COMMENT ON THE PRODUCTIVITY COMMISSION

POSITION PAPER

The Australian Dental Council (ADC) is grateful to the Productivity Commission for the opportunity to comment on the Commission's Position Paper.

The ADC would like to make some general comments before commenting on specific recommendations.

There is concern that the Position Paper focuses very heavily on medicine and does not recognize the differences between the medical model and those of other health disciplines which, in the case of dentistry, is a much simpler model. The imposition of a medical model on dentistry would run the risk of compromising many aspects of regulation, assessment and training which operate very effectively at present.

An example is the flexibility of crossing traditional areas of practice. The ADC has representation of the Dental Hygienists' Association of Australia and the Australian Dental and Oral Health Therapists' Association on its Council. Some of the Dental Registration Boards also have such representation which has allowed better communication and greater flexibility in changes to areas of practice. There has also been very significant integration of training programs which has provided valuable synergies.

It is felt that the Commission should recognize such differences rather than assume that "one model will suit all". There are many aspects of self regulation that have functioned efficiently and equitably in dentistry and it would constitute a backward step for these to be changed to comply with an imposed model.

It is feared that the proposals of the Commission would create another layer of regulation with associated additional costs and bureaucratization. The ADC carries out its functions efficiently, with a high level of satisfaction from those with whom it deals and **at absolutely no cost to governments**, either Federal or State. It is funded entirely from contributions from the Dental Boards and fees for assessment and examinations.

A small profession such as dentistry relies heavily on the commitment and generosity of its members in processes such as registration, clinical training of students, continuing education, accreditation and assessment. Many of these services are provided either at no cost or levels which amount to a significant loss of income. Self regulation in the profession encourages support from the profession. The ADC could not function efficiently or at present cost levels without the expertise of dentists, dental hygienists and dental therapists and their willingness to support the maintenance of standards. It is uncertain that this support would be forthcoming if an imposed bureaucratic model were to be imposed.

The ADC has difficulty in making a sound assessment when none of the proposals in the Position Paper have been costed. Clearly there would be considerable costs to be balance against perceived benefits.

Draft Proposal 4.1
The National Advisory Committee on Oral Health (NACOH) produced the National Oral Health Plan in 2004. Included within the structure of NACOH, a Working Group was formed by the Australian Health Workforce Officials Committee (AHWOC) to examine workforce issues associated with dentistry and the allied oral health professions. This work has had the full support of the ADC and it would be foolish and inefficient for a proposed health workforce improvement agency to repeat this exercise or to ignore the recommendations made.

Draft Proposal 5.1
The ADC would support this proposal as far as it goes. Funding allocated by the Department of Health and Ageing should be quarantined for the specific health discipline rather than going to combined health faculties where it is possible that intended funding may not fully reach the specific discipline after re-allocation at a faculty level.

Draft Proposal 5.2
Universities should retain autonomy in the establishment of curricula . It is the role of the accreditation process to assure registration bodies that graduates of a particular program are of an adequate standard to be registered. Curriculum varies from program to program and this diversity brings about a constant review process for the attainment of the highest standards. The proposed advisory health workforce education and training council must not impose curricula. Hypothetically, it would be quite possible to do so if the “advisory” role was to be connected with funding. In such an event this would have to be considered the directing of curricula.

Draft Proposal 5.3
This proposal relates more to medicine than dentistry. However the ADC would support the general direction of the proposal for explicit payments to those providing infrastructure support or training services. The National Oral Health Plan drew particular

attention to severe workforce problems in rural and remote areas. Explicit funding for infrastructure in rural and remote areas would permit added clinical training places to be made available to undergraduates with a view to alleviating the shortage of dentists, dental hygienists and dental therapists.

