

**Review of the patient safety,  
patient quality and consumer  
benefit implications of the  
Dental Board of Australia's  
proposed revised *Scope of  
Practice Registration  
Standard***

July 2019

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## 1. Executive Summary

- 1.1 In March 2019, the Council of Australian Governments (COAG) Health Council (CHC) asked the Australian Commission on Safety and Quality in Health Care (the Commission) to undertake an independent review on the patient safety implications of the revised *Scope of Practice Registration Standard* proposed by the Dental Board of Australia.
- 1.2 The Commission convened an independent panel to support the review into the patient safety and quality and consumer benefit implications of the proposed revised *Scope of Practice Registration Standard* of the Dental Board of Australia. The independent panel provided technical advice to the investigative work undertaken to support the review, which included analysis of documentation on complaints and other matters from the Australian Health Practitioner Regulation Agency (AHPRA), the Dental Board of Australia, the Australian Dental Association and the NSW Dental Council; a literature review by an external consultant; and a desktop review of grey literature and other documents.
- 1.3 The review did not find any evidence to suggest that the proposed revised *Scope of Practice Registration Standard* will have an adverse effect on patient safety and quality.
- 1.4 The Dental Board of Australia's proposed changes to the *Scope of Practice Registration Standard* are broadly in line with contemporary dental care provision in health systems similar to Australia.
- 1.5 In Australia, an accreditation scheme for education courses for all dental health professionals has been in place for some time. Each of the registrable profession types has a clearly articulated scope of practice and this is supported by a code of conduct to which the professions must adhere.
- 1.6 There is some evidence that a number of under-serviced Australian communities may benefit from the removal of the structured relationship with a dentist and the bar on

independent practice of non-dentist professionals in terms of improved access and shorter waiting and referral times.

1.7 It is also possible that the population as a whole may benefit from greater choice in the dental professional that they visit as well as some cost saving.

## **2. Introduction**

### **Purpose**

2.1 At its 8 March 2019 meeting, the Council of Australian Governments (COAG) Health Council (CHC) requested the Australian Commission on Safety and Quality in Health Care (the Commission) to independently assess the patient quality and safety implications and the consumer benefit of the proposed revised *Scope of Practice Registration Standard* of the Dental Board of Australia.

2.2 The current *Scope of Practice Registration Standard* has been in effect since 30 June 2014. Since the start of the National Registration and Accreditation Scheme, the Dental Board of Australia has moved to implement changes to the *Scope of Practice Registration Standard* that encourage a responsive, risk-based approach that aligns with the Scheme's regulatory principles and the Board's broad regulatory framework, to strengthen healthcare teams and recognise the roles and responsibilities of all dental practitioners.

2.3 The key changes to the *Scope of Practice Registration Standard* recommended by the Dental Board of Australia centre on the proposed removal of the requirement for a structured professional relationship between a dentist and dental therapists, dental hygienists and oral health therapists, and the proposed removal of the bar on independent practice for dental therapists, dental hygienists and oral health therapists.

2.4 The Australian Dental Association and a small number of dentists expressed concern about the implications of the new revised standard for patient safety, in particular, the removal of structured professional relationships.

2.5 As requested by CHC, the Commission undertook an independent review to assess the patient quality and safety implications and consumer benefit of the proposed revised *Scope of Practice Registration Standard*.

2.6 The Commission appointed a panel of experts to provide oversight and technical advice to the review. Membership included representatives from the dental sector, a state/territory government official, a consumer representative and Commission officials. The list of members is provided in **Appendix 1**. The panel's referral guidance is provided at **Appendix 2**. The panel met three times by teleconference to consider the evidence and analysis, literature review and draft report.

2.7 To support and provide evidence to the review the Commission conducted the following:

- Review and analysis of relevant documentation and data held by the AHPRA, the Dental Board of Australia and Australian Dental Association
- Review and analysis of the Australian and international literature on the safety and quality of alternative models of dental service provision
- Desktop review and analysis of workforce and oral health data.

### **3. Background**

3.1 The Dental Board of Australia regulates dental practitioners in Australia. It is established under the *Health Practitioner Regulation National Law Act 2009* (Cth) and is supported by AHPRA. The Dental Board of Australia sets professional standards, ensures that only health practitioners who are suitably qualified to practise in a safe, competent and ethical manner are registered, and handles notifications, complaints, investigations and disciplinary hearings with respect to dental practitioners.

3.2 There are five divisions of registration as a dental practitioner in Australia:

- Dentists (includes both general and specialist dentists)
- Dental hygienists
- Dental prosthetists

- Dental therapists, and
- Oral health therapists.

