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Australian dental policy reform and the use of dental therapists and hygienists

By
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submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

Deakin University December 2002
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CANDIDATE DECLARATION

I certify that the thesis entitled

Australian dental policy reform and the use of dental therapists and hygienists

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I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

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ABBREVIATIONS & ACRONYMS

ACDLA Australian Commercial Dental Laboratories Association
ADA Inc. Australian Dental Association Incorporated (Federal parent body)
ADANSWB Australian Dental Association New South Wales Branch
ADATB Australian Dental Association Tasmanian Branch
ADA VB Australian Dental Association Victorian Branch
ADC Australian Dental Council
ADTA Australian Dental Therapists Association
AHMAC Australian Health Ministers Advisory Council
ATDQB Advanced Dental Technicians Qualifications Board (Regulatory authority under Victorian 1972 Dental Technicians Act)
CDHP Commonwealth Dental Health Program (ran from 1994-1996)
COAG Council of Australian Governments (colloquially, the Premiers Conferences)
CORA Council of Regulating Authorities (National body convened to deal with dental technicians and prosthetists standards of practice, qualifications and training, does not accredit courses of training)
DAAA VB Dental Assistant’s Association of Australia, Victorian Branch
DAWR Dental Auxiliary Workforce Review- carried out in Victoria in 1996 in response to the proposal to move dental auxiliary education to the University of Melbourne
DBV Dental Board of Victoria (Regulatory authority under the Victorian 1972 Dentists Act)
DHAA Inc. Dental Hygienists Association of Australia (Federal)
DHAANSWB Dental Hygienists Association of Australia New South Wales Branch
DHAA VB Dental Hygienists Association of Australia Victorian Branch
DHS Department of Human Services (Victorian state government, covers health, aged and community services portfolios since 1996, previously called the department of Health and Community Services (DH&CS)
DHSV Dental Health Services Victoria (provider agency for public sector dental services in Victoria)
DTLC  Dental Technicians Licensing Committee (Regulatory authority under Victorian 1972 Dental Technicians Act)
NCC  National Competition Council (Commonwealth statutory body with authority to oversee implementation of the National Competition Policy)
NCP  National Competition Policy
NSWDTA New South Wales Dental Therapists Association
TDHHS Tasmanian Department of Health and Human Services
TDTA Tasmanian Dental Therapist Association
VDTA Victorian Dental Therapist Association

DEFINITIONS

**Advanced Dental Technician:** (Also known as dental prosthists) A dental technician with additional training to allow for independent practice ie. direct contact with the public in the prescription, manufacture and supply of dentures, partial dentures and mouthguards. ADT’s with an endorsement to do so are able to supply and fit partial dentures. Until 2002, Victorians seeking the services of an ADT for partial dentures must first acquire a Certificate of Oral Health from a dentist. Licensed to practice in Victoria by the Advanced Dental Technicians Qualifications Board under the 1972 Act and as dental prosthetists under the 1999 Act.

**AHMAC Pilot Proposal:** A proposal which was endorsed by AHMAC in 1995 was to establish a pilot program to test whether a dental auxiliary with additional training can provide a specified range of high quality care to adults in a more cost effective manner than previously, while maintaining standards consistent with existing service provision. Funding for the pilot came from the state Health Departments and had the support of all the state public sector Dental Directors who together, acted as consultants to the project. Victoria and NSW agreed to host pilot sites. An
aggressive campaign by the ADA managed to delay the project until the funding ran out. It is still on AHMAC’s agenda but has been relegated to inactive status.

**Dentistry:** The provision of dental care; dentistry is carried out by a range of registered and non-registered dental care providers: dentists, dental specialists, dental therapists, dental hygienists, dental technicians, dental prosthetists, and dental assistants.

**Dental Auxiliary:** A generic term used to describe a profession that is complimentary to dentistry; usually applies to both dental therapists and dental hygienists.

**Dental Caries:** disease of the hard tissues of the teeth, dental decay.

**Dental Hygienist:** A primary dental care provider (auxiliary) focusing on the prevention of oral disease in all age groups, particularly periodontal disease. Periodontal diseases involve the breakdown of the supporting structures of the teeth which can end with tooth loss. Their skills include charting, cleaning and polishing of teeth and restorations, root debridement for the prevention and treatment of periodontal disease, fluoride application and orthodontic assistance, radiography, oral health counselling and education and in some states, the application of fissure sealants and local anaesthesia. Dental hygienists in Australia have provided treatment under the prescription of a dentist who must be on-site and may only employ one hygienist at a time. They may be employed in both the public and private sectors but mostly work in the private sector. Training in Victoria comprises a two year tertiary Diploma course at the University of Melbourne, in South Australia it requires a two year TAFE Diploma requiring dental nursing qualifications for entry and in Queensland is part of a three year degree program which also includes dental therapy.

**Dental Prosthodontist:** Advanced Dental Technicians’ preferred title

**Dental Specialist:** A dentist who possesses a higher degree or qualification and expertise in a special branch of dentistry. Such dentists usually limit their practice to this branch and must be registered by the Board. Specialist branches of dentistry in Victoria include Endodontics, Orthodontics, Periodontics, Prosthodontics, Oral and
Maxillofacial Surgery (which also requires registration as a Medical Practitioner)
Oral Radiology, Public Health Dentistry, Forensic Dentistry and Special Care
Dentistry.

**Dental Technician or dental mechanic**: Manufactures dental prostheses (eg
dentures, partial dentures, crowns, bridges) and appliances (eg. orthodontic plates)
under prescription from a dentist, specialist or prosthelist. Trained under
apprenticeship; until 1999 licensed by the Dental Technicians Licensing Committee
in Victoria but not universal. Do not have direct contact with the public.

**Dental Therapist**: An operative primary dental care provider (auxiliary) whose
focus is the prevention and treatment of oral diseases in children and adolescents,
particularly dental caries. Their skills include examination, radiography, preventive
interventions such as fluoride therapies and fissure sealants, restoration (fillings) of
teeth including pulpotomies and extractions of deciduous teeth, oral health
counselling, education and health promotion. Dental therapists have (until June
2000) provided treatment under the general supervision of a dentist in the public
sector, and refer treatment beyond their skills to a dentist. Training has moved from
state auspiced schools to the University sector all states other than NSW. Victoria,
New South Wales and Western Australia offer two year Diploma courses and
Queensland and South Australia offer three year degree courses which also include
dental hygiene training.

**Dentist, Dental Surgeon**: A dental care provider who can provide any aspect of care
required to achieve oral health according to their competencies. Qualification in
most states requires a five year university course eg. Bachelor of Dental Science. In
some states a voluntary intern program exists and some universities are considering
graduate entry.

**Fissure Sealant**: A resin coating applied to the chewing surfaces of the teeth (over
the fissures) to prevent dental decay.

**Oral Health Therapist**: A dental auxiliary qualified in both dental therapy and
dental hygiene. In Victoria this requires completion of the Diploma in Oral Health
Therapy (dental therapy) and completion of the additional one year lateral entry
program in dental hygiene or vice versa. In Queensland and South Australia, oral
health therapists graduate with a Bachelor of Oral Health Therapy completed in an integrated program over three years at the Universities of Queensland and Adelaide respectively.

**Periodontal disease**: Pathology or disease of the gum and supporting tissues of teeth

**Practice protection**: Defining the practice area of a health care profession under legislation. For example, the Victorian Dental Practice Act of 1999 contains a definition of dentistry which has the effect of prescribing the boundaries of dental practice so that only those registered under the Act may practice in that area ie only registered dental care providers may provide dental care; physiotherapists or nurses may not.

**Pulpotomy**: A treatment carried out on the nerve of badly decayed teeth to preserve their presence and function- most commonly applied to deciduous (first) teeth in children.

**Title protection**: Refers to the protection of certain titles by an Act for registered practitioners alone (eg dentist, nurse, medical practitioner, dental surgeon). It is therefore an offense for a person not registered by that Act to use the title or give the impression that they are registered under the Act.
ABSTRACT

Oral diseases including dental caries and periodontal disease are among the most prevalent and costly diseases in Australia today. Around 5.4% of Australia’s health dollar is spent on dental services totalling around $2.6 billion, 84% of which are delivered through the private sector (AIHW 2001). The other 16% is spent providing public sector services in varied and inadequate ways. While disease rates among school children have declined significantly in the past 20 years the gains made among children are not flowing on to adult dentitions and our aging population will place increasing demands on an inadequate system into the future (AHMAC 2001). Around 50% of adults do not receive regular care and this has implications for widening health inequalities as the greatest burden falls on lower income groups (AIHW DSRU 2001).

The National Competition Policy agenda has initiated, Australia-wide, reviews of dental legislation applying to delivery of services by dentists, dental specialists, dental therapists and hygienists and dental technicians and prosthetists. The review of the Victorian Dentists Act 1972, was completed first in 1999, followed by the other Australian states with Queensland, the ACT and the Northern Territory still developing legislation. One of the objectives of the new Victorian Act is to “…promote access to dental care”. This study has grown out of the need to know more about how dental therapists and hygienists might be utilised to achieve this and the legislative frameworks that could enable such roles.

This study used qualitative methods to explore dental health policy making associated with strategies that may increase access to dental care using dental therapists and hygienists. The study used a multiple case study design to critically examine the dental policy development process around the Review of the Dentists Act 1972 in Victoria; to assess legislative and regulatory dental policy reforms in other states in Australia and to conduct a comparative analysis of dental health policy as it relates to dental auxiliary practice internationally.

Data collection has involved (I) semi-structured interviews with key participants and stakeholders in the policy development processes in Victoria, interstate and overseas, and (ii) analysis of documentary data sources. The study has taken a grounded theory
approach whereby theoretical issues that emerged from the Victorian case study were further developed and challenged in the subsequent interstate and international case studies. A component of this study has required the development of indicators in regulatory models for dental hygienists and therapists that will increase access to dental care for the community. These indicators have been used to analyse regulation reform and the likely impacts in each setting.

Despite evidence of need, evidence of the effectiveness and efficiency of dental therapists and hygienists, and the National Competition Policy agenda of increasing efficiency, the legislation reviews have mostly produced only minor changes. Results show that almost all Australian states have regulated dental therapists and hygienists in more prescriptive ways than they do dentists.

The study has found that dental policy making is still dominated by the views of private practice dentists under elitist models that largely protect dentist authority, autonomy and sovereignty. The influence of dentist professional dominance has meant that governments have been reluctant to make sweeping changes. The study has demonstrated alternative models of regulation for dental therapists and hygienists, which would allow wider utilisation of their skills, more effective use of public sector funding, increased access to services and a greater focus on preventive care. In the light of these outcomes, there is a need to continue to advocate for changes that will increase the public health focus of oral health care.
PREFACE

Dental diseases are among the most prevalent and costly health conditions facing our health system (AHMAC 2001). Tooth decay, edentulism and periodontal disease rank first, third and fifth among the top twenty most prevalent diseases in Australia (AIHW 2000). While disease rates among children have declined significantly in the last 20 years, corresponding gains have not flowed on to adults. Around half of Australia’s adults do not receive regular care and demand for services has been predicted to grow as the population ages and increasingly retains its teeth (AIHW DSRU 2002).

Approximately 85% of Australian oral health services are provided by private dental practices leaving around 15% to public sector services. Several studies have demonstrated however, that low to middle income people have difficulty with access to services because of cost and that the costs are not adequately mediated by insurance (AIHW DSRU 2001, Schoefield 1997, Alister et al 1994, Lewis et al 1996). For low income groups, who experience higher rates of disease and rely on meagre public safety net services, co-payments and waiting lists of up to three years significantly reduce their access to care (Holm et al 2001, AHMAC 2001).

Dental therapists and hygienists provide oral health care with a health promoting orientation incorporating low to medium technology treatment services. Their services come at a lower cost than those of dentists partly because their tertiary education is of two to three years duration rather than the five years required for practice as a dentist. Both dental therapists and hygienists Australia-wide however, have been required by legislation to work under the supervision of dentists under tightly prescribed regulatory regimes. This has limited the range of settings and client groups that have access to both their preventive and treatment services and often prevents them from providing services for which they are educationally prepared. Greater utilisation of dental therapists and hygienists could reduce the costs of dental care by distributing service provision according to service needs rather than the confines of legislation.

Given that dental care in Australia is provided principally through a market based system and there is little immediate prospect of this changing due to dominant
ideologies and concomitant pressures on health spending, there is an imperative to
determine how the inequalities between need for and supply of dental services can be
reduced. Mechanisms such as reducing disease levels through prevention, reducing
the costs of services and altering the mix of suppliers are all worthy of investigation.

