

14 May 2018

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Dear Dr Lockwood

**Re: Consultation on a proposed revised Scope of practice registration standard and Guidelines for scope of practice**

**Executive summary**

The Australian Dental Association (ADA) supports Option 1. The ADA objects to all of the elements of Option 2 for the following reasons:

a. [Remove reference to programs to extend scope:](#)

Dental Board of Australia (DBA) must make clear that CPD cannot be the vehicle from which a practitioner can broaden their scope of practice beyond the core knowledge and skills that were based on the initial qualification(s) leading to registration and the division of their registration. If allied dental practitioners (ADPs; i.e. dental hygienists, dental therapists, oral health therapists, and dental prosthetists) are enabled to expand their scope of practice their education must be equivalent, both in theory and clinical assessment, to a dentist. Option 2, as currently outlined on this issue, does not do this. Ultimately, the DBA should adopt the full specified scope of practice for each ADP as outlined by the ADA's 2013 submission on the review of the Scope of Practice Registration Standard (SoP RS).

b. [Clarify expectations around education, training and competence:](#)

The ADA does not support this approach. It is inconsistent with the DBA's stated intentions to remove the add-on programs to extend scope and to have a practitioner's potential scope of practice to be delineated by their initial qualifications that formed the basis of their registration, their division of registration and their competence in the skills within those. The intention of CPD is to provide further skills of treatment modalities within the broader confines of the qualification and the practitioner's division of registration.

c. [Remove the requirements of 'independent practitioner':](#)

d. [Remove the requirement of a structured professional relationship:](#)

The consultation paper outlines a number of perceived problems with the SoP RS which Option 2, to remove the restriction on independent practice of allied dental practitioners (ADPs; i.e. dental hygienists, dental therapists, oral health therapists, dental prosthetists) and the requirement for them to work in a structured professional relationship (SPR) with a dentist, claims to address. The following table outlines the myths and facts surrounding the consultation paper's discussion of these problems and the extent to which Option 2 proposes to rectify them.

<b>Myth</b>	<b>Fact</b>
Dental treatment will cost less for patients	Nil evidence in Australia nor overseas. Most overseas models of ADP independent practice show little if any cost reduction
Patients will have increased access to dental care	The ADA is unaware of examples where there was not already an existing dentist providing services. Despite ADPs being able to own a practice and maintain an SPR have not set-up a practice in areas where there are no existing dental services, little alone in remote and very remote regions
ADP currently cannot treat patients to their full scope of practice	Both public and private practice enable ADPs, if working to a prescribed treatment plan, to practice to their full scope without the dentist being on the premises. The SoP RS preserves full autonomy of all dental practitioners within their scope of practice, provided they work in a SPR with a dentist trained in the full range of dental diagnosis, assessment and treatment modalities. The SPR ensures there are no gaps in patients' assessment or treatment
SPR causes confusion	No evidence SPR have caused confusion
Scope of practice for ADPs is well defined	Significant confusion as the DBA refuses to list duties of care for various categories of ADPs that fall in their scope
Removing the restriction on independent practice for ADPs will alleviate workforce shortages	The Health Workforce Australia <i>Health Workforce 2025 – Oral Health</i> report irrevocably refutes a dental workforce shortage. The report indicates there will be a dental workforce oversupply until at least 2025
ADPs will increase after-hours access to dental treatment for patients	Nil evidence in Australia
There is public demand for independent practice for ADPs	Nil evidence in Australia

The ADA strongly questions the basis on which Option 2 proposes removing the requirement that ADPs work in a SPR with a dentist. While the consultation paper makes reference to Recommendation 2 in the HWA *Scope of practice review oral health practitioners* report (HWA OHP report) that the SoP RS be reviewed to remove the bar on 'independent practice' in five years, the consultation paper has selectively omitted HWA Recommendation 1 which states:

*The Dental Scope of Practice Registration Standard be reviewed to remove "supervision" from clause 6 and the definition in the Standard and incorporate changes as follows:*

*Dental hygienists, dental therapists and oral health therapists exercise autonomous decision making in those areas in which they have been formally educated and trained. **They may only practise within a structured professional relationship with a dentist.** They must not practise as independent practitioners. They may practise in a range of environments that are not limited to those with on-site dentists.*

*The Dental Board of Australia in its review should also consider providing definitions of "autonomous decision making", "structured professional relationship" and "independent practitioner" to provide a greater level of clarity for oral health practitioners.*

HWA's recommendations – which have been subsequently reflected in the current SoP RS – state that ADPs may only practise within a SPR with a dentist and must not practise as independent practitioners. **None** of the HWA OHP report's recommendations suggest reviewing the SPR requirement.

The SPR provides a transparent mechanism from which ADPs, with varying levels and types of education and training, can clarify their scopes of practice that enables each dental practice to define the level and kind of support provided by a dentist. Should both the restrictions on ADP independent practice, and the requirement for ADP to work in a SPR with a dentist be removed, Option 2 would remove the obligation for all dental practitioners to have in place detailed, practice specific clinical governance arrangements. This will create unnecessary risks to the quality and safety of dental care.

## Overview

Thank you for providing the ADA with the opportunity to comment on DBA proposed revised Scope of Practice Registration Standard (SoP RS) and Guidelines for scope of practice (proposed changes/the proposal).

The ADA is extremely disappointed the DBA is proposing such a direction given there is no evidence presented to suggest the current system is failing to protect public safety nor has any attempt been made by the DBA to source such evidence.

The DBA's consultation paper puts forward a number of arguments some in support of the proposed changes. However, the validity of some of the arguments is questionable. The ADA supports Option 1 – maintain the status quo for the reasons outlined in this submission.

As noted in the consultation paper, the DBA undertook a review of the SoP RS in 2013 and included changes to incorporate the recommendations from Health Workforce Australia's (HWA) report from the *Scope of practice review oral health practitioners* report. This included removal of supervision requirements for dental hygienists, dental therapists, and oral health therapists and strengthening of the requirements for a team approach to dental care. Notwithstanding the lack of evidence underpinning the recommendations in the HWA report, the ADA believes the inclusion of references to the requirement that allied dental practitioners (ADPs; i.e. dental hygienists, dental therapists, oral health therapists and dental prosthetists) work within a structured professional relationship (SPR) with a dentist will ensure public safety. Once introduced, this was supported and widely advocated by the ADA.

