Australian Dental Association Inc.
Submission to the Senate Community Affairs Committee Regarding National Registration and Accreditation Scheme for Doctors and other Health Workers.

ABOUT THE AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry, and

- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health care.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

The ADA thanks the Senate Community Affairs Committee for the opportunity to respond to the Senate's Terms of Reference for this enquiry. The ADA comments that responding to the Senate's concerns at this time is hampered by the fact that "Bill B" under the Scheme, although past due for publication, is not yet available for comment. As a consequence some speculation as to what will eventuate is required in the response to the Senate's concerns.

GENERAL BACKGROUND

Improvement to the safety and quality of delivery of health services was the initial objective for the creation of a national scheme and this focus must be maintained with no provision for compromise[1]. Provided this remains the central thread or focus of the new scheme being created and it is done efficiently in a cost effective way, the ADA will support the process to National Registration and Accreditation.

Notwithstanding those comments, the ADA has the following serious concerns:

a) From the various consultation papers prepared in the review process for the creation of the new registration and accreditation scheme, it is apparent that to facilitate this, a significant level of bureaucracy is being created. The ADA has impressed upon the Practitioner Regulation sub-committee the need for efficiency and economy in creation of the bureaucracy surrounding the scheme. The greater the level of bureaucracy, the greater will be the level of red tape and associated compliance required by professionals

[1] IGA re NRAS, 26 March 2008, accessed at http://www.nhwt.gov.au/natreg.asp on 25 April 2009

under the scheme. Increase in administrative time spent by practitioners will impact adversely upon time available for actual health care delivery. The ADA urges the Committee to ensure that an efficient bureaucracy is created so as to not impinge upon practitioner health service provision time. (For more detail see comments at paragraph **(b)** of the terms of reference below.)

b) Hand in hand with the creation of a large multilayered bureaucracy will be increased costs. It is clear from the papers published to date that it is the intent of the scheme that it will be self-funded. Increases in the cost of the bureaucracy will result in increased registration costs which will in turn adversely impact upon the cost of health services. Every effort must be made to ensure that costs of registration remain economic (via a simple and efficient structure) and that with the benefits of scale that can be utilised, registration costs will diminish for the benefit of all Australians.

c) From the outset, the ADA has been concerned as to the existence of an underlying thread of a possible workforce reform agenda. Problems that are confronting health care delivery in Australia must not be addressed by the provision of compromised care. Australia can be proud of the safety and quality of health care delivered and this must be maintained. (For more detail see comments at paragraph **(c)** of the Terms of Reference below.)

d) This reform process is occurring when many other similar or related reforms are being explored. These include (to name a few):

   - Projects being conducted by the Australian Commission on Safety and Quality in Health Care (ACSQHC) on Standards creation and Practice and
   - The National Health and Hospitals Reform Commission interim report and anticipated final recommendations.

These activities are creating a potentially complex environment for reform and care will have to be taken that these activities are properly coordinated.

Reference is made to the ADA Policy on *Dental Acts and Boards* and *Regulatory Authorities* attached to this paper.

EXECUTIVE SUMMARY.

The ADA's primary concerns about the development of the new Scheme are:

- In the development of the scheme and any reform implemented pursuant to it, considerations relating to the safety and quality of health care delivery must be at the core of any change. Political expediency must never be a consideration.

- The Scheme outline to date provides a scheme that is overly bureaucratic and unnecessarily complex and must be re-designed so it is more efficient and responsible. The new Scheme must be economic for the health professional and the patient. Registration fees in real terms must not exceed current levels.

- The development of Standards and associated scopes of practice must be left to the health board for each profession or professional group.

- The complicated environment of reform in which this Scheme is being introduced.

The ADA has made numerous submissions to the Health Workforce Principal Committee on this matter but summarises its recommendations to the Senate Community Affairs Committee as follows:

- Maintain the central focus of reform (with no scope for compromise) to the maintenance of safe and quality health service to the community.

- Ensure that only properly trained health service providers deliver services for which they are, in the view of their national board, adequately trained and competent in.

- The ADA calls for the Agency Management Committee to be dispensed with.

- Place the role of Policy determination solely where it best rests for the various health professions, namely with the National Specific Health Profession Board.

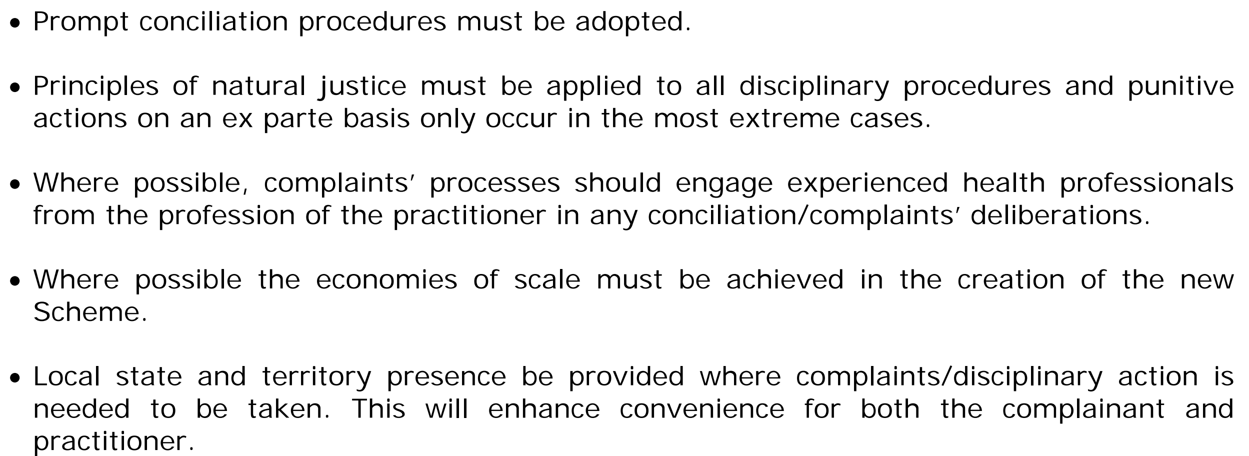
- The National Board for each profession should be made responsible for budget development and expenditure; with the administrative side of such function being conducted by the central National Agency.

- Development of standards for the registration function and accreditation of training and qualifications for relevant health professions should remain separate and be carried out independently of each other.

- The Standards' creation function should rest solely with the Health Profession Board and not be subject to Ministerial intervention as is proposed in the Scheme design to date.

- The National Dental Board ideally should be constituted as per the ADA Policy provided.

- Any complaints and resolution process for health professionals should focus on the health and safety of the patient and not be a venue for commercial disputes. Patients only, as the recipients of the health service, should have access to complaints and disciplinary procedures.



- Prompt conciliation procedures must be adopted.

- Principles of natural justice must be applied to all disciplinary procedures and punitive actions on an ex parte basis only occur in the most extreme cases.

- Where possible, complaints' processes should engage experienced health professionals from the profession of the practitioner in any conciliation/complaints' deliberations.

- Where possible the economies of scale must be achieved in the creation of the new Scheme.

- Local state and territory presence be provided where complaints/disciplinary action is needed to be taken. This will enhance convenience for both the complainant and practitioner.

TERMS OF REFERENCE.

The ADA has been actively involved in the development of the process for reform in relation to National Registration and Accreditation. It has made ten submissions to the Health Workforce Principal Committee. The Senate Community Affairs Committee would be well served by fully reviewing all submissions made by interested parties in this process. The ADA submissions can be found on its website www.ada.org.au

The Community Affairs Committee for the Inquiry has identified the following areas in respect of which it seeks comment. Bearing in mind the considerable written material provided by the ADA and other parties to the Health Workforce Principal Committee, the ADA will attempt to be succinct in its replies to the Community Affairs Committee.

The ADA responds to each of the Terms of Reference as follows:

(a) the impact of the scheme on state and territory health services;

While the creation of a National Registration and Accreditation model will impact on the bureaucratic aspects of dentistry, such as registration of Australian trained dentists and other oral care practitioners, overseas trained dentists and oral care practitioners and the accreditation of dental courses, it should not, in itself, have any significant impact on the actual delivery of state and territory dental services. In general the ADA says that the community can be very confident in the safety and quality of how dental services are delivered in Australia. The current problems with public state and territory dental schemes are a matter of under resourcing.

Where the impact may occur on state and territory health service delivery is if a workforce agenda is allowed to politicise the way in which dental health services are delivered. More will be said about this under heading **(b)** below when dealing with patient care and safety. At this point the ADA reiterates the point that the creation of a national scheme creates the potential for Australia wide workforce changes. While notionally this may appear to be a way to address potential workforce shortages or cost of service delivery, it may impact adversely on the quality of the service being delivered, without achieving the intended aims. It would be all too easy for reform to equate with compromise with the provision of permission for the lower skilled practitioners being able to perform services for which they are not adequately trained nor competent in, therefore placing their patients at risk and no cost saving.

Recommendations:

i. Maintain the central focus of reform (with no scope for compromise) to the maintenance of safe and quality health service to the community.

ii. Ensure that only properly trained health service providers deliver services for which they are, in the view of their national board, adequately trained and competent in.

(b) the impact of the scheme on patient care and safety;

Any reform process must have as its core the provision of safe and quality service delivery.
In preparing for a national scheme, the process will necessitate the creation of professional standards, determining the level of the quality and skill required of practitioners against which they are to be assessed to obtain registration.

It is the ADA's view that creation of such standards must rest solely with the profession concerned. In dentistry, the creation of professional dental standards must rest with the National Dental Board. This Board, to be made up of appropriately trained skilled practitioners, must determine the level of knowledge and skill required for registration in that profession.
The ADA has some concerns that in the Scheme as devised, (from what can be gleaned from Bill A and related documents) the proposed Agency Management Committee and National Agency have too much authority as compared to that possessed by the various national boards. Currently as outlined, the Agency Management Committee possesses the authority to determine the Policy of the National Agency, which in turn holds the funding for the operation of the Agency/ Scheme itself for the professions.

This structure is defective in that it:

- Is an overly bureaucratic and cumbersome structure with financial costs associated with no appreciable benefits. Too many unnecessary layers of bureaucracy are created. These will be costly and will result in increased registration costs for the professions and commensurate increases in costs of health care delivery.
- Creates an Agency with a policy development role; when it is not equipped to perform that task. Policy development and standard development for the various health professions must rest with those with the requisite skills to provide it - namely the national boards.
- Places funding for the scheme and budget management for each profession with the Agency and not with requisite Health Board. The ADA contends that it is the Boards of the various professions which are best equipped to carry out these functions; as it is the Boards that have the required knowledge and expertise to make these determinations for their professions.

Recommendations:

iii. The ADA calls for the Agency Management Committee to be dispensed with.

iv. Place the role of Policy determination solely where it best rests for the various health professions, namely with the National Health Profession Board.

v. The National Board for each profession should be made responsible for budget development and expenditure; with the administrative side of such function being conducted by the central National Agency.

(c) the effect of the scheme on standards of training and qualification of relevant health professionals;

Registration and accreditation:

At the outset of this submission the point was made that ensuring maintenance and improvement in safety and quality in health care delivery must be paramount in the development of the new scheme. To achieve this, the creation of standards of training and qualifications of relevant health professions must be left to those best equipped to develop them and implement them. In the ADA's view this must be the central role of the board for each profession.

The ADA insists though that the role of developing standards for the registration function and then the accreditation of training and qualifications for relevant health professions as against those standards should be separate and both should be carried out independently of each other. As is envisaged in the modelling of the Scheme to date, the role of standards' creation (and thus the determination of the level of qualifications that are to be obtained by the registrant) for a particular health profession should rest with the Board. The ADA wishes to make the point that this function should rest solely with the Board and not be subject to Ministerial intervention as is proposed in the Scheme design to date. Remembering that maintenance of safety and quality is to be paramount, standards' creation and with it the development of scopes of practice should only logically be determined and implemented by the professionals that have the required knowledge and are experienced in the profession for which the standards are being developed.

Ministers should not have the power to dismiss standards created by a health board. Ministers have no expertise here whereas the health board, compromising experts, clearly does, and as such, the role should be within the sole domain of the health board.

Once those standards and scopes of practice are identified by the health board, there should then be another body that accredits training provided to ensure that the training undertaken will result in a student attaining the level of knowledge and skill required by the standards. This should be a role done independently from the Board and such a body would independently accredit the courses of training being offered by educational institutions.

In the case of dentistry, the ADA maintains that the appropriate body for this will be the existing Australian Dental Council. This organisation has more than adequately carried out this function to date and should be appointed to conduct this task into the future. It may however be able to have a smaller board than it currently has.

The reason why the ADA is insistent on this function being carried out separately to the role of standards' creation by the health board is that accreditation of training to achieve those standards should be independent of the standards' creators. If it is not kept separate there is a risk that roles will become blurred and for expediency, standards could be lowered to meet inappropriate training levels. It is in the public interest that there is no such room for compromise and independent assessment against independently created standards is the best insurance to avoid this.

At the same time the National Board must have an overriding obligation that in such standard making and training assessment, the standards required to be achieved remain appropriate for each particular profession and do not inappropriately create any unnecessary overlap. It would be wasteful for standards of a profession to unnecessarily largely overlap with standards or scopes of practice for another. This would create confusion in the mind of the public and risk services being sought by the public and delivered by inappropriately trained professionals.

Clear cut divisions in skills' training are essential for the maintenance of a profession and every effort should be made by an overriding national board to ensure the efficient allocation of training resources and skills.

Composition of the National Dental Board:

Central to the support of the ADA to the creation of National Registration and Accreditation Scheme is the absolute necessity for the creation of an expert and skilled National Dental Board.

It is essential to remember that the National Dental Board will be assuming a role and function that will not be required of other health boards. That is it will be involved in the administration of a number of dental care practitioners, i.e. dentists, dental hygienists, dental therapists and dental prosthetists. As such it will require some special skills to ensure that standards' development for each of these classes of practitioners is conducted appropriately. The dentist is the team leader of the dental team and is the dental professional trained in all aspects of dentistry; dental auxiliaries are only trained in certain aspects of dentistry and as such it is essential that in constructing a national dental board, the majority of the board is made up of dentists as the team leader.

They are after all the most knowledgeable and skilled practitioner in the dental team and are therefore best placed to ensure the creation of proper standards of practice for the dental team. Reference should be made here to:

- ADA Policy on *Dental Acts and Boards* and *Regulatory Authorities* referred to earlier.
- The ADA submissions to the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee. See:

  http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Implementation%20Project/Australian%20Dental%20Association%20Inc.pdf

In summary the ADA's position as stated in its Policy is that:

"Any Board must be expert with regard to the practice of the whole of dentistry.
Therefore the composition of the Board must be based on expertise and allow for representation of oral health practitioners other than dentists.

Boards should be composed of the following:

- *Dentists, who should –*
  - *constitute a majority of the Board;*
  - *include a representative of the Deans of Dental Schools of Australia, and*
  - *be practising in a clinical setting, without a condition on their registration;*
- *one of each of the registered allied dental care providers;*
- *one consumer representative; and*
- *one lawyer.*

Appointment of dental care provider Board members, especially dentists, should include some who are elected by their peers."

Recommendations:

vi. Development of standards for the registration function and accreditation of training and qualifications for relevant health professions must remain separate roles and should be carried out independently of each other.

vii. The Standards' creation function should rest solely with the Health Profession Board and not be subject to Ministerial intervention as is proposed in the Scheme design to date.

viii. The National Dental Board must be constituted as per the ADA Policy provided with this submission.

(d) how the scheme will affect complaints management and disciplinary processes within particular professional streams;

The ADA can do little more here than repeat the central messages that it has delivered in its submissions to the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee and you are referred to that document. See:
http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Proposed%20Complaints%20Arrangements/Australian%20Dental%20Association%20Inc.pdf

Your attention is also drawn to the ADA Policy on this issue which is attached. (Complaints Resolution-Policy 4.4).

As outlined in the ADA's submission referred to in the preceding paragraph, there needs to be "local content" in relation to complaints handling. Not all complaints will require determination before a tribunal or a national board and it is here that the ADA would suggest that a "local" board presence would be essential to provide the facility for essential counselling and conciliation. Such processes often result in a more satisfying outcome for both the patient and the practitioner at a fraction of the cost and time of the more litigious route.

Recommendations:

ix. Any complaints and resolution process for health professionals should focus on the health and safety of the patient and not be a venue for commercial disputes. There are other processes for that. Patients only, as the recipients of the health service, should have access to any complaints and disciplinary procedures.

x. Prompt conciliation procedures must be adopted as a first measure.

xi. Principles of natural justice must be applied to all disciplinary procedures and punitive actions on an ex parte basis only occur in the most extreme cases.

xii. Where possible, complaints' processes should engage experienced health professionals from the profession of the practitioner in any conciliation/complaints deliberations.

(e) the appropriate role, if any, in the scheme for state and territory registration boards;

The dental boards of the various states and territories have played a very valuable role in the development of dentistry in Australia. With time though the multiplicity of the boards in Australia has created some confusion as to how dentistry is being practised in Australia. In each state and territory some differences in the scopes of practice of the various professional groups that make the dental health workforce have been created. In some jurisdictions some dental auxiliaries are able to carry out some tasks while in other jurisdictions they are not. With such professionals crossing borders there is some clouding of permissible duties and confusion created as to what is and what is not able to be done by such professionals.

One of the major advantages in the creation of a national scheme is that uniformity will be able to be restored. This would lead to uniform training and employment Australia wide.

Accordingly, the ADA sees logic in the discontinuation of state and territory registration boards. At the same time though the ADA would agree to members of those boards being retained and used in the newly formed boards or disciplinary panels created. Considerable corporate knowledge and expertise is held by members of those boards and maintenance and utilisation of the skills acquired is essential the creation of a viable and workable national scheme.

Recommendations:

xiii. Where possible the economies of scale be obtained in the creation of the new national scheme.

xiv. Local state and territory presence be provided where complaints/disciplinary action is needed to be taken. This will enhance convenience for both the complainant and practitioner.

(f) alternative models for implementation of the scheme.

If the strong recommendations made above in this paper are adopted then in general terms the design of the scheme is acceptable to the ADA. The ADA, in this response to the terms of reference has attempted to finesse the proposed design with minimal change but with the effect of creating a more consumer and practitioner effective and useable scheme while at all times maintaining the degree of safety and quality that exists in current dental health delivery in Australia.

Mechanisms for review have been proposed that will enable the scheme to keep abreast of developments and modify standards and scopes of practice to reflect appropriate and contemporary practices.

CONCLUSION

The ADA remains committed to the development of the concept of a national scheme for the registration and accreditation of the dental health workforce. It recognises the inefficiencies inherent in having separate boards in each State and Territory with associated bureaucracies that deal with less than 14,000 practitioners in an area where delivery of dental health care should be uniform regardless of where dental services are delivered. With the creation of a national perspective for these processes, there is potential for greater certainty and safety in health delivery will eventuate.

In this submission the ADA has made some very practical suggestions as to how the current draft scheme must be revised and improved to achieve the desired outcomes.

The ADA would be happy to present to the Committee on any issue that the Committee feels warrants further comment.

Dr Neil D Hewson
President
Australian Dental Association Inc

29 April 2009.

DENTAL ACTS AND BOARDS[1]

1 Introduction

1.1 Background

Dentistry was first regulated by legislation in Britain in 1878 and two years later in New Zealand. In Australia, the first Dental Act received Royal Assent in the colony of Victoria on 16 December 1887. Since then the practice of dentistry has been regulated by the States and Territories to provide protection and safety to the public.

In 1992 the Commonwealth Government and every State and Territory Government passed Mutual Recognition Acts, which guaranteed a practitioner registered in one jurisdiction could automatically register in any other. This led to the formation of the Australian Dental Council (ADC) which was charged by the Boards to accredit courses of education and training leading to registration of dental practitioners and also to examine overseas trained dentists.

In April 2007 the Council of Heads of Australian Governments (COAG) announced the structure that from 1 July 2008 would administer the national process of registration for nine professional groups that at the time were registered in every jurisdiction. COAG's decision included the establishment of nine separate National Registration Boards, one for each professional group.

1.2 Definitions

1.2.1 BOARD is a Federal, State or Territory dental registration board.

1.2.2 DENTAL ACT is any Federal, State or Territory Act that has a primary purpose to regulate the practice of dentistry.

1.2.3 FITNESS TO PRACTISE includes:

- the applicant's mental and physical health;
- the applicant's command of the English language;
- the applicant's criminal history;
- any deregistration, suspension, condition or limitation imposed under a similar law; and
- the applicant's recency of practice.

1.2.4 RECENCY OF PRACTICE means that a practitioner has maintained an adequate connection with the profession since qualifying.

Recency of practice requirements may include:

- the nature, extent and period of practice;
- the nature and extent of any continuing professional development undertaken;
- the nature and extent of any research, study or teaching relating to dentistry; and
- the nature and extent of any administrative work relating to dentistry.

[1] This Policy Statement is linked to other Policy Statements: *2.1 Dental Workforce, 2.2 Dentists, 2.3 Allied Dental Personnel, 2.4 Specialisation in Dentistry, 2.8 Overseas Trained Dentists, 2.9 Recency of Practice, 4.7 Regulatory Authorities, 4.10 Accrediting Authorities, 5.3.1 Healthcare Workers (incl. Students) Infected with Blood-Borne Viruses, 5.3.2 Management of Impaired Practitioners & 5.13 Advertising in Dentistry*

1.2.5 RENEWAL OF REGISTRATION is the process of re-registering a person already registered.

2 Principles

2.1 Purpose of Regulation

To ensure the health and safety of the community, it is essential to regulate dental practice as it includes irreversible, invasive and exposure prone procedures and potentially fatal risks.

2.2 Dental Act Objects

The Objects of a Dental Act should be to:

2.2.1 Protect the public by ensuring that health care is delivered by health care providers in a professional, safe and competent way; and

2.2.2 Uphold the standards of practice within the health professions; and

2.2.3 Maintain public confidence in the health professions; and

2.2.4 Provide a uniform system to deal with complaints, investigations and disciplinary proceedings relating to health care providers, and to the management of impaired practitioners; and

2.2.5 Provide a system to deal with complaints about practitioners that is complementary to the States and Territories health complaints commissions.

2.3 Boards

Boards must reflect contemporary community expectations of standards of dental care, as well as those of oral care providers and other relevant scientific and standard setting bodies. In order for Boards to function effectively, Board members must understand the role of Boards, and must have or acquire a broad knowledge of health, governance, communication and legal issues.

3 Policy

3.1 Boards

3.1.1 *Composition of Boards*

Any Board must be expert with regard to the practice of the whole of dentistry. Therefore the composition of the Board must based on expertise and allow for representation of oral health practitioners other than dentists.

Boards should be composed of the following:

- Dentists, who should –
  constitute a majority of the Board;
  include a representative of the Deans of Dental Schools of Australia, and
  be practising in a clinical setting, without a condition on their registration;
- one of each of the registered allied dental care providers;
- one consumer representative; and
- one lawyer.

Appointment of dental care provider Board members, especially dentists, should include some who are elected by their peers.

3.1.2 *President and Vice President of the Boards*

The President and Vice-President of the Boards must be dentists.

3.1.3 *Role of Boards*

The role of Boards should be to:

- protect public health and safety by -
  setting minimum standards of dental practice through promulgation of Codes of Practice, Policies and Guidelines,
  counselling and/or disciplining oral care providers, and
  maintaining a Register, part of which is open to the public;
- register dental care providers.

3.1.4 *Governance of Boards*

Good governance of Boards should include the following:

- measures to ensure that appointees are competent to be Board members;
- use of outside expertise;
- decisions based on evidence; and
- consultation with stakeholders before promulgation of Codes, Policies and Guidelines.

3.1.5 *Communication with Registrants*

- It is essential that Boards keep their registrants fully informed on matters pertaining to the regulation of dental practice within the Board's jurisdiction.
- Communication with all registrants should include:
  Annual Reports,
  provision of a complete set of statutory requirements to registrants, i.e. the Act, Regulations, Codes of Practice and Guidelines,
  any update of statutory requirements,
  education of registrants via seminars, information sheets etc. to assist their compliance with the statutory requirements,
  availability of Dental Register.

3.1.6 *Communication with the Public*

- It is essential that Boards inform the public on relevant matters pertaining to the regulation of dental practice within the Board's jurisdiction.
- Communication with the public should include:
  availability of that part of the Dental Register which is open to the public,
  Annual Reports,
  current statutory requirements

  but, should not include:
  any claims lodged or settlements determined,
  any conditions on registration that are not current,
  the naming of impaired providers who are not currently practising,
  any previous penalties levied against a dental care provider.

3.2 Registration

3.2.1 *Types of Registration*

There must be provision for separate registers of:

- dentists including dental specialists; and
- operative allied dental personnel -
  dental hygienists

dental therapists, and
dental prosthetists (denturists).

3.2.2 ***Criteria for Registration***

All registrations must be based on the holding of appropriate qualifications, fitness to practise and recency of practice.

3.2.3 ***Accreditation of Qualifications***

Accreditation of qualifications should be done by an accrediting authority although such a body may be part of or should report to a board.

3.2.4 ***Examination of Holders of Unaccredited Qualifications***

Boards must have the power to decide if the holders of unaccredited qualifications have an equivalent qualification to an accredited Australian qualification and have the power to examine such persons. However Boards should delegate this assessment and examination function to an accrediting authority.

3.2.5 ***Fees***

Registration fees must be calculated on a cost recovery and apply equally to all practitioners.

3.2.6 ***Renewal of Registration***

Registration must be renewed every year and practitioners must continue to meet fitness to practise and recency of practice requirements.

3.3 Restriction of Practice and Definition of Dentistry

3.3.1 ***Restriction of Practice***

The Dental Act must make it illegal for persons who are not dentists to practise dentistry. Exceptions should be made for:

- students and other dental registrants for their scope of practice;
- medical practitioners (for dental emergencies);
- anyone to provide first aid in emergencies; and
- removal of primary teeth without local or general anaesthetic by parents or other persons.

The removal of primary teeth by parents or other persons without local or general anaesthetic should also be excluded from the restriction.

The scope of practice and supervision requirements for operative allied dental personnel should be defined in Regulation along with prescribed qualifications.

3.3.2 ***Definition of Dentistry***

The practice of dentistry should be defined in Dental Acts as:

- diagnosis or management of conditions of the mouth of a person;
- performance of any invasive and/or irreversible procedure on the natural teeth or parts of a person’s body associated with their natural teeth;
- provision of artificial teeth or dental appliances or insertion of artificial teeth for a person; or
- making an intraoral adjustment of artificial teeth or dental appliances for a person.

3.4 Obligations on Registrants and Other Persons and Entities

3.4.1 *Restriction of Titles*

- The titles for dentists that should be protected and reserved are "dentist", "dental surgeon" and "dental practitioner".
- The recognised titles for each dental speciality should be protected and reserved for persons registered as specialists.
- The titles for operative allied dental personnel that should be protected and reserved are "dental hygienist" and "dental therapist", and "dental prosthetist" or "denturist".
- Students enrolled in dental education programs should be identified as such. Examples are "student dentist", "orthodontic registrar", "oral and maxillofacial surgery trainee".
- The use by any dentist of the honorary title "doctor" should be continued.

3.4.2 *Falsely Holding Out*

There must be provisions in Dental Acts prohibiting persons who are not registered as any category of registrant from holding themselves out as registrants and also to ensure registrants only use titles for which they have been registered. It should also be an offence to hold out falsely another person to be a registrant if they are not. Persons also should not be allowed to use the word "specialist" or "speciality" or "specialty" in circumstances that indicate or could reasonably be understood to indicate, that the person provides professional services in an area of dentistry that is not presently recognised as a speciality.

3.4.3 *Advertising*

Provisions giving the Board power to act against false, misleading and deceptive advertising should be included in a Dental Act.

3.4.4 *Payment for Referrals*

Payments for referrals and receiving payments for referrals must be prohibited.

3.4.5 *Professional Standards*

Dental Acts should give Boards the power to make Codes of Practice and other professional standards.

3.4.6 *Penalties*

The penalties applicable to persons successfully prosecuted for breaches of the obligations above should be substantial to deter illegal practice and to protect the public.

3.5 Complaints

3.5.1 *Who May Make Complaints*

A complaint against a registrant may be made by any person including but not limited to a patient, a patient's representative or another registrant.

3.5.2 *Who May Receive Complaints*

The Board or a commission may receive a complaint but whichever receives the complaint must report it to the other authority if it concerns the treatment of a patient.

3.5.3 *Role of State Health Complaints Commissions [commissions]*

Commissions are to undertake the assessment and conciliation of complaints. If any jurisdiction does not have a commission then a committee appointed by the Board should undertake this role.

3.5.4 *Assessment of Complaints*

Where a complaint is kept by the Board or is referred by a commission, the Board must be empowered to assess the complaint before deciding to investigate it or not.

3.6 Investigations

3.6.1 *Conduct of Investigations*

Boards must decide whether to investigate a complaint or a matter about a registrant unless directed to investigate by the Minister. Boards and investigators appointed by them must have adequate powers to conduct investigations.

3.6.2 *Notice of Investigation*

As soon as practicable after deciding to investigate a complaint or practitioner, Boards must give the practitioner concerned notice of the investigation.

3.6.3 *Investigators*

Any investigator appointed by the Board will be provided with written authority to conduct the investigation and will provide proof of such appointment when required.

3.6.4 *Reports of Investigation*

The investigator on completion of the investigation will give the Board a preliminary report of investigation. The Board as soon as practicable after receiving a preliminary report will prepare its report of investigation and may adopt the preliminary report with or without changes.

3.6.5 *Actions Open on Completion of Report of Investigation*

Boards must decide to do one of the following:

- If a Board believes the matter is one deserving suspension or deregistration as a penalty it must refer the matter to hearing by a Tribunal;
- If the matter follows action to suspend immediately the practitioner and the investigation indicates further disciplinary action is necessary, a Board must refer the matter to a Tribunal;
- Otherwise the Board may
    - refer the matter for disciplinary action by a committee of the Board, which may conduct a hearing or action by correspondence or enter into an undertaking with the practitioner, with the practitioner’s agreement, about the practitioner’s conduct or practice;
    - refer the matter to a commission with the commission’s agreement;
    - deal with the matter under the Part of the Dental Act dealing with impairment;
    - take no further action.

3.7 Immediate Suspension and Imposition of Conditions

3.7.1 *Protective Purpose*

Boards must have the power to effectively respond to imminent threats posed by registrants to the wellbeing of vulnerable persons. Boards must have the power to suspend or impose conditions on the registration of the practitioner.

3.7.2 *Minimum Necessary*

Boards must take appropriate action to protect the vulnerable persons.

3.7.3 *Natural Justice*

Boards must allow a practitioner reasonable time to respond to a complaint or action before taking action themselves.

3.7.4 *Board must Investigate or Refer for Hearing*

Once a Board has decided to take action it must decide to either investigate the matter or refer it directly to a Tribunal.

3.7.5 *Right of Appeal*

A practitioner subject to action by a Board may appeal the Board's decision to a Tribunal. In the case of suspension, the Tribunal shall deal with the appeal expeditiously.

3.8 Informal Disciplinary Processes

Informal disciplinary processes are those conducted by a Board or its committee and must have the following characteristics:

3.8.1 The penalties open to a Board or its committees shall be restricted to caution, reprimand and undertakings.

3.8.2 The practitioner shall not be entitled to legal representation at any hearing.

3.8.3 There shall not be public access to informal processes.

3.8.4 The practitioner must have the right to request a formal hearing by a Tribunal.

3.8.5 The recording of penalties on the public register must be at the Board's discretion.

3.9 Formal Disciplinary Processes

3.9.1 A Tribunal should be a Judge of the Federal Court advised by a dentist and a practitioner of the same profession and category as the practitioner subject to the action.

3.9.2 The practitioner before a Tribunal shall be entitled to legal representation.

3.9.3 All formal proceedings should be open to the public unless decided otherwise by the Tribunal.

3.9.4 The Tribunal may impose penalties including deregistration, suspension, conditions and fines which must be paid to the Board.

3.9.5 Any adverse disciplinary decision of the Tribunal must be recorded on the public register.

3.9.6 Any conditions imposed by the Tribunal upon the practitioner should be for not more than three years. Thereafter the conditions can be reviewed by the Board.

3.9.7 In any review by a Board pursuant to 3.9.6, the Board shall be at liberty to impose further restrictions on the practitioner as may be consistent with the Tribunal's earlier findings.

3.10 Monitoring Compliance with Disciplinary Decisions

3.10.1 *Power to Monitor Compliance*

Boards must have adequate powers to monitor and enforce compliance with orders of a Tribunal, conditions and undertakings.

3.10.2 *Appointment of Inspectors*

Boards shall appoint inspectors with similar powers to investigators for the purpose of monitoring compliance with orders, conditions and undertakings. It is possible that a person may be appointed as both an inspector and an investigator.

3.11 Appeals

3.11.1 *Appeals Authorities*

Appeals against decisions of a Board shall be made to the Federal Court. If the matter involves a complaint by a patient, the appeal shall be made to a Tribunal.

Appeals from Tribunals shall be by way of customary process for appeals from the Federal Court.

3.11.2 *Who May Request Appeal*

A practitioner subject to a decision of a Board or a Tribunal may appeal that decision or a Board may appeal a decision of a Tribunal.

3.11.3 *Appeals to be Dealt with by Re-hearing*

Any appeal is to be dealt with by re-hearing.

3.12 Impairment

Boards must have the power to deal with impaired practitioners in a process separate from the usual disciplinary processes. Continued practice by practitioners recovering from impairment is not inconsistent with maintenance of professional standards and safety of the public.

Policy Statement 4.9

Adopted by ADA Federal Council, May 30, 2007.

REGULATORY AUTHORITIES

1 Introduction

1.1 Regulatory authorities became involved in the practice of dentistry when it was first regulated by legislation in Britain in 1878 and two years later in New Zealand. In Australia, the first Dental Act received Royal Assent in the colony of Victoria on December 16, 1887. Since then, the practice of dentistry has been regulated by the States and Territories to provide protection and safety for the public.

1.2 **Definitions**

1.2.1 BOARD is a State or Territory dental registration board.

1.2.2 DENTAL ACT is any State or Territory Act that has a primary purpose to regulate the practice of dentistry.

1.2.3 DENTISTRY is the science and art of preventing, diagnosing and treating diseases, injuries, developmental and acquired defects of the teeth, joints, oral cavity and associated structures, within the context of general health.

1.2.4 DENTAL CARE PROVIDER is a person registered by a Board to provide dental care.

1.2.5 STANDARD SETTING ORGANISATIONS are independent bodies which set standards that may apply to dental practice, e.g., Standards Australia.

2 Principle

2.1 **Purpose of Regulation**

To ensure the health and safety of the community, it is essential to regulate dental practice as it includes irreversible and invasive procedures and potentially fatal risks.

3 Policy

The regulation of dental practice should have the following elements and features.

Boards

3.1 Boards should regulate via:

3.1.1 Dental Acts, which should include:

- eligibility and procedures for registration;
- definition of dentistry;
- administration of the Board;
- administration of the Dental Register;
- restriction of practice to registered persons;
- specification of penalties for unprofessional conduct; and
- obligations on registrants and other persons including advertising standards.

3.1.2 Regulations, which should include:

- supervision and scope of practice of registered allied dental personnel; and
- recognised specialties.

3.1.3 Codes of Practice and Guidelines, which must only be an elaboration of the Act and should include:

- infection control standards;
- record keeping standards; and
- indemnity cover requirements.

Dental Education Accrediting Authorities

3.2 Dental Education Accrediting Authorities should:

3.2.1 Accredit Australian University Dental Schools, TAFE colleges and courses leading to:

- dental qualification;
- specialist recognition; and
- allied dental qualification.

3.2.2 Assess the suitability for practice in Australia of persons with overseas dental qualifications.

3.2.3 Set uniform criteria for recognition of qualifications for registration.

Health Complaints Authorities

3.3 Health Complaints Authorities, which are established by the Government to mediate and conciliate where necessary between patients and dental care providers, where patients have complaints about health care treatment problems or about the behaviour of the dental care provider.

Standard Setting Organisations

3.4 It is essential that any external body that sets standards for dental practice, which may be adopted by Boards, should consult widely and ensure that its standards are practical, cost effective and able to be incorporated into everyday dental practice.

Uniformity

3.5 There should be an Australia-wide uniformity in the following areas:

- Dental Acts and Regulations;
- recognition of dental specialties;
- scope of practice and training of allied dental personnel; and
- recognition of qualifications.

Related Legislation

3.6 Specific legislation for dental practice:

- may complement other Acts, e.g., Trade Practice Act;
- should not duplicate other Acts and regulations, e.g., Privacy and Discrimination; and
- should be consistent with legislation of other areas of health care.

Policy Statement 4.7

Adopted by ADA Federal Council, April 22/23, 2004.
Amended by ADA Federal Council, April 7/8, 2005.
Amended by ADA Federal Council, April 20/21, 2006.
Amended by ADA Federal Council, May 30, 2007.
Amended by ADA Federal Council, November 13/14, 2008.

APPENDIX TO POLICY STATEMENT 4.7

LEGISLATION AFFECTING DENTISTRY

1 Commonwealth Legislation

Corporations Law 1990
Health Insurance Act 1973
Health Insurance Commission Act 1973
Mutual Recognition Act 1991
National Health Act 1953
National Health and Medical Research Council Act 1972
Privacy Act 1998
Superannuation Guarantee Act 1992
Therapeutic Goods Act 1989
Veterans' Affairs Entitlement Act 1986
Various Taxation Acts

2 State Legislation

Accident Compensation Acts
Business Names Acts
Criminal Injury Compensation Acts
Dangerous Goods Acts
Dental Acts
Drugs, Poisons and Controlled Substances Acts
Environmental Protection Acts
Equal Opportunity Services Acts
Evidence Acts
Freedom of Information Acts
Health Acts
Health Services [Conciliation and Review] Acts
Industrial Relations Acts
Medical Practice Acts
Occupational Health and Safety Acts
Partnership Acts
Privacy or Health Records Acts
Therapeutic Goods Acts
Transport Accident Acts
Workers' Compensation Acts

Related ADA Guidelines for Good Practice

Consent in Dentistry
Emergencies in Dental Practice
Patient Information and Records
Sedation for Dental Procedures

COMPLAINTS RESOLUTION

1 General Principles

The Australian Dental Association [ADA] recognises it has a number of obligations with respect to complaints concerning professional duties.

1.1 The interests of the patient must always be paramount.

1.2 The ADA should maintain mechanisms which aim to ensure its members practise dentistry at the highest possible standard.

1.3 Self-regulation by the dental profession should be preserved and promoted.

2 Responsibility

2.1 The ADA recognises its responsibility for matters concerning conduct, performance and standards in the provision of services by its members.

2.2 The ADA may provide a mechanism to resolve a dispute where a dentist, who is a member of the ADA, is the subject of a potential or actual formal complaint about that member's conduct, performance or standards in the provision of services.

2.3 The ADA may co-operate in a mechanism to resolve a dispute where a dentist, who is not a member of the ADA, is the subject of a potential or actual formal complaint about that dentist's conduct, performance or standards in the provision of services.

2.4 The ADA recognises the role of the Dental Boards, State Health Complaints Commissions and other statutory authorities in the resolution of complaints.

3 Conciliation

3.1 Conciliation is a process which attempts to resolve differences between dentists and complainants without recourse to adjudication. It may be made available through the ADA or other bodies.

3.2 The ADA, through its Branches, may provide an avenue for conciliation in addition to or in conjunction with Dental Boards, state health complaints Commissions and other statutory authorities.

3.3 Conciliation should be available to deal with complaints concerning all dentists.

3.4 The means for conciliation should be available as a primary response to a formal written complaint.

3.5 The conciliatory mechanism should use the services of experienced dental practitioners.

3.6 Information provided by a practitioner who is the subject of a complaint during conciliation should remain privileged and be quarantined from future adjudicative or civil proceedings.

4 Adjudication

4.1 Where conciliation mechanisms have failed to resolve a dispute then the matter may proceed to adjudication utilising either peer review mechanisms or appropriate statutory authorities.

4.2 In matters requiring adjudication, preference should be given to peer review mechanisms which allow assessment of the appropriateness and quality of care.

4.3 Statutory review applies to all registered dentists and is regulated by Government.

Policy Statement 4.4

Adopted by ADA Federal Council, November 21/22, 2002.
Amended by ADA Federal Council, November 15/16, 2007.

APPENDIX TO POLICY STATEMENT 4.4

PRINCIPLES OF PEER REVIEW

1. Peer Review is a system by which the dental profession assumes a responsibility for reviewing matters concerning the performance of a dentist in carrying out professional duties, upon receipt of a formal complaint.

2. Peer Review is intended to provide assessment of an alleged deficient practice.

3. Appropriate matters for assessment by Peer Review might include (but are not limited to):

   3.1 propriety of treatment;

   3.2 appropriateness of care;

   3.3 quality of services rendered;

   3.4 reasonableness of fees;

   3.5 questions of overall provider competency.

4. The following guidelines should apply to the operation of Peer Review:

   4.1 Assessment of a complaint against a practitioner must be by a committee composed of the practitioner's peers.

   4.2 All parties concerned should agree to recognise the authority and finding of a Peer Review Committee.

   4.3 A Peer Review Committee should employ established parameters for the assessment of clinical quality and professional performance.

   4.4 Clinical assessment may be made only with the consent of both patient and practitioner.

   4.5 Where clinical assessment of a patient is undertaken, a Peer Review Committee may engage independent consultants, who should be remunerated.

   4.6 A consultant's report shall be in writing, limited to facts, and must only be made to the Peer Review Committee.

   4.7 Members of a Peer Review Committee and its consultants must be afforded protection against litigation arising from their participation in the review.

   4.8 Where either party initiates legal procedures in connection with a complaint, the review shall cease.