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The Dental Hygienists' Association of Australia Inc.

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Submission to the House of Representatives
Standing Committee on Health and Ageing's
Inquiry into Adult Dental Services in Australia

Authorised by

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Contents

About DHAA Inc.

The Dental Hygienists' Association of Australia (DHAA) Inc., established in 1975, is the peak body representing registered dental hygiene service providers. Membership includes registered dental hygienists, oral health therapists, undergraduate dental students and affiliate members from dental industries. The DHAA Inc. represents leaders in oral health who have been actively practising evidence based clinical practice and non-communicable disease management for many years. Despite this long history of professional practice, the role and skills of a dental hygienist professional are not well understood by policy-makers and are therefore outlined below.

The Professional Expertise of a Dental Hygienist

Dental hygienists are trained dental professionals who specialise in preventive oral health, focusing on techniques that ensure oral tissues and teeth are maintained and remain healthy in order to prevent dental disease, especially common diseases such as dental caries, gingivitis and active periodontitis.

Disease prevention is the expertise of dental hygienists and oral health therapists and is fundamental in the management of oral health. They also have a significant role in the management of non- communicable disease. This includes periodontal disease, cardiovascular disease, oral cancers, diabetes, respiratory disease in aged care facilities, diet and nutrition, and smoking cessation. Dental hygienists and oral health therapists and dental therapists are the primary preventive oral health providers and are the acknowledged experts in the field of dental disease prevention by our dental professional and health service provider colleagues.

The skills, knowledge and training of the dental hygienist professional are extensive. Training includes health sciences, human biology, anatomy and physiology, microbiology, pathology, oral medicine, dental medicine, pharmacology, dental materials, periodontics, risk factors, etiology of disease, cariology, orthodontics, geriatric dentistry, special needs dentistry, oral health promotion and education, dental public health, preventive dentistry, community dentistry, minimal intervention, dental radiography, temporary restorations, local anaesthesia and clinical practice, including diagnosis and treatment planning within scope of practice.

The National Law requires the same level of professional responsibility from dental hygienists and oral health therapists as it does from dentists, dental specialists and dental prosthetists in that all practitioners must have their own professional indemnity insurance and radiation licences. They are also required to complete 60 hours of mandatory continuing education in a three year cycle.

The DHAA Inc. acknowledges that all dental practitioners are part of a team who work together within their particular areas of competence to provide the best possible care for their patients. However, the notion that dental hygienists, oral health therapists, and dental therapists are ancillary health care providers is misconceived.

Dental hygiene and oral health therapy are unique, highly qualified preventive professional disciplines. This position is supported by the Australian Industrial Relations Commission (AIRC) 2009 Decision via a successful Award variation application from the DHAA Inc. (re MA000027 – Health

Professionals and Support Services Award 2010) to remove dental hygienists from the award and have them declared award free. In supporting the DHAA Inc.'s application, the Full Bench of the AIRC recognised that dental hygienists are not ancillary health care providers and therefore accepted that the closest comparison profession to dental hygiene is the employed dentist.[1]

Our objective is the effective delivery of quality oral health services, improving oral health and therefore also general health. Dental hygienists are employed throughout Australia as academics and educators by tertiary and vocational education providers to develop, deliver and evaluate programs which educate future providers of public and private oral health services. They have a critical role in maintaining standards which deliver the highest possible care to all population groups and in developing education strategies that align with the optimum provision of oral health care within an array of policy frameworks in States and Territories of Australia.

Comments on the National Partnership Agreement

The DHAA Inc. welcomes the National Partnership Agreement (NPA) for adult public dental services as part of the Dental Care Reform Package. These are important initiatives as far as they go. However, the public dental system remains focused on the treatment of dental problems. DHAA Inc. believes that the most necessary reform is a paradigm shift to a preventive model of care, which aims to prevent problems developing rather than simply offer a long waiting list for treatment once they arise.

DHAA Inc. would like to see a replacement for the recently abandoned Chronic Disease Dental Scheme (CDDS). The Australian Government has not outlined any viable replacement for this scheme. As a result, many chronically ill patients are without a scheme focused on their needs.

