AUSTRALIAN DENTAL and ORAL HEALTH THERAPISTS' ASSOC Inc.

14th May 2018

Dr John Lockwood
Chair
Dental Board of Australia
G.P.O. Box 9958
Melbourne VIC 3001

dentalboardconsultation@ahpra.gov.au

Dear Dr Lockwood,

I am writing to you on behalf of the Australian Dental and Oral Health Therapists' Association (ADOHTA), which is the peak representative body for Oral Health Practitioners (OHPs) in Australia that includes dental hygienists, dental therapists, and oral health therapists.

The ADOHTA thanks the Dental Board of Australia (the Board) for providing the opportunity to comment on the Review of the Scope of Practice Standard (the Standard). We have worked together with our colleagues from the Dental Hygienists' Association of Australia (DHAA) to have a shared understanding on this consultation

We would firstly like to raise the question about why the Board sees a need to continue to have a Scope of Practice Standard. No other health practitioner group registered under the Australian Health Practitioner Regulation Agency (AHPRA) has a Scope of Practice Standard, which renders this review and its proposals somewhat redundant. It is the ADOHTA's view that the regulatory framework provided by AHPRA is adequate to protect the public against the risks inherent in receiving dental care, which includes;

- the Health Practitioner Regulation Act (the National Law) itself and its practice registration and title protection mechanisms,
- the Accreditation processes for courses leading to registration,
- the Code of Conduct, and
- the Standards and Policies and their accompanying sanctions.

It is the ADOHTA's view that the proposed Scope of Practice Standard adds complexity to the regulatory framework that offers no added benefits to the community in terms of protection. Indeed, it runs counter to the principles of the National Competition Policy, which requires that regulation be minimised in order to enhance competition and reduce costs, while maintaining safe and high quality dental practice. It is our view that this regulation adds unnecessary policy layers, costs to the community and does not meet the public good test; it therefore should be dispensed with altogether.

While we hold this view, we welcome the intention of the Board to treat OHPs the same as all other registered practitioners under the Board's jurisdiction. This is well overdue and we applaud this move. OHPs have historically and consistently, clearly recognised, and worked within, the boundaries of their

scope of practice and the Board's own data on notifications and complaints supports this. It is clear that there is not a need to impose additional regulation on their practice.

The ADOHTA have long asserted that the imposition of a structured professional relationship and the designation around '…not (being) independent practitioners…' applied to OHPs was inconsistent with standard approaches to health practitioner regulation, and removing this phrasing is absolutely necessary. We remain of the view that this wording should not be in the Standard and as such support its removal as recommended by the Board.

The ADOHTA endorses the requirement that all dental practitioners practice within their education, training and competence. We also acknowledge that the proposed revised standard has incorporated the recommendations made by Health Workforce Australia in 2011 in their report on Oral Health Practitioners' Scope of Practice Review. This proposed approach accurately aligns with the regulatory framework consistent with all other registered dental practitioners under the National Scheme.

As part of the public consultation process, the ADOHTA wishes to address the guiding questions presented by the Board.

1. From your perspective, how is the current registration standard and guidelines working?

The current registration standards and guidelines have largely met the objectives of the National Scheme, which has the primary objective of protecting the public from the risks inherent in receiving dental care. The ADOHTA argues however, that there is significant evidence to demonstrate that there are several mechanisms in the current standard, which limit competitiveness and consumer choice and which are duplicated thus adding cost and no regulatory benefit.

The requirements for a 'structured professional relationship' and the clause that states dental hygienists, dental therapists and oral health therapists must not practise as 'independent practitioners' within the current standards has created confusion amongst the dental profession and is unnecessary over-regulation. We understand this viewpoint is shared with our colleagues from the DHAA. A structured professional relationship with a dentist is not practical because as autonomous practitioners;

- OHPs will (and should) consult with and refer to, more than a dentist, with other appropriately trained health practitioners, including more experienced OHPs, dentists, dental specialists and other health practitioners.
- Many dental practitioners, and members of the public do not understand the differences between 'autonomous practice' and 'independent practice' and why these words are in place.
- The mechanism of accreditation of educational programs and registration to practice is sufficient to ensure safe practice without these components. Our education programs enable graduate OHPs to practice in a dental team environment as autonomous practitioners who are responsible for the dental treatment services they provide.

