Griffith UNIVERSITY

Health Workforce Study
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It is very easy to forget about the oral health workforce and concentrate on the supply of doctors, nurses and allied health professionals around Australia. This is because the Commonwealth does not directly fund the dental services – the exceptions being dental services for eligible persons through Veterans Affairs, a Medicare rebate for surgery associated with cleft palate and health insurance rebates for ancillary cover with private health insurance funds. Public dental services are funded by states and territories whereas private dental services are funded through under workers' compensation and third party insurance or by individuals themselves.

The oral health workforce consists of specialist dentists, dentists, dental therapists, dental hygienists, dental technicians, dental prosthetists, dental assistants and dental practice managers.

Most commentators would agree that there is a shortage of oral health workers across Australia, particularly in regional, rural and remote areas.

Suggestions:

1 Consultation:
I urge the Committee to meet with representatives from the universities and TAFE Colleges, the professional associations (not only the Australian Dental Association), the Australian Dental Council and consumers (Australian Council of Social Service in Sydney, Health Issues Centre in Melbourne and Consumers' Health Forum of Australia in Canberra).

2 Education and Training:
HECS funded places should be increased for the education and training of specialist dentists, dentists, dental therapists, dental hygienists, dental technicians and dental prosthetists.

3 Public Sector Workforce:
Dental graduates could be bonded for 1-3 years after graduation to work as Interns or House Officers in hospital dental clinics across Australia. Medical graduates are required to successfully complete time as an Intern and House Officer for 3 years before working as a Registrar for another three years. There is an anomaly here as dental graduates are allowed to work as registered dentists straight after they have finished their studies.

4 Health Insurance Funds:
A. Presently, Dental Therapists and Dental Hygienists are providing dental services for patients in the private sector. These include fillings, extractions, scale and clean,

oral hygiene instruction, assistance with orthodontic banding, periodontal cleaning and examinations. However, all health insurance rebates are accounted for as if a dentist has performed all the procedures. This means that the health insurance data of dental procedures performed is not an accurate representation of the work performed, i.e. as a dentist may employ 5 Dental Hygienists, it looks as if s/he is cleaning 5 people's teeth at the one time. Dentists, dental therapists and dental hygienists be accredited for the actual work they do, not just assuming that dentists perform all the work.

B. There needs to be a review of the private health insurance dental rebate system to take into account the skills and training of the different providers, namely, dentists, dental therapists and dental hygienists. I would suggest that dental therapists and dental hygienists should receive lower rebate than if a dentist performed the same procedure. This would be similar to dentists and dental prosthetists that are reimbursed at differential rates for dental treatment through the Department of Veterans Affairs. This would also be similar to ophthalmic surgeons and optometrists who receive differential rebates for the same procedure, i.e. initial eye examination (approximately $10 differential). This could amount to huge savings for the private health insurance funds in ancillary benefits for dental procedures.

C. The greatest barrier for persons for going to a dentist is *cost*. If we can reduce the cost of dentistry, then more people should be able to access dental care when and where necessary. The promotion of a more competitive market in oral health care has the potential to reduce costs and increase services to those who need it. I am keen to see that the benefits of increased competition are now passed on to patients via reduced dental fees. An open competitive market in dentistry should be inclusive of provider numbers, item numbers and private health insurance rebates for dental therapists, dental hygienists and oral health therapists along the lines of those already established for dental specialists, dentists and dental prosthetists in Australia.

5 Regional, Remote and Indigenous Issues:
The Commonwealth could include the services of Dental Therapists and Dental Hygienists in its More Allied Health Services Program as an option for extending the capacity of dentists in rural and remote areas. Furthermore, funding could be earmarked for some direct positions in identified health services (community controlled by Indigenous boards).

6 Divisions of General Dental Practice:
Unlike medicine that has a well-developed network of Divisions of General practice across Australia, there are no Divisions of General Dental Practice in Australia. Continuing education, research and project activities are undertaken by universities, professional associations and Departments of Health. Through networking and pooling of resources, Divisions of General Dental Practice could coordinate after-hours services for specific local government areas. In summary, Divisions of General Dental Practice have the potential to significantly boost access to continuing education, professional support, research activities, after-hours services and pilot projects for the more effective and efficient delivery of dental services for all Australians.