DHAA Inc. also believes the NPA needs to address legislative barriers to accessing preventive dental services. The Dental Board of Australia is currently reviewing the Scope of Practice Registration Standard. As part of that process, DHAA Inc. is lobbying for dental hygienists to have their own provider numbers. This would improve access to the services of a dental hygienist and increase uptake by removing one significant barrier, namely cost. At present, consumers cannot claim out-of-pocket costs for preventive services, either from their private health insurance or from Medicare.

Response to the Terms of Reference

DHAA Inc. will address each point in turn.

1. *Demand for dental services across Australia and issues associated with waiting lists;*

Demand for adult dental services is undoubtedly high across Australia. State Dental Services and the Australian Research Council for Population Oral Health (ARCPOH) will no doubt be able to provide substantial data to support this point.

[1] Rule 5 of the Australian Industrial Relations Commission Rules Work Place Relations Act 1996 (Section 576H of the Act)

Unmet needs are especially obvious in the public sector where patients are estimated to wait between 2-5 years for treatment in some cases[2]. This means that people in lower socio-economic groups are effectively rendered helpless in accessing the dental care that they need, since they cannot afford to see a private dentist and are dictated to by the public sector waiting list.

As waiting lists get longer, simple needs are left to fester until they become full blown emergencies. This maladministration results in higher costs to the public purse and direct loss of income for the patient, not to mention significant and prolonged dental pain and discomfort and worsening health outcomes. It is worth reiterating that most users of public services are from low socio-economic groups who could not afford dental treatment or loss of wages to begin with.

The increasing demand for dental services is very noticeable in the aged care sector. As the population ages, people are retaining more of their teeth for longer. Dental hygienists can be the primary clinicians assessing the dental risk of older people, preventing aspiration pneumonia, strokes and other avoidable diseases, as well as creating appropriate referral pathways where necessary.

In 2007, General Practice Victoria (GPV) reported that carers in all regions listed dental care as the most frequently requested service within aged care facilities[3]. The authors deemed the necessary expansion of services too costly because of the existing barriers to dental hygienists practising independently. These regions now fall under Medicare Locals rather than GPV.

Whilst it is often assumed that excess demand for services indicates an undersupply of appropriately trained professionals, DHAA Inc. does not believe this to be the case as regards access to dental services. Rather, there are major structural flaws in the model of service delivery which create avoidable bottlenecks in the system. Reforms need to concentrate on identifying and relieving these pressures.

We need to combat the existing 'drill and fill' mentality by utilising dental hygienists and oral health therapists in the primary prevention and treatment phase. This empowers the patient through education, oral health instruction and practice, diet and exercise recommendations and preventive care for dental diseases. Ultimately, people become advocates for their own oral and general health.

DHAA Inc. argues that such a shift to a preventive model of care, based around direct patient access to a dental hygienist operating under his or her own provider number, would be of tremendous benefit. Such services could be offered in community settings such as aged care facilities, schools, prisons, homeless shelters, migrant hostels and in mobile clinics servicing rural and remote areas.

DHAA Inc. appreciates the value of multidisciplinary teams and envisages dental hygienists working alongside other dental professionals in order to address the significant unmet needs in the public and private sectors.

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[2] *Report of the National Advisory Council on Dental Health*, 23rd February 2012, page 21.

[3] *Aged Care Access Initiative Needs Assessment and Program Plan for the Victorian Divisions' Network 2008 – 2009,* General Practice Victoria, September 2008, page i

2. *The mix and coverage of dental services supported by state and territory governments, and the Australian Government;*

The Australian dental system is split into two broad streams, public and private. The private sector is by far the greatest provider of dental services in Australia, meaning that individuals must pay for the majority of their care. Most dental hygiene services are facilitated by programs operating in the private sector. Indeed, almost two-thirds of concession card holders make use of the private system[4].

Adult access to the public system, funded by state and territory governments, is restricted to concession card holders and is focused on treating existing dental problems, rather than on preventive care. As a result, dental hygienists play only a minimal role in the public system.

