SUBMISSION TO PRODUCTIVITY COMMISSION

Contribution of the Not for Profit Sector

The dental profession – working for the community's oral health

The Australian Dental Association Victorian Branch Inc. (ADAVB) is pleased to present this response to the Issues Paper on the Contribution of the Not-for Profit Sector.

We welcome the study's focus on improving the measurement of the sector's contributions, and removing obstacles to maximising its contributions to society.

Broad view of the sector

ADAVB supports the broad view taken of the composition of the not-for-profit (NFP) sector in the Issues Paper.

This view aligns with the approach taken by the recent Senate Standing Committee on Economics in their report on 'Disclosure regimes for charities and not-for-profit organisations' (December 2008).

About the ADAVB

The ADAVB is one of the 147,000 Australian incorporated associations mentioned in the Senate Committee report, and we have been registered under the Associations Incorporation Act (Victoria) since 1991. The ADAVB was formed in 1928 following the merger of earlier dental organisations dating back to 1884, and now represents over 2800 members in both the public and private sectors. It is affiliated with the Australian Dental Association Inc, the federal body representing over 10,000 dentists nationally. The ADA operates as a federation of independent bodies rather than having a national structure.

Our mission statement is:
"The ADAVB is an association of dentists committed to advancing the art, science and ethics of dentistry, the care of the oral health of all Victorians and the professional lives of its members." (emphasis added)

This emphasis is added to highlight the Branch's commitment to serve the welfare of the entire community as well as the membership. This is a defining characteristic of a profession that places the welfare of patients first.

In terms of our accountability, we prepare and publish annual reports in accordance with our obligations under the Associations Incorporation Act (Vic) 1981, and in addition to lodgement with the Registrar of Incorporated Associations, copies of these are provided to the National Library and the State Library of Victoria.

Improving the measurement of the sector's contributions

The Issues Paper recognises that there are many different types of NFP organisations, and the professional association segment of the sector is a recognisable category. Within that category health professional bodies are also readily identifiable as a sub-category. Even within this sub-category, a wide variety of approaches is evident, and each tends to have a unique service profile.

Table 2 (p.10) describes a range of activities usually included within the sector. ADAVB is involved in eight of the 12 types of activities listed:

- Culture and Recreation through documentation of local dental history via an online archive and conduct of social and sporting functions for members.
- Education and professional development of members and their staff - Partnering with the Melbourne Dental School, the ADAVB is the lead provider of continuing professional development (CPD) for dentists in Victoria, and helps members meet their regulated obligation of 40 hours of recognised CPD every two years. We employ a full time knowledge management officer who is responsible for managing a dental library housed within the Branch. This person assists members in keeping up to date with the scientific evidence base for clinical decision making. Through a separate innovative partnership with the Cooperative Research Centre for Oral Health Science (CRC-OHS) based at Melbourne University, we are establishing a dental practice based research network called eviDent. This actively involves practitioners in research projects aimed at improving dental treatment, and accelerating the transfer of scientific findings into daily practice.
- Health promotion and personal support.
    - Through the engagement of an international human resource, risk management and health services company, we offer confidential personal counselling support to members.
    - Oral health promotion campaigns are conducted both directly, and in partnership with organisations like Quit Victoria, Nutrition Australia (Victorian Division) and the Cancer Council. Smoking cessation training is offered to members so they can help patients obtain

access to quit counselling. The ADA joined with the Obesity Policy Coalition and the Parents Jury to lodge a successful complaint with the ACCC against Coca-Cola regarding advertising suggesting that it was a myth that Coca-Cola rots your teeth.

