, should be made with caution.
All estimates are published with 95% confidence intervals.
Non-sampling error is minimised by collecting data similar to routinely recorded clinical data. Data are also collected by clinicians who are accustomed to recording oral health measures.
Indigenous status was reported for all jurisdictions other than Queensland. Children were reported as ‘Non Aboriginal’, ‘Unknown’, ‘Aboriginal’, ‘Aboriginal and Torres Strait Islander’ according to child/parent’s report to examining clinician. There were about 1.4% children reported as ‘Unknown’; 2.9% of children did not report their indigenous status.
The survey also was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people. In this data set, there are about 4.6% of children recorded as either Aboriginal, Aboriginal and Torres Strait Islander or Torres Strait Islander.

Coherence:

The population of children attending school dental services can be influenced by local policies, which may change from time to time. Changes in local policies should be considered when making comparisons between jurisdictions and across time.
Data for children attending services in Victoria for 2009 were not made available at the time of preparing this publication. In New South Wales, the SDSs targeted only schools identified by the state government Department of Education & Communities as being disadvantaged. Children at these schools were screened and entered the SDSs only if they required treatment. Therefore, the children in the SDS population in New South Wales would have greater need for treatment than both New South Wales children generally and children from other jurisdictions, therefore creating bias in the data. Consequently, New South Wales did not collect data for the CDHS.

Relational attributes

Related metadata references:

Has been superseded by Child Dental Health Survey 2010

- AIHW Data Quality Statements, Standard 18/08/2014