Despite the billions of dollars allocated to it, the public system is essentially a slow-to-arrive ambulance at the bottom of the oral health cliff, servicing only those patients who cannot afford to access other services in a timely manner. As these patients often have co-morbidities, their care can be complex and resource-intensive.

DHAA Inc. believes it is time to build the fence at the top of the cliff, by restructuring the public (and indeed the private) system into a preventive model of care. The work of dental hygienists needs to be embraced by the public sector, as a vital way of increasing throughput and maintaining oral health (and by extension, general health) in vulnerable patient groups.

Global efforts are shifting in the direction of preventive care, with the World Dental Federation adopting prevention focused models of delivery. In September 2011, the United Nations General Assembly High Level Meeting convened to discuss world health issues, exploring the topic of 'Foundation stones to be laid for non- communicable disease prevention'. DHAA Inc. is part of the global dental community and a long standing member of the International Federation of Dental Hygienists. We are committed to health reform and community access to dental health professionals working within their scope of practice as part of a team approach to dentistry.

One of the most significant developments occurred in Canada in 2006 when Bill 171 was introduced into the legislature to increase access to preventive health care for the people of Ontario. The Bill included amendments to the Regulated Health Professions Act 1991 and impacted delivery of service by hygienists to the public. It also included the creation of new colleges and re-orientated the functions of existing colleges.[5]

Since the passing of this Bill, the Ontario College of Dental Hygienists has developed a number of useful resources to guide professionals. DHAA Inc. particularly recommends the following documents be used to inform discussions in Australia:

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[4] Ibid.

[5] Richardson Fran, *Bill 171: The Implications for Dental Hygienists*, Milestones, March 2007.

- Dental Hygiene Standards of Practice - http://www.cdho.org/reference/english/standardsofpractice.pdf
- Standard of Practice for Self-Initiation - http://www.cdho.org/Reference/English/StandardsSelfInitiation.pdf
- Entry to Practice - http://www.cdho.org/Otherdocuments/EntryToPractice.pdf

The public sector is uniquely placed to facilitate dental hygiene services in community settings, many of which are also government funded. As noted above, there are numerous possible ways to reach patients, the most obvious being aged care facilities, homeless hostels, prisons and deliberate outreach into rural and remote areas. Allocating dental hygienists their own provider numbers would remove administrative and financial barriers to the provision of these services. Amending the Scope of Practice Registration Standard would allow direct access to a dental hygienist, who could refer patients in need of treatment to a dentist.

The recently closed Chronic Disease Dental Scheme provided a targeted program to assist people with chronic illness to access preventive oral health care from a dental hygienist or oral health therapist. Yet the Australian Labor Government shut this scheme down a few months ago, offering no replacement scheme to assist adults with chronic disease to access dental care. This was a short-sighted move.

If any improvement is to be made to the oral health of adults, then all forms of government need to be involved. Much clearer guidelines are needed to ensure that each government's role and contribution is clearly defined to avoid confusion, blurred communication, duplication or omission.

3. *Availability and affordability of dental services for people with special dental health needs;*

Adults with special dental needs include those with physical or mental disabilities or chronic illnesses such as cancer or HIV. These adults have some of the most complicated dental issues, such as crowding, tongue thrust, poor oral hygiene due to poor dexterity or autonomy, erosion, hypersensitivity, and dysphagia to name but a few. Yet it is well documented that good oral health is the foundation to good general health, especially for those with an already decreased quality of life.

Preventive dental services need to be provided at group homes for people with disabilities, special schools and other similar settings. Dental hygienists need their own provider numbers to support these services. Both Medicare and health insurance providers need to recognise item numbers 131 (dietary advice) and 141 (individual oral hygiene instruction) when provided by a dental hygienist in order to reduce the consumer's out of pocket expenses.