- The ADAVB continues to be a staunch advocate of water fluoridation. Our advocacy and work with the Victorian Government has resulted in more than 80% of Victorians receiving fluoridated water, which is recognised by international scientific authorities to be one of the most cost effective and beneficial preventive health care initiatives.
- Notices are published on issues like swine flu for the information of members and the public.
- Another health service which may not be widely recognised is our support for the outstanding work done by forensic odontologists and the profession at large in identifying victims of disasters and crimes. In the recent Victorian Bushfires for example, where the heat of the fires destroyed much of the DNA that might have been used to identify remains, dental records were the primary source of identification for over 66% of victims. We estimate that about 90 practitioners were directly involved in assisting the Victorian Institute of Forensic Medicine on this occasion. The ADAVB worked closely with the Disaster Victim Identification team to alert members to the need to provide access to their records to assist the identification process. We have subsequently followed up affected members with offers of assistance and counselling, recognising that some had lost many patients who were also friends and neighbours.

- Environment - partnering with EPA Victoria and Victorian water boards, has resulted in ADAVB conducting the very successful Dentists for Cleaner Water project, which provides incentives for dentists to fit ISO 11 143 compliant amalgam separators in their practices to filter out mercury bearing wastes that would otherwise enter the sewerage system. This project will result in dentists spending about $7 million on capital equipment and receiving subsidies totalling over $800,000. A project manager, funded by Government agencies, oversees the scheme. With a target of 1000 practices fitting compliant devices by 2011, over 30% have already done so within nine months of the project's launch. Further environmental sustainability projects are currently being developed in partnership with the Australian Dental Industry Association, representing suppliers of dental materials and equipment. ADAVB has also worked with the water industry in educating members about the importance of back-flow prevention – dental waste flowing back into water mains.

- Advocacy on behalf of dental patients through the Victorian Oral Health Alliance (www.voha.org) and other activities and submissions. On behalf of both the public and private sectors of the profession, ADAVB makes representations to Government and agencies on a wide range of policy issues.
- Philanthropic programs within Australia such as encouraging members to donate their time to a clinic being run by the Sacred Heart Mission in St Kilda, to a Brotherhood of St Laurence Program for unemployed youth in the Frankston area and for semi-retired members to work in public clinics to help reduce waiting lists.
- International aid projects, mainly in the Asia-Pacific region. Members arranging aid trips to countries in the region are assisted with calls for materials, equipment and additional aid team members.
- Professional Association – promoting and regulating members' professional interests.
    - Guidelines are published on a wide range of matters affecting the quality and safety of dental care infection control, drugs and poisons, radiation safety, therapeutics, electrical safety, and waste management, amongst others. Both the ADAVB and ADA Inc. provide professional and industry standards.
    - Assistance is provided to hospitals and other Government funded agencies with the credentialling of dentists seeking to work in these facilities – an important safety and quality mechanism. Guidelines on credentialling and defining the scope of practice of dental personnel were prepared by the ADAVB to assist Directors of Medical Services in understanding the application of these processes to dental service providers.
    - The ADAVB offers a conciliation service to assist patients to resolve disputes with dentists over treatment.

    - Member services include newsletters which, amongst other matters, advise on regulatory compliance and emerging issues regarding the safety and quality of dental care.
    - Members are kept informed of issues, developments, and clinical matters through Group held across the State. Members in remote areas access information electronically through the Branch website and email messages.
    - Sponsorship of student visits to rural areas to promote better distribution of the oral health workforce is another example of a community service provided by the ADAVB. This further demonstrates the Branch's continuing support for regional dentistry.
    - Extensive support is provided to overseas trained dentists seeking to complete examinations to become registrable in Australia. The

ADAVB has almost 300 members in this category. Their free membership entitles them to library facilities, professional development, and mentoring and personal support. These candidates have no other form of organised support – certainly none from Government agencies, despite skilled migration programs having enticed them to come to Australia.

- New graduates are assisted to understand their entitlements as employees entering the workforce, and ethical practice is promoted from their commencement.
- Members seeking employment are brought together with others offering employment via a free employment register.
- Employer members are advised on their obligations when hiring staff, with HR services provided by a specialist third party so that the industrial and OH&S requirements are understood and met.

