



Australasian Academy of Paediatric Dentistry

SUBMISSION: DENTAL BOARD OF AUSTRALIA

DRAFT “SCOPE OF PRACTICE REGISTRATION STANDARD”

AND DRAFT “GUIDELINES”

19TH JUNE 2013

VISION STATEMENT

The Vision of **Australasian Academy of Paediatric Dentistry** is optimal dental health for infants, children and adolescents including those less fortunate with special needs. Constant review of process is paramount.

The Australasian Academy of Paediatric Dentistry is the principal professional organisation representing the Oral Health interests of children. The Paediatric Dentist is recognised as the Specialist Primary Oral Health Care Provider.

MISSION STATEMENT

The **Australasian Academy of Paediatric Dentistry** is a professional organisation of Professionally trained Dental Health Care providers whose primary concern is the practice, education and continuing research specifically related to Paediatric Dentistry. The purpose shall be the advancement of the Specialty of Paediatric Dentistry for the benefit of community oral health.

GLOBAL ORGANISATIONS

International Association of Paediatric Dentistry (IAPD)

American Academy of Pediatric Dentistry (AAPD)

Australasian Academy of Paediatric Dentistry (AAPD)

European Academy of Paediatric Dentistry (EAPD)

International Dental Federation (FDI)

International College of Dentists (ICD)

Pierre Fauchard Academy (PFA)



EXECUTIVE SUMMARY

The Australasian Academy of Paediatric Dentistry (AAPD) welcomes the opportunity to comment constructively upon the draft “Scope of practice registration” and draft “Guidelines – Scope of Practice”, in order to provide a quality of service not only to the 48% of our population of 23 million Australians who are privately insured, but also the “working poor” and the 3.4 million children who are not afforded regular dental care by private practitioners who provide greater than 83% of the dental man power working hours beyond that which is offered in the public sector.

RECOMMENDATIONS

AAPD recommends opposition to the extended scope of practice in the following areas

Dental Practitioner	Scope	Recommendation
DH	Analgesia (RA)	No
	Dental Treatment under general anaesthesia or neurolept analgesia	No
DT	Periodontal Diagnosis and instrumentation skills	No
DT DH BOH	External Tooth Whiting	No
DT DH BOH	Limited Orthodontic Treatment	No
DT	Direct Restorations for Adults	No
DT BOH	Stainless Steel Crowns	No
DP	Occlusal Splints	No
	Orthodontic Appliances	No
	Intra-oral Appliances for Sleep Apnoea and snoring	No

Key: DH, Dental Hygienist; DT, Dental Therapist; BOH, Bachelor of Oral Health; DP, Dental Prosthetist.

SUBMISSION

1. Background • Definitions
 - History
2. Key Changes
 - 1 Support
 - 2a Supervision requirements
 - 2b Definitions
 - 2c Independent Practitioner
 - 3 Reduction in the prescriptive nature of the standard
 - 4 Further clarification of the standard
3. Further Considerations
 1. Workplace agreements
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4. Annexures
 - ADA Policy Statement 3.2 P1-2
 - ADA Policy Statement 3.3 P1-11

AAPD suggests that the Dental Board of Australia now has the opportunity to rationalise education, ongoing professional development and successfully enabling a higher quality of care for our patients of both ends of the financial spectrum. To that end, politicians are aware of dentistry as a major part of medical health.

There is not a shortage of dental practitioners, but rather a maldistribution of service providers in rural and remote areas as well as some suburban areas. Dentistry does not enjoy the favours of government incentives to provide such services.

A A P D

Australasian Academy of Paediatric Dentistry



BACKGROUND

The Australasian Academy of Paediatric Dentistry (AAPD) is the pre-eminent paediatric dental specialist authority promoting childrens' oral health.

"Dentistry is the science and art of preventing, diagnosing and treating diseases, injuries, developmental and acquired defects of the teeth, joints, oral cavity and associated structures within the context of general health." (Annexure A1, ADA Policy Statement 3.2)

"A Dentist is an appropriately qualified dental care provider, registered by the Board (Dental Board of Australia) to practice all areas of dentistry." (Annexure A1)

"Allied Dental Personnel are those, other than dentists, working in the provision of dental services – namely dental assistants, dental therapists, dental hygienists, dental prosthetists, dental laboratory assistants, dental technicians and master technicians." (Annexure B1 ADA Policy Statement 3.3)

HISTORICAL BACKGROUND

Dental Therapists evolved from a concept that with 2 years of training, and under direct supervision a service to children in rural and remote areas could be provided at a lesser cost than that provided by a dentist. In the main, dental therapists were female. However, when therapists had boyfriends in capital cities, the sociological problems began, and after 2 years or so in "the bush" transfers back to the cities ensued.

Dentists were required in cities to supervise and teach, so therapists in country areas were not under "direct supervision" (eg Adelaide "supervised" Whyalla) and therapists had "prescriptive treatments" to undertake.

As therapist numbers built up jobs had to be found in the cities, and in the late 1980's it was proposed by SADS that therapists treat adults in the "Home for Incurables" with direct access. This was rightfully strongly opposed by the ADA successfully. Training/Education by the University of Adelaide was defeated at a meeting of the Senate of the University of Adelaide.

Now thirty years later "here we go again", trying to provide 'poor people with poor dentistry', and by that is meant limited scope. (Annexure C1 Advertiser 29.5.2013)

There are two salient features that the Board might consider:

- If Dental Therapists (DT) or Bachelors of Oral Health (BOH) have co-shared lectures with dental students, the standards for acceptance by educators are different. So that no credits are given for students of DT or BOH who wish to undertake Dentistry as a career – they start from Year 1 BDS.

This is the case at the University of Adelaide by the Dental School.

- In all States of Australia except for Victoria and Tasmania there is a requirement for supervision.

84% of children in Rural Victoria have untreated decay by 4yrs.

12% of children younger than 5yrs have experienced dental pain.

47% of Australian children aged 12yrs have decay in permanent teeth.

150% increase in decay rates in 6-7yr olds in SA from 1998 to 2007 (ARCPOH June 2011).

One is tempted to suggest that the employment of DT and BOH has not been a total success.

However, since dentist graduate numbers have increased since 2010 (Manpower study Mar 2013) and are likely to continue, the provision of services may improve.

- Health Partners terminated the services of "Allied Dental Personnel" in SA in Feb 2012 (DT and BOH) as they found a dentist could provide a full range of professional services for the \$ spend.

A A P D

Australasian Academy of Paediatric Dentistry



The Australasian Academy of Paediatric Dentistry now provides contribution to the draft “Scope of practice registration” and draft “Guidelines – Scope of Practice”.

KEY CHANGES

1. Support the team approach to dental care.

The Dental Team working cohesively together within their areas of expertise provide the best quality of care for their patients is supported by AAPD in order to provide the best quality of care.

2a. Supervision requirements

Allied dental personnel may only practise within a structured professional relationship with a dentist.

They must not practise as independent practitioners except Dental Prosthetists.

