

*Review of  
Dentists Act 1972  
and  
Dental Technicians Act 1972  
Final Report  
July 1998*





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## *Executive Summary*

The Minister for Health commissioned a review of the *Dentists Act 1972*, *Dental Technicians Act 1972* and associated Regulations in accordance with the Victorian Government *Guidelines for the Review of Legislative Restrictions on Competition* for National Competition Reviews. This report contains the findings and recommendations of an independent review panel following consideration of public submissions.

The panel identified a number of existing legislative provisions which can potentially impede competition. These restrictions fall into the categories of professional registration (protection of professional titles, areas of practice and prescribed duties) and restrictions on business and advertising as well as on the utilisation of dental auxiliaries (dental therapists and dental hygienists) and advanced dental technicians.

The panel considered a new regulatory approach, shifting the traditional focus of professional registration as a 'point of entry' regulation to a more explicit competency-based focus which emphasises the minimisation of health risks and harm to the public.

Following the clarification of policy objectives and consideration of relevant issues, the panel recommended a new *Dental Practice Act 1998* for contemporary and evolving dentistry to cover the dental profession in its entirety (*Recommendations 1 and 2*).

The key reforms recommended are categorised as follows:

### ***Provisions to streamline and modernise the profession***

- Retention of a registration scheme with a limited list of protected professional titles (*Recommendations 3, 4, 5 and 6*).
- Retention of a narrow definition of dentistry in legislation which focuses on protection of the public's health and safety (*Recommendations 7, 8 and 9*).

### ***Pro-competitive provisions***

- Removal of ownership restrictions on dental practices and laboratories (*Recommendations 10 and 11*).
- Removal of the restriction of disparaging remarks within the dental profession (*Recommendation 12*).
- Removal of the operational ratio of one dental hygienist per dentist (*Recommendation 13*).
- Removal of the public sector employment restrictions on dental therapists allowing them to also work in the private sector (*Recommendation 15*).

### ***Transitional-type provisions***

- Dental therapists to continue to operate on persons aged 17 years and under, until skills and qualifications have evolved to a level which does not endanger public health and safety (*Recommendation 16*).
- All dental auxiliaries to continue to work under the supervision of a dentist until clinical evidence indicates 'autonomous' practice does not endanger public health and safety (*Recommendations 14 and 17*).
- Requirement of a dentist issued oral health certificate prior to insertion of a partial denture by a dental prosthetist to be 'grandfathered' after 12 months unless a public health and safety case is made for its retention on the basis of good clinical evidence (*Recommendation 18*).

### ***Regulatory provisions***

- A new Dental Practice Board to be established and charged with the objectives of promoting the community's access to dental care and to minimise the community's exposure to the health risks in dentistry (*Recommendations 19 and 20*).
- The board to operate in accordance with Victoria's health practitioner model for 'unprofessional conduct' and 'impaired providers' (*Recommendations 21 and 22*).



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# 1. Introduction

## 1.1 Purpose of the Review

In 1995, the Council of Australian Governments (COAG) agreed to implement National Competition Policy (NCP). This agreement committed all Governments to a consistent national approach to fostering greater economic efficiency and improving the overall competitiveness of the Australian economy.

Under NCP, the Victorian Government is obliged to review and, where appropriate, reform all legislation and regulation which restricts competition in accordance with the guiding legislative principle set out in the *Competition Principles Agreement*:-

‘Legislation should not restrict competition unless it can be demonstrated that:

- The benefits of the restriction to the community as a whole outweigh the costs.  
and
- The objectives of the legislation can only be achieved by restricting competition.’

The Victorian Government has established a timetable and issued a set of guidelines for reviewing all legislation and regulation in all portfolio areas in accordance with this principle. The Victorian Government is committed to completing its NCP legislative review program before the year 2000.

The concurrent reviews of the *Dentists Act 1972* and the *Dental Technicians Act 1972* are part of the comprehensive NCP legislative review program in Victoria.

The Victorian Government’s commitment to the guiding legislative principle does not imply that competition policy objectives should necessarily take precedence over other public policy objectives. To accommodate the broader relevant public policy considerations, the dental legislation has also been reviewed with regards to:

- Mutual recognition of registered professions in Australia.
- The model administrative features of health practitioner legislation in Victoria.
- Recommendations from a key dental policy document *Future Directions for Dental Health in Victoria (1995)*.
- Recommendations from the *Dental Auxiliary Workforce Review (1993)*.

## 1.2 Administrative Arrangements

The review has been conducted in accordance with the semi-public review model as described in the *Victorian Government Guidelines for the Review of Legislative Restrictions on Competition*.

The terms of reference for the review are stated in Appendix A.

The review was undertaken by an independent panel of three individuals who are neither directly engaged in the dental profession nor in the regulation of that profession. The panel members were: Mr Robert Doyle (Chair), Parliamentary Secretary to the Minister for Health, Professor Graeme Ryan, Chief of Clinical Services, Inner and Eastern Health Care Network, and Dr Chee-Wah Cheah, Assistant Director, Reform Policy, Department of Treasury and Finance.

A discussion paper was issued in December 1997 and disseminated to all relevant stakeholders and the general public. Public notices of the review and calls for submissions were advertised in major newspapers as well as on the Internet. More than 80 public submissions were received over a three-month period from a variety of sources including the existing regulatory authorities, professional associations, education institutions and members of the general public.

**This report has been prepared by the panel for the Minister of Health who commissioned the review. The findings and recommendations contained herein are those of the panel and they do not necessarily represent the views or policies of Government.** Following receipt of this report by the Minister, the Department of Human Services will prepare a proposed Government response for the Minister's consideration.





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## 2. *The Market for Dental Care*

Providers of dental care services in Victoria consist of dentists, dental specialists, dental auxiliaries (dental hygienists and dental therapists), advanced dental technicians and dental technicians.<sup>1</sup> About 85 per cent of practising dentists work in private practices. Advanced dental technicians and dental technicians also operate largely within the private sector. Dental hygienists are mainly employed in private practices. In contrast, dental therapists can only be employed within the public sector to help deliver public dental care programs such as the school dental services.<sup>2</sup>

Dentists comprise the largest provider workforce with approximately 2415 registered members (including specialists).<sup>3</sup> Around 80 per cent of all private dental practices are located in the metropolitan area and the rest are distributed across regional and rural Victoria.

The public sector also provides dental care services through the Community Dental Program (including the Victorian Denture Scheme, Special Needs Programs, specialist services and the Rural Initiative Program), the School Dental Program and the Dental Intern Program. In 1997-98 public dental programs in Victoria have a budget of \$47 million.

Consumers do not seek access to dental care simply for its own sake, but for the 'satisfaction yielding' outcomes or attributes embodied in dental services. Examples of such attributes include successful courses of preventive and curative treatment, proficient pain management and aesthetically pleasing appearances.

One defining demand-side characteristic of dental care is that consumers are generally unable to determine product or service quality **before** the product or service in question has been rendered by a dental care provider. Dental care is a type of 'experience good'.<sup>4</sup> As with other experience goods, consumers of dental care services will shop around and search for (or discriminate among) providers on the basis of proxies and other observable indicators of service quality.

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<sup>1</sup> (a) Throughout this report, the term 'dental auxiliaries' is used to denote dental therapists and dental hygienists (b) Dental assistants are also part of the dental workforce but are not a registered profession. Further details on the composition of the workforce and the nature of services provided by the respective professional groups are summarised in Appendix B.

<sup>2</sup> *Future Directions for Dental Health in Victoria*. Department of Human Services, August 1995.

<sup>3</sup> The Dental Board of Victoria Annual Report. Year ending 30 September 1997. It is estimated that only 85 per cent of registered dentists practise in Victoria (*Future Directions for Dental Health in Victoria*, Department of Human Services, August 1995).

<sup>4</sup> A good (or service) is an experience good if consumers can determine its characteristics only after purchase. Philip Nelson introduced this concept in his seminal article 'Information and Consumer Behaviour,' *Journal of Political Economy* 1970; 78(2).

In recent years, more consumers have sought price estimates before using dental services. Consumers will also rely on non-price indicators to infer quality. These include observations of educational qualifications (and specialist status where relevant), vintage of office amenities and clinical equipment, word-of-mouth descriptions of a dentist's personality and reputation, and the dentist's age and length of service (as proxies of professional experience). The search costs for consumers can be affected by regulations that narrow or restrict the informational basis upon which consumer choice decisions are made, for example, restrictions on comparative advertising and use of testimonials.

Markets for dental care are usually local markets. The private dental practices in any given local market can be differentiated to an extent, either in terms of observable variations such as the age of a practice, the location of offices and accessibility (that is, hours of operation); or in terms of perceived variations in the amenities and practice characteristics offered by the dental care provider. This implies a degree of substitutability as consumers can choose between the services offered by one practice and the differentiated services offered by another practice in the same local market.

There is also a degree of 'substitution at the margin' between the various groups of trained dental care providers. For example, dental hygienists are able to clean and polish teeth, advanced dental technicians can fit dentures and dental therapists can apply preventive sealants. Sometimes product substitution is also possible when there is a range of treatment options available. For example, missing teeth could be replaced with a bridge, denture or implants depending on the circumstances.

The scope for product and process substitution is constantly expanding with modern developments in treatment methods (such as dental implants and preventive sealants) and technology (for example, the use of composite resins and bonding agents as restorative materials). It is expected that products and services in the dental care market will continue to improve and diversify with the introduction of new technologies such as computer-assisted restorations and lasers.

The principal-agent relationship between patients (that is, consumers) and dental care providers (that is, dentists, dental specialists, advanced dental technicians and dental auxiliaries) is characterised by knowledge discrepancies in favour of the provider. Patients are usually not as well-informed as providers or they lack the independent ability to judge the risks of alternative treatments (including non-treatment), the efficacy of dental products and services or the proficiency of the provider.

It is generally accepted that a market may fail to allocate resources efficiently when the relevant information for decision making is distributed asymmetrically between market participants (that is, consumers and providers). In this regard, government regulation may be warranted where there is a clear public interest at stake. The regulatory experience in Australia and overseas shows that governments have traditionally relied

upon professional registration as a form of quality-control mechanism which restricts the practice of dentistry (with its attendant health risks) to persons with recognised training and competencies.