The DBA states there is now a need to incrementally change the scope of practice requirements of dental practitioners to meet the objectives and guiding principles of the National Scheme which include: protection of the public, facilitation of access to health services and enabling a flexible, responsive and sustainable workforce. The consultation paper explicitly states it is because of these principles that changes to the registration standard are required yet it does not provide the evidence to support its proposals.

Prior to the ADA responding to the four main changes proposed by the DBA, it would like to register considerable disappointment with the manner in which this consultation has been conducted.

The ADA was made aware there was a confidential process on a revised scope of practice standard for dental practitioners ahead of a public consultation. When an enquiry by the ADA was made to the DBA as to the process of consultation, the ADA was advised it was an 'internal' consultation only. However, in late 2017 the ADA became aware this 'internal' consultation included parties external to the DBA and the Australian Health Practitioner Regulation Agency (AHPRA), namely other dental practitioner peak bodies and jurisdictional health departments.

As you are well aware, the ADA is the peak body representing dentists in Australia. Dentists operate around 7,500 dental practices across Australia where approximately 85% of all registered dental practitioners practise and provide about 83-85% of the total dental services in Australia. State dental directors, who we believe were part of the 'internal consultation', are only responsible for the delivery of 15% of dental services in Australia. The proposal seeks to change the underpinning structure that supports an existing collaborative, team-based approach to providing quality safe dental care. For the preliminary consultation of such a proposal to not seek input from the ADA or dentists (the only practitioner within the dental team that has undertaken the training and education covering the complete breadth of dentistry and oral care), raises strong doubts about whether its proposals would have any benefit whatsoever to existing dental team arrangements and would maintain the current excellent safety and quality of patients' oral care.

In spite of this, the ADA urges that the DBA gives due consideration and weight to this submission, which reflects the views of the vast majority of dentists, dental practices and registered dental practitioners in Australia.

The ADA's survey of its members on the DBA's proposal received 6,733 responses – i.e. almost 40% of registered dentists in Australia. An overwhelming 93% majority said they **did NOT support the proposed changes** (6,257).

## 1. Remove reference to programs to extend scope

The ADA supports this proposal as the DBA acknowledges:

*The demand for these programs has decreased over time with the content of these programs largely incorporated in the approved programs of study leading to registration.*

However, the ADA believes the following statements are ambiguous and contradictory and urges the DBA to provide greater clarity around its intended role for CPD.

The consultation document states that:

29. For these reasons, the Board proposes to remove reference to Programs to extend scope from the registration standard and guidelines giving effect to the Board's decision to phase out the approval process of these programs, and for these programs to be continued to be delivered as continuing professional development. The Board proposed that moving forward, dental practitioners wishing to **"broaden their knowledge, expertise and competence"** may do so by completing CPD. All dental practitioners are required to undertake CPD activities and/or to attend CPD courses that comply with the Board's CPD registration standard and guidelines. Dental practitioners are expected to self-assess whether their selected CPD activities/courses provide them with the sufficient clinical experience **to incorporate a new procedure/technique/treatment into their clinical practice.**

...

30. All dental practitioners must only perform those dental procedures for which they have been educated and trained and in which they are competent, as per the registration standard and the guideline. Dental practitioners who are not educated and trained to perform a certain treatment cannot undertake that type of treatment. However, they can obtain the required skills and knowledge through CPD programs, relevant to core knowledge and skills based on the initial qualification(s) leading to registration and the division in which they are registered.

...

32. Education providers wishing to deliver programs to extend scope of practice may consider delivering these courses as continuing professional development. The Board strongly encourages education providers to develop and deliver CPD programs in line with the Board's registration standard and guidelines on CPD, the Board's scope of practice registration standard and guidelines and the Code of Conduct.

(ADA highlights and bolding)

The first highlighted section appears to imply that attempts to broaden scope can occur via CPD.

However, para 30 of the DBA's proposal states that further CPD on treatment modalities can occur so long as they are "relevant to the core knowledge and skills based on the initial qualification(s) leading to registration and the division in which they are registered".

That is to say it is the original qualifications of an approved programme of study that sets the foundation of education. Training that, coupled with the relevant division, defines the potential field of the scope of practice for that type of practitioner. CPD in turn can provide additional education and training within that field.

Para 32 appears to contradict the previous definition and is contrary to the DBA's *CPD Guidelines* which states: "CPD programs alone cannot be used to increase scope of practice". The DBA's suggestion that education providers offering CPD programs should only offer programs in line with the DBA's Registration Standard and Guidelines and the Code of Conduct in the absence of some form of accreditation process for CPD programs is neither practical nor useful.

The DBA must make it clear that CPD cannot be the vehicle from which a practitioner can broaden their scope of practice beyond their core knowledge and skills based on initial qualification(s) leading to registration and the division of their registration. In other words, the DBA must not allow for CPD to enable ADPs to perform procedures that were not part of their core foundational qualification; that is, it cannot be a means to bypass

formal education so they may be able to perform procedures that only a dentist has had the required training to safely perform. Furthermore, if the clinical governance arrangements, which involve ADPs working in a SPR with a dentist are removed as recommended in the proposal, there would be no clinical oversight or supervision of the clinical application of such CPD by ADPs which would increase risk to patients.

In contrast, the United Kingdom (UK) model defines which scopes can be expanded with additional CPD; however, more importantly, with approved courses and within approved areas of practice.

This highlights the inadequacy of the existing scope of practice documentation. Overseas ADPs that have independent practice must have a collaborative agreement in place with a dentist and most restrict how many such agreements can be held by a registered dentist. The confusion is compounded by lumping all registered dental care providers in Australia as dental practitioners. This creates significant confusion for the public as they have no idea which registered dental provider is actually providing the service; i.e. a dentist or an ADP. The ADA is not aware of any other country that has registration for dental providers all lumped as 'dental practitioners'. In the United States (US) they are referred to as 'Mid Level Providers' (MLP) and in the UK each registrant's functions are specified.

The ADA strongly advocates returning to previous definitions of registrants with complete protection of title of each registrant. This offers the maximum protection and clarity for the public.