The aim of the study, therefore was to investigate the process and outcomes of policy
making around dental auxiliary practice in Victoria, interstate and internationally
with a focus on the potential to increase access to dental care.

In order to do this, the policy making process associated with the National
Competition Policy (NCP) review of the Victorian dental legislation has been
studied. This has been augmented, through comparative case study methods, with
analysis of legislative and regulatory dental policy reforms, driven by NCP, in two
other Australian states. Further, the regulation of dental therapists and hygienists in
international settings has been examined for variance and evidence of models that
may increase access to dental care. This thesis reports this research and draws
conclusions about how dental regulatory policy might be shaped to increase access to
dental services, what the Australian policy reform processes have produced and the
forces that shaped those outcomes.

Chapter One provides a detailed review of the literature to contextualise the
problems around the relationships of demand for and supply of dental care services.
It describes the delivery mechanisms, costs and funding of services and the
occupational mix and task distribution. It concludes by looking at the literature
around dental therapy and hygiene practice internationally and in Australia, and at
how existing policy has influenced the distribution of dental services.

The second chapter focuses on the theoretical frameworks for examining public
policy making, with a focus on health policy including its developmental processes,
structural aspects and the nature of interest group interplay. There is also an
examination of the role of expertise in policy making with particular emphasis on the
definition and role of the professions.

Chapter Three describes the methodological framework and research methods
adopted within the study. Included in this is the methodology for qualitative research
and the ethical issues posed in a study of a public process. Following on from this,
chapter three then provides a detailed description of the methods used within this study.

Chapter Four describes the results of the case study of the Victorian dental legislation review process. It presents the experiences and perceptions of individuals who were involved in the policy development process, triangulated with documentary evidence, to critically examine the influences that shaped the outcomes.

Chapter Five provides a detailed discussion of these results and examines the broader structures that underpinned and shaped the policy outputs by drawing on the theoretical aspects of policy making reviewed in Chapter Two. This is followed by a discussion of how the policy review outputs are likely to impact on the dental policy making environment and its capacity to supply dental services in the longer term. This chapter also develops, out of the literature and findings, regulatory indicators for increasing access to dental services. It concludes with a number of emergent hypotheses that are to be further examined in the interstate comparative studies discussed in Chapter Six.

Chapter six firstly describes the methods to be used in the interstate comparative case studies including the case selection criteria. The second part of Chapter Six describes the findings of the case study of the review of the Tasmanian dental legislation including a discussion structured around the emergent hypotheses from the Victorian study. The third part deals similarly with the study of the New South Wales legislation review. This chapter concludes with a summary of the key changes to the regulation of dental therapists and hygienists delivered by dental legislation reviews around Australia.

In addition to the detailed Victorian case study and the two interstate case studies, three international cases were examined, based the development and use of regulatory models not used in Australia. These brief case studies, which relied on secondary data and contextualising interviews have not been examined in as much detail as the Australian case studies. They nevertheless make an important contribution to the development of the study findings. They have been included as an Appendix to the thesis.
Chapter Seven concludes the thesis by examining the outcomes of the case studies against the indicators for increasing access to care and providing recommendations for regulatory models for dental therapy and hygiene practice. It also develops conclusions about the relationships between outcomes and processes in this policy environment and their implications for dental public health.
CHAPTER 1: ORAL HEALTH IN AUSTRALIA: A PUBLIC
HEALTH ISSUE

'It is clear to the Committee, that in their current state, neither the public nor private dental systems are efficiently meeting the needs of all Australians. A large number of Australians are unable to access private dental care and the experience of those reliant on the public system is that it cannot currently deliver services to meet the needs of all its clients. Burgeoning waiting lists, the increasing focus on emergency rather than maintenance or preventive work and cuts to services mean that, for many, the likelihood of accessing appropriate care is diminishing... The Committee also notes that, the longer members of the community have inadequate dental care, the more their problems will compound and the more difficult and expensive it will be to rectify those problems.'

Senate Community Affairs Reference Committee, 1998

1.1 Dental disease in Australia

Oral diseases including dental caries and periodontal disease are among the most prevalent diseases in Australia today (AHMAC 2001). Dental trauma, cleft lip and palate and oral cancers also contribute to the $2.6 billion spent on oral disease and disorders each year (AIHW 2001). While disease rates among school children have declined significantly in the past 20 years the gains made among children are not flowing on to adult dentitions at the same rate. While the cohort effect of water fluoridation sees a dental caries differential in those under and over 25 years of age, there is also an increase in untreated disease experience related to a reduction in utilisation of preventive and treatment services among adults. Around 50% of adults do not receive regular care (ABS 1995, AIHW DSRU 2001a) and the costs to the community of treating dental disease in 1992 were second only to those of cardiovascular disease (NHMRC 1992). Recent research also demonstrates that the flow on effects of poor oral health apply not only to poor nutrition status and other diet related disorders, but also to other systemic diseases such as cardiovascular and cerebrovascular diseases, low birth weight babies, otitis media and delayed growth and development (Slavkin and Baum 2000). Further, Australians suffer significant social problems including difficulty in finding employment, a substantial loss of productive time at work and reduced social competence as a result of poor oral health (Brotherhood of St Lawrence 1998, Spencer and Lewis 1988).
Population health strategies such as water fluoridation and widely accessible publicly funded school dental services over 20 years have paid some dividends. Australian children now enjoy levels of oral health comparable to the best in the world. Disease prevalence rates for 12 year olds in 1997 were 0.86 decayed, missing and filled teeth (DMFT) per child, the second lowest among OECD countries (Spencer 2001a). On the surface this measure of oral health is good but there are still problems. Early childhood caries results in 34% of preschool aged children entering school with dental decay and 9.1% of 5 year olds with untreated decay in 4 or more teeth. While significant gains have been made in permanent teeth, the highest levels of decay still occur in deciduous teeth and there has been little change in disease prevalence for these teeth over twenty years (Armfield et al 2000).

Adolescents appear to leave behind the gains of childhood fairly quickly. By the age of 15 years, caries experience has more than doubled to 1.99 DMF teeth per child with only 41% decay free (down from 61% of 12 year olds) (Armfield et al 2000). Australia-wide, around 62% of primary school children receive dental care through the School Dental Services; this reduces to around 30% among 13-16 year olds (Armfield et al 2000). Dental decay is cumulative however caries incidence increases disproportionately in the adult years.

By the time early adulthood is reached disease levels are around 5 DMFT1, and increase rapidly to reach approximately 19 teeth with caries experience by middle age resulting in increasing need for care into the aging years (NOHS 1987-88). Only half of this age group make an annual dental visit, with 45% of these visits being made for a problem rather than a check-up (AIHW DSRU 2001c). Australia’s 35-44 year olds hold 21st place among OECD countries, averaging around 13.6 teeth affected by decay and with 39% of people over 65 edentulous. Further, increased tooth retention in middle aged and older adults has increased the risk of recurrent and new decay, chronic degenerative problems such as tooth wear, tooth fracture and root caries (AHMAC 2001). Edentulism represents a failure of all previous preventive and treatment services so that the outcome is complete tooth loss. In a national

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1 The most comprehensive data available for this age group comes from the National Oral Health Survey (NOHS) undertaken in 1987. More recent research has been carried out by the DSRU in 2000, indicating an average DMFT of 3.66 for 20-24 year olds, with around 14% having DMFT of over 8 however this sample was conducted in metropolitan, fluoridated Adelaide and is acknowledged as likely to be an under-representation of the oral health needs of this age group nationally (AIHW DSRU, August 2000).
telephone interview survey carried out in 1999, 16.6% of those over 25 years of age had received an extraction at their last dental visit. The highest extraction rate by age group was reported among 25-44 year olds (18.6%) with health card holders in receipt of publicly funded services most likely to have a tooth extracted (33.4%) (AIHW 2001a).

Edentulism (or dental mortality) is decreasing, with older adults increasingly retaining their natural teeth into old age (Spencer et al 1994a). This improvement is related more to changing oral care expectations than changes in disease patterns (AIHW DSRU 1998a). Heavily filled natural teeth require higher levels of maintenance than dentures because of the need to restore fractures, provide increasingly complex restorative and prosthetic services and monitor caries levels (Dooland 1992, Spencer 2001a). Further, the need for preventive and curative periodontal services increases with age (AIHW DSRU 1998a). Up to two-thirds of older adults are financially disadvantaged which reduces their ability to purchase services, placing greater demands for care on the public sector. The patterns of our aging population will ensure increasing demand for care in the future as more people retain their teeth into old age (AIHW DSRU 2000a, AHMAC 2001).

The consequences of oral neglect increase in significance and impact on general health in the elderly. Oral cancers, for example produce higher mortality than many other cancers (including cervical cancer) often as a consequence of late diagnoses (AHMAC 2001). In 1997, in Victoria, 331 in every 100,000 people over 60 years of age were diagnosed with oral cancers representing 2.35% of all cancers with almost twice as many males as females affected (ACC 2000). Only 61% of dentate individuals and 16% of edentulous individuals over 60 years old had visited a dentist in the past 12 months (AIHW 2001b). These issues are exacerbated among nursing home residents whose access to care is complicated by immobility, dependence, multiple and chronic medical conditions and medications, and poor oral hygiene (AIHW DSRU 2000b).

Despite the data indicating reductions in the rates of edentulism, adults from lower income groups still tend to receive extractions more often than restorations. This is in part due to the cost of care, late presentation of problems, the value placed on teeth and the capacity to discuss alternative treatment options (Roberts-Thomson et al
The injection of funds by the Commonwealth government during 1994-96 via the Commonwealth Dental Health Program saw a reversal of this trend for the period of the program. However, since the program's withdrawal in 1996, waiting lists have once again lengthened and treatment options for these lower income individuals have again become limited resulting in extractions rather than restorations (Roberts-Thomson 1998).

Socio-economic circumstances have a clear relationship to risk status for dental disease, with the highest levels of disease prevalence occurring in those least able to access care (Sanders and Spencer 2001, Lewis et al 1995). People from low income backgrounds, people in rural areas, the elderly, the home-bound, Aboriginal and Torres Strait Islanders and the disabled all demonstrate higher levels of dental disease and greater difficulties accessing dental care (AIHW DSRU 2000a, AIHW DSRU 2001a). While those from non-English speaking backgrounds show lower rates of edentulism, they report more experience of toothache, lower levels of dental insurance and greater difficulties in paying dental bills (AIHW DSRU 2000d).

The problems inherent in a predominantly market based distribution of dental care have been clearly demonstrated by the dental health status, and access to care of Australians. This system has left us with three categories of dental care recipient:

- middle to upper income individuals who are able to engage in the market which provides ready access to high quality and technically advanced care (Spencer 2001a);

- those low income and disadvantaged individuals and families who are holders of Health Care Cards and able to access public sector services. In many settings Health Care Card Holders face rationing through the use of co-payment mechanisms and have difficulty gaining access to timely dental care. (Holm et al 2001) The outcome of such rationed services is that delayed treatment leads to people in pain seeking emergency rather than general care through the public sector, and evidence indicates that they are increasingly receiving extractions rather than restorative services. There are currently some 500,000 people on waiting lists for public dental care around Australia (Spencer 2001a) and;

- the low to middle income groups (earning below about $40,000 per year) who are unable to afford care and do not qualify for publicly funded care (AIHW DSRU
2001a). It appears that this last group, when faced with pain from toothache, in some cases seek care from their medical doctors in the form of pain relief and antibiotics – at best a temporary relief which represents a cost shift to the Medical Benefits Scheme (Short 1999a).

In summary, there are three key aspects to the community’s requirements for dental care. Firstly there is the issue of high levels of disease prevalence across the whole community requiring greater attention to oral health promotion and preventive care. Secondly there is the issue of unmet need for services largely concentrated in lower income groups and others least able to access services. Thirdly there are the cohort patterns associated with fluoridation and increasing retention of teeth among an aging population which results in greater need for lower technology services among the young to middle aged and increasing needs for higher technology services among middle aged and older adults.
1.2 THE POLITICAL ECONOMY FOR ORAL HEALTH

Increases in technology and the spiralling costs of health care, combined with the unpredictable nature of ill health have meant that purely market based distribution of health services has not been considered viable. Since the earliest notions of state responsibility for welfare, governments have searched for ways to deliver health services in affordable and equitable ways. The result is that most health care in Australia is subsidised by universal health insurance (Medicare) and taxation augmented by smaller or larger degrees of private health insurance and government safety net provisions, dependent on the government of the day (Leeder 2001). The oral cavity however, has been considered a separate entity from the rest of the body in considerations of health status and is largely excluded from such funding mechanisms (Hancock 1999, Gardner 1995, Willis 1989).