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### 3. *Legislation and Objectives*

The *Dentists Act 1972* establishes The Dental Board of Victoria to regulate the practice of dentistry. Under the Act, the board is charged with the responsibility to register suitably qualified dentists and specialist dental practitioners and to license suitably qualified dental auxiliaries. The board also has a function under the Act to deal with complaints relating to dental practice.

The *Dental Technicians Act 1972* establishes the Dental Technicians Licensing Committee and the Advanced Dental Technicians Qualifications Board to license suitably qualified dental technicians and advanced dental technicians respectively to perform specified duties. Both regulatory authorities also have the function under the Act to deal with complaints about licensed persons.

**The panel notes that there are no stated objectives in either Act nor in Hansard when the relevant legislation were enacted in 1972.**

The Dental Board of Victoria has interpreted its enabling legislation as providing it with:

- The function to administer the Act and subordinate regulations 'for the benefit of the dental health of the public in Victoria'.
- and
- The authority to ensure that 'high standards of professional behaviour and competence are maintained in the conduct of dental practice'.<sup>5</sup>

The board's interpretation of the legislation is consistent with a regulatory approach which focuses on individual behaviour and the application of sanctions against those transgressing professional disciplinary standards. This is also the approach of the Advanced Dental Technicians Qualifications Board and the Dental Technicians Licensing Committee.<sup>6</sup> The objective that can be inferred from this regulatory model is the protection of the community from egregious dental practice among a minority in the profession as well as by those who are not qualified to provide safe dental care.

The panel acknowledges that this should be a key objective of regulation and that the necessary protection should be linked to the setting and maintenance of minimum competencies in the provision of dental care.

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<sup>5</sup> *A Guide for Dentists, Dental Therapists, Dental Hygienists*. The Dental Board of Victoria, 1997.

<sup>6</sup> Advanced Dental Technicians Qualifications Board and the Dental Technicians Licensing Committee, Reports to the Minister for Health for the period ending 30 June 1997.

There is a body of overseas research and evidence which suggests that there are limits to the level of public protection that can be achieved through professional registration.<sup>7</sup> A registration regime does not necessarily guarantee correspondence between the qualifications required for registration and the applied clinical practice. Regulatory and disciplinary authorities are likely to find it difficult to monitor and observe important quality variables such as the level of care and the sophistication of clinical judgement exercised by providers. Furthermore, there is a risk that sole professional control over a registration regime could result in a regulatory approach that promotes private interests rather than public goals and objectives.

An alternative and more recent approach to public health and safety regulation emphasises the environmental causes of harm to the public (for example, drink driving in relation to automobile accidents). In parallel to this, recent international developments in health professional regulation have increasingly focused on the manner in which accepted clinical practices (or departures thereof) and related organisational arrangements affect the incidence of iatrogenic injuries (that is, injuries caused accidentally or otherwise by clinicians). This so-called environmental approach to public health and safety seeks to minimise the risks of public harm through the use of appropriate quality assurance and risk management mechanisms.<sup>8</sup>

In addition to ensuring that competency standards for dental care providers are established and enforced, the panel considers that the effectiveness of professional registration could be enhanced by complementary mechanisms to facilitate:<sup>9</sup>

- Continuing competency and maintenance of currency in knowledge and skill base.
- The availability, obtainability and comprehensiveness of dental services in the community.
- Utilisation of allied professionals where such persons are competent and less costly.

The panel also considers it important for Government to shift the traditional focus on professional registration as a 'point of entry' regulation; to a more explicit competency-based focus which emphasises the minimisation of health risks and harm to the public.

The panel therefore recommends that Government incorporates the following public policy objectives in a modern legislative framework for contemporary and evolving dentistry:

- **To promote the community's access to dental care.**
- **To minimise the community's exposure to the health risks in dentistry.**

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<sup>7</sup> Trebilcock MJ. Regulation Service Quality in Professional Markets published in Dewees DN. *The Regulation of Quality*, Butterworths, Toronto, 1983.

<sup>8</sup> See in particular the World Health Organisation's Ottawa Charter, 1996.

<sup>9</sup> Cohen HS, Mike LH. Toward a More Responsive System of Professional Licensure. *International Journal of Health Services* 1974; 4: 265-72.

The existing *Dentists Act 1972* and *Dental Technicians Act 1972* (and associated Regulations) should be repealed and replaced by a single piece of new legislation to govern the profession in its entirety.

### ***Recommendations***

- 1. That existing legislation and associated Regulations be repealed and replaced with a single Dental Practice Act for the dental profession in its entirety.*
- 2. That the purpose and objectives of the new Act be to promote the community's access to dental care and to minimise the community's exposure to the health risks in dentistry.*







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## 4. *Legislative Restrictions on Competition*

Competition is a market process that can lead to lower prices for a given level of service quality and a range of services that matches the expressed demand of consumers. Competition is a means toward achieving greater economic welfare for the community. In the context of the marketplace for dental care, the competitive process works most efficiently when consumers are well-informed, that is, consumers are aware of the identity, location, fees, and mix of services of alternative dental care providers.

The panel has identified a number of existing legislative provisions which can potentially impede competition by limiting the scope for innovation and flexibility in dental practices or which can directly constrain consumer choice.<sup>10</sup> The restrictiveness of professional registration stems from the protection of professional titles, areas of practice and prescribed duties. There are other legislative restrictions on business and advertising as well as on the utilisation of dental auxiliaries and advanced dental technicians.

### **4.1 Professional Registration and Protection of Title and Practice**

#### **4.11 Background**

In Victoria (as in most other jurisdictions), the dental workforce registration or licensing system is underpinned by legislation.<sup>11</sup> In addition to limiting practice to only those who have met minimum entry requirements, the registration scheme in Victoria extends to reservation of titles for registered persons.

Registration means the listing of the names (and other relevant details) of dental care providers on a register maintained by regulatory authorities. Registration is often extended to mean that only registered persons are permitted to use certain titles that are protected under the legislation. Dentists and dental specialists are registered and have reserved titles (for example, oral and maxillofacial surgeon). Unregistered persons cannot use the title 'dentist', 'dental practitioner', 'dental surgeon', 'surgeon dentist' or 'mechanical dentist'.

Licensing means that practise is restricted to only those individuals who are issued with licences. Sometimes only licensed persons are permitted to use reserved titles. Dental auxiliaries, advanced dental technicians and dental technicians are licensed to perform specific duties within dentistry. There is no clear title protection for dental auxiliaries. There is however title protection for the professional designations of 'advanced dental technician' and 'dental technician'. Similarly, unregistered persons cannot use the title 'dental technician', 'dental prosthetist' or 'dental mechanic'.

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<sup>10</sup> See *Review of Dentists Act 1972 and Dental Technicians Act 1972 Discussion Paper*, 1997.

<sup>11</sup> Dental assistants are neither registered nor licensed but they are 'regulated' within a supervisory relationship with dentists.

Currently the legislation specifically prohibits unregistered people from practising dentistry which is defined in the *Dentists Act 1972* as:

**Dentistry includes the performance of any operation upon the natural teeth and their associate parts of a person, the construction or adjustment of artificial teeth for a person, the giving of any dental treatment, attendance or advice to any person or the examination of the natural or artificial teeth of a person for any purpose.**

It is an offence for anyone to practise dentistry other than a registered dentist and persons in groups that are specifically exempted in legislation. The exceptions are:

- Registered medical practitioners.
- Dental students in a school approved by the board.
- Dental auxiliaries (and students) within prescription.
- Radiographers.
- Dental technicians and advanced dental technicians (and apprentices) in accordance with the *Dental Technicians Act 1972*.
- Anyone who provides emergency treatment without reward to a person who is in pain and no dentist or medical practitioner is available.

#### **4.12 Findings and Recommendations**

Professional registration and licensing (including the protection of title and practice) can impede competition by restricting market entry. Registration and licensing have the effect of limiting admittance to the profession (and hence marketplace) to those who are suitably qualified.

A registration scheme which relies upon a legislative definition of dentistry can dampen market competition by confining the practice of dentistry (or parts thereof) to those who are registered. It could also potentially curb the legitimate activities of allied health professionals and inhibit the development of new and associated professions.

Numerous submissions argued that the public will benefit from the protection offered by a registration and licensing system which preserves and maintains the standard of dental care offered by suitably trained dental care providers. Both these systems set the minimum entry standards and provide a means of identifying those who have attained the requisite level of training.

It is generally acknowledged that the marketplace for dental care (or any other good or service) works best when consumers are well-informed. In this regard, reserved titles are potential signals which can help to inform the public in their choice and selection of qualified dental care providers. Furthermore, reserved titles may also help to reduce the

one-off search costs borne by consumers in an unfamiliar marketplace for complex dental services.

To achieve the objective of minimising the public's exposure to the health risks in dentistry, the panel considers that only registered persons should be able to practise dentistry as defined in legislation. There are safeguards against a variety of health risks (some of which apply to dentistry) in other legislation such as the *Health Act 1958* and the *Drugs, Poisons and Controlled Substances Act 1981*. However, the coverage and effectiveness of the public protection extended by these legislation depends on complementary institutional arrangements which are not necessarily available in dentistry. For example, registered doctors are granted a provider number under Medicare, but there are no equivalent arrangements in dentistry.

There is a question of whether the extent of regulation which currently applies to the respective divisions of dentistry is commensurate with the riskiness of the activities under the respective divisions. An appraisal of the relative levels of public health risks in dentistry is provided in Appendix C. On the basis of this appraisal, the panel considers that practice and title protection would be the most effective way of dealing with the identified risks in dentistry.

The panel recommends that dentists, dental specialists, dental auxiliaries and advanced dental technicians should be registered in divisions which reflect the training requirements approved by a Dental Board; and that the following titles should be reserved for registered persons:

- Registered dentist, dental surgeon and dental practitioner.
- Registered dental specialist.
- Registered dental auxiliary.
- Registered dental prosthetist, advanced dental technician.

The panel considers that it would be more efficient for all divisions of the dental profession to be subject to registration (instead of registration for some divisions of the profession and licensing for others) because registration and licensing essentially achieve the same regulatory end.