3.3 The different scopes of practice of the registered dental practitioners are set out in **Appendix 3**.

3.4 Dental assistants and dental technicians are non-registered members of the dental team who support dental practitioners.

3.5 The Dental Board of Australia's registration data indicate that in March 2019, there were 23,629 dental practitioners registered in Australia. Of these, 75% were dentists, 8% were oral health therapists, 6% were dental hygienists; 5% were dental prosthetists, and 4% were dental therapists. A small number of practitioners (81) had dual registrations across two or more professional groups<sup>1</sup>.

3.6 The Dental Board of Australia approves accreditation standards developed by the Australian Dental Council which are used to assess programs of study leading to registration to ensure these programs equip individuals with the knowledge, skills and professional attributes necessary to practise in Australia. Overseas qualified dental practitioners wishing to be registered in Australia must reach equivalent standards in order for registration to be considered.<sup>2</sup>

3.7 In addition to overseeing accreditation of training and setting registration standards, the Dental Board of Australia has published a Code of Conduct for dental practitioners, in keeping with the codes published by the boards of the other registered health professions. The code clearly articulates the legal and ethical obligations of dental practitioners to ensure that they provide the best and safest possible health care for their patients.

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<sup>1</sup> Dental Board of Australia. Statistics. Registrant Data Table – March 2019.

<https://www.dentalboard.gov.au/About-the-Board/Statistics.aspx>

<sup>2</sup> <https://www.ahpra.gov.au/Registration/Registration-Process/Overseas-Practitioners.aspx>

3.8 On behalf of the Dental Board of Australia, AHPRA receives and investigates notifications from patients or other individuals who have concerns or complaints about the performance or conduct of a dental practitioner or student. If AHPRA receives a notification, it is assessed and investigated to determine if a practitioner is practising appropriately and safely in accordance with the policies, codes and guidelines published by the Dental Board of Australia. Based on the outcome of an assessment or investigation the Dental Board of Australia can:

- Restrict a dental practitioner's ability to practise
- Caution a practitioner
- Impose conditions or accept an undertaking from a practitioner
- Refer a practitioner to a performance and professional standards panel, or a health panel, or
- Refer a practitioner to an independent tribunal.

3.9 AHPRA handles notifications about dental practitioners in all states except New South Wales, which operates in a co-regulatory system with the Dental Council of NSW.

3.10 Section 38 of the *Health Practitioner Regulation National Law Act 2009* (Cth) gives the Dental Board of Australia the authority to develop registration standards defining the scope of practice of registered dental practitioners. The dental profession is the only profession within the National Registration and Accreditation Scheme to define and regulate the roles of all members of a team providing health care within that profession. The Dental Board of Australia's scope of practice standard includes the training of non-dentist dental practitioners within the dental team.

3.11 The Dental Board of Australia commenced a review of the registration standard in mid-2017, and following a national consultation, the following changes were proposed:

- Remove the bar on independent practice for dental hygienists, dental therapists and oral health therapists
- Remove the requirement of a structured professional relationship for dental hygienists, dental therapists and oral health therapists
- Remove reference to 'add-on' programs to extend scope of practice

- Clarify expectations around education, training and competence.

3.12 The Dental Board of Australia has overseen important changes to the education programs for dental hygienists, dental therapists and oral health therapists. The current training programs for these practitioners are considered sufficient to support professionals working in team-based settings without a structured professional relationship, and without increased risk to public safety<sup>3</sup>.

## **4. Methodology**

### **Request for documentation**

4.1 The review sought details of complaints and notifications made to the Dental Board of Australia relating to practitioners' performance and/or conduct for the financial year 2017-18. It was thought a single financial year would provide a sufficiently representative sample.

4.2 The Dental Board of Australia provided a summary of the data held which involved 539 lodged notifications, mainly concerning the performance and conduct of dentists.

4.3 The review subsequently sought, and was provided by the Dental Board of Australia, details of complaints and notifications specifically in relation to dental therapists, oral health therapists and dental hygienists from all states and territories except NSW.

4.4 Eight complaints in relation to dental therapists, oral health therapists and dental hygienists had been received by the Dental Board of Australia in 2017-18. Of these, three related to dental therapists, four oral health therapists and one dental hygienist.