General anaesthesia is the medical procedure that renders the patient unconscious, allowing for the safe and humane provision of medical, dental, diagnostic and surgically invasive procedures. Specialist Paediatric Dentists provide comprehensive dental and surgical treatment under GA on a regular basis. This treatment is effective and useful in the treatment of pre-cooperative, anxious and fearful patients – as well as those with special needs, physical and medical compromise. In many cases, the provision of high quality dental care can only be provided under such conditions, due to the complexities and limitation of access otherwise encountered.

The provision of safe and effective dental treatment under GA has significant positive impacts on the quality of life (QoL) for children and their families. The AAPD recognises that oral health is an integral part of all QoL parameters across the community and that access to optimal dental care is a right for all children and adolescents.

The cost for provision of such treatment under GA is often substantial. To this end, the AAPD supports both Public and Private health care providers in ensuring that adequate insurance coverage, realistic reimbursements, suitable dental rebates and appropriate diagnostic services are made available to those in need.

The AAPD is keen to support specialist dental and surgical practitioners within hospitals (Private and Public), approved day care centres and suitable surgical facilities to ensure unrestricted access to operating lists – in order to facilitate treatment and provision of care under GA.

However, the AAPD is very concerned with the prospect that provision of such complex treatment within hospital/day stay facilities may be undertaken by less qualified practitioners and auxiliaries.

AAPD requests a required formal education to treat patients, children and adults, under general anaesthesia, as an-add on course for dentists.

The AAPD strongly maintains that specialist training is required in conjunction with a clear ability to diagnose, treat and manage a multitude of patient conditions – in concert with our medical and surgical colleagues.

AAPD is acutely aware that Hospital administrators would be extremely anxious and concerned with the prospect that less skilled oral care practitioners could obtain admitting rights and clinical privileges which would adversely impact on patient care, patient and Health Fund Insurance costs.

AAPD would not support any extension to the current format of auxiliary and ancillary oral care providers – particularly if allowed to perform treatment under reduced supervision, extending their scope of practice or allowing for treatment to be performed under sedation or general anaesthesia.

It is the surgeon who is in charge of the general anaesthetic theatre – a point often lost in debate by the dental profession.

2b AAPD concurs with the proposed change to insert a definition under Definitions of a structured professional relationship as outlined on P7 of 23 of the Public Consultation document 8 May 2013.

A. Notwithstanding, AAPD will oppose add on courses inter alia and endorses the preclusion of:

- Interceptive orthodontics
- Inhalation sedation courses (Relative Analgesia)
- Pharmacology (eg for the prescription of analgesics or antibiotics)

For DH, DT, BOH and DP.

B. DT and BOH also be restricted to the forceps extraction of teeth under local anaesthesia.

- No treatment under Relative analgesia, Neurolept Analgesia or General Anaesthesia.
- No surgical extractions
- No limited orthodontic services

2c AAPD agrees with HWA and the need to include a definition of “Independent Practitioner”.

3 AAPD agrees with the reduction in the prescriptive nature of the standard.

Notwithstanding, the scope of activities of Dental Prosthetists should be clarified.

Dental Prosthetists may construct:

- Sleep Apnoea devices
- Orthodontic Appliances
- Implant retained devices

AAPD would oppose “supply” of such appliances/devices directly to patients.

4. AAPD welcomes “Further clarification of the standard”.

For Dentists there should be an “Extension of Scope of Practice” list of programmes in areas where the dental practitioner was not afforded the opportunity in the basic qualification degree.

Concern is expressed where the basic qualification for eg DT and BOH could extend their beliefs of competency outside their skill set.

AAPD would like the Dental Board of Australia to also consider the structural working practice relationship in the dental team:

1. Workplace Agreement

The scope of practice may be decreased depending on the needs and demands of the employer and the patients attending.

2. Professional Indemnity Insurance

At all times the dental practitioners and staff need to be Insured to be Registered and have continued their skill set (CPD units).

Some Hospitals (Private in SA) require that Guild be notified of names and addresses of staff.

The insurance companies have even dental assistants notated on Policies. This at present is at no extra fee.

AAPD accepts that at all times for Registration, Indemnity Insurance must be obtainable.

3. Other World Practices – American Academy of Pediatric Dentistry 12 April 2012

AAPD draws the attention of the Board to the documentation of the Kellogg Foundation, USA, and the American Academy of Pediatric Dentistry.

“As the recognized leader in children’s dental and oral health, the AAPD is strongly committed to improving the oral health status of America’s children, through a variety of advocacy, service and public education initiatives. Therefore, the AAPD wants to ensure that the best interests of children come first and foremost in any strategies that address access to oral health care. The majority of AAPD member dentists are Medicaid providers, demonstrating on a daily basis that pediatric dentists care deeply about access to care. Although we are pleased that a compendium of literature related to the use of non-dentist providers that offer dental services throughout the world has been compiled, we remain unconvinced of the potential effectiveness of this type of model in the United States. The AAPD remains dedicated to the concept of a dental home as the best way to support the oral health of ALL children through the provision of the full range of dental services within the context of a relationship with the dentist.” **AAPD President Dr. Rhea Haugseth April 10, 2012**

4. Oversupply of Dental Workforce October 2012 (Annexure D1-4)

- Oversupply by 440 dentists over the next 5 years.
- ACODS expect that 920 students will graduate in 2013

AAPD values the opportunity to make constructive contribution to the Dental Board of Australia through the Public Consultation process for “Draft Scope of practice registration standard and guidelines”.

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DENTISTS¹

1 Introduction

- 1.1 Dentists were one of the first formally trained health practitioners.
- 1.2 Dentists in Australia have a proud tradition of voluntarily supporting Australian Dental Schools and dental research.
- 1.3 Dentists in Australia have a strong culture of cooperation by sharing experiences and knowledge.
- 1.4 Dentists have a strong culture of philanthropy.
- 1.5 A dentist is the only dental practitioner entitled to use the title "dentist" and may also be known as a dental surgeon, surgeon dentist or by a specialist dentist title.
- 1.6 Dentist training involves five to seven years training at university and so the Board and governments recognise dentists as the principal dental provider.

1.7 **Definitions**

- 1.7.1 BOARD is the Dental Board of Australia.
- 1.7.2 A DENTIST is an appropriately qualified dental care provider, registered by the Board to practise all areas of dentistry.
- 1.7.3 DENTAL PRACTITIONER is a person registered by the Board to provide dental care.
- 1.7.4 DENTISTRY is the science and art of preventing, diagnosing and treating diseases, injuries, developmental and acquired defects of the teeth, joints, oral cavity and associated structures within the context of general health.

2 Principles

- 2.1 Dentists being the most completely and highly trained dental care provider should be central to the delivery of dental treatment.
- 2.2 All Australians should have access to modern, comprehensive oral health care.
- 2.3 Dental care providers should only perform those duties for which they are formally trained.
- 2.4 Dentists perform invasive and irreversible procedures and should be registered.
- 2.5 Universities should only award Doctorate degrees when the programme involves a substantial component of original research.