As indicated in the previous section, the flow on effects of this separation has been an inequality in access to dental care. This notion of access to care has a range of components, defined variously as availability (geographic, numbers of providers), effectiveness (cost, clinical), appropriateness (social and cultural acceptability), timeliness and affordability (Dooland 1992, Gulliford et al 2001, AHMAC 2001). Key among concerns related to dental care availability is the ability of consumers to overcome physical barriers to access such as disability, immobility, distance or long waiting times due to a shortage of services. Effectiveness may be related to clinical outcomes which can include the perceptions of both consumers and providers about need, prevention and costs of care and definitions of appropriate oral health outcomes. In economic terms, cost-effectiveness may refer to the use of a mix of providers, services or materials which result in similar outcomes for differing costs (AHMAC 2001). There is also the possible mismatch between professional demands, consumer needs and past experiences, and the uptake of services which can affect a consideration of appropriateness of services (Gulliford 2001). For example, differences in cultural expectations between Aboriginal consumers and mainstream health services may result in a reluctance to use services (COA 2003). Timeliness of access to dental care is important because a dental lesion may develop from reversible to restorable to tooth mortality over a period of time; early intervention clearly offers the best opportunity for optimal oral health outcomes. Affordability is
influenced by financial factors that may encourage or inhibit both the delivery and use of services as well as the indirect costs of utilising services (such as time lost from work) (Gulliford 2001). Access to dental services in many of these aspects is considered to be both inadequate and inequitable (AHMAC 2001) and this chapter goes on to explore some of the issues and contributors to this.

1.2.1 Supply: dental services in Australia

Dental care in Australia is delivered via market based systems with very limited safety net provisions for disadvantaged people. Around 5.4% of Australia’s health dollar is spent on dental services totalling around $2.6 billion, 84% of which is private expenditure (AIHW 2001). The other 16% is spent providing public sector services including School Dental Services, Adult emergency and limited general services, Department of Veterans Affairs Services and the Denture Schemes. Of the $104 million contributed by the Commonwealth in 1998-99, $97 million was spent on health insurance premium rebates leaving a direct federal contribution of just $6 million. State and local governments have been responsible for delivering services and their expenditure totalled $305 million in 1998-99 (AIHW 2001, Spencer 2001a)

1.2.1.1 The public sector

Each state develops service provision policy independently, resulting in variations in both funding and management arrangements. Victoria’s public sector services are purchased from the provider agency Dental Health Services Victoria (DHSV) which provides direct services through its own hospital and community clinics and subcontracts to both private and public sector clinics. The School Dental Service at present provides care to children between 0 and 12 years of age (year six) and health care card holders up to 18 years (DHSV 2001). Most other states provide care to all children up to age 18 due to earlier engagement with the federally seeded scheme (Spencer 2001a). Adult Concession Card holders in Victoria can receive emergency and general services subject to co-payments of $20 and $80 respectively and full dentures for $100. Waiting times for general and denture services average 21-22 months with a range of 5-36 months depending on the location of the service (VAGO
2002, DHSV 2001, Kefford 2002). The Veterans Affairs scheme is federally funded but locally administered. In Victoria, all services are subject to co-payments with the exception of children’s’ services to Health Care Card holders.

After the state dental hospitals, School Dental Services have been the longest running public dental services. Many states established rudimentary schemes in the years after the first world war and concerns about the state of child oral health fed discussions at federal level during the 1940s about a nationalised scheme to be incorporated into the proposed national health scheme of the Chifley government (Robertson 1989, Gardner 1995). Poor resourcing, lucrative private practice\(^3\) and the small pool of dentists available, particularly during the second world war meant that the service was never really effective (Robertson 1989).

As a result, an NHMRC committee was established to make recommendations in relation to dealing with the problem of poor child oral health (NHMRC 1965). This recommendation resulted in the expansion of existing School Dental Services into a federally funded program. The Whitlam government in 1972, established the scheme based on the model operating in New Zealand, providing special purpose grants to establish training schools for dental therapists and dental service infrastructure. The Fraser government absorbed this funding back into general revenue in 1981-82 again contracting federal government involvement in dental services (Lewis 2000).

The responsibility for developing public dental services again reverted to the states by the 1980s with adult services being provided through the dental hospitals and some community health services. The Layton Medicare Review of 1986 again declined to include dental services (other than some maxillo-facial surgery) in Medicare based in part on the active opposition taken by the dentist profession who stated that it ‘…was neither warranted nor desirable…’ (MBRC 1986, Lewis 1996). In 1994-96, the Commonwealth (Labour) government acknowledged the large amount of unmet treatment needs identified by the National Health Strategy (Dooland, 1992) and established the Commonwealth Dental Health Program (CDHP)

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2 The Commonwealth government directly funds services for Veterans, Indigenous Australians and the armed services, dental services related to the cleft lip and palate scheme and some in-patient services under Medicare amounting to less than 3% of all dental services (Spencer 2001a, AHMAC 2001).

3 The spelling and use of the terms practice (as a noun) and practise (as a verb) while grammatically correct have, in many documents, come to be replaced by the term practice. As this appears to represent common usage, for the sake of consistency I have used the term practice to represent both terms throughout this thesis.
with funding totalling $100 million per year. This program used both public sector infrastructure and services purchased via the private sector to provide care to low income adults and pensioners. Some $278 million was committed over four years, allocated to the states on a proportional basis related to health concession card holder numbers and on condition that the states maintain their current funding levels. In 1996, the first budget of the newly elected Liberal-Coalition government abolished the program on the grounds that waiting times for public sector services had been reduced, ironically using its success as a reason to hand back responsibility to the states for public sector services (Brennan et al 1997a, Lewis 2000). The response from the states was varied. Queensland, for example, chose to maintain existing services by replacing the funding from the state budget, South Australia and Victoria chose to redesign the existing service provision and introduce consumer co-payments and in NSW there were simply less services available resulting in growing waiting lists Dooland 1999, Short 1999a, Bragg 1999).

In 1994 there were 7667 dentists practising in Australia representing a rate of 43 per 100,000 people which compares favourably with New Zealand and the UK with 37:100,000 and the United States where there around 60:100,000 people. The majority of Australian dentists work in capital cities however, with rates of 51 per 100,000 compared with only 27:100,000 people in the rest of the country. This is an issue for access to services by consumers of both private and public sector services (AIHW DSRU 2002). Around 84.6% of dentists work in general practice and 10% in specialist practice. Approximately 81% work in private sector practices with another 9.4% working in hospitals leaving around 5% delivering school dental or community programs (Szuster and Spencer 1997c).

1.2.1.2 The private sector

Private sector services, comprising the vast majority of the expenditure on dental services, are provided largely through solo or small group practices. They operate on a fee for service basis engaging with that portion of the population who can afford to purchase them. Forty-seven per cent of private sector dentists in Australia operate out of solo practices which have no formal networks (other than professional association)

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4 Approximately half a million eligible adults are waiting for access to general dental care in public dental clinics. Waiting times are over three years in many clinics in most States and Territories, which is longer than the accepted standard time interval between dental visits (AHMAC 2001)
or external evaluative mechanisms other than business viability. Group practices tend to be small with around 60% comprising only two dentists (Lewis 1996). They operate only in competition with each other and with the very limited public sector providers and use practice financial viability as a measure of success.

Fees for dental services are the responsibility of individual providers and for this reason, the Australian Dental Association (ADA) argues that dentists compete with one another (ADAVB 1998). Prior to the implementation of National Competition Policy, the ADA developed and published a recommended fee scale for the use of its members (Millsteed 1996) but they now advise their members to calculate their own. The ADA however maintains a role in providing guidance to dental practitioners about fees, publishing average fees collected using survey data on a regular basis and providing advice about the calculation of fee structures to their members ADA 1999. The industry norm appears to be around 65% of gross spent on overheads and 35% profit (FMRC 1997, ADATB Feb 2001).

Competition principles argue that market competition and the choices consumers make operate to ensure that the most cost-effective and best quality services will prevail (DP&C 1996). Many authors have argued that this expectation is more complex when applied to health services (Baum 1998, Hancock 1999, Palmer and Short 2000). Information asymmetry places health care consumers in a position of disadvantage and this, combined with the market monopoly that dentists have achieved through legislation, represents a market failure which has the effect of protecting anti-competitive behaviour (Robertson 1989, Millsteed 1996)

1.2.2 Supply: costs and funding

The Health Expenditure Bulletin reports that prices for oral health services in Australia as a whole have increased sharply with an increase in prices of 39.2% between 1990 and 2000 (AIHW 2001). These price increases were attributed to new technologies and stricter infection control standards, however when compared with all health services, where the increase for the same period was only 20.8%, the cost increases are significant\(^5\). Price Waterhouse Coopers (2000), in a study of the

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\(^5\) The Consumer Price Index for the same period showed about a 25% increase (100.9-125.2) over the same period which included the introduction of GST in 2000 (4% increase between 1999-2000) (ABS 2002). Health
Queensland dental market found that the average hourly rate for dentist services in 1998 was $225.60 with a profit margin of around 20% of revenue (FMRC 1997). Rates vary little across Australia and the report notes it is difficult to detect price competition because there is little service substitution and all states regulate the provision of oral health care such that dentists experience a monopoly position within their market (Price Waterhouse Coopers 2000).

Schoefield (1997) in a study of the utilisation of ancillary health services concluded that people on low incomes had difficulty accessing ancillary services, particularly dental care; a finding supported by evidence from the National Health Strategy (Dooland 1992), the Brotherhood of St Laurence (1998) and the AIHW DSRU (2001a). Analysis of age adjusted ABS data showed that there was a significant positive relationship between income and dental visits; low income people reported almost half the incidence (21%) of dental visits over a six month period of persons from the highest income (38%) group (Dooland 1992). The apparent income barrier to dental services is probably directly related to the cost of dental care as over 81% of dentists work in private practice and their fees are the highest of any ancillary health services.

Alister et al (1995) found that financial burden is often cited as a reason for persons not visiting a dentist, reflecting both direct and indirect costs of dental services to the individual. A survey conducted of Melbourne residents by telephone in 1995 found that 31.1% of respondents were most likely to avoid dental visits because of the costs involved in accessing private care (Lewis et al, 1995). A national telephone survey (AIHW DSRU 2001a) showed that one in three people avoided or delayed visiting or had to forego recommended or desired treatment because of cost. Almost one in five would have a lot of difficulty paying a $100 dental bill (AIHW DSRU 2001a).

The decision to engage in the market has been shown to be responsive to both prices and pain. While some consumers delay or avoid care because of cost, others make

The AHCAC Steering Committee for National Planning For Oral Health concluded that;

'Dental fees are increasing at twice the rate of fees for other health services, progressively moving private dental services out of reach of lower and middle income earning Australians.'

AHCAC (2001), Oral Health of Australians:

services are largely GST exempt so that an increase of 20.8% in prices of health services would seem to match CPI changes.
discretionary judgements about the need for services based on the pain being experienced. For example, people suffering toothache may be less concerned about prices than those who require maintenance treatment. Various studies have concluded however, that demand for dental services does demonstrate price responsiveness (Manning and Phelps 1979 and Hu 1981) and that this is probably exacerbated by the lack of support provided by Medicare (Price Waterhouse Coopers 2000).

Health insurance helps mediate the costs of dental services to some degree and the federal government subsidy of private health insurance also applies to ancillary insurance. However, only 19.3% of low income people (health care card holders) have private health insurance compared to 40% of non-card holders. As income increases, so the proportion of those with insurance increases, so that 62% of those earning $100,000 or more per year hold ancillary health insurance. The result is that the largest proportion of government subsidy goes to those in higher income brackets. Further, the average cost of purchasing dental insurance is about $322.58, and returns only about half the costs of dental visits, representing a much larger proportion of a low income earner’s resources (Spencer 2001a, Lewis 1996).