The descriptive occupational titles of *dentist*, *dental surgeon* and *dental practitioner* were selected for their common usage in the community and the profession. A short list of reserved (that is, registered) titles is preferred over a longer list as the latter option may confuse consumers in the marketplace. The public is further protected by a provision in legislation which makes it an offence for any persons to use 'any other title calculated to induce a belief that the person is registered'. This provision will cover instances where an unregistered person employs the simple term 'dentist' to induce a belief that the person is a registered dental care provider.

The panel considers that the clinical expertise for determining evolving areas of specialities resides with the dental profession. Specialists should therefore be registered in areas defined and re-assessed by the board from time to time but the categories of specialties should not be prescribed in legislation. This means that if a person is qualified in a specialty recognised by the board, then the person may use the title specified by the board for example, 'orthodontist'. Persons not suitably qualified will not be able to use the title 'dental specialist' or any other title calculated to induce a belief that the person is qualified to practise in an area of speciality (for example, the term 'orthodontist' if this is a title specified by the board).

The generic term *dental auxiliary* is a flexible title that will accommodate an evolving area of professional practice in response to changing dental needs. Dental auxiliaries should be registered in areas defined and re-assessed by the board from time to time but the categories of dental auxiliary, as in the case of specialists, should not be prescribed in legislation. It is expected that dental auxiliaries will continue to be registered in the current areas of dental therapy and dental hygiene. It is possible that other titles may become relevant and deemed appropriate by the board as the scope of competencies evolve over time.

The panel agrees with a recommendation from the *Dental Auxiliary Workforce Review 1995* that the title 'advanced dental technician' be changed to 'dental prosthetist' to achieve consistency with preferred national terminology. Both the new term 'dental prosthetist' and the old term 'advanced dental technician' should be protected titles. It should also be an offence for dental prosthetists to hold him or herself out as a prosthodontist (dental specialist) under Victoria's health practitioner model, which should help to address concerns of possible public confusion.

The panel recommends the maximum penalty be imposed on an unregistered person using a reserved title or any other title calculated to induce a belief that the person is registered. The penalty should also apply to unregistered persons claiming registration or holding out to be registered, carrying out an act that is required to be carried out by a registered person or claiming to be qualified to practise.

It is intended that only qualifications approved by the board will lead to registration. However, there does exist the potential for public confusion if an educational institution title were to be used to suggest that graduation from the institution would lead to registration. In the same way that titles for practitioners provide protection, the panel also considers that there are net public benefits in retaining a select list of protected titles (*viz.* dental institute, dental hospital, dental college, college of dentistry, school of dentistry or similar titles) for educational institutions recognised by the board.

### **Recommendations**

3. *That dentists, dental specialists, dental prosthetists and dental auxiliaries be registered in divisions reflecting their qualifications.*
4. *That the titles registered dentist, dental surgeon, dental practitioner, dental specialist, dental auxiliary, dental prosthetist and advanced dental technician be reserved for registered persons only.*
5. *That the maximum appropriate penalty be available against unregistered persons who: use protected titles or other titles to induce a belief of registration; claim to be registered; hold themselves out as registered; carry out an act required to be carried out by a registered person; or claim to be qualified to practise dentistry.*
6. *That there be title protection for educational institutions approved by the board.*

The panel notes that dental technicians are expected to undergo a level of training before practising. However, dental technicians are not normally required to undertake duties which would expose the public to significant health risks for example, utilisation of restricted drugs and ionising radiation. Furthermore, clinicians who deal directly with dental technicians will have incentives (such as a desire to provide a safe service to consumers under their care) to contract with suitably trained dental technicians.

Therefore, the public benefit case for registering dental technicians (which includes title protection and prescribed duties) is not as compelling as that which applies to the other divisions of the dental profession.

Given the intrinsic restrictiveness of a registration system, the panel considers that there are less restrictive means of protecting the consumers of dental technician services. There are risks of cross-infection when impressions are sent to the laboratory for appliance construction or when dental technicians take shades from the consumer's natural teeth. However, these risks could be addressed by a professional code of optimal practice which might require clinicians to assure themselves that their dental technician of choice has undertaken the requisite training in infection control.

The panel has concluded earlier that only registered persons should be able to practise dentistry as defined in legislation to minimise the potential harm to the public. The panel received a number of submissions which argued that the public interest is best served by restricting dentistry (as defined in legislation) to those who are suitably trained and qualified.

The panel considered the range of definitions put forward by various submissions and decided on a definition which reflects the objective of minimising the public's exposure to the health risks in dentistry:

**Dentistry includes the diagnosis and management of conditions of the mouth and/or the performance of any invasive and/or irreversible procedure upon the natural teeth and/or associate parts for a person, and the construction and/or intraoral adjustment of artificial teeth or appliances for a person.**

The panel considers it appropriate to provide a new board with a power under legislation to develop a code of optimal practice on the question of what is or is not an allowable activity under the definition.

For example, a maternal and child health nurse using a mouth mirror is arguably practising dentistry under the proposed definition. It would not be appropriate for a code of optimal practice to reserve this low risk activity to a registered dental care provider. Conversely, it is expected that the same code of optimal practice would reserve dental extractions to a registered dental care provider with the requisite competencies because of the higher risks involved. Other non-registered dental personnel, such as dental assistants and dental technicians, should be able to perform activities that fall within the legislative definition so long as the attendant risk is no greater than if the activity had been carried out by a dentist. A new board should be charged with the function to outline these tasks in a code of optimal practice.

The role of Government in private dentistry does not extend beyond setting the appropriate standard of public health and safety that is expected by the community. The Government's main concern is in maintaining a threshold level of risk, below which public health would be threatened. It is expected that the board will give due regard to this principle in developing the code of optimal practice for the entire dental profession.

Duties should not be prescribed in legislation or subordinate regulation. Instead, all qualified and registered dental care providers should operate under the proposed definition of dentistry within their respective areas of competency. The panel considers that the best way to achieve dynamic efficiency gains is to allow 'self-determination' of competencies and training requirements by the profession. The dental profession is in a much better position (relative to a government) in determining the competency levels that are commensurate with a new or innovative dental procedure. It is expected that the board will consult the dental profession and educational institutions in developing the code of optimal practice in relation to competencies.

The new board should be given appropriate disciplinary powers to ensure that practitioners work within their competencies. If a dental auxiliary works outside of their competency then the supervising dentist and the dental auxiliary should be held responsible by the board.

As is currently the case, registered medical practitioners, students (of occupations that lead to registration under the Act) and any person who assists another person in pain without fee or reward (for example, in an emergency when an appropriately qualified person is not available) should be allowed to practise dentistry.

It should be an offence for unregistered persons to practise dentistry as defined in legislation and as outlined in the code of optimal practice. The panel recommends that the maximum appropriate penalty be made available against illegal practice of dentistry. Both the police and the board should have the power to prosecute non-registered persons practising dentistry.

### ***Recommendations***

- 7. That 'dentistry' be defined as 'includes the diagnosis and management of conditions of the mouth and/or the performance of any invasive and/or irreversible procedure upon the natural teeth and/or associate parts for a person, and the construction and/or intraoral adjustment of artificial teeth or appliances for a person' in the new Act.*
- 8. That all registered persons practise dentistry in accordance with competencies determined by the board.*
- 9. That there be the maximum appropriate penalty available against unregistered persons who practise dentistry.*

## **4.2 Business and Advertising Restrictions**

### **4.21 Background**

The panel notes that under the current legislation, the ownership of dental practices is restricted to registered dentists although the board has exercised its power to exempt certain organisations including the crown, health funds, municipal councils, public hospitals and community health centres.<sup>12</sup> Similarly, a person is not able to conduct, manage or be in charge of a dental laboratory unless the person is a dentist, dental technician or advanced dental technician.

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<sup>12</sup> Provisions in the current legislation such as dentists being required to practise in their own name, the exclusion of intermediaries and the types of employment that a dentist can engage in, which mean at a practical level to the Dental Board that only dentists can own dental practices.

Dentists and advanced dental technicians are also not permitted to advertise in a way that is false, deceptive or misleading; or to make disparaging remarks about their respective peers.

#### **4.22 Findings and Recommendations**

Restrictions on the ownership of dental practices and laboratories limit those with managerial skills from entering the market. Such restrictions also have the effect of inhibiting the development of new business approaches to organising dentistry and allied professional services. This legislative restriction may also distort the pattern of resource allocation in the overall dental industry. Finally, the restriction imposes an opportunity cost on the community in terms of the foregone innovation or efficiencies in dental service delivery.

The panel was presented with arguments in submissions that ownership restrictions should be retained for reasons of maintaining professional integrity and quality of dental care. There are concerns that an owner who is an unregistered dental care provider, may be driven by commercial imperatives to compromise the quality of care offered. There are also concerns that entrepreneurial ownership of dental practices would create insurmountable legal problems of accountability and compensation (or liability) in the event of dental misadventures.<sup>13</sup> However, there was no evidence presented to support the view that entrepreneurs or non-dental professionals are, relative to dental care providers, predisposed toward unethical behaviour.

The panel notes that the issue of professional integrity has not arisen with the ownership and operation of dental practices by bodies and organisations approved by the board. The panel accepts that vulnerable professionals could be influenced by unscrupulous entrepreneurial owners but notes that this scenario is no different from one where an unscrupulous dentist-owner seeks to influence and compromise the professional integrity of an employee-dentist. It is inconceivable that practising dentists or dental technicians would choose to maintain or abandon their ethical and professional norms according to the identity of the owner of a dental practice or laboratory. It could be expected that entrepreneurs would be just as wary as dental-owners, to ensure that quality care and services are provided to the public by competent employee-dental care providers.

The panel acknowledges that there are issues of accountability and liability if the restrictions on ownership of dental practices and dental laboratories are removed. However, the panel has been counselled that these issues can be addressed by existing corporate law and that remedies are also available under common law. Any owner, operator or partner of a dental practice, whether dentist or non-dentist, will be jointly and

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<sup>13</sup> According to this argument, the problems can be exacerbated by the use of shell companies.



severally liable under the tort of negligence for any dental misadventures of the employee-dentist.

In summary, the panel does not consider that ownership restrictions are necessary to achieving the public policy objectives of legislation for the dental profession. The panel supports the principle of professional integrity but notes that the ethical norms associated with professionalism do not necessarily offer any guidance on efficient ways of organising human and capital resources in dentistry.