¹ This Policy Statement is linked to other Policy Statements: 3.1 Dental Workforce, 3.3 Allied Dental Personnel, 3.4 Specialisation in Dentistry, 3.8 Overseas Qualified Dentists, 3.9 Regency of Practice, 3.10 Clinical Practice Placements, 3.12 Benefits of Defined Health Professions, 3.15 Post Graduate Year One Programmes, 4.1 Continuing Professional Development & 5.21 Regulatory Authorities

3 Policy

- 3.1 Education and training of dentists must be to degree level in a programme of at least five years duration conducted by a tertiary institution in the higher education sector and accredited by the Australian Dental Council (ADC). Postgraduate and dental degrees must be equivalent to five year undergraduate programmes and must be of at least four year duration. The title of such a qualification should be a Bachelor of Dental Science, Bachelor of Dental Surgery or Bachelor of Dentistry.
- 3.2 Selection for entrance into such a programme should not be based solely on academic performance and may include:
- communication skills, including competence in the English language;
 - state of health, including being blood borne virus free;
 - good character; and
 - physiological suitability to be a health practitioner.
- 3.3 A one-year clinical placement year is supported provided assistance and mentoring is given to enhance the knowledge and skills of the student/graduate.
- 3.4 Voluntary one year postgraduate programmes are supported provided they are based on mentoring and the continuing professional development of the graduates and not just the provision of service.
- 3.5 Specialist dental training must be of at least three years duration and should be consistent nationally.
- 3.6 Overseas qualified dentists must satisfactorily fulfil ADC and Board requirements before practising in Australia.
- 3.7 The dentist as team leader must be responsible for diagnosis, treatment planning, delivery of dental procedures and continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel working directly with them.
- 3.8 Dentists providing dental care within clinical practice must maintain an appropriate level of professional indemnity cover.
- 3.9 Dentists should conduct themselves in accordance with the Australian Dental Association and their Branch Codes of Ethics.
- 3.10 Dentists have ethical and legal obligations to engage in continuing professional development throughout their practising careers.

Policy Statement 3.2

Adopted by ADA Federal Council, November 21/22, 2002.
Amended by ADA Federal Council, April 22/23, 2004.
Amended by ADA Federal Council, November 13/14, 2008.
Amended by ADA Federal Council, November 18/19, 2010.
Amended by ADA Federal Council, November 15/16, 2012.

ALLIED DENTAL PERSONNEL¹

1 Introduction

- 1.1. Over the years dental workers other than dentists have been introduced into the dental workforce. This varies around the world depending on the particular country's existing dental workforce, resources, political climate but rarely on evidence based analysis.
- 1.2. The Australian Health Ministers' Conference 2004 has determined a National Health Workforce Strategic Framework. The first guiding principle of this framework asserts that 'Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.'
- 1.3. There remains a substantive but lessening need for simple restorative treatments and patient removable dentures while there is an increasing demand for diagnostic, preventive and complex treatments that are only performed by dentists.
- 1.4. In the period of 2004 to 2012 there has been a sharp increase in the numbers of allied dental personnel students becoming eligible to practise in Australia. Several new allied dental personnel programmes have been established.

1.5. **Definitions**

- 1.5.1 ALLIED DENTAL PERSONNEL are those, other than dentists, working in the provision of dental services – namely dental assistants, dental therapists, dental hygienists, dental prosthetists, dental laboratory assistants, dental technicians and master dental technicians.
- 1.5.2 BOARD is the Dental Board of Australia.
- 1.5.3 INSTRUCTION is the oral elaboration of "prescription" and may include a teaching component.
- 1.5.4 INVASIVE PROCEDURES are those where entry to the tissue, body cavities or organs of a patient occurs, or where surgical repair of traumatic injury to a patient is undertaken.
- 1.5.5 NON-REGISTRABLE allied dental personnel are those whose autonomous duties and tasks do not include any invasive dental procedures.
- 1.5.6 PRESCRIPTION is detailed written instruction provided by a dentist to allied dental personnel, and usually specifies the treatment to be performed.
- 1.5.7 RANGE OF PRACTICE is the duties an individual dental practitioner can practice, within their category's scope of practice, for which they are formally educated and trained in programmes accredited by the Australian Dental Council, and are currently competent.
- 1.5.8 REGISTRABLE allied dental personnel are those whose autonomous duties and tasks include invasive dental procedures.
- 1.5.9 SCOPE OF PRACTICE is a clearly defined list of prescribed duties within dentistry for each category of dental practitioner which should be delineated by regulation.

¹ This Policy Statement is linked to other Policy Statements: 3.1 Dental Workforce, 3.2 Dentists, 3.8 Overseas Qualified Dentists, 3.9 Recency of Practice, 3.10 Clinical Practice Placements, 3.15 Post Graduate Year One Programmes, 4.1 Continuing Professional Development & 5.21 Regulatory Authorities

- 1.5.10 SUPERVISION is the direction and/or oversight (including guidance and support) by dentists of the performance of duties by allied dental personnel. Supervision can be direct (i.e., the dentist is physically present in the treatment facility at all times the patient is being treated by allied dental personnel) or indirect (i.e., the dentist need not be physically present in the treatment facility, but must be able to be contacted at all times the patient is being treated by allied dental personnel).

2 Principles

- 2.1. All Australians should have access to modern, comprehensive oral health care.
- 2.2. Australia must be largely self sufficient with regard to the training of the dental workforce.
- 2.3. Clearly defined scopes of practice for allied dental personnel will assist:
- educational institutions to provide national uniform training outcomes;
 - members of the dental workforce to better understand each others' roles;
 - the public to understand each practitioner's role; and
 - the accreditation of allied dental personnel training.
- Allied dental personnel should only perform those duties within their range of practice,
- 2.4. Education and training institutions should use uniform nomenclature for qualifications for each category of the dental workforce.
- 2.5. Only allied dental personnel who perform invasive and irreversible procedures should be registered.
- 2.6. The dental workforce training numbers for each category of allied dental personnel should be based on the requirements and demand of the community.

Responsibilities of Dentists

- 2.7. The dentist must be responsible for the diagnosis, treatment planning, and delivery of dental procedures and the continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel in the conduct of prescribed duties for which they are legally accountable.
- 2.8. With respect to allied dental personnel other than dental prosthetists, it is the responsibility of the dentist to:
- ensure that all members of the dental workforce at all times have appropriate competence and formal training for the tasks that are delegated to them i.e. work within their range of practice;
 - have an understanding of the roles of all members of the dental workforce;
 - inform patients that a specified part of their treatment is to be undertaken by allied dental personnel;
 - monitor and supervise the performance of allied dental personnel;
 - consult with patients regarding the treatment plan and to instigate referral to specialists;
 - provide adequate prescription and instruction to ensure that the procedures and/or treatment to be performed are understood;
 - be available for consultation and management of any complications that may occur; and
 - ensure that all delegated procedures have been performed satisfactorily.

Responsibilities of Allied Dental Personnel:

- 2.9. It is the responsibility of allied dental personnel to:
- have a complete understanding of the role of all members of the dental workforce;
 - carry out only those delegated tasks within their range of practice i.e. for which they are formally educated and trained and have appropriate competence;

- refer to a dentist any condition or task which is outside their range of practice, including changes in a patient's health status or medication; and
- if applicable hold appropriate professional indemnity cover.

3 Policy

3.1 The future dental workforce should provide services that:

- are population based;
- are patient focused;
- lead to the coordinated, non-fragmented provision of oral health services;
- are preventively oriented;
- should ensure an adequate dental workforce in rural and remote areas; and
- are delivered efficiently and effectively.

