From: [redacted]
To: dentalboardconsultation
Subject: response to DBA changes
Date: Wednesday, 19 June 2013 10:05:18 PM

The standard of dental care provided in Australia is among the best in the world.

This level of quality is no accident. It has come about because the standards of education and training of dentists in Australia is world class. The regulatory structures surrounding dental practice contribute to ensuring safety and quality by placing the dentist at the forefront of diagnosis and treatment planning.

But standards of care are potentially being put at considerable risk as a result of work being undertaken in reviewing the Dental Board of Australia's (DBA) Scope of Practice registration standard.

A recently released report from Health Workforce Australia (HWA) on a review of the Scope of Practice of oral health therapists, dental therapists and dental hygienists recommends the removal of the requirement for supervision of dental hygienists, dental therapists and oral health therapist by dentists.

These dental practitioners represent just 16% of the total registered dental practitioner workforce, yet the recommendations in the Report give the impression that as a result of the DBA Registration standard, their scope of practice is limited and this supposed limitation is having a significant impact on the delivery of oral health services to the Australian community.

The recommendations in the Report are neither balanced nor objective and are based on assumptions that are grossly incorrect.

The ADA believes it is critical that the premise upon which any reforms to the dental workforce occur are justified and underpinned by quality of care and safety of the public.

It is in this context that the ADA makes the following comments and dispels some of the misconceptions portrayed throughout this report.

HWA Project Approach

The study undertaken by HWA was, in the Association's view, cursory at best. The approach taken to the project is stated as including consultation with the community, dental professionals, peak bodies, government providers, regulatory bodies and dental educational institutions. It would seem from this statement that no stone was left unturned in seeking to understand fully the extent of the issues being considered.

It is therefore a matter of concern that the Report does not even list the Australian Dental Council (ADC) among the groups it consulted. As the independent national standards body for dental education and training, the ADC is best placed to provide advice as to the content of curriculum leading to the award of a qualification that meets the requirement for registration as a dental hygienist, dental therapists, oral health therapist and dentist. Had the ADC been

adequately consulted, the project team may well have discovered early on in the project that the requirement for supervision of such practitioners is founded in the knowledge that their education and training is limited.

The project adopted an unusual methodology. Firstly, the survey sought to gather information from two cohorts, dental health professionals and consumers, yet there was no difference in the questions asked of both groups. This is highly unscientific, given the depth in knowledge of the service by dental health professionals when compared to that of consumers, and thus the approach will limit the value of the information gleaned from the survey.

Secondly, for most consumers, the differentiation between the scope of practice of a dental hygienist and a therapist (dental or oral health) is unlikely to be well known. The ADA would proffer the view that in many cases consumers do not know which of these practitioners is treating them.

And to claim that the recommendations in the report are supported by the literature is plainly false.

The articles reviewed and used as evidence were strongly biased to papers that supported the use of therapists rather than being inclusive of the extensive literature which demonstrated the negative impacts of expanding the scope of practice of therapists.

Claims about workforce supply

The argument about workforce shortages was raised as a justification for extending the scope of practice. This suggestion is based on the assumption that an oral health therapist can replace a dentist. To suggest that oral health practitioners can provide the same level of care to patients as that of a dentist ignores the difference in education and training between dentists and oral health practitioners.

If the two practitioners were interchangeable, then there would be no need to identify where the scope of practice of one ends and the other continues.

The competencies of an oral health practitioner – regardless of whether they trained as a hygienist, therapist or oral health therapist, are a subset of the skills and competencies of a dentist and while these practitioners are highly valued members of the dental team, they do not have the necessary education and training to perform at the same level of a dentist.

Supervision is a long-standing practice

The use of the word supervision in registration standards is not new. Prior to the introduction of National Registration and Accreditation, dental practitioners were registered according to state based legislation. This legislation repeatedly stated that dental hygienists and dental therapists were required to practise under the supervision of a dentist. So to suggest, as is stated in the Report, that the move to national registration and the introduction of a national registration standard has in some way resulted in unintended and negative impacts is incorrect.

As it is currently worded, the Standard allows for all practitioners to work to their full scope of practice. It recognises that the education and training of these

practitioners is not offered to the same academic level as that of a dentist and that training levels differ depending on whether the oral health practitioner was TAFE or University trained.

The Board's Standard accommodates that some oral health practitioners will need more support and supervision than others but ultimately, it ensures that the safety and wellbeing of the patients is foremost.

The HWA Report also claims that oral health practitioners are often more available in rural and remote areas. The data upon which this assertion was based is six years old. More recent reports were and are openly available. Current data on workforce distribution indicates that there is no statistical difference between the distribution of the dental therapy workforce to that of dentists.

Dental hygienists, dental therapists and oral health therapists with their education in oral health promotion and prevention are ideal to deliver preventive care.

In fact the reason that the role of a dental therapist was introduced in Australia was to address a gap in service provision to children. So for governments to encourage them to move out of this area of service delivery when the Commonwealth Government is introducing a Child Dental Benefits Scheme is completely nonsensical.

These oral health practitioners were trained to perform a specific role and function. Notwithstanding the fact that many hygienists and therapists have since undertaken further training and hold qualifications in both hygiene and therapy, their training is unlikely to have prepared them for independent and unsupervised practice akin to what is being suggested in the report.

Dr Matthew Kei