A study of the services provided by private practices to those holding dental insurance in 1993-94 revealed that the services they received were different to those received by uninsured people. Insured people attended more dental visits and received more preventive, crown and bridge and endodontic services, equivalent amounts of diagnostic and restorative services and less extractions. While it is possible to argue that increasing visitation rates lead to increases in invasive procedures through supplier inducement, those with insurance cover received less extractions than those without. The authors concluded that insurance cover is positively associated with oral health although lower income groups may show a weaker preventive orientation through the subordination of ‘...future welfare to current survival’ (Brennan et al 1997b). This study demonstrated a “more favourable” service mix among insured than non-insured people which points to the conclusion that less expensive dentistry might make such favourable treatment more readily accessible to a wider proportion of the population.

Schoefield (1997) concluded that there were three policy directions that might help overcome the barriers to access. These were to increase public provision of services;
to subsidise the provision of private services through mechanisms such as Medicare, (a move which has been vigorously opposed by the Australian Dental Association (MBRC 1986, Lewis 1996) and, to indirectly subsidise services through private health insurance incentives.

1.2.2.1 Insurance and the US system

The dental service delivery system in the US has developed an insurance based mechanism for delivering dental services loosely termed managed care, which has developed since the Nixon government passed the Health Maintenance Organization (HMO) Act 1974. In 1993, 87% of large companies (with over 500 employees) and 47% of small companies offered dental benefits with 20% growth annually of dental HMOs (Clouse 1999). An HMO (often an insurance company) acts as a purchasing agent for dental services which it then sells on to employers for incorporation into employee salary packages. However 150 million Americans lack dental insurance and many more have only limited dental insurance (Clouse 1999).

Such schemes allow benefits under a variety of arrangements. Capitation schemes provide for a fixed amount to be paid to a dentist to provide all care for a designated client or their family. Indemnity schemes negotiate fees for services based on bulk purchasing. Clients in both cases will usually be required to receive treatment under preferred provider arrangements or from staffed clinics.

Nasser (1996) observed that dental insurance differs from medical insurance because the risk is different. Dental diseases are more highly prevalent and of lower severity than most other diseases which makes it less profitable for insurance companies unless premiums are high. Dental disease patterns are predictable and offer little risk of catastrophic losses to insurers but are chronic in nature and in the demand for treatment (Moen 1999, Durig in Prince 1998). Capitation plans tend to suit insurance companies better by controlling costs and utilization more and transferring the risk to the dentist. Tevacek (1994) predicted that the goal will be to convert indemnity plans to capitation plans in the longer term with the use of higher fees, high co-payments and limits on annual payments.
All such schemes have the disadvantages of reducing client choice, squeezing profit margins for dentists, and generating profits for a third party. The American Dental Association is opposed to such schemes on the grounds that managed dental care is a cost containment system that directs the utilization of insurance benefits by restricting the type, level and frequency of treatment. They argue that it limits access to care and controls the level of reimbursement for dental services, with the goal of reducing costs and increasing accountability to purchasers (American Dental Association 1987). Clouse (1999) argues that under managed care schemes, dentists are forced to employ cheaper (and potentially lower quality) treatment and technology alternatives, delay treatments, use alternative lower cost laboratories than they would otherwise choose to use and ration appointments to ensure profits to remain financially viable. This has the potential to encourage under-serving or placing at risk the range of services available and/or requiring co-payments for or excluding expensive or specialty care. Chiordo and Tolle (1999) observe that the risk of litigation where ethics are compromised around the quality of patient care and the range of treatment alternatives offered is significant. Managed care has the potential to create conflicts of interest in the patient-practitioner relationship because of the intrusion of a third party in the form of a practitioner-insurer relationship which places different demands on providers of care (Emanuel and Dubler 1995). They may also allow for selection of clients (those who are healthiest) and only apply to those people in the workforce (and in many cases, their dependents).

The advantages of such schemes are that they increase access to services by reducing costs and spreading payments over an annual salary. They also force input efficiencies such as the wider utilisation of dental auxiliaries and place a stronger emphasis on preventive services and treatment evaluation (Meskin 1995, Chiordo and Tolle 1999). Many plans have moved to audit processes to evaluate and supervise the delivery of care, performing on-site inspections of infection control and working conditions. There is concern about the allocation of funds for such purposes as compared with the allocation of benefits to provision of care. (Clouse 1999) and Moen in 1999 asserted that administration costs accounted for 30-40% of managed care plan costs. Meskin, however observed in a 1999 editorial in the Journal of the American Dental Association that ‘...since 1986 in the US, net real income for all dentists has increased by 31% and for specialists by 40.9%...’, equalling or exceeding income growth in other health professions and surpassing medical GPs.
Annual work hours have not changed, however more patients are being treated, and dental graduates with under 10 years experience report average net incomes of $100,000 and specialists $150,000.

However, the American Dental Association asserts that dentists are likely to continue to resist growth of HMOs and have proposed an alternative plan based on direct reimbursement of dentists’ fees administered directly by employers. This plan draws on the low risk and high predictability of dental care needs whereby an employer funds the risk directly and reduces administrative costs to around 10% (Moen 1999). They argue that it overcomes the weakness of managed care by allowing choice of provider but removes the evaluative strength and downward pressure on prices offered by managed care (Prince 1998). The American Dental Association has committed $2.5 million per year for the next three years for advertising and promotion of the plan in an effort to get ‘…insurance companies out of the equation…’(Prince 1998).

Hartley (1999), in a study of nurse-midwives and their relationship with physicians, argues that the development of the managed care environment in the United States has led to a shift away from specialization and physician autonomy to a system focused on cost-containment. Managed care in the health market involves the use of external occupational groups (such as insurers and financiers) in the provision and evaluation of physicians’ services which has led to a compromise in medicine’s self-regulation and autonomy. This has increased the use of generalist and primary care providers and has led to a shift in the distribution of professional power and inter-occupational dominance. Evolution of state policy favouring non-physician providers has granted more autonomy and independence to, for example nurse-midwives, nurse practitioners and physician assistants resulting in increasing demand for and supply of these practitioners. Such an increase in supply has been seen to alter their relationship with physicians from a complementary and subordinate role to a more substitute and competitive role (Scheffler et al, 1996). Dental auxiliary practice is widely accepted in the US6 and it seems that managed care is providing similar incentives to look for least cost options for providing dental care.

6 Federation Dentaire Internationale (FDI) data for 2000 shows that there are 1.93 dentists for each hygienist and around 1 hygienist for every 3500 population in the US compared to Australia which has only 1 hygienist for every 14 dentists and around 1 hygienist:23,136 population (FDI 2001).
The Australian Dental Association (ADA) has also expressed concerns about the intervention of insurance companies in their practices. Their concerns relate to the amount of control insurance companies are attempting to exert over the practice of dentistry and the interference in patient care by third parties (ADA 2000). There are also concerns about rebate levels and loss of profits (ADATB Feb 2001, ADANSWB Sept 2001). In most Australian dental legislation (prior to the reviews), the on-selling of dental services was prevented by clauses which prevent dentists practising or billing in other than their own names or the supply of dental services by an intermediary. Legislation has also placed limitations on practice ownership. In NSW and Victoria, health funds and friendly societies could own dental practices (State government of Victoria, 1972, State Government NSW 1989) and in some states where ownership restrictions have been lifted the environment is changing and corporate entities are purchasing practices. There are also moves by some health insurance funds to contract providers under preferred provider schemes as insurance companies move to ‘no-gap’ or ‘known-gap’ polices in response to the Federal Government’s Lifetime Health Cover initiatives (ADATB Feb 2001, ADANSWB Oct 2001). The ADA has learned from their US counterparts and recommends against both the proposed changes to practice ownership laws and the insurance company driven changes to individual practitioner relationships and billing arrangements (ADA 2000, ADASAB 2000, ADATB Feb 2001, ADANSWB Oct 2001).

While it is generally not life threatening, the effect of dental disease is widespread, long term and cumulative, and the disadvantaged suffer a greater burden of disease (Brennan et al 1997a, Lewis et al 1995). Dental treatment interventions can be complex and costly and exclusion of dentistry from Medicare and comprehensive insurance mechanisms in Australia has made it unattainable for many. Managed dental care has the potential to increase access to services, particularly for those who would otherwise not receive dental care, by spreading the costs of care, putting downward pressure on dental pricing and stimulating input innovation (Millsteed 1996). However, the concerns about high administration costs and third party profits remain, and managed dental care has not addressed the needs of casual workers and those not in employment in the US.
1.2.3 Supply: task distribution in dental care

Like many other types of health care, dentistry has several occupational streams that have evolved or developed in response to changing technologies and demands for care. Dental therapists, dental hygienists and dental prosthetists all now deliver care as auxiliary professions in combination with dentists and dental specialists, in what is often described as a team environment. Dental technicians are responsible for the manufacture of dental prosthetics—dentures, mouthguards, crowns, bridges and orthodontic appliances under prescription of a dentist. Dental prosthetists are dental technicians with advanced training who may prescribe, manufacture and insert dentures and mouthguards independently. Dental therapists and hygienists (collectively known as dental auxiliaries) provide low to medium technology, preventive and clinical care of dental decay and periodontal diseases respectively, as well as oral health promotion.

Figure 1.1 below shows the range of dental care providers and their market positions with blue and white boxes representing dental care providers. Yellow boxes and arrows represent private sector consumers and their service access points and the green shows public sector consumers. The white arrows represent referral pathways.

Figure 1.1 : Provision of Dental Services.
While dentists’ and dental prosthetists’ services can be accessed directly by consumers, the services of dental hygienists and technicians may only be accessed via referral from dentists. Dental therapists’ services may also be directly accessed but only by children through the public sector’s School Dental Services where they work as part of a team with dentists. Dental hygienists may be employed in public sector services but the majority (97%) are employed in private service provision (Szuster and Spencer 1997b). The services of dental specialists are usually accessed via referral from a dentist but may be directly accessed by consumers.

1.2.3.1 Dental therapists

Dental therapists operate in a primary care role, carrying out low to medium technology dental care and health promotion, referring patients to a dentist for services which are beyond their skills. Up until July 2000, dental therapists in most states of Australia were limited to public sector employment with School Dental Services providing care to children and adolescents under the general supervision of a dentist and with the assistance of a dental nurse. Their skills include examination, diagnosis and treatment planning, radiology, preparation of cavities and their restoration with amalgam and plastic filling materials, pulp therapies and extractions of deciduous teeth, clinical preventive services such as prophylaxis and scaling, fissure sealants and fluoride therapies, diet counselling and oral health education and promotion. In practice, a dentist will attend a Victorian dental therapist’s clinic weekly or fortnightly for half a day to attend to referral patients, mostly comprising orthodontic referrals, higher complexity restorations such as fractured incisors or endodontia and permanent extractions. The overwhelming majority of dental care for children in Australia is provided by dental therapists (Dooland 1992).

Tasmania was the first state in Australia to begin training dental therapists in 1966, followed by South Australia in 1967, Western Australia in 1971, New South Wales in 1974, Queensland in 1975 and Victoria in 1976 (Gussy 2001). In 1996, a national data collection found that there were 1773 dental therapists in Australia of which

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1 Prior to legislation reviews around Australia, dental therapists were limited to public sector employment in all states except Western Australia making this diagram current at June 2000.
2 In most states of Australia, there are 9 dental specialties; orthodontics, periodontics, prosthodontics, oral surgery or oral and maxillofacial surgery, paedodontics or paediatric dentistry, endodontics, dent-maxillofacial radiology, public health dentistry and, oral pathology and oral medicine. In general terms, registration as a specialist requires the completion of a Masters degree and some specialty experience. (Dental Practice Board of Victoria, 2001)
1289 or 72.7% were practicing. Of this number, only 19 were male and four were of Aboriginal or Torres Strait islander descent. This study also showed that in six out of seven states, around 95% of therapists work in the School Dental Service with only Western Australia allowing private practice employment. Ratios of therapists to population were low ranging from 2.9:100,000 population in Victoria to 12.8:1000,000 population in Western Australia (Szuster and Spencer, 1997a). Table 1.1 shows the distribution of the dental workforce in Australia in 1999-2001 aggregated from a number of sources. Of interest, are the relatively low ratios of dental therapists to population in Victoria (1:21,565) and NSW (1:27,388) compared with Queensland where there is one dental therapist per 8,806 people and Tasmania (1:9,400).