Further, the ADA is not aware of any other country in which independent practice for ADPs exists where their registration is not accompanied by a specified scope of practice. The current DBA scope of practice for dentists and ADPs has no such specific scopes listed. Ultimately, the scopes of practice should list what each registrant is permitted to perform. It should describe the areas that a practitioner with the knowledge, skill and experience can practice safely. Both US and UK models of registration do this. This current review offers the opportunity to implement such descriptions of scope of practice and enhance public knowledge of permitted services by each level of registration which can only enhance patient safety. It also protects ADPs knowing their registrable scope of practice. **The ADA insists that if ADPs are enabled to expand their scope then their education must be equivalent to that of a dentist, both in theory and clinical assessment.** The DBA demands the capacity of overseas trained dentists to display that their competency to practice is equivalent to that of an Australian trained dentist and any lowering of this demand for ADPs is both hypocritical and a danger to the public.

The ADA's response to the DBA's 2013 review of the SoP RS stated:

#### Dental Hygienists

*As part of the dental team dental hygienists provide oral health assessment and limited examination, treatment, management, and education for the prevention of oral disease to promote healthy oral behaviours to patients of all ages. This includes periodontal/gum treatment, preventive services and other oral care. Dental hygienists may only work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental hygienist to be registered is a minimum two year full time or dual-qualified three year full time formal education program.*

*The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.*

*Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:*

- Such treatment plan shall be effective for not more than twelve months; and*
- The need for examination of the patient by the dentist after completion of the treatment plan by the dental hygienist will depend on the needs of the patient, the treatment provided and the experience and competency of the dental hygienist.*

*The range of duties which a dental hygienist is permitted to perform include:*

- a. Established procedures associated with chair side assisting and practice management;*
- b. Oral health education;*
- c. Instruction in monitoring and recording of plaque control routines and recording of periodontal disease;*
- d. Prophylaxis;*
- e. Polishing of restorations;*

- f. Fluoride therapy, application of remineralising solutions and desensitising agents;
- g. Debridement to remove supragingival deposits from teeth;
- h. Debridement to remove subgingival deposits from teeth;
- i. Application and removal of rubber dam;
- j. Application of non-invasive fissure sealants;
- k. Taking of alginate impressions other than for the fabrication of prosthetic appliances;
- l. Removal of periodontal packs;
- m. Taking of dental radiographs;
- n. Orthodontic band sizing;
- o. Removal of orthodontic appliances including orthodontic cements and resins;
- p. Placement and removal of non-metallic separators and alastic modules; and
- q. Administration of local anaesthesia by infiltration and mandibular nerve block.

#### Dental prosthetists

Dental prosthetists work as independent practitioners in the assessment, treatment, management and provision of removable dentures; and flexible, removable mouthguards used for sporting activities. The education requirement for a recent graduate dental prosthetist is a three-year full time formal education program (including a dental technician course).

Dental prosthetists who are formally educated and trained in a program of study approved by the National Board. They may construct various types of intra-oral appliances, and may only provide removable prostheses for the purposes of replacing missing teeth, and mouthguards for protection against sporting injuries. They may construct, but not provide prostheses supported by implants. This is due to the clinical issues which are beyond their scope, and which are implicit in the training of dentists.

The range of services which a dental prosthetist may provide include:

- a. fabrication, maintenance and repair of complete and partial dentures;
- b. fabrication of mouthguards, occlusal splints, medicament trays and stents; and
- c. fabrication of appliances used in orthodontics, oral and maxillofacial surgery and other special areas of dentistry.

#### Dental therapists

Dental therapists provide oral health assessment, treatment, management and preventive services for pre-school and school aged children. This includes a limited range of restorative treatments, primary tooth removal, additional oral care and oral health promotion. Dental therapists must only work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental therapist to be registered is a two year full time or dual-qualified three year full time formal education program approved by the Board or recognised as equivalent by the Australian Dental Council.

The range of duties which a dental therapist may perform should be restricted to prevention of dental diseases and control of dental caries in school children namely:

- a. Established procedures associated with chair side assisting and practice management;
- b. Oral health education;
- c. Oral health examination;
- d. Taking of dental radiographs;
- e. Application and removal of rubber dam;
- f. Pre- and post-operative instruction;
- g. Irrigation of the mouth;
- h. Fluoride therapy, application of remineralising solutions and desensitising agents;
- i. Debridement to remove deposits from teeth;
- j. Taking of alginate impressions other than for the fabrication of prosthetic appliances;
- k. Application of fissure sealants;
- l. Direct coronal restoration of primary and the permanent teeth of school children;
- m. Pulpotomies in vital primary teeth;
- n. Administration of local anaesthesia only by infiltration and mandibular nerve block; and

o. Forceps extraction of primary teeth under local anaesthesia.

#### Oral health therapists

Oral health therapists are dual qualified as a dental therapist and dental hygienist and can provide the range of services as detailed for these personnel. However, the core of their education and knowledge is based in oral and public health promotion.<sup>1</sup> They must only work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for an oral health therapist to be registered is a three-year full time bachelor degree formal education program.

The ADA supports the use of all members of the dental team in the provision of services to patients and therefore recommends that the Board does not include a definition of dentistry in the Standard.

#### Definition of dentistry

The ADA does not support any reference to a definition of dentistry within the Standard or Guidelines.

The definition of restricted dental practice was included in section 121 of the National Law to ensure that only registered practitioners can perform these acts. However, the practice of dentistry is broader than the list of restricted practices referred to in the National Law.

The ADA believes that a definition is not required as it is important that dentistry continues to encapsulate the wider scope of dental practice and the potential for growth and development of the profession in response to changing models of care, new technologies, treatment modalities and the burden of oral disease. Secondly, to have a definition that applies to ADPs does not reflect the restriction in their scope of practice.

Furthermore, to place a definition in the Standard may potentially restrict the utilisation of other dental personnel. For example, dental assistants with Certificate IV qualifications are skilled in the application of dental radiography and digital dental photography techniques. The inclusion of the proposed definition of dentistry in the Standard would not permit this and may therefore have unintended consequences beyond the registered dental practitioner workforce.

The ADA supports the use of all members of the dental team in the provision of services to patients and therefore recommends that the Board does not include a definition of dentistry in the Standard.

However, in the alternative scenario if the DBA does not adopt these recommendations, the ADA urges that Option 1 should be adopted.

