

Scope of practice review

Oral Health Practitioners



An Australian Government Initiative

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Executive Summary

In March 2010 the Dental Board of Australia released a Scope of Registration Practice Standard relating to dental hygienists, dental therapists and oral health therapists (collectively called oral health practitioners). In summary this standard identified that oral health practitioners could perform procedures for which they are formally educated and in which they are competent, but not as independent practitioners, and only under the supervision of a dentist. The Australian Health Workforce Ministerial Council approved the Scope of Practice Registration Standard and requested that the Dental Board of Australia review and potentially revisit the standard within 18 months to assess if the approved standard had any unintended and negative impacts on the Scope of Practice of oral health practitioners.

Health Workforce Australia was requested to consider the role and scope of dental therapists, dental hygienists and oral health therapists prior to the Dental Board's review and to identify any potential future arrangements that may broaden the practice of oral health practitioners. The Project Team were contracted to prepare this report to assist HWA in its deliberations.

The Project Team undertook an extensive process of consultation with the community, dental professionals, peak bodies, government providers and regulatory bodies and dental educational institutions, through meetings, interviews and focus groups.

An on-line survey based on narrative research was conducted which generated 702 stories describing dental experiences and a survey of current dental education offerings was undertaken with educational institutions.

A national and international literature review was undertaken.

An Expert Reference Group was established to advise and support the project.

The report findings are set in the context of a trend internationally towards extension of oral health practitioners' Scope of Practice within a collaborative/autonomous teamwork model as a way to afford better access to preventative care of children and services for underserved groups thereby reducing the burden of oral disease.

The *Healthy Mouths, Healthy Lives* report recognises and addresses the need for policy and systems change to improve oral health outcomes and associated costs:

“To improve oral health outcomes, dental practitioners and service systems need to expand their focus to address, in a systematic way, population health issues such as the promotion of a dentally healthy lifestyle and behaviours, and the early identification and treatment of oral health problems.

This requires a greater team approach within dental practice, involving general and specialists dentists and other oral health practitioners—hygienists, therapists, prosthetists and others as appropriate. Greater integration of the range of oral health practitioner education has the potential to foster team dentistry, as well as retaining flexibility in education and training capacity to meet changing population needs. There are a number of opportunities to make better use of the various members of the oral health workforce, including: increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary and maintenance oral health care including health promotion; and more effective use of the existing workforce, for example, dental assistants providing oral health education and oral radiography”.

This call is in line with the *Australia's Health Workforce* report of the Productivity Commission, 2005. This report 'sought to identify reforms which would produce a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes'.

The literature review reports that Australia has a high proportion of dentists to oral health practitioners compared to other countries. There is a need to determine the appropriate innovative workforce model to deliver cost effective equitable care to the Australian public and then determine the mix of graduating practitioners. There is evidence that a more preventive model will reduce the cost of oral care compared to the traditional model.

The Project team has concluded that:

Firstly, there have been unintended and negative impacts from the Dental Board of Australia's Scope of Practice Registration Standard that are affecting the abilities of dental hygienists, dental therapists and oral health therapists to work within their current potential Scope of Practice. This has arisen through confusion amongst dentists and these oral health practitioners about what is allowed within the Dental Board of Australia's standard, what tasks oral health practitioners have been educated to undertake and the impediment caused by the requirement for supervision.

A lack of clarity about the difference between independent practice and autonomous decision making was confusing to many dental practitioners. Some saw it as relating to oral health practitioners' ability to undertake autonomous decision making, while others saw it as being able to set up as a sole trader. While the Scope of Practice Registration Standard says oral health practitioners exercise autonomous decision making, they cannot work without supervision (i.e. as an independent practitioner).

The majority of the dental educational providers educate the current graduates to work without supervision in their current Scope of Practice. They advocate structured professional relationships where they refer a patient when outside of their Scope of Practice.

It could be argued that university trained 'professionals' do not need a Scope of Practice Standard – it is their professional duty to work within the Scope of Practice for which they are educated and competent. However, the Project Team has accepted advice from across the professional groups consulted that change may need to be incremental in order for all parts of the profession to be confident in oral health practitioners' abilities to work independently (including many oral health practitioners themselves).

The Project Team's recommendation of a continuation of the Scope of Practice Registration Standard is for an interim medium term standard that should be considered for removal within five years.

Secondly there is a demand from oral health practitioners and many dentists for an extension of Scope of Practice but few opportunities to realise this through additional appropriate education.

There is compelling evidence internationally that an extension of Scope of Practice through appropriate education improves access for the community to dental services with no apparent quality and safety issues.

Broadening the Scope of Practice is particularly relevant in relation to the treatment of people of all ages. Current age limitations are imposed by the different education and training provided by the dental schools and are considered to have negative impacts on continuity of care, resulting in ineffective use of oral health practitioner skills and increased waiting times. There are further issues about the provision of emergency treatment in rural and remote areas and in prescription and radiation practice inconsistencies. The custom and practice in different States and Territories has emphasised these problems.

The Project Team has been unable to identify an age restriction within the current standard and concludes that the frustrations experienced about this issue are primarily caused by misperceptions of the current standard and difficulties in

accessing further training. There is support from the community for dental therapists and oral health therapists to continue providing dental services past the traditional age limits imposed in each jurisdiction.

There are significant unmet needs for dental services across the nation, particularly socially disadvantaged adults, government health care cardholders, migrants, especially non-English speakers and particularly Indigenous Australians - 'Closing the Gap' for Indigenous people is just as important in oral health care as other aspects of care and indeed inter-connected with general health outcomes. There is also a growing need amongst the aged population and people living in rural and remote areas. The public and private sector programs cannot meet demand for general dental care and there is inconsistent access through a mal-distribution of dental practitioners.

In underserved areas such as rural and remote locations the availability of dental practitioners is low when compared with capital cities. The uneven distribution of dentists between capital cities and other regions in the States/Territories is a significant feature of the current labour force, with practicing rates for capital cities averaging 55.7 dentists per 100,000 population compared with 31.4 for other areas within the States/Territories. However, dental therapists are distributed more evenly by remoteness area, with higher rates outside major cities.

While the issue of a mal-distribution of dental professionals and large areas of unmet need is generally agreed, there are widely differing views about the potential solutions to this problem. Peak organisations, managers of public dental services and many individual practitioners believe that one of the solutions to this issue is encouraging an increased Scope of Practice for dental hygienists, dental therapists and oral health therapists. In particular they support oral health practitioners treating patients of all ages within a collaborative professional relationship (without supervision). This would result in a more flexible workforce better able to respond to the needs of rural, remote and Aboriginal communities, older and institutionalised people and other disadvantaged groups. The Australian Dental Association however believes that the solution lies in increased government funding to support a growing cohort of dentists to meet this unmet need.

There is general agreement across the dental profession that an individual's SoP is related to their education and training as well as competency. There is therefore no disagreement that there is not, nor should there be artificial barriers within the standard. The area of disagreement centres around the availability, cost, length and requirements for further education to enable oral health practitioners to work more broadly.

In order to keep the costs of upgrading programs to reasonable levels it is essential that all training and education is not confined to tertiary providers.

There is a strong case for the use of Continuing Professional Development (CPD) as a delivery mechanism. Programs should be risk assessed and those that are identified as high risk should be provided where the program participant's competencies are tested before they undertake the activities unsupervised outside of the educational program. It is the Project Team's view that these programs should be presented by providers approved by the Dental Board of Australia and these providers will be responsible for undertaking the risk assessment and developing the program. As part of being an approved provider they may be subject to occasional audit by the Dental Board of Australia to ensure standards are maintained.

The Project Team concludes that dental hygienists, dental therapists and oral health therapists could make a greater contribution to the dental care of all Australians and particularly to underserved groups by increasing their Scope of Practice based on appropriate training.

The report's recommendations are grouped into four themes:

1. The Scope of Practice Standard

- a) Adjust the Scope of Practice Standard to reflect team based practice with autonomous decision making and without supervision requirements for review within five years, with a view to remove the bar on independent practice. There is a need to provide definitions for greater clarity for oral health practitioners.
- b) Clarify the age restriction as there is clear agreement from all parties, that provided there is appropriate formal education, the age barrier can be removed. There is no age barrier in the current standard with the exception of the education requirements and competency
- c) Develop a general description of all dental practitioners which is understandable by the public. It is important to describe the practitioner in a generic fashion rather than by a list of duties which is inflexible over time and is seen as inconsistent with the concept of being a professional within a particular Scope of Practice
- d) Assist dental professionals to simply describe their Scope of Practice and update it regularly
- e) Develop and implement a national communication strategy to explain and describe the current standard and any changes

2. The Dental Education System

- a) Provide upgraded education programs for oral health practitioners with earlier (non-university) qualifications to achieve equivalent education levels and competencies to that held by recent graduates, including through the use of Recognised Prior Learning or credit provisions

- b) To increase Scope of Practice through Continuing Professional Development undertaken with accredited providers, including competency testing in high risk subject areas
3. A Strong Identity for Oral Health Practitioners
- a) To improve their recognition within the profession
 - b) To promote their value to the community
 - c) To engage in research particularly through post graduate education
4. Innovative Workforce Models
- a) Review the appropriate workforce number and mix of dental practitioners with a view to providing more cost effective services with a strong preventive focus
 - b) Development of a team model of interdisciplinary dental practice

Finally, the report addresses two other issues raised which may have an impact on the Scope of Practice but are not directly the focus of this project but relate to legislation review, specifically:

- a) State and Territory Radiation and Safety Acts to achieve national consistency
- b) Review the provision of provider numbers for oral health practitioners

List of Recommendations

Action is proposed in six main areas;

- The current Scope of Practice Standard
- A national communication strategy
- The dental education system
- Innovative workforce design
- A strong identity for oral health practitioners
- Other legislation review that affects Scope of Practice

Adjust the Scope of Practice Standard

RECOMMENDATION 1

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 practice 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.

RECOMMENDATION 2

Within five years the Scope of Practice Standard be reviewed to remove the bar on “independent practice” from the Standard and retain only the paragraph that relates to formal education and competency requirements that applies to all dental practitioners.

RECOMMENDATION 3

Oral health professionals continue to function within the limits of their education and competency and that the Dental Board of Australia clarifies that there are no age restrictions.

RECOMMENDATION 4

The Dental Board of Australia lead a consultative process with all the professional peak bodies to determine a plain English description of each dental practitioner category.

RECOMMENDATION 5

The Dental Board of Australia lead a consultative process with the professional peak bodies to describe the Scope of Practice of a newly graduated practitioner and develop a document that allows individuals to clearly document their Scope of Practice in relation to that description. This process would commence with a clear definition of Scope of Practice.

Develop and implement a national communication strategy

RECOMMENDATION 6

The Dental Board of Australia develop a comprehensive national communications strategy to explain and describe an updated Scope of Practice Standard after the review.

Enhance the dental education system

RECOMMENDATION 7

The Australian Government and jurisdictions (where appropriate) consider support for earlier trained oral health practitioners to upgrade their qualifications to the equivalent of recent graduates.

RECOMMENDATION 8

Dental education institutions be actively encouraged to support the provision of Recognised Prior Learning or credit processes for earlier non-university education and experience of oral health practitioners.

RECOMMENDATION 9

The Dental Board of Australia accredit education providers to provide education and training to upgrade practitioners' skills to the competency levels described in the current Australian Dental Council documents on Professional Attributes and Competencies.

RECOMMENDATION 10

The dental education providers upgrade their current entry level oral health practitioner curricula to the minimum competency levels described in the current Australian Dental Council documents on Professional Attributes and Competencies and in addition achieve consistent practice within Australia. Examples include intraoral and extraoral radiography, diagnosis and treatment planning, Stainless Steel Crowns, tooth whitening, limited orthodontic treatments and direct simple restorations for adults.

RECOMMENDATION 11

Education and training for additional scope must be provided by organisations accredited by the Dental Board of Australia to provide such education and training as part of Continuing Professional Development.

RECOMMENDATION 12

The Dental Board of Australia develop a decision making framework that allows education providers to determine, according to risk, when the education and training needs to be competency tested.

[Explore and evaluate innovative workforce models](#)

RECOMMENDATION 13

A review be undertaken of the appropriate workforce number and mix of practitioners required to provide a larger, more cost effective workforce with a strong preventive focus and provision of simple restorative services. This could involve a large scale pilot with an evaluation to provide a strong evidence base for change in the Australian health care environment.

RECOMMENDATION 14

All dental practitioners be provided with education and training as interdisciplinary team members as part of the development of an innovative workforce model.

Develop a strong identity for oral health practitioners

RECOMMENDATION 15

The oral health practitioner peak bodies are encouraged to develop active working arrangements to promote a strong sense of identity and worth for their professions through joint publications, presentations at conferences, research and data collection.

RECOMMENDATION 16

The dental education providers be actively supported by the Australian Government to develop post graduate education and training for oral health practitioners. This would support a research and publication agenda.

Other Legislative Review

RECOMMENDATION 17

Jurisdictions to review the various Radiation Acts to ensure that oral health practitioners are not restricted from providing services to a level comparable to the maximum level provided by their interstate colleagues.

Project Background

1.1 The Project Overview

In March 2010 the Dental Board of Australia (DBA) released a Scope of Practice Registration Standard (the Standard) relating to dental hygienists, dental therapists and oral health therapists. (Attachment 2) They also released a “frequently asked questions guide” titled FAQ: Scope of Practice Registration Standard. (Attachment 3) The Scope of Practice Standard in summary indicates that dental and oral health practitioners may only perform procedures for which they are formally educated and in which they are competent. In addition, the Standard was prescriptive around independent practice only being available to dentists and dental prosthetists. All other oral health practitioners require supervision by a dentist.

This caused some concern to the Australian Health Workforce Ministers' Council (AHWMC) and after consideration they decided to approve the Standard but agreed that the DBA review the Standard in 12-18 months time and potentially revisit the existing Standard. The DBA was particularly requested to assess if the approved Standard had any unintended and negative impacts on the Scope of Practice (SoP). In addition, Health Workforce Australia (HWA) have been requested to review the role and scope of dental therapists, dental hygienists and oral health therapists prior to the review of the Standards for SoP by the DBA. The HWA work plan outlines that the review will revisit the SoP of dental therapists, dental hygienists and oral health therapists in order to identify any potential future arrangements that may broaden their practice.

The DBA was established under the *Health Practitioner Regulation National Law Act 2008* (the Act). It has a number of objectives that go beyond past jurisdictional Board's roles of protecting the public. Other objectives include improving access and enabling development of a flexible, responsive and sustainable oral health workforce.

The SoP issues have triggered debate within the dental and oral health professions for many years. This is a familiar matter that has occurred in other professional groups within the health workforce. Traditionally, the debate on oral health professional SoP has been held within the profession with little input from the Australian community that requires care.

A significant issue in the Australian community is access to dental services. Many people within the community and the dental profession believe that extension to SoP of dental hygienists, dental therapists and oral health therapists may provide more accessible dental care to the community in terms of cost and particularly in rural and remote communities.

It is also recognised by all that there is a need for a significant increase in funding to be able to provide universal access to dental services for the Australian population. Other members of the dental profession believe that as oral disease is largely preventable and these practitioners are highly skilled in prevention and health promotion, particularly in targeting the social determinants of health, they should not be further developed into a 'cutting' clinician.

The nature of work has changed. The definition of what it means to be a dental hygienist, dental therapist or oral health therapist has changed, and so has the boundaries between these groups and dentists. For instance, super-specialisation is the trend; multiple experts in specific areas are called upon to treat patients, instead of the practitioner being a general service provider. Confusion may exist between different service providers where, for instance, conventionally-trained practitioners may understand their role to be something other than new graduates and the future workforce.

Thus there is a pressing need to formally redefine the role and work boundaries for these various practitioner groups.

While there are divergent views relating to the SoP issues, there have also been incremental changes over the years that have expanded the SoP. It is likely that any future changes are likely to be incremental as well.

1.2 The Project Brief

This project is to provide HWA with recommendations, supported by quantitative and qualitative data, best practice evidence globally (including a review of current and relevant literature) and consultation results, relating to the DBA's Standard for the oral health workforce.

Specifically the project is to provide:

- A clear description of the current attitudes of the profession and stakeholder community groups on the adequacy of dental care, particularly for marginalised groups
- An analysis of areas of agreement and disagreement between stakeholders on the best response to any identified deficiencies,
- An assessment of the potential of dental therapists, oral health therapists and dental hygienists to further contribute to dental care, and under what conditions, and

- Recommendations on future directions for the HWA, DBA and the Australian Government to consider to address areas of deficit including (but not limited to):
 - Further work required to clarify workforce needs and demands as educational institutions incorporate the newly developed competencies and attributes developed by the Australian Dental Council (ADC)
 - Potential structural changes that need consideration, and
 - Actions that could be taken to improve access to appropriate dental care for all Australians, especially in underserved areas.