4.5 Six notifications involved performance and two involved conduct.

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<sup>3</sup>Dental Board of Australia, 2019, [www.dentalboard.gov.au](http://www.dentalboard.gov.au)



4.6 Seven were reviewed by the Dental Board of Australia (one complaint which had been intended as a general inquiry was withdrawn by the enquirer) with the following outcomes:

- In relation to five of the reviews, no further action was deemed necessary
- A caution was issued in relation to one matter which was a non-clinical conduct matter
- A caution was issued in relation to one matter, regarding one practitioner, but no formal action was deemed necessary.

4.7 In New South Wales complaints made against dental hygienists, dental therapists and oral health therapists are directed to the Dental Council of NSW.

4.8 In 2018-19 the Dental Council of NSW received 11 complaints relating to non-dentists. Two complaints related to the practice and activities of dental hygienists, three to dental therapists and six to oral health therapists.

4.9 Of the 11 complaints received, five were discontinued or no further action was taken; two were referred to AHPRA; action is yet to be determined in relation to two complaints; one practitioner was referred for counselling; and one had conditions imposed.

4.10 Six of these complaints related to clinical care or treatment or issues relating to scope of practice. The remaining five complaints involved advertising, communication and billing.

4.11 Of the six complaints relating to scope of practice and/or clinical care, action against the subject of the complaint was taken on only three occasions.

4.12 The practice locations where the subjects of the complaints practised reflected the distribution of practitioners with a slight bias towards practitioners practising in metropolitan areas.

4.13 The review also wrote to the Australian Dental Association seeking any de-identified data regarding complaints made about dentists, dental hygienists, dental therapists and oral health therapists which would be relevant to the review. Neither the Australian Dental Association nor or its state and territory counterparts hold any such data.

4.14 The review found that the proportion of complaints made against non-dentist practitioners is of the same magnitude or less than the complaints brought against dentists.

### **Literature review**

4.15 The Commission appointed Amplexa Consulting to undertake a literature review of available evidence to better understand the safety and quality implications and potential consumer benefits associated with the proposed change to the structural relationship between dentists and other dental health professionals; and to identify if similar models have been implemented successfully in international settings.

4.16 The literature review considered international models of practice including New Zealand, North America, Canada, Europe (Scandinavia, Netherlands, France and Germany), and Japan, and considered publications from 2014 to 2019 using key terms relevant to the scope of the literature review.

### **Review of workforce and oral health data**

4.17 The review undertook a desktop analysis of publicly available data on the oral health workforce and population oral health to consider access to services in the context of the review.

4.18 Information on the numbers and types of dental professionals per population and where they practice shows the relative geographical dispersion of dental practitioners, in the four categories relevant to this review, in metropolitan, regional and rural and remote areas, and from that information, an indication can be obtained about access to dental services.

4.19 Similarly, information on oral health in geographical populations allows assumptions about access to dental services.

### Workforce

4.20 Data discussed below were sourced from the Australian Institute of Health and Welfare (AIHW)'s website<sup>4</sup>. The information on that website comes from the National Health Workforce Data Set which combines data from the National Registration and Accreditation Scheme with data collected from the Dental Workforce Survey conducted at the time of a practitioner's annual registration or renewal. The most recent analysis available from the AIHW used data up to 2016.

4.21 The data set includes information on the size and characteristics of the dental workforce (dentists, dental hygienists, dental therapists, dental prosthetists and oral health therapists).

4.22 Dentists form the largest part of the dental workforce in Australia. In 2016, the number of dentists in Australia was 16,549 equating to 57.7 full-time-equivalent (FTE)<sup>5</sup> dentists per 100,000 population. 75% of all registered dental practitioners in Australia were registered dentists.

4.23 The dental workforce is increasing. The number of all registered dental practitioners in Australia increased from 20,469 in 2013 to 22,042 in 2016. But the increase varies across professions. Rates of increase of FTE workforce per 100,000 population were greatest for oral health therapists, possibly reflecting the increased recognition of oral health therapy as a discipline in Australia<sup>6</sup>. The FTE rate of dental therapists per 100,000 population fell by 0.6 from 2013 to 2016. Table 1 shows these changes in the rate of dental practitioners per 100,000 population.

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<sup>4</sup> AIHW. Oral health and dental care in Australia. Web report. <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/data-sources#workforcedataset>

<sup>5</sup> By defining supply in terms of the FTE rate, meaningful comparisons of supply can be made across geographic areas and over time.

