AUSTRALIAN DENTAL ASSOCIATION

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Red Tape Committee
Department of the Senate
PO Box 6100
Canberra ACT 2600
By email: redtape.sen@aph.gov.au

Dear Committee

RE: Red Tape Committee – Health Services

Thank you for providing the Australian Dental Association (ADA) with the opportunity to provide feedback on the Senate Committee's (Committee) Inquiry into red tape within health services (Inquiry).

The red tape health services experience varies depending on the appropriateness of each government policy and programme and its relationship to the provision of the particular area of healthcare service. In responding to the Terms of Reference of this Inquiry, the ADA will confine its discussion to the areas that pertain to dentistry in Australia.

While some regulations discussed in this submission could apply to multiple sections, they are grouped according to the prominent shortcomings of the regulation in question. This submission will also group responses to a number of terms of reference where appropriate.

The effect of red tape on health services, in particular:

Terms of Reference b. any specific areas of red tape that are particularly burdensome, complex, redundant or duplicated across jurisdictions;

1. Regulatory Duplication

i. Red tape by state jurisdictions

Dental practices are mainly procedural, unlike routine general practitioner medical practices which tend to provide treatments of a consultative nature and do not regularly perform surgical procedures in their rooms. Consequently, their procedural nature means that dental practices stand to be subject to a much higher level of regulatory oversight. As an example, the list of standards and controls applicable in Victorian dental practices (**Appendix 1**) mirrors the experience in other jurisdictions. These standards and regulations are numerous and detailed. Compliance requires considerable effort.

ii. Infection Control

Dentists and other dental practitioners are one of a few regulated health professionals who must declare as part of their annual registration renewal that they have complied with their profession's infection control

guidelines (in this case the Dental Board of Australia (DBA)'s Guidelines on Infection Control (Guidelines)). The DBA's Guidelines require compliance with:

- National Health Medical Research Council (NHMRC) Guidelines for the Prevention and Control of Infection Control in Healthcare;
- Australian and New Zealand AS/NZS 4815 (Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of associated environment); and
- Australian and New Zealand AS/NZS 4187 (Reprocessing of reusable medical devices in health service organisations)
- ADA Guidelines for Infection Control.

In particular, AS/NZS 4815 and 4187 are detailed and complex and compliance with these alone require considerable effort.

Dentists are already subject to the following regulatory Commonwealth requirements and have at their disposal materials to help facilitate their compliance:

Regulatory requirements:

- DBA Code of Conduct for Registered Health Practitioners;
- Vaccine preventable diseases and immunisation programs;
- NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare;

Compliance aids:

- ADA: The Practical Guides to Dental Equipment and Materials;
- Department of Health and Ageing Creutzfeldt Jacob Disease Infection Control Guidelines 2013;
- Hand Hygiene Australia 5 Moments Dentist;
- Hand Hygiene Australia Generic Community Hand Rub Moisturiser Audit;
- National Hand Hygiene Initiative;
- Risk based workforce immunisation program for dental practices;
- Workforce Immunisation Information Sheet.

Despite this declaration of compliance, in some jurisdictions dentists are also expected to take an additional step. For example, in the Australian Capital Territory dentists are required to apply for a dedicated infection control licence, and in Queensland an infection control management plan must be prepared.

These different sets of rules, imposed by different tiers of government entities and jurisdictions, effectively duplicate requirements that form part of every registered dental practitioner's scope of practice as set by the regulator (DBA, one of the Boards under the Australian Health Practitioner Regulation Agency, AHPRA).

Already, there exists a national regulator that sets standards to which practitioners must comply. Compliance with the regulator's standards entitles the practitioner to practise as it demonstrates they can safely and effectively operate as a health practitioner.

Despite the practitioner having satisfied the DBA's requirements, dental practices that participate in Practice Accreditation are required to comply with the Australian Commission for Safety and Quality in Health Care (the Commission)'s National Safety and Quality Health Service (NSQHS) Standards (Standards) – in this case to "Standard 3 Preventing and Controlling Healthcare Associated Infections". This requires the practice to demonstrate its adherence to the Standard showing that infection control measures, practices and protocols are in place. These measures, practices and protocols significantly replicate requirements the practitioner had to meet as part of their registration. What can minimise the burden of this duplication is for such requirements to be directly targeted towards non-dental practitioner practice owners rather than dental practitioner practice owners.

iii. The self-regulatory model

Despite the problems associated with the hospital-based focus of the Standards and their duplication with other regulatory processes, nonetheless the ADA has sought to facilitate the dental profession's compliance with the Standards through a self-regulatory model of practice accreditation based upon a small office practice model. ADA continues to actively engage with the Commission to try to develop supporting materials for the Standards that are relevant to a primary health care setting. However, ultimately these requirements should be better targeted towards non-dental practitioner practice owners rather than dental practitioner practice owners; as the latter already have regulatory requirements as part of their registration.

iv. Ownership and use of radiation machines

Currently, across most jurisdictions in Australia, dentists are required to purchase two sets of licences with respect to radiation machines such as intra-oral, rotational tomography X-rays and Cone Beam Volumetric Tomography (CBVT). One licence is to own or possess the machine, and the other is to use it. The same duplication with two licences applies for Class 4 laser equipment, one to possess and one to use. This duplication is inefficient and unnecessary.