In addition to this, there are communities who have poor access to dental services, who have been disadvantaged by these requirements because of misinterpretations that have prevented OHPs from providing dental services. Opportunities exist for effective triaging in areas with reduced access to care and to address high prevalence of oral disease rates including residential care, rural and remote areas and outreach communities, where systems such as tele-dentistry could be used to their full advantage. This change is likely to improve the transition towards a stronger focus on preventive models of dental care. Some employers still believe that OHPs cannot practice without the presence of a dentist because of the wording of the current standard. There are also issues with private health insurance, government funded schemes and rebates that arise because of the misleading language in the current standard.

The current registration standard and guidelines are also in conflict with the COAG Principles for best-practice regulation, in relation to:

a) Unnecessary restriction of competition among health practitioners;

- The hierarchical approach imposed by the current standard (requiring a structured professional relationship for some providers) has meant that OHPs must currently work in a 'bundled' structure with dentists, which limits competitiveness within the industry. 'Unbundling' dental practitioners allows them to practice in more innovative and diverse settings and teams which will enhance access to services and potentially alter pricing mechanisms at the market margins. People living in, for example, small communities, geographically isolated communities and residential care settings (all of which are underserved population groups) do not have choices about which practitioners they would like to see and indeed, often have no services at all. This is an impediment to the intended benefits of National Competition Policy,; the wording in the current standard which impose this effect should be removed .

- The requirement that OHPs may only expand their individual scope of practice (within the scope of practice of the profession) by attending formally approved courses and programs imposes unnecessary restriction on competition. This requirement has been only imposed on OHPs under the current standard and represents an impediment to both the development of individual practitioners and the concept of the 'level playing field'. This requirement is inconsistent with other dental practitioners regulated under this standard and with accepted approaches used by AHPRA to enable health practitioners' continuing professional development.

  In addition, the onerous demand for formally approved course programs is also a deterrent for educational providers to offer them, which limits the opportunities available to OHPs. This unintentionally narrows the potential development and utility of the profession overall. It also results in many OHPs being unable to offer clinical services that would be cost-effectively achieved under the proposed Scope of Practice Standard. Adding and developing skills consistent with baseline educational preparation is a desirable activity that contributes to public good by extending the benefits of Australia's investment in tertiary education thus maximising public good from that investment.

b) Unnecessary restriction of consumer choice; the inability of OHPs to expand their individual scope of practice through continuing professional development activities within the existing regulatory framework leads to an unnecessary restriction of consumer choice. Clinical services that could be provided cost-effectively by our profession by expanding individual scope of practice, without the requirement for formal accreditation by the Board, , currently need referral, delegation or handover to another dental practitioner, potentially increasing their cost and limiting consumer choice of their provider.

The ADOHTA therefore supports the proposal to remove the need for accreditation of continuing professional development programs and the designation of such programs as "Add-On Programs" in order that OHPs are able to maintain their scope of practice and develop it in line with community needs through continuing professional development. This would bring the regulation of OHPs into consistency with other registered dental and health practitioners.

2. Are there any issues that have arisen from applying the existing registration standard and guidelines?

We wish to reinforce our concerns from our previous submission:

The requirement for practise by dental hygienists, dental therapists and oral health therapists within a structured professional relationship adds confusion: all dental practitioners should seek advice and refer patients when their needs are beyond their expertise and scope of practice. i.e. no practitioner

should practise in isolation. Dental hygienists, dental therapists and oral health therapists have always practised in a consultative and referral relationship with dentists, dental specialists and other health practitioners and their education prepares them for practise within this context. There is over 50 years of evidence to show that this has been done safely and responsibly by these dental practitioners. There is no evidence to impose inconsistent regulation on these dental practitioners within the standard. These clauses are additional regulation which adds no additional benefit to the public safety.