Categories

3.2 The following categories of allied dental personnel in Australia are recognised:

Non-registrable:

- dental assistant;
- dental laboratory assistant;
- dental technician; and
- master dental technician.

Registrable:

- dental hygienist;
- dental therapist; and
- dental prosthetist.

Regulation of Practice of Allied Dental Personnel

3.3 Dental hygienists, dental therapists and dental prosthetists must be registered and practise in accordance with all statutory requirements. Regulation of practice must be vested in the Board enacted by legislation under the relevant Federal, State or Territory Acts which must provide that:

- the scope of practice is clearly defined with a list of duties;
- the course of training is prescribed;
- registration is required and a register regularly maintained; and
- penalties apply for contravention of any provisions of the relevant Act.

3.4 Dental laboratories, especially those not owned and/or controlled by persons registered with a Board, should be accredited by a competent agency.

3.5 Provider numbers must only be issued to those members of the dental workforce who are registered to practise as independent practitioners by Boards.

Education and Scope of Practice of Allied Dental Personnel

3.6 Education and training for allied dental personnel must reflect their defined scope of practice, which should be nationally uniform.

3.7 The training of registrable allied dental personnel should be focused on prevention rather than restorative dentistry and exodontia.

Dental Assistant

- 3.8 Basic education and training of dental assistants must be at Certificate III level in the vocational sector and in accordance with the National Competency Standards. The title for such a qualification should be Certificate III in Dental Assisting.
- 3.9 With additional education and training in clearly defined areas to Certificate IV level in the vocational sector, and in accordance with the National Competency Standards, the duties of dental assistants extend to:
- dental assisting – oral health promotion;
 - dental assisting – dental radiography;
 - dental assisting – technical procedures;
 - dental assisting – general anaesthesia and conscious sedation; and
 - dental assisting – dental practice administration.
- 3.10 Duties shall comprise established procedures associated with chair side assisting, infection control and practice administration.
- 3.11 A dental assistant must work under the supervision of a dentist or suitable allied dental personnel as detailed in Appendix 2 to this Policy Statement.
- 3.12 Education and training numbers of dental assistants should be in alignment with the numbers of dentists and registrable allied dental personnel.

Dental Hygienist

- 3.13 Education and training of dental hygienists must be to at least Diploma level and of at least two years' duration. The education and training should be conducted in either the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental hygiene training and accredited by the Australian Dental Council (ADC). The title for such a qualification should be a Diploma / Bachelor of Dental Hygiene.
- 3.14 The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.
- 3.15 Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:
- such treatment plan shall be effective for not more than twelve months; and
 - the need for examination of the patient by the dentist after completion of the treatment plan by the dental hygienist will depend on the needs of the patient, the treatment provided and the experience and competency of the dental hygienist.
- 3.16 The role of the dental hygienist in the provision of dental treatment shall be subject to the following :
- 3.16.1 The dental treatment must be supervised by a dentist who is on the premises at the time of treatment, except in the case of dental treatment within categories referred to in paragraph 3.16.2 a. to h. provided on the premises of long term residential care, either government or licensed under local government legislation, for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call.
- 3.16.2 The dental treatment must fall within the following scope of practice:
- a. established procedures associated with chair side assisting and practice management;
 - b. oral health education;
 - c. instruction in monitoring and recording of plaque control routines and recording of periodontal disease;

- d. prophylaxis;
- e. polishing of restorations;
- f. fluoride therapy, application of remineralising solutions and desensitising agents;
- g. debridement to remove supragingival deposits from teeth;
- h. debridement to remove subgingival deposits from teeth;
- i. application and removal of rubber dam;
- j. application of non-invasive fissure sealants;
- k. taking of alginate impressions other than for the fabrication of prosthetic appliances;
- l. removal of periodontal packs;
- m. taking of dental radiographs;
- n. orthodontic band sizing;
- o. removal of orthodontic appliances including orthodontic cements and resins;
- p. placement and removal of non-metallic separators and alastic modules; and
- q. administration of local anaesthesia by infiltration and mandibular nerve block.

- 3.17 Education and training numbers of dental hygienists should be in alignment with the demand for preventive services.

Dental Therapist

- 3.18 Education and training of dental therapists must be to at least Diploma level and of at least two years' duration. The education and training should be conducted either in the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental therapy training and accredited by the ADC. The title for such a qualification should be a Diploma / Bachelor of Dental Therapy.
- 3.19 A dental therapist must work under the supervision of a dentist.
- 3.20 The duties of dental therapists shall be restricted to prevention of dental diseases and control of dental caries in school children.
- 3.21 The provision of treatment by a dental therapist must fall within the following scope of practice:
- a. established procedures associated with chair side assisting and practice management;
 - b. oral health education;
 - c. oral health examination;
 - d. taking of dental radiographs;
 - e. application and removal of rubber dam;
 - f. pre- and post-operative instruction;
 - g. irrigation of the mouth;
 - h. fluoride therapy, application of remineralising solutions and desensitising agents;
 - i. debridement to remove deposits from teeth;
 - j. taking of alginate impressions other than for the fabrication of prosthetic appliances;
 - k. application of fissure sealants;
 - l. direct coronal restoration of primary and permanent teeth;
 - m. pulpotomies in vital primary teeth;
 - n. administration of local anaesthesia only by infiltration and mandibular nerve block; and
 - o. forceps extraction of primary teeth under local anaesthesia.

- 3.22 Education and training numbers of dental therapists should be in alignment with the need for simple restorative treatments in children.

Dental Laboratory Assistant

- 3.23 Education and training of dental laboratory assistants must be to Certificate III level conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be Certificate III in Dental Laboratory Assisting.
- 3.24 A dental laboratory assistant must work under the supervision of a dental technician or dentist.

- 3.25 The duties of a dental laboratory assistant shall consist of the following established laboratory procedures:
- a. pouring impressions;
 - b. producing custom-made trays;
 - c. constructing occlusal registration rims;
 - d. constructing mouthguards;
 - e. articulating models; and
 - f. transferring records.

Dental Technician

- 3.26 Dental technician education and training must be to Diploma level and at least two years' full time study with a period of structured learning of at least one to two years. The training should be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be a Diploma in Dental Technology.
- 3.27 A dental technician may work independently of a dentist, but must adhere to the prescription of a dentist and is not permitted any direct dealings with members of the public except in the case of non-invasive shade taking at the direction of the dentist.
- 3.28 The duties of a dental technician shall consist of the following established laboratory procedures:
- a. fabrication, maintenance and repair of complete and partial dentures;
 - b. fabrication of inlays, onlays, veneers, crowns and bridges;
 - c. fabrication of mouthguards, occlusal splints, medicament trays and stents; and
 - d. fabrication of appliances used in orthodontics, oral and maxillofacial surgery and other special areas of dentistry.

Master Dental Technician

- 3.29 A master dental technician must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be an Advanced Diploma in Dental Technology.
- 3.30 The advanced training for a master dental technician shall include:
- a. attachments to implants in complete and partial dentures;
 - b. precision attachments associated with inlays, onlays, crowns and bridges;
 - c. greater depth understanding of materials and processes; and
 - d. ceramic systems, CAD/CAM .
- 3.31 Education and training numbers of dental technicians should be in alignment with the need for custom-made dental prostheses and appliances.