No Government agency could or would cover all of these functions, which are provided by the ADAVB and funded chiefly by members. The value of these roles and functions for the community has not been measured, and the present Commission research study is therefore a welcome development.

Professional organisations representing the health professions are sometimes undeservedly described as 'professional unions' or 'medieval guilds' as if they only serve the interests of their members and provide no discernable benefit to the community. This is a characterisation which we believe is profoundly unjust and unjustified. Of course professional bodies are intended to provide member benefits, and this is a key function. However the long tradition of health professional bodies is also to serve the health interests of the community, and to promote the welfare of the patients before the welfare of members. The notion of the 'social contract' is alive and well in the health professions, offering significant benefits to the community, although these are often unseen and unheralded.

Our membership spans both the private and public sectors. This fact, and our commitment to a Code of Ethical Conduct, means that we are bound to address a diverse set of concerns, including those of public dental patients and the agencies that are provided with insufficient resources to meet demand for public dental services. The ADAVB has advocated for public dental services for many years, and has demonstrated its commitment to improve the oral and general health of the Victoria community.

In mentioning the ADA Code of Ethics, we note that it has long been recognised, that "*the ethics of a profession are not imposed by legislation but self-inflicted and voluntarily accepted for the purpose of establishing and maintaining an honourable pattern of behaviour recognised by both its members and the community it serves*". (Seear, J. Law and Ethics in Dentistry, 1975, p.103)

The *Dental Ethics Manual*, published by the World Dental Federation (FDI) in 2007, notes:
"... ethics should not be confused with law. One difference between the two is that laws can differ significantly from one country to another while ethics is generally applicable across national boundaries. In addition, ethics quite often prescribes higher standards of behaviour than does the law, and occasionally situations may arise where the two conflict. In such circumstances dentists must use their own best judgement whether to comply with the law or follow ethical principles. Where unjust laws conflict with ethical principles, dentists should work individually and collectively to change the laws. (FDI World Dental Federation, Dental Ethics Manual, 2007, p.20)

Any Code of Ethics, such as ADA's Code, can only be a guide to personal judgment. The principles and values that are enshrined in the Code need to be absorbed and lived by the professional in order to have the desired force and effect. When faced with an ethical dilemma, no-one resorts to reading the guidelines in order to make their decision. They make the choice between all possible responses according to an inner compass – the product of a lifetime of experiences and learnings about right and wrong; about what works and what constitutes a mistake.

Recognition of the importance of this 'ownership' issue would be most helpful when Governments are dealing with professional groups such as dental surgeons.

Removing obstacles to maximising the sector's contributions to society

Pre-requisites for success

In terms of aligning community and professional interests, Governments need to recognise that working in partnership with professional associations offers a much stronger likelihood that practitioners will make the required commitment to meet policy objectives than using a top-down approach. This is because members have a shared sense of 'ownership' of the initiatives. If people feel that they are being dictated to by others, who have no appreciation of the complexities of their work, they will tend to resist change proposals rather than comply. Where their association makes a commitment on their behalf and puts measures in place to assist them, they will usually be more supportive.

The continued improvement in delivery of dental services over recent years needs to be acknowledged. The Australian Research Centre for Population Oral Health surveys of population dental health confirm that the present model is working effectively, and should only be augmented rather than radically redesigned. While access to care is still an issue for a significant population

group, the relative size of the group has decreased. Maldistribution of the workforce is an issue but not an overall shortage.

The turnover of Departmental officers from time to time leads to a loss of corporate knowledge. Public servants should accept offers of advice from professional associations when seemingly new initiatives are being considered that have been trialled in the past. Such action could provide savings to the public purse.

Regulation a 'blunt weapon'

Regulation should be used as a last resort and only when attempts at a cooperative approach have been unsuccessful. Inspection and compliance monitoring programs are much more expensive to administer than professional support programs, which offer practical assistance and focus on best practice. Lifting people up and shining a light on exemplars is a much stronger change management strategy than prosecuting them for failing to comply. A shared commitment to high purpose and altruism will always win over the use of fear and threats.