Ultimately there should be a greater move towards harmonisation and mutual recognition of licensing requirements and licences provided and obtained for the operation and use of radiation machines. However, the ADA questions whether these licencing systems adequately recognise that dental practitioners, as part of their scope of practice, already have the competence and qualifications to safely perform their duties in these areas (such as with respect to infection control mentioned above). With respect to radiation equipment, there may be a need to continue the requirement for practices to have an equipment licence. However, dental practitioners are more than qualified to operate X-ray equipment without having to process additional red tape through the form of additional licences imposed by particular state/territory governments (see **Appendix 2** for a summary of the licensing requirements across the state/territories). ADA agrees there should be a licence to use Class 4 laser equipment, since unlike X-ray equipment, training in the use of lasers is not part of normal dental education.

NSW is one example of where red tape was reduced in this area over a decade ago. The argument was made that dentists, by virtue of their training, did not require annual registration to operate many of these machines. The ADA NSW Branch successfully worked with the then relevant NSW minister and advisors in the NSW Environmental Protection Agency (EPA) in conjunction with the university to implement this change.

v. Drugs and Poisons Legislation

The drugs and poisons legislation across the states and territories are unnecessarily duplicative. This duplication has an onerous impact on dentists and dental practices that have a presence across jurisdictional boundaries requiring them to be familiar with particular regulations and the differences between them.

Case Study: Medication safety

Appendix 3 outlines the plethora of regulatory instruments relating to medication safety that currently apply in different states and territories. There is little justification for this range of regulatory instruments as medication safety practices should be based on uniformly agreed, evidence-based protocols. While the states and territories appropriately have responsibility for enforcement, greater harmonisation of medication safety regulation should occur. Commonwealth instruments and frameworks such as the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) have been constructively used to promote uniform scheduling of substances and labelling and packaging requirements throughout Australia (accordingly, the decisions and classifications made under the SUSMP are included in the relevant legislation of the states and territories). Additionally, this SUSMP can be the vehicle that can be leveraged to generate greater harmonisation with respect to medication safety. Alternatively, the Committee should recommend the harmonisation of state and territory drugs and poisons legislation by adopting a legislative approach similar to that used to establish a national system of health practitioner registration and regulation (the Health Practitioner Regulation National Law – otherwise known as the 'National Law'). The states and territories can enact mirroring legislation to both preserve the enforcement functions of the latter and use the opportunity to harmonise their Drugs and Poisons Acts.

2. Inefficient and misdirected regulation

i. Registration renewal requirements

Currently, dentists are required to renew their registration with AHPRA annually to enable them to practise. Annual renewal processes create an administrative burden for both the practitioner and the regulator. The ADA suggests that the Committee review the need for an annual registration renewal process for health practitioners thereby reducing the regulatory burden on all parties. Using dental practitioners as one example, currently they are required to annually confirm they have a professional indemnity insurance policy, report any changes in their criminal history, that they are compliant with infection control and other DBA guidelines. Additionally, for dental practitioners with sedation endorsement, they are required to state annually they have completed the required advanced medical emergency training.

Annual renewal should not require confirmation a practitioner has maintained current indemnity insurance or the other requirements outlined above. If a practitioner's circumstances change, they MUST rectify or notify as appropriate (e.g. a change in criminal history). Policy makers can strengthen compliance with this requirement to declare such changes, within a reasonable time, by applying penalties for failure to do so or applying conditions/suspensions of registration where appropriate.

One option would be to renew registration on a triennial basis, in line with the requirement for dental practitioners to report on their continuing professional development (CPD). It is understood and mandatory that requirements pertaining to maintaining current indemnity insurance, etc. and in the meantime, would be a continuing obligation for all health practitioners.

ii. Working with children checks and clearances

Dental treatment is perceived as a visceral invasive experience and accordingly, dentists are required not only to have the appropriate qualifications, education and experience to work in such a field, but also meet the appropriate character and behavioural standards expected of all health practitioners.