<sup>6</sup> Tsang, AKL. (Ed) *Oral Health Therapy Programs in Australia and New Zealand: Emergence and Development*. Knowledge Books and Software. 2010

*Table 1: Rate of dentists, dental hygienists, dental therapists, and oral health therapists per 100,000 population, 2013-2016*

Rate per 100,000 population	Dentists	Dental hygienists	Dental Therapists	Oral health therapists
2013	55.4	4.6	3.6	3.2
2016	57.7	4.7	3.0	4.9

4.24 The geographic dispersion of dentists, oral health therapists and dental therapists varies with remoteness as shown in Table 2.

*Table 2: 2016: rate of dentists, dental hygienists, dental therapists, and oral health therapists per 100,000 population, by remoteness*

2016: Rate per 100,000 population	Dentists	Dental hygienists	Dental Therapists	Oral health therapists
Major cities	64.4	5.6	2.6	5.1
Inner regional	43.1	2.5	3.7	4.4
Outer regional	39.1	2.6	3.9	4.0
Remote / very remote	25.0	1.3	4.0	2.4

4.25 Major cities had the highest FTE rate of dentists (64.6), dental hygienists (5.6) and oral health therapists (5.1). Inner regional areas had the highest FTE rate of dental prosthetists (6.0) and remote and very remote areas had the highest FTE rate of dental therapists (4.0). Generally, there are more dental practitioners practicing in major cities than there are in regional and remote areas. However, the inverse is true for dental therapists.

### Oral health

4.26 Data in this section were sourced from the AIHW website which used data from the National Child Oral Health Study 2012–14<sup>7</sup>.

<sup>7</sup> AIHW Oral health and dental care in Australia. Web report. March 2019. <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/healthy-mouths>

4.27 Overall, people living in regional and remote areas have poorer oral health than those in major cities<sup>8</sup>, and oral health status generally declines as remoteness increases<sup>9</sup>.

4.28 The following table shows measures of oral health status in children by remoteness.

*Table 3: variation oral health status in children by remoteness*

Per cent of children 5 - 14 years old with:	Visible plaque accumulation	Gingivitis	Periodontitis	Missing teeth due to caries
Major city	38.8	19.6	22.2	4.9
Inner regional	49.6	26.8	24.4	7.3
Outer regional	49.8	23.2		5.7
Remote / very remote	62.8	38.1		9.6

4.29 In 2016–17, about 70,200 hospitalisations in Australia for dental conditions may have been prevented with earlier treatment<sup>10</sup>.

## 5. Discussion

### Patient safety

5.1 The literature review found that high levels of patient safety and quality are ensured through publication of standards of practice, codes of conduct or ethics and clinical guidelines. Common themes are seen across codes of conduct and ethics guidelines in different countries and from different professional bodies. The most notable variation is whether specific guidelines are published defining the scope of practice for different dental practitioner roles.

<sup>8</sup> COAG Health Council 2015. Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024. Adelaide: South Australian Dental Service

<sup>9</sup> Dudko Y, Kruger E, Tennant M. A national analysis of dental waiting lists and point-in-time geographic access to subsidised dental care: can geographic access be improved by offering public dental care through private dental clinics? Rural and Remote Health 2017; 17: 3814. <https://doi.org/10.22605/RRH3814>

<sup>10</sup> <https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/dental-care>

5.2 Most countries have the ability to mandate adherence to the standards through regulation and registration to practice. Practitioners found to have breached expected standards are liable to face disciplinary action.

5.3 There is considerable variation in the scope and depth of standards across different professional bodies however there are common themes across all standards, particularly in codes of conduct and ethics guidelines. The most notable variation is whether specific guidelines are published defining the scope of practice for dental practitioner roles.

5.4 Independently practicing, non-dentist dental professionals are widespread in countries with healthcare systems comparable to Australia. Dental therapists are more common than dental hygienists though exact ratios vary from country to country and across states and territories within a country. Dental prosthetists have been practising independently in Australia for many years and often work as part of the wider dental team<sup>11</sup>.

5.5 Non-dentist dental professionals were originally intended to address gaps in the dental workforce particularly in rural and remote areas of many countries such as Canada and the USA or where the number of dentists did not meet demand requirements such as New Zealand.

5.6 In the countries compared in the literature review, the degree to which the various non-dentist professionals can practice independently also varies with the highest levels of independent practice seen in schools, areas of socio-economic disadvantage and rural and remote regions.

5.7 Models of care across the world differ slightly from those in Australia in terms of scope of practice however professional practice is similarly governed through accredited standards of education and clearly defined scope of practice. Many countries require

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<sup>11</sup> <https://www.adpa.com.au/dentalprosthetistsandyou/what-is-a-dental-prosthetist>

non-dentist professionals to have a licence to practice and to be registered with a state or national body which is responsible for maintaining the standards of dental care provided.