The panel therefore recommends repeal of the direct or implied statutory restrictions on the ownership and operation of dental practices and laboratories. As a corollary, the panel also recommends that it should be an offence for an employer (dental or non-dental) to unduly influence an employee to perform dentistry in a manner detrimental to the welfare of the consumer.

### ***Recommendations***

*10. That there be no direct or implied legislative restrictions on dental practice or laboratory ownership.*

*11. That it be offence under the new Act for an employer to unduly influence an employee to perform dentistry in a manner detrimental to the welfare of the consumer.*

The panel notes that markets tend to perform better when consumers make informed choices on the basis of market signals and information. However, it would not be in the public interest to allow the dissemination of false, deceptive and misleading information.

The panel also notes that legislative safeguards against false, deceptive and misleading advertising currently exist in the Commonwealth *Trade Practices Act 1974* as well as in the State's fair trading legislation. However, the panel accepts that, enforcement of advertising prohibitions in a dental care marketplace could be more effectively handled by an industry-specific and, arguably, better resourced and dedicated regulator in the form of a professional Dental Practice Board.

With respect to dental professionals disparaging one another, the panel notes the argument that public confidence in the profession could be undermined if this behaviour was allowed to occur. This argument is not unique to the dental profession and it refers more to notions of desirable professional behaviour rather than to protection of the public from health risks. Remarks of a disparaging nature could be dealt with under the

common law of libel. Therefore, the panel is not persuaded that the legislative restriction on disparaging remarks is necessary to achieving the objectives of legislation.

### ***Recommendation***

*12. That false, deceptive or misleading advertising be an offence under the new Act.*

## **4.3 Restrictions on the Utilisation of Dental Auxiliaries**

### **4.31 Background**

Dental hygienists are a preventive dental auxiliary. The areas in which hygienists provide dental care include: dental health education, measurement of gum disease, cleaning teeth, taking impressions of teeth for study moulds, taking dental radiographs, checking for loose or broken orthodontic appliances and other orthodontic-related duties and fluoride applications.

Dental hygienists are required by law to work under the supervision, direction and control of a dentist although these terms are not defined in legislation. Usually the dentist examines the patient, makes a diagnosis and treatment plan, provides instructions to the dental hygienist for treatment and checks treatment on completion. Further, dental hygienists are legally required to work in a one-to-one ratio with a dentist in a dental practice.

Dental therapists are an operative dental auxiliary providing dental care to preschool, primary school and secondary school children. Their prescribed duties include: undertaking examinations, dental health education, taking dental radiographs, cleaning teeth, administration of local analgesia, placing fillings in deciduous and permanent teeth, fluoride applications, polishing fillings, extraction of deciduous teeth and placing preventive sealants.

Dental therapists are also required to work under the supervision, direction and control of a dentist although these terms are not defined in legislation. Dental therapists are not required to work in any specified ratio with a dentist. In practice, a dentist is usually not present when a dental therapist performs work. A dental therapist examines a patient, identifies some conditions and recognises others as abnormal and performs specified procedures. Dental procedures and services that a dental therapist is not qualified to perform are referred to a dentist.

By law, dental therapists can only be employed by the Department of Human Services or by a registered funded agency authorised by the Minister for Health. In effect, dental therapists can only work in the public sector.

Since 1996, Dental Health Services Victoria (DHSV) has been the only public agency authorised to provide the School Dental Service. Dental therapists make up about 80 per cent of the school dental clinical workforce and were first introduced in 1975 because of a shortage of dentists to cope with the high prevalence of dental decay in the 1960s and 1970s.

#### **4.32 Findings and Recommendations**

Although these restrictions are (technically) not anticompetitive in intention, they do create inefficiencies in the way in which human resources can be combined and deployed within the dental profession.

The one-to-one ratio is a form of input regulation which restricts the use of a complementary input in the production of dental care. Economic theory suggests that if a legal restriction on the use of a complementary input (that is, a hygienist) is binding, then the productivity of the unrestricted input (that is, the dentist) will decline relative to that of the restricted input.<sup>14</sup> Furthermore, the overall efficiency of a dental practice may be impaired when the restriction prevents dentists from using auxiliaries for tasks which they are qualified to perform. Evidence from overseas research suggests that restrictions on the use of dental auxiliaries then raises the price of dental procedures and the average price of a dental visit.<sup>15</sup>

The input restriction can also potentially impose a social cost by inadvertently denying the community access to proper dental care. For example, a dentist may be performing activities for which an auxiliary is also qualified to undertake. An auxiliary working within their competencies can then free the dentist for the more complex tasks commensurate with the dentist's skills and competencies.

The panel did not receive any evidence that the one-to-one supervisory ratio confers any net public benefits.

On the contrary, numerous submissions argued that there may be more efficient ways of combining resources to deliver dental services of a given quality standard. An artificial numerical constraint on the use of auxiliary inputs will only serve to narrow the options for a dental practice and indirectly discourages the development of team dentistry. As an alternative to a prescribed ratio, a registered dentist should be able to freely choose the team arrangements in accordance with their clinical and business judgement about the practice. If large numbers of dental hygienists were supervised by a single

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<sup>14</sup> De Vany AS et al. The Impact of Input Regulation: The Case of the US Dental Industry. *Journal of Law and Economics* 1982; Oct (XXV): 367-81.

<sup>15</sup> Liang JN, Ogur JD. *Restrictions on Dental Auxiliaries: An Economic Policy Analysis*, Bureau of Economics Staff Report, Federal Trade Commission, 1987.

dentist and quality deteriorated, then consumers would be likely to hear about the poor quality of the practice. To the extent that dental care is an 'experience good', dentists are unlikely to discount the incentive effect arising from the need to maintain a good market reputation.

The panel was not presented with any clinical evidence to support the proposition that hygienists should be allowed to work independently and without supervision by a dentist. The panel accepts that the practice of dentistry may well evolve along this direction but it should be incumbent upon the board to continually review and research the requisite competencies for such an eventuality.

Since the public benefit case for autonomous practice by hygienists has yet to be demonstrated, the panel recommends that the requirement for supervision be retained and that the new board be charged with the responsibility for detailing the appropriate supervision arrangements in a code of optimal practice.

In the past there have been various accepted definitions of supervision in the dental profession. However, the profession should not revert to the previous definitions documented by the existing Dental Board. The panel strongly supports a team approach to dentistry with dentists offering guidance and advice to dental auxiliaries. A modern definition of supervision should be cast in terms of the collegial arrangements that characterise a team approach to dentistry.

### **Recommendations**

*13. That the restrictive one-to-one ratio for dental hygienist-to-dentist be removed from the Regulations.*

*14. That the requirement for dental auxiliaries (dental hygienists) to work under the supervision of a dentist be retained in the Regulations until evidence based on sound clinical research shows that removing the requirement will not endanger public health and safety.*

Dental therapists are restricted because they can only provide services to clients of the School Dental Service. To the extent that these auxiliaries constitute a trained workforce, dental therapists could be utilised more efficiently in the delivery of dental care.

Enabling dental therapists to work in the private sector and for a greater number of public agencies could possibly benefit the public by lowering prices for dental services. Dentists could be potentially freed up for more complex procedures and the private sector may be able to tender competitively to provide school dental services.

Public health and safety objectives can be achieved without restricting the employment of dental therapists to the public sector. The distinction between a client of a dental therapist in the public or private sector is artificial and immaterial because the services provided and the risks involved are identical.

The panel notes that if the legislative restriction is removed and therapists are able to seek employment in the private sector, there may be implications for public dental programs (for example, School Dental Services) that are currently delivered by DHSV. In this regard, it would be important for DHSV to monitor, assess and (if necessary) deal with any service delivery implications in consultation with Government. It should be noted that Government can choose to meet its objectives for public dental health in a variety of ways, including the use of purchaser-provider arrangements and contracting.

As discussed earlier (see section 4.12), the panel has concluded that dental care providers should work within their competencies and that the appropriate areas of competency should be determined by the board in consultation with educational institutions and the dental profession.

The present competencies of dental therapists are targeted towards a specific client group comprising of persons aged 17 and younger. There is a possibility for dental therapists to upgrade skills and qualifications to expand duties in the future. The pilot project of the Australian Health Ministers' Advisory Council is one avenue for evaluating whether a dental auxiliary with additional training can provide a specified range of high quality care to adults in a more cost effective manner.

The panel notes that dental therapists work within the level of their competencies under minimal supervision. However, the public benefit case for autonomous practice by dental therapists has yet to be demonstrated on the basis of clinical evidence. The panel accepts that the practice of dentistry may well evolve along this direction and it should be incumbent upon the board to continually review and research the requisite competencies for such an eventuality.

The panel therefore recommends that dental therapists continue to work under supervision and that the new board be charged with the responsibility for detailing the appropriate supervisory arrangements in a code of optimal practice using the same principles discussed for dental hygienists.

## **Recommendations**

15. *That the public sector employment restriction on dental therapists be removed from legislation.*
16. *That the current practice which restricts dental therapists to treating persons aged 17 years and under be continued until evidence based on sound clinical research shows that removing the restriction will not endanger public health and safety.*
17. *That the requirement for dental auxiliaries (dental therapists) to work under the supervision of a dentist be retained in the Regulations until evidence based on sound clinical research shows that removing the requirement will not endanger public health and safety.*

## **4.4 Restriction on Advanced Dental Technicians**

### **4.41 Background**

Following a recommendation of the *Dental Auxiliary Workforce Review* in 1995, advanced dental technicians have been able to provide partial dentures directly to consumers in addition to full dentures and mouthguards. But a partial denture can only be provided if the consumer has a 'certificate of oral health' issued by a dentist within the previous 12 months.

The stated purpose of the oral health certification is to enable a dentist to confer with the consumer over the range of potential treatment options and to confirm for the consumer that there is no underlying condition that may adversely affect the planned treatment. At the time of introduction of partial dentures, no bridging course was available although a suitable course has since been developed.

### **4.42 Findings and Recommendation**

Although the intention of this requirement is to minimise the health risks to consumers, it also has the effect of constraining consumer choice and increasing the cost of dental care. The requirement imposes a compliance cost on consumers and the magnitude of this cost depends on a number of factors such as geographical location, ease of accessibility to dentists and the cooperation of local dentists. For example, it may be more difficult for a rural consumer to obtain a certificate of oral health if they do not wish to pay for an examination or other dental treatment provided by the dentist.