1.2.3.2 Dental hygienists

Dental hygienists also work under the supervision of a dentist providing preventive and periodontal treatment interventions on the prescription of a dentist. They examine patients, collecting and recording oral health information, take radiographs, polish and remove deposits from teeth, take impressions and carry out root debridement and dressings for periodontal treatment. They also work in orthodontic practices as clinical assistants checking, maintaining and removing orthodontic appliances and maintaining oral hygiene. In some states they also administer local anaesthesia and apply fissure sealants (DHAAVB 1998). Their role is also preventive including dietary counselling, oral health education and promotion and the provision of fluoride therapies. There are no limits on the age range or employment settings of dental hygienists but they predominantly work in private practices and in most states require the on-site presence of dentist.

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99 The numbers of dental labourforce listed in Table 1 may be over-estimated where dental practice board registrations are used. This is due to some practitioners (particularly dentists) being registered in more than one state or territory and to inclusion of people who are registered but not practising for various reasons. The mix of data sources was used because some states do not register all their dental practitioners and currently available AIHW DSRU data sets were incomplete or not recent enough to reflect increases in dual qualifications and graduations.
<table>
<thead>
<tr>
<th>Numbers</th>
<th>Aust</th>
<th>Vic(^{10})</th>
<th>NSW</th>
<th>QLD(^{11})</th>
<th>WA</th>
<th>TAS(^{12})</th>
<th>SA</th>
<th>NT</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop(^{13})</td>
<td>19,570,000</td>
<td>4,765,900</td>
<td>6,463,500</td>
<td>3,566,400</td>
<td>1,883,900</td>
<td>470,000</td>
<td>1,497,600</td>
<td>195,000</td>
<td>310,800</td>
</tr>
<tr>
<td>Dentists(^{14})</td>
<td>10,873</td>
<td>2502</td>
<td>4050</td>
<td>1925</td>
<td>1050</td>
<td>172</td>
<td>912</td>
<td>76</td>
<td>186</td>
</tr>
<tr>
<td>Dental(^{15}) assistants</td>
<td>9477</td>
<td>5091(^{16})</td>
<td>3000</td>
<td>1651</td>
<td>1015</td>
<td>169</td>
<td>854</td>
<td>66</td>
<td>232</td>
</tr>
<tr>
<td>Dental(^{17}) therapists</td>
<td>1572</td>
<td>221</td>
<td>236(^{18})</td>
<td>405*</td>
<td>275(^{19}) + 214=489</td>
<td>50*</td>
<td>123(^{20})</td>
<td>17</td>
<td>15*</td>
</tr>
<tr>
<td>Dental(^{21}) hygienists</td>
<td>778</td>
<td>220</td>
<td>198(^{22})</td>
<td>48*</td>
<td>120</td>
<td>1</td>
<td>150(^{23})</td>
<td>9</td>
<td>32(^{24})</td>
</tr>
<tr>
<td>Oral health(^{\dagger}) therapists(^{25})</td>
<td>28(^{26})</td>
<td>91</td>
<td>275</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technicians(^{27})</td>
<td>2016</td>
<td>400</td>
<td>650</td>
<td>641</td>
<td>170*</td>
<td>25*</td>
<td>250</td>
<td>Unknown(^{\star})</td>
<td>55</td>
</tr>
<tr>
<td>Prosthetists(^{28})</td>
<td>1046</td>
<td>312(^{29})</td>
<td>350</td>
<td>155</td>
<td>80</td>
<td>63</td>
<td>37</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>DTher:pop</td>
<td>1:12,449</td>
<td>1:21,565</td>
<td>1:27,388</td>
<td>1:8,806</td>
<td>1:3,852</td>
<td>1:9,400</td>
<td>1:12,175</td>
<td>1:11,470</td>
<td>1:20,720</td>
</tr>
<tr>
<td>DHyg:pop</td>
<td>1:25154</td>
<td>1:21,163</td>
<td>1:32,644</td>
<td>1:47,300</td>
<td>1:15,699</td>
<td>1:470,000</td>
<td>1:9,884</td>
<td>1:21,667</td>
<td>1:9712</td>
</tr>
<tr>
<td>Dentist:DTher</td>
<td>6.9 :1</td>
<td>11.3 :1</td>
<td>17.1 :1</td>
<td>4.7 :1</td>
<td>2.1 :1(^{30})</td>
<td>3.4 :1</td>
<td>7.4 :1</td>
<td>4.4 :1</td>
<td>12.4 :1</td>
</tr>
<tr>
<td>Dentist:DHyg</td>
<td>14 :1</td>
<td>11.4 :1</td>
<td>20.4 :1</td>
<td>40.1 :1</td>
<td>8.7 :1</td>
<td>172 :1</td>
<td>6.1 :1</td>
<td>8.4 :1</td>
<td>5.8 :1</td>
</tr>
</tbody>
</table>

* Not registered in these states prior to legislation reviews so numbers are estimated
\(^{\dagger}\) includes those qualified and registered as both a dental therapist and dental hygienist; these individuals are included in, not extra to therapist and hygienist numbers in the preceding columns

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\(^{10}\) Source of Victorian data: Dental Practice Board of Victoria Dec 2001


\(^{12}\) Source of Tasmanian data: Dental Practice Board of Tasmania, Jan 2002

\(^{13}\) Source ABS: Jan 2002b, Australia’s Population 2000

\(^{14}\) Source: State Dental Registration Boards as of 31 December 2001

\(^{15}\) Source: AIHW estimates 1992

\(^{16}\) As estimated by Victorian Oral Health Labourforce Study (AIHW DSRU 2000e)

\(^{17}\) Source: AIHW Dental Statistics and Research Unit, 1996 (Szuster et al 1996), * not registered in these states

\(^{18}\) New South Wales Dental Therapists Association

\(^{19}\) Source: WA Dental Board which registers Dental Therapists (private sector practicemn qualiﬁed as both therapist and hygienist), and School Dental Therapists separately as well as Dental Hygienists: 214 are school dental therapists (public sector) and 275 are dental therapists (both public and private)

\(^{20}\) Source: SA Dental Therapy Association

\(^{21}\) Source: State Dental Registration Boards as of 31 December 2001

\(^{22}\) Source: Dental Board of NSW

\(^{23}\) Source of South Australian data: Dental Board of South Australia

\(^{24}\) Source: Australian Capital Territory Dental Board

\(^{25}\) Source: State Dental Therapy Associations: personal communication Jan 2002

\(^{26}\) Dental Practice Board of Victoria; personal communication Jan 2002

\(^{27}\) Source: Council of Regulating Authorities 2001, *not registered in these states

\(^{28}\) Source: Council of Regulating Authorities 2001

\(^{29}\) In Victoria there is also one person registered as both a dental hygienist and a prosthetic (DPBV, Jan 2002)

\(^{30}\) This ratio is misleading because school dental therapists are restricted to the public sector while dental therapists may also work in the private sector and tend to do so. So, a ratio of dentist: school dental therapist: at 4.9:1 is a closer equivalent to the other states and a ratio of 2.6:1 dentist: dental therapists + hygienists is more equivalent to the other states' ratios of dentist: hygienist

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Dental hygiene is a relatively new profession in Australia, first legislated for in South Australia in 1971, which until 1995 was the only state to provide training. It was only legalised in Victoria in 1989, ACT and the Northern Territory in 1996, Queensland in 1987 and in NSW in 1990 and until 2001, not permitted in Tasmania (DHAA 2002). Practice ratios range from 0.5:100,000 population in NSW to 4.2:100,000 population in South Australia. A 1996 national data collection found only one dental hygienist who was male and one Aboriginal or Torres Strait Islander and that around 95% worked in private practices (Szuster and Spencer 1997b). Of interest is the rise in numbers of hygienists across Australia over the past few years. The survey carried out in 1996 (Szuster and Spencer 1997b) found a total of 227 practising hygienists whereas dental registration board data in December 2001 shows that number has more than tripled to 778 (see Table 1.1). In Victoria, dental therapists and hygienists now have almost equal numbers compared with only 44 hygienists in 1996. Western Australia and South Australia have the highest ratios of dental hygienists reflecting a longer history of practice and training.

1.2.3.3 Role, Education and Legislation

Delegation of dental auxiliary skills (referred to in legislation as ‘duties’, for example see Appendix 1) is tightly defined under legislation in each state of Australia. While the core concepts of the occupational groups are the same, the technical definition of the range of services they may provide differs, and so, in consequence does their training.

Dental hygienists generally have a role more complimentary to that of a dentist, providing services under direct delegation and, when included in a dental practice may be associated with an up to four-fold increase in non-surgical periodontal services, with little change in the associated dentists’ service patterns. Further, the mix of services tends to be different where practices employing dental hygienists also provide more preventive services and less oral surgery and restorative services indicating perhaps a less invasive approach to treatment generally (Brown et al 1994). Alternatively, dental therapists are largely substitute service providers, initiating and providing their own services as a primary provider and referring those beyond their skills on to a dentist. The conception of their role was as a substitute provider (NHMRC 1965) and several studies
and proposals since that time have found that a range between 50% and 69% of services commonly provided by dentists are also provided by dental therapists (Rogers 1995, Millsteed 1996, VDTA 1998). So where a dental hygienist were added to a practice, more complimentary services of a preventive or periodontal nature are likely to be provided. Where a dental therapist were added to a practice it is likely that more diagnostic, restorative and preventive services would be added (AIHW DSRU 1998a); as a substitute to the services provided by a dentist.

Current legislation does not rely on educational preparation or competency but rather on prescriptive lists of services to determine practice boundaries. Therapists and hygienists crossing state boundaries are often subject to de-skilling or re-skilling in order to comply with local regulations regardless of practice experience or competence (VDTA 1998). Not all states register or license dental therapists and hygienists; in some states they practice under exemption from the Dentists Acts (therapists in Tasmania, South Australia, New South Wales, Queensland) and in others a dentist applies to the Dental Board for permission to employ them (hygienists in NSW and Queensland).

Qualification for practice as a hygienist or therapist requires a 1500-2100 hour, tertiary course of education and training over two years in most cases requiring university level entrance requirements generally with pre-requisite studies in English and Biology (Torrens Valley TAFE 2001, University of Melbourne 2002a, University of Queensland 2000). The University of Melbourne’s Diploma of Oral Health Therapy program graduates both dental therapists and hygienists with a common core first year and separate second year streams (University of Melbourne 2002a). Diploma courses are also offered at the Westmead College of Dental Therapy in NSW and the Gillies Plains College of TAFE (dental hygiene) in South Australia. Curtin University in WA offers Associate Diplomas in both Dental Hygiene and in Dental Therapy with only small annual intakes. In 1998, the University of Queensland offered the first Bachelor Degree in Australia for dental auxiliaries, which qualifies graduates for registration as both dental therapist and hygienist. In 2002, the University of Adelaide offered a Bachelor of Oral Health, also graduating dual skilled auxiliaries. The University of Otago in New Zealand has up-graded their Diploma program to offer a Bachelor of Dental Therapy in 2002 and the University of Auckland is proposing to offer a Bachelor of Dental Therapy in 2004 (University of Melbourne 2002c). This is in keeping with international developments in dental
hygiene education where many countries offer three and four year programs awarding bachelor degrees (Hovius and Blitz 2001).

It is clear that there is significant overlap in the range of skills and approaches to care of dental therapists and hygienists. There have been proposals for the development of a ‘hybrid’ dental auxiliary combining the skills of a dental therapist and dental hygienist for some time (Barmes 1983, Wright FAC 1991, Nuffield Foundation 1993, DH&CS 1995, Wright J 1995). The University of Queensland is currently the only course graduating a single auxiliary with both skills, referred to as an oral health therapist. Graduates however, must still separate the application of their skills into dental therapy or dental hygiene practice and are limited to public sector practice as dental therapists (Price Waterhouse Coopers 2000). Since 1971 in Western Australia however, there have been dental therapists working in the private sector providing both dental therapist and dental hygienist services under prescription of a dentist (Gussey 2001). The Gillies Plains College of TAFE in South Australia has been offering a program since around 1980 enabling dental therapists to add the skills of dental hygiene and the Universities of Melbourne and Queensland both commenced bridging programs in 1999 for eight and 26 students respectively (Calache 2002, Short 1999b). The University of Melbourne also offers bridging program to enable dental hygienists to add dental therapy skills. Table 1.1 shows the numerical distribution of single and dual trained auxiliaries registered and practising in Australia.

1.2.4 Regulation of dental therapists’ and hygienists’ services

‘The para-professional can be valuable in increasing the supply of dental care and thereby decreasing its price. State licensing systems should permit flexible use of para-professionals in the provision of dental services, consistent with the protection of public safety, rather than create a bar to their utilisation. Para-professionals should be allowed to perform expanded functions commensurate with their training and competence; dentists should not be allowed to use their control of licensing boards to inhibit the utilisation of the para-professional. Many of the restrictions placed on dental auxiliaries by contemporary licensing systems are unjustifiable in view of empirical evidence and the recognised purposes of licensing.’ (MacBride 1974).