While this principle is essential, its application in the regulations relating to the requirement for dental practitioners to obtain the relevant working with children checks and clearances is not consistent across the states and territories. Ultimately, working with children checks and clearances should form part of the health practitioner registration process; i.e. being a registered health practitioner should in turn automatically confirm the ability to work with children until otherwise restricted.

iii. Administrative requirements

Administrative requirements in Commonwealth dental schemes can always be improved. For instance, the Child Dental Benefit Schedule (CDBS) permits bulk billing dentists to obtain written financial consent once from an eligible patient yet for those dentists that do not bulk bill, this written consent needs to be obtained at every visit. There is no ostensible reason in terms of quality and safety of dental treatment for this to occur; as patients under both scenarios are eligible under the CDBS and initially written and financial consent has been obtained.

3. Unnecessary and costly regulation and deregulation

i. Costly deregulatory actions by the Therapeutic Goods Administration (TGA)

In 2015, the TGA supported enabling businesses to claim an exemption for having to place products on the Australian Register of Therapeutic Goods (ARTG) if the value of the products sold is fifteen times or less the charge that would have been payable to the TGA. The problem is that the threshold where businesses can claim an exception for the charge dropped to $0 from 1 July 2015. According to the Australian Dental Industry Association as a result of this the dental industry faced an overall 30% increase in charges to place products on the ARTG. The TGA conceded to the Senate Community Affairs Legislation Committee that they were not able to address the issue until the following year; which meant that the TGA will in actuality continue to receive these higher charges. This situation in turn risked the dental industry passing on the arbitrary increase in costs which will ultimately be borne by patients.

4. Inconsistent and unclear regulation

i. Regulatory confusion and lack of clarity with respect to treatments and products

Case study: Teeth whitening products

Teeth whitening products is one area in which there is an inappropriate lack of regulatory clarity and delineation. In Australia, a number of authorities have expressed views on the limitations that should be imposed on the use of tooth whitening products. For example:

- The Australian Competition and Consumer Commission (ACCC) has the view that the *Competition and Consumer Act 2010* (Cth) provides it with the power to bar dental practitioners from providing take home whitening kits containing levels of hydrogen peroxide above 6% or carbamide peroxide above 18%. The ADA has repeatedly put forward the view that this is an excessive encroachment upon dental practitioners' ability to safely prescribe such treatment to patients.

- The current SUSMP classifications with respect to teeth whiteners state that only those products that contain hydrogen peroxide above 6% hydrogen peroxide or carbamide peroxide above 18% can only be used by dental practitioners. The ADA is seriously concerned with setting the threshold at this level as it enables those non-registered and unqualified, such as beauticians, to be able to access and use teeth whitening products on unsuspecting consumers below these levels. The risk to public safety is the burden arising from this inappropriately framed regulation.

- The DBA has a Fact Sheet on Teeth Whitening which states, amongst other things: that

> *It is an offence under section 121 of the National Law to perform a restricted dental act if you are not a registered dental or medical practitioner.*
>
> *A restricted dental act includes performing any irreversible procedure on the human teeth or jaw or associated structures such as the use of teeth whitening substances identified under schedule 10 of the Poisons Standard (containing more than 18 per cent carbamide peroxide or more than six per cent hydrogen peroxide).*

Previously, the ADA has outlined to the DBA, Australian Government Department of Health and the ACCC, that the 6% (hydrogen peroxide) / 18% (carbamide peroxide) thresholds are too high to be performed by non-dental practitioners and pose a risk to public safety. The ADA's Policy Statement 2.2.8 Teeth Whitening (Bleaching) By Persons Other Than Dental Practitioners (www.ada.org.au – under Policies and Guidelines) states that only dental practitioners with formal education and competence in teeth whitening (bleaching) should use teeth whitening (bleaching) agents incorporating hydrogen peroxide at concentrations exceeding 3% or carbamide peroxide exceeding 9%.

Scheduling classifications of teeth whitening products is one area where regulation must be strengthened to set the appropriate restriction for access to these products by the unqualified. Where appropriate, regulation naturally will outline the requirement that qualified health practitioners work to high standards of safety. More critically regulation must always ensure that the untrained and unqualified cannot place themselves and others at risk. The untrained and unqualified do not have the education and experience to meet safety standards in the first place, and should not be permitted to provide in any form of health treatment to others under any circumstances.

Terms of Reference a. The effects on compliance costs (in hours and money), economic output, employment and government revenue;

Terms of Reference c. The impact on health, safety and economic opportunity, particularly for the low-skilled and disadvantaged;

In 2006 the ADA commissioned an analysis from Access Economics, *Cost of Compliance for Australian Dental Practices*.

Access Economics referred to the fact that gross regulation-related costs for dental practices averaged $64,200 (equivalent to $84,400 in 2016) across Australia, or $302.1 million ($397 million in 2016) across all private dental practices in 2005.[1]

Whilst this analysis occurred in 2006, the impact of regulation in Australian dental practice has not largely changed but is likely to have increased particularly with the advent of the National Law and the manner in which it has been implemented as outlined above. Typically, dentists continue to work in independent small business practices, and therefore are more prone to the burden of red tape. Regardless of the type of red tape

[1] https://www.rba.gov.au/calculator/annualDecimal.html

that currently exists in the dental sector, dentists are required to spend more time and resources to ensure compliance with red tape. This burden of compliance makes dentists less likely to be innovative and entrepreneurial; not to mention they will be less able to treat more patients. Similarly, the time and resources required to navigate and comply with red tape will lead to higher costs of care for patients. These barriers in turn are the hardest to overcome by the disadvantaged. In some instances, people could be dissuaded from undertaking a career as a health practitioner due to the regulatory burden. Ultimately, this is not in the public interest.

Terms of Reference d. The effectiveness of the Abbott, Turnbull and previous governments' efforts to reduce red tape;

Please refer to discussion under 3. (i) in response to Terms of Reference b. When it comes to dental services, there is greater room for improvement by the Abbott/Turnbull to reduce red tape. Regulation and deregulation activities should always occur through close consultation with relevant stakeholders affected in that sector.

Terms of Reference f. Alternative institutional arrangements to reduce red tape, including providing subsidies or tax concessions to businesses to achieve outcomes currently achieved through regulation;

Terms of Reference g. How different jurisdictions in Australia and internationally have attempted to reduce red tape; and

Terms of Reference h. Any related matters.

In terms of jurisdictional moves to reduce red tape, the Committee should draw lessons from work by the ADA NSW Branch to remove annual registration to operate radiation machines. This reform occurred a decade ago, and involved liaising with the then relevant NSW minister and advisors in the NSW Environmental Protection Agency (EPA) in conjunction with the university.

The ADA recognises that health services are distinct sector whereby financial and other incentives may not necessarily give rise to achieving outcomes intended by regulation.

However, the ADA believes that where possible, a uniform national approach to government regulation is preferred, whether it be in terms of licencing requirements for the ownership and use of radiation devices in medical settings or the scheduling classifications of medicines. Uniform and consistent regulation, developed in consultation with the dental profession, will ensure that patients and consumers receive safe, quality oral health services.

Yours sincerely

Dr Hugo Sachs
President

APPENDIX 1 – Inventory of legal and regulatory compliance obligations of dentists

Federal Legislation	Regulatory agency / activity
Corporations Law (1990) Vol. I & II *Reprint No. 2 5/96*	ASIC
Education & Training Legislative Amendments Act (1996)	
Fringe Benefits Tax Assessment Act (1986) *Reprint No. 2 8/96*	ATO
Health Insurance Act (1973) *Reprint No. 6 8/98*	HIC
Health Insurance Commission Act (1973) *Reprint No. 4 6/96*	HIC
Human Rights & Equal Opportunity Commission Act (1986) *Reprint No.3 3/94*	HREOC
Income Tax Assessment Act (1997)	
Mutual Recognition Act (1992)	ATO
National Health Act (1953) *Reprint No. 6 8/98*	DPBV
National Health and Medical Research Council Act (1992)	
Racial Discrimination Act (1975) *Reprint No. 6*	
Superannuation Guarantee (Administration) Act (1992) *Reprint No.2 7/96*	ATO
Therapeutic Goods Act (1989) *Reprint No.2 99*	TGA
Veterans Entitlement Act (1986) *Reprint No.3 96*	DVA
Workplace Relations Act (1996) *Reprint No.5 3/00*	OWS
Victorian legislation	
Accident Compensation Act (1985) *Reprint No. 10 7/00*	TAC
Transport Accident Amendment Act 2000	TAC
Accident Compensation (WorkCover Insurance) Act (1993) *Reprint No. 5 6/99*	VWA
Business Names Act (1962) *Reprint No. 5 3/99*	Consumer Affairs
Crimes Act (1958) *Reprint No. 15 1/99*	Victoria Police
Dangerous Goods Act (1985) *12/99*	EPA
Dental Practice Act (1999)	DPBV
Drugs Poisons and Controlled Substances (1981) *Reprint No. 5 12/98*	DHS
Environment Protection Act (1970) *Reprint No. 13 1/99*	EPA
Equal Opportunity Act (1995) *Reprint No. 3 7/98*	
Essential Services Act (1958)	
Evidence Act (1958) *Reprint No. 13 9/99*	
Fair Trading Act (1999)	Consumer Affairs
Financial Management Act (1994) *Reprint 4 4/99*	
Freedom of Information Act (1982) *Reprint 5 1/00*	
Health Act (1958) and subsequent Amendments *Reprint No. 9 1/99*	
Health Services Act (1988) *Reprint No. 6 7/99*	DHS
Labour and Industries Act (1985) *Reprint No. 10 1/97*	
Long Service Leave Act (1992) *Reprint No. 2 3/97*	
(to be replaced by "Fair Employment Act (2003)" – March sitting of Parliament)	
Medical Practice Act (1994) *Reprint No. 2 9/98*	MPBV
Medical Treatment Act (1988) *Reprint No. 4 11/98*	MPBV
Mental Health Act (1986) *Reprint No. 6 6/00*	DHS
Mutual Recognition (Victoria) Act 1998	
Occupational Health and Safety Act (1985) *Reprint No. 5 11/98*	
Partnership Act (1958) *Reprint No. 5 2/99*	
Payroll Tax Act (1971) *Reprint No. 7 9/99*	SRO
Psychologists Registration Act (2000)	PRBV
Radiation Safety Act	DHS
State Employees Retirement Benefit Act (1979) *Reprint No. 4 10/99*	
State Superannuation Act (1988) *Reprint No. 4 7/99*	
Therapeutic Goods Act (1994) *Reprint No. 1 5/99*	
Transport Accident Act (1986) *Reprint No. 7 7/00*	
Vital State Industries (Works & Services) Act (1992)	
Vocational Education & Training Act (1990) (No. 45) *Reprint No. 3 9/98*	
Workers Compensation Act (1958) *Reprint No. 14 9/99*	

Victorian Regulations	
Accident Compensation Regulations (1990) due for sunset 3/00 7/99 Dangerous Goods Storage and Handling Regulations (2000) Dental Practice Regulations (2000) Drugs, Poisons and Controlled Substances Regulations (1995) /00 Environment Protection (Prescribed Waste) Regulations (1998) 10/00 Environment Protection (Scheduled Premises and Exemptions) Regulations (1996) Fair Trading Regulations (1999) Freedom of Information Regulations (1998) Health (Radiation Safety) Regulations (1994) 11/97 Health (Infections Diseases) Regulations (1990) 8/99 Medical Practice Regulations (1994) Mental Health Regulations (1998) Occupational Health and Safety (General Safety) Regulations (1988) Pathology Services Accreditation Regulations (1990) extended to 2/01 State Superannuation Regulations (1998) Workers Compensation Regulations (1995)	
DPBV Codes of Practice	
Clinical waste management (ANZ…)	EPA
C003 Dental Records updated 10 October 2006 *See also I013 Information on Dental Records &* *I004 Consent: Assisting patients to make well-informed decisions*	DPBV
C007 General Anaesthesia & Conscious Sedation updated 08 August 2006 in line with changes made by ANZCA to its documents PS9(2005) & T1(2006)	DPBV
C004 After Hours Service updated 11 July 2006	DPBV
C006 Infection Control updated 13 June 2006 in line with the release of the updated & renamed AS/NZS 4815:2006 *See also I011 Information on Infection Control* See also *Department of Ageing's Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting* [January 2004] See also AS/NZS 4815[2006], *Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment*	DPBV
C009 Dental appliance therapy for the treatment of sleep disorders	DPBV
C008 Professional Boundaries *See also I012 Information on Professional Boundaries*	DPBV
C005 Continuing Professional Development updated 09 August 2005, wording of point 14 modified for consistency; updated 11 October 2005, new point 14 added, subsequent points re-numbered *See also I008 Information on Continuing Professional Development*	DPBV
C002 Practice of Dentistry by Dental Hygienists and Dental Therapists	DPBV
C001 Practice of Dentistry by Dental Prosthetists	DPBV
Occupational Health and Safety (First Aid) Code of Practice (1995) Occupational Health and Safety (Manual Handling) Code of Practice (1988) Occupational Health and Safety (Workplaces) Code of Practice (1988) Occupational Health and Safety (Hazardous Substances) Code of Practice (2000)	

APPENDIX 2

Radiation Licencing Requirements[2]

General Dental X-Ray Sources (Including Intra-Oral X-Ray Units, Panoramic X-Ray Units and Cephalometric X-Ray Units)

State / Territory	Authority	Licence to Own	Licence to Use	Source
QLD	Radiation Health, Health Protection Unit of the Department of Health	Any person (e.g. dentist or dental practice owner) who seeks to possess X-ray equipment, laser apparatus or a radioactive substance must apply for a possession licence. Along with a possession licence the following are required: Radiation Safety and Protection Plan Appointment of a Radiation Safety Officer Approval to Acquire and/or Approval to Relocate Certificates of Compliance One possession licence can cover multiple radiation sources, including intra-oral, extra-oral and CBVT	All dental practitioners and practitioner who use dental radiation apparatus (laser apparatus or x-ray equipment) for dental purposes must hold an appropriate use licence issued. There are three separate use licences required to cover the three areas of dental radiography: 1. Intra-Oral 2. Extra-Oral 3. Cone Beam (see table below) Use licences may only be issued to persons who have appropriate skills and knowledge of the principles and practices of radiation protection, as well as expertise in the use of the radiation apparatus relevant to the type of practice The term of a use licence may be for one, two or three years	https://www.health.qld.gov.au/radiationhealth/healthrelated/dental https://www.health.qld.gov.au/radiationhealth/healthrelated/licence https://www.health.qld.gov.au/radiationhealth/healthrelated/possession
NSW	NSW Environment Protection Authority	Any person who owns or sells a source of regulated material (sealed source devices, ionizing radiation devices and radioactive substances) must	Dentists, hygienists and therapists need a licence if using orthopantomograms (OPGs) for general dental radiography	http://www.epa.nsw.gov.au/radiation/licensing/licensingcriteria.htm#dental http://www.epa.nsw.gov.au/radiation/licensing/licexemptsupervis.htm

[2] Disclaimer: This reference should be used as a guide only. For a definitive outline of obligations please refer to the relevant Department/Agency.

		hold a radiation management licence.	*Must provide evidence of current registration as a dental practitioner from the Australian Health Practitioner Regulation Agency (AHPRA)* Dental assistants/nurses must provide evidence of attainment of an approved course of study to be eligible for a licence to use OPGs for general dental radiography. Exemptions to user licence requirements apply for dental practitioners in relation to use of extra-oral x ray apparatus with intra-oral image receptors for dental diagnostic purposes, as long as – they are registered as a dental practitioner with AHPRA; and – meet all requirements of the Code of Practice and Safety Guide for Radiation Protection in Dentistry in relation to the use of the apparatus. A person registered as a student in the dental profession under the Health Practitioner Regulation National Law, who uses extra-oral x-ray apparatus with intra-oral image receptors for dental diagnostic purposes, is exempt from user licence requirements provided they have immediate supervision at all times while using the apparatus during clinical experience training, and general supervision at all other times	
ACT	Health Protection Service, ACT Health, ACT Government	A licence to possess any source of radiation is required. There is one licence application form for both possession and use, on which the applicant indicates whether they wish to be licenced to possess, use, or both.	Required. See notes under Licence to own. Applicants seeking a licence to use radiation sources for dental practice must be registered as a dental practitioner with AHPRA.	http://www.health.act.gov.au/public-information/businesses/radiation-safety/apply-radiation-licence
VIC	Department of Health and Human Services, State Govt. of Victoria	Management Licences are required by the dentist or legal entity (e.g. John Smith Dentistry) that wishes to possess a radiation source.	You must apply for a 'Use Licence' before you use radiation sources. Use licences authorise the holder to use specified types of radiation sources for a specified purpose. If you wish to use a different type of equipment than that for which you are already licenced you need to apply to vary your licence.	https://www2.health.vic.gov.au/public-health/radiation https://www2.health.vic.gov.au/public-health/radiation/licensing/radiation-use-

			Dentists, therapists and hygienists must be registered with AHPRA to apply for a licence. Therapists and hygienists who wish to use Panoramic/Cephalometric radiographic units must provide evidence of specific training.	licences/radiation-use-licence-prerequisites
TAS	Radiation Protection Unit Department of Health and Human Services Population Health, Tasmanian Government	One licence is required to both own and use dental x-ray sources equipment. To be automatically eligible for a licence, dentists must be registered as a dentist with AHPRA If circumstances change e.g. you want new people to be authorised to deal with your radiation sources, or you want to dispose of a source and/or acquire a new one or a different type of equipment, you must apply to amend your licence before acting.	A licence is required. There is not a separate application form for this: the practitioner or practice who is licenced to possess or own the equipment must add your details to their licence.	http://www.dhhs.tas.gov.au/publichealth/radiation/apply_for_a_licence/radiation_apparatus_licensing
SA	SA Environment Protection Authority (EPA)	All owners of ionising radiation apparatus are required have a licence to possess a radiation source (an apparatus)	Under section 31 of the Radiation Protection and Control Act 1982 persons operating ionising radiation apparatus are required to be licensed by the EPA. Note that operating an apparatus includes setting or adjusting exposure parameters or energising the X-ray tube Current registration with the Dental Board of Australia (AHPRA) **OPG without cephalometry:** *Current SA licence to operate an ionising radiation apparatus (intra-oral condition); and graduation from the University of Adelaide within the last 5 years; or successful*	http://www.epa.sa.gov.au/business_and_industry/radiation/faqs http://www.epa.sa.gov.au/files/4771332_dxr_licence_prerequisites.pdf http://www.epa.sa.gov.au/business_and_industry/radiation/dental_professionals

			completion of an accredited course (section 4.3) within the last 5 years **OPG with cephalometry: Current SA licence to operate an ionising radiation apparatus (intra-oral condition); and successful completion of an accredited course** Alternatively, persons can pass an examination administered by the EPA on radiation safety	
WA	Radiological Council of WA	Not required.	Not required. Dental practitioners registered with AHPRA do not require a licence to own and use irradiating apparatus for dental radiography (intraoral, OPG and cephalometric x-ray equipment). The current WA requirements use of for use of intraoral, OPG and cephalometric x-ray equipment are: – For intraoral, x-ray apparatus may be operated by registered dentists or dental ancillary staff (who have completed Cert IV in Dental Radiography or equivalent) working under the direction and supervision of a registered dentist. The dentist is not necessarily required to be on site at the time. – For OPG and cephalometric, x-ray apparatus may be operated by registered dentists or dental ancillary staff (who have completed Cert IV in Dental Radiography or equivalent) working under the direction and personal supervision of a registered dentist. The dentist is required to be on site at the time.	http://www.radiologicalcouncil.wa.gov.au/
NT	Radiation Protection Unit, Environmental Health Branch, NT Government	A licence to possess is required before you can register any radiation source.	A separate use licence is required. To be eligible you must be registered as a dental practitioner with AHPRA.	https://nt.gov.au/industry/licences/radiation-licences-for-medical-and-dental-practitioners/dental-practitioners

			Practitioners who seek to use orthopantomograms (OPG) must provide evidence of appropriate training to operate OPG equipment	https://nt.gov.au/industry/licences/radiation-compliance-certificates-and-registrations/licence-to-possess-a-radiation-source

Licensing prerequisites – Dental Cone Beam Volumetric Tomography (CPVT) use[3]

Please note that references to Cone Beam Volumetric Tomography (CBVT) is often referred to as Cone Beam Computed Tomography (CBCT) and 3D Volumetric imaging units. Note that this should not be confused with multislice computed tomography (MCT). For more information see ADA Policy Statement 6.22 – Dento-Maxillofacial Cone Beam Volumetric Tomography

STATE/ TERRITORY	OWN	USE	SOURCE
QLD	A possession licence must be obtained by a person seeking to possess or be in control of a radiation source, for a particular purpose Individuals or corporations may hold this licence Along with a possession licence the following are required: Radiation Safety and Protection Plan Appointment of a Radiation Safety Officer Approval to Acquire and/or Approval to Relocate Certificates of Compliance One possession licence can cover multiple radiation sources, including intra-oral, extra-oral and CBVT The 'possession' licence issued to owners of CBVT equipment calls from the radiation management plan to include protocols for CBVT use at the particular installation	Only registered dentists with training from an approved course may be issued a 'use' licence Courses from two Queensland Universities have been approved New graduates will have been deemed to have received suitable qualification as part of the undergraduate dental course The Cone Beam (CBVT) licence is generally obtained after the other two licences (intra-oral and extra-oral radiation) have been obtained, and is usually obtained after graduation on an 'as-required' basis by practitioners	https://www.health.qld.gov.au/radiationhealth/healthrelated/dental.asp https://www.health.qld.gov.au/radiationhealth/healthrelated/possession.asp https://www.health.qld.gov.au/__data/assets/pdf_file/0022/146362/30254.pdf

[3] Disclaimer: This reference should be used as a guide only. For a definitive outline of obligations please refer to the relevant Department/Agency.

STATE/ TERRITORY	OWN	USE	SOURCE
NSW	Any person who owns or sells a source of regulated material (sealed source devices, ionizing radiation devices and radioactive substances) must hold a radiation management licence and comply with licence conditions	Dentists, dental hygienists, dental therapists and dental assistants/nurses need a licence if using dental cone beam computed tomography (CBCT) for general dental radiography. To be eligible for a licence you must provide: evidence of current registration from AHPRA or successful completion of Certificate IV dental assisting; and evidence of successful completion of: Manufacturer's or supplier's cone beam CT applications training course; or In-house cone beam CT applications training provided by an appropriately licenced person	http://www.epa.nsw.gov.au/radiation/licensing/licensingcriteria.htm#dental http://www.epa.nsw.gov.au/radiation/management/faq.htm
ACT	One licence is required to both possess and use dental CBVT equipment Must be: registered as a dental practitioner with Australian Health Practitioner Regulation Agency (AHPRA); and Have training, knowledge and or experience in radiation safety with respect to dental 3D volumetric X-ray apparatus	One licence is required to both possess and use dental CBVT equipment. You must be: registered as a dental practitioner with Australian Health Practitioner Regulation Agency (AHPRA); and Have training, knowledge and or experience in radiation safety with respect to dental 3D volumetric X-ray apparatus Note: you can apply for mutual recognition to have an existing licence in another State or Territory recognised	http://www.health.act.gov.au/public-information/businesses/radiation-safety/apply-radiation-licence
VIC*	Those who possess (own, sell) a 'radiation source' for conducting a radiation practice need to hold a 'management licence' (in the case of the dental profession this is usually the dentist or dental practice owner)	All users must have a radiation use licence. Dentists using a Dental 3D volumetric imaging unit (CBCT) must be registered as a Dentist with the Australian Health Practitioner Regulation Agency (AHPRA), AND • Must have successfully completed, within the last 12 months, recognised training course DEN4, AND • Must have successfully completed, within the last 12 months, recognised	https://www2.health.vic.gov.au/public-health/radiation https://www2.health.vic.gov.au/public-health/radiation/licensing/radiation-use-licences/radiation-use-licence-prerequisites