5.8 There is a growing trend to integrate the training and education of dental hygienists and dental therapists to create a combined therapist / hygienist's role similar to the Australian oral health therapist. This reflects contemporary developments in dentistry where oral health therapists have a key role as a primary oral health care provider<sup>12</sup>.

5.9 One study looking at the sustainability of oral health services in remote and Indigenous communities in Western Australia found that one of the key lessons was the development of a strong clinical governance framework and a support network<sup>13</sup>. A second study in Victoria demonstrated that dental hygienists had the skills and knowledge necessary for undertaking a dental examination for residents of aged care facilities. They correctly identified the majority of residents that required a referral to a dentist and proved capable of formulating appropriate dental hygiene treatment plans for residents<sup>14</sup>

### **Patient quality**

5.10 The patient quality implications were measured through a review of complaints brought to the attention of the regulator. Complaints data was analysed to identify breaches of the code of conduct, scope of practice issues and the professions about whom complaints were made.

5.11 The data demonstrates through the complaints system within the Australian context there are very low levels of complaints about the conduct of non-dentists. The review has been unable to identify any data or research that would suggest that the proposed

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<sup>12</sup> Tsang, AKL. (Ed) *Oral Health Therapy Programs in Australia and New Zealand: Emergence and Development*. Knowledge Books and Software. 2010

<sup>13</sup> Kruger, E. Jacobs, A., Tennant, M. Sustaining oral health services in remote and Indigenous communities: a review of 10 years' experience in Western Australia. *International Dental Journal* (2010) 60. 129-134

<sup>14</sup> Hopcraft M. S., Morgan M. v., Satur J. G. et al. Utilizing dental hygienists to undertake dental examination and referral in residential aged care facilities. *Community Dent Oral Epidemiol* 2011;39: 378-384

changes to the *Scope of Practice Registration Standard* would lead to an increase in practitioners practicing outside their scope of practice.

5.12 The literature review found little to no evidence that the safety and quality standards of dental care have been impacted by non-dentist professionals employed in alternative models of dental service provision. Furthermore, the literature points to safety and quality standards continuing to be met under expanded models of dental care provision.

5.13 Information available about complaints lodged in the United Kingdom or New Zealand do not provide evidence of a proportional number of complaints against non-dentists in independent roles.

### **Consumer benefit**

5.14 The literature review shows that the proposed changes have the potential to increase the capacity of the dental healthcare workforce to respond to current and emerging public health needs, particularly in regional and remote areas of Australia. For consumers, it potentially removes an unnecessary barrier to the access of safe and quality dental care. If aligned to other independent models, most consumers will continue to have a primary relationship with their dentist but will have greater choice about which dental professional they visit and the cost associated with that choice.

5.15 Information on the numbers and types of dental professionals per population and where they practice shows an undeniable skew in the geographic dispersion of dentists towards metropolitan areas – the major cities. This pattern of practice provision is mirrored in the dispersion of oral therapists and dental hygienists, but the dispersion of dental therapists is the opposite. There are more dental therapists per population practicing in rural and remote areas, indicating a capacity to augment provision of dental services in areas where dentists are in short supply.

5.16 Access to fewer dental practitioners than in metropolitan areas, coupled with longer travel times and limited transport options to services, affects the oral health care that



rural Australians receive<sup>15</sup>. Available data shows discrepancies in oral health status between groups in urban and rural areas<sup>16</sup>; oral health status declines with rurality and remoteness. Evidence from the literature review suggests that rural and remote communities would benefit from more flexible models of dental care provision where dental hygienists and oral health therapists played a greater role in examination and treatment with referral to a dentist where appropriate. In rural and remote communities in other countries, the capacity of the role of the non-dentist professional to operate independently has improved access, reduced costs and improved oral health.

## **6. Findings**

6.1 The Dental Board of Australia's proposed changes to the *Scope of Practice Registration Standard* are broadly in line with contemporary dental care provision in health systems similar to Australia. Internationally, alternative models of care have evolved to address a number of public health concerns and are largely directed at improving access, reducing costs and improving oral health, an important contributor to overall health status.

6.2 The safety of these alternative models of care is based on accredited courses of education, codes of conduct, professional registration standards and legislative frameworks that make professionals who breach established standards liable to disciplinary action by national or state boards.

6.3 In Australia, an accreditation scheme for education courses for all dental health professionals has been in place for some time. Each of the registrable profession types has a clearly articulated scope of practice and this is supported by a code of conduct that must be adhered to. Systems are in place to address reported breaches of the code or standards of practice.