The 12 month validity for an oral health certificate does not appear to have any basis on health or clinical grounds because oral conditions can change significantly under 12 months. In some circumstances dentists have practised defensively by either issuing certificates with limited validity or refusing to issue any certificates.

The panel notes that, with the exception of Victoria and Queensland, no other Australian jurisdictions (where advanced dental technicians provide partial dentures) have the requirement for a dentist-issued oral health certificate.

Consumers should be free to choose on a cost basis whether they prefer certain (allowable procedures) to be done by dentists or advanced dental technicians. Retaining the requirement for an oral health certificate will continue to impose an unnecessary compliance cost on certain segments of the community. The utility of the oral health certificate has not been scientifically evaluated since it was first introduced and therefore it has not been possible to assess whether there have been any countervailing benefits to the public.

The panel recommends that the requirement for an oral health certificate be repealed after 12 months unless there is clinical evidence that doing so will endanger public health and safety.

***Recommendation***

*18. That the restriction of requiring an oral health certificate be repealed after 12 months unless there is clinical evidence that its repeal will endanger public health and safety.*







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## 5. *Administrative Issues*

As discussed in section 3, the panel acknowledges that a key objective of regulation is the protection of the community. A recent environmental approach to public health and safety regulation includes complementary mechanisms such as continuing maintenance of competence and community access to dental care.

Professional registration has a role in minimising the health risks and harm to the public although the panel's proposed focus is competency-based rather than 'point of entry' regulation.

The dental workforce is a single workforce that consists of interdependent professions sharing interrelated issues. Therefore, the panel proposes the establishment of a single regulatory authority, a body corporate called the Dental Practice Board, adopting the main features of Victoria's health practitioner model.

### **5.1 Regulatory Authority**

#### **5.11 Functions of a Dental Practice Board**

The Dental Practice Board should carry out its functions with regard to the public policy objectives of community access to dental care and minimisation of exposure to health risks in dentistry.

Proposed functions of the Dental Practice Board are:

- To register persons who comply with the requirements of the Act as to registration so that they may hold themselves out as registered under the Act.
- To approve courses which provide qualifications for registration under the Act.
- To investigate the professional conduct or fitness to practise of persons registered under the Act and impose sanctions where necessary.
- To promulgate a code of optimal practice.
- To advise the Minister on any matters relating to its functions.
- When so requested by the Minister, give to the Minister any information reasonably required by the Minister.
- Any other functions conferred on the board by the Act.

Importantly, clinical decision making about the practice of dentistry should rest with the professional board.

The Governor in Council should have the power to make regulations.

The board may delegate powers and functions to a member of staff of the board excluding the power to: grant or refuse registration, impose conditions on registration, conduct hearings, and the delegation power itself. The registrar or authorised member of the board may take proceedings for the board.

The board should be expected to take cognisance of the Minister's recommendations if the Minister believes that the board is not acting within the spirit of the Act.

## **5.12 Structure**

It is proposed that there be nine board members nominated by the Minister and appointed by the Governor in Council following public advertisement. Nine was deemed a reasonable number given the size of the workforce and the requirement for the board to be manageable but inclusive of all dental care providers.

Appointments should not exceed three years and reappointment should be possible.

Consistent with Victoria's health practitioner model, one lawyer and two lay persons should be appointed to the board. The appointment of non-dental members is consistent with a regulatory approach that promotes public interest.

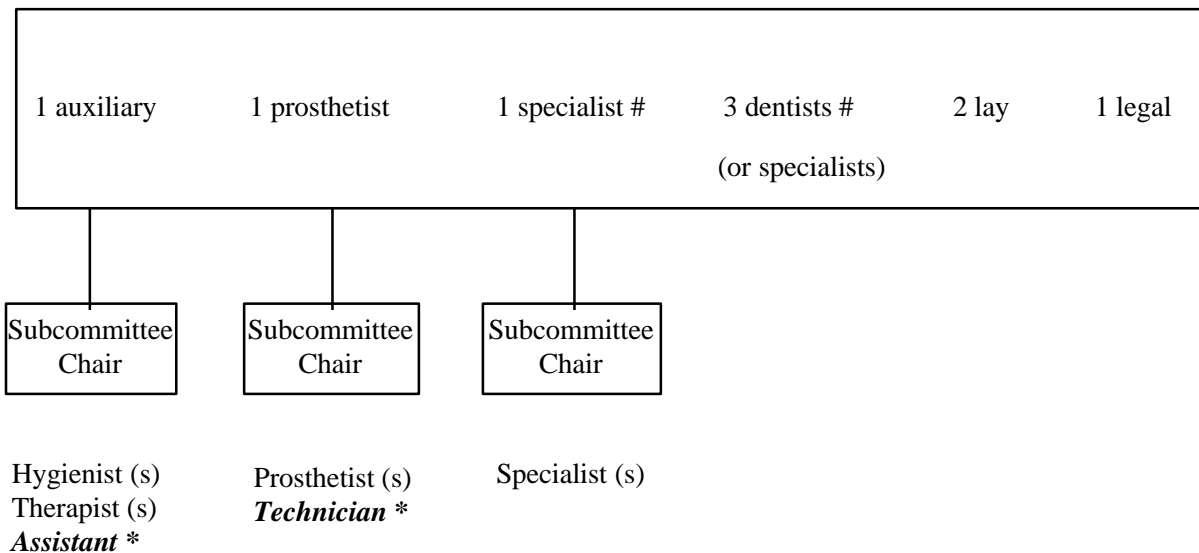
Other board members should be one dental prosthetist, one dental auxiliary (dental therapist or dental hygienist) and four dentists. At least one of these dentists should be a specialist.

The structure of the proposed Dental Practice Board reflects an expectation that boundaries between dental health professions will become more flexible in the future.

Further, there should be three subcommittees; one constituted of dental auxiliaries, one of dental prosthetists and technicians and one of dental specialists. Chairs of these subcommittees should be registered persons who are directly appointed as board members. Functions and membership of the subcommittees should be at the board's discretion. The inclusion of a dental assistant on the dental auxiliary subcommittee and a dental technician on the dental prosthetist subcommittee should be at the board's discretion. The board should also have the power to form any other subcommittees it may require from time to time for its own good practice.

The president and deputy president should be dentists (or dental specialists) nominated by the Minister and appointed by the Governor in Council following public advertisement. The deputy president should preside in the absence of the president. If both are absent, then board members should elect another dentist member to preside. The presiding person should have a deliberative and a second or casting vote when an even number of board members sit.

The proposed structure of the board is summarised below:



**Key:**

# = president and deputy president should be dentists or specialists

\* = inclusion should be at the board's discretion

Other recommended administrative features of the Dental Practice Board originating from the model include:

- Member may be removed if three consecutive meetings are missed without leave.
- Member may resign in writing.
- Governor in Council may at any time remove a member.
- Governor in Council may appoint an acting member.
- Fees and allowances are fixed by the Governor in Council (for board members and constituent subcommittee members).
- Majority of members constitutes a quorum.
- Subject to the Act, the board may regulate its own proceedings.
- Decision is not invalid if there is a vacancy or defect or irregularity in appointment of any members.
- Members' interests must be declared before the matter is considered at a meeting.
- Member with interest may take part in discussion but must leave when voting.
- Board may employ any persons necessary to maintain register and administer the Act.

### ***Recommendation***

*19. That a Dental Practice Board be established to promote access to dental care and to regulate dental professionals for the protection of the public.*

## **5.2 Registration**

### **5.21 Qualifications**

The panel recommends that a person be qualified for registration according to the model, that is, if that person has successfully completed a course of study approved by the board, has an equivalent qualification, passed an examination set by or on behalf of the board or has a dental qualification recognised in another State or Territory of the Commonwealth.

The board may choose to recognise courses accredited by the Australian Dental Council or equivalent.

Fraudulent registration should carry a penalty of 240 units (\$24,000) or imprisonment for a period of two years or both.

### **5.22 Refusal of Registration**

The panel recommends that the board should have the power to refuse registration on grounds consistent with the Victorian health practitioner model. That is, character not in the public interest, alcohol or drug dependence, guilty of an indictable offence, outstanding proceedings with the board, physical or mental impairment, insufficient competency in speaking or communicating English and previous cancellation or suspension.

The panel emphasises that refusal of registration on the above grounds should not be automatic but discretionary.

### **5.23 General and Specific Registration**

The panel recommends the Victorian health practitioner model for general and specific registration. This requires an application to be in writing with evidence of qualification and accompanied by the fee fixed by the board for 12 months. The applicant may also be required to provide evidence of insurance against civil liability in connection with dental practice.

Specific registration may be granted to enable an applicant to undertake supervised study or training, to fill a teaching or research position, to exchange practice with a registered practitioner or to meet an identified need. For example, a person who is not fully conversant in English may be registered specifically on an understanding that they work under the supervision of a dentist and agree to undertake a course in English within a certain timeframe.

The board should also have the power to impose conditions, limitations or restrictions on general and specific registration as it sees fit.

#### **5.24 Outcome of Application**

The panel recommends Victoria's model provisions which require the board to notify the applicant of the outcome and, if refused, the reason for refusal and information about the right of review. An appeal about a decision to refuse application (refuse renewal, impose conditions, limitations or restrictions) can be made within 28 days to the Victorian Civil and Administrative Tribunal.

If registration is granted, the board should issue a certificate of registration detailing the practitioner's name, qualifications, date of issue and any imposed conditions, limitations or restrictions. It should not be mandatory for a practitioner to display the certificate although this may be appropriate in a professional code of optimal practice.

If the registration of a practitioner has been suspended or cancelled, the registration certificate should be returned or a penalty of 20 units (\$2,000) may be imposed by the board.

#### **5.25 Renewal of Registration**

The panel recommends annual renewal of registration, applied for by the practitioner. The board may refuse renewal on the same grounds as refusal for granting registration. In addition, the board may refuse renewal of registration if the applicant has not had sufficient experience in dentistry in the preceding 5 years.

This latter requirement is a feature of the most recent Victorian health practitioner legislation. It ensures that the entry standard is maintained over a lifetime of the practitioner and is consistent with the panel's recommended regulatory approach.

#### **5.26 Register**

The panel recommends that the register should contain the model features, that is, the name, address or addresses, qualifications, initial registration date, number, details of any current suspension, condition, limitation or restriction and any other relevant matter

such as the division in which the person is registered. All registration details should be able to be accessed by the public excluding private addresses. A person should be able to obtain a copy of or an extract from the register on payment of a fee fixed by the board. Practitioners should notify the board of a change of any of their particulars on the register within 14 days or face a penalty of 10 units (\$1,000).

### ***Recommendation***

*20. That the Victorian health practitioner model for registration be adopted as described.*

## **5.3 Unprofessional Conduct**

The standard Victorian model for dealing with unprofessional conduct outlined in Appendix D is recommended by the panel.

This approach consists of a preliminary investigation conducted by an officer of the board, solicitor or investigator or subcommittee of the board of not more than three members. This is followed by options of proceeding no further, an informal hearing or a formal hearing depending on the board's determination.

Until investigation (and a hearing if necessary) is complete, the board may suspend a provider. The panel did not support the imposition of conditions on practice as an option because this is inappropriate if the public is potentially in danger.

The panel recommends the model definition of unprofessional conduct which is summarised as follows:<sup>16</sup>

- Professional conduct which is of a lesser standard than that which the public or peers might reasonably expect.
- Professional misconduct.
- Infamous conduct in a professional respect.
- Providing excessive health services.
- Influencing the conduct of a dental practice to compromise patient care.
- Guilty of:
  - an indictable offence.
  - an offence where ability to continue to practise is not in the public interest.
- An offence under this Act or any other Act.

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<sup>16</sup> The definition is detailed in the *Physiotherapists Registration Bill 1998*.

- Breach of the Code of Optimal Practice.

Informal hearings consists of not more than three board members including at least one peer provider. Members who conducted the preliminary investigation are excluded. The provider is not entitled to legal representation and the hearing is closed to the public.

A formal hearing consists of not less than three board members including at least one peer provider and one lawyer. Members who conducted the preliminary investigation and informal hearing (if held) are excluded. The provider is entitled to legal representation and the hearing is open to the public.

If there are not enough members to serve on panels or special expertise is required, the board may request the Governor in Council to appoint another person to a panel. A 'preapproved' list of suitable people, especially of lawyers, was accepted.

The penalties available for engaging in unprofessional conduct not of a serious nature are: counselling, caution, reprimand and education. The suggestion of the option of education was deemed a useful addition to the model by the panel. The penalties available for engaging in unprofessional conduct of a serious nature are: education, condition, limitations, restriction, suspension, penalty and a fine of 100 units (\$10,000) maximum which has been increased from the model of 20 units.

It is noted that the legislation should ensure that providers subject to investigation under the current legislation can continue to be investigated by the new board. Similarly, the legislation should ensure that providers under investigation can be pursued even if they choose not to renew their registration.

The panel does not support the costs of a hearing being recovered from the guilty provider as it was deemed inappropriate for the board to have a financial incentive to penalise providers.

### ***Recommendation***

*21. That the Victorian health practitioner model for unprofessional conduct be adopted as described.*

## **5.4 Impaired Dental Providers**

The standard Victorian model for dealing with impaired dental health providers outlined in Appendix E was recommended by the panel.

This approach consists of a preliminary investigation conducted by a board member when the board believes that a provider's ability to practise may be affected by physical or mental health, incapacity or alcohol or drug dependence. If agreeable, the impaired provider undergoes a medical examination by a medical practitioner.

Although it is expected that this medical practitioner would consult other health practitioners as necessary in forming an opinion, the panel accepts that the legislation should allow flexibility to draw on other expertise such as an infectious disease specialist or peer provider. Even though a team approach was deemed acceptable, the panel insists that the report must come from the medical practitioner.

The results of the medical examination are reported to the board and the impaired provider if the outcome is not prejudicial to their health. If the outcome is prejudicial to the health of the impaired provider then the report should be given to another medical practitioner and a peer provider as nominated by the impaired provider. The panel stresses it is essential that the peer provider is fully informed about the imperatives of communicating certain information in the report back to the impaired provider, especially when the impairment is of a psychiatric nature.

If the impaired provider does not agree to a medical examination then the matter should be referred to a formal hearing. The panel considers that although a formal hearing is open to the public, the individual provider's rights should be overridden by public interest. There is no place for an informal hearing (which is closed to the public) because the public is potentially at risk if the board has decided to pursue the matter.

In accordance with the current requirement under the *Medical Practice Act 1994*, medical practitioners should be required to report the ill health of any registered dental provider to the board; not just dentists, which is currently the case.

***Recommendation***

*22. That the Victorian health practitioner model for impaired providers be adopted as described.*





## *Appendix A: Terms of Reference*

### **National Competition Policy Review of Legislative Restrictions on Competition**

**Review of the *Dentists Act 1972, Dentists Regulations 1992, Dentists (Fees) Regulations 1996, Dentists (Qualifications) Regulations 1997, Dental Technicians Act 1972, Dental Technicians Regulations 1992, Dental Technicians (Fees) Regulations 1996 and Dental Technicians (Advanced Dental Technicians) Regulations 1996.***

#### **Terms of Reference**

The review of the dental legislation has been commissioned by the Minister for Health in accordance with the *Victorian Government Timetable for the Review and Reform of Legislation that Restricts Competition*, determined in accordance with National Competition Policy.

#### **Legislation to be Reviewed**

The review will examine the case for reform of legislative restrictions on competition contained in the *Dentists Act 1972, Dental Technicians Act 1972* and associated regulations in accordance with the *Victorian Government's Procedural and Methodological Guidelines for the Review of Legislative Restrictions on Competition*.

In particular, the review will provide evidence and findings in its report in relation to the following:

- Clarify the objectives of the legislation.
- Identify the nature of the restrictions on competition.
- Analyse the likely effect of the restriction on competition and on the economy in general.
- Assess and balance the costs and benefits of the restriction.
- Consider alternative means of achieving the same result including non-legislative means.

In examining reform options, the review will also examine the applicability of key administrative features of the model health practitioner legislation.

In examining reform options, the review will also examine the applicability of recommendations from *Future Directions of Dental Health in Victoria* (August 1995) and the *Dental Auxiliary Workforce Review* (March 1995).

The review will also examine efficiencies through modernisation and integration of legislation across dental professional groups and the removal of any regulatory duplication.

## **Reform Options**

The review should specifically address the appropriateness of removing professional and business restrictions in the dental profession such as:

- The regulation of entry into registration/licensing.
- The division of professional services into areas of practice.
- Professional conduct and how it is regulated.

It should also ensure consumers are adequately informed of the qualifications of each dental professional and also facilitate interstate practice under mutual recognition.

## **Review Arrangements**

This review is to be established and conducted in accordance with review Model 2, (semi-public) contained in the guidelines. This will entail a call for public submissions and targeted consultation with a reference group and a range of other key stakeholders at the discretion of the review panel.

## **Key Dates**

Public notice/call for submissions will be made by December 1997 when a discussion paper is released. Submissions should be provided to the review secretariat by early March 1998. The review panel will report its findings and recommendations to the Minister in July 1998.

A discussion paper and the recommendation report will be submitted to the Department of Human Services Steering Committee for Legislative Review under National Competition Policy.

## **Secretariat**

The review secretariat will support the review panel by managing the consultation process and compiling public comments for the panel's consideration.

The review secretariat will be located in the Division of Aged, Community and Mental Health, Department of Human Services. The contact details of the secretariat are phone 9616 8697, fax 9616 6130 or address: Dental Health Unit, Level 2 /555 Collins Street, Melbourne, 3000.



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## *Appendix B: The Dental Workforce*

	<b>Dentist</b>	<b>Dental specialist</b>	<b>Dental hygienist</b>	<b>Dental therapist</b>	<b>Dental technician</b>	<b>Dental prosthetist</b>	<b>Dental assistant (nurse)</b>
<b>Approx. number registered/licensed.</b>	2,415 including specialists		64	234	375	333	No statutory register.
<b>Training in Victoria.</b>	5 year Bachelor of Dental Science, The University of Melbourne.	Dental degree plus 2 year postgraduate degree. Oral and maxillofacial surgery is approximately 8 years.	2 year Diploma in Oral Health Therapy, The University of Melbourne.	2 year Diploma in Oral Health Therapy, The University of Melbourne.	4 year apprenticeship through Royal Melbourne Institute of Technology - Certificate level 1V.	Dental technician with Advanced Diploma through Royal Melbourne Institute of Technology - Certificate level V1.	No formal training required.
<b>Dental services provided.</b>	Provide full range of oral care.	Perform more complex procedures of a particular discipline.	Under supervision, perform prescribed preventive services.	Under supervision, perform prescribed dental services including examinations, preventive services, some fillings, and extractions.	On prescription or under supervision, make or repair dentures, crowns, bridges and other oral appliances.	Duties of a dental technician plus full dentures, mouthguards and partial dentures direct to public.	Under supervision, provide assistance to dental providers eg. chairside assistance, handling dental materials and equipment and practice administration.
<b>Requirement to be registered/licensed with a regulatory authority.</b>	Yes. The Dental Board of Victoria.	Yes. The Dental Board of Victoria.	Yes. The Dental Board of Victoria.	Yes. The Dental Board of Victoria.	Not clearly stated in legislation. Dental Technicians Licensing Committee.	Yes. Advanced Dental Technicians Qualifications Board.	No.
<b>Title e.g 'dentist', 'dental technician' reserved for registrants/licensed persons only.</b>	Yes.	Yes.	Not clearly identified.	Not clearly identified.	Yes.	Yes.	Not registered.

	<b>Dentist</b>	<b>Dental specialist</b>	<b>Dental hygienist</b>	<b>Dental therapist</b>	<b>Dental technician</b>	<b>Dental prosthetist</b>	<b>Dental assistant (nurse)</b>
<b>Practice of dentistry restricted to registrants/licensed persons only.</b>	Yes. Dentistry defined in Act.	Yes. Specialties within dentistry are listed but not defined in legislation.	Specific duties within dentistry prescribed for dental hygienists.	Specific duties within dentistry prescribed for dental therapists.	Specific duties within dentistry prescribed for dental technicians.	Specific duties within dentistry prescribed for advanced dental technicians.	Not registered.
<b>Supervision.</b>	n/a.	n/a.	Work under the supervision, direction and control of a dentist in a 1:1 ratio.	Work in the public sector under the supervision, direction and control of a dentist. Legally able to provide limited services to preschool age children and primary and secondary school children.	Work to the prescription of or under the supervision of a dentist or advanced dental technician.	Deal directly with the public for provision of full dentures and mouthguards. Provide partial dentures if the consumer has first obtained a certificate of oral health from a dentist.	Work under the supervision of a dental provider although this is not stated in any legislation.