Dental Prosthetist

- 3.32 A dental prosthetist must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be an Advanced Diploma in Removable Dental Prosthetics.
- 3.33 The scope of practice for dental prosthetists is that they may independently provide treatment to the public limited to the provision, in healthy mouths, of flexible mouthguards and patient removable dentures not associated with implants.
- 3.34 All patients should be examined by a dentist prior to treatment by a dental prosthetist.
- 3.35 Education and training numbers of dental prosthetists should be in alignment with the demand for patient removable dental prostheses.

Career Path

- 3.36 Education and training institutions should facilitate entry of allied dental personnel into dental workforce training courses that are at a higher level than their current qualification (e.g. dental assistants training to become dental hygienists). This provides a career path for allied dental personnel within the dental workforce based on appropriate training.

Policy Statement 3.3

Adopted by ADA Federal Council, April 10/11, 2003.
Amended by ADA Federal Council, November 11/12, 2004.
Amended by ADA Federal Council, November 10/11, 2005.
Amended by ADA Federal Council, November 2/3, 2006.
Amended by ADA Federal Council, April 12/13, 2007.
Amended by ADA Federal Council, November 15/16, 2007.
Amended by ADA Federal Council, November 13/14, 2008.
Amended by ADA Federal Council, November 12/13, 2009.
Amended by ADA Federal Council, November 18/19, 2010.
Amended by ADA Federal Council, April 12/13, 2012.

APPENDIX 1 TO POLICY STATEMENT 3.3
ALLIED DENTAL PERSONNEL
AUSTRALIAN QUALIFICATIONS FRAMEWORK

SECONDARY SCHOOLS SECTOR	VOCATIONAL EDUCATION AND TRAINING SECTOR	HIGHER EDUCATION SECTOR
		Doctoral Degree
		Masters Degree
		Graduate Diploma
		Graduate Certificate
		Bachelor Degree
	Advanced Diploma	Associate Degree Advanced Diploma
	Diploma	Diploma
	Certificate IV	
Senior Secondary Certificate of Education	Certificate III	
	Certificate II	
	Certificate I	

APPENDIX 2 TO POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL MODEL STANDARDS STATEMENT FOR DENTAL ASSISTANTS EDUCATIONAL AND SUPERVISORY REQUIREMENTS FOR DENTAL ASSISTANTS

Introduction

Dentists, dental therapists and dental hygienists and their employers have a responsibility to know a dental assistant's clinical and educational experience, scope of duties in keeping with appropriate Federal, State or Territory legislation and regulations, and supervisory requirements during the provision of oral health care procedures. There is no necessity for dental assistants to be registered.

Purpose

This Standards Statement describes the supervisory responsibilities and the relationship between the scope of duties and educational experience associated with the employment of dental assistants

Scope of Duties

A dental assistant is primarily employed as a clinical assistant to the dentist. Their duties include clinical chair side assisting, maintaining infection control standards and to assist in practice administration.

The usual duties of a dental assistant are in accordance with their educational and clinical experience and require the direct supervision of a dentist, dental therapist and dental hygienist depending on the tasks undertaken by the dental assistant.

Educational and Clinical Experience

All dental assistants should be encouraged and supported to gain entry qualifications in dental assisting or recognition of equivalence, which has been issued by an Australian registered training organisation. Qualifications in dental assisting are particularly suited to the Australian Apprenticeship/Trainee pathway, which involves on-the-job and off-the-job training

There are several levels of dental assistant educational and clinical experience that are recognised.

1. A dental assistant undergoing on-the-job training for at least six months and has no prior work related experience. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.
2. A dental assistant undergoing on-the-job training and off-the-job training for a period of at least 12 months. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.
3. A dental assistant qualified in a nationally based Certificate III in Dental Assisting or its equivalent working under the supervision of a dentist, dental therapist or dental hygienist. Minimum units include:
 - 3.1 Communicate and work effectively in health
 - 3.2 Comply with infection control policies and procedures in health work
 - 3.3 Process reusable instruments and equipment in health work
 - 3.4 Participate in OHS processes
 - 3.5 Prepare for and assist with oral health care procedures
 - 3.6 Assist with dental radiography
 - 3.7 Assist with the administration in dental practice
 - 3.8 Apply first aid
4. A dental assistant qualified in a nationally based Certificate IV in Dental Assisting¹ or its equivalent working at an advanced level under the supervision of a dentist, including:
 - 4.1 Dental Assisting – dental radiography
 - 4.2 Dental Assisting – oral health promotion
 - 4.3 Dental Assisting – technical procedures (also known as 'extended duties'²)

- 4.4 Dental Assisting – general anaesthesia and conscious sedation
- 4.5 Dental Assisting – dental practice administration

Supervision

The legal and ethical responsibilities associated with the actions and omissions of a dental assistant are attributed primarily to the supervising dentist. Any allied dental personnel or employer involved in the supervision of the dental assistant may also be liable

Compliance with Board and statutory regulatory bodies is essential. Consultation to clarify any matters related to a dental assistant's qualifications, experience and competence to perform advanced scopes of duties or undertake on the job training may be required to attain nationally based Certificate IV qualifications in Dental Radiography and Technical procedures such as taking an impression for study models.

The clinical responsibilities for the patient remain with the dentist, dental therapist and dental hygienist providing the treatment and/or providing supervision at all times.

All advanced duties undertaken by a dental assistant should be in accordance with a written treatment plan prepared by a dentist.

During the performance of an advanced duty by a dental assistant, a dentist should be on the premises to:

- Provide supervision
- Provide advice and consultation in relation to authorised dental assistant activities
- Be available for referral in relation to other matters falling outside the competence of an individual dental assistant

All the above supervisory responsibilities of dentists apply equally to dental prosthetists conducting independent practice.

Patient Consent

Appropriate patient consent is to be obtained prior to the dental assistant undertaking any advanced duty involving direct patient contact

The patient may decline to have the dental assistant undertake the advanced duty and elect to have a dentist, dental therapist or dental hygienist to complete the task. The choice of dentist, dental therapist or dental hygienist is dependent on the task and the dentist's supervisory obligations.

Records

A dental assistant undertaking advanced duties must maintain a signed work record of each patient contact recording the date and procedure undertaken.

The name of the dental assistant performing an advanced duty should be entered into the patient record for that procedure according to the usual standards for record keeping.

Misrepresentation

When undertaking advanced duties involving direct contact with the patient, a dental assistant, supervisory dentist and employer should not hold out or represent a dental assistant as a dental care provider to the patient or through advertising.

² Health Training Package HLT07 found at www.cshisc.com.au

³ Terminology this section according to nationally based competency units, Health Training Package 07

APPENDIX 3 TO POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL

GLOSSARY OF TERMS

PREFERRED TITLE	ALTERNATE TITLE	OCCUPATION APPROPRIATE FOR AUSTRALIA
Dental Assistant	Dental Nurse	Yes
Dental Hygienist		Yes
Dental Therapist		Yes – short term
Dental Laboratory Assistant		Yes
Dental Technician	Laboratory Dental Technician	Yes
Master Dental Technician		Yes
Denturist	Clinical Dental Technician, Advanced Dental Technician, Dental Prosthetist	Yes – short/medium term
Maxillofacial Prosthetist and Technologist		No
Orthodontic Chair Side Assistant		No
Orthodontic Technician		No
Orthodontic Therapist		No
Oral Health Therapist		No
Practice Manager		Yes (not Allied Dental Personnel)
Receptionist		Yes (not Allied Dental Personnel)

Parents to pay in child dental plan

A PLAN is set to cut waiting times for public patients to see a dentist in the South-East at the same time the Australian Dental Association has warned the Medicare rebate will not cover the average dental fee.