## 2. Clarify expectations around education, training and competence

The DBA's proposal to clarify expectations around training and competence states:

*38. The Board proposes to amend both descriptions to make its expectations clear in regard to adult scope. Dental therapists and oral health therapists need to self assess their individual scope of practice in respect of their individual education and training. **Dental therapists and oral health therapists, who are currently not educated and trained to provide dental therapy treatment to adult patients, cannot undertake this type of treatment. However, they can obtain the required skills and knowledge through CPD programs, by building upon their core knowledge and skills that they have developed through their initial qualification(s) leading to registration.*** (ADA bolding and underlines)

The ADA does not support this approach because it is inconsistent with the DBA's stated intentions to remove the add-on programs to extend scope and to have the initial qualifications of that practitioner and their division of registration to delineate the field of the potential scope of practice for that practitioner. CPD intention should be to provide further skills of treatment modalities within the broader confines of the qualification and the practitioner's division of registration as per ADA comments above for Section 1.

The proposal outlined above is essentially the DBA's attempt to address the variance in ADPs' education and training courses in terms of the types of dental therapy/hygiene treatment modalities that can be applied to patients of certain age groups. Accordingly, this approach that CPD can cover any 'gaps' that may exist from the initial qualification that leads the (ADP) practitioner to be registrable directly contradicts the intention of the DBA's proposal to phase out add-on programs as well as the stated rationale for that approach; being that such

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<sup>1</sup> Ford PJ, Farah CS. Oral health therapists: what is their role in Australian health care?; *Int J Dent Hygiene*. DOI: 10.1111/j.1601-5037.2012.00564.x

initial qualifications and the respective dental practitioner division the person belongs to sets the overarching field on which they can define their scope of practice.

Where there are differences between the education, skills and training provided by dental practitioner's foundational qualifications that need rectifying and more consistency moving forward is desirable, this should not be done by the proposed changes but through broader accreditation processes. CPD, which has no overarching accreditation framework to ensure this consistency, is not the appropriate means to address potential gaps between the qualifications of one practitioner compared to another like practitioner. Such expansion of scope should only be accessible through programs provided by suitable tertiary institutions and accredited by the Australian Dental Council.

### **3. Remove the requirements of 'independent practitioner'**

The DBA proposes removing the 'bar on independent practice' in the SoP RS on the basis that the practice requirements related to independent practice has been a source of confusion. The consultation paper refers to feedback from stakeholders as suggesting that the requirement has "little meaning in contemporary dental practice and restricts the flexibility of the e-healthcare models which are reflective of the needs of the population". The ADA represents more than 15,000 registered dentists, more than half of whom are dental practice owners; to the best of the ADA's knowledge, dental practice owners have not been consulted, so the ADA questions the validity of the 'stakeholder feedback'.

There is no evidence to support the claim that the current model restricts the flexibility of e-healthcare models. The ADA questions exactly what dental healthcare service the DBA is referring to under its reference to e-healthcare. At this point in time dentistry has not been included in the My Health Record programme nor has there been an any indication it will be in the near future. Changes in registration standards cannot be made based upon assumptions on a set of circumstances that do not exist.

Contemporary private dental practice is not confused under the current SPR model other than confusion caused by the DBA's refusal to define and list the services within ADPs' scope of practice that they can perform. Instead of clarifying the issue, the DBA will create much greater confusion under the umbrella of enabling ADPs independent practice and via the reflective self assessment which would not improve the safety of the public. Ultimately, the DBA should list the scopes of practice each ADP can perform as have other overseas jurisdictions.

The DBA also suggested in the consultation paper that the low number of notifications related to ADPs supports the view that it is appropriate to remove the restriction on them from working independently. The ADA would argue that these findings irrevocably indicate that the current requirement for ADPs to work within a SPR relationship with a dentist is working well and is likely to be the reason why there are low notifications lodged against ADPs. There is absolutely no evidence provided in the consultation paper to justify the removal of the reference that ADPs must not practice as independent practitioners nor the requirement that they operate within a SPR (the latter will be discussed in more detail below). This proposal ignores the primary purpose of national health practitioner registration – ensure the protection of the public – and seems more about responding to pressure from certain stakeholders putting personal interests ahead of public safety and best clinical practice. Other than countries that have total government funded dental care, the ADA is not aware of any other jurisdiction where ADPs can practise without some form of collaborative agreement with a dentist that contain supervision aspects within those agreements. Most states in the US with independent MLP even have specifically defined supervision categories. The ADA does not advocate such specific definitions as the current SPR adequately encompasses both the collaborative and supervision aspects required to protect the public.

Please note the reasons the ADA does not support removal of the requirement of a SPR outlined below also apply to why it is not appropriate that the DBA remove the bar on independent practice for ADPs.

### **4. Remove the requirement of a structured professional relationship**

As stated above the ADA opines that the proposed changes:

- i. Are based on a poorly misunderstood understanding of the roles, qualifications, and competencies of ADPs in the dental team that are defined by their education and qualifications as well as legal requirements;

- ii. Fail to recognise that SPRs efficiently address the difference in individual ADPs' skills and education underpinned by the varying kinds of qualifications they have obtained; and
- iii. Will not improve access to care or lower costs of treatment for patients.

In other words, patients risk not having their treatment needs comprehensively assessed and treated nor will they receive increased access to dental care were the DBA's proposed changes implemented.

- i. [The role of ADPs as a dental team member means they should work in the dental team and have a corresponding clinical governance relationship with a dentist](#)

The DBA's proposal does not adequately recognise that all ADPs, dental hygienists, dental therapists and oral health therapists have distinct roles in the dental team. ADPs are educated and trained to perform a subset of all procedures that a dentist can do; their scope is a subset of dentistry, not all of it. This is why it is crucial that clinical governance arrangements, provided by a SPR, require that ADPs work under supervision and the support of a dentist.

To use one example, the skill set of an oral health therapist after three years of university training, and a dental student after three years at dental school are not the same.

Typically, a student dentist at the end of their third year can perform:

- Dental examinations for routine conditions (however, oral health therapists cannot diagnose and treatment plan complex cases);
- Take X-rays (however, oral health therapists cannot not to interpret cone beam image sets);
- Perform all types of intra-coronal restorations, to remove deciduous teeth where it is a simple extraction (however, oral health therapists can only perform some of these); and
- Treat all forms of periodontal disease (however, oral health therapist can only treat less severe periodontal disease, where surgery is not required).