## *Appendix C: Public Health Risks and Existing Regulation*

The major public health risks in dentistry are summarised below.

<b>Risk category</b>	<b>Health risk</b>	<b>Persons at risk</b>
Infection	Infectious diseases for example, hepatitis, HIV, tuberculosis	<ul style="list-style-type: none"><li>• General public</li><li>• Consumer</li><li>• Non-dental providers for example, receptionist, cleaner</li><li>• Dental Providers:<ul style="list-style-type: none"><li>– Dentist</li><li>– Dental auxiliaries</li><li>– Dental assistant</li><li>– Dental Prosthetist</li><li>– Dental Technician</li></ul></li></ul>
Radiation	Somatic effects for example, cancer Genetic effects for example, birth defects	<ul style="list-style-type: none"><li>• Consumer</li><li>• Non-dental providers</li><li>• Dental Providers:<ul style="list-style-type: none"><li>– Dentist</li><li>– Dental auxiliaries</li><li>– Dental assistant</li></ul></li></ul>
Drugs	Access to restricted substances for inappropriate personal use or illegal dentistry	<ul style="list-style-type: none"><li>• General public</li><li>• Non-dental providers</li><li>• Dental Providers:<ul style="list-style-type: none"><li>– Dentist</li><li>– Dental auxiliaries</li><li>– Dental assistant</li></ul></li></ul>
Behaviour	Post traumatic stress or other adverse outcomes	Consumer
Competence	Morbidity and mortality including dental morbidity and mortality	Consumer

This section describes some of the Victorian Acts and Regulations relevant to public health risks in dentistry. For infection, radiation and drugs, legislation is aimed at employing preventive measures with penalties for failure to take these measures.

In the case of behaviour, the legislation provides for mechanisms to deal with inappropriate behaviour once it has occurred.

For competency, professional registration/licensing boards set minimum requirements. However, issues relating to quality of treatment are usually dealt with by the Health Services Commissioner who may consult professional associations. Consumers may also seek redress in the courts if a duty of care has been breached and harm is caused.

## **Infection**

All dental providers, consumers and the wider public are at risk of infectious diseases in dentistry. These include those transmitted by inoculation such as Hepatitis B and C and HIV and by inhalation such as tuberculosis. The risk of seroconversion to Hepatitis B and HIV respectively through occupational transmission (for example, needlestick injury) has been documented as 20-25 per cent<sup>17</sup> and 0.29 per cent<sup>18</sup> respectively. Estimates for Hepatitis C from parenteral exposure are 3 per cent<sup>19</sup> and 1.7-6.2 per cent.<sup>20</sup> Risks to patients from infected health care workers are less well-documented and for HIV has been given as between 1:42,000-1:1,000,000.<sup>21</sup>

The *Dentists Regulations 1992* state that a dentist must ensure that premises are clean and hygienic and steps are taken to prevent or contain the spread of infectious diseases. Since 1991, the Dental Board has conducted 14 hearings under the *Dentists Act 1972* of registered dentists for inadequate infection control. The Dental Board uses the National Health and Medical Research Council's Infection Control in the Health Care Setting (April 1996) as its standard.<sup>22</sup> Standards Australia also publishes a standards for cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment and maintenance of associated environments in health care facilities.

Under the *Occupational Health and Safety Act 1985* employers are required to, provide and maintain a working environment that is safe and without risks to health. There were 27 reported workcover claims for open wounds in dentistry which increase the risk of infection since 1985-86 and three in dental laboratories.<sup>23</sup>

Under the *Environment Protection Act 1970* it is an offence to cause an environmental hazard with biomedical waste. The Dental Board has held 12 hearings since 1991 under the *Dentists Act 1972* into professional misconduct of registered dentists related to unacceptable biomedical waste disposal.

## **Radiation**

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<sup>17</sup> Wood PR. *Cross Infection Control in Dentistry: A Practical Guide*. Wolfe Publishing, England, 1992.

<sup>18</sup> Henderson DK, Fahey BJ, Willy M, Schmitt JM, Carey K, Koziol DE, Lane HC, Feido J, Saah AJ. Risk of Occupation Transmission of Human Immunodeficiency Virus Type 1 (HIV-1) Associated with Clinical Exposures. *Annals Int Med* 1990; 113(10): 740-746.

<sup>19</sup> Australian Dental Association (Vic Branch) submission to the Dental Legislation Review, 1998.

<sup>20</sup> Moinari A. Hepatitis C Virus Infection. *Dent Clin North Am* 1996; 40(2): 309-25.

<sup>21</sup> Australian Dental Association (Vic Branch) submission to the Dental Legislation Review, 1998.

<sup>22</sup> *The Dental Board of Victoria Bulletin*, Issue 2/96, August 1996.

<sup>23</sup> Victorian Workcover Authority. Claims reported as at 30 June 1997.



Dentists, dental auxiliaries, dental assistants and consumers are at risk from radiation. Radiation in dentistry is classified as ionising, that is, it has the ability to alter the atoms which make up biological tissue. Some effects of radiation require a threshold dose to manifest, however it is most unlikely that the threshold below which no effects will occur will ever be exceeded in consumers subjected to dental radiation.<sup>24</sup> Other effects which do not require a threshold dose, such as fatal malignancy, have been estimated at 1.3 cases per million panoramic radiographs.<sup>25</sup>

Under the *Health Act 1958*, a person must not operate an ionising radiation apparatus ('x-ray machine') unless the person is a holder of a licence. Licence categories include: dentist, dental therapist and dental hygienist. Furthermore, a person must not use an ionising apparatus unless it is registered under Health Act 1958. The *Health (Radiation Safety) Regulations 1994* specify safety precautions and personal monitoring requirements. The National Health and Medical Research Council published a *Code of Practice for Radiation Protection in Dentistry* (1987) and recommendations for limiting exposure to ionising radiation in 1995. Standards Australia has developed standards for dental radiographic film and x-ray machines which minimise radiation.

The Dental Board has held two hearings since 1991 under the *Dentists Act 1972* into professional misconduct of registered dentists related to unregistered dental x-ray machines. Under the *Occupational Health and Safety Act 1985* employers are required to provide and maintain a working environment that is safe and without risks to health.

## Drugs

Access to drugs, poisons, controlled substances and drugs of dependence is a potential risk to dental providers who work where these substances are stored and used (usually dentists, dental assistants and dental auxiliaries). Also, members of the public are at risk if they access these substances for their own inappropriate use or if persons illegally practising dentistry are supplied with these substances.

The *Drugs, Poisons and Controlled Substances Act 1981* entitles dentists to obtain, possess, use, sell or supply most poisons, controlled substances and drugs of dependence. The *Drugs, Poisons and Controlled Substances Regulations 1995* set out the obligations of dentists such as the requirement to store certain substances in a lockable storage facility. Since 1991, the Dental Board has conducted 13 hearings under the *Dentists Act 1972* into the professional conduct of registered dentists related to failing to secure restricted substances.

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<sup>24</sup> Keur JJ. Radiographic Screening of Edentulous Patients: Sense or Nonsense? A Risk-Benefit Analysis. *Oral Surg Oral Med Oral Pathol* 1986; 62: 963-7.

<sup>25</sup> Wall BR, Kendall GM. Collective doses and risks from dental radiology in Great Britain. *Br J Radiol* 1983; 56: 511-16.

The Act also sets out offences regarding unauthorised persons possessing or supplying drugs and licensed persons supplying drugs to unauthorised persons. Since 1994, there have been five documented cases of unregistered persons practising dentistry in possession of schedule four drugs (for example, local anaesthetic) and one person in possession of drugs of dependence.<sup>26</sup>

## **Behaviour**

The behaviour of the dental provider is a risk for the consumer directly involved who may, as a result of inappropriate behaviour, suffer post traumatic stress and other adverse health outcomes.

The *Health Services (Conciliation and Review) Act 1987* provides an independent and accessible review mechanism for users of health services. The Health Services Commissioner categorises behavioural issues as access to care, communication, cost and rights.

Since 1991, the Dental Board has conducted five hearings under the *Dentists Act 1972* into the professional conduct of registered dentists related to failure to ensure confidentiality of records (1), issue of inappropriate accounts(1), failure to keep accurate dental records (2) and abuse of the position as a dentist to foster a sexual relationship (1).

Under the *Dental Technicians Act 1972*, dental technicians and dental prosthetists can be investigated for improper or discreditable conduct.

Other more serious social offences such as fraud are dealt with under the *Crimes Act 1958*. Since 1991, the Dental Board has conducted five hearings under the *Dentists Act 1972* into the professional conduct of registered dentists related to fraud.