Draft Proposal 6.1

The ADC already has a well established and rigorous process for the accreditation of dental undergraduate and postgraduate university programs. In addition the ADC accredits training programs for dental hygienists and dental therapists most of which are now conducted in the universities. The ADC has also established a process of certification for programs which do not lead to registration. The Accreditation Committee of the ADC is a joint committee of the ADC and the Dental Council of New Zealand and this is mutually beneficial in the assurance of consistency between Australia and New Zealand and gives substance and dependability to Trans Tasman Mutual Recognition.

The ADC would support the concept of a national accreditation standards to help bring about improved consistency of process but would oppose such a proposal if there was any risk that the well respected processes in place were lost or compromised. The ADC would need to have more information on how such an accreditation advisory body would be formed, operate and how it would relate to different professions. This is a situation where there is a real risk that the imposition of a medical model would result in the loss of an excellent existing system which is both efficient and cost effective.

The ADC has dialogue with the General Dental Council (UK) and the Commissions on Dental Accreditation of Canada and the USA on accreditation processes. At present there are discussions which may lead to Canada, USA and Australia recognizing each other's accreditation processes with a view to facilitation of movement between countries.

If a national body were to "…..take over responsibility for the range of existing accreditation processes carried out by such bodies as the….Australian Dental Council…..although not necessarily all their work." This could result in a less profession specific and relevant process, a more bureaucratic process and certainly a far more expensive process. It would risk the loss of an excellent process without the Commission being aware of the merits of that which they wish to replace. It would be doubtful if a national health body would receive anything remotely like the level of commitment at present received from the dedicated dental professionals who form the accreditation teams.

The ADC process is well established, respected by stakeholders and self-funding. This function is performed at no cost to any government.

Draft Proposal 6.2

The ADC already performs these functions on a national basis and is responsible to the State and Territory Dental Boards. Examinations are benchmarked against final year dental students and practising dentists. Clinical examinations are subject to independent review. Examiners are drawn from a range of dentists including academics, practising dentists, both Australian and those who have previously qualified by way of the ADC examinations. Again the ADC would welcome the Commission looking at the examination process before recommending its replacement or modification. The imposition of a standard or medical model would risk the loss of a well benchmarked, relevant and efficient process which is now facilitating the admittance to practice of more dentists than any of the Australian University Dental Schools.

Draft Proposal 7.1
The ADC would support consistent national standards for registration, greater ease of movement across state borders and access to a national compilation of registers providing these standards are profession specific and do not impose irrelevant or inappropriate conditions on the functions of the Boards. The ADC has a standing committee, the Uniformity Committee, which seeks to produce equivalent outcomes in all States and Territories. Current items under discussion are recency of practice and mandatory Continuing Professional Development.

Draft Proposal 7.2
The ADC would support this proposal.

Draft Proposal 7.3
Support for this proposal would require greater detail of the precise nature of supervision by the delegating professional. Distinction would need to be made between delegation to another health professional as part of a team approach and independently practising health professionals. In cases where delegation to a different registered health professional occurs eg dental hygienist or dental therapist, that person should assume responsibility for his/her actions within the prescribed range of duties while the delegating dentist should assume responsibility for the overall treatment planning.

Draft Proposal 8.1
The ADC would support this proposal

Draft Proposal 8.2
The ADC would support this proposal

Draft Proposal 9.1
Not applicable to dentistry

Draft Proposal 9.2
The ADC would support this proposal providing there was sufficient input from existing sources such as the Australian Research Centre for Population Oral Health of the Australian Institute of Health and Welfare.

Draft Proposal 10.1
The ADC would support this proposal if extended to include the workforce requirements of the indigenous communities.

Draft Proposal 10.2
The ADC would support this proposal providing this did not involve any reduction in standards and that all job redesign was accompanied by sufficient and appropriate training.

Draft Proposal 10.3
As above. The ADC would support regionally based education and training and notes that this is beginning to occur in dentistry, dental hygiene and dental therapy.

Draft proposal 11.1
The ADC supports this proposal.

Australian Dental Council
November 9, 2005