Dental hygienists are skilled in interacting well with people of all abilities. Thorough training equips them to serve in all facilities as the primary preventive clinician. Dental hygienists are usually comfortable in human relationships and their services are easily portable. But DHAA Inc.'s members feel thwarted by the lack of clear pathways to allow practice in different settings, such as homes for people with special needs, with appropriate reimbursement. If access is improved, a great many more patients can be saved from avoidable pain and emergency treatment.

Vignette 1 – Oral Health of Adults with Physical and Mental Disabilities

Stella Cristini represents Victoria on DHAA Inc.'s National Council. In 2001, she undertook a 12 month research project on the oral health of adults with physical and mental disabilities, in conjunction with Scope Victoria. This involved assessing the oral health of those living in community homes. As part of this project, Stella trained the carers and participants of varying ability levels in oral hygiene instruction, prevention, diet and market products, Carers learnt about their own oral health, acquired skills and could better understand why oral health care was invaluable to their clients on a daily basis. Results showed poor oral hygiene, gingivitis and periodontitis were the greatest concerns along with the lack of access to dental treatment.

By far the highest single achievement of the project was that tooth brushing and interproximal care became part of each individual's personal daily care. Previously, something as basic as tooth brushing had not been listed as a requirement in the daily care book.

The project ended after 12 months but having seen the vital importance of dental hygiene services in community homes, Stella spent several years continuing similar work in a voluntary capacity on top of her clinical duties. Here, she shares one man's story:

> *There was a man named Steve. He was 32 years of age. I immediately took a liking to him because of his big smile and his willingness to interact with me. He had a sharp mental capacity but also a high level of physical disability. He also had a hypersensitive reflex, which meant that his facial reflexes (including his mouth) were not well controlled, dependent on how firmly his face was touched. His mouth could snap shut at any time whilst oral hygiene or treatment was being carried out if the touch was too gentle. The carers informed me that Steve had <u>never</u> had his teeth brushed! I was horrified. I spoke to Steve and asked him if I could have a look inside his mouth. I explained to him that he needed to open wide so that I could place my mirror in his mouth. To everyone's amazement Steve opened his mouth for me for as long as I needed him to. His teeth and gums were in a state of complete neglect. His teeth were indistinguishable as they were covered with thick calculus and there was an accompanying, incomparable stench. I was extremely sad as I knew Steve was very interested in having as normal a life as possible. He loved going shopping and to the pub. Unfortunately there are many Steves out there whose only dental experience consists of being placed under general anaesthetic for emergency treatment to relieve pain!*

Meaningful reform needs to serve people like Steve. When discussing policy improvements and legislative barriers to reform, it is all too easy to lose the sense of what dental care means to an individual.

4. *Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations;*

The dental system operates on a different financial model to the rest of the Australian health system. Individuals pay for the majority of their care, both in health insurance premiums and in out of pocket expenses.

The Australian Institute of Health and Welfare estimates that, in 2009-2010, Australia spent a total of $7.690 billion on dental services. Of this:

- $4.698 billion (62%) was paid by private individuals;
- $1.257 billion (16%) was paid by the Australian Government;
- $1.076 billion (14%) was paid by the private insurance funds, through membership premiums; and
- $628 million (8%) was paid by state and territory governments[6].

These are large numbers. When both out of pocket expenses and insurance premiums are included, consumers pay for 76% of the costs of the dental system.

These costs are not evenly spread. Dental hygienists treat some chronically ill patients in private practice. It is fairly easy to bring to mind a Mr X, who has diabetes, has survived chemotherapy and radiotherapy for two bouts of cancer, has had surgery to remove parts of his bowel and uses a colostomy bag. Furthermore, Mr X has had joint replacement surgery, lives in chronic pain and only sleeps two hours a night. As a result of his general ill health and his chronic pain, Mr X's oral health is poor, with major destruction to hard dental tissue and chronic periodontal infections. As a result, some teeth need to be extracted. A preventive course of periodontal treatment is required to save any of this patient's teeth that can be saved. This treatment adds further to his out of pocket expenses.

Such costs should have been covered by the Chronic Disease Dental Scheme but this has been dismantled. There are chronically ill people like Mr X in private practices every day in the same predicament.

