



11TH May 2018

dentalboardconsultation@ahpra.gov.au

RE: Scope of Practice Standard Review

I am writing to you as President of the Queensland Branch of the Australian Dental and Oral Health Therapists' Association (ADOHTA QLD), which is the peak representative body for Oral Health Practitioners (OHPs) that includes dental therapists, dental hygienists and oral health therapists.

We appreciate to opportunity to comment on the Review of the Scope of Practice Standard.

The Dental Board of Australia's preferred option of the revised Scope of Practice Standard has the potential to remove the confusion and misunderstanding which has arisen from ambiguous wording and the misinterpretation of this. We applaud the Boards initiative in correcting this.

We welcome the intention of the Board to treat oral health practitioners the same as other registered practitioners under the Board's jurisdiction. This is well overdue and we applaud this move. Oral Health Practitioners have historically and consistently, clearly recognised, and worked within, the boundaries of their scope of practice and the Board's own data on complaints supports this. It is clear that there is not a need to impose additional regulation on their practice.

ADOHTA have long asserted that the imposition of a structured professional relationship and the designation around '...not (being) independent practitioners...' applied to OHP's 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.

ADOHTA QLD endorses the requirement that all dental practitioners practice within their education, training and competence. We are pleased to see 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 and, that this proposed approach more accurately aligns with the regulatory framework consistent with all other registered health professional under the National Scheme.

As part of the public consultation process, the ADOHTA QLD 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 Standard whilst meeting the objectives has however facilitated the misunderstanding of the wording used and the intent of the document and therefore overly restrictive practices by employers in some areas has ensued. ADOHTA QLD believes 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 that 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 an unnecessary over-regulation. Many 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 Boards definition of 'independent practice' further adds to the confusion. The mechanism of accreditation of educational programs and registration to practice is sufficient to ensure safe practice without these components.

In addition to this, opportunities exist for effective triaging in areas with reduced access to care and high dental 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 is the change may improve to transition to a preventive and more modern model of dental care. These communities have been disadvantaged by the requirements of the current Scope of Practice because of misinterpretations that have prevented oral health practitioners from providing services. Some employers still believe that they (OHPS) cannot practice without the presence of a dentist because of the wording of the current standard. There are also issues with 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 oral health practitioners must currently work in a 'bundled' structure with dentists which limits competitiveness within the industry. 'Unbundling' these 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 and as such should be enabled; the current standard has the opposite effect.
 - The requirement that dental hygienists, dental therapists and oral health therapists may only expand their individual scope of practice (within the scope of practice of the profession) by attending formally approved course programs imposes unnecessary restriction on competition. This requirement has been only imposed on oral health practitioners 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 practitioner 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 also adds an additional cost layer to the provision of these courses which adds another barrier to further acquisition of skills. This unintentionally narrows the potential development and utility of the profession overall. It also results in many dental hygienists, dental therapists and oral health therapists 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 by maximising public good from that investment.
- ADOHTA QLD 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 oral health practitioners 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.

b) Unnecessary restriction of consumer choice:

- The inability of dental hygienists, dental therapists and oral health therapists 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 by our profession currently need referral, delegation or handover to another dental practitioner, limiting consumer choice of provider.
- The hierarchical approach imposed by the current standard (requiring a structured professional relationship for some providers) and vertical leadership (terminology indicates old style of business management) restricts the possibility for flexible pricing for services delivered by different members of the dental team. E.G. AHPRA current workforce data indicates individual dentists 'over servicing' due to OHPs working under their provider number. This is a misrepresentation of the dental workforce, inaccurate record keeping and statistical data. The current system also creates increase risk responsibility for the individual dentist currently allowing OHP's to provide services under their provider number. We wish to promote horizontal leadership and ensure responsibilities/risk are spread equally and transparently amongst dental and oral 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 the patient's needs are beyond the practitioner's 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 practitioners. There is no evidence to impose inconsistent regulation on these practitioners

within the standard. These clauses are an 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.

All health practitioners should practise in consultation with other practitioners where patient needs require and this is covered in the Board's Code of Conduct. This raises the question of what this definition means. ADOHTA QLD 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. It is clear that such a clause 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. All other registered health professionals do not have Scope of Practice Standard. The quality and safety of dental care provided by dental hygienists, dental therapists and oral health therapists is globally well known. 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 a requirements 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. Sanctions for breaches of this standard apply equally to all who are registered by the Dental Board of Australia. There is no evidence to suggest that oral health practitioners should be treated any differently.

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

ADOHTA Qld questions why the Dental Board of Australia sees a need to continue to have a Scope of Practice standard. No other health practitioner group registered under AHPRA has a Scope of Practice standard which renders this review and its proposals somewhat redundant. It is ADOHTA's view that the regulatory framework provided by AHRPA which includes;

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

is adequate to protect the public against the risks inherent in receiving dental care. It is 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. It is our view that this regulation adds unnecessary policy

layers and costs to the community and does not meet the public good test; it therefore should be dispensed with altogether.

While 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:

- a) Remove the requirement for a 'structured professional relationship' for dental therapists, hygienists and oral health therapists. ADOHTA considers that the Code of Conduct for dental practitioners 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.
- b) 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 from the registration standard. The language by all standards (DBA 2014, HWA 2011, ADOHTA 2013) is now redundant and should not be included. This will effectively recognise and enable the professional roles and responsibilities of all dental practitioners and their regulation.
- c) 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).
- d) 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, ADOHTA supports the removal of the prescriptive terminology from each division description outlined in the guidelines.

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.

6. 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.

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

- a) The ADOHTA proposes that the wording within the Recency of Practice section is unclear.

"Do I practise across the range of my clinical scope at a suitable frequency to remain competent?"

Perhaps it can be rephrased to:

"Do I practise across the range of my clinical scope frequently enough to remain competent?"

- b) 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 delegate clinical procedures to other members of the dental team including dental prosthetists, dental hygienists, dental therapists and oral health therapists. Some patient care requires referral directly to health practitioners other than dental or medical practitioners including maternal and child health nurses, speech pathologist or diabetes educators as examples. We suggest that broader terminology should be used in this section.

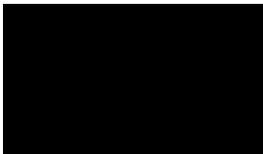
The ADOHTA recommends the sentence to rephrase to:

“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.”

8. 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



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