Only student dentists' education and training, not those of an oral health therapist, enables the former to:

- Interpret a complex medical history including the medicines used by patients;
- Diagnose complex oral conditions;
- Read a cone beam image set;
- Undertake endodontic treatment;
- Place more complex types of restorations including those with layering;
- Understand how to select dental materials and how they work;
- Design a partial denture (and wax up dentures, make special trays etc);
- Manage a medical emergency; and
- Determine what dental procedures require advanced radiology, conscious sedation or general anaesthetic.

This difference arises because what oral health therapists study during their three years of university is not the same as a student dentist. There are some overlaps and shared content in first year, but student dentists cover topics in their third year that are not in the curriculum for oral health therapists, such as:

- Advanced biosciences including immunology, microbiology, physiology and pharmacology;
- Surgical anatomy of the head and neck;
- Oral medicine;
- Advanced radiology;
- Endodontics and dental trauma;
- Removable prosthodontics;
- Oral and maxillofacial surgery; and

- Prescribing drugs and medicines.

Then, during their fourth year, student dentists study complex periodontal therapy, dental implantology, surgical periodontics, maxillofacial surgery, oral medicine, paediatric dentistry, special needs dentistry, molar endodontics, fixed prosthodontics, occlusion, and orofacial pain. Lastly and most importantly, across their fourth and fifth years, student dentists develop their skills in comprehensive treatment planning, learning how it all inter-relates.

The roles, skills and training of the members of the dental team are definitely not the same. When the concept of oral health therapists was developed, a key consideration was bolstering the preventive and health promotion components of this new team member – adding to rather than replacing dentists. Oral health therapists within the team can help drive a shift towards disease prevention, because the vast majority of dental disease is potentially preventable. Therefore, oral health therapists and all ADPs work will be the most effective provided that they continue to work under clinical governance requirements within a dental team that enables dentists to provide supervision and support where required.

The education and training of ADPs recognises that they are not being trained in the full range of dental diagnosis, assessment and treatment modalities and accordingly require that they work collaboratively with a dentist who will ensure that there are no gaps in patients' assessment or treatment. This fundamental outcome is being ignored by the DBA proposed changes and the inherent safety of the patient and the delivery of the highest standard of dental care possible is being abrogated. The requirement for an SPR is the mechanism to not only define the dental team and its clinical governance processes, but implement arrangements that reflect local practices' and dental practitioners' circumstances (such as the variation in the type of education and qualification that an ADPs may have obtained – this point will be further discussed below). Allowing ADPs independent practice as proposed will effectively remove a structure that will create potential, unnecessary safety and quality risks to patients. The proposal will weaken the collaborative team approach that exists within dentistry, reduce workforce flexibility and will risk adverse patient health outcomes. The DBA has provided no evidence that there is guaranteed overall cost benefits to patients. Overseas reviews have failed to substantiate widespread savings and in some cases there have been increased costs to patients. Despite claims that independent practice of ADPs would improve access to dental care in remote regions this has been an abject failure. Many states in the US have realised that the access to dental care in remote regions has not improved.

The DBA's proposed changes have not adequately recognised the regulatory and legal restrictions on ADPs activities that are based on the fundamental difference between a dentist and ADPs in the dental team; such as laws regulating that only dentists can prescribe drugs and perform skin penetration. Allowing ADPs independent practice and removing the requirement of an SPR increases the risk that ADPs may practice far beyond what is not only legally permitted, which also creates risk to patient safety.

ii. [SPR ensure public safety and quality of dental care by addressing the variation in ADPs' education and training](#)

ADPs such as dental therapists, dental hygienists and oral health therapists are not a homogenous group. Their qualifications range from Advanced Diplomas (AQF6) through to Bachelor Degree (AQF 8). A SPR with a dentist ensures that those with lower level qualifications are suitably supervised while allowing those with the competencies and skills to work to a higher scope of practice do so in the knowledge that a registered dentist is available to support them. The proposal to remove the requirement for an SPR would not fill the gaps associated with ADPs' variations in their level and types of qualifications; this in turn increases risks to patient safety and quality of treatment. An SPR reinforces the collaborative, dental team approach by requiring documented and articulated supervision which will no longer be required by the DBA proposal. Removing the requirement for a SPR and removing the limitation that does not permit an ADP to independently practice effectively institutes a 'one size fits' all approach that deems those ADPs who have lower AQF qualifications to effectively be able to practice without a requirement they be accordingly supervised and supported by a dentist. The DBA proposal exposes patients to inappropriate levels of risk.

SPRs provide a framework that ensures appropriate referral pathways are clearly delineated and that collaboration – a key practice that ensures patients receive the best and safest possible care, occurs. The current SPR model ensures that ADPs are supported by dentists, who are the only dental practitioner trained to assess the patient's medical status and have the background knowledge in general medicine and pharmacology to determine how treatment can be provided safely for those with complex medical and dental conditions. Dental

treatment, involving invasive and irreversible procedures (including administration of local anaesthetic) has a significant risk profile which would be further heightened should the DBA remove the requirement for ADPs to work in a SPR with a dentist be removed as well as remove the bar on ADPs being independent practitioners.

Appropriately, the requirement for an SPR allows for the scope of practice of individuals to fall under the clinical governance arrangements of the practice at an individual capability level. It is an elegant means to address not only the variation in the qualifications, skills and competency that underpin each ADP's practice, but also to clarify the particular level of supervision that support dentists will provide in each case. It encourages a true team approach to patients' dental care. Australia has seen dental therapists, dental hygienists and oral health therapists all work in the same practice in a collaborative manner under the current SPR and overseas experiences also reflect this.

Therefore, the DBA's proposed changes are unnecessary given that the current system is working well and is considered best practice internationally. There is no evidence nor calls from the community indicating that the current system is not working adequately in terms of safety or quality of care. The minimal number of complaints and notifications against ADPs outlined by the consultation paper show that the current system works. SPR requires the dentist to work with ADPs in a manner where the former provides clinical guidance on the dental procedures that can be performed, based on the latter's individual education, training and competence. There already exists an incentive for dentists to work to ensure that hygienists, therapists and OHTs use their full scope within the existing registration standard. The more ADPs can do, the more patients can be seen and treated by the practice which is in the interests of patients and the practice safety and care standards.

The positive recommendation that the DBA should be promoting, that would benefit all SPRs would be the detail the scope of practice of each dental practitioner type as outlined in the ADA's 2013 submission on the last review of the SoP RS, extracted under Section 1 above. This is a position supported internationally and would remove any confusion or ambiguity and will provide greater clarity for the ADC's accreditation activities.

### iii. [Access and costs of dental care will not be improved](#)

The consultation paper argues that the proposed amendments to the SoP RS will "facilitate access to services" but makes no reference to how these changes will result in increased access or provides any evidence to substantiate such claims. The ADA is of the view that there is no available evidence to support such claims.

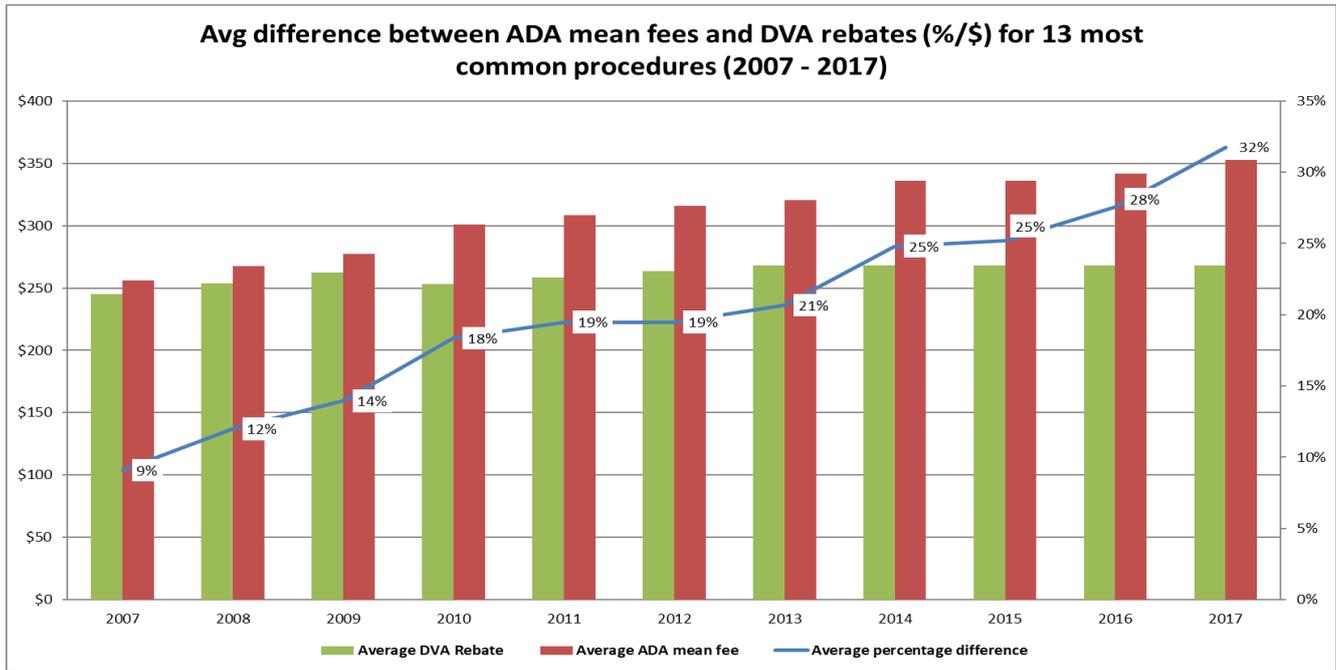
The argument that ADPs will provide services cheaper has not been demonstrated and we reiterate that prosthetists previously used this lower cost and improved dental care access to remote and very remote regions. Prosthetists also publicly suggested that services would cost 20% less than dentists for the same service and they would be able to provide those services.

Chart 1 below shows that the Department of Veterans' Affairs dental fee schedule are on average over 30% lower than average private practice dentists fees. In spite of this, dentists have continued to participate in this program to support veterans. However, since their claims of lower fees, prosthetists have effectively reneged on the cost benefits they said would accrue, campaigning for fee parity with dentists. Private health insurers have also reported that average fees charged by prosthetists have not been lower than those of dentists.

The Australian evidence is that despite prosthetists stating as part on their mantra that they could provide removable prosthetic appliances cheaper than dentists, they now charge equivalent or higher fees and lobby for parity in fees to dentists in publicly funded schemes.

Furthermore, very few prosthetists practise in remote regions (see Chart 2 below). Independent practice for prosthetists has not resulted in increased workforce supply of those practitioners in remote regions and ADA would opine this would similarly be the case for ADPs in Australia. This experience has also been reflected in several states in the US, that is that increased remote area access to care and lower fees have not eventuated.