Private dental services should be reasonably accessible and affordable for otherwise healthy middle and high income individuals and families living in metropolitan or regional areas. Nonetheless, cost of living pressures such as mortgage stress and rising utility prices are squeezing many household budgets.

Whilst many go to the dentist when they start to experience some discomfort, the uptake of preventive dental care in private practice is lower than it should be, perhaps owing to cost pressures or perhaps because some people are unaware of the link between oral health and general health, or of the link between the health of their periodontium and the longevity of the expensive new crown or implant that has just been fitted.

Dental services are not readily available or affordable for those on lower incomes or those living in rural and remote locations. Some consumers are disadvantaged both financially and geographically. The public dental system fails to be the safety net it should be for many reasons. These certainly include its short-sightedness in failing to utilise the full skills of dental hygienists and oral health therapists.

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[6] Quoted in *Report of the National Advisory Council on Dental Health*, 23rd February 2012, pp 22-23

Achieving oral health in rural and remote areas requires a long term plan utilising human and financial resource sin the most effective ways, including providing more positions for dental hygienists and therapists in these settings. Incentives could include scholarships and compensation for living far away from home.

DHAA Inc. strongly believes that active outreach is necessary in community settings in order to assist hard to reach groups. The two examples provided below show how such services can work in a city centre homeless shelter and in a remote area.

Vignette 2 - Dental Care for Homeless People

The DHAA Inc. is involved in and offers some financial assistance to supported models of direct access which are delivering safe and effective preventive care within the community. *The 7.30 Report* recently profiled one such service operating within a homeless centre in Adelaide. That report can be viewed at http://www.dhaa.info/ or at http://www.abc.net.au/news/2012-03-16/dental-disadvantage/3895564

In this situation, triage and screening takes place within the homeless centre. Using a modified version of OHIP 14 (oral health impact profile), a questionnaire assesses the self-perceived needs of people using homeless services in the Adelaide CBD. Screening off site in this manner is more cost effective and efficient as meeting individuals in their local environment enables some primary measures to be put in place to minimise the frequent emergencies this group of people experience.

Once the questionnaire has been completed, a visual inspection is undertaken using a mirror and light to determine decayed, missing or filled teeth (DMFT) and signs of periodontal disease. Basic oral hygiene instructions are given. Those in need of further care are referred to a designated clinic for comprehensive examination and treatment planning by a dentist.

The dental, oral health and dental hygiene undergraduates who have placements at this setting are supervised by a dentist and experienced dental hygienist off site. Conferring with district nurses, social workers and support agencies ensures appropriate information is gathered, recorded and reported to all health care providers involved in care.

This process has been duplicated for a research project involving refugees at the Red Cross. Students are supervised by an experienced dental hygienist and / or dentist for the purpose of information gathering and basic oral hygiene instruction. This information will then be analysed and compared with the general population. Identification of some chronic and semi-acute problems has resulted in a reduction in emergency appointments.

DHAA Inc. was also involved in a pilot project in Queensland at the Homeless Connect Day in May 2012. Oral health screening was made available using the Oral B van with equipment and materials supplied by other dental companies. The huge number of guests that attended the day (over 1,200) all had a story to tell and wanted oral health screening done; chairs were set up to allow for those happy to wait.

This program would be a perfect example of dental hygienists and oral health therapists providing oral health support to members of the greater community, where it is desperately needed. All that is needed is the removal of legislative barriers which prevent dental hygienists operating under their own provider numbers.

Vignette 3 – Dental Hygiene in the Pilbara, WA

Populations in rural and remote regions suffer from poor oral health and low levels of access to dental services. The need for innovative models of service delivery is acknowledged by health officials and professional groups but progress has been slow.