Parents will have to pay for about 20 per cent of their child's dental treatment under Julia Gillard's child dental scheme because the Medicare rebate is less than the average fee.

The Australian Dental Association has also warned the scheme would provide a rebate only for basic treatments. Children who need space maintainers, general anaesthetics and other simple orthodontics will not be covered.

This would affect treatment

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of children with disabilities and toddlers who need general anaesthetics to make treatment less traumatic for them, the association said.

The \$620 million a year Growing up Smiling scheme, due to begin in January 2014, will provide more than 3.4 million children living in families who receive the Family Tax Benefit A with up to \$1000 in dental treatment from Medicare every two years.

ADA president Dr Karin Alexander slammed the details of the scheme.

"This government will be known as the government that introduced 'poor dentistry for poor people' because this scheme as currently designed does just that," she said.

A spokesman for Health Minister Tanya Plibersek said the ADA welcomed the scheme when it was announced last year. More than 47 per cent of Australian 12-year-olds have decay in their permanent teeth and Ms Plibersek said the program "will help alleviate this social and economic disadvantage by assisting families in greater financial need ..."

An ADA and SA Dental Ser-

vice plan to get public patients into private dentists aims to further reduce Mt Gambier's three-year waiting list.

December figures showed public patients in Mt Gambier waited an average 44.7 months, which had reduced to 35.6 months by March after another dentist was employed.

"The SA average is 17 months, we still think that is too long," SA Dental Service acting executive director Anne Pak-Poy said after a meeting at the South-East yesterday.

"If Mt Gambier could drop from 35 months to 17 months over the next six months we would be extremely happy with that," she said.

- with Jordanna Schriever

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committee report

SPECIAL PURPOSE COMMITTEE – DENTAL WORKFORCE REPORT

Report to FEDERAL COUNCIL

BACKGROUND

The National Oral Health Plan 2004-2013¹ (NOHP) identified that a significant proportion of the population, mainly those dependent on public dentistry, could not access dental care and that there would be insufficient dentists to provide the additional services. This led to an increase in the number of universities offering dental programmes and a concurrent increase in the number of students accepted into existing programmes.

There is no agreed international standard for an ideal dental workforce size. The NOHP¹ did not identify a target dentist population ratio for Australia. It forecast that in 2010 there would be 10,239 dentists practising and that would amount to a shortage of 1,500 providers.

As shown later in this report, this shortage had probably disappeared by 2006 and certainly by 2009, by which times there were already 12,212 and 13,830 dentists registered.

Despite the increase in training place, there is a continued misconception within government bodies and the general public, that there is a shortage of dentists.

What is more likely the case is that there is some maldistribution of the workforce between metropolitan and rural and remote areas. The reasons for this maldistribution are not clear but are due in some large part to practise viability and the personal choice of practitioners.

Recognising the importance and urgent need to address this perception, the Australian Dental Association (ADA) Inc. Federal Executive established a Special Purpose Committee of Dental Workforce (SPC DW) to examine the issue in detail.

The SPC DW were asked specifically to:

- Analyse dentist workforce data collected by Boards and dental workforce inputs;
- Survey graduates of the last two years as to their dentist employment status;
- Analyse dentist employment vacancies, and
- Make recommendations and report to Federal Executive on future inputs to dental workforce and on increasing opportunities for dentists.

SPC DENTAL WORKFORCE

Dr Rick Olive AO (Chairman)	Dr Leonard Crocombe
Dr Matthew Hopcraft	Professor Johann De Vries
Dr Michael Jonas	Dr Shane Fryer

WHAT DO WE KNOW ABOUT THE CURRENT WORKFORCE?

Data about the dental workforce has been produced intermittently only over the last decade and is usually out of date by the time it is published. The reason for this is a lack of emphasis on oral health and the dental workforce and greater allocation of workforce planning resources to the medical and nursing workforce.

Detailed data about the workforce in conjunction with predicted demand for services is fundamental to undertake workforce planning. The following section provides an overview of some of the issues with processes for collection of dental workforce data and understanding the dental workforce, demographics and characteristics.

DENTAL LABOUR FORCE DATA

Since the early 1980s, state and territory dental boards distributed a Dental Labour Force Survey in conjunction with the annual registration process.

The Dental Labour Force Survey collects information on the demographic and employment characteristics of dental practitioners who were registered in Australia at the time of the survey. The data collected from this survey is provided to the Australian Institute of Health and Welfare Dental Statistics Research Unit (DSRU) located in the Australian Research Centre for Population Oral Health (ARCPHO) for aggregation. The statistics gathered are then reported on a national, state and territory level to inform oral health service planning.

However, there are a number of limitations with the survey results as the numbers reported are estimates only of the workforce. This is due to the fact that not all practitioners complete the survey and those that do, do not necessarily answer every question. For example, in 2006, response rates ranged from as low as 33.1% in the ACT to 90.7% in NSW. Secondly, the survey tool was not always distributed to all practitioners at the same time, so in some states and territories, the data were collected by the DSRU directly. To accommodate for this, data are weighted to account for the population being examined (i.e. the total number of practitioners registered) and imputed for non-response questions.

There has also been significant delay between the collection of the data and the release of national statistics. This is due in part to the fact that there is a delay between the data being collected and state and territory health departments providing the information to the AIHW, despite an agreement between Health Ministers that this occur in a timely manner. Another contributing factor is that the DSRU has not been funded to provide a report on an annual basis.

The most recent reports issued by the DSRU relate to data collected in 2006² and 2009³.

WHAT INFORMATION IS AVAILABLE FROM THE DENTAL BOARD OF AUSTRALIA?

In 2010, Australia introduced a national registration scheme for health professionals. The registration of dental practitioners is now undertaken by a single registration body, the Dental Board of Australia (DBA).

As part of the move to the national scheme, and in response to decreasing response rates across all health professional groups, it was agreed that the workforce survey would be conducted electronically as part of the registration process. While still voluntary, it is hoped that this will improve response rates.

In May 2012, the DBA, in conjunction with the Australian Health Practitioner Regulation Authority (AHPRA), published its first report providing a statistical breakdown about registrants⁴. Table 1 provides a summary of the numbers reported over time by the DSRU and the DBA.

Table 1: Dental registration data by practitioner

Employment category	2006	2009	2012**
Dentist	12,212	13,611	14,223
Dental hygienist	784	1,067	1,216
Dental therapist	1,380	1,412	1,162
Dental hygienist & dental therapist	N/A*	N/A*	514
Dental hygienist/dental therapist/dental prosthetist	N/A*	N/A*	2
Oral health therapist	410	663	614
Dental prosthetist	1,080	1,220	1,165
Dental prosthetist/dental hygienist	N/A*	N/A*	2
Total	15,866	16,973	18,898

*Data on double registration was not reported

** Data from Dental Board of Australia

More recent data issued by the DBA in August shows that the number of registrants in each category of practitioner has increased further.