Where associations are not convinced of the public benefits of a policy initiative, then their views should be respected rather than immediately dismissed as self-interest.

Is regulatory reform helping?

The ADAVB has seen no evidence of any reduction in the regulatory burden its members operate under. For the dental profession, the much vaunted commitment to reducing red tape appears to be offset and overshadowed by burgeoning new federal bureaucracies associated with the forthcoming national registration and accreditation scheme, as well as practice accreditation, numerous patient safety measures, national health and hospital reform measures, consumer law reforms and national workforce taskforce initiatives. The opportunity cost imposed by this red tape continues to reduce practitioners' ability to deliver appropriate care to patients. This also applies to the operation of the association and distraction from its service commitments.

In many instances the health reforms are triggered by issues in medical services or in large institutional settings, and they have little relevance to office-based dental practice where most dental services are delivered in Australia.

We are all used to the intense cycle of consultation about new measures about one year after a new Government takes office, as reviews are concluded and reports are published. The ADAVB has found itself responding to all of the above listed reforms and more.

Some small organisations simply do not have the resources to do justice to the scale and complexity of the changes being sought by the Government. This leads to a form of paralysis in which some organisations and groups either give up on trying to cover all the dimensions of change, or worse, refuse to cooperate, because the number and frequency of the change initiatives is impractical to address. **Good change management takes people with it rather than herding them over a cliff.**

Critique of policy direction

A good example of a situation where the dental profession was opposed to Government policy direction is the Productivity Commission's support for extending the duties of ancillary providers in its research report *Australia's Health Workforce* (January 2006), which was opposed by the ADA. The Commission supported proposals from reformers like Prof Stephen Duckett, who has argued that workforce substitution was a useful strategy to address alleged shortages in various health professions. Over the next few pages we discuss this case study in contribution of a professional association to defence of the public interest.

ADA opposition to extending the duties of dental therapists has been characterised as a vested interest group being protectionist in its stance, when in fact the ADA was primarily concerned that practitioners with limited training and skill were going to be used to treat patients with complex health needs, and that those patients would consequently suffer from inadequate care.

There is a place for ancillary providers working under delegation of more comprehensively qualified care coordinators, but not where the lesser trained practitioner is made the primary provider. Such an approach will place patients at risk of harm, and be irresponsible public policy. Our opposition to workforce substitution is based on our commitment to patient welfare rather than the interests of our members.

Given that dental therapists, dental hygienists and dental prosthetists (denturists) are part of the registered dental workforce it could be argued that workforce substitution has already occurred in dentistry. These people provide treatment under delegation from dentists, which was previously only provided by dentists.

When we hear that Prof. Duckett also advocates radical reform of practitioner training so that they are not provided with the range and depth of clinical training that the profession considers necessary to ensure patient safety, makes

his workforce reform proposals anathema to the profession. His proposals that practitioners should be trained on a 'just in time' basis rather than a 'just in case' approach, and that we need a generic healthcare worker rather than well trained professionals, are considered a form of vandalism and a serious threat to patient welfare.

> *"ICT facilitated access to state of the art care paths and protocols changes the nature of the required educational preparation for health professionals. Currently, professional education is based on a "just in case" model of attempting to acquaint students with skills and knowledge to prepare them for a wider range of conditions than might possibly be faced in practice. In the future, service delivery (and provider knowledge) could be on a "just in time" basis where care protocols can guide the professional through the diagnosis and treatment process."*
> (Duckett, S. Australian Health Review May 2005 Vol 29 No 2, p.203)

It is hard for the profession to understand how a Government agency such as the Productivity Commission can give credence to these proposals, when at the same time the Government is using the Australian Commission on Safety and Quality in Health Care to promote much more stringent patient safety measures. The fundamental contradiction in these two parallel developments remains a mystery to the ADA.