The purpose of regulation of an industry is to protect the public from the risks inherent in the delivery of its services; in this case to ensure that good quality dental services are delivered in a safe fashion. Along with a raft of industrial laws and service agreements, the usual means for achieving this is to enact legislation
regulating admission and discipline of practitioners (MacFarlane 2000, Dix 1998). Typical components of regulation are the establishment of an official list or 'register' of those who have met standards of competence (qualification) for practice, the approval of courses of training for practitioners, the setting and maintaining of behavioural and practice standards (through disciplinary procedures), and the provision of information to consumers to mediate an imbalance of knowledge about dentistry (information asymmetry). Typically, the state will establish a licensing authority or board to carry out these tasks (McFarlane 2000, Dix 1998, DHS 1997b, DOH 1990, Shepard 1978, MacBride 1974). Australia led the world with this model of regulation with the establishment of the Medical Council of Tasmania in 1837 (Dix 1998) and today dentists in Australia and around the world are regulated this way, as are many dental therapists and hygienists.

1.2.4.1 US and other international literature evaluating dental occupational mix

In the United States of America, dental hygienists have existed for around 100 years (Darby and Walsh 1995) and now carry out most of the functions that dental hygienists and dental therapists do in Australia. These functions exist in different combinations and with different types of supervision dependent on state legislation, but all under the title of a dental hygienist (ADHA 1999b). Reviews of legislation relating to dental hygiene practice have been under debate for over twenty years in the US. Reviews of the literature have revealed little recent material but a substantial body of work was carried out from the late 1970s through the 1980s examining the economic, legal and political aspects of changes to dental auxiliary legislation. Interest has focussed on whether de-regulation of dental auxiliary practice can deliver lower prices, increased productivity and greater access without a threat to quality of care.

MacBride (1974) and Shepard (1978) maintained that dental regulatory authorities (Boards) in the US were typically drawn from and nominated by the professionals that they regulate, and generally excluded consumers or non-practitioners on the grounds that they did not have enough expertise to understand dental issues. They observed that these Boards operated independently of other health agencies and enjoyed a high degree of autonomy but that they generally reflected the interests,
business and health concerns of practicing dentists. They articulated these interests as being the protection of the market for their own practice at the cost of subordinating the public interest.

Several studies have shown that the utilisation of dental auxiliaries increases the productivity of dental practices and reduces the costs of providing certain services while maintaining quality of dental care (Weiss 1971, MacBride 1974, Liang and Ogur 1987, Dooland 1992, Gaughwin et al 1996, Christensen 1999). Like Australia, the US dental hygienist practices under prescriptive regulations describing supervision, employment conditions and practice boundaries prescribed by lists of services. Salop et al (1984) showed that under certain conditions, regulation of an industry will increase market prices more than the average cost of producing the services. Where restrictions prevent dentists from utilising auxiliaries to perform tasks they are qualified to perform, the restrictions reduce the efficiency of production of dental services and increase the prices consumers pay (Liang and Ogur 1987). For example:

- where legislation requires that a dentist provide on-site supervision of a dental hygienist, the cost of the service must include the dentist’s time as well as the hygienist’s time;

- where a patient must see a dentist before they can have access to the services of a hygienist the costs will include both the dentist and the hygienist regardless of need\(^{31}\);

- where a dental hygienist is qualified to carry out a procedure, for example administer local anaesthesia or fissure sealants, but state laws do not include it in the ‘list of duties’, the provision of that service is less efficient and more costly than it need be;

- where a new treatment technology emerges that is within the range of competence of a dental auxiliary but state laws are not flexible enough to incorporate it, the ability of the practice to incorporate it efficiently into production is lost\(^{32}\);

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\(^{31}\) Referred to as gatekeeper controls (DP&C 1996)

\(^{32}\) Referred to as dynamic innovation (DP&C 1996).
where a hygienist provides a service which is charged at the same rate that a
dentist charges, the price does not reflect the cost of providing that service33.

De Vany (1982) and MacBride (1974) concluded that restrictions on dental auxiliary
use (such as prescriptive definition of practice, limits on client groups, requirements
for supervision and barriers to portability of qualifications) raise dental service costs
and may increase the fees charged for those services.

Liang and Ogur (1987) carried out a study for the US Federal Trade Commission
into the price and service quality effects of restrictions on the employment of dental
auxiliaries. They concluded that there was evidence to support the view that auxiliary
use restrictions:

- distort the combination of inputs in the production of dental services,
- raise costs of production, and
- lead to higher service prices.

Their study also addressed quality of care by carrying out a literature review that
documented experiments in public health, university, military and private practices.

They concluded, based on the empirical evidence, that:

"...quality is not decreased when expanded functions are delegated to auxiliaries who have been
trained in those functions... (and that)... there was no statistically significant differences in quality
between procedures performed by an auxiliary and those performed by dental students... or
dentists" (Liang and Ogur 1987)

They also concluded that if restrictions were relaxed, consumers would pay lower
prices for dental services and that at lower prices, consumers would buy more dental
services (Liang and Ogur 1987).

In all but three US states, supervision of dental hygienist practice must be either
'direct' which requires that treatment be authorized and the dentist is present while it
is being carried out, or 'general' requiring authorization but not physical presence of
the dentist. Washington state permitted unsupervised practice in non-office settings
beginning in 1984 and Colorado sanctioned independent dental hygiene practice in
all practice settings beginning in 198634 (Perry et al 1997, Astroth and Cross-Poline

33 Referred to economic rents (Liang & Ogur 1987)
34 The day after the law took effect, two Colorado residents and the dental accrediting body sued the state. They
alleged the law would affect the accrediting body's ability to accredit dental hygiene programs and that the
residents were at risk of death or serious injury from unsupervised dental hygiene practice based on their medical
conditions. The case was dismissed in September 1989 but appealed to the State Supreme Court which referred it
back to the Court of Appeal where the decision to dismiss the case was upheld (ADHA 1988, also reported in
Astroth et al 1998).
In July 1999, California enacted legislation allowing independent practice by dental hygienists, following a politically troubled pilot project to examine the employment of independently practising dental hygienists. This pilot study found that independent dental hygiene practices charged lower prices than traditional dentist practices and increased access for lower income patients (Kushman et al 1996, Perry et al 1997, Freed et al 1997). Perry, Freed and Kushman (1997) found that new patients in established independent dental hygiene practices were more likely to be non-white, younger and report a lower family income; those groups with historically lower rates of dentist utilization. The other group who chose to utilise these practices were more highly educated young women. The investigators concluded upon the evaluation of this pilot that:

'...given the methods used in this study, the evidence indicates that independent dental hygienist practice did not increase the risk to the health and safety of the public or pose an undue risk of harm to the public' (Freed et al 1997).

These findings are consistent with findings from a similar study carried out in 1994 in Colorado (Astroth and Cross-Poline 1998).

Studies in the field of primary health care draw similar conclusions about improving access to care through the use of nurse practitioners. There is evidence of high levels of community acceptance and integration with existing health services provision and a reduction of up to 39% in the costs of care (Martin and Hutchinson 1999, Baldwin et al 1998). Hartley (1999) found that demand for nurse-midwives’ services has come from the higher educated middle class (who have a preference for less interventionist birthing procedures) and lower income groups for whom cost is an issue. This study showed that greater utilization occurs in populations with high managed care penetration, favourable state policy environments and a more educated demographic base and that rural and low income population areas were good candidates for extension of nurse-midwife practices (Hartley 1999). Many countries around the world have moved to models using advanced practice or nurse practitioners in an effort to better utilise existing resources to mediate the costs and extend the reach of medical services (Scheffiler et al 1996, Martin and Hutchinson 1999, DHS 1999).

Dental hygienists and therapists exist in many other countries around the world and have been repeatedly shown to provide high quality and cost effective services (Johnson 2001b, Nuffield 1993). Many European countries utilise dental hygienists’
services and the Scandinavian countries in particular have experimented with
different models of care and service mix. Örhn et al (1996) showed that when the
diagnostic abilities of dentists and dental hygienists were compared across all age
groups, there was no significant difference. They concluded that no patient with
restorative treatment needs would have been neglected if the dental hygienist had
performed the examination, and possibly more accurate non-restorative treatment
would have been rendered. Studies carried out in both Norway and Sweden showed
that hygienists can be cost-effective providers of services to children in a primary
care role (Wang 1994, Hannertz and Westerberg 1995). In 1993 in a major review of
dental auxiliary practice in the United Kingdom, the Nuffield foundation
recommended the wider and more flexible use of auxiliary professions based on their
ability to provide services of high quality at a lower cost (Nuffield Foundation 1993).
The World Health Organization (1994) endorsed this view arguing that:

"...Figures collected by the British Government show that up to 80% of ‘items of
service’ now largely carried out by dentists could in principle be carried out by
properly trained auxiliaries, less highly trained and less expensively employed than
dentists. Auxiliaries are more prevention oriented and ...routine examinations could
be carried out by auxiliary staff, providing the data on which dentists could base
treatment planning..." (Nuffield Foundation 1993).

1.2.4.2 Australian studies

International findings are supported by local studies related to the quality and cost-
effectiveness of dental care provided by dental therapists which indicate that it is
equal to or better than that provided by dentists alone. (Barnes 1983, Gaughwin et
al 1996, Riordan 1997). In 1983, David Barnes, then Chief of the Oral Health Unit
of the World Health Organisation undertook a review of the South Australian School
Dental Service to examine and report on quality of care and effectiveness of its
services provision. He described the quality of care as excellent, cost effective and
efficient in creating “...an excellent preventive and treatment blend, promoting
better oral health and health attitudes and behaviour.” (Barnes 1983). A South
Australian study conducted in 1996 comparing care provided by the private and
public sectors found that children’s oral health outcomes were better where they had
received their dental care from the School Dental Service, where the majority of care
is provided by dental therapists with off site supervision (Gaughwin et al 1996). A
client satisfaction survey carried out by the public sector dental service provider in
Victoria in 1999 found that 93% of children’s service users were satisfied with the
dental treatment their children had received from the School Dental Service (DHSV 2000). All three of these studies have looked at the outcomes from public sector services provided by the combined therapist/dentist model which sees the overwhelming majority of dental care provided by dental therapists working in a primary care role (Dooland 1992).

Millsteed (1996), in a study of the costs of anti-competitive behaviour in the Australian dental industry found that the ten most commonly provided dental services to eligible veterans in 1993/94, comprising 60.09% of all dental services for that financial year, were treatment services and procedures currently being provided by dental therapists to primary and secondary school students in Australia. She made two estimates of the potential to make dental expenditure savings. The first was based on direct substitution of therapists for dentists in appropriate areas (public and private practices) showing a $238 million saving representing 14.2% of recurrent national expenditure on dental services in 1992-93. The second model involved only the private sector and was calculated using Commonwealth Dental Health Program (CDHP) service data showing that total CDHP service costs could be reduced by 19% or the equivalent of $223 million nationally. Spencer et al (1994a) found that the predominant work effort by general dental practitioners was that of low to medium technology level, further confirming that dental therapists could be utilised in the provision of lower cost basic dental procedures to wider client groups.

Until 2001, Victorian local government Preschool Dental Programs employed dentists to deliver their services. Of the 34,565 services provided to Victorian preschool children under this scheme in 1993-94 using fully qualified dentists, 60% were educative, 28% were diagnostic and 8% restorative most of which could have been delivered by a dental auxiliary at much lower cost. Analysis on the basis of salaries alone shows that costs are inappropriately high as a result of using dentists to deliver these low technology dental services to preschool children. Under the Victorian Preschool Dental scheme in 1993/94, the average cost of a course of care was $265; in South Australia where dental therapists were used to provide these services, the average course of care cost $52.49 (Millsteed 1996).

A study carried out by the Victorian Dental Therapist Association (VDTA) in 1998 estimated that regulatory restrictions could cost existing Victorian consumers of
dental services somewhere between $10 million and $30 million per year. The VDTA argued that removing the employment and client group restrictions on dental therapists could lead to significant price falls for consumers and improved access to dental care, particularly for people on low incomes or those facing physical or geographical barriers to dental care. Reducing the cost of dental care could lead to an increase in preventive dental care through encouraging demand for price sensitive services such as oral examinations or preventive services. These extra consultations would significantly improve the oral health status of the Victorian community. Reduced prices for dental care would mean engagement with a wider market - more people could get regular care. For people with limited amounts to spend on dental care, reduced prices would mean more services for the same spending which would increase their access to preventive services. Increased capacity to access preventive services would result in better oral health status across the whole population in the long term (VDTA 1998).