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<sup>15</sup> COAG 2015; Bishop LM & Lavery MJ 2015. Filling the gap: Disparities in oral health access and outcomes between metropolitan and remote and rural Australia. Canberra: Royal Flying Doctor Service of Australia

<sup>16</sup> Kruger E and Tennant M A baseline study of the demographics of the oral health workforce on rural and remote Western Australia. Australian Dental Journal 2004; 49:(3):136-140

6.4 Data from complaints in Australia, United Kingdom and New Zealand do not indicate a quality issue with non-dentist professionals and their practice. However, an absence of evidence does not indicate an absence of a problem. The Dental Board of Australia may wish to consider systems to monitor compliance with professional standards and the code of ethics rather than relying on the complaints system to highlight emerging quality problems.

6.5 The potential consumer benefits of the proposed changes to the *Scope of Practice Registration Standard* can be articulated from the literature, although the number of articles located was low and the evidence of variable quality. It can be shown that in systems with alternative models of care, patients have shorter wait times for examination and treatment especially in the young and in rural and remote areas. There may be some cost efficiencies associated with alternative models both to the consumer and to the health system.

6.6 Contemporary oral health practice reflects the need to incorporate effective primary oral health care to address the changing dental needs of the population, driven by demographic and epidemiological changes, particularly for older Australians, Indigenous Australians and people living with disability<sup>17</sup>.

6.7 There is no evidence that the proposed changes to the *Scope of Practice Registration Standard* will have an adverse effect on patient safety and quality. There is some limited evidence internationally that in Australia, a number of vulnerable communities may benefit from the removal of the structured relationship with a dentist and the bar on independent practice of non-dentist professionals. It is likely that rural and remote communities will have improved access and shorter waiting times for examination treatment and referral to a dentist where appropriate. It is also possible that the population as a whole may benefit from greater choice in the dental professional that they visit as well as some cost saving.

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<sup>17</sup> Tsang, AKL. (Ed) *Oral Health Therapy Programs in Australia and New Zealand: Emergence and Development*. Knowledge Books and Software. 2010

6.8 With the predicted changes in population, there is a pressing need to rethink how dentistry is delivered in the future. Role-substitution and supplementation has a role to play for all of the predicted changes and challenges ahead<sup>18</sup>.

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<sup>18</sup> Brocklehurst and Macey: Skills-mix in preventive dental practice – will it help address need in the future?  
BMC Oral Health 2015 15(Suppl 1)

## **7. Appendices**

APPENDIX 1: Review Panel

APPENDIX 2: Referral Guidance

APPENDIX 3: Summary of scope of practice

### **APPENDIX 1: Review Panel**

Dr David Filby PSM, Board member, Australian Commission on Safety and Quality in Health Care

Ms Leslie Arnott, Consumer advocate

Dr Clare McNally, Lecturer, Melbourne Dental School, Melbourne University

Professor Clive Wright AM, Associate Director and Clinical Professor, Centre for Education and Research on Ageing

Professor Laurence Walsh AO, Professor of Dental Science, University of Queensland

Associate Professor Janet Wallace, Head of Discipline, Oral Health, University of Newcastle

Mr Chris Robertson, Executive Director Strategy and Policy, AHPRA

Ms Kirstine Sketcher-Baker, Inter-Jurisdictional Committee member, Australian Commission on Safety and Quality in Health Care

Mr Mike Wallace, Chief Operating Officer, Australian Commission on Safety and Quality in Health Care

Mr Herbert Down, Director Clinical Care Standards, Australian Commission on Safety and Quality in Health Care

Ms Catherine Katz, Director Strategy and Development, Australian Commission on Safety and Quality in Health Care

## Referral guidance

### Independent panel to review Dental Board of Australia revised scope of practice registration standard

#### Purpose

The Council of Australian Governments (COAG) Health Council (CHC) has requested the Australian Commission on Safety and Quality in Health Care (the Commission) to independently assess the patient quality and safety implications and the consumer benefit of the revised scope of practice registration standard of the Dental Board of Australia.

The key changes in the standard recommended by the Dental Board of Australia centre on the proposed removal of the requirement for a structured professional relationship between a dentist and dental therapists, dental hygienists or oral health therapists, and the proposed removal of the bar on independent practice for dental therapists, dental hygienists and oral health therapists.