The Pilbara region of north-west Western Australia is one such area. Port Hedland is a rapidly growing regional town of 19,000, expected to reach 27,000 by 2015. It has only two dental clinics: a private clinic servicing 80% of the population at a ratio of 1 dentist to 17,000 people; and a government clinic servicing the remainder of the population. Similarly, Karratha has three dentists serving 20,000 local residents as well as army personnel. To the resentment of some locals, numbers swell by an estimated 3,000 fly-in, fly-out (FIFO) miners who prefer to seek dental treatment at their work locations. Overall, this indicates a conservative ratio of 1 dentist per 8,000 people in Karratha.

Remote Pilbara towns such as Onslow, Tom Price and Paraburdoo rely on FIFO private contracted services and intermittent provision from mobile dental clinics providing treatment to school-aged children. These mobile clinics may only appear once every 12-24 months and do not provide continuity of care. Some children have never seen a dentist and local shire staff report the incidence of co-morbidity is common among Aboriginal children in Onslow.

Karratha dental professionals and local government staff confirm that most remote centres in the Pilbara rely on intermittent FIFO dental services and a high proportion of the treatment they provide is emergency care. Waiting times for non-urgent treatment can be 6-8 weeks.[7] School nurses report visible evidence of oral disease in children. Whilst these nurses endeavour to provide oral health education as part of a general hygiene program, the lack of dental services mean preventive practises have little support.

Rural and remote based school nurses, Karratha private dental staff, and Port Hedland public health dental staff strongly endorse the need for dental hygiene services in both the larger centres of Karratha and Port Hedland and the remote Pilbara townships. The medical based primary health care model applied to the medical services provided by nurses and medical staff in these regions would enable a dental hygienist to enter the health care team as a valued participant. Medical staff acknowledge and welcome the services dental hygienists can provide in reversing and arresting disease. They also support the opportunity for dental hygienists to use their skills to provide the urgently needed oral health education in these locations.

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[7] Wright W. *DHAA Inc. Bulletin* February 2012 Issue 24 (18-19)

Again, if a direct access model were adopted and supported legislatively it would facilitate the inclusion of a dental hygienist as a member of a health care team delivering services in rural and remote areas where there are very few, if any, other options for dental care available to the community.

5. *The coordination of dental services between the two tiers of government and with privately funded dental services;*

Put simply, there is very little in the way of coordination of dental services between the two tiers of government or the private sector. There are obvious duplications in child services[8] but some overlaps in adult services too. Most concession card holders cannot access the public services they are entitled to in a timely manner so use private services; veterans receive care through the DVA but may also be eligible for a concession card. The Australian Government enters the private market by providing a 30% rebate on private health insurance costs. Finally, each state or territory offers something slightly different in terms of services provided, eligibility criteria, and co-payments charged.

Though there were administrative difficulties, the DHAA Inc. is saddened by the dismantling of the Chronic Disease Dental Scheme (CDDS) operated by the Australian Government. This failed in any case to include the services of dental hygienists and oral health therapists. Oral health impacts directly on systemic health, especially in those with chronic diseases but the lack of a rebate discouraged such patients from seeing a dental hygienist. They were then deprived of the opportunity to receive preventive care and advice which would have helped them to help themselves in the longer term.

The CDDS was supposedly replaced by Grow Up Smiling, yet this scheme only covers children. Another such scheme is sorely needed for adults with chronic disease. Clear guidelines would be required from the outset to ensure medical and dental professionals were aware of their responsibilities. DHAA Inc. believes any new scheme should incorporate a compulsory preventive treatment and care component to be carried out by a dental hygienist or oral health therapist.

Whilst Grow Up Smiling may be a good initiative when judged only on its own merits, the dental needs of adults have been completely neglected. Yet adults are the caretakers of their children's health. Most parents intend to do their best for their children but through lack of experience or education are unaware of the importance of their own oral health and thus struggle to be effective role models and advocates for their offspring.

6. *Workforce issues relevant to the provision of dental services.*

There are several workforce issues that need to be addressed in the provision of dental services. As noted above, DHAA Inc. does not believe the high levels of unmet need are due to staffing shortages but rather to failure to utilise the full skill set of each dental team member, thus creating artificial

[8] The Australian Government Medicare Teen Dental Plan covers 12-18 year olds; the states offer a range of services for children up to 18.

bottlenecks. Workforce models need to be changed to enable smoother pathways through the system.