1.2.5 How dental policy has influenced the distribution of dental services

The issue central to the distribution of dental care in Australia is cost. There are two aspects to this issue, one is the cost of services and the other is who should pay for them.

Dental care is expensive, but unlike other health care, the cost is not mediated by governments in an equitable fashion. Low income people have a ‘...ragged and torn safety net...’, the working poor are the subjects of a ‘trough in funding’ and the affluent who have the capacity to engage in the market on their own terms receive high levels of government subsidy through rebated health insurance (Spencer 2001a). Spencer, in a commissioned paper for the Australian Health Policy Institute, argues that the key problems related to this are the inadequacy of the dialogue between the federal and state governments in relation to the provision of services, buck passing, short rather than long term approaches and a lack of integrated and creative solutions. He argues that oral health should be considered as integral to general health and that current inequities could be mediated by a re-shaping of the policy environment incorporating a re-allocation and three-fold increase in public sector funding levels (Spencer 2001a).
The other aspect to the provision of dental services is the cost of providing them. Dental care, like other health care, is costly. Currently, the provision of dental services is regulated by state legislation that limits the mix of service production inputs. Regulation defining the roles and relationships of the various dental occupational groups has the effect of structuring service provision. This has the effect of limiting dynamic innovation and the opportunity to reduce prices through service production efficiencies. It is this aspect of dental service provision that is the subject of this thesis.

Several authors have proposed the wider utilisation of dental auxiliary skills in the provision of dental services (AHMAC 1996, Dooland 1992, Lewis 1996, Millsteed 1996, SCARC 1998). The US literature in particular demonstrated that regulation which limits the services that auxiliaries may provide, forces rigid supervision and prescription by dentists and prevents portability and development of skills to meet local needs, resulting in higher costs and prices of dental services. In 1995 the Australian Health Ministers Advisory Council (AHMAC) gave support to a project to test the use of a dental therapist type auxiliary in the provision of services to adults and in 1998 the Senate Community Affairs References Committee recommended that states review their legislation with a view to more efficient use of dental auxiliary skills. Neither initiative has made much progress.

Millsteed (1996) argued that the full application of the Federal Government’s National Competition Policy ought to be made to the dental industry. Her study used Commonwealth Dental Health Program (CDHP) data to show that the utilisation of dental therapists’ services as substitutes for dentists’ services could have resulted in national program savings of 19% over the four CDHP funding years, that is around $53.83 million. She concluded that barriers to both horizontal competition (which limits the practice of dentistry to dental practitioners) and vertical competition (which prevents competition among dental practitioners by limiting aspects of dental practice to certain providers) within the dental professions require examination. She found that horizontal barriers to competition are largely self regulatory whereas vertical barriers are generally legislative in nature and that both imposed significant costs on the community in relation to its access to dental services. Her view was that dentists have sought to maintain these barriers to protect their monopoly over the dental market using quality of care arguments without empirical basis. Their control
of regulatory procedures has made it difficult for dental auxiliary professions to operate independently and competitively and that there has been a historical and collective resistance by the dental profession to reform and review (Millsteed 1996, Lewis 1996, VDTA 1998)

1.2.5.1 National Competition Policy and the provision of dental care

Under neo-liberal thinking, reducing health care costs is considered to be achievable if the barriers to effective competition are reduced among health professionals (DP&C 1996, Hancock 1999). A national policy to encourage competition and the creation of a “level playing field” fits with this way of thinking by creating a market for health which works to reduce the barriers to effective competition (such as monopolistic behaviours) and stimulates more cost-effective outputs (Millsteed 1996).

In this environment, the Hilmer Review recommended the implementation of National Competition Policy and amendments to the Trade Practices Act to include application to the previously exempt health industry (Hilmer 1993). In April 1995, at a Meeting of the Council of Australian Governments (COAG), all states and territories agreed to unilaterally apply National Competition Policy to all areas of industry including the health sector. This Competition Principles Agreement established agreed principles for structural reform of public monopolies, competitive neutrality between the public and private sectors, prices oversight of utilities and other corporations with significant monopoly power, a regime to provide access to essential facilities and a program of review of legislation restricting competition. The agreement also included a commitment from the Commonwealth government to three rounds (or tranches) of payments to the states for compliance, dependent on States meeting agreed reform objectives as assessed by the National Competition Council (NCC). These objectives included reviews of all legislation including occupational regulation applying to health practitioners (COAG 1995, DP&C 1996).

The main elements of reform applicable to occupational regulation include the application of Part IV of the Trade Practices Act 1974 which includes competitive conduct rules, the consideration of non-legislative mechanisms to protect consumers and the reviews of anti-competitive legislation which may have implications for the licensing arrangements for certain occupations and the professions. Anti-competitive
behaviour may arise from government restrictions on professional standards and rules of conduct enforced by professional bodies. Such restrictions include licensing, function splitting, and restrictions on ownership and advertising and fee regulation. Occupational licensing (or registration) is considered to be anti-competitive because it imposes barriers to market entry for non-registered service providers potentially inflating prices. Function splitting includes arrangements which prevent occupational groups from competing with each other. Restrictions on ownership (for example professional practices) may prevent multi-disciplinary service provision, limit opportunities for economies of scale and the application of generic managerial or business skills and can increase the costs of running practices. Advertising restrictions can reduce the amount of information available about the range of services, hindering consumers’ ability to compare services and may increase search costs. They can also limit the ability of new businesses to attract clients, protecting the interests of existing businesses. The publication of fee scales purporting to be based on costs of services can operate as a de-facto minimum scale or monopoly pricing, artificially inflating prices and reducing competition (Industry Commission 1995). A study carried out by the Industry Commission (1995) of several professions identified the restrictions in the various states’ Dentists Acts as potentially anti-competitive. In particular these were the restrictions applied to dental auxiliaries (numbers, limited duties and supervision) and the ownership and advertising restrictions.

Each state in Australia has developed separate dental practice regulation applying to delivery of services by dentists, dental specialists, dental therapists and hygienists and dental technicians and prosthetists. While the detail of these Acts is different in each state, the broad mechanisms such as registration, discipline, ownership and advertising limits, auxiliary restrictions and fee setting are similar. Under the NCP agenda, each state was required to pass NCP application legislation and develop review timetables by July 1996, aiming to finish their legislation reviews by June 2000 (COAG 1995). This deadline was later extended to June 2002 (COAG 2000).

1.2.5.2 The relationship between regulation, competition and access to dental services

As discussed earlier, there is evidence that the broader use of dental auxiliaries would increase access to dental care and that the barriers to this have been
established by dental practice regulation. Regulatory mechanisms can increase or decrease utilisation of the skills of dental therapists and hygienists and subsequently the costs of providing dental care. The following list of regulatory mechanisms is drawn from the literature evaluating and reporting the utilisation of dental therapists’ and hygienists’ skills, the economic literature assessing barriers to competition and the existing dental practitioner regulation from Australia and overseas.

1. Community access to regulatory policy making - where Boards are comprised of all dentists the capacity to protect the interests of the profession is increased (MacBride 1974, DOH 1990).

2. Registration of dental therapists and hygienists under a Dental Practitioner Act places the onus of professional practice on the practitioner with rights to practice as an assurance of public protection. This reduces the need for other potentially anti-competitive mechanisms (such as limiting or prescribing practice, supervision etc).

3. Gatekeeper controls on service provision increase costs through bundling- where services provided by one dental care provider are tied to services provided by another (Liang and Ogur 1987, DP&C 1996).

4. Costs of care are increased where regulation limits the number of dental therapists or hygienists a dentist works with- i.e. ratios are defined (Liang and Ogur 1987, Industry Commission 1995).

5. Access to services is restricted where limits are placed on the employment settings of therapists and hygienists. This limits the range of clients and providers who have access to their services.

6. Dynamic innovation is reduced where skills or services are tightly prescribed (or bundled) by regulation limiting the capacity to reduce costs (MacBride 1974, DP&C 1996).


8. Advertising limits have the effect of restricting the information a consumer has available, increasing transaction costs associated with making dental service purchasing choices. It also reduces the visibility of complementary or substitute services (e.g. dental therapist and hygienist services) where regulations prevent practice stationery, print media and noticeboards promoting their services.
1.2.6 Conclusions

The key issues at the interface of health policy and the economy are the high and ever rising costs of health care and the ethical arguments related to its rationing. Governments have faced increasing health budgets with little ability to alter the demands for and costs of care. Dentistry has encountered similar issues but these are exacerbated by its market based service delivery, exclusion from Medicare and the inability of private health insurance to adequately mediate the costs. The high costs of dental care have meant that whole sections of the community are, in fact, not consumers of dental care due to its inaffordability. Public health dentistry has had limited government support, and only transient injections of Commonwealth funding. Small amounts of state funding in this area have highlighted the need to find more cost-effective and equitable ways of providing dental care. Dental disease is one of the most prevalent diseases in our community and is projected to create increasing demands for care into the future (AHMAC 2001).

The regulation of the dental market has created rigid service delivery models allowing little flexibility to alter service inputs. Only dentists are able to provide dental services freely, with dental specialists, therapists, hygienists, prosthetists and technicians subject to regulations which limit their client groups, business arrangements, employment and range of services. Of these, the greatest limitations apply to dental hygienists and therapists, who are subordinate to dentists, limited in their practice and regulated by dentists.

Better use of dental auxiliary skills has the potential to reduce the costs (and prices) of dental care, making it more accessible to more people. Dental therapists and dental hygienists have skills that match the needs of many of the under-serviced groups in our community and the capacity to provide for increased access to dental care. Up to June 2001, the majority of models utilising dental therapists’ skills were operating in the public sector with children. Given the capacity to work in the private sector, dental therapists, like dental hygienists could provide greater potential to reduce the costs and prices of dental services. Similarly, dental hygienist practice is so closely supervised and prescribed that there is no capacity to incorporate dental services into general health services nor provide outreach to under-served and immobile populations.
There is however, a need for regulatory mechanisms to be altered and pricing mechanisms to directly reflect this cost-effectiveness in order that this benefit may flow on to the consumer in the marketplace. Economic evaluations suggest that better utilisation of the skills of dental therapists and hygienists will not only increase the size of the market due to reduced prices, but will also increase the amount of services provided and improve access to dental services. (Liang and Ogur 1987, Millsteed 1996, VDTA 1998). This can improve oral health status because diagnostic and restorative services then become more affordable, preventive services become more accessible and waiting lists for public care are reduced by providing more services for the same expenditure.

The application of National Competition Policy to the dental industry has the potential to alter the regulation of dental practice in Australia. NCP has initiated reviews of dental practice legislation with the imperative to de-regulate the industry and remove barriers to competition. Many of the identified barriers exist as accepted aspects of dental practice regulation.

In summary:

- dental disease in Australia is widespread and costly;
- a predominantly privatised market under monopoly control of the dentist; profession contributes to inefficiencies and inequalities in access to dental care;
- Commonwealth and State Governments are in a position to address these inefficiencies and inequalities in dental care delivery through policy and associated regulatory changes;
- National Competition Policy has provided the opportunity to make these changes; and,
- the changes that are likely to flow from application of NCP to dental health services threaten dentists’ monopoly control of the market.

This study therefore examines:

(i) options for more efficient and equitable dental health care delivery in Australia; of interest is the range of ways in which dental hygiene and therapy practice regulation has been addressed in other places. Canada, the United Sates of America, the United Kingdom, Europe, and New Zealand share economies and health care systems with similar oral health needs and occupational mixes to that of Australia. They also face
similar issues in relation to projected oral health needs into the future. The models they have used to regulate practice and their policy development mechanisms have the potential to offer solutions to some of the problems faced by the Australian setting.

(ii) policy development aimed at improving efficiency and equity with a focus on processes and outcomes of policy development in an environment of strong opposition to policy change.

There is a need to know more about the application of National Competition Policy to the review of dental legislation and whether empirical material related to the cost-effectiveness of dental therapists and hygienists will be incorporated into regulatory change. Of interest is the way in which new regulation will be developed and whether it will attend to the empirical material described above. The development of policy incorporates many components including social, epidemiological, political and economic influences. The contribution made by various stakeholders, empirical evidence and the issues shaping governments’ approaches to the problems presented combine in unique ways to produce particular outcomes. The questions about how policy around dental service delivery is made also require answers.

