DSSWA DENTAL SPECIALISTS SOCIETY OF WESTERN AUSTRALIA

Tuesday, 8 May 2018

To the Dental Board of Australia

In response to your call for public consultation regarding the proposed changes to the Scope of Practice for Dental Therapists, Dental Hygienists and Oral Health Therapists, please accept the following submission on behalf of the Dental Specialists Society of Western Australia (DSSWA). The society represents 71% of registered Dental Specialists within the state of Western Australia.

Regulation of the profession of Dentistry was introduced at the turn of last century to minimise public harm and to aid the public in identifying registered and appropriately educated practitioners. The role of the Dental Board of Australia and AHPRA within society is primarily the protection of the health of individuals within the community. It is essential that this role is maintained and takes precedent over a perceived need to make public health decisions on accessibility to health care.

DISSOLUTION OF THE STRUCTURED PROFESSIONAL RELATIONSHIP (SPR)

The Structured Professional Relationship (SPR) was introduced to accommodate a flexible team approach and has operated successfully since its inception. It is in fact considered best practice on an international level. The recent call for change has arisen in the public sector, however the impact of such a decision must, by default, affect the private sector and will do so to the detriment of the greater profession. To remove the Structured Professional Relationship places the process of examination and diagnosis in the hands of a clinician with only basic “screening” training and removes the appropriate checks and balances that exist within the Structured Professional Relationship.

The development of the Oral Health Therapist as an Allied Health Professional has significantly broadened the scope previously applied to Dental Hygienists and Dental Therapists. Whilst it has been suggested that Dental Hygienists and Dental Therapists could attend further education to effectively increase scope to the level of Oral Health Therapists, this has only been suggested under the auspice of accredited training programs, not self-reflective Continuing Education (Ford and Farah 2013). Given the diversity of prior education standards and content delivery, it is inappropriate to collect Dental Therapists, Dental Hygienists and

Oral Health Therapists under one umbrella and apply a universal solution to public health concerns.

CHEAP LABOUR AND ACCESS TO DENTAL CARE

The suggestion that Dental Therapists, Dental Hygienists and Oral Health Therapists will provide a cheap source of labour to provide access to dental care is a flawed argument. The obvious comparison is the Dental Prosthetists who, 40 years ago, were going to provide cheaper dentures. In 2018 they are more expensive than dentists and furthermore are now providing treatment way out of their Scope of Practice such as sleep apnoea devices, occlusal splints, restorations on dental implants and are actively involved in mail order dentistry.

If indeed the push in the private sector is being driven by corporates and health insurance companies, it is prudent to recall that their responsibilities lie with the shareholders of the company, not individual patients within their care. If corporate entities are wanting to provide a low wage model of delivery of care it will not be for the benefit of the public. Rather it will be so that corporate businesses can employ supposedly cheaper labour and increase profit margins for the benefit of shareholders.

While it could be argued that this is speculative, the costs of running a safe and accredited dental practice do not permit the payment of wages to Allied Dental Professionals in a standalone model within the private sector. This model has been trialled in 2017 in Western Australia with well-qualified Allied Dental Professionals. They were given independence on a financial level within the context of a Structured Professional Relationship (unpublished data). The test case was unsuccessful and demonstrated that over a full twelve (12) month period, Allied Dental Professionals with fully appointed books were unable to sustain the costs of running a safe independent practice and draw a wage. As no employee will work for no wage, the alternative solutions are either that the running of independent practices will become unsafe and pose a direct risk of harm to the public, or that the direct and increased costs of services provided by Allied Dental Professionals in independent practice will be passed on to the public, negating the argument that Allied Dental Professionals provide access to cost effective dental care.

Within the private sector, there is currently an over-supply of fully qualified Dentists in the Australian community. It already costs more per hour to employ a Dental Hygienist, Dental Therapist or Oral Health Therapist than it does to employ a new graduate dentist. It would be a wiser decision to utilise a more highly trained, existing workforce more effectively than to introduce a greater number of workers.

SELF-REFLECTIVE LEARNING

There is a significant difference between continuing education to consolidate an existing Scope of Practice, and continuing education to increase a Scope of Practice.

Under the current model of ongoing learning, Continuing Professional Development (CPD) is largely undertaken outside accredited Universities and Colleges and can be delivered by any person, with or without dental qualifications, with no requirement to subject the content to peer reviewed scrutiny. This avenue of education should only be utilised to consolidate a clinician's existing knowledge base, rather than increasing a Scope of Practice. It takes a very structured theoretical and practical course, accredited by peers and the relevant authorities, conducted over many months, to actually influence a clinician's Scope of Practice (Brown et al 1994). The only regulated, structured and accredited training courses are those already provided by the Universities and Royal Australian College of Dental Surgeons.

PRESCRIPTIVE TERMINOLOGY

Removing prescriptive terminology allows greater flexibility of interpretation of Scope of Practice. Whilst most clinicians will adhere to broad guidelines, there will always be a number who believe their own abilities are far greater than they are (Dunning-Kruger 1999). In the absence of clear prescriptions the risk of interpretation is too great resulting in increased risk of public harm. The Dental Specialists Society of WA asserts that the Code of Conduct as a standalone guideline is <u>not</u> sufficient for Dental Therapists, Dental Hygienists and Oral Health Therapists to ensure they continue to work within their Scope of Practice. The Code of Conduct must be supported by a clearly defined and regulated Scope of Practice.

To allow the proposed deregulation of dentistry is to follow in the path of the banking sector which is now the subject of a Royal Commission. Deregulation of the banking sector allowed the "average" Australian to be ruined by the greed and arrogance of large financial institutions. Whilst money can be recovered to some extent, dental health once lost leaves the "average" Australian dentally disabled and irreparably damaged. Health professions, just like the financial sector, require firmly set guidelines and legislated boundaries to define the Scope of Practice. It is disappointing that members of the dental profession are requesting the Dental Board of Australia and AHPRA to maintain standards of dental education, to uphold the existing Structured Professional Relationships and to protect the public from harm.

It would be tempting to argue, that as Dental Specialists we feel the need to "protect our turf" and deny Dental Therapists, Dental Hygienists and Oral Health Therapists the rights to practice. In fact, nothing could be further from the truth. These Allied Dental Professionals form a crucial role in the Structured Professional Relationship. Many of us employ Allied Dental Professionals to provide patients access to specialist level dentistry in a more cost-effective manner. Removing the legal requirement for the checks and balances that exist within the Structured Professional Relationship will increase our work load as patients require more complex intervention and reparative dental care. This will be at the cost of the dental health of the public, not only financial cost but irreparable biological cost will be incurred. It will also be at the cost of resources provided by the Dental Board of Australia and AHPRA through the escalation of mandatory reporting of cases of harm. We urge the Dental Board of Australia and AHPRA to maintain the existing structure and protect the public <u>before</u> harm is caused, rather than relying on the profession to repair damage to the dental health of the

public, our patients, and ultimately risk an investigation into the regulation of health practices in Australia.

In summary, the proposal by the Dental Board of Australia and AHPRA to remove the structured professional relationship governing the scope of practice of Dental Therapists, Dental Hygienists and Oral Health Therapists is not supported by members of the Dental Specialists Society of Western Australia. Furthermore, the suggestion that individual clinicians should utilise "self-reflective" learning to increase their scope of practice is an unsuitable proposal and will not ensure appropriate clinical standards are achieved. The proposed changes will place the public at risk of harm. This is considered a direct conflict with the Dental Board of Australia's mission statement.

Yours sincerely

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BIBLIOGRAPHY

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