#### Methodology

The Commission will convene a panel to undertake the independent review. The panel membership will consist of:

- Chair – Dr David Filby (Commission Board member)
- Member – Professor Laurence Walsh
- Member – Professor Clive Wright
- Member – Associate Professor Janet Wallace
- Member – Clare McNally
- Consumer – Leslie Arnott
- AHPRA representative – Chris Robertson
- Jurisdictional representative – Kirstine Sketcher-Baker, QLD
- Commission executive – Michael Wallace
- Commission – Catherine Katz
- Commission – Herbert Down
- Secretariat – Nonnie Oldham

The panel will meet as soon as possible to finalise the methodology to assess safety and quality implications and consumer benefits for the review. The methodology will include a forensic review of all relevant documentation and interviews with key informants.

The review will call for relevant documentation from appropriate organisations as soon as possible.

#### Governance

The Commission will lead and coordinate all aspects of the review.

#### Findings and Recommendations

A final report, including recommendations, will be provided as a paper to CHC at its meeting on 1 November 2019. Papers are due to the AHMAC Secretariat by Friday 19 July 2019.

## Appendix 3

	<b>Dentists</b>	<b>Dental hygienists</b>	<b>Dental prosthetists</b>	<b>Dental therapists</b>	<b>Oral health therapists</b>	<b>(Other – no registrable Australian equivalent)</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>- Full scope of practice in the profession of dental care.</li> <li>- Specialist registration categories</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative care, including periodontal/gum treatment</li> <li>- Work within a structured professional relationship with a dentist.</li> </ul>	<ul style="list-style-type: none"> <li>- Work as independent practitioners in the assessment, treatment, management and provision of removable dentures; and flexible, removable mouth guards used for sporting activities.</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative and restorative care</li> <li>- Treat children and adolescents</li> <li>- Treat adults if specifically trained</li> <li>- Work within a structured professional relationship with a dentist.</li> </ul>	<ul style="list-style-type: none"> <li>- Dual qualified as a dental therapist and dental hygienist.</li> <li>- Extended preventative and restorative care</li> <li>- Treat children and adolescents; adults only if specifically trained</li> <li>- Work within a structured professional relationship with a dentist.</li> </ul>	
<b>Canada</b>	<b>Dentists</b>	<b>Dental hygienists</b>	<b>Dental technician, dental technologist</b>	<b>Dental therapists</b>		<b>Professional dental assistants</b>
	<ul style="list-style-type: none"> <li>- Examine, diagnose and perform emergency or required procedures.</li> </ul>	<ul style="list-style-type: none"> <li>- Variable scope of practice depending on province/territory,</li> <li>- Supervised or independent practice</li> <li>- Preventative care (all)</li> <li>Restorative and basic orthodontic treatment, limited prescribing (independent)</li> </ul>	<ul style="list-style-type: none"> <li>- Provide oral devices under prescription from a dentist</li> <li>- Generally no clinical care</li> </ul>	<ul style="list-style-type: none"> <li>- Basic clinical dental treatment, preventive services and restorative care</li> <li>- Private and public health settings</li> <li>Consultative/referral relationship with a dentist.</li> </ul>	<ul style="list-style-type: none"> <li>- No equivalent identified</li> </ul>	<ul style="list-style-type: none"> <li>- Provide care under the supervision of a dentist.</li> <li>- Practice in both private and public health settings.</li> </ul>