Chart 1



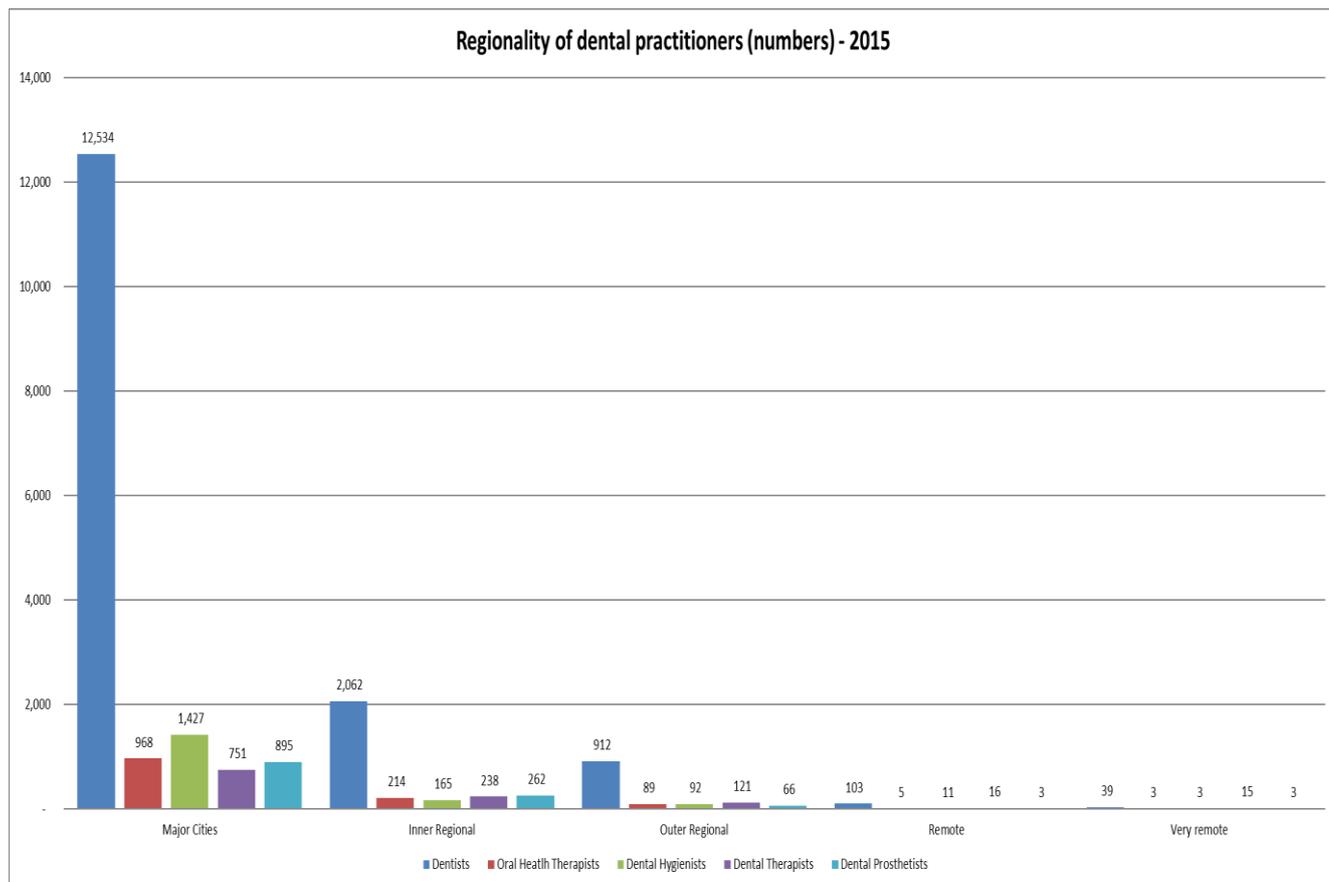
The DBA's primary function is to protect the public within the context of the national registration and accreditation scheme. Within this scheme, the DBA is required to consider the potential flow on effects of its decision on other health professional groups included in the scheme. The requirement for structured collaborative care arrangements is embedded in the registration of nurse practitioners and midwives and the changes proposed by the DBA have the potential to have far reaching consequences on these other professional groups. Similarly, there is currently a requirement for enrolled nurses (Division 2) to work under the supervision of a registered nurse which could be challenged if precedent of the DBA proposed changes are established within the dental practitioner registration model.

*Dental workforce supply and distribution considerations*

There has been a prolonged oversupply of dental practitioners in Australia. The HWA *Health Workforce 2025 – Oral Health* report found that this oversupply of dental practitioners in Australia was expected to continue until 2025. In undertaking their study, HWA consulted broadly, and examined closely who is providing dental services and the type of dental services being provided in both public and private sectors. HWA applied seven alternative workforce planning projection scenarios, including increasing the demand for services, increasing productivity, reducing both migration and university graduate numbers. All scenarios presented the same result: That the supply of the dental workforce is projected to exceed demand for some significant time - at least until 2025.

Analysis of the National Health Workforce Dataset (see Chart 2 below) shows that dentists far outnumber ADPs in all locations regardless of remoteness. That is to say that dentists are best placed to and are providing the most care to those in non-metropolitan areas. Rather than removing the requirement for ADPs to work in a SPR with a dentist, government policy should instead be geared to support patients' access to those dental practitioners that are already working in non-metropolitan areas (the majority being dentists).

Chart 2



It is highly unlikely that removing the restriction from independent practice for ADPs will *ipso facto* result in a large increase in ADP practices being established in low socio-economic and non-metropolitan areas. The underpinning startup costs and need for a sustainable patient base required by all dental practices will continue to apply and would not materially vary just because the practice owner or practitioner is an ADP. These costs will not change because of the DBA proposal to remove the requirement for ADPs to work in a SPR with dentists and to remove restrictions on ADP independent practice.

What should also be kept in mind is that the dental profession disagrees with the consultation paper's suggestion that the costs of the proposal will be minimal and do not substantially change current requirements. The cost of professional indemnity insurance for ADPs is likely to increase as indemnity providers consider the absence of a requirement for a SPR with a dentist. There may even be a rebound effect on future employment of ADPs if the SPR collaborative care model is dismantled, leading to increased fees to patients. This has been a consequence in some states in the US. The ADA has already provided comment on the effect on fees with independent practice by prosthetists and how this is likely to occur in the case of ADPs as well if the DBA's proposed changes were implemented.

If the core problem being tackled is one of cost, the solutions should focus on providing care to those already suffering from dental disease, strengthening and expanding the eligibility of those under a safety net system, and bringing dental health education and disease prevention into underserved communities. The ADA's Australian Dental Health Plan, is the dental profession's comprehensive framework for what the Australian Government can do to improve access to dental care for the remaining 30% of Australians who experience difficulty due to disadvantage.

*International evidence does not support the case for change*

When it comes to the overseas experience with allowing ADPs independent practice, one needs to be cautious in interpreting the results and applying this to Australia because their training and scope of practice varies

greatly. With that in mind, international experience suggests that there has been little improvement to patient access to care.

As previously stated, in some parts of the US, analysis of the economic viability of independent practice led by ADPs (or defined as 'MLP' by the study) found that across five states, Connecticut, Kansas, Maine, New Hampshire, and Washington, those arrangements require "at least 50 per cent of patients that pay market-based fees", for a MLP dental practice to be viable. It is unlikely that low socio-economic and non-metropolitan areas would be able to meet this requirement.

it was believed that dental therapists would accept much lower salaries than dentists because their tuition fee debt on graduation is less, and if their salaries were less then dental care should be less expensive. Formal assessments of costs for dental therapists and oral health therapists in the US did not show reduced costs, so that assertion has yet to be proven. The most comprehensive assessment (conducted in the US state of Minnesota) reported "no evidence that the emergence of dental therapists has resulted in cost savings to the state, more equitable distribution of dental health professionals, or improved access to care for low income, uninsured, and underserved populations."<sup>2</sup>

An economic evaluation of independent practice of dental therapists in the US found that they generated 1.96% of price reductions for patients; and that was described as the "(largest possible) price reduction".<sup>3</sup>

A study in Colorado found that, when it came to independent practice for dental hygienists:

*"Patients are not able to reali[s]e significant saving from unbundling the services of the hygienist from those of the dental office. ... the model does not generate substantial economic incentives for dental hygienists to undertake the business risk of opening an independent practice. ... Since unsupervised hygienists' fees are not lower, the incentive for the hygienist to establish a private practice with the attendant investment requirements and business risk is very weak."*<sup>4</sup>

There has been little improvement to patient access to care.

### **Enabling ADPs' independent practice and removing the requirement for a SPR will not improve public safety and quality but risks the opposite**

Noting that there has been no dental practice or quality and safety of care problem clearly identified by the consultation paper for which the DBA's proposed changes would actually solve, the main problem that the DBA should address is actually the following:

The smorgasbord of variation in the education, skill and qualifications of ADPs, from those obtained in the Vocational Education and Training sector to the higher education sector (not to mention variation in skills taught within and between qualifications). This variation has made clarity of ADPs' roles and their capabilities within each individual practice difficult to ascertain.

The DBA's challenge is to devise a response that works within the following:

- 1) ADPs' education and qualifications provide a specific subset of dental skills and procedures in dentistry, underpinning their role within a dental team where the dentist has the full spectrum of education and training in dental treatment and assessment. ADPs are not dentists and their foundational training appropriately outlines the critical importance of working within a collaborative manner with dentists – whom can ensure that any additional oral health needs are identified and treated; and
- 2) Legal requirements reflect the above training differences and appropriately limit ADPs and the public from performing certain practices that can only be safely and competently done by dentists – such as prescribing medicines. Such restrictions are in place to ensure public safety.

The DBA has, until this proposal, in fact already addressed the above problem in a way that sensibly managed its support of the dental profession, dentists and ADPs; as well as navigated the legal and regulatory landscape underpinning the provision of quality and safe dental care by dental practitioners. The DBA has in fact done this

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<sup>2</sup> Academy of General Dentistry, 'A Review of the Minnesota Dental Therapist Model: Has the Midlevel Provider Expanded Access to Care?', *AGD impact*, May 2016, at 22

<sup>3</sup> Beazoglou T. J., Lazar V. F., Guay A. H., Heffley D.R., Bailit H.L., 'Dental Therapists in General Dental Practices: An Economic Evaluation', *Journal of Dental Education*, August 2012, 76(8): 1082 at 1089

<sup>4</sup> Brown, L.J., House, D.R., Nash, K.D., 'The Economic Aspects of Unsupervised Private Hygiene Practice and its Impact on Access to Care', *Dental Health Policy Analysis Series*, 2005 at 12-13

through the requirement that all dental practitioners work in a SPR and that ADPs be restricted from independent practice. Under this framework dentists have primary responsibility for clinical guidance and governance; is insured for that clinical governance and is ultimately responsible for the safety of the patient under their care. The current SPR framework is the simplest way to provide this support and review of ADPs' treatment and is simple to manage.

The ADA is not aware of any public complaint or dissent with the current SPR; nor cases where the SPR has resulted in risk to patient safety nor their quality of care. In fact, the SPR has provided a structure, and transparency around roles and the range of treatment and assessment that ADPs can do, that is specific to their individual education, skills, training and competence, at the local practice level for the whole dental team.

The current framework simply requires that ADPs have a documented professional relationship with a dentist. It does not require them to be constantly supervised or restricted unnecessarily in service provision. The requirement for an SPR, is flexible and fit for purpose, allowing ADPs to receive varying levels of supervision and support from their dentist that reflects the capabilities of that individual practitioner. Furthermore, as dental practitioners with corresponding training and education within that subset of dentistry, whether it be dental hygiene and/or therapy, ADPs' right to practice autonomously is appropriate and is specifically provided for by the existing SoP RS. The SPR supports and protects that autonomy by establishing and requiring appropriate clinical governance and collaboration and for that to be specified so that all members of the dental team can work effectively.

The SPR is an elegant means to maximise the existing scope of all ADPs, ensuring the continuation of quality dental care in the safest way possible. There has been no case made on safety and quality grounds, nor in terms of patient access to dental care, for the DBA to remove the SPR requirement and to institute ADPs independent practice. Removing the requirement for ADPs to work in a SPR with a dentist will instead create unnecessary risks to the safety and compromise quality of dental care provided to the public.

Removing both ADPs independent practice restrictions for ADPs and the requirement for an SPR would effectively remove an obligation that all dental practitioners have detailed, practice specific clinical governance arrangements in place. The proposed changes would create a considerable gap in the delivery, assessment, monitoring and management of patients' oral care. Current dental education and training and the legal prohibitions on dental acts point to the importance of all dental practitioners practising within their roles and what they have been trained to do. However, alone this is not adequate. Implementing these changes would effectively mean that the DBA is withdrawing from overseeing and regulating the practice of dentistry by all dental practitioners and instead create a clinical governance vacuum that exposes patients to risk of lesser quality care and risk to their safety for no justifiable reason in terms of clinical effectiveness nor in terms of patient access to care.

The DBA's goal should always be to raise standards and quality of health care providers. Its proposed changes to the SoP RS claims to provide better harmonisation but in actuality would lower standards that put the Australian community at greater risk for benefit to patient's care for no improvement to healthcare access. Increasing access to care should never be a justification for lowering the quality of care or removing clinical governance.

The proposed changes are unprecedented in the developed countries of the world, are imprudent and put the health and welfare of all Australians at risk for no demonstrable benefit. The ADA strongly encourages that these potentially reckless changes be abandoned and the effective and safe current practices be retained.

The ADA urges the DBA to adopt Option 1.

Yours sincerely,



Dr Hugo Sachs

Federal President

