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Chairman, Dental Board of Australia

## **Re: Scope of Practice Public Consultation**

I am writing this submission to convey my worries over the consequences of the Dental Board's proposed changes to the Scope of Practice Registration Standard.

As an established senior dental academic and a practising dentist, and having worked both in government and private sectors it is my strong opinion that the proposed changes not only will fail to address the affordability issues affecting dental care in Australia at present but even more worrisome, will lower the quality of care delivered to the patients.

It is not difficult to anticipate that these changes will result in a two-tier dental healthcare system and most likely will generate an increased number of patients with multiple missing teeth requiring complex, and hence costly restorative treatments.

At this point, the arguments offered by the proponents of these changes are speculative at best. Any data quoted regarding the benefits of the proposed changes is not directly applicable to Australian landscape and severely lacks the robustness that would justify such a drastic change in the dental profession. Along these lines, please allow me to briefly further my point on why independent practice by dental auxiliaries will fail to deliver on its advertised benefits.

The debate is extensive but in this submission I will argue only two intrinsically interlinked key aspects, which I believe will further show why these changes are fundamentally flawed and are highly unlikely to serve the patient's interest:

- Failure in delivering comprehensive oral healthcare and
- False economy in medium and long term.

**Failure in delivering comprehensive oral healthcare.** The concept of comprehensive oral healthcare is deeply ingrained in the way we are training dentists in all the schools in Australia. It is considered best practice in establishing and maintaining oral health and there is a wealth of research substantiating its benefits. At its core lays the ability of the dentist to diagnose across the whole spectrum of oral disciplines, from the status of oral hygiene to temporomandibular joint dysfunctions and oral cancer. Consequently, it requires sound knowledge and competency in diagnosis across all dental disciplines and the ability to produce an individualised management plan for each and every patient.

During training a dentist goes through, and is required to achieve a set of competencies in diagnosis and provision of treatment in virtually all dental disciplines. By contrast, dental auxiliaries have limited exposure to the breadth and depth of the dental disciplines and is highly unlikely that upon graduation and even with practical experience they would acquire the diagnosis skills comparable with those of a dentist. It is hazardous to claim that a CPD course can appropriately substitute years of professional training or provide the necessary competencies.

As a result the diagnosis produced by dental auxiliaries will be truncated and incomplete and hence so will be the management plan that will be instituted for the patient. Needless to say that the biological, psychological and the medico-legal implications of misdiagnosis or diagnosis failure can be quite severe.

And as such, how is it the interest of the patients being better served by offering an incomplete diagnosis and management plan?

**False economy in medium and long term.** This is a rather foreseeable consequence of the absence of a comprehensive diagnosis and management plan. Without it, patients cannot be offered the full range of treatment options so that they can make an informed decision.

Assuming that indeed independently practising dental auxiliaries will be capable to deliver a range of procedures at lower costs than a dentist (although this is highly questionable), and considering their scope of practice limitations in delivering and implementing a comprehensive management plan, this can result only in a compartmentalised delivery of treatment, i.e. the patient will receive some but not all the treatments necessary to establish and maintain oral health.

Therefore, the outstanding treatment needs if, of course identified, will still be managed by dentists or dentist specialists. However, this will take place outside of the framework of a comprehensive treatment plan. Current dental treatment philosophy and evidence-based practice emphasises the importance of a coherent management plan in which discipline components integrate with the endpoint of establishing a functional and healthy oral cavity. In this scenario, essentially the patient will have to be examined at least twice by two different practitioners (the auxiliary and the dentist or the specialist) and will have two management plans which are unlikely to be fully compatible.

Another real risk to a patient subjected to such a fragmented approach is the management of complications. Every invasive procedure carries a certain amount of risks of complications and dentists are trained and competent in managing the vast majority of these. Clinical management of these complications are outside of the scopes of practice of dental auxiliaries and hence they are required to be managed by a dentist or a specialist thus increasing the costs.

It is rather obvious to any neutral observer that such a piece-meal approach will actually lower the quality of care, increase costs and likely will negate any immediate financial benefits of lower fees for some procedures. It is also rather easy to anticipate that under such circumstances the rate of tooth loss will increase and will actually drive up the costs by ramping up the need for costly prosthodontic and restorative treatments. Considering that the life expectancy of the population increases steadily and so do the expectations of dental oral healthcare, one can only reason that the long-term costs are going to be very high.

It is my opinion that the proposed changes will actually backfire in medium to long term and will do very little to improve in real terms the affordability and the cost of dentistry in Australia. Furthermore, the most dangerous and detrimental effect of these changes on the population will be the institutionalisation of a two-tier healthcare system, in which some of the patients will not receive the most appropriate comprehensive management not necessarily because they cannot afford it but rather because they are not aware that this is what is required to establish and maintain oral health.

To all its faults, the dental healthcare system currently operating in Australia inclusive of the structured professional relationship has managed to deliver high standards of care comparable to those in any other developed country. While larger affordability of dental treatment is indeed an ongoing issue, it is not unique to Australia and until now no country or system has managed to actually solve it.

There is clear evidence in this very country showing that increasing the number of practitioners will not result in an increased affordability. Over the span of little more than a decade the number of dentists in Australia has almost doubled, the fees increases were constantly below the inflation index and yet somehow the affordability has not been improved. Consequently, any non-biased observer will acknowledge that perhaps other solutions should be sought outside what is a largely functional dental system.

In closing, I will leave you with the following question: would send your children, spouses or parents to a dental practitioner knowing that she or he won't be able to produce a comprehensive diagnosis and management plan, cannot manage the complications that may occur during treatment and will refer them to another two or three practitioners just to have their problems resolved??

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