There are increasing numbers of dental hygienists and oral health therapists being trained but not utilised. There is a saturation of employment within the private sector meaning some new graduates cannot find work. There is also an unofficial downward shift on wages. Furthermore, dental hygiene graduates are struggling to find employment in the public sector as the dentist in charge will often hire a graduate dentist instead. Dentists and hygienists offer quite different services. Dentists are not experts in prevention. In contrast, dental hygienists actively promote a preventive paradigm.

DHAA Inc.'s main point is that there are not too many graduates but rather insufficient opportunity to position them where patients most need to find them. All the right pieces are on the chess board but they are not lined up to play. This limitation is directly related to the lack of provider numbers for dental hygienists and to the public sector's failure to engage single strain trained dental hygienists (the government does hire a very small number of oral health therapists). The Medicare framework does not actively support any preventive services, with the exception of the new Grow Up Smiling scheme for children, due to commence in 2014.

Yet, as discussed above, we know high numbers of people are experiencing progressively worse oral health because they cannot access preventive dental care. This situation is extremely frustrating to DHAA Inc. Our members want to be used to their full potential, to be present in the dental care of the population at every stage of the lifespan, including critical care. We are the best trained professionals in achieving oral health and should be prominently employed in this capacity.

Our ultimate goal is to improve the general health of the population, alongside other dental professionals. Dental hygienists and oral health therapists should be the primary caretakers of preventive oral health in hospitals, aged care facilities, community homes, prisons and all other institutions, yet legislative barriers make this extremely difficult to achieve.

DHAA Inc. highlights the following workforce issues:

1) Autonomy:
    - Provide dental hygienists with their own provider numbers, in line with other senior allied health professionals, to enable us to operate within our scope of practice in all types of facilities. Dental hygienists are highly qualified professionals, legally responsible for our service quality, and should be recognised and remunerated as such.

2) Mobilisation of workforce:
    - Dissolve the legislative barriers that stop dental hygienists and oral health professionals from operating at our full capacity;
    - This includes allowing scope for the dental hygienist to be recognised as the team leader if s/he is the most appropriate person for that role. Should a graduate dentist of limited experience automatically be the team leader when other members may have far more experience in extraction of deciduous teeth, or periodontal disease and treatment? Does this really produce the best outcomes for patients or simply serve to prop up traditional professional hierarchies?

3) Financial support:
   - Increase the rebate on item numbers relating to preventive treatment and services carried out by dental hygienists and oral health therapists. Dental hygienists will then be able to invoice for their services in relation to their level of experience and the treatment performed, in line with other professionals.

4) Guardianship of funds in aged care:
   - Create an independent body with a pool of funds (from the resident's pocket) for residents of aged care facilities to access required dental and health care. Affordability is a significant barrier to residents of aged care, especially if power of attorney has been vested in someone unwilling to release funds for necessary dental care.

5) Environment:
   - Create a dental space in community facilities. This would need to include a dental chair, suction unit, sterilisation unit (autoclave), instruments etc.

6) Accreditation:
   - Amend the accreditation process for nursing homes to require the provision of dental health prevention and care. This would involve employing dental hygienists and oral health therapists in these settings. This can be facilitated as part of the e-health model trial.

7) Central registry:
   - Create a register of all dental hygienists and oral health practitioners available across Australia to improve access to services.

Conclusion

In summary, DHAA Inc. believes there are significant problems in both access to and affordability of dental services for adults. The system underutilises the skills of dental hygienists and patients suffer as a result.

A paradigm shift to preventive care is needed, with dental hygienists on the front line to help people maintain good oral health. Once our members have their own provider numbers, they can provide their services with accompanying rebates, thus encouraging uptake from patients worried about affordability. We can also provide our services in outreach settings, deliberately focusing on sub-groups of the population known to be at higher risk. Finally, DHAA Inc. would like to see a replacement for the CDDS so that patients with chronic health conditions are able to access the oral health care they need.

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