STATE/ TERRITORY	OWN	USE	SOURCE
		equipment training course DEN5-1 or DEN5-2 or DEN5-3 or DEN5-4 or DEN5-5	
TAS	One licence is required to both own use dental CBVT equipment. To be automatically eligible for a licence, dentists must be registered as a dentist with AHPRA	One licence is required to both own use dental CBVT equipment. To be automatically eligible for a licence, dentists must be registered as a dentist with AHPRA. To be licenced to use CBCT, you must attach evidence of having successfully completed, within the last 12 months, a recognised training course (Cone Beam CT Theory Course (DEN-4)) or evidence of your intention to complete such a course	http://www.dhhs.tas.gov.au/publichealth/radiation http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0012/53040/RPA0001_individual.pdf
SA	All owners of ionising radiation apparatus are required have a licence to possess a radiation source (an apparatus)	Dentist must have a licence to use CBVT; and Hold a recognised qualification and be registered with AHPRA; or Pass an examination administered by the EPA on radiation safety; or Pass a course which has been approved by the EPA for the purposes of issuing a licence	http://www.epa.sa.gov.au/business_and_industry/radiation/dental_professionals http://www.epa.sa.gov.au/business_and_industry/radiation/owners_of_radiation_apparatus
WA	A licence is required to both own and use dental CBCT equipment – one or both can be applied for on the same form. To be automatically eligible for licence (for the purpose *Dental – Radiology*), dentists must be registered with AHPRA with the specialty of 'dento-maxillofacial radiology'	See left. The same licence form is used	http://www.radiologicalcouncil.wa.gov.au/Pages/FAQ/Dentists.html
NT	Dentists who wish to own dental CBVT must apply for a licence to possess and a certificate of registration	You must be licenced to use CBCT; registration with AHPRA as a dental practitioner is a prerequisite. It is a condition of the standard licence that holders wishing to use CBVT equipment must receive training in the use of CBVT by a nationally recognized training provider.	http://health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/45/52.pdf&siteID=1&str_title=Dental%20Information%20Sheet.pdf

APPENDIX 3: Medication Management Regulatory Frameworks By Australian Jurisdiction

State	Regulatory Framework
ACT	Therapeutic Goods Act 1989 (Commonwealth)
	Therapeutic Goods Regulations 1990 (Commonwealth)
	Standard for the Uniform Scheduling of Drugs and Poisons
	Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)
	Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT)
NSW	Therapeutic Goods Act 1989 (Commonwealth)
	Therapeutic Goods Regulations 1990 (Commonwealth)
	Standard for the Uniform Scheduling of Drugs and Poisons
	Poisons and Therapeutic Goods Act 1966 (NSW)
	Poisons and Therapeutic Goods Regulation 2008 (NSW)
	Guide to poisons and therapeutic goods legislation for medical practitioners and dentists (NSW Dept Health)
QLD	Health Act 1937
	Health (Drugs and Poisons) Regulation 1996
	Health Regulation 1996
	(Part 4 – Dispensary and Part 16 – Therapeutic Goods and Other Drugs).
	Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
VIC	Therapeutic Goods Act 1989 (Commonwealth)
	Therapeutic Goods Regulations 1990 (Commonwealth)
	Drugs Poisons and Controlled Substances Act 1981 (Victoria)
	Drugs Poisons and Controlled Substances Regulations 2006 [reviewed 2012] (Victoria)
SA	South Australian Controlled Substances Act 1984
	Controlled Substances (Poisons) Regulations 2011
	Code of Practice for The Storage and Transport of Drugs of Dependence
	Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
WA	Poisons Act 1964
	Poisons Regulations 1965
	Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)

TAS	Poisons Act 1971
	Poisons Regulation 2008
	Therapeutic Goods Act 2001
	Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
	POISONS (DECLARED RESTRICTED SUBSTANCES) ORDER 1990
NT	MEDICINES, POISONS AND THERAPEUTIC GOODS ACT 2012 (NT)
	Medicines and Poisons Control Department (NT)
	Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)