We ask the Commission and the Government to recognise that when their representatives attack 'professional silos' they are perceived to be attacking professional standards and high quality care. This is reinforced when they also focus on needing to reduce the cost of care, and promote the use of lower trained operatives as substitutes for professionals.

In our view **the bodies of knowledge accumulated by health professions having focussed attention within their fields and disciplines are the basis on which Australia is able to proudly state that it has one of the best health systems in the world.**

According to an Access Economics Report (20 January 2009, prepared for the Australian Association of Pathology Practices) on Health expenditure and outcomes:

> *"To assess Australia's overall performance in terms of outcomes relative to health system costs, OECD countries were ranked 1 to 30 for each data series – expenditure relative to GDP and per capita, public share, life expectancy, PYLL and health status. Two 'summary measures' were then calculated to assess:*
> - *the 'total' score, a metric measuring the 'bang for buck' from total health spending; and*

- *the 'public' score, a metric measuring the 'bang for buck' from public health spending.*

Using these metrics, Australia has the best performance from its public health expenditure of any OECD country, and the fourth highest performance from its total health expenditure (behind Japan, Spain and New Zealand)." (pp, 3-4) emphasis added

A recent development being promoted by the National Health Workforce Taskforce appears to be related to the workforce substitution agenda. The core competencies framework project seeks to identify shared competencies that all healthcare workers should possess. This is justified on the grounds that there are common skills which patients should be able to expect from all healthcare providers. To some extent we agree with that view – especially as it relates to communication with patients, and ensuring that they are able to give informed consent to the treatment they are offered.

For any given competency in the proposed framework however, we suggest that when the Dreyfus Model (novice to expert) is applied to the various qualification levels applicable across the span of healthcare, there would be not one, but at least 35 different levels of competency (shown as levels 1a to 7e in the chart below).

	Cert III	Cert IV	Diploma	Higher Diploma	3 year Degree	5 Year Degree	Post Grad Degree
Novice	1a	2a	3a	4a	5a	6a	7a
Advanced Beginner	1b	2b	3b	4b	5b	6b	7b
Competent	1c	2c	3c	4c	5c	6c	7c
Proficient	1d	2d	3d	4d	5d	6d	7d
Expert	1e	2e	3e	4e	5e	6e	7e

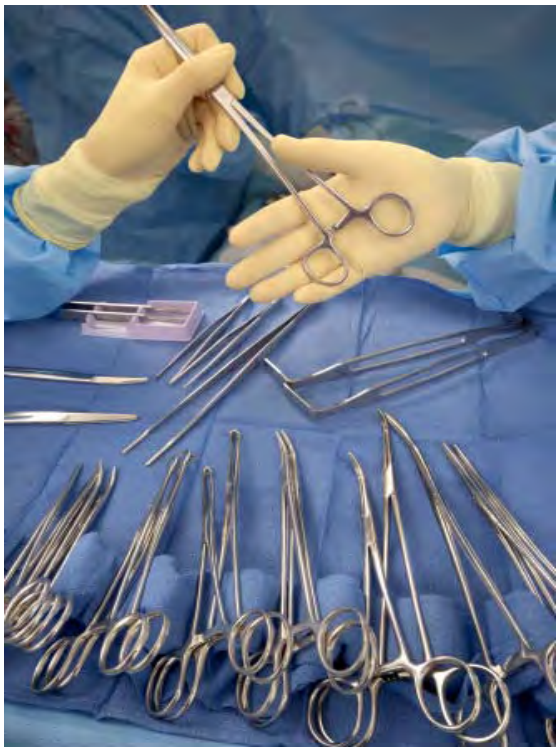
The competency framework does not so much identify shared competencies but rather agreed dimensions or domains, in which health care workers are expected to demonstrate different types and levels of competence.

Competency is a relative term. In dentistry there are various defined operatives, each of which may deal with certain common areas, but at different levels of complexity.

The degree of competency is both graded within each occupation and between occupations. An 'expert' dental therapist does not equate with an 'expert' dentist, nor would an 'expert' dentist equate with an 'expert' specialist dentist. The wheel diagram below illustrates this point.

The competence of a beginning Certificate III dental assistant cannot reasonably be compared with that of an experienced oral and maxillofacial surgeon who has worked for 30 years in their specialty having completed eight years of post graduate study and been granted dual registration as a medical practitioner and specialist dentist. This example is restricted to the range within the dental discipline and does not even venture to compare the difference in levels of competency in the same domain between practitioners in unrelated fields e.g. pharmacist and dental technician. Shared competencies are a nonsense at this level.

Suggestions that workforce substitution can be advanced by identification of core competencies need to be exposed for being irrational and impractical.



On the one hand we have the community, media and the courts demanding that greater specialisation and skill training is evident in our health service delivery so that we avoid adverse and sentinel events, and on the other we have Government agencies and Ministerial Councils seriously suggesting that the rich and highly articulated bodies of knowledge in each of the health professional fields are troublesome silos that need to be done away with in the interests of 'flexibility' – not public safety.

A practitioner's 'flexibility' within a field requires the highest level of training across all detailed areas of content, rather than the most basic training. Therefore, the most flexible healthcare workers are not ancillary personnel. They are professionals, because their training has prepared them to be adaptable to a wide range of circumstances and patient needs – including those they have not encountered before. This training allows them to follow the path of an accepted clinical care protocol - without a textbook or a website to guide them.

Dental Treatment Fields and Levels

* General practitioner dentists are trained to diagnose and provide treatment across all fields, and to a quite complex level.
* Dental specialists do advanced training to deal with extremely complex work within a narrow field.
* Ancillary dental providers are trained to do basic diagnosis and provide basic treatment in only some aspects of dentistry.

Volunteer workforce

ADAVB's Council and Executive Committee meet once every six weeks (3.5 hours on average) and we estimate that these elected members spend at least three hours between each meeting on Branch business. This equates to 23 people by 6.5 hours by eight meetings – a total of 1196 hours or 31.47 person days.

The ADAVB has 12 standing committees and five ad hoc committees on which a total of 160 members provide honorary service. They each meet on average once every two months for about 2.5 hours and members will generally spend an average of around 1.5 hours on committee work between meetings also. We therefore estimate that our volunteer workforce each contributes an average of 24 hours per annum of their time to association business. This totals 3840 hours or 101 person days before any account is taken of time spent preparing seminar presentations, contributing to aid projects and mentoring colleagues.

This time commitment is dwarfed by the wider contributions dentists make on an honorary basis. Dentists voluntarily perform the roles of editors, authors, seminar presenters, clinical demonstrators and honorary lecturers at dental schools, book reviewers, accreditation panel members, credentialling panel members, mentors, and many others. The skills gained in such voluntary work further support the community when dentists utilise their skills for the benefit of community groups such as school councils, sporting organisations, service clubs and societies. Our society depends on these voluntary contributions to be able to receive quality dental services. This professional contribution to society is too frequently overlooked when politicians or public servants suggest that professional associations are self-interested organisations.

Constraints on Innovation

The establishment of the dental practice based research network noted on page 2, is an example of a highly worthy innovation constrained by a lack of suitable seed funding.

Research grant bodies are looking for a strong research track record so a start-up venture with a sound approach is unlikely to gain funding when they are competing against long established research institutes and university personnel. They will therefore struggle to get through the development stage and move into full implementation.

We note that funding such as that provided through the Victorian Community Support Grants does not appear to be available to support a professional body like the ADAVB to build the capacity of a professional community to undertake research projects that will ultimately build better dental services for the benefit of the entire community.

We respectfully suggest that innovation grants or skill development grants should be made available to assist the NFP sector to make even more effective contributions to the public good.

ENDS

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