WHAT DOES THIS TELL US ABOUT THE DENTAL WORKFORCE?

Between 2006 and 2012, the dental workforce increased by 3,032 or 19%. During the same period the population of Australia increased from 20.7 million to 22.6 million or 9.3% approximately.

The number of dentists registered increased by 2011 or 16.4% but it is more difficult to identify the actual growth in allied dental practitioner numbers by practitioner (dental hygienists, dental therapists and oral health therapists) as prior to 2006, oral health therapists were categorised as either a dental hygienist or a dental therapist. That said, it is possible to identify that when added together, there has been a substantial growth in allied dental practitioner numbers overall from 2,574 in 2006 to 3,510 in 2012 (36%).

The 2012 figures reported are based solely on the registration data. Further breakdowns of workforce characteristics and demographics are not available.

In light of this the following commentary about workforce growth and distribution is based on the dental labour force collection 2009, published by the DSRU³.

- In 2009, of the 12,041 dentists in the dental workforce, 11,882 were practising dentistry, 100 were on extended leave and 49 were looking for work.

- The number of dentist registrations per 100,000 of population increased from 55.4 to 62.0 between 2000 and 2009, while the rate of practising dentists increased from 46.9 to 54.1. The difference between numbers registered and practising is because some who were registered were overseas; some were registered in more than one jurisdiction and some were not practising for other reasons including family commitments and unemployment.

- The DSRU report 2012³ also indicated that between 2000 and 2009 the number of dental hygienists practising increased from 415 to 943 and the number of dental therapists practising decreased from 1,317 to 1,234. In 2009 there were also 590 oral health therapists practising.

IS THE PROFILE OF THE WORKFORCE CHANGING?

The issue of the feminisation of the profession of dentist is sometimes cited as a reason that more dentists are needed. There has been a larger growth in the number of female dentists in the workforce between 2000 and 2009 than males over the same period of time. Female dentists are on average almost nearly nine years younger than male dentists.

The 2009 labour force survey results showed that of the 30.9% of dentists who worked part-time, there was a higher percentage of female dentists than males (45.3% to 24%). However, the total part-time hours worked by both groups has remained steady.

Looking back at previous results, the 2006 labour force survey² showed that the average hours worked by dentists did not drop below 35 hours per week until age 60 years for female dentists and age 65 years for male dentists. Historically, dentists approaching retirement have reduced their working hours. This has changed since the increase in workforce numbers became more obvious.

The 2012 DSRU report³ shows that in 2009, just three years later, all age groups of female dentists except for the under 30 years group worked fewer than 35 hours per week on average.

This is consistent with other groups where females represent the majority of the workforce. The DSRU report³ also shows that the average hours worked by dental hygienists dropped between 2000 and 2009 from 29.6 to 28.7 hours. Working hours declined similarly for dental therapists and oral health therapists: 65.4% of dental hygienists, 63.9% of dental therapists and 48.3% of oral health therapists worked part-time.

IS WORKFORCE DISTRIBUTION KEEPING TRACK WITH POPULATION GROWTH

The growth in the Australian population could also be considered as a measure of demand for more dentists. The population is concentrated on the Eastern seaboard and around the southern west coast of Australia. (Fig 1)

The ADA has recently plotted the distribution of dental practices and as might be expected, practice locations reflect the population distribution. (Fig 2)

Fig 1. Australian population distribution areas in Australia with population density over 117 persons per square kilometre.



Data: Australian Bureau of Statistics, 2011 Census.
Image: Richard Chirgwin

committee report

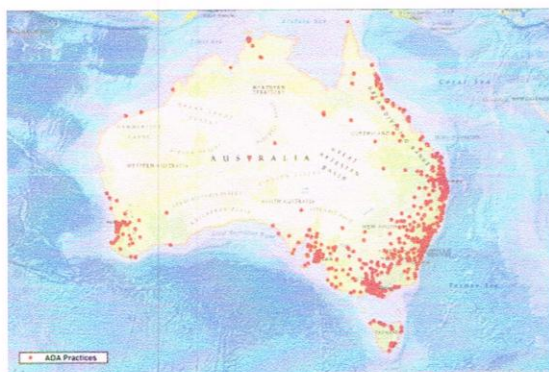


Fig 2. ADA member practices distribution

According to the Australian Bureau of Statistics the Australian population grows by 1.5% on average per year. It is reasonable to expect that the population of dentists should increase similarly. This calls for about 213 extra dentists each year to meet growth.

The DSRU 2012³ reports that the average practising rate for Australia in 2009 was 54.1 dentists per 100,000 of population. It also identifies the number of dentists practising in each remoteness area. There were 115 practising in remote or very remote areas and 628 practising in outer regional areas and 1,731 practising in inner regional areas. If dentists could be enticed to each of these areas to make up to the average practising rate for Australia in 2009 then there would be opportunities for employing another 1,303 dentists, and this represents slightly less than half those currently in training.

Table 2. Population, number of dentists and possible opportunities for dentists by remoteness area.

Remoteness area	Population 2010	No. of dentists 2009	Potential no. of dentists	Shortfall
Inner regional	4,395,119	1,731	2,378	647
Outer regional	2,083,742	628	1,127	499
Remote/very remote	502,372	115	272	157
Total	6,981,233	2,474	3,777	1,303

HOW DOES AUSTRALIA COMPARE TO OTHER COUNTRIES?

The FDI World Dental Federation has published the dental workforce demographics of 75 countries on its website. Whilst the FDI World table presents data which is up to 12 years old, it shows 38 countries with more dentists per 100,000 of population than Australia.

Based on the recent 2012 DBA data⁴, and assuming that there has been no significant change in workforce numbers in comparative countries, it can be assumed that Australia would now be ranked 10 places higher than in 2006 on dentist numbers alone.

The FDI World Dental Federation data shows that in 2006, Australia had mid-level dentist to population ratios amongst OECD countries. Those with significantly more dentists per head of population had much higher levels of taxation (Denmark, Norway, and Sweden) or different economic fundamentals (Iceland and Greece), including former communist bloc countries (Bulgaria, Czech Republic, Croatia, Latvia, Lithuania and Poland).

HOW MANY DENTISTS ARE WE TRAINING?

There has been a rapid increase in the number of dental students being trained in Australia. This was predominantly in response to the decisions of various regional universities to offer courses to meet the demand for places in dental schools and because the NOHP indicated a dental workforce shortage based on publications by Australian Research Centre for Public Oral Health and the DSRU.

This increase in student numbers has now resulted in increased numbers of dentists and other dental practitioners graduating and entering the dental workforce.

The Australasian Council of Dental Schools Inc. (ACODS) has provided data on the number of students enrolled in undergraduate courses leading to registration as a dental practitioner in Australia for 2012.

These figures (Table 3) show that since 2006, there has been an increase of 1,653 students in dental programmes. When compared to 2003 numbers this figure rises to 2,391. There are now 2,734 students enrolled in courses leading to registration as a dentist and 860 in oral health programmes.