## **Competence**

The dental consumer is at risk from inadequacies in examination, diagnosis, treatment planning and treatment performed. The risk is variably present, depending on the dental provider. For example, dental hygienists do not examine, diagnose or treatment plan - competency in this case is limited to the actual treatment performed. Dental technicians contribute to treatment provision by manufacturing appliances requested by the clinician but dental technicians do not examine, diagnose or develop treatment plans. Minimum competency standards are set through a registration system. However, cases relating to standards of treatment are usually dealt with by the Health Services Commissioner who may involve professional associations. The Health Service

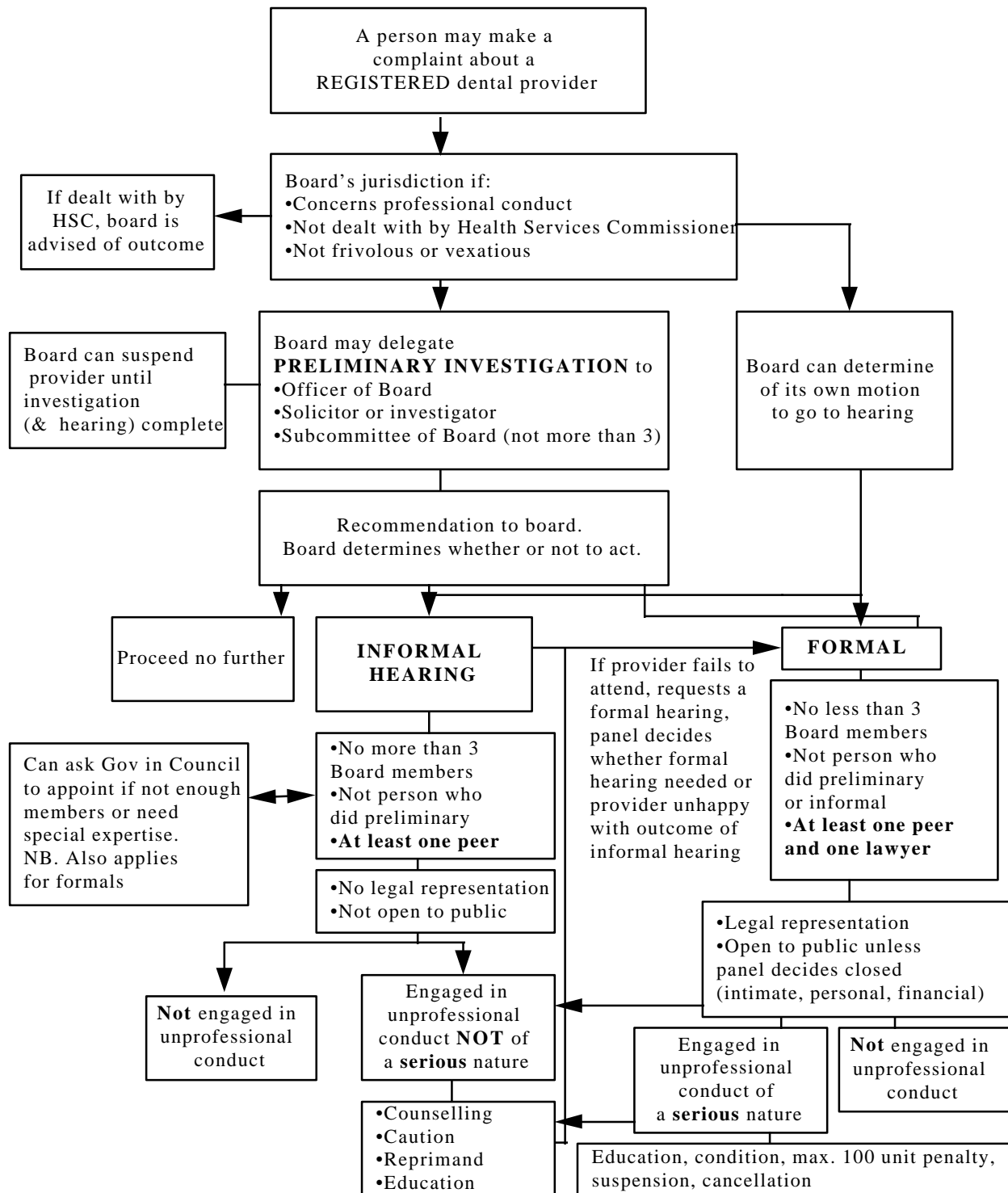
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<sup>26</sup> The Dental Board of Victoria files.

Commissioner classifies complaints about treatment into the following categories: inadequate diagnosis, inadequate treatment, medication, negligent treatment, rough treatment, unskilful treatment, wrong diagnosis and wrong treatment. Consumers may also seek civil redress in the courts if a duty of care is breached and harm is caused.

Under the *Dental Technicians Act 1972*, dental technicians and dental prosthetists can be investigated for incompetent practice. Both the *Dentists Act 1972* and the *Dental Technicians Act 1972* have provision for dealing with dental providers suffering ill health who may pose a risk to public health and safety.

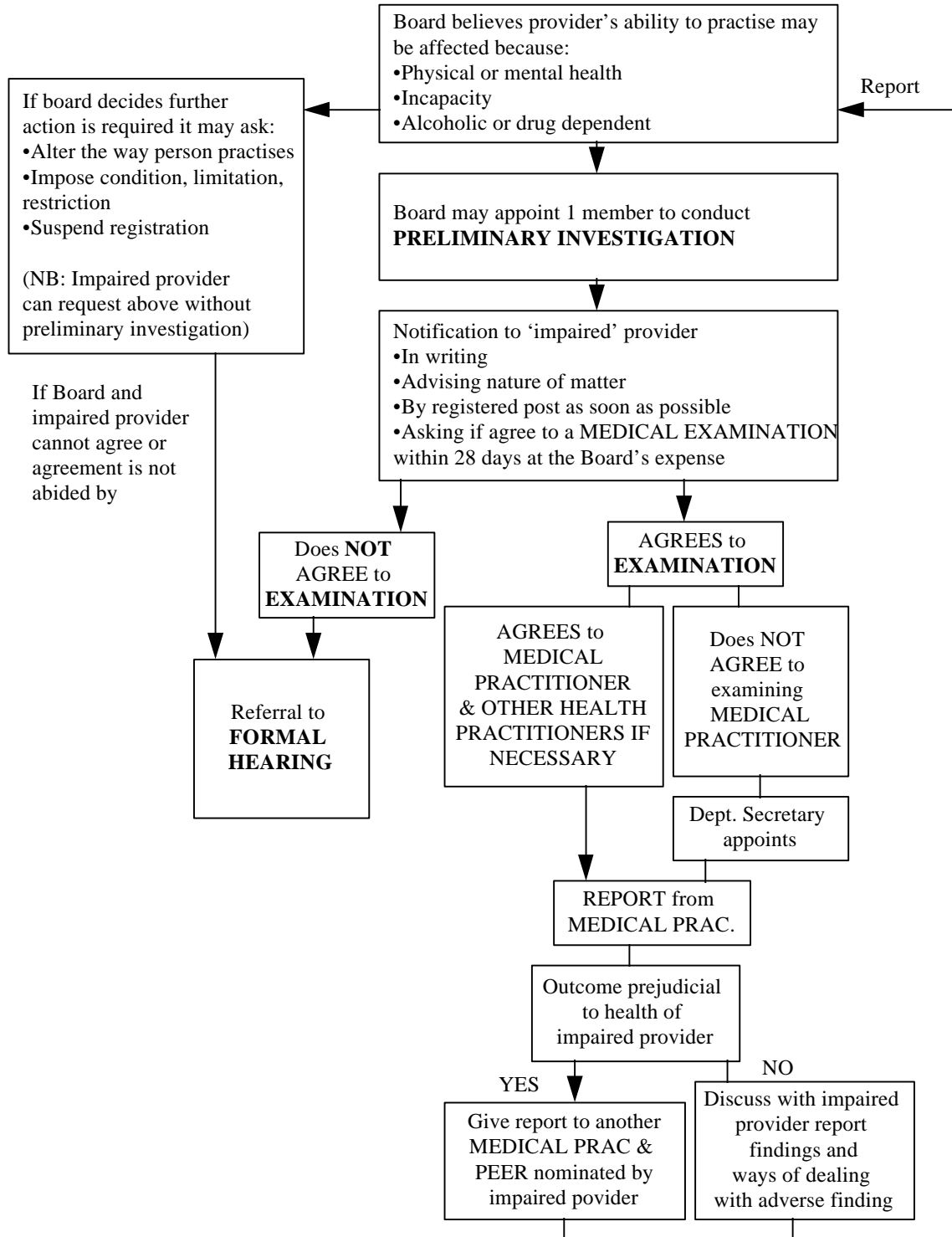








# Appendix E: Impaired Provider Model









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## *Appendix F: List of Submissions*

### **Individuals**

J Lipshatz  
G Morris  
D Adams  
G Wexler  
H Atkinson  
J De Klijn  
P & C Martin  
D Fenwick  
J Harcourt OAM  
A Cherk  
L Moloney  
M Perrin  
D Colbourne  
W McGlone  
C A McAliece  
J Uren  
D Pavia  
M Kiely  
H Orams  
G Howell  
E Crawford  
G Jankoff  
T Synnot  
P Fitz-Walter  
C & W Ang  
J Rasmussen  
R King  
J Graham  
M Vitagliano  
M Aldred  
R Gower  
R Hindle  
E Amon, D Pavia, T Stolz & A Wood  
T Sudjalim  
W Knapp  
T Ang  
M Stephens  
P Tan  
S Chandu  
W Fary  
H Best  
W Chow  
R Kelly  
J Locke  
P Pirnat  
T Deen  
S Harris  
J Evans  
M Spencer  
E Perry & P Woodruff  
Health Services Commissioner  
Bachelor of Dental Science Students

## **Organisations**

Australian & New Zealand Academy of Endodontists  
Australian & New Zealand Academy of Prosthodontists  
Australian Society of Orthodontists (Vic Branch)  
Dental Assistants' Association of Australia (Vic Branch)  
Maryborough District Health Service  
Private Dental Surgeries Association  
Australian Dental Association (Vic Branch)  
The Dental Board of Victoria  
Dental Health Services Victoria  
Australian Health Professionals Association  
Ministerial Advisory Committee on HIV/AIDS and Related Diseases  
Dental Hygienists Association of Australia (Vic Branch)  
Victorian Dental Therapists Association  
Melbourne Dental Students Society  
Co-operative Federation of Victoria  
Advanced Dental Technicians Qualifications Board Victoria/Dental Technicians  
Licensing Committee  
HIV Dental Education Association  
Australian Society of Periodontology (Vic Branch)  
Australian Dental Association  
Australian & New Zealand Association of Oral and Maxillofacial Surgeons (Vic  
Members)  
Australian Commercial Dental Laboratories Association  
Royal Australasian College of Dental Surgeons  
Dental Hygienists' Association of Australia  
School of Dental Science, The University of Melbourne  
Australian Dental Council  
Oral Health Special Interest Group of the Public Health Association of Australia  
Moreland City Council  
Commonwealth Department of Veterans' Affairs  
Medical Practitioners Board  
Dental Prosthetist and Dental Technicians Association of Victoria  
Australian Dentists Trained Overseas Association  
Allied Professional Health Care Pty Ltd  
Diamond Valley Hospital