1.3 The Project Methodology

The project methodology included 6 critical stages:

- a) Establishment of an ERG of stakeholders to provide advice and guidance
- b) An on-line survey based on a narrative research methodology
- c) Meetings, interviews and focus groups with individual consumers and dental professionals
- d) Major organisational stakeholder consultations
- e) National and international literature review
- f) A survey of dental education institutions to establish current curriculum content.

A) Expert Reference Group

An ERG comprising representatives of key stakeholders groups has been established to assist HWA and the Project Team throughout the review to ensure that all matters of relevance are captured in the Review process.

The role of the Scope of Practice Expert Reference Group was to provide advice and guidance to assist HWA in undertaking the review including:

- Providing input into a literature review to capture national and international SoP matters
- Assisting with the survey design to optimise identification of the matters relating to SoP
- Promoting participation in the survey process by as many stakeholders as possible
- Facilitating consultation opportunities in relation to resolving any identified SoP matters
- Liaison with other stakeholders where appropriate

The ERG was chaired by a senior representative of HWA. Members offered their expertise, skills and experience in oral health as consumer or professional representatives to ensure that the SoP Review was executed in a manner that will deliver the best outcomes for HWA and stakeholders. Members were representatives of the following stakeholder groups:

- Australasian Council of Dental Schools
- Australian Dental and Oral Health Therapists' Association
- Australian Dental Association
- Dental Board of Australia
- Dental Hygienists' Association of Australia
- Health Workforce Principal Committee
- Indigenous Dentist Association of Australia
- Victorian Aboriginal Community Controlled Health Organisation
- National Rural Health Alliance
- Public dentistry providers

a) On-Line Survey

The project employed an on-line survey based around narrative research methodology. Originally developed for use by US Intelligence agencies involved in counter terrorism assessments and now used widely by civilian organisations and governments, the survey instrument gathers and analyses the experiences of key stakeholders within a defined area of interest.

In the study, anecdotes were elicited on the experience of accessing dental care from members of the public, and anecdotes relating to the provision of responsive and sustainable oral health care from dental professionals. These anecdotes were analysed with a 'Scope of Practice' focus.

Central to the survey methodology is the understanding that human society has evolved with storytelling as the most powerful form of knowledge transfer. Telling stories of experiences on a specific subject is natural and easy, and it provides material at the right level of abstraction for deep comprehension. To understand how people see their world, and to better learn of their experiences, aspirations or anxieties, we need only to listen to the stories they tell. The narrative-based methodology not only produces a body of quantitative and qualitative data, but provides an extensive evidence base of first hand, real world experiences to support any subsequent findings.

The survey method allowed us to record, tag and analyse hundreds of stories related to the project. Unlike conventional surveys where the questions rigidly constrain the choice of replies, narrative formats allow the respondent to

focus their replies on areas that they feel are most pertinent to their personal experience, allowing for much richer and more nuanced insight into the prevailing conditions.

A subsequent series of questions further clarified the story teller's intent, removing any ambiguity or misinterpretation which could otherwise skew the analysis. A series of 'filter questions' are then applied to focus the story's context on specific areas of interest.

Once collected and aggregated the Project Team could see how the respondents experience the situation under consideration and can identify the recurring instances of similar stories that are indicative of common experiences, or widely held beliefs or attitudes.

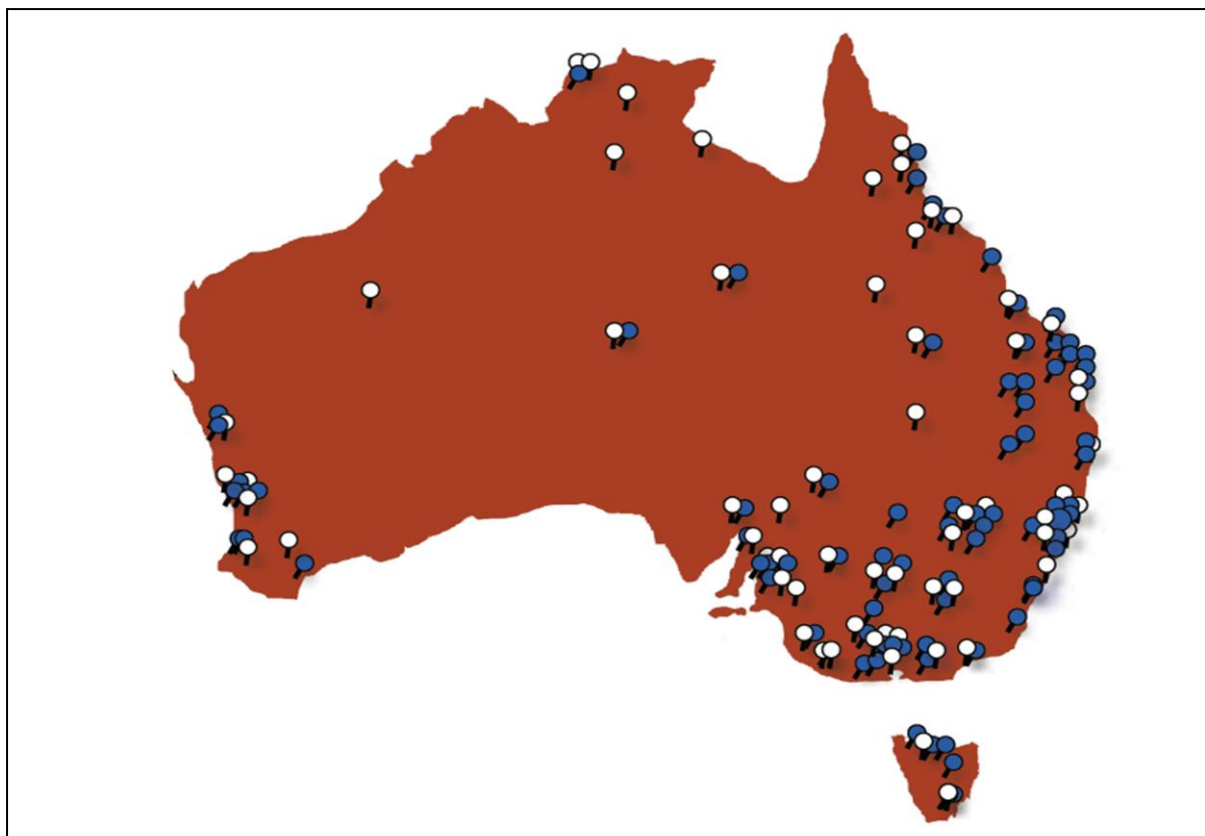
The survey was conducted in three phases and these are described in more detail in Volume 2 and the reporting contains both qualitative and quantitative analysis.

The software used for the collection and analysis of narrative material has been developed by Cognitive Edge Pte Ltd. Through the use of the Cognitive Edge SenseMaker® suite, incorporating SenseMaker® Collector to gather the narrative data, and SenseMaker® Explorer to reveal the insights generated during the analysis phase.

The survey generated 702 stories – 54.4% from dental professionals and 45.6% from consumers.

The main characteristics of the respondents are as follows:

- 21% were people born outside of Australia
- 2.4% were Aboriginal and Torres Strait Islanders
- 77% were women
- 39 % were aged 25-44, 50% aged 45-64, and 4% aged 64+
- 81% of consumers were treated in private practice
- 11.3% were dentists, 8.4% dental hygienists, 16.5% dental therapists and 13.8% oral health therapists
- Responses were received from every State and Territory, from capital cities, other urban areas, rural towns and regional centres and remote areas



Map 1: 702 stories were received from all over Australia. The coloured pins show the distribution of stories contributed by members of the dental and oral health workforce, people with an interest in dental and oral health care issues, and members of public who use the services provided by dental and oral health care practitioners.

c) Meetings, Interviews and Focus Groups with Individual Consumers and dental professionals

Approximately 250 individuals were directly consulted in either face-to-face interviews, telephone interviews, meetings or focus groups.

Outcomes from these consultations are discussed in chapter 4.

d) Major Organisational Stakeholder Consultations

The Project Team met with the following bodies:

- Australasian Council of Dental Schools
- Australian Dental Association
- Australian Dental and Oral Health Therapist Association
- Dental Board of Australia
- Australian Jurisdictional Dental Directors (Public dentistry)
- Dental Hygienist Association of Australia

In most cases initial meetings were held with groups and individual representatives of these organisations to allow them to raise issues and challenges and to confirm or deny the findings from the survey results. A follow up meeting was subsequently held to discuss possible solutions and directions for the report.

e) National and International Literature Review

A literature review was undertaken and the full document is included in Volume 3.

All peak bodies were invited to submit material or references to publicly available material for inclusion in the literature survey. They were also sent the first draft of the literature review for further comments and provision of additional literature.

f) A survey of Dental Education Institutions to Establish Current Programs

A survey of dental education institutions was undertaken to identify current programs:

- Charles Sturt University
- Curtin University
- Griffith University
- La Trobe University
- TAFE SA
- University of Adelaide
- University of Melbourne
- University of Newcastle
- University of Queensland
- University of Sydney

The results of the survey are included at Attachment 4.

Concepts and Context

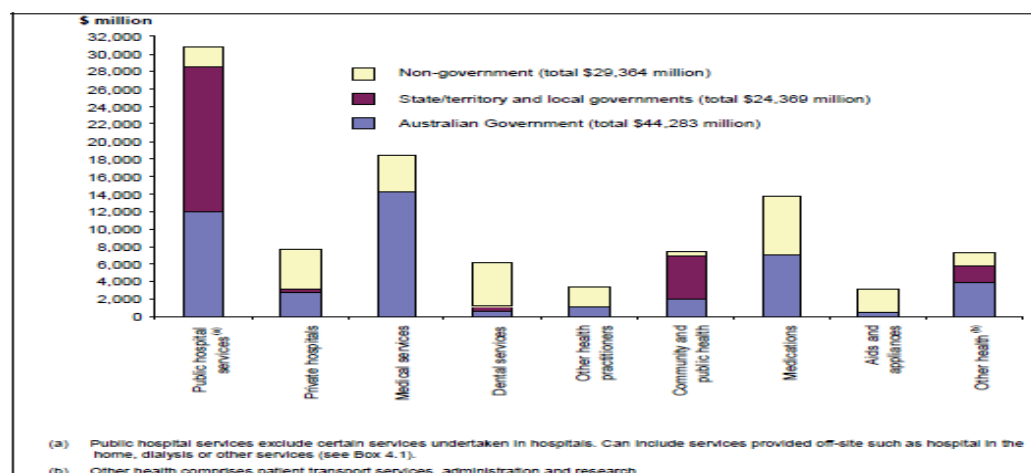
2.1 The Current & Historical Health Environment

Australia has a predominantly publicly funded health system providing universal access to healthcare that is funded through taxation and a compulsory health insurance levy. Medicare is the national insurance scheme that subsidises payments for services provided by doctors, provides free public hospital care and subsidised pharmaceuticals. About 68% of total health expenditure is funded by Governments and 32% from private sources including private health insurance.

The complexity of the Australian Health System is exacerbated by both public and private funders and providers. Within the Government sector there are delineation of roles between the Commonwealth and the States. There is also a small amount of local Government funding. Traditionally the Australian Government has been the policy maker and the majority funder with the State and Territory Governments being the majority public providers described in agreements with the Federal Government.

Dental services are the only health services where universal access to healthcare does not apply. The majority of dental services in Australia are funded on a private basis either with or without private insurance. Public dental services are provided to concession cardholders and their dependents and are mainly funded through State and Territory Governments. Demand for public dental care exceeds the ability of dental services' to supply treatment resulting in long waiting lists of up to five years.

Access to dental services is significantly affected by cost to the individual. The comparison of the funding streams is well presented in the following graph.¹



¹ AIHW Health Expenditure Australia 2007-2008, Series Number 37. Sept 2009

Available at <http://www.aihw.gov.au/search/?q=health+expenditure>

Oral Health policy is described in *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013* that was prepared by the National Advisory Committee on Oral Health (NACOH), established by the Australian Health Ministers' Conference (AHMC) in August 2001, and comprising representatives from the Commonwealth, State and Territory governments, professional and consumer groups, and academic and educational bodies. There is a national oral health monitoring group that reviews the implementation of the plan. *Healthy Mouths Healthy Lives* builds on the work of the Australian Health Ministers' Advisory Council (AHMAC) Steering Committee for National Planning for Oral Health, which released *Oral Health of Australians: National planning for oral health improvement: Final report* in 2001.

This plan is based on the evidence that there are links between oral health and general health. Oral Health is needed for overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.

The health care workforce equates to about 6% of the total workforce and there have been significant workforce shortages for some time. The current Government agenda, through HWA, has been to significantly increase the number of graduates from the various health professions. In addition there has been the introduction of a national registration system for health care professionals and support for expanded SoP professionals e.g. nurse practitioners, midwives, etc.

The *Health Practitioner Regulation National Law Act 2009* (the Act) resulted in the replacement of the pre-existing 85 State and Territory Boards with 10 National Boards, of which one is Dental, active from 1 July 2010. The dental practitioner workforce has been included in the reform agenda with reported workforce shortages and increased enrolments into dental and oral health therapy courses.

There have been a number of health care reforms over the previous decade that have had incremental effects as they require the agreement of both Federal and State Governments. The main changes have involved private health insurance rebates, increasing the Medicare payment schedule to doctors, co-ordinated care programs, national policy implementation, quality and safety initiatives, e-health initiatives and workforce planning.

In 2008 the National Hospitals and Healthcare Reform Commission was announced to undertake a major review of the health system. This has resulted in a number of significant changes. The Commonwealth Government will become the majority funder of Australian public hospitals, by funding 60% of the efficient price for all public hospital services as well as 60% of capital, research and training in public hospitals.

It has announced new governance structures including Local Hospital Networks and Medicare Locals. The Commonwealth Government will take full funding and policy responsibility for GP and primary health care services in Australia.

There are currently no reforms relating to dental services but a National Advisory Council on Dental Health was recently announced by the Government to provide high level advice to Government. The Council will look at current dental services, provide advice on future needs and priorities for future reform, and play a key role in providing advice on future dental policy.

The service delivery model in Australia is changing. It is predominantly provided in the private sector, traditionally in single person practices. Over the last decade, many practitioners have combined into joint practices and there has been growing corporatisation of these practices. The recent Medicare funded Teen Dental Program and Chronic Disease Dental Scheme have introduced a major public funder/insurer into the dental funding environment. The National Health Reform Agenda has raised the concept of a Denticare funding model that would have major implications for the private sector. This would put significant pressure on the current service delivery models as will the potential effects of Medicare Locals and Local Hospital Networks.

The use of technology has significantly influenced the practice of dentistry but new communication and e-health technology will enable alternative service delivery models to be explored, particularly in rural and remote areas.

2.2 Description of the Dental Profession

The practice of dentistry is a health science that involves the study, diagnosis, prevention, and treatment of diseases, disorders and conditions involving the mouth and the adjacent areas and their impact on the human body. Dentistry is widely considered necessary for complete overall health. Doctors who practice dentistry are known as dentists. The other members of the dental team providing oral health care are dental hygienists, dental therapists and oral health therapists. Dental specialists and dental prosthetists are also providers of oral health services. Each of these dental practitioners is registered with the DBA and has a SoP that is a subset of the practice of dentistry. Dental assistants and dental technicians support these dental practitioners to deliver dental services.

A dentist undertakes the practice of dentistry within the scope of the practitioner's approved education, training and competence.

A dental therapist's practice is as a team member in the practice of dentistry and is determined by approved education, training and competence. A dental therapist's major role is in the provision of oral health assessment, treatment, management and prevention services for children, adolescents and adults (depending on training).

Disease prevention and oral health promotion and maintenance are core activities. Dental therapists practise in a team situation with a practising dentist.

A dental hygienist's practice is as a team member in the practice of dentistry and is determined by approved education, training and competence. A dental hygienist's major role is in the provision of oral health education and the prevention of oral disease to promote healthy oral behaviours. Dental hygienists practise in a team situation with a practising dentist.

An oral health therapist's practice is as a team member in the practice of dentistry and is determined by approved education, training and competence. Oral health therapists are dental practitioners that are dually qualified as dental therapists and hygienists. Oral health therapists also practise in a team situation with a practising dentist.

Dental prosthetists work as independent practitioners in making, fitting, supplying and repairing removable dentures and flexible, removable mouthguards.

The DBA register dental specialists, dentists, oral health therapists, dental therapists, dental hygienists and dental prosthetists.

The majority of dental practitioners in Australia are dentists followed by dental therapists, dental hygienists and oral health therapists. A significant percentage of dentists practice in solo practices in Australia with about 80% of the dental workforce functioning in the private sector.

The Dental Therapist has a long tradition of being part of the dental team primarily providing dental care to children through the school dental services. Dental hygienists have a long tradition of providing oral and dental preventive care. In contrast to other developing nations, Australia does not have a high ratio of dental hygienists practising in private and public dental practices. In some countries the majority of dental practitioners are dental hygienists. Oral health therapists are dual qualified dental practitioners (dental therapy and dental hygiene) graduating with a three year bachelors degree. Oral health therapists can register as a dental therapist, dental hygienist and or oral health therapist.

Dental hygienists practice primarily in the private sector, where as dental therapists traditionally practice in public dentistry. Very few dental hygienists work in public dental services in Australia.

Recently the ADC developed "Professional Attributes and Competencies" for dentists, dental therapists, dental hygienists and oral health therapists (attachment 5). The details of the competencies will provide valuable guidance to the DBA, ADC and dental education institutions concerning education of future graduates in Australia.

2.3 Scope of Practice

a) **Scope of Practice as provided in the Act and regulated by the DBA and Australian Health Practitioner Regulation Agency (AHPRA).**

SoP is outlined in the Act as being a discretionary registration standard that National Boards may choose to develop. The AHWMC must approve and may revoke an approval of any registration standard. When the DBA Australia recommended the Scope of Practice Standard the AHWMC requested it be reviewed, in particular to consider any unintended consequences resulting from the implementation of the Standard. The Act does not provide a definition of Scope of Practice.

Scope of Practice is normally a terminology used by Registration Boards to describe the practice that a registered individual is permitted to practice. It is often defined by the extent of an individual's education and competency. The nursing profession uses the following definition of SoP and distinguishes between the profession's and the individual's SoP.²

A profession's SoP is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform. The scope of professional practice is set by legislation – professional standards such as competency standards, codes of ethics, conduct and practice and public need, demand and expectation. It may therefore be broader than that of any individual within the profession. The actual scope of an individual's practice is influenced by the:

- *Context in which they practise*
- *Consumers' health needs*
- *Level of competence, education, qualifications and experience of the individual*
- *Service provider's policy, quality and risk management framework and organisational culture.*

The DBA released their Scope of Practice Standard to take effect 1 July 2010 (Attachment 2). This was followed up with FAQ's: Scope of Practice Registration Standard (Attachment 3). Of particular relevance are the following clauses:

² ANMC National Framework for the Development of Decision Making Tools for nursing and midwifery practice.

Dental practitioners must only perform those dental procedures:

- *For which they have been formally educated and trained in programs of study approved by the Board; and*
- *In which they are competent*

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 practice 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 direct supervision.

One of the significant issues is that the Scope of Practice Standard refers to formal education and the ADC that accredits the formal courses will consider those courses in terms of their individual SoP. This circular reference is an issue as there are no clear definitions of SoP and no descriptions of the SoP for each practitioner group. This is a role that needs to be undertaken by the DBA in consultation with the practitioner stakeholder groups. The definition needs to apply to all practitioner groups equitably, be simple to implement, satisfy all the functions of the Act, must not be restrictive or constrain future expansion of scope of practice.

b) Scope of Clinical Practice – Dental Hygienists, Dental Therapists and Oral Health Therapists

Scope of Clinical Practice is now currently defined by the education received by Oral Health Practitioners and their competency. All dental therapists, dental hygienists and oral health therapists can provide a range of diagnostic and preventive procedures, such as fissure sealants, professional application of remineralising agents and oral health education and promotion. The current training in Australia provides some variation of Scope of Clinical Practice predominantly due to education occurring in different States with past different State legislation. (Attachment 4)

The SoP of each dental practitioner group that undertakes the practice of dentistry is different but overlaps at different points in time. Individuals also have variations from their peers due to their individual formal education and competencies. The issue in describing the different dental practitioners' SoP is difficult due to the overlapping of the inter-professional boundaries. This is also confusing for the general public.

2.4 Legal Frameworks

There are three Commonwealth Acts and their State and Territory counterparts that have the most effect on the Scope of Practice Standard. They are the:

- Registration - *Health Practitioner Regulation National Law Act 2009 (the Act)*
- Pharmaceuticals - *National Health Act 1953* and various State and Territory Acts (Health Acts)
- Radiation Safety – Various State and Territory Acts and the *Australian Radiation Protection and Nuclear Safety Act 1998 (Radiation Acts)*

a) Registration Related Legislation

Australia has a federal system of government, comprising a Federal Government and six State and two Territory governments. From 01 July 2010, a new national registration and accreditation scheme was outlined in the Act for health professions, including dentistry, replacing separate legislation covering registration in each State and Territory. This Act established the Australian Health Practitioner Regulation Agency (AHPRA) responsible for the implementation of the National Registration and Accreditation Scheme across Australia. It supports the various health practitioner Boards including the new national Dental Board of Australia.

To practise dentistry in Australia you must be registered with the DBA.

Dentists work in general practice or specialise in one of the following principal fields: Endodontics, Oral and Maxillofacial Surgery, Orthodontics, Paediatric Dentistry, Periodontics, Prosthodontics, Oral Medicine, Oral Pathology, Oral Surgery, Dento-maxillofacial Radiology, Special Needs Dentistry, Forensic Odontology and Public Health Dentistry. Dental Hygienists, Dental Therapists and Oral Health Therapists work within defined areas of the practice of dentistry.

b) Pharmaceuticals Related Legislation

The Pharmaceutical Benefits Scheme (PBS), along with Medicare, is a key component of Australia's health system. The PBS provides access to necessary and lifesaving medicines at an affordable price. Current provisions governing the operations of the PBS are embodied in Part VII of the *National Health Act 1953* (National Health Act) together with the *National Health (Pharmaceutical Benefits) Regulations 1960* made under the National Health Act. The National Health Act was amended in 1978 to allow dentists to prescribe a limited range of antibiotics, antibacterial and antifungal drugs as pharmaceutical benefits. Dentists could prescribe benefits under the PBS from April 1979. Oral health practitioners cannot currently prescribe under the National Health Act but can administer some topical agents and local anaesthesia.

Each State also has its own Drug and Poison's Act or equivalent and these are all referenced on AHPRA's website under 'Links to State and Territory Drugs and Poisons Legislation'.

c) Radiation Licensing Related Legislation

The legislation relating to radiation protection and licensing is predominantly State and Territory based. There is a Code of Practice and Safety Guide for Radiation Protection in Dentistry published in 2005 by the Commonwealth body called the Australian Radiation Protection and Nuclear Safety Agency. The aim is that it is used to guide States and Territories when they are reviewing legislation. Many have not reviewed the legislation for some time. The current legislative reform in this area is being lead by the Commonwealth with the aim of a nationally adopted strategy to achieve uniformity. The Australian Radiation Protection and Nuclear Safety Act 1998 acknowledged there are nine jurisdictions in Australia in the area of radiation protection.

2.5 The Role of Government and Regulatory Bodies

a) National Councils of Government

The Health, Community and Disability Services Ministerial Council is established under the authority of the Council of Australian Governments (COAG), and comprises the following forums:

- Australian Health Ministers' Conference
- Australian Health Ministers' Advisory Council (CEOs of each jurisdiction's health department)
- Community and Disability Services Ministers' Conference
- Community & Disability Services Ministers' Advisory Council
- Australian Health Workforce Ministerial Council - the membership of which comprises the Health Ministers from the Commonwealth Government and all State and Territory Governments.

The AHWMC is the approving authority for the establishment and operation of a national registration and accreditation scheme for health practitioners managed by relevant professional practice Boards.

The Health Workforce Principal Committee (HWPC) provides advice on health workforce issues to AHMAC and provides a forum for reaching agreement on key national level health workforce issues which require government collaborative action.

The objectives of the national registration and accreditation scheme provide the basis for the functions and operations of the associated boards. These are **(Health Practitioner Regulation National Law Part 1 Section 3)** —

- (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and*
- (b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and*
- (c) to facilitate the provision of high quality education and training of health practitioners; and*
- (d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and*
- (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and*
- (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.*

b) The Dental Board of Australia

The DBA came into legal effect on 1 July 2010 and:

- a) manages the national registration of dental practitioners including dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists and
- b) enforces the Health Practitioner Regulation National Law for registered dental practitioners.

The DBA lists its functions as including³

- *registering dentists, students, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists*
- *developing standards, codes and guidelines for the dental profession*
- *handling notifications, complaints, investigations and disciplinary hearings*

³ Dental Board of Australia website: Functions of the Board.
Available at <http://www.dentalboard.gov.au/About-the-Board.aspx>

- *assessing overseas trained practitioners who wish to practise in Australia*
- *approving accreditation standards and accredited courses of study*

In addition the DBA has a particular responsibility to *facilitate access to services provided by health practitioners in accordance with the public interest.*

The Australian Dental Council, while not a government body, is critical to the functions of the DBA as an agency for the DBA. The DBA delegates its responsibility to manage quality and standards of education and accreditation to the ADC.

The ADC recommends to DBA the standards of education required for each oral/dental professional group, including the required minimum competencies for each individual group on graduation as a newly qualified practitioner. The ADC also recommends to the DBA accreditation of courses provided by dental education institutions. The DBA makes the final decisions concerning the accreditation status of existing and new programs.

2.6 Education Programs and Accreditation

Currently there are 12 education institutions offering dental and oral health programs in Australia with an additional two institutions in New Zealand (e.g. University of Otago and Auckland University of Technology). These dental schools are Charles Sturt University, Curtin University, Griffith University, La Trobe University, TAFE SA, University of Adelaide, University of Melbourne, James Cook University, University of Newcastle, University of Queensland, University of Western Australia and the University of Sydney.

A number of new dental programs started in Australia in the last few years (e.g. La Trobe University, James Cook University, University of Newcastle and Charles Sturt University), especially focussing on regional areas. New programs are from time to time being developed.

Dental education must be accredited in order to provide their graduates the options to register and work as dental practitioners after graduation. The ADC undertakes visitations to dental and oral health programs by peer review teams. According to the ADC the "purpose of accreditation is both to assure the quality of educational programs and to promote improvements in quality".

Dental programs usually will receive an accreditation status for 7 years and Oral Health programs for 5 years. New programs must follow the process of the DBA to obtain approval to start a program. This includes an accreditation visit by the ADC.

Education programs are all publically funded. Most dental programs admit students directly from high school, however, it is becoming more popular to have graduate entry programs for the dental programs. Most oral health programs are three year bachelor degree programs.

Currently dental and oral health programs funding from Government is at the highest banding level. This baseline funding is being reviewed by Government.

HWA is providing clinical teaching funds to support growth in student numbers over 2009 student numbers to dental schools.

Dental and oral health students follow a unique educational model where they commence actual service provision as part of their education at the commencement of their course. Students graduating are equipped to start registered practice immediately after graduation from the dental education institutions. Universities either manage their own patient care facilities (clinics/hospitals) or work in partnership with State Public managed facilities to provide dental care. Dental schools also provide the education of dental specialists in Australia.

The Australasian Council of Dental Schools (ACODS) has reported that the programs in 2011 had a combined student intake of 3358 dental and oral health students. The effect of the new dental schools in Australia combined with an increase in numbers of most of the traditional programs meant that there was a significant increase in student numbers.

The Australian Institute of Health and Welfare (AIHW) dental statistics and research unit provide the data for the number of oral health practitioners in 2006 and predict an increase of 2.5 times by 2015 and by 2025 the number of oral health practitioners per 100,000 population is expected to increase by 52%.⁴

During the consultation period there was an increasing concern that the number of total graduates would reach levels in the near future that would affect the ability for graduates to gain employment. This has been reported as probably having been exacerbated by the global financial crisis and the reduced demand for dental services in the private sector.

One major issue in Australia is the mix of practitioners. Traditionally most of the dental workforce has consisted of dentists. This is not the case in other countries. The Australian workforce model is expensive to the community and it is appropriate that as part of the reform agenda consideration be given to changing the workforce profile.

⁴ AIHW DRSU: Ju X & Teusner D 2011. Oral health practitioner labour force projections, 2006-2025. research report series no.52. Canberra:AIHW

2.7 Continuing Professional Development

Continuing professional development has become a standard to practice for *all* registered dental practitioners.

“The standard has been approved by the AHWMC on 31 March 2010 pursuant to the *Health Practitioner Regulation National Law (2009)* (the National Law) with approval taking effect from 1 July 2010.” The DBA defines CPD as the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

According to the DBA a practitioner must:

- a) *complete a minimum of 60 hours of CPD activities over three years*
 - *80% of the minimum 60 CPD hours must be clinically or scientifically based*
- b) *make a declaration of their compliance with requirements at the time of annual renewal*
- c) *maintain their own records detailing their CPD activities for audit purposes*
- d) *produce evidence of their CPD activities when requested to do so by the Board”.*

2.8 Add-On Programs of Study

Currently practitioners can extend their range of skills by undertaking educational add on programs that the DBA has formally approved for the purpose. These programs can be used by graduates to bring their training up to the same level as current graduates or to extend their SoP.

There is a perception that there are different rules for dentists to that of oral health practitioners. The add-on courses are difficult to get approved and this is reflected in the low number of add-on courses available. Dentists are seen to upgrade their skills using the training vehicle of CPD.

There does not appear to be a clear delineation between when CPD should be used and add on courses approved. The current courses available do not seem to be risk rated.

There is a view that add on courses should only apply to high risk procedures for all practitioners, if at all. Other views are that as professionals, all dental practitioners are provided with the educational framework to be able to upgrade to new skills as technology advances. The cost benefit to the community of using an add-on course rather than CPD should be carefully considered.

2.9 Professional Attributes and Competencies

To assist in performing its accreditation function as appointed by the DBA, the ADC has developed documents describing the professional attributes and competencies of newly qualified dental practitioners. These documents were developed in consultation with key stakeholders who include education providers, professional associations, and the DBA and Australian jurisdictional health departments.

These documents will be used by the ADC in its accreditation of dentistry, dental hygiene, dental therapy and oral health therapy education and training programs, and in the assessment and examination of overseas qualified dentists, dental hygienists and dental therapists seeking to practise in Australia.

It is anticipated that educational institutions seeking to have their education and training programs accredited by the ADC will use the document to assist them to develop their curriculums in preparation for the accreditation process.

The ADC completed the development of Professional Attributes and Competencies for dentists in June 2010 with dental therapists, dental hygienists and oral health therapists in June 2011. (Attachment 5)

According to the ADC all dental practitioners in Australia should be:

'a scientifically oriented, technically skilled, socially sensitive, professionally minded practitioner who adheres to high standards of professional conduct and ethics and who can function safely and effectively as a member of the health care system on graduation and throughout their professional career'.⁵

It is crucial to the understanding of the documents to define a "**competency**" as *"Competency includes knowledge, experience, critical thinking and problem solving skills, professionalism, ethical values, diagnostic and technical and procedural skills. These components become an integrated whole during the delivery of patient care by the competent practitioner. Competency assumes that all behaviours are performed with a degree of quality consistent with patient well-being and that the practitioner self-evaluates treatment effectiveness. The term covers the complex combination of knowledge and understanding, skills and attitudes needed by the graduate. Competencies are outcomes of clinical training and experience"*

To be a **competent practitioner**: *" the behaviour expected of the beginning practitioner. This behaviour incorporates understanding, skill, and values in an integrated response to the full range of requirements presented in practice."*

⁵ Australian Dental Council website - Professional Attributes and Competencies Statements for Dentists, Dental Hygienists, Dental Therapists and Oral Health Therapists
Available at <http://www.adc.org.au/adcmajoractivities.html>

These Professional Attributes and Competencies Statements will provide more national consistency but will still allow universities to go beyond the current SoP by how they interpret these Statements. They are also designed to enable dental schools to capture changing technologies and work practices over time.

Research and Consultation Findings

3.1 What Consumers Told Us

Consumers were consulted by members of the Project Team through the survey and focus group meetings.

Their feedback highlighted the following issues:

- The challenge of access in remote areas
- Age restrictions and their impact
- Waiting times
- The importance of the relationship between the patient and the provider
- The cost barriers for some patients
- Time, distance, transport and travel demands for rural, regional and remote areas
- The importance to overall health when dental health is well managed
- How good the service is when it is accessible from either a dentist or an oral health practitioner
- The importance of preventative dentistry
- The critical need for all people to have access to dental care

Survey results

There were 320 consumer stories that were mainly focused on issues around access, with over 50% of all stories describing difficulties in obtaining timely dental care. Access issues were most pronounced for regional, rural and remote patients, where access to care is compounded by a paucity of adult dental care and the travel/cost involved in obtaining it. For urban consumers access was synonymous with stories about public dental services, particularly in cases of expensive dental work and long waiting lists. Many of these stories related the physical, emotional and psychological cost of having to wait for an extended time to see a dental professional with dental issues that are physically obvious.

Story 1

"I live on a rural property only 4 hours from Brisbane and only half an hour from two towns yet I have to travel 140km (each way) to access any dental services. My dentist provides a top service but every time I have a check-up or seek treatment not only is there the actual cost of the dentist (expensive) but also I have to take a day off to be treated and then there is the cost of travel. Whilst I can afford it what about the people who cannot?"

Access issues were most critical for remote consumers, aged and institutionalised patients.

A sizeable number of stories related by consumers mentioned SoP restrictions in relation to access to care, particularly those stories dealing with personal dental emergencies. Frustration was expressed at not being able to be treated by an oral health practitioner in times of need, even when a pre-existing carer relationship had been established.

Around 15% of all consumer stories commented on the disproportionately high costs involved in dental treatment. Stories from consumers in the lower income bracket describe decisions to "avoid hot or cold food" because the costs of remedial dental work were out of their reach.

Other marginally poor consumers detail frustrations at meeting the cost of dental care without Medicare assistance. Many consumers report the frustration at discovering that even with good quality private health cover, the gap payments are still too large to meet without significant financial sacrifice.

A large collection of consumer stories were themed around personal care issues. These stories deal with issues of pain management (both good and bad accounts), treatment issues (good and bad), dental staff manners, and complex care issues such as those involving disabled patients, nervous children and adults with special needs (HIV sufferers, etc).

Story 2

"I have used the school dental service for my three children since they were small. They are now too old to use the service and they have to go to my dentist. He isn't as nice and calm as the dental therapist that they are use to, which has put them off going. I want them to continue to go to a dental therapist when they are Adults."

Some consumers made comment on their perceptions that school dental services had been closed and they were unable to obtain care for their children other than at a private practice. These comments were made in a number of locations around Australia.

Several stories contributed by consumers identify the SoP issues that govern the care provided by the oral health practitioners with whom they engage.

Some stories revealed consumer alarm when told that the therapist who was extracting their son's teeth last week is not qualified to extract adult teeth, and question why their children should be subjected to "second rate care that is not good enough for adults but OK for kids"; other consumers describe feelings of frustration that access to a dentist will take a considerably longer time, when the oral health practitioner could be treating them almost immediately; or annoyance

at not being able to be treated by a dental professional (oral health practitioner) who they know and trust, having witnessed treatment on their children over a prolonged period of time

Other stories contributed by consumers express gratitude to the hygienists, therapists and oral health therapists who they see as being specifically empowered to keep them out of the dentist's chair.

The consumer stories clearly identified the sense of empowerment experienced when the oral health care system is adequately resourced and functioning well.

Consumers expressed satisfaction and gratitude when they are being treated with respect and having their circumstances and treatment plan fully explained to them, having their pain effectively managed and being able to access dental care in a timely and efficient way.

Three issues summarise the strongly negative stories told by consumers; the excessively high cost of dental care, difficulty of access and unsatisfactory treatment.

The stories about cost that dominated the strongly negative responses from consumer issues were largely around costly dental work resulting in treatment being abandoned or not attempted, and the lack of universal dental care resulting in low income consumers being left with compounding health issues.

Access was seen as particularly problematic in times of severe pain, when waiting lists were long, even for emergency care. Rural and remote consumers felt access issues most acutely, with the time and travel costs to distant dental care facilities adding to the financial strain of their treatment.

Unsatisfactory treatment was experienced in both physical and social manifestations. Inadequate pain management during treatment, and re-occurring problems post-treatment were seen as unsatisfactory. Social manifestations of unsatisfactory treatment included the inflexibility of the health system, and rude or insensitive behaviour by dental professionals and their reception/office staff.

Some consumers can identify the different roles played by various members of the dental care team and the overwhelming sense of gratitude expressed toward dental professionals who engage with them on an empathetic level.

Stories contributed by consumers describe personal transformation as a result of good dental care. Their anecdotes relate improved self esteem, smiling again after years of embarrassment about the state of their teeth, and improvements in their personal relationships.

Feedback from focus groups

Focus groups were held in Townsville, Perth and Melbourne and were attended by a diverse group including general consumers, people with mental health issues and disabilities, people from a culturally and linguistically diverse background, Aboriginal community members and aged care representatives.

The issues raised in these discussions were identical with the issues generated by the survey.

Story 3

"I worked in remote Aboriginal communities in Arnhem Land. While a very rewarding experience with the children I treated I found it very frustrating that I could help the Adult population who were constantly coming to me for help. I have the knowledge, skill and resources to treat their problems but because of the scope of practice I am unable to help adults. I find daily that parents of the children I treat comment that they would come to me for treatment but wouldn't go to the Adult service in the next room."

3.2 What Dental Practitioners Told Us

Dental practitioners have been consulted individually through the project survey, interviews and meetings. The survey elicited 382 stories from dental professionals and members of the Project Team have talked to approximately 250 dentists, hygienists, dental therapist and oral health therapists.

The following is a summary of the issues raised:

- The existence of significant rural and remote access issues
- Different training across the States and resultant confusion
- Perceived age limitations, the differences between States and the need for greater consistency
- Confusion associated with radiation protection and rules
- Confusion for patients not always receiving reimbursement from health funds due to the lack of provider numbers for oral health practitioners
- Frustration by oral health practitioners at a perceived lack of recognition and respect for their work
- Dental hygienists and therapists report that they are not working to the full capacity for which they were trained
- Confusion about the SoP for oral health practitioners and dentists
- Lack of clarity about the implications of the "supervision" required under the SoP

- Concern by some dentists about patient safety and the SoP of oral health practitioners
- Board standards that seem liberal on paper have become more conservative and practice restricted as they are being interpreted
- Interest by some dentists in expanding the SoP of the oral health practitioners they work with
- Concern from dentists about their legal vulnerability with their interpretation and implementation of SoP
- The importance of team work and the success and effectiveness achieved when there is mutual respect

Survey results

The survey elicited stories about larger systemic issues playing on SoP conditions including the desire by oral health workers for more autonomous practice, a perception of outmoded legislation which limits their ability to provide efficient care for patients and limited opportunities for training to increase their SoP.

Independent practice demonstrated by separate provider numbers recognised by health insurance companies would provide a degree of recognition of the professional status of oral health workers.

Legislative restrictions are seen by some respondents as a limitation on their ability to provide efficient care. The most common instance of legislated inefficiency surrounds the ability of oral health practitioners in some States to take and report on certain types of dental x-rays, while in other states they cannot.

There is a perception that the current SoP restricts the ability of oral health practitioners to practice in areas of dental care in which they are suitably trained. In aggregate, the stories told by oral health practitioners describe the current SoP as restricting their ability to practice in areas of dental care in which they are suitably trained. In response to questions on professional competence, dentists registered reasonably strong support for the current SoP, but significantly there was negligible support for it from the oral health practitioners.

The word 'supervision' in the National Registration Scope of Practice Standard is not seen as a requirement by oral health practitioners and some dentists but seems to have remained as a legacy of the historical divide within the dental profession. Unfortunately many dentists still see therapists in the role and model of care that instigated their original use in the late 1970's and early 1980s. At this time therapists had been trained specifically to work within the government sector only in the School Dental Service, and the notion of 'supervision' of a group of 'young female dental therapists', who were envisaged to stay in the profession for a few years, marry and leave was seen as essential.

This in fact did not happen, with many dental therapists remaining in the workforce for many years. Since that time there have been many changes within the oral health industry and health sector which have initiated marked changes in the role and capabilities of dental and oral health therapist.

The progression to tertiary education for oral health therapists has seen the beginning of the evolution of a professional group with the potential to positively impact the health sector in a much broader way than via the 'dental office' or 'clinical setting'. As the foundation for oral health therapists' clinical skills is within a much broader public health and health promotion sphere, they have the potential to advance oral health on a population, community and individual setting.

The stories related by both professionals and consumers were overwhelmingly about the sense of empowerment experienced by both groups when the oral health care system is adequately resourced and functioning well.

Oral health practitioners are confident of their abilities, whether or not they are given the freedom to fully exercise them. Professional stories of frustration include age limitations and inefficiencies through not being able to apply existing skills to save patients time and money.

Story 4

"I was recently treating a 17 year old patient and they required numerous simple restorations however they were turning 18 in 2 weeks time. The trouble with this was I could not restore all of the teeth before their 18th birthday and our adult service already has extensive waiting lists. If we were able to do simple restoration on all patients it would eliminate the need to have them sitting on unnecessary waiting lists and reduce the episodic courses of care that usually occur in our adult service."

Accounts of experiences that take place in rural, regional and remote Australia describe limitations imposed on care through perceived SoP restrictions; outmoded legislation/ system constraints; and the additional demands placed on regional oral health practitioners who practice at a geographical distance from dentists. Particular stories related to the perceived limitations resulting in either seeing their patients suffer, or having to instruct other, less experienced or well trained health professionals (both dentists and General Practitioners) to do work the oral health practitioner is not legally able to do.

In relation to education and training, issues cited included State differences, inadequate extension training, and a perceived danger of non-dentist professionals providing complex or invasive treatments.

Professionals relate the sense of satisfaction that goes well beyond the physical work. They describe the sense of satisfaction at seeing improvements in their patient's lives, at observing that the information and instruction imparted to patients about their

oral health has been adopted, with consequent improvements in overall health, and feeling valued as a member of the team. The 84 negative or strongly negative stories told by professionals ranged over a variety of themes that centred around frustrations experienced while trying to provide patients with the highest quality dental care.

Professionals cited effective teamwork as a major factor in effective patient management and improved professional satisfaction.

Outcomes from interviews and meetings

The outstanding result from these individual and small group consultations was that they confirmed the outcomes of the survey. The advantage of the consultations was that matters could be explored in depth and the impacts of the current situation became clearer.

The confusion among dentists and oral health practitioners about the detail of the SoP is obvious and there has been a marked pulling back on the scope of activities of oral health practitioners as a result of this confusion. This is clearly a significant unintended consequence of the new Scope of Practice Standard.

Key issues causing frustration for dental hygienists, dental therapists and oral health therapists, identified in interviews and meetings, included:

- They are trained to do a lot of procedures but many are not allowed to use their full scope of the practice. This is as a result of
 - A set of rules/policies established by some employers that restricts practice
 - A lack of understanding by the dentist (particularly the practice owner) of the SoP of oral health practitioners, what they have the capacity to do and their capacity to add to the practice revenue
 - Concern with the DBA standard and confusion with its meaning in practice
- Unclear rules about the management of patient care when a dentist is not available including interpretations about the meaning of supervision. The perceptions among some dentists and oral health practitioners about their ability to exercise autonomous decision making versus their inability to practise independently and whether these two concepts are different. Oral health professionals voiced a strong view they don't want to work as sole traders but want to be autonomous within a practice environment – referring to the dentist when needed. This links strongly to the issue of diagnosis and treatment planning

- There is a lot of confusion about what people can do and what they can't for example:
 - Examination and treatment planning. Many are trained in these activities but past State Boards have not allowed them to undertake the duties – even though they are trained
 - Issue over training that has occurred overseas e.g. use of relative analgesia, extraction of permanent teeth and if, with the current standard, they can carry out those tasks
- There is a need for access to additional training (e.g. to pick up skills that they were not previously trained for but is standard now) Oral health professionals are concerned that this training is not available, and that if it is made available it will be unnecessarily long and expensive.
- The issue that there are many experienced practitioners who have competencies gained through experience rather than training who are looking for a system that enables formal recognition of competencies and recognition of prior learning when seeking further training
- Some dual trained people are not sure what they can do and what they can't when they are treating a particular patient and usually acted as either a therapist or hygienist on any particular patient.
- Dentists are not trained to work with dental hygienists, dental therapists or oral health therapists and are not sure how to work as part of a team within a collaborative practice model

3.3 What Peak Bodies Told Us

Dental Hygienists' Association of Australia (DHAA)

The DHAA identified their profession as important to the oral health of all Australians. The profession of Dental Hygiene began in Australia in 1976, when dental hygienists became a recognised dental professional within the State of South Australia. Other Australian States and Territories have progressively introduced the profession on their statutes since 1981, and dental hygienists may now lawfully practice across Australia.

Dental hygiene services work in public and private general and speciality dental practices (although a higher percentage work in private general practices), programs for research, professional education, community health, hospital and institutional care of disabled persons and the armed services.

Dental hygienists are responsible for the prevention of oral diseases, management of periodontal diseases and assisting their patients to maintain an optimum level of oral health.

The DHAA believes that dental hygienists have a proven track record of practising safely and within the guidelines of the current Code of Practice. Since the introduction of the Code in 2002 there have been no formal hearings into allegations of professional misconduct involving dental hygienists.

The DHAA gave the following feedback to the Project Team:

- They are well trained professionals, but many are not utilizing all the skills their training and experience has equipped them with
- There is a lack of recognition and respect by some dentists for them as practitioners
- Many hygienists don't have control over the services they provide and are often overridden by a dentist
- Health funds don't always recognize preventive services and sometimes don't pay if the hygienist does the service rather than the dentist
- Patients should be able to directly access a hygienist. Dental hygienists want access to provider numbers and want autonomous practice within a team environment. They are not looking for sole trader status
- Concern was expressed about the lack of use of hygienists in the public sector
- The DHAA believes that as the links between oral health and general health receive recognition this will lift the demand for hygienists
- Increases in SoP need to occur in aged care, pre & post natal, adolescent, correctional facilities, etc – hygienists need to be able to go out independently with provider numbers
- Dentists don't know what the hygienists do or what their SoP is
- There is a need to train dentists, oral health therapy and hygiene students together. Urgently need to learn how to be a multi-disciplinary team
- Newer dentists have demonstrated more interest in an effective team approach

DHAA believes that access to dental care, particularly in underserved populations is limited in a system where the dentists must examine all patients first. They see this as a barrier to access and that they could provide direct services to patients in critical areas such as residential aged care facilities, hospitals, homebound people in

private residence, Indigenous and underserved rural communities, maternal and child health centres and schools. The hygiene services appropriate for direct provision include oral health promotion and education, an initial oral examination, development of a dental hygiene diagnosis and treatment plan, provision of dental hygiene care as deemed appropriate by the hygienist and referral to a dentist where required.

Australian Dental and Oral Health Therapists' Association (ADOHTA)

The ADOHTA describes dental therapists as having practised as registered professional members of the dental team since the 1960s within a collaborative and referral model of team care (with dentists, dental specialist and other health care professionals, as determined by the needs of their patients). Within their individual SoP they provide oral health care for children, adolescents and in some states young adults and adults including examination, treatment and prevention, with a strong preventative focus. Their range of skills is a subset of dentistry and they provide their services as professionals undertaking autonomous decision making within their SoP.

While newer as a profession, oral health therapists are trained as both dental therapists and dental hygienists and are registered to practice in both areas within their individual SoP.

The ADOHTA believes that dental therapists and oral health therapists have a long history of practicing professionally within their SoP. They assert that they have been practicing independently from dentists, responsibly recognising the boundaries of their scope and referring appropriately to dentists.

They are individually responsible for the quality of care they provide, hold independent professional indemnity insurance and registered with and accountable to the Dental Board of Australia for their performance quality. The ADOHTA advocates that dental therapists and oral health therapists provide at least the same standard of care as that of a dentist, within their SoP and the services they provide. They are regulated within the same framework as dentists, have different expertise and training and see it therefore as inappropriate for them to be subject to the supervision of dentists. The introduction of "supervision" is seen as creating a hierarchy where collaboration had previously existed.

The ADOHTA supports the team based approach to dentistry with oral health professionals practicing within a structured professional relationship with a dentist. They see this as being a description of what currently occurs throughout Australia. They view this structured professional relationship as being one of consultation and referral.

The ADOHTA promotes a model of professional practice that includes direct billing to patients and the allocation of provider numbers by insurance companies and Medicare. These measures are seen as opportunities to increase access to their services, reduce costs and removal of an excess layer imposed by indirect billing.

Australian Dental Association (ADA)

The ADA is an organisation of dentists which has as its primary objective to encourage the improvement of the oral and general health of the public and the promotion of the ethics, art and science of dentistry and support members to provide safe, high quality professional oral care. There are Branches of the Association in all States and Territories. Membership is voluntary and over 90% of dentists in Australia are members. This membership implies an obligation for members to practise their profession in accordance with the high standards laid down by the Association.

The ADA believes that the issue of poor access to oral health service is due to a maldistribution of the dental workforce, not a shortage of dentists. In addition there is an urgent need a significantly higher allocation of Government funds to improve access. The ADA recognise that access to services in rural and remote areas is a problem but this cannot be addressed by altering the SoP of any one member of the oral health team. Solution is to increase funding for promotion and prevention, invest in oral health of children and prioritise oral health at all levels of government.

The ADA supports the current SoP standard on structured professional relationships with a dentist – the intent of this is to allow “allied oral health practitioners to practise to their full scope in a collaborative relationship”. The ADA sees the current environment as an excellent example of collaboration and teamwork.

The ADA supports any attempt to reduce the ambiguity about role of oral health practitioners for both dentists and oral health therapists.

The ADA describes the essential role of dentists in development of oral health assessments as a result of their training in anatomy, physiology, pathology, epidemiology, critical thinking and technical competence. There is a view that it is much more efficient as the dentist can provide a range of treatments in one visit. Allied oral health workers have a more limited subset of skills and may need to refer a patient to a dentist for the remaining care.

The ADA recognise that allied oral health care providers have “been shown to deliver effective, safe and quality services to patients” but don’t have the complex technical skills of dentists. Extending their skills in order to achieve a greater SoP is time consuming and expensive and in the view of the ADA “would not, in most cases, avoid the need for dual services to the patient by both the dentist and oral health practitioner”

A possible unintended consequence of expanding the SoP of oral health practitioners may be to lessen the focus on children and adolescents. There is a great need in the public health system for public education and prevention and dental therapists and dental hygienists “with their strong educational background in public health are ideally suited to this role”

The ADA supports “a future dental workforce that can provide efficient and effective services that are: population and preventatively based; patient centred; co-ordinated and non-fragmented within a quality and safety framework.

The ADA supports the requirement for “supervision” in the interests of public safety

They recognise that allied oral health care providers have “been shown to deliver effective, safe and quality services to patients” but these members of the team do not have the complex technical skills of dentists, rather they have a more limited subset of skills. The ADA asserts the essential role of dentists in the development of oral health assessments as a result of their training in anatomy, physiology, pathology, epidemiology, critical thinking and technical competence. In addition they consider this to be an efficient service delivery model as dentists can provide a range of treatments in one visit.

Extending the skills of oral health practitioners in order to achieve a greater SoP would be time consuming and expensive and in the view of the ADA “would not, in most cases, avoid the need for dual services to the patient by both the dentist and oral health practitioner” and therefore be an inefficient service delivery model.

Australasian Council of Dental Schools (ACODS)

At a meeting with ACODS the individual schools made the following points:

- The dental and oral health institutions are the primary provider of education programs in Australia.
- The curriculum and content of the three year Bachelor of Oral Health (Oral Health Therapy program) was in most programs at their limits, and would require a review of the current curriculum to include additional education modules if required.
- One option for extension of scope programs may be extending the program for a period of time, as has happened in the Netherlands recently where the dental hygiene program was extended from three to four years to accommodate expanded SoP requirements.
- Another option may be to provide extension of scope education and training as a post graduate program.

- The intake of oral health students in education programs in Australia has shown a steady increase over the last 10 years. One of the oral health therapy programs has recently been discontinued (e.g. Griffith University).
- The current oral health programs have some education and training inconsistencies between dental schools.
- Education programs will in future have to use the ADC professional competencies as guideline for their programs and this may secure a more consistent approach nationally, as well as a consistent graduate nationally.
- Some university programs will be more educationally progressive than others occasionally associated with a strong reform agenda that may progress the SoP boundaries.
- Universities are by definition institutions of higher learning and exist because they generate new knowledge through research.
- Most programs use educational models incorporating patient centred patient care and providing clinical placements in various settings ensuring the necessary and appropriate experience for the future graduates.
- Many believed that their core business was to provide award courses and they were not in the business to upgrade qualifications, provide add on courses, etc
- Funding remains the main challenge for already severely resource challenged education programs. Changes to SoP will have resource implications for the dental schools and that needs to be considered.

National Rural Health Alliance (NRHA)

The NRHA advocates for all Australians to have equitable access to appropriate health services, regardless of where they live with a fair distribution (30%) of public resources being allocated to services for the 30 per cent of the population who live in rural and remote areas. This includes advocating for a commitment from governments for a national investment in oral and dental health.

The NRHA is concerned that there is a dental workforce shortage and that a serious mal-distribution exists between both rural and urban and public and private practice settings.

The following picture was provided by the NRHA in 2009:⁶

- Dentists are one third as prevalent in remote areas as in major cities and only one half as prevalent in rural areas

⁶ Proposal to the National Health and Hospitals Reform Commission for a Rural Australia Dental Undergraduate Scholarship (RADUS) Scheme MARCH 2009

- In 2005 there were just 19.8 dentists for every 100,000 remote Australians compared with 58.6 per 100,000 in the cities
- Over 40% of regional/remote practising dentists are over 50 years of age compared with just under 30 per cent in major cities
- 33.7% of regional/remote dentists report themselves busier than they would prefer, compared with 17.0 per cent in major cities
- Australia has the second worst adult oral health of all OECD countries
- Over 30 per cent of the population lives in rural Australia where dental services are less accessible, less available and less affordable
- Waiting times for an appointment in private practices are 3.9 weeks in regional/remote areas and 1.6 weeks in major cities
- People aged 25-44 living outside major cities are only half as likely to visit a dentist as city dwellers
- Nationally, there are around 650,000 people on waiting lists for public dental care, with an average waiting time of 27 months. Rural people are likely to be over-represented on those waiting lists.
- Lack of access to fluoridated water in many parts of rural and remote Australia has contributed to higher levels of tooth decay and tooth loss.

Dental hygienists, dental therapists and oral health therapists are seen as critical resources to expanded services in prevention and basic treatment in rural and remote areas.

Dental hygienists, dental therapists and oral health therapists are seen as critical resources to expanded services in prevention and basic treatment in rural and remote areas.

The NRHA is concerned to achieve a flexible workforce of dentists and oral health practitioners who can work to the extent of their SoP as a patient centred team to meet the needs of rural and remote Australians.

3.4 What Government and Statutory Bodies Told Us

Dental Board of Australia (DBA)

The DBA is limited by the Act and the registration standards as approved by the AHMWC. They are aware of the review of the Scope of Practice Standard by HWA

and have held off their review until this review is finalised. They are anticipating being able to leverage off this review following advice and recommendations about the SoP Standard from the AHMWC.

The DBA indicated that if the Minister outlined the activities that they wanted, e.g. expanding a SoP then they would see its role as determining the training program that would be appropriate.

They are also addressing the educational framework options for SoP training, whether they should approve providers, add on courses, accept CPD, etc.

They also acknowledge the confusion that has arisen from the Scope of Practice Standard, even with publishing the follow up Frequently Asked Questions document. Within the resources they had available, they did undertake a program to disseminate the standard but this appears to have been inadequate.

Public Dental Directors

Public dental directors are a group of all the jurisdictional public oral health leaders within Australia that meet regularly to share ideas and discuss opportunities to improve the oral health of Australians.

The public dental directors support the removal of the word supervision as they do not see it as appropriate. Dental therapists, dental hygienists and oral health therapists are trusted professionals and the supervision word reinforces a power relationship that does not exist. There was some concern that the structured professional relationship caused as much confusion as the interpretation of supervision. They recognise that dental professionals are confused about what oral health practitioners can and can't do.

Overall there was general agreement that the team based environment could be expressed through a structured professional relationship. It was important that this was simple and pragmatic and not overly prescriptive. The team model needs to be flexible, particularly in rural and remote areas.

The Directors expressed a need to still be able to make decisions about priorities and resource allocation that may focus the activities of their employees to a more limited range than their SoP would allow. The public health system is generally not using hygienist's skills, so oral health therapists may need to work across the public and private system to keep their competencies and recency of practice. Some services were now deliberately providing the dual opportunities in a bid to improve recruitment and retention.

They indicated that there should be ways to expand competencies to provide greater range of skills through CPD if possible. They would seek approval as providers so they can provide in-house training.

They expressed a need for cultural change and evolution of the profession from a 'cottage based' single practitioner industry model to larger practices with interdisciplinary teams.

They expressed concern that the DBA needed to express more fully the other functions of the Act besides just the health and safety of the public. It is a balance between all the objectives including access and a sustainable workforce.

The dental directors expressed a strong desire for increasing SoP to allow oral health therapists to treat adults with simple direct restorations. They understood the risk that they may lose these practitioners to the private sector but indicated that the flexibility this offered in the workplace was worth that risk. They reiterated a renewed focus on care for children and preschool children, although that was not consistent around Australia due to resourcing constraints.

They saw that an artificial age restriction works against continuity of care. Some States see the transition from working with children and adolescents to all age groups as not having SoP or training implications.

3.5 What Dental Education Institutions Told Us

In order to obtain information from the dental and oral education institutions in the country a survey was undertaken of the 12 programs offering Dental Hygiene, Dental Therapy, or Oral Health Therapy at 10 Australian Education Institutions. (Attachment 4)

The aim of the survey was to evaluate the consistency of education programs across the country of similar programs. All of the programs surveyed are accredited by the ADC. This survey was done before the approval of National Accreditation Professional Competencies and Attributes by the ADC.

There are currently seven oral health therapy programs, three dental hygiene programs and two dental therapy programs.

The survey outcome shows some inconsistency between programs, limitations concerning education scope, that were dictated by previous State legislation (e.g. different age restrictions), some programs like La Trobe that has been the first program to offer an accredited course in simple restorative care for adults, most programs provide integrated learning experiences for their students, supervision and teaching differs.

The Literature Survey

An extensive literature review was undertaken of current and in some cases historic literature. It is attached to this report in Volume 3.

This literature review provides a national and international description of the professions of Dental Therapy, Dental Hygiene, and Oral Health Therapy. In addition, it discusses related SoP matters of these groups. In particular, the review includes the following topics:

1. Historical perspectives of Dental Therapy, Dental Hygiene, and Oral Health Therapy
2. Current workforce roles and scope of practice in Australia
 - 2.1 Current oral health policy and services
 - 2.2 Current workforce roles, numbers of students and practitioners, and variations in their scope of practice
3. International scopes of practice and published evidence
 - 3.1 International perspectives on scope of practice
 - 3.2 Published evidence concerning workforce models of best practice
4. Future workforce drivers and perspectives
 - 4.1 Improving access to care and addressing oral health disparities and inequalities
 - 4.2 The team approach to comprehensive patient-centred oral health care
 - 4.3 Changing practitioner roles and its impact on future workforce planning

The desktop literature review comprises published evidence concerning workforce scope of practice relating to the professions of Dental Therapy, Dental Hygiene, and Oral Health Therapy focussing on the peer-reviewed literature.

The review considers the relatively recent history of these professions from the beginning of the 20th century, and their current workforce numbers, roles and scope of practice in Australia. It examines the scopes of practice of these and similar oral health professionals internationally and published evidence concerning their efficacy and contribution to patient care. This focuses on international jurisdictions with similar health care systems including the UK, Canada, USA, The Netherlands, Malaysia and South Africa. Finally it addresses future workforce drivers and challenges.

Dental services consume a significant proportion of the cost of Australian health care. The AIHW (2003)⁷ found that about \$3.7 billion were spent on dental services in the year 2001-02, representing 5.5 per cent of total health expenditure.

Importantly, Australian dental services are mainly providing treatments for established dental caries (decay) and periodontal disease (gum disease) - while these problems have been demonstrated to be safely and effectively preventable⁸.

However, the ability of the public and private dental sectors to provide the dental services demanded by Australians is severely threatened by a worsening national shortage of dental providers. In 2003, it was estimated that by 2010 there would be 1,500 fewer oral health providers (general and specialist dentists, dental therapists, dental hygienists, oral health therapists, prosthetists and dental assistants) than would be needed just to maintain current levels of access⁹. This was based on estimates that the demand for dental visits would increase from 23.8 million in 1995 to 33.2 million in 2010. In response, the annual number of oral health practitioners graduating from Australian institutions is now anticipated to increase more than 2.5 times, to 335 by 2015. Overall, the number of oral health practitioners per 100,000 population is expected to increase by 52%, from 10.8 oral health practitioners per 100,000 population to 16.2 by 2025¹⁰.

Over the projection period 2006–2025, the AIHW reports that the number of practising:

- oral health therapist numbers will increase the most, more than 460%, from 371 to 2,117
- dental hygienist numbers are expected to more than double, from 674 to 1,458
- practising dental therapist numbers are projected to decrease by 61%, from 1,171 to 443.

This is in line with the increasing supply of dual degree courses resulting in a Bachelor of Oral Health (BOH) qualification.

⁷ Australian Institute of Health and Welfare (AIHW) (2003) Health expenditure Australia 2001-02. Health and Welfare Expenditure Series no. 17. AIHW cat. no. HWE24. Canberra: AIHW.

⁸ US Department of Health and Human Services (2000) Oral health in America: A report of the Surgeon General – Executive summary. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

⁹ Spencer AJ, Teusner DN, Carter KD, Brennan DS (2003) The dental labour force in Australia: The Position and Policy Directions, AIHW Cat no. POH 2, Australian Institute of Health and Welfare Population Oral Health Series No.2, Canberra.

¹⁰ Australian Institute of Health and Welfare 2011. Oral health practitioner labour force projections 2006–2025. Research report series no. 52. Cat. no. DEN 209. Canberra: AIHW

Australian jurisdictions vary in the SoP allowed for dental hygienists and therapists and oral health therapists. Variation in such legislation regarding oral health professionals' SoP can affect ability to meet unmet needs, and ensure patients' equitable access to oral health care.

The Healthy Mouths, Healthy Lives report (p40)¹¹ recognises and addresses the need for policy and systems change to improve oral health outcomes and associated costs:

“To improve oral health outcomes, dental practitioners and service systems need to expand their focus to address, in a systematic way, population health issues such as the promotion of a dentally healthy lifestyle and behaviours, and the early identification and treatment of oral health problems.

This requires a greater team approach within dental practice, involving general and specialist dentists and other oral health practitioners... Greater integration of the range of oral health practitioner education has the potential to foster team dentistry, as well as retaining flexibility in education and training capacity to meet changing population needs. There are a number of opportunities to make better use of the various members of the oral health workforce, including: increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary and maintenance oral health care including health promotion; and more effective use of the existing workforce”.

This call is in line with the subsequent report of the Productivity Commission *Australia's Health Workforce* (Productivity Commission, 2005). This report 'sought to identify reforms which would produce a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes'.¹²

The Productivity Commission report also examined the need for workforce innovation. However, it found that 'the evidence suggests that various opportunities for more significant workforce innovation, including broadening scopes of practice and more major job redesign, have not been progressed, or even properly evaluated.'

¹¹ Healthy Mouths, Healthy Lives. Australia's National Oral Health Plan 2004-2013. Australian Health Ministers Advisory Council (AHMAC). National Advisory Committee on Oral Health (NA-COH), Adelaide, SA: Government of South Australia: on behalf for the Australian Health Ministers Conference, 2004.

¹² Productivity Commission (2005) *Australia's Health Workforce*, Research Report, Canberra. Available at <http://www.pc.gov.au/study/healthworkforce/finalreport/index.html>. Accessed September 2011.

The review findings support these proposals.

Research literature reviewed is of varying methodological quality, with a general improvement in the past decade. Evidence demonstrates significant variations to the SoP that oral health professionals provide around the world. This includes nature of supervision, ranging from direct supervision, to collaborative practice with dentists on site or off-site (including remote) and completely independent practice. In addition, there are significant variations in the age groups that these professions are currently able to serve. Overall, teamwork and promotion and prevention are emphasized.

Consistent with other emerging professions, the literature shows that there is considerable contention regarding their current and future SoP both nationally and internationally.

Internationally the definite trend in the published literature is towards extensions of scope and concern about improving workforce models to afford better access to preventive care of children and services for underserved groups. There is no evidence that extensions of scope have caused any deleterious effects on the public. Extensions of scope and collaborative/autonomous teamwork models accompanied by increasing numbers of practitioners are advocated as ways of affording better access opportunities and reducing the burden of oral diseases.

Significant Issues

5.1 Introduction

There were reported a number of unintended and negative effects on oral health practitioners' SoP. Both the employers and the oral health practitioners were confused in their interpretation of the SoP Standard and had changed their SoP. Some reported some significant changes.

The major issues related to:

- confusion about the SoP Standard
- lack of educational opportunities to achieve contemporary SoP competencies
- frustration about the lack of workforce innovation opportunities, and
- major job redesign to ensure equitable access to oral health care and requests for expansion of SoP.

There was debate about the need for a SoP Standard with the argument that 'professionals' are provided with an ethical framework and professional obligation to ensure that they practice within a SoP for which they have been formally educated and competent.

5.2 Current Scope of Practice Confusion

a) Supervision and independent practice

In the current SoP Standard, the DBA has determined that 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 practice 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 direct supervision.

An independent practitioner is defined as a practitioner who may practise without supervision; and supervision as oversight, direction, guidance and/ or support.

The DBA provides the following explanation in addition: The term supervision in the SoP Standard is defined as oversight, direction, guidance and/or support; which is a broad and flexible definition and does not require the person providing the supervision to be physically on site.

For oral health therapists, dental therapists and dental hygienists the supervision requirements could be met through ensuring that a structured professional relationship exists with a dentist who could be consulted as necessary via any means.

The surveys, literature review and consultations clearly indicate this is the major area of confusion and has caused the most significant unintended and negative impact on the SoP of dental hygienists, dental therapists and oral health therapists.

In addition, the majority of the dental educational providers educate the current graduates to work without supervision in their current SoP. They advocate structured professional relationships where they refer or consult regarding a patient when outside their SoP.

Independent practice was confusing to many dental practitioners. Some saw it as relating to their ability to undertake autonomous decision making, while others saw it as being able to set up as a sole trader (i.e. 'hang up their shingle'). While the SoP Standard says that they can undertake autonomous decision making, they cannot work without supervision (i.e. as an independent practitioner). This was confusing to all professional groups. There was little support for being able to 'hang up their shingle'.

Project Team Assessment

The Project team supports the removal of supervision from the SoP Standard and the maintenance of the concept of a structured professional relationship. It is important that the structured professional relationship is simply described in terms of the consultative and referral arrangements that may be put in place and not overly prescriptive and restrictive. Ideally it would be reviewed at least annually.

The Project Team believes that all practitioners as professionals should and do work within a structured professional relationship. It believes in the medium term that there is little need to continue with the statements barring independent practice. In the short and interim term, it supports the maintenance of the bar on independent practice provided the definition is changed to that of 'being outside a structured professional relationship'.

b) The Age Scope

Age limitations imposed by the SoP Standard due to the different education and training provided by the dental schools have consequences.

Stories relate the impacts of age restrictions on continuity of care; describe the restrictions placed on highly trained oral health practitioners treating persons over 18 years of age resulting in ineffective use of practitioner skills as well as increased waiting times for patients to receive care that could have been more expeditiously provided.

Story 5

"I took my daughter to visit the kid's dentist at the Health centre. Because we don't get dentists visit very often I wanted her to check my teeth. She said she couldn't because she couldn't treat adults. I was confused because she did fillings on my daughter and I know she has taken my nephew's tooth out. She is really good with the kids"

The custom and practice in different States and Territories has emphasised these problems. States and Territories that have allowed adult treatment have demonstrated a greater capacity to provide a flexible workforce. In those States and Territories there are specific protocols and policies that outline the structured professional relationship and what Dental Therapists can do for adults. This is seen as a very safe and high quality way of operating¹³. In South Australia the extension to Dental Therapists treating adults 18–30 years is not seen as a SoP change, but as an extension of the existing scope to an older age range.

Project Team Assessment

There is general agreement across the dental profession that an individual's SoP is related to their education and training as well as competency. There is therefore no disagreement that there is not, nor should there be an artificial age barrier within the SoP Standard. The area of disagreement centres on the availability, cost, length and requirements for further education to enable oral health practitioners to work across all age groups.

The most significant benefit in expanding the age scope for oral health therapists is to provide a flexible workforce professional that could be utilised in an innovative workforce model that could improve oral health outcomes for the Australian community.

La Trobe University has incorporated the extension of the provision of simple direct restorative care to adults into their undergraduate curriculum. The evaluated add-on pilot course by Dental Health Services Victoria and approved by the Dental Practice Board of Victoria for dental therapists to provide similar treatment to adults was 203 hours including half that time being for clinical components under direct

¹³ Calache H & Hopcraft M, Evaluation of a Pilot Bridging Program to Enable Australian Dental Therapists to Treat Adult Patients. J Dent Educ 2011;75(9):1208-1217

supervision. Some dental education institutions indicate the possibility of another year of fulltime study. This then raises the question of efficiency and cost of this expansion.

Dental education providers would need to be able to adjust their curriculums to provide the education for oral health therapists to perform simple direct restorations on any age person. In addition there is a need to be able to offer current graduates the opportunity to upgrade their education and training.

The Project Team has been unable to identify an age restriction within the current SoP Standard and concludes that many of the frustrations experienced about this issue are primarily caused by misperceptions of the current SoP Standard and difficulties in accessing further training. There is support from the community for dental therapists and oral health therapists to continue providing dental services past the traditional age limits imposed in each jurisdiction.

c) Uncertainty about the roles and description of different practitioners

Interviews with dental and oral health practitioners identified a current confusion with the SoP for dental hygienists, dental therapists and oral health therapists resulting in practitioners reducing their SoP.

There is no clear definition of SoP to assist practitioners to identify their limits of practice. The interdisciplinary boundaries overlap, as is appropriate, but that also causes confusion.

The DBA refers to SoP being described by a practitioner's formal education and their competency. The ADC currently accredits courses to ensure the stated aims of the course (by the educational provider) are achieved and implies that that will establish the SoP. The new attributes and competencies will set a more consistent accreditation standard in future.

There are issues for the community in not understanding the differences between practitioner categories and when a patient would see one professional rather than another. Currently the DBA through enforcing the Act protects the title of each of the dental practitioners. There is no published description of what each category of professional is and the broad range of activities that may be undertaken by each. This description would assist to describe the SoP of the individual practitioners and could also be used as a reference in conjunction with the ADC's documents relating to the *Attributes and competencies of the newly graduated dentist/dental hygienist/dental therapist/oral health therapist.*

It is seen as critical by most respondents in this project that this description does not become a return to a definitive list of duties which is considered to be restrictive and not adequately responsive to a rapidly changing medical and dental world.

Project Team Assessment

The Project team supports the development of a definition of the SoP by the DBA that should then lead to a generic description of each practitioners SoP.

The Project team concludes that a simple description of the various practitioners would be beneficial to facilitate greater understanding by the community of the different categories of practitioners, gain greater respect for the work of oral health practitioners and to guide the accrediting body and dental education institutions.

d) Scope of Practice and Scope of Activities

It is important to address the question of the scope of activities undertaken by oral health professionals as these activities are not necessarily linked to an individual's SoP.

While the SoP of any individual will set boundaries on what that professional will and will not do, the activities they actually undertake within a dental practice (whether public or private) are related to the needs of the practice and the business arrangements that practice. For example, a public health provider may set a priority on the treatment of children (even though the oral health practitioner has a SoP that includes all ages) and will seek to fill its positions to carry out functions with children. Similarly, a private practice owner may define the professional gap in their service and seek to fill specifically to that gap.

It is recognised that this is current practice and that many oral health professionals have therefore opted for more than one part-time position in order to keep the currency of their SoP.

It is important also to note that oral health practitioners may be the owners of a dental practice and also work within that practice. As owners they are free to determine the range activities for all staff they employ. As oral health practitioners they must operate within their SoP in a professional relationship with a dentist.

Project Team Assessment

The business arrangements within which dental hygienists, dental therapists and oral health therapists practice are separate to their competency to practice and are properly the purview of the employer.

Concern has been expressed by some (mostly dentist) participants in this project that an increase in SoP for oral health practitioners will result in a decrease in attention to the dental health of children and adolescents. This topic is considered a matter for employers, particularly governments, who will establish their priorities based on need and current policy directions.

The Project team does not consider that public health policy and directions should dictate the SoP of oral health practitioners who should be free to negotiate the use of their services with any employer based on their individual SoP and the needs of the employer.

e) Prescription and Radiation Practices and State legislations

The major issues relating to prescribing and radiation practices are the differences between the State and Territory legislations. There is less impact with the various jurisdictions prescribing legislation as oral health practitioners cannot prescribe drugs but they do dispense them through topical applications e.g. Fluoride varnish and administering local anaesthetics. During the survey and consultation phases it was apparent that there was a demand from oral health practitioners for increased opportunities to prescribe simple pain and antibiotic medications to manage emergency situations in rural and remote areas. This would require additional education and would be an increase to SoP.

The major issue related to the radiation practices as it had an effect on the ability of some practitioners in some States to be able to obtain the appropriate education due to the State legislation. Some of this legislation is very old and not contemporary and fails to recognise these new practitioners as being able to undertake certain procedures. Most would be expected to be able to take and interpret all intraoral and extraoral radiographs like orthopantomographs (OPG) and lateral cephalometric (Ceph) radiographs). There are some discrepancies in training due to State legislation.

Story 6

"Radiation Health Act in Queensland is 30 years out of date and is not consistent with the National Law - that for which you have formal education and training and for which you are competent. Under the Radiation Health Regulations in Qld, as a dental therapist, I am not allowed to prescribe a periapical radiograph nor read it in a diagnostic manner. I have received formal education and training to prescribe a periapical and read it - but I'm prevented from delivering this dental service to my patients."

There is a Code of Practice and Safety Guide for Radiation Protection in Dentistry published in 2005 by the Commonwealth body called the Australian Radiation Protection and Nuclear Safety Agency. The aim is that it is used to guide States and Territories when they are reviewing legislation. Many jurisdictions have not reviewed the legislation for some time.

Project Team Assessment

The Project Team considers that it would be advantageous to the profession and the community for there to be consistency in training in this area and proposes that the AHMWC recommend to all jurisdictions that the various radiation and protection Acts be reviewed to remove barriers that prevent appropriately trained health professionals to provide services to the community. This would allow Dental education institutions to consistently teach Bachelor of Oral Health programs including taking and interpreting all intraoral and extraoral radiographs. It would also allow other oral health practitioners like dental assistants be able to assist clinicians by taking radiographs similar to what has occurred in South Australia for decades. This review would affect other health professionals throughout Australia and increase access to services by the community.

5.3 Demand for dental services and access to care

There are a number of impediments to access to dental services for members of the public. Costs of care, regulatory barriers, workforce distribution and public knowledge can all be impediments to access to dental care.¹⁴

a) Unmet needs and demands

The Australian Research Centre for Population Oral Health identifies in many reports the inconsistent access to dental care across the nation and the unmet needs of socially disadvantaged adults, government health care cardholders, migrants especially non-English speakers and Indigenous Australians. There is also a growing need amongst the aged population and people living in rural and remote areas. The public and private sector programs cannot meet demand for general dental care. The majority of dental services in Australia are funded on a private basis and are funded through third party insurers. Public dental services currently have long waiting lists with many people waiting for 12 months or longer for care. In addition, it is clear from the waiting lists that the number of people accessing care is significantly lower than would be expected for the population. This leaves a large unmet demand within the community.

¹⁴ Martin Gulliford, Equity and Access to Health Care, 2001

Story 7

"I am a dentist. The waiting list at our clinic for eligible adults is long and there is only one public dentist to provide care and no local private dentists do public work. The majority of people on the waiting list who are younger adults have simple treatment needs – needs that are similar to the treatment dental therapists provide every day to children and adolescents. Yet the rules seem to prevent dental therapists providing this care for adults. It is highly frustrating that so many people are waiting for treatment when they need not."

The community is affected as a result of not providing for the unmet demand. It is reflected in lost productivity from people suffering from dental disease including pain and infections that could pose challenges with systemic effects for the general health of these suffering people and resultant costs to the health system.

The project survey identified significant issues related to an inability of the community to access dental care when they need it at a cost they can afford. This relates to emergency, preventive and general comprehensive dental care.

b) Rural and remote

There are frequently shortages of dental practitioners in regional, rural and remote Australia. The uneven distribution of dentists between capital cities and other regions in the States/Territories is a significant feature of the current oral health labour force. However dental therapists are distributed more evenly by remoteness area.¹⁵ The SoP Standard as it applies to oral health practitioners has some unintended side effects in regional, rural and remote settings.

Stories and feedback from dental professionals and patients describe situations where an unsupervised oral health practitioner is the only dental practitioner available, and patients are left with no recourse to limited dental care (including pain control) when a dentist is unavailable.

Anecdotal accounts describe declining adult oral health in geographically remote locations where the sole care provider is a resident oral health practitioner who is prevented from providing adult care, and visiting dentists are seen infrequently or sometimes are seen as culturally inappropriate (usually for gender reasons).

¹⁵ Improving oral health and dental care for Australians. Prepared for the National Health and Hospitals Reform Commission, Spencer and Harford ARCPOH The University of Adelaide 2008.

Story 8

"I was working in a remote community when an aboriginal elder (80 years) presented with pain associated with a loose 25. As Dental Therapists are not registered to perform extractions on permanent teeth in the NT, the gentleman had to be medivaced out the following day to have the tooth extracted."

Project Team Assessment

While the issue of a mal-distribution of dental professionals and large areas of unmet need is generally agreed, there are widely differing views about the potential solutions to this problem. Peak organisations, managers of public dental services and many individual practitioners believe that one solution to this issue is encouraging an increased SoP for dental hygienists, dental therapists and oral health therapists in relation to treating patients of all ages within a collaborative professional relationship with a dentists (without supervision) would result in a more flexible workforce able to respond better to the needs of rural, remote and Aboriginal communities, older and institutionalised people and other disadvantaged groups. The ADA however believes that the solution lies in increased government funding to support a growing cohort of dentists to meet this unmet need.

It is not within the scope of this project to consider government funding mechanisms and allocations – rather to make an assessment of the potential of dental therapists, oral health therapists and dental hygienists to further contribute to dental care, and under what conditions.

The Project Team concludes that dental hygienists, dental therapists and oral health therapists could make a greater contribution to the dental care of all Australians and particularly to underserved groups by increasing their SoP, based on appropriate training, to include treatment of all age groups. There is published evidence that this training does not need to exceed 203 hours. It is also worthy of consideration to develop a course to assist practitioners in rural and remote areas to provide emergency care to all ages.

c) Underserved groups

Story 9

"I visited a close friend in an aged care residency in my local community. I noted the lack of support and training for both residents and aged care staff in oral health services. ...The resident operations manager acknowledged their need for more oral health supportive services and requested anything I was willing to offer. No dentist was available to do this. Due to scope of practice limitations insisting that a dentist must first conduct an examination before I could legally pick up a

toothbrush or scaler to clean a resident's mouth I regrettably was unable to respond to this need."

There were numerous examples of oral health practitioners who could provide significant services to the disadvantaged in the community but were restricted by the current supervision practices, particularly for dental hygienists. Examples of particular note relate to providing services in residential facilities like aged care or disability housing.

There are many opportunities to assist these population groups in a more cost effective manner. This may require additional training but there are many opportunities where that will not be required.

Project Team Assessment

Support be given to oral health practitioners to provide services in underserviced areas for disadvantaged members of our society e.g. aged care, disability housing, homeless, etc.

5.4 Critical Importance of Education Programs

Throughout this project dental professionals, their peak organisations and government bodies have stressed the crucial role of education and training as the core of an individual's SoP. In addition the consumers had expectations that their treating oral health practitioners were appropriately educated and trained. There are four major issues to be addressed relating to education of oral health practitioners.

a) Inconsistent oral health practitioner training standards

Education of oral health practitioners is considered "uneven" between individual practitioners by dentists and the oral health practitioners. Differences in legislation and education between States before the new national Act was introduced and between local and international dental professionals promotes added uncertainty as to the exact nature of the oral health practitioner SoP.

Project Team Assessment

Existing and new education programs will have to follow the minimum standards for accreditation that will be set by the DBA and used by the ADC to accredit programs. Programs will therefore, have to abide by the national standards in a more uniform manner than currently. There is also a need to offer current graduates and opportunity to upgrade their competencies to the maximum level of current graduates.

b) Upgrading/Maintenance of Competencies to Contemporary Standards

During the consultation there were many practitioners who requested the opportunity for people to upgrade from the older Diploma programs to receive the equivalence of the current university education. Many were concerned about their lack of ability to undertake post graduate or add on courses because of this lack of educational equivalence.

In contrast many jurisdictional dental directors and heads of schools indicated that there had been a number of courses offered over the last decade and there was now little take up or demand. Practitioners indicated that there were significant access issues for them to participate in education e.g. cost, distance, time required to undertake the education

It also appeared that the opportunities like RPL and credit were limited at the Universities and many people indicated that they received no credit and were expected to undertake the whole course again to achieve a Bachelor degree qualification.

Project Team Assessment

Education programs should have the responsibility to provide the necessary opportunities for oral health practitioners to achieve a Bachelor degree qualification. This would involve undertaking accessible degree completion programs/ courses, most likely using distance blended learning (online and distance education with some hands-on courses). The key would be to provide sufficient courses and programs nationally for the perceived demand.

The university system should more actively consider RPL and credit systems and apply them in a less restrictive manner and carefully consider some form of affirmative action policy to allow these clinicians access to achieve academic parity with new graduates.

c) Education to Increase Scope of Practice

There is an increasing interest from oral health practitioners and many of their employers both public and private to gain access to education that will adjust their SoP.

There are two components of training required. The first is to update older graduates to contemporary practices and the other is to expand their SoP. There are currently no risk assessments as to the most appropriate style of education, that is CPD or a formally approved add-on program or a program provided by a formally approved provider.

Some current examples exist of demand for additional programs to adjust SoP. They relate to the provision of emergency care to adults in rural and remote areas, provision of services to aged and disability residents and another is to extend the current simple direct restorative care to adults.

There is a need for oral health practitioners in rural and remote areas to have access to education to manage certain dental emergencies in a more comprehensive manner. There are many examples of extreme pain and suffering resulting from dental disease that could benefit adult members of rural and remote communities.

Education courses and programs are required to provide opportunities for developing the competencies of oral health practitioners to manage certain dental procedures in adults. There are currently two approved courses where simple direct restorative care can now be provided to adults over the age of 25. One of these courses is part of the undergraduate Bachelor of Oral Health and the other is a pilot course developed by Dental Health Services Victoria and approved by the Dental Practice Board of Victoria. There is a high demand for access to these courses particularly to current working graduates.

The model to provide education must be accessible in terms of cost and availability and it also must be risk assessed.

Project Team Assessment

The education that needs to be provided should be normally through CPD. Each program should be risk assessed. Those that are identified as high risk should be provided where the program participant's competencies are tested before they undertake the activities unsupervised outside of the educational program.

It is the Project Team's view that these programs should be provided by approved providers who will be responsible for having undertaken the risk assessment and developing the program. The DBA could assist educational providers by designing a risk assessment and decision making framework. As part of being an approved provider they may be subject to occasional audit by the DBA to ensure standards are maintained

d) Education of dental practitioners to work as interdisciplinary teams

The surveys and consultation clearly described some excellent examples both in the public and private sector of excellent interdisciplinary team practices with well described structured professional relationships that work in a mutually respectful work environment. These teams appeared to have very few problems with the current SoP Standard and all practitioners worked to the full extent of

their SoP. They also differentiated between new practitioners and experienced practitioners as to the level of supervision or advice that was expected in the structured professional relationships. It was also clear that the opposite occurred where there was little to no teamwork, little respect for one another and experienced practitioners working within a limited SoP.

It also appears that very few of the dental education institutions had integrated training between all dental practitioners and most rarely shared clinical space. There appears to be no formal training on how to work as teams although there is some evidence in one State that this is commencing when students receive placements into community clinics.

In addition, it is clear that many practitioners are unaware of what the SoP is of the other practitioners in the dental workforce.¹⁶ This leads to poor teamwork, a lack of respect and a restriction of SoP of some of the practitioners.

Project Team Assessment

There is a need for all oral health practitioners to understand the SoP of each of the dental workforce members. In addition, training and experience during the entry level qualification should include components on working in interdisciplinary teams.

There would be significant value to practices to have dentists and oral health practitioners to be trained and coached to work together as a team with an interdisciplinary approach.

5.5 Lack of appreciation of the role of oral health practitioners

Many oral health practitioners describe a lack of appreciation of the role that preventative care plays in general health and oral health. Stories in the survey cite the poor utilisation of hygienists in the public sector as manifestations of the general indifference toward preventative care by many in the profession, and the consequent poor appreciation of the skill levels of the oral health workforce.

Broader education of the beneficial results of preventative dental care is cited as a necessary step in gaining widespread acceptance of oral health care as a profession.

Oral health practitioners need assistance in describing their SoP. Each dental practitioner undertakes a SoP within the total practice of dentistry. No one practitioner undertakes all the practice of dentistry. Specialists have very specific scopes, usually in one field of dentistry.

¹⁶ Gallagher JL, Wright DA (2002) General dental practitioners' knowledge of and attitude towards the employment of dental therapists in general practice.

Dentists will practice at varying levels in all fields of dentistry. Dental therapists, hygienists and oral health therapists work within most of the fields of dentistry but at reduced levels from dentists and at different levels to one another.

Oral health practitioners report that there is a low level of understanding among some dentists and practice owners about their capacity and competencies and that they often find it difficult to describe with authority what they are able to undertake. This is supported by the literature review. These practitioners are seeking some assistance in professionally describing their SoP which would give them and their employer's confidence.

Project Team Assessment

As there is an increasing emphasis on working in teams, and as dental practices become larger, it will be critical for all team members to describe their individual SoP and how that SoP will contribute to the professional team approach.

5.6 Innovative workforce models

The Healthy Mouths, Healthy Lives¹⁷ report discusses the workforce issues: "Greater integration of the range of oral health practitioner education has the potential to foster team dentistry, as well as retaining flexibility in education and training capacity to meet changing population needs. There are a number of opportunities to make better use of the various members of the oral health workforce, including: increasing the utilisation of the dental therapist/hygienist workforce to increase the capacity for primary and maintenance oral health care including health promotion: and more effective use of the existing workforce"

This is consistent with the Productivity Commission Report *Australia's Health Workforce (Productivity Commission, 2005)* where they found "the evidence suggests that various opportunities for more significant workforce innovation, including broadening scopes of practice and more major job redesign, have not been progressed, or even properly evaluated."

The literature review reports that Australia has a high proportion of dentists to oral health practitioners compared to other countries. There is a need to determine the appropriate innovative workforce model to deliver cost effective and equitable care to the Australian public and then determine the mix of graduating practitioners.

¹⁷ Healthy Mouths, Healthy Lives. Australia's National Oral Health Plan 2004-2013. Australian Health Ministers Advisory Council (AHMAC). National Advisory Committee on Oral Health, Adelaide, SA: Government of South Australia: on behalf of the Australian Health Ministers Conference, 2004

There is evidence that a more preventive model will reduce the cost of oral care compared to the traditional model.¹⁸ This should translate into a higher number and proportion of oral health practitioners rather than dentists being graduated.

Various individuals consulted expressed increasing concern about the workforce projections into the future in addition to the service provider mix not being appropriate as it should reflect a more preventive focus than currently.

Project Team Assessment

It would seem appropriate that HWA consider the workforce projections and need into the future and consider a reform agenda as to the workforce mix and profile of the different dental practitioner mix.

There is a need for a major review of the appropriate model of care for improving oral health from a population health perspective. A pilot program of a significant scale, involving a number of alternative models, should be implemented and evaluated.

The results of this evaluation should then be used to guide the number of entry level programs that are available for oral health practitioners versus dentists.

Future workforce demands need to be re-assessed in light of the increasing number of graduates and any potential increases in demand for care, e.g. significant additional public funding for oral health services.

5.7 Provider numbers and Medicare

Under the Health Insurance Regulations, a provider number is allocated by Medicare Australia and 'identifies the practitioner and the places where the practitioner practices his or her profession. Practitioners are also required to use their provider number to identify themselves when referring to other health professionals, for diagnostic testing and prescribing pharmaceuticals. Currently dentists have provider numbers but this is not the case for dental therapists, dental hygienists and oral health therapists. The provider number is also for use by private health insurers in relation to reimbursement of claims for services provided".

Until recently, the predominant use of a provider number by dentists was in relation to claiming through private insurers and referring to specialist practitioners and ordering diagnostic tests and pharmaceuticals. Previously there was limited Commonwealth Medicare funding provided for cleft palate cases.

¹⁸ Warren, E et al, Modeling the Long Term Cost Effectiveness of the Caries Management System in an Australian Population (2010), International Society for Pharmacoeconomics and Outcomes Research

Now more recently the Medicare Teen Dental Program (MTDP) and Chronic Disease Dental Scheme allow dentists with provider numbers to provide Commonwealth funded dental services. The MTDP also allows dental hygienists and oral health therapists to render services on behalf of dentist with provider numbers and for billing to occur through their provider numbers.

To be eligible to provide Medicare services, non-medical practitioners, allied health professionals, dentists, dental specialists, participating midwives and participating nurse practitioners must be:

- registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
- registered with Medicare Australia to provide these services.

Practitioners eligible to provide Medicare services need to apply in writing to Medicare Australia for a provider number.

During the survey and consultation phase, it became clear that there are some issues with the lack of provider numbers for dental therapists, dental hygienists and oral health therapists. They find that they need to bill through the dentists with whom they have structured professional relationship but there was a lack of consistency about which funding schemes could provide dental services. This is allowable under the Medicare Teen Dental Program but not allowable under the Chronic Disease Dental Scheme. In addition private health insurers are inconsistent in allowing billing through the dentist's provider number for services provided by dental hygienists or dental therapists. This can result in patients being significantly out-of-pocket.

Many of the oral health practitioners believe that they work independently within their SoP and this should be reflected in the provision of a Medicare provider number. They cite a range of other service providers who are not university trained but who have the professional credibility of their own provider numbers.

While there was some discussion about the possibility of a cheaper fee for the relevant items of service, this had not been universally considered.

Project Team Assessment

It is difficult to understand the absence of provider numbers for this group of university trained professionals, however the wider implications on the health system have not been investigated as part of this project and so no recommendation has been made on this matter. This could be considered by Government as part of a broader reform agenda. At the very least it needs to be considered at the same time as the recommended review within five years to remove the bar of independent practice for Oral Health practitioners.

The Way Forward

6.1 Introduction

In order to determine the appropriate way forward it is necessary to consider the matter from several perspectives and to assess the objectives of each of the stakeholder groups.

Dental hygienists, therapists and oral health therapists consider that their skills and abilities are underutilised and that they could make a larger contribution to the oral health of Australians by having their education and competencies more fully recognised. They have noticed a reduction in their previous SoP imposed by their employer, in both private and public practice, as a result of the introduction of the DBA's SoP Standard. They do not see "supervision" of their work by a dentist as appropriate, rather they seek acknowledgement of their autonomous decision making, within a clinical practice team that works in a collaborative manner. They believe that they can work remotely as part of a team, and provide services to a broader range of the population. They seek improved access to opportunities to update, up-skill and expand their SoP, preferably through a CPD pathway. There was little support for establishing independent practices outside of a structured professional relationship.

Dentists are concerned with the safety of the public and comprehensive preventive treatment for children and adolescents. While the ADA believes that oral health professionals cannot work without supervision, this is not a universal position held by all dentists. Some dentists seek to expand the tasks undertaken by dental hygienists, dental therapists and oral health therapists, question their need to "supervise" oral health practitioners and are confused by what the SoP actually allows. Many employers have limited the SoP of their current employees (dental hygienists, dental therapists and oral health therapists) to ensure they do not attract any reviews from the DBA. While some dentist employers reduce SoP for business reasons, most did so due to the lack of clarity about the SoP.

Governments and their Departments have broad concern for the health of the community and are interested in expanding the range of patients seen and duties undertaken by oral health professionals who may be less costly than dentists and often available in rural and remote areas. Paradoxically they are also concerned that an expansion of scope for all dental hygienists, dental therapists and oral health therapists may result in a shift to the private sector resulting in increased wages and less workforce for public dentistry, particularly for children. On balance they are supportive of an expansion of SoP for oral health practitioners.

The community are wishing to achieve greater access to dental treatment from appropriately qualified dental practitioners at an affordable cost. In the public system this means greater access for adults in disadvantaged groups including low income, people with disabilities, the elderly, Aboriginal and Torres Strait Islander people and people in rural and remote areas. In the private system this generally was described as services closer to home where there is not extensive and costly travel.

To respond to the objectives of each of these stakeholder groups, action is proposed in six main areas;

- Adjusting the current SoP Standard
- Implementing a national communication strategy
- Enhancing the dental education system
- Evaluate pilot programs of innovative workforce design
- Develop a strong identity for oral health practitioners
- Investigate other legislation review that affects SoP

6.2 Adjust the Scope of Practice Standard

a) Supervision and autonomous practice

The confusion experienced by dental hygienists, dental therapists, oral health therapists and dentists lies in the interpretation of the words “supervision” versus “exercising autonomous decision making in those areas in which they have been formally educated”. Given that all dental practitioners must work according to their education and competence (and are held accountable by the DBA and hold professional indemnity insurance to do so), oral health practitioners working within a team environment need guidance and support only. A collaborative practice agreement could document the structured professional relationship including the referral pathways, the clinical supervision for less experienced professionals and provide for clinical guidance when required.

The Project Team have considered the New Zealand approach for dental hygienists outlined in the Literature Review and suggest it could apply to all oral health practitioners:

Dental hygienists practise in a team situation with clinical guidance provided by a practising dentist or dental specialist.

Furthermore clinical guidance is defined as:

“The professional support and assistance provided to a dental hygienist by a practising dentist or dental specialist as part of the provision of overall integrated care to the patient group.

Dental hygienists and dentists/specialists normally work from the same premises providing a team approach. Clinical guidance may be provided at a distance but appropriate access must be available to ensure that the dentist or specialist is able to provide guidance and advice, when required, and maintain general oversight of the clinical care outcomes of the patient group. Dental hygienists are responsible and accountable for their own clinical practice within their SoP but the dentist or dental specialist is responsible and accountable for the clinical guidance provided”.

RECOMMENDATION 1

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 practice 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.

All practitioners should work within a structured professional relationship. All professionals are educated to make autonomous decisions and as such should be able to work as independent practitioners. While not all the dental profession is supportive of removing the bar on independent practice, it should be considered for removal within five years.

RECOMMENDATION 2

Within five years the Dental Scope of Practice Registration Standard be reviewed to remove the bar on “independent practice” from the Standard and retain only the paragraph that relates to formal education and competency requirements that applies to all dental practitioners.

b) Clarify the age restriction

Currently there are a range of ages that Oral Health Therapists and Dental Therapists can treat individuals for direct simple restorations. All dental education institutions teach to age eighteen. There are some variations that allow adults to be treated as a result of different education opportunities, predominantly provided in Victoria.

There is clear agreement from all parties that provided there is appropriate formal education the age barrier can be removed. There is no age barrier in the current SoP Standard with the exception of the education requirements and competency.

RECOMMENDATION 3

Oral health professionals continue to function within the limits of their education and competency and that the Dental Board of Australia clarifies that there are no age restrictions.

c) Develop a general description of all dental practitioners

It is clear that there is confusion within the general population as to the roles of all the dental practitioners. It would be beneficial to the public to be able to describe, in simple terms what each practitioner does. It is important to describe the practitioner in a generic fashion rather than by a list of duties. A list is inflexible over time and is seen as inconsistent with the concept of being a professional within a particular SoP. This description could be part of the Scope of Practice Standard, or included in the Q&A attached to the SoP Standard.

It would be beneficial to develop these descriptions in consultation with the individual professional peak bodies. It is also important that they be presented to the public so that they understand that each practitioner provides a subset of the full practice of dentistry and that occasionally there is overlap in their SoP.

These descriptions could also be used as general guidance for the accreditation bodies.

RECOMMENDATION 4

The Dental Board of Australia lead a consultative process with all the professional peak bodies to determine a plain English description of each dental practitioner category.

d) Assist dental professionals to describe their scope of practice

It is essential to emphasise that the scope of each field of dentistry depends mainly on a person's education and competency when they are registered for a specific practitioner group at a given point in time and therefore can scale up or down. Practitioners need to be able to simply describe their current SoP and update it regularly.

A tool could be developed which may assist in determining an individual practitioner's SoP. It could be applied to all members of the dental team including specialists. It could include documentation that outlines the following:

- Level of qualifications and education (including CPD and formal education):
 - Use as a reference the ADC's Dental Council 'Professional attributes and competencies of the newly qualified dental hygienist/dental therapist/oral health therapist'
 - Consider qualifications from dental education institutions
 - Consider CPD
 - Consider expanding practice education e.g. add-on and post graduate courses

- Level of competence that will be dependent on experience
 - Provide position descriptions, employment contracts, structured professional relationship documentation (e.g. collaborative practice agreements), work experience and/or referees to support clinical experience

RECOMMENDATION 5

The Dental Board of Australia lead a consultative process with the professional peak bodies to describe the Scope of Practice of a newly graduated practitioner and develop a document that allows individuals to clearly document their Scope of Practice in relation to that description. This process would commence with a clear definition of scope of practice.

e) **Develop and Implement a national communication strategy**

It is clear from the consultations that the introduction of the new Dental Scope of Practice Registration Standard was not universally understood and there is still a high level of confusion and misinformation. There have been unintended consequences resulting in oral health practitioners themselves and/or their employers reducing the SoP for oral health professionals.

A national communications strategy to explain and describe the current SoP Standard and any changes would result in better outcomes for dentists, allied professionals and the community.

This strategy should include, but not be limited to:

- seminars
- explanatory documents and fact sheets, blogs (including information on the web)
- attendance at peak body meetings and conferences
- develop information brochures and DVDs to assist discussions within practices
- newsletters
- on-line training
- good practice case studies and examples of effective collaborative practice agreements

RECOMMENDATION 6

The Dental Board of Australia develop a comprehensive national communications strategy to explain and describe an updated Scope of Practice Standard after the review.

6.3 Enhance the Dental Education System

a) To achieve current competency levels

There is a need to support oral health practitioners with earlier (non-university) qualifications to upgrade their education to achieve equivalent education levels and competencies to that held by recent graduates.

RECOMMENDATION 7

The Australian Government and jurisdictions (where appropriate) consider support for earlier trained oral health practitioners to upgrade their qualifications to the equivalent of recent graduates.

Many earlier trained oral health practitioners have received little support from university education providers to receive credit for previous education, training and experience. They have been expected to undertake the complete course to upgrade to current qualification levels.

RECOMMENDATION 8

Dental education institutions be actively encouraged to support the provision of Recognised Prior Learning or credit processes for earlier non-university education and experience of oral health practitioners.

Some practitioners have lost recency of practice¹⁹ and require training to update their competencies. Others trained some years ago when a clinical practice was not included in the curriculum.

¹⁹ Dental Board of Australia website - Dental Recency of Practice Registration Standard Available at <http://www.dentalboard.gov.au/Registration-Standards.aspx>

An option could be to provide education by DBA approved education provider facilities (such as universities continuing education programs and public dental agencies). These training opportunities would be ideal for practitioners that would ideally be able to receive a significant component of the clinical training in a directly supervised work environment.

RECOMMENDATION 9

The Dental Board of Australia accredit education providers to provide education and training to upgrade practitioners' skills to the competency levels described in the current Australian Dental Council documents on Professional Attributes and Competencies.

There is inconsistency of education and training between dental education institutions within Australia. There are a number of areas that cause confusion and it seems appropriate that these institutions update their curriculums to achieve the national competencies and consistency.

RECOMMENDATION 10

The dental education providers upgrade their current entry level oral health practitioner curricula to the minimum competency levels described in current Australian Dental Council documents on Professional Attributes and Competencies and in addition achieve consistent practice within Australia. Examples include intraoral and extraoral radiography, diagnosis and treatment planning, Stainless Steel Crowns, tooth whitening, limited orthodontic treatments and direct simple restorations for adults.

b) To increase Scope of Practice

It is necessary for education and training to be provided to enable oral health practitioners to increase their SoP Practice. These currently must be DBA approved courses and as such this has resulted in very few courses existing in Australia. This makes it very difficult for these practitioners to achieve the current competency levels outlined by the ADC or increase their SoP. There is criticism of the fact that most courses to update dentist's SoP are not DBA approved and the same 'rules' should apply to oral health practitioners.

It has been suggested that these courses be provided by Universities but they have indicated that this education market is not their core business and it is unlikely that they would support this type of program. Many universities are associated with CPD activities that would be their only avenue of service provision other than a post graduate qualification. The current approved add-on courses are not sufficient for post graduate certification.

A solution may be that DBA approved providers of education (e.g. public service providers, professional associations, university continuing education providers, etc) deliver these programs. The course participants would need to undertake a competency assessment if the courses were identified as high risk.

RECOMMENDATION 11

Education and training for additional scope must be provided by organisations accredited by the Dental Board of Australia to provide such education and training as part of Continuing Professional Development.

There is a need to identify areas of education that present higher risks to the public if the competency is not achieved. It is suggested that a decision making framework be determined by the DBA that allows education providers to determine when competency testing is required.

RECOMMENDATION 12

The Dental Board of Australia develop a decision making framework that allows education providers to determine according to risk, when the education and training needs to be competency tested.

6.4 Explore and Evaluate Innovative Workforce Models

Despite the calls for innovative workforce models through the National Oral Health Plan, the Productivity Commission Report and many other forums there has been little progress in workforce innovation. There are international models and research that indicate that a more population based approach with a stronger preventive focus with a workforce predominantly made up of oral health practitioners will produce more accessible cost effective care.

There is a need for a large scale Australian pilot that will clearly test that hypothesis in the Australian environment.

The results of that pilot could then be used to determine the appropriate workforce profile with the expectation that the dental education providers would respond accordingly. At the same time it is imperative that the future workforce projections be reviewed in light of the recent huge increases in graduate numbers and the desired workforce profile. The current workforce profile with its predominance of dentists is an expensive model and probably not cost effective.

RECOMMENDATION 13

A review be undertaken of the appropriate workforce number and mix of practitioners required to provide a larger, more cost effective workforce with a strong preventive focus and provision of simple restorative services. This could involve a large scale pilot with an evaluation to provide a strong evidence base for change in the Australian health care environment

Any innovative workforce model would benefit from all of the workforce practitioners being educated to become successful members of an interdisciplinary team.

RECOMMENDATION 14

All dental practitioners be provided education and training as interdisciplinary team members as part of the development of an innovative workforce model.

6.5 Develop a Strong Identity for Oral Health Practitioners

Dental hygienists, dental therapists and oral health therapists all report a sense of their contribution being undervalued, their university training and therefore their professionalism as not being appropriately recognised and their treatment as second class citizens. The Project Team also noticed evidence of this.

The separate oral health practitioner groups operate separately and would benefit from working together more systematically on areas such as research and the public

presentation of their professions. They are currently fractured across states, between public and private and between occupational groups.

Clarifying the differences between these groups may assist in the preparation of promotional material targeted at both dentists and the public.

The oral health practitioners need to actively engage in research of their practice, outcomes of their practice and the public benefit. Peak bodies need to work with tertiary institutions to ensure relevant and current research is undertaken, and agreements made between the peak bodies for the consistent capture of workforce data and other statistical information. They need to be able to demonstrate the complex and sophisticated contribution they make to the oral health of the community and how much more they could provide with more opportunities.

RECOMMENDATION 15

The oral health practitioner peak bodies are encouraged to develop active working arrangements to promote a strong sense of identity and worth for their professions through joint publications, presentations at conferences, research and data collection.

Part of establishing a strong professional identity is the availability of post graduate and research capacity. Current oral health practitioners have little opportunity to progress within their chosen profession and those that do choose post graduate options are often choosing other disciplines.

RECOMMENDATION 16

The dental education providers be actively supported by the Australian Government to support the development of post graduate education and training for oral health practitioners. This would support a research and publication agenda.

6.6 Other Legislation Review

Some issues have been raised that have an impact on the SoP or have been raised during the review process that clearly relate to other pieces of legislation.

The various State Radiation Acts are currently having the most effect on SoP. These restrictions resulting from State Acts would be affecting other health professionals.

Any changes to prescribing would also need to be mindful of the implications for dental practitioners as well as other health professionals.

RECOMMENDATION 17

Jurisdictions to review the various Radiation Acts to ensure that oral health practitioners are not restricted from providing services to a level comparable provided by their interstate colleagues.

Attachments

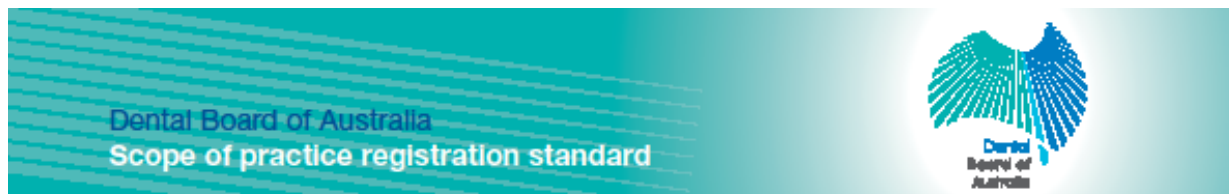
1. Acronyms & Glossary
2. Dental Board of Australia – Scope of Practice registration standard
3. Dental Board of Australia – FAQ's Scope of Practice registration standard
4. Dental Education Institution Survey
5. ADC professional attributes and competencies of the newly qualified -
Dental Hygienist
Oral Health Therapist
Dental Therapist

Acronyms & Glossary

ACODS	Australasian Council of Dental Schools
ADA	Australian Dental Association
ADB	Australian Dental Board
ADC	Australian Dental Council
ADOHTA	Australian Dental & Oral Health Therapists' Association
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHWMC	Australian Health Workforce Ministerial Council
BOH	Bachelor of Oral Health
Ceph	Cephalometric radiographs
COAG	Council of Australian Governments
CPD	Continuing Professional Development
DBA	Dental Board of Australia
DPBV	Dental Practice Board of Victoria
DHAA	Dental Hygienists' Association of Australia
DHSV	Dental Health Services Victoria
ERG	Expert Reference Group
FAQ	Frequently Asked Questions
HCE	Health Complaints Entities
HWA	Health Workforce Australia
HWPC	Health Workforce Principal Committee
OPG	Orthopantomographs
Oral Health Practitioners	Dental hygienists, dental therapists, oral health therapists
Project Team	Consultants Cole, Carroll, Dunn, de Vries
RPL	Recognised Prior Learning
SoP	Scope of Practice
SoP	Scope of Practice Registration Standard

Attachment 2

Scope of Practice Registration Standard



Authority

This standard has been approved by the Australian Health Workforce Ministerial Council on 22 April 2010 pursuant to the *Health Practitioner Regulation National Law (2009)* (the National Law) with approval taking effect from 1 July 2010.

Summary

All registrants are required to base their practice on the scope of practice definitions outlined in this standard.

Scope of application

This standard applies to all applicants and all registered practitioners. It does not apply to students and practitioners who have nonpractising registration.

Requirements

1. A dental practitioner must not direct another registered practitioner to undertake dental procedures or give advice outside that person's education or competence.
2. Dental practitioners must only perform those dental procedures:
 - a) for which they have been formally educated and trained in programs of study approved by the Board; and
 - b) in which they are competent.
3. Dentists work as independent practitioner who may practise all parts of dentistry and are the clinical team leaders. Dentists may supply and fit dental appliances for the treatment of sleep disorders. They must work in cooperation with the patient's medical practitioner who is responsible for the medical aspects of the management of sleep disordered breathing.
5. Dental prosthetists work as independent practitioners in making, fitting, supplying and repairing removable dentures and flexible, removable mouthguards.
6. 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 practice 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 direct supervision.

Definitions

Independent practitioner means a practitioner who may practise without supervision.

Supervision includes oversight, direction, guidance and/or support.

References

Dental Board of Australia, *Guidelines for Registration Standards — Scope of Practice Standard* (may be developed)

National Standards in Dentistry Project — undertaken by the Dental Boards of Australia and New Zealand in consultation with the Australian Dental Council

Review

This standard will commence on 1 July 2010. The Board will review this standard at least every 18 months.





FAQ's: Scope of Practice Registration Standard

Why did the Board develop a broad Scope of Practice Registration Standard?

There was a lot of variation amongst State and Territories regarding how 'scope of practice' for dental practitioners was regulated. Therefore the Board set a broad scope of practice requirement. The Board expects that dental practitioners will use sound professional judgment when it comes to assessing their own, and other colleagues, scope of practice and work within their education, training and competence.

What is the scope of practice of a dental practitioner?

A dental practitioner can perform dental procedures for which they have been formally educated and trained in programs of study approved by the Board and in which they are competent. The Board will release a list of add-on programs of study in August/September 2010; these will reflect those that previously existed in State and Territories.

Has the Board's Scope of Practice Registration Standard changed the way I can practice?

No, the Standard is drafted to reflect the current scope of practice which existed in Australia for all dental practitioners, and this includes dental practitioners in all divisions of the register.

What are the supervision requirements of the Board's Scope of Practice Registration Standard?

The term *supervision* in the Standard is defined as oversight, direction, guidance and/or support; which is a broad and flexible definition and does not require the person providing the supervision to be physically on site. For oral health therapists, dental therapists and dental hygienists the supervision requirements could be met through ensuring that a structured professional relationship exists with a dentist who could be consulted as necessary via any means.

Dental Institution Survey

HWA Scope of Practice Survey of Dental Education Institutions

Introduction

A survey was undertaken of the 12 programs in Australia presenting Dental Hygiene, Dental Therapy, or Oral Health Therapy at 10 Australian Education Institution.

The aim of the survey was to evaluate the consistency of education programs across the country of similar programs. Note: All the programs are accredited by the ADC. This survey was done before the approval of National Accreditation Competencies & Attributes by the Australian Dental Council.

Institutions	Program	Length	Course
Adelaide	BOH	3 Years	OHT
Charles Sturt	BOH	3 Years	OHT
Curtin	Ass Degree	3 Years	OHT
Curtin	Ass Degree	3 Years	DH & DT
Griffith	BOH	3 Years	OHT
La Trobe	BOH	3 Years	OHT
Melbourne	BOH	3 Years	OHT
Newcastle	Grad Dip	1 Year	DT
Newcastle	BOH	3 Years	OHT
TAFE-SA	Adv Dip	2 Year	DH
Sydney	BOH	3 Years	OHT
UQ	BOralH	3 Years	OHT

Note:

1. Curtin Ass Degree in DH and Ass Degree in DT will be phased out
2. Griffith BOH program phased out

Summary:

- 7 OHT Programs
- 3 DH Programs
- 2 DT Programs

Survey Outcome

1. Regulations

a. National Regulations

Yes: All Programs educate according to the National Regulations

b. State regulations. Mostly National, however, NSW, Victoria and Queensland focus education on previous State Regulations.

Note:

- i. Limitations in aspects of dental practice
- ii. Do not include Adult restorative (except La Trobe)
- iii. Permanent extractions not part of any program
- iv. Melbourne: educate students to treat up to age 25 years
- v. Focus on collaborative team approach for majority of programs.
- vi. Sydney: Training focus on NSW Scope of Practice

2. Diagnosis and Treatment Planning

2.1 Limitations for DT relate to aspects not in Scope of Practice eg: permanent extractions, orthodontics, non vital teeth, acute and chronic – dental infection, soft tissue pathology, medically compromised patients, and limited for most to children up to 18 years.

2.2 Variations: not in Scope of Practice, as medically compromised patients. Mostly under prescription of a Dentist.

2.3 Victoria had no age limit before National Board – Melbourne dental School train to age 25 years for restorative care and La Trobe has no age limit for restorative care.

2.4 Other States up to age 18 years for restorative care.

3. Local Anaesthesia

3.1 All administer (DT,DH,OHT)

4. Age Restrictions

4.1 Children 4-18 years (restorative): DT

4.2 Periodontal Care: All ages: DH + OHT

4.3 Fissure Sealants: All ages: DH +OHT

4.4 Restorative Polishing: All Ages: DH + OHT

4.5 La Trobe: Direct Simple restorations: All ages (OHT)

4.6 Normally refer beyond 25 years in Victoria unless DT/OHT have undertaken training.

5. Dental Imaging and Interpretations

Consistent intraoral dental imaging education in the programs, specific to the requirements for DT, DH and OHT. Some variation relating to extraoral imaging. Variations:

- i. Most extraoral involves OPG (Not Lat Ceph)
- ii. UQ takes but does not interpret extraoral
- iii. La Trobe interprets but does not take extraoral
- iv. CSU does not provide extraoral education

6. Treatment/Procedures

- a. Simple restorations consistent (see Note)
- b. Stainless Steel Crowns – all programs accept for two
- c. Permanent extractions – no Programs
- d. Limited Orthodontics – Most with three exceptions
- e. Tooth Whitening (DT) – Half of the programs
- f. Tooth Whitening (DH) – All except two

Note:

- i. Restorations excluding La Trobe
 - Deciduous teeth
 - Pulpotomy
 - May be class 1, 2, & 3 on permanent teeth in patients under 18 years where the cusps or incisal edge not involved or the risk of pulp exposure.
- ii. Limited Orthodontics
 - Limited supportive procedures like, impressions, orthodontic band removal.
 - Band sizing, placement and removal of brackets, archwires and other orthodontic hardware components.

7. Supervision in clinical Practice

Consistent supervision: Most programs have a dentist available in clinic, except for three programs. However, usually an oversight dentist.

8. Team Approach to Integrated Education

- a. Some clinical sessions together, but some apart
- b. Most programs the students perform clinical work in a collaborative autonomous way
- c. Most programs, students do not perform clinical work under prescription. Some instances only where appropriate. Students are however, prepared to work in a consultative relationship with dentists.
- d. Clinical placements for most programs are not done in an integrated way. Mostly a timetabling and staffing logistic of achieving integration.

Note:

- i. Dental Therapy clinical practice sessions for children are done mostly separately.
- ii. DH sessions in later years done in an integrated way with dental students.
- iii. Treatment plans are approved and signed by clinical supervisors.

Summary

1. Most programs are consistent in their approaches to DT, DH, OHT educations.
2. Some exceptions are noticeable
 - 2.1. Integrated clinical practice
 - 2.2. Tooth Whitening
 - 2.3. Stainless steel crowns
 - 2.4. Limited orthodontic treatments
3. None of the programs educate students to perform permanent extractions
4. One program educates students to do direct Simple restorations for patients to the age of 25. Another program trains for direct simple restorations on all ages.
5. Most radiology procedures and interpretation practices are consistent
6. All programs focus on prevention, health promotion and a collaborative team approach.
7. All programs do Local Anaesthesia.
8. Additional observations
 - 8.1. Students are educated to communicate with patients of all ages
 - 8.2. Students are educated to “Manage” patients of all ages

Recommendations

1. Share survey outcome with programs and ADC.

ADC professional attributes and competencies of the newly qualified:

- *Dental Hygienist*
- *Oral Health Therapist*
- *Dental Therapist*



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