Table 3. Total number of undergraduates in Australian dental programmes

Year	Undergraduates
2006	2,064
2007	2,366
2008	2,866
2009	3,063
2010	3,274
2011	3,513
2012	3,717

Of these students, there are 440 dental and 18 oral health therapy students who are international full fee paying students. The recent government announcement that these students upon graduation may now work in Australia has, at the stroke of a pen, potentially made the workforce oversupply worse by 440 dentists over the next five years.

ACODS expect that 920 students will graduate from dental and oral health programmes in 2013.

Conversely, the number of specialist dentists being trained is not following suit. While the training programmes for orthodontists and oral and maxillofacial surgeons have continued uninterrupted, many of the other dental specialties have dwindled in output.

ACODS report that there are 74 dentists enrolled in courses leading to specialist qualifications in 2012, only 14% of the total dental intake in the same year. Overall specialist dentists have represented 11 to 12% of the dentist workforce and this percentage has remained stable.

The impact of declining levels of specialist training in a number of disciplines has implications for the replacement of the specialist workforce. General practitioners may therefore have to undertake specialist type work that they may not have performed. This may have safety and quality of care implications.

An area where specialist dentist workforce shortages are likely to be felt is within the academic workforce. This section of the workforce is ageing and there are fewer graduates seeking an academic career.

Despite substantial increases in the number of dental and oral health therapy programmes offered across Australia, the number of full-time academic staff has increased by only 67 full-time equivalent (FTE).

This issue is best demonstrated by the increase in staff to student ratio.

In 2003, the ratio of academic to student was 1:7.6. In 2012, the ratio has increased to 1:13.6. This represents almost a doubling of student numbers each academic has to engage. Again safety and quality implications may arise.

HOW MANY DENTISTS WHO QUALIFIED OVERSEAS ARE ENTERING AUSTRALIA?

Another significant supply of dentist to Australia is through the skilled migration pathway. The Australian Dental Council provides a process for recognition of qualifications gained overseas on behalf of the Dental Board of Australia and its predecessors, the state and territory dental boards.

There have always been a small number of dentists who qualified overseas migrating to Australia. However, as a consequence of the NOHP the occupation of 'dentist' was added to the Skilled Occupation List (SOL) by the Department of Immigration and Citizenship. The SOL is used to determine eligibility for permanent independent skilled migration.

As a result the number of overseas qualified dentists taking and passing the examinations and assessments of the ADC has grown exponentially and beyond all expectations (Table 4).

Between 2000 and 2004 there were 249 dentists who successfully completed the ADC assessment process. Between 2005 and 2010 there were 1,041 successful.

Table 4. Number of overseas qualified dentists successfully completing the ADC exam by year.

Year	No of dentists
2000	51
2001	52
2002	37
2003	48
2004	61
2005	110
2006	158
2007	156
2008	171
2009	204
2010	242

When presented as a trend, the exponential growth in overseas qualified dentists entering the workforce in Australia can be clearly understood. (Fig 3)

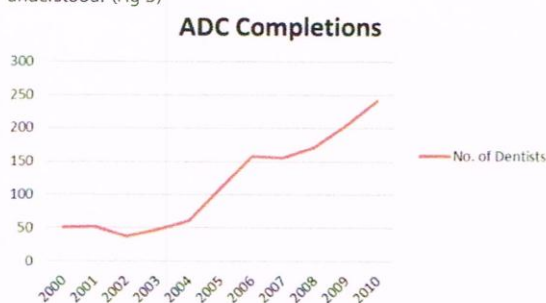


Fig 3: ADC Completions by year

Source: Australian Dental Council

Recently, Skills Australia has placed the occupation of dentist on the flagged list, which means a continued monitoring of the labour market due to signs that graduate outcomes, i.e. the percentage of graduates achieving full-time employment, may be falling as supply increases. This may lead to removal of 'dentist' from the list. In May 2011 Skills Australia noted that shortages were no longer evident with dentist employers in both metropolitan and regional areas generally attracting multiple suitable applicants and experiencing little difficulty filling their vacancies.

ARE DENTISTS RETIRING AS EXPECTED?

The DSRU dental report 2012³ shows that in 2009 there were 1,803 practising dentists aged 60 years or more and 2,803 aged 50 to 59 years. There are many more dentists in training than are needed to replace retiring dentists over the next decade.

In fact every dentist over the age of 50 years would have to retire over the next five years to match the number of dentists who will

graduate or pass the ADC exam in the next five years to maintain the current status. Nothing like this level of retirement is evident from the statistics.

Schofield et al.⁵ surveyed dentists aged more than 50 years in NSW in 2007 and found that more dentists than ever before intended to work past age 65 years. In fact 63% of these dentists plan to work beyond age 65 years.

ARE NEWLY QUALIFIED DENTISTS FINDING WORK?

The DSRU 2012 report³ shows there were 59 dentists unemployed in 2009.

Anecdotal evidence suggests that there has been a significant shift in the jobs market and employment profiles are leaning towards increased part-time employment in dentistry and drying up of jobs. Unless there is a significantly increased commitment to public funding of dentistry, it is reasonable to say the market for dentists is saturated or somewhat oversupplied.

ADA Inc. has offered members the opportunity to post job vacancies on its website since 2007. This facility has been available in hard copy ADA publications. The utilisation of this website service has been increasing every year since then. Historically, the dentist vacancies have been for full-time positions. However, more than half of the dentist vacancies currently advertised are now part-time.

The number of jobs advertised in 2007 was 165 increasing to 785 in 2011, and these included jobs for dentists, dental hygienists, dental therapists, dental assistants and practice managers. Most of the jobs are for dentists. Since December 2010 the data on these jobs has also included full-time, part-time or locum descriptions, although consistent data on this delineation is only available since July 2011.

The proportion of full-time and part-time dentist jobs has remained steady for the past year with slightly more part-time jobs advertised than full-time jobs; 75% of all dentist jobs are advertised in NSW and Queensland.

The period of time that job advertisements remain posted on the ADA Inc. website and the number of jobs posted has been decreasing. In 2007 some dentist jobs remained open for more than one year. In July 2012 there were no jobs posted for more than three months. These data should be interpreted with caution as other influences may be responsible, such as members shifting their job advertisements from the *News Bulletin* to website; the increased awareness of the website facility over time and also the protocol introduced by ADA, which enabled the organisation to remove advertisements after a period of time.

ADA Inc. also conducts dental practice surveys of members every three years. The survey reports for 2001, 2004, 2007 and 2010 are published on the members' area of the ADA Inc. website.

It is clear that an increasing proportion of the ADA members are only employed part-time in dental practice. Based on responses from the ADA Dental Practice Survey, the part-time employment rate among ADA members increased from 6% in 1997 to 21% in 2010. These data may underestimate the level of underemployment of dentists because the 2006 labour force survey reported by DSRU² showed 27.2% worked part-time and the 2009 survey³ showed 30.9% worked part-time.

There is a difference between the ADA dental practice survey's definition and the DSRU definition of part-time. ADA counts those working fewer than 30 hours per week, or 1,200 hours per year, as part-time, while DSRU counts those working fewer than 35 hours per week as part-time. Part-time employment is very likely to be the early indicator of underemployment and growing unemployment in dentistry.