While the study adopts a grounded theory approach to data collection and analysis, it nevertheless draws on a number of theoretical frameworks to assist in framing the study and interpreting study findings. Key among these theoretical frameworks are those associated with policy, health policy and policy analysis, and professional dominance. These theoretical frameworks are discussed in the following chapter.
CHAPTER 2: HEALTH POLICY AND THE ROLE OF EXPERTISE

2.1 Policy and policy analysis

This study is interested in dental health policy as a sub-set of health policy, and in particular, policy related to the interaction between dental workforce regulation and the delivery of dental care. Current Australian policy related to these issues was reviewed in Chapter 1. The first section of this chapter focuses on policy analysis frameworks and some key theoretical perspectives associated with health policy development. The second section discusses the role of expertise in policy making and examines the applicability of this influence on the nature of past dental policy making.

The policy literature contains many diverse perspectives on policy, policy development processes and policy analysis. This section provides an overview of these perspectives. This literature has shaped the development of this study and is drawn on to assist in analysing and interpreting the study findings later in the study.

2.1.1 What is policy?

Policy may be described as a statement of behavioural intent at an institutional or collective level frequently appearing as a document describing a course of action. Palmer and Short (2000) describe standing rules, predictions and statements of future intent and descriptions of past actions as examples of policy. A policy may have distributive, directive or regulatory functions; it can also clarify public values and intentions, commit money or services in a specific way or grant rights and entitlements (Lowi 1972, Hogwood and Gunn 1984, Considine 1994). In this sense, where it deals with rights, services and resources, there may be recognition of the interests engaged in its development. It then becomes the output of a process where ‘...values, interests and resources compete through institutions to influence government action,’ (Davis et al 1993). While it may represent the expression of a single perspective, it is more often the result of collective agreement, reflecting the pressing and squeezing of interest groups on one another and upon those with the power to give such expression authority. It is often reflective of the values of those in a society with the resources to be heard, and as such can be seen as the concrete expression of power (Hancock 1999).
Palmer and Short (2000) propose that health policy has some special characteristics worthy of consideration. Firstly, health policy is always public policy involving governments because of the nexus between health and economic status which has been ideologically accepted by Australian governments since federation. Australian state and federal governments have been involved in health surveillance, regulation, funding and service provision at various levels since that time (Gardner 1995). Secondly health policy has a special role for expertise giving the medical (and dental) professions in particular, rights and privileges that have shaped our policy environment in a particular way. Thirdly, the unpredictability of illness, the complexity of health care and the difficulties associated with being an informed consumer of health services makes the policy decision making more complex than in other fields. Further, more recently, agendas driven by neo-liberal policies incorporating economic rationalism (Carroll 1992), corporate managerialism (Yeatman 1993) and the National Competition Policy have altered the health policy landscape. The ability to apply purely rationalist or market based thinking has, however been shown to have its limitations in health policy (Hancock 1999). These overlaps between economic and social policy and the relationships between the allocative, clinical and ethical aspects of the provision of services and the promotion of health makes for a highly complex area of policy making (Gardner 1995, Palmer and Short 2000, Baum 1999).

2.2 Health policy analysis; theoretical perspectives

In health policy, the complexity described above gives rise to a number of analytical perspectives; how the professions interact with the policy process and their subsequent influence on the outcomes; how the outcomes affect or are affected by the needs of consumers; whether policy should be evaluated against economic, social, preventive or clinical outcomes; and the impact of policy at individual, community or population levels. There are also approaches that examine the development of policy looking at sequence, process and rationality. More sociologically focused approaches look at the interaction of stakeholders and power in the development process and subsequent policy outputs. There are also approaches which analyse the outputs (the product of a policy review) and their implementation where the translation of written
intent into action is examined, and those that focus on evaluation where the impact and outcomes of the policy are assessed against the pre-defined goal or problem.

Ham and Hill (1993) suggest that there are also different purposes for examining policy and that these relate to an academic interest in advancing understanding along with the need for advocacy and participation in policy making requiring practitioner knowledge.

The focus of this study is on an examination of the process of dental policy making in order that advocacy for public health approaches to oral health may be made effective. Policy analysis in this study will therefore focus on the study of policy process drawing on content and output to develop insight and understanding. Policy evaluation will be based only on policy outputs as the scope for evaluation of policy implementation is limited by time constraints. An increased knowledge of policy and the policy process can then be used to contribute to advocacy in the dental policy process.

The following section of this chapter will look at approaches to analysis from organisational and social perspectives and conclude by describing the approach to analysis taken in this study.

2.2.1 Theoretical frameworks for analysis

Anderson (1984, in Palmer and Short 2000) developed a framework for analysis which described sequentially patterned action identifying five key stages of policy making. This model holds that the first stage is where problem identification and agenda setting occur. This is followed by policy formation or development, which is followed by adoption where policy is enacted or formalised and then implemented. The implementation stage may incorporate adjustment as the policy is brought into practice. Implementation is then followed by evaluation where monitoring, analysis of impacts and criticism may occur initiating a cyclic return to the agenda setting or
formulation stage where major adjustments are required (Davis et al, 1993). Palmer and Short (2000) make use of this model although along with Milio (1988) they argue that the social and political context of policy making is critical to its analysis. They urge examination of the roles of key actors, interest groups, institutions and political processes in order to understand the basis of policy decision making. Hogwood and Gunn (1984) further developed the process component of the framework where they emphasise that interaction between both stages and participants throughout the process is important.

Many authors also draw on Easton’s (1965) model which sees political systems as subject to continuous demands. Easton sees the system remaining stable because the participants accept and support its capacity to adjudicate competing demands. Demands such as requests for allocations or the adoption of values (inputs) are processed in a ‘black box of decision making’ to become outputs. The policy output is a product of its inputs (supports and demands) and is distinguished from outcomes which are the effects policies have on the community (in Gardner 1992, Palmer and Short 2000, Considine 1994).

Ham and Hill (1993) point out that while Easton recognises the significance of ‘withinputs’ there is insufficient recognition of the role of politics on the shaping of demands. They also make the point that this framework does not adequately deal with the decision making process and that a more sophisticated analysis is required to enable a ‘penetration of the black box’ in order to strengthen the explanatory power of the analysis. They seek an incorporation of the interactions of people, power and rationality as important to the outcome (Ham and Hill 1993). While the process approach is an important one, it can struggle to make visible the historical and wider social and economic conditions and the exercise of power which can operate in a policy environment.

Sabatier proposed a framework for policy analysis in 1993 (which was further refined in 1998) that identified the influences of both social and political factors in a policy decision making process. His Advocacy Coalition Framework identifies two sets of ‘exogenous variables’ as the basically stable and fundamental socio-economic values, constitutional structure and attributes of the problem area, and the external system events such as policy impacts from other systems, governing coalition values, public
opinion and changes in socio-economic conditions. His penetration of the 'black box' requires acknowledgement that these exogenous parameters and events interact with the values, constraints and resources of the actors who are arranged into one or more advocacy coalitions. Sabatier defined advocacy coalitions as groups of people who share normative and causal beliefs about policy problems and who engage in co-ordinated activities in order to influence policy decision making. This framework asserts that policy outputs flow from the interaction of both exogenous (social and economic factors) and the interactions of the advocacy coalitions (Sabatier and Jenkins-Smith 1999).

Considine (1994) is also critical of Easton's system because of its presumption of internal stability and its lack of recognition for the roles and interplay of policy actors. He, like Sabatier asserts that the relationships inside the policy system need not be stable; hierarchical relationships for example may exist without consensus but are still interdependent and will shape policy actions, meditations and outputs. He asserts that policy reflects the history and structure of the policy system and is the product of particular kinds of systems built from material and cultural interdependence. The system not only determines the dominant ideologies which shape it but also the range and levels of participation (and networking) of the key social interests. His analysis therefore relies on a systemic and network analysis to understand and explain policy development. He identifies four key aspects of a policy system as being:

- the policy institution (for example, a local government, department or institution such as a hospital and the policy making mechanisms that exist there),
- the political economy (the service mechanisms and funding sources, supply and demand relationships),
- the policy culture (the dominant values and assumptions which underpin the policy process), and
- the policy actors (the policy makers, key stakeholders and interests).

Each system will acknowledge particular types of values and beliefs articulated by particular actors and the dynamic nature of policy making will result in new conflicts and alliances evolving from each policy process. Policy innovation occurs when there is an institutional system for increasing the value of a particular perspective or
solution - altering the cultural values of a system occurs through the expert networking of key social interests. In this way, material and cultural interdependence contribute to structures and interests, and these help to define the range of options available, and also how dominant opinions come to be heard (Considine 1994).

So, in order to critically examine the policy development process, there is a need to examine the relationships of supply and demand and the interdependence and actions of policy actors and interest groups and the way they shape the culture. This approach has been used in the analysis of the results of the Victorian policy review process.

Policy actors, including the policy leaders and institutions have strategic approaches to making policy which will affect the way decisions are made. Ham and Hill (1993) observe that analysis of decision making falls broadly into two schools; one explores the relationship between rationality and decision making; the other focuses on power, interest groups and decision making. The rational approaches have been used to assess the approaches taken by policy institutions to policy making in this study. The other approach has informed the analysis of the policy system and its participants. The theoretical perspectives related to these aspects of decision making are explored next.

2.2.2 Rationality

Rationality can be thought of as an approach that bases decisions on what is considered to be the best or most efficient means of achieving a particular outcome (Willis 1995). A range of models and processes for achieving policy outputs is described in the literature. They fall largely into three categories; rational comprehensive decision making, incrementalism and mixed scanning (Palmer and Short 2000).

Simon (in Ham and Hill 1993) asserted in 1945 that rational comprehensive decision making involved evaluation of the full range of possibilities and their consequences followed by making a decision in a rational fashion based on the outcomes which would best suit the values of the organisation. Critics of this model pointed out that individual limitations and interpretations of the organisation's values would lead to different outcomes. The difficulty in setting common goals has also been noted (Kingdon 1995). Practicality also means that often the full range of possibilities and
outcomes could not be considered (due to time or resource constraints) so that range selectivity might be applied resulting in a bounded rationality. This bounded rationality would then produce an outcome referred to as ‘satisficing’, or choosing a solution which is most workable or ‘good enough’ (Davis et al 1993, Ham and Hill 1993).

In 1959 Lindblom described an alternative to rational policy making that he referred to as incrementalism. He argued that it was a sound prescriptive model because of its ability to resolve problems through successive limited comparison of alternatives. This model involves incremental adjustments to existing policies which reduces the range of possibilities that need be considered at each stage. Change therefore occurs in a more evolutionary fashion with a greater capacity to satisfy participants (in Ham and Hill 1993, Kingdon 1995). Dror (1964) criticised incrementalism as a prescriptive model for its conservatism and its inability to deal with disputed goals and because it favours the already dominant ideology (in Davis et al 1993). Both Dror (1964) and Etzioni (1967) sought a middle way between rational comprehensiveness and incrementalism which would reduce the amount of information required for decision making but still allow for change to occur. Etzioni proposed that mixed scanning was both a prescriptive and explanatory model that emphasised the distinction between fundamental (or broad sweep) and incremental (or narrower, more detailed) decisions. Fundamental decisions are taken via a broad and rational review of the field allowing long term outcomes to be assessed and direction to be set. Incremental decisions provide for more detailed attention to specifically identified or problematic issues with more limited options within the set range (in Ham and Hill 1993, Hogwood and Gunn 1984).

Other critics of rationality such as, Cohen, March and Olsen (1972) argued that people (organisations) do not always clearly define their goals but rather produce decisions in a more ad hoc fashion with problems rather than goals as the driving forces. They described a policy setting as a kind of organized anarchy where participants move around policy decision points in a fairly fluid and opportunistic fashion seeking problems to which they can apply their solutions. The policy environment becomes a place where solutions look for problems and issues and values look for decision situations. Policies grow out of the ‘...mix of 'garbage' in the can and how it is processed’. Problems may be resolved or may drift into another
setting to be resolved by a different mix. Rational decision making and goal setting is not apparent, but rather solutions to problems are drawn opportunistically from the ‘policy primeval soup’ accumulating in the ‘can’. Policy making under this ‘garbage can’ model requires three conditions to come together: problem recognition, policy proposