The Dental Workforce and Access to Care Crisis Demands an Outside-the-Box Solution

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Today, more than two million Pennsylvanians live in areas with little to no access to dental care. There are more than 200 federally-designated Dental Health Professional Shortage Areas in our state. Even those individuals

fortunate enough to have the resources and proximity to dental care are finding it difficult to schedule appointments. The profession is facing a structural imbalance in the dental workforce with too few hygiene providers. This is destabilizing the economic viability of dental practices and the careers of oral health professionals. It is time we think outside-the-box and consider a collaborative, tiered workforce model.

Pennsylvania currently operates at roughly a 1:1 ratio of dental hygienists to dentists. The PA Coalition for Oral Health has suggested a 2:1 ratio. However, demographic trends, part-time work patterns, and the growing need for periodontal care and public health dental hygiene providers suggest the state may ultimately require 3.5 hygienists per dentist to support adequate preventative care. While the number of dental school graduates has increased with new and expanding programs, the number of dental hygiene school graduates has remained flat.

Ratios are projected to worsen as retirements accelerate. A recent survey revealed that nearly a third of hygienists plan to retire in the next six years and a third plan to work part-time. The bucket of hygiene providers is leaking faster than we can fill it. RDH Magazine recognizes the trend in an article titled *Is Dental Hygiene a 10-year Career?*

We need to increase hygiene program capacity and graduates, but establishing and maintaining programs comes with considerable expense and regulatory burden. Even if we could double the number of new programs tomorrow, it would take more than a decade to navigate away from the cliff we are about to fall off. Without decisive action, the current workforce imbalance will lead to a systemic collapse of preventive care delivery.

The silver lining is that there is a solution that can offer new career opportunities and bring together all stakeholders—patients, organized dentistry, organized dental hygiene, legislators, public-health leaders, and patient advocates. Such a unified approach can overcome the professional fragmentation that has historically stalled oral-health reform.

A collaborative solution that modernizes dentistry with a tiered preventive workforce would be a grand bargain that benefits all camps. This structure parallels successful team-based models already used in dentistry. Just as Expanded Function Dental Assistants (EFDA) have successfully become a key in supporting dentists with their restorative skills, a similar role that supports hygienists can focus specifically on prevention. The model introduces a structured care team consisting of Licensed Hygiene Assistants (LHAs), Registered Dental Hygienists (RDHs), and Advanced Practice Dental Hygienists (APDHs). The key to industry acceptance and quality patient care is that the LHAs would be required to work under dentist and APDH supervision, a role that would allow hygienists to pursue further education and professional growth in clinical capacities.

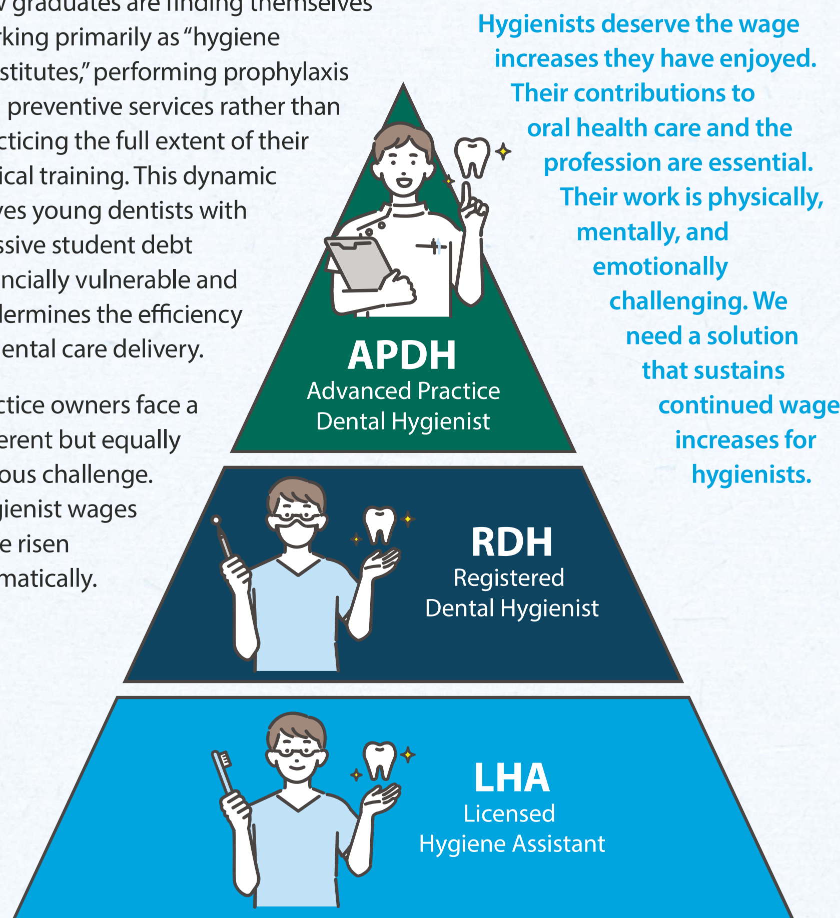
The tiered structure may seem like a radical idea for a hygiene profession that has not really changed much since its inception, but doing nothing is not an alternative. Young dentists are graduating into a broken industry. Dental school graduates are now burdened with average student loan debt that exceeds $300,000, and many carry balances twice as much. To service this debt, young dentists require productive clinical schedules. However, in many markets, practices are starting to struggle to support additional dentists because patient flow is constrained by hygiene staffing shortages.

Without hygienists generating preventive visits and exams to identify restorative needs, dentists cannot operate efficiently. As a result, some new graduates are finding themselves working primarily as "hygiene substitutes," performing prophylaxis and preventive services rather than practicing the full extent of their clinical training. This dynamic leaves young dentists with massive student debt financially vulnerable and undermines the efficiency of dental care delivery.

Practice owners face a different but equally serious challenge. Hygienist wages have risen dramatically. Some markets have seen increases as much as 50% in the last five years, reflecting a widening gap between supply and demand. These wage increases are colliding with a second economic reality: Insurance reimbursement rates for preventive services have remained largely stagnant.

Many practice owners report that hygiene services are becoming financially unsustainable. As a result, dentists are beginning to consider difficult decisions including performing hygiene procedures themselves, limiting their practice to fee-for-service patients, or no longer offering preventive services altogether. All of these responses ultimately reduce patient access to care.

Hygienists deserve the wage increases they have enjoyed. Their contributions to oral health care and the profession are essential. Their work is physically, mentally, and emotionally challenging. We need a solution that sustains continued wage increases for hygienists.



Even with wage increases, we are still going to see hygienists leave the profession en masse if we don't empower them with structural changes to the workforce. Dr. Linda Straub-Bruce highlights the growing frustration and professional burn out in *The Lived Experiences of Factors Contributing to the Intent to Leave the Clinical Hygiene Profession in Pennsylvania*. She has documented high levels of occupational strain among dental hygienists, including musculoskeletal injury risk and dissatisfaction related to limited professional autonomy.

Dr. Staub-Bruce also reports that hygienists want to practice at a higher clinical level, play a greater role in patient care coordination, and participate in leadership activities. Some dental hygiene programs are accepting less than 10% of an applicant pool that has already been narrowed through prerequisite education. Competitive admissions yield highly capable, extremely intelligent, motivated individuals. These graduates want to work with their brains as much as their hands. Yet the traditional hygiene role structure limits these individuals to a narrow set of repetitive clinical tasks, with few opportunities for career advancement or leadership.

In any industry, the delivery model that proves economically sustainable ultimately prevails. Efforts to increase access to care through public funding or non-profit subsidy will never be guaranteed. However, team-based care that better leverages the skills of dentists, hygienists, and trained ancillary providers can offer a viable solution. A successful model must simultaneously support competitive wages, professional growth, financial

sustainability for dental practices, and expanded patient access to affordable care.

In the tiered hygiene model, LHAs would serve as preventive providers supporting hygienists and working under the close supervision of both an APDH and a dentist. Their responsibilities could include radiographic procedures and patient education, but their primary focus would be on the labor-intensive mechanical debridement of teeth, including corneal polishing and scaling in patients that are not periodontally compromised.

Education and licensing requirements could mirror the pathways and programs that currently exist for EFDAs in Pennsylvania. The opportunities would offer family sustaining wages and provide a career entry point for many individuals that are not currently able to gain admission to hygiene programs. Many local high school career and technical centers are reporting that very few of their graduates are being accepted into hygiene programs. An LHA that enjoys and embraces clinical care can ladder into hygiene programs over time and become an RDH.

With LHAs managing routine, repeatable procedures, RDHs can be free to focus on higher-level preventive care, periodontal management, and patient counseling. It would also provide an opportunity to expand scope of practice for RDHs to possibly include soft tissue curettage, nitrous oxide administration, laser use within scope of practice, etc. With additional training and experience, perhaps a bachelor's degree that offers management, education, and medical courses, RDHs could ladder up to become licensed as APDHs.

APDHs could have a scope of practice that allows them to perform hygiene diagnosis, develop hygiene treatment plans, and exercise limited prescriptive authority. Above all, APDHs would supervise LHAs collaboratively with dentists.

This role differs from Public Health Dental Hygiene Practitioners (PHDHPs) by creating a structured supervisory and leadership role within clinical practices. It would leverage the workforce, and hopefully free more providers to pursue and embrace PHDHP opportunities to help bolster community-based services.

In clinical practice, an APDH could greet patients, review records, update medical histories, and perform wellness checks. They then could prescribe services for periodontally healthy patients and pass off to an LHA to take radiographs, scale, and polish. The APDH could return at the

end of the appointment with the dentist for the exam to aid in co-diagnosis and scheduling.

The efficiencies this model provides are significant. For example, a two-doctor practice in a traditional hygiene staffing model might involve:

- Five RDHs at $45/hour
- One hygiene assistant at $22/hour
- **Total hourly cost of wages = $247/hour**

In a tiered team-based model:

- One Advanced Practice Dental Hygienist at $60/hour
- Three Licensed Hygiene Assistants at $28/hour
- Two RDHs at $45/hour
- **Total hourly cost of wages = $234/hour**

The model simultaneously reduces operating costs and increases compensation while expanding preventive access.

For decades, progress in oral-health workforce reform has been slowed by professional turf wars. Dentists worry about loss of control, economics, and clinical standards. Hygienists worry about loss of professional autonomy and are frustrated with a limited scope of practice and little to no opportunity for clinical advancement. Policymakers struggle to reconcile competing messages.

The solution requires what might be called a **"grand bargain."** Dentists support a wider scope of practice, leadership opportunities, and self-regulation for hygienists. Hygienists support team-based care that includes new preventive provider roles. Patients gain dramatically expanded access to care.

Pennsylvania's oral health system stands at a crossroads. A workforce model built around a 1:1 hygienist-to-dentist ratio cannot sustain a prevention-focused system capable of serving the state's population.

Without reform, access to care will continue to decline, preventive services will shrink, and both dentists and hygienists will face growing professional strain.

But crisis also creates opportunity. By embracing a collaborative, tiered preventive workforce, Pennsylvania can modernize oral health care, strengthen professional careers, and dramatically expand access for patients. Achieving this will require cooperation among dentists, hygienists, educators, policymakers, and patient advocates. If those stakeholders can move beyond professional turf and unite around a shared goal—better care for patients—the Commonwealth can build a dental workforce ready to meet the needs of the next generation.