Hong Kong	<b>Dentists</b>	<b>Dental hygienists</b>	<b>(Dental technicians)</b>	<b>Dental therapists</b>		<b>(Dental surgery assistants)</b>
	<ul style="list-style-type: none"> <li>- Implement and promote oral health management</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative care and oral health education</li> <li>Work under the prescription and supervision of a dentist</li> <li>- Primarily private settings</li> </ul>	<ul style="list-style-type: none"> <li>- Registration not required</li> <li>- Manufacture dental devices</li> <li>- Lab-based, no clinical care.</li> </ul>	<ul style="list-style-type: none"> <li>- Preventive care, basic dental treatment and oral health education.</li> <li>- Public employees</li> <li>- Provide care to all primary school children</li> </ul>	<ul style="list-style-type: none"> <li>- No equivalent identified</li> </ul>	<ul style="list-style-type: none"> <li>- Work closely with dentists in the clinic to provide dental services to patients.</li> </ul>
New Zealand	<b>Dentists</b>	<b>Dental hygienists</b>	<b>Clinical dental technicians and dental technicians</b>	<b>Dental therapists</b>	<b>Oral health therapists</b>	<b>(Orthodontic auxiliaries)</b>
	<ul style="list-style-type: none"> <li>- Assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex</li> <li>- Public and private settings</li> <li>- Specialist registration categories</li> </ul>	<ul style="list-style-type: none"> <li>- Oral health education and preventative care</li> <li>- Clinical guidance or direct clinical supervision under a dentist</li> </ul>	<ul style="list-style-type: none"> <li>- <i>Dental technician</i></li> <li>- Provide oral devices under prescription from a dentist or clinical dental technician</li> <li>- <i>Clinical dental technician</i></li> <li>- Extended provision of oral devices under prescription from a dentist, limited patient contact</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative &amp; restorative care</li> <li>- Treat children and adolescents up to the age of 18.</li> <li>- Consultative working relationship with a dentist</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative &amp; restorative care</li> <li>- Consultative professional relationship with one or more dentists</li> </ul>	<ul style="list-style-type: none"> <li>- Assist a dentist or orthodontist in implementing orthodontic treatment</li> <li>- Direct supervision by a dentist or orthodontist</li> </ul>
UK	<b>Dentists</b>	<b>Dental hygienists</b>	<b>Dental technicians, clinical dental technicians,</b>	<b>Dental therapists</b>		<b>(Dental nurses, orthodontic therapists)</b>
	<ul style="list-style-type: none"> <li>- Diagnose and treat oral disease, including orthodontic treatment, prostheses, and oral &amp; periodontal surgery</li> <li>- Private and public settings</li> <li>- Specialist registration categories</li> </ul>	<ul style="list-style-type: none"> <li>- Preventative care</li> <li>Treatment of periodontal disease and promoting good oral health practice.</li> <li>- Independent or team practice</li> <li>- Private and public settings</li> </ul>	<ul style="list-style-type: none"> <li><i>Dental technicians</i></li> <li>- Provide dental devices to a prescription from a dentist or clinical dental technician.</li> <li>- Repair dentures direct to patients</li> <li><i>Clinical dental technicians</i></li> </ul>	<ul style="list-style-type: none"> <li>- Preventative and restorative care</li> <li>- Treat adults and children.</li> <li>- Independent or team practice</li> <li>- Public and private settings</li> </ul>	<ul style="list-style-type: none"> <li>- No equivalent identified</li> <li>- Dual hygienist-therapist training available</li> </ul>	<ul style="list-style-type: none"> <li><i>Dental nurses</i></li> <li>- Provide clinical and other support to registrants and patients in a variety of dental settings</li> <li>- Do not diagnose or do treatment plans for patients.</li> </ul>

			<ul style="list-style-type: none"> <li>- Provide complete dentures direct to patients, other dental devices on prescription from a dentist.</li> <li>- Usually lab-based, working alone or as part of a team.</li> <li>- Public and private settings</li> </ul>			<p><i>Orthodontic therapists</i></p> <ul style="list-style-type: none"> <li>- Carry out certain parts of orthodontic treatment under prescription from a dentist.</li> </ul>
<b>USA</b>	<b>General dentists</b>	<b>Dental hygienists, advanced dental hygienists</b>	<b>Dental technicians, dental laboratory technicians</b>	<b>Dental therapists, dental health aide therapists</b>	<b>Advanced dental therapists</b>	<b>(Community dental health co-ordinators)</b>
	<ul style="list-style-type: none"> <li>- Diagnose, treat, and manage overall oral health care needs, including gum care, root canals, fillings, crowns, veneers, bridges, and preventive education.</li> </ul>	<ul style="list-style-type: none"> <li>- Variable scope of practice depending on state, including both supervised and independent practice</li> <li>- Preventative care (all)</li> <li>- Restorative and basic orthodontic treatment, limited prescribing (independent)</li> </ul>	<ul style="list-style-type: none"> <li>- Manufacture dental prosthetics including bridges, crowns, and dentures under prescription from a dentist or hygienist</li> <li>- No direct patient contact</li> </ul>	<ul style="list-style-type: none"> <li>- Usually provide routine preventive and restorative care</li> <li>- Under direct supervision by a dentist.</li> <li>- Dental health aide therapists have a more limited scope of practice.</li> <li>- Generally practise in tribal/indigenous communities</li> </ul>	<ul style="list-style-type: none"> <li>- Extended scope of treatment compared to dental therapists, including non-surgical extraction of certain diseased teeth, and more.</li> <li>- Under indirect supervision by a dentist</li> </ul>	<ul style="list-style-type: none"> <li>- Provide community-based prevention, care coordination, and patient navigation</li> <li>- Primarily practise in under-served rural, urban and Native American communities.</li> </ul>