The interpretation that '*they must not practise as independent practitioners'* can be misinterpreted between professional bodies, employers and health practitioners. The restrictive inclusion of this phrase is in direct conflict with the ideal of autonomous practice and working within a dental team environment. We understand this viewpoint is shared with our colleagues from the DHAA.

All health practitioners should practise in consultation with other health practitioners where patient needs require, and this is covered in the Board's Code of Conduct. The ADOHTA is unclear about what informs a decision to treat registered dental hygienists, dental therapists and oral health therapists differently to registered dental prosthetists and dentists. We understand this viewpoint is shared with our colleagues from the DHAA. It is clear that such a clause in the current Standard acts to limit access to dental care provided by our profession.

3. **Is the content and structure of the proposed revised registration standard and guidelines helpful, clear, relevant and more workable than the current registration standard and guidelines?**

We contend that the proposed revised Scope of Practice Standard is unnecessary under the principles of the National Scheme, which recognises the importance of public protection using minimal regulatory force. No other registered health professionals have Scope of Practice Standard. The quality and safety of dental care provided by dental hygienists, dental therapists and oral health therapists is well known globally. Our profession has the lowest number of notifications within the dental profession, and of those, most are low risk in nature. We recognise the need for all dental practitioners to abide by the Board's Code of Conduct, which we feel is of sufficient weight to mandate the requirement for safe practice and to protect the public. The Code of Conduct is used frequently and referenced to support the decision-making process by all State and Territory registration and notification committees, including co-regulatory functions. Sanctions for breaches of this standard apply equally to all who are registered by the Board. There is no evidence to suggest that OHPs should be treated any differently. We understand this viewpoint is shared with our colleagues from the DHAA

4. **Is there any content that could be changed or deleted in the proposed revised registration standard and guidelines?**

While the ADOHTA has the view that a Scope of Practice Standard is not necessary, if a decision is made to retain this Standard, we support the following proposals for regulatory changes:

1) Remove the requirement for a '*structured professional relationship'* for dental therapists, hygienists and oral health therapists. The ADOHTA considers that the Code of Conduct[1] details more appropriately the important standards for dental practitioners in understanding the expected ways of working. This includes that dental practitioners must work within the limits of their educational preparation, competence and scope of practice and refer patients for care that is outside their scope of practice.

2) Remove the term '*independent practitioner'* from the standard. At the time of the last review in 2014 the Board agreed that it would incrementally remove the bar on independent practice

[1] Dental Board of Australia (2014) Code of Conduct. Available at: http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx

from the registration standard. The language by the Board[2] and Health Workforce Australia[3], and the ADOHTA[4] render this terminology confusing and redundant and it should be removed as proposed by the Board. This will effectively recognise and enable the professional roles and collaborative responsibilities of all dental practitioners and their regulation.

3) Remove reference to '*Programs to extend scope'* giving effect to the Board's decision to phase out the approval process of these programs. Going forward, these programs can continue to be delivered as continuing professional development (CPD). This is consistent with the Board's direction to phase out programs to expand scope, which will be implementation from 2019.[5]

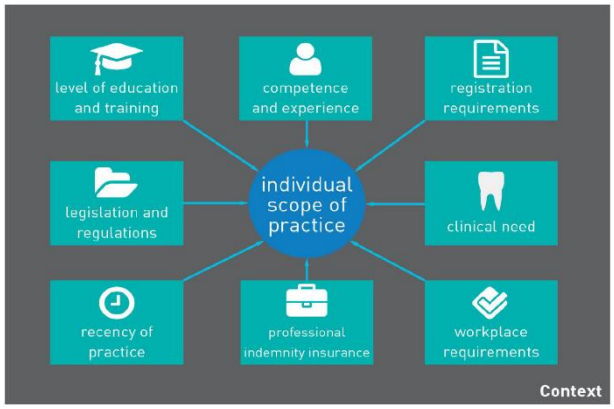
4) Clarify expectations around education, training and competence. As accreditation standards, competencies and processes for approving programs of study are now well established under the National Scheme, the ADOHTA supports the removal of the prescriptive terminology from each division description in the Boards documents and enables a reliance on the descriptors and competencies outlined in the guidelines and the Australian Dental Council's "Professional competencies of the newly qualified dental hygienist, dental therapist and oral health therapist"[6].

5. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?

The ADOHTA has no preference to the review period changing from three to five years.

Do you have any other comments on the proposed revised registration standard and guidelines?

The ADOHTA has no further comments on the proposed revised registration standard and guidelines. However, the ADOHTA requests the Board to consider providing training and clearer guidance on how dental practitioners can expand their scope of practice within their profession, including the difference between the professions' scope and the individual scope. We understand this viewpoint is shared with our colleagues from the DHAA. The illustration presented by the Board would be beneficial to help explain what influences the individual's scope of practice, and it should be promoted more broadly to assist dental practitioners to provide safe dental practice.



[2] Dental Board of Australia (2018) Consultation paper - Scope of practice registration and guidelines for scope of practice. Available at: http://www.dentalboard.gov.au/documents/default.aspx?record=WD18%2f25099&dbid=AP&chksum=zMPcJMdiIWP0NUEZRB2B9A%3d%3d

[3] Health Workforce Australia (2011) Scope of practice review – Oral Health Practitioners. Available at: https://submissions.education.gov.au/forms/archive/2015_16_sol/documents/Attachments/Australian%20Dental%20and%20Oral%20Health%20Therapist.pdf

[4] Australian Dental and Oral Health Therapists' Association (2014) Position Statement – Direct Access to Services. Available at: https://adohta.net.au/webroot/filebrowser/upload/files/PS2%20Direct%20Access%20to%20Services.pdf

[5] Dental Board of Australia (2017) Programs to expand scope. Available at: http://www.dentalboard.gov.au/Accreditation/Programs-to-extend-scope.aspx

[6] Australian Dental Council (2016) Competencies of the newly graduated dental therapists, dental hygienists and oral health therapist, ADC , Melbourne https://www.adc.org.au/sites/default/files/Media_Libraries/PDF/Accreditation/Professional Competencies of the Newly Qualified DH DT OHT Final.pdf

6. **Is the content and structure of the new reflective tool helpful, clear and relevant?**

The ADOHTA proposes that the wording of the following is unclear. “Do I practise across the range of my clinical scope at a suitable frequently to remain competent?” Perhaps it can be rephrased to:

> *“Do I practise across the range of my clinical scope frequently enough to remain competent?”*

The ADOHTA recommends the following sentence be worded to reflect best practice.

> *“Most practitioners will encounter a threshold at which the nature or complexity of certain patient treatments will require referral, delegation or handover to a practitioner with the appropriate scope of practice, such as a dentist, specialist or medical practitioner.”*

All health practitioners must work and provide clinical care within their scope of practice and delegation or handover can occur in a number of directions. It is not unusual for some dentists or dental specialists to provide a clinical handover for dental procedures to other members of the dental team including dental prosthetists, dental hygienists, dental therapists and oral health therapists. In addition, certain complex procedures may be within the scope of practice for a profession but not within the individual’s scope of practice, which would also require delegation or handover. Some patient care requires referral directly to health practitioners other than medical practitioners such as maternal and child health nurses, speech pathologist or diabetes educators as examples. We suggest that broader terminology should be used in this section. The ADOHTA recommends the sentence to rephrase to:

> “Most practitioners will encounter a threshold at which the nature or complexity of certain patient treatments will require referral, delegation or handover to another dental or health practitioner with the relevant skills, experience and competency to perform the procedure.”

7. **Is there anything missing that needs to be added to the new reflective tool?**

The ADOHTA recommend a reference to continuing professional development requirements and its relevance within the “Education and training” domain

Yours sincerely

[redacted]

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