Executive Summary

Bulk-Billed Mobile Dentistry Model for Remote Areas

Mobile Dentists / Dental+ — scalable curative oral healthcare for underserved populations

1. What the bulk-billed model is

The bulk-billed model developed by Mobile Dentists / Dental+ is a scalable care and financing model for populations with high curative oral-health needs and limited access to regular dental care. It was developed from nearly a decade of field experience with underserved groups, including asylum seekers, prisoners and socially vulnerable populations. The model starts from the real treatment burden of a defined population: how many fillings, extractions, endodontic treatments, cleanings, imaging procedures and prosthetic interventions are actually required.

The key principle is to move away from isolated, fragmented consultations and instead organise oral healthcare as a pre-budgeted population-level programme. A target group is first defined, screened and clinically assessed. The required curative care is then delivered by mobile multidisciplinary dental teams. After the initial phase, the measured care need is translated into a transparent forfaitary or population-based budget.

2. Why it is relevant for remote areas

The model is particularly relevant for rural, remote, island, outermost and Arctic regions where access to dentistry is limited by distance, transport barriers, shortage of dental professionals, climate, socio-economic conditions or weak local healthcare infrastructure. In such settings, care cannot depend solely on patients finding their way to a traditional dental practice. Care needs to be organised and brought to the community.

The programme focuses on essential curative dentistry: pain relief, infection control, tooth preservation and functional rehabilitation. It is designed for high-need populations where untreated oral disease may affect nutrition, sleep, speech, school participation, employability, dignity and social participation.

3. How the care pathway works

Step	Purpose
Population mapping	Define the target region, population size, age distribution, local dental access, geography, infrastructure and logistical constraints.
Screening and triage	Organise on-site oral-health screening, registration, informed consent, diagnosis and treatment planning.
Dedicated treatment days	Deploy mobile multidisciplinary dental teams to provide fillings, extractions, endodontic treatment, cleanings, imaging where required and functional care.
Measurement of real care burden	Analyse chair time, number and type of procedures, transport cost, administrative workload and logistical cost.
Conversion into a capped model	After approximately 500 to 1,000 treated and

	evaluated persons, translate the real care need into a capped forfaitary or population-based bulk-billing budget.

4. Financial structure

The financial model is designed to make essential curative dentistry predictable and budgetable. The final cost per patient is not fixed on assumptions alone. It is preferably calculated after an initial pilot phase in which the actual treatment load and operational cost are measured.

The model can be organised in three ways: a forfaitary model with a capped cost per patient regardless of the individual treatment load; a needs-based model based on the exact measured oral-health burden of the population; or a dedicated dental-time model based on effective chair time and multidisciplinary treatment capacity.

5. Cost-efficiency benchmark – Belgian high care needs population (asylumseekers)

The existing Fedasil model offers a useful benchmark for high-need populations. The figures below illustrate how the bulk-billed model can reduce cost compared with conventional tariffication. For remote areas, these figures should be recalibrated after the pilot phase, because transport, accommodation, climate, local regulation and geography may materially affect the final price.

Tariffication model	**Benchmark Asylumseekers** all curative care included	**Population dependable Prisoners, homeless, remote populations**
Regular Belgian legal tarification	EUR 613 / patient	To be completed after pilot
Shortened curative care pathway	EUR 422 / patient	To be completed after pilot
Flat-rate Mobile Dentists model	EUR 360 / patient	To be completed after pilot
Bulk-billed curative model	EUR 332 / patient	To be completed after pilot
Potential saving under dedicated bulk billing	Up to 47% in existing models	To be calculated on measured remote-area data

6. Quality and safeguards

- Post-calculation: the estimated model is checked against the actual number of treated patients and the actual care delivered.
- Bulk billing and effective chair time: the model is based on dedicated treatment capacity, avoiding fragmented separate billing for elements such as preventive explanation, informed consent and aftercare.
- Transparent reporting: the care delivered can be reported by treatment category and, where applicable, by nomenclature code, allowing comparison with conventional tariffication.
- Clinical quality monitoring: specialist procedures can be reviewed internally, including before-and-after image review by a supervising dentist or clinical manager.
- Informed consent: consent is added to the patient record, with individual approval for extractions.

- Aftercare and local capacity: the model can include aftercare protocols, emergency capacity, local knowledge-building, preventive worker training and a flagging system to identify preventive-care needs.

7. In one sentence

The bulk-billed model is a way to organise mobile curative dentistry for underserved or remote populations in a planned, measurable and affordable way: it starts from the real care need of a defined population, delivers essential treatment at scale, and converts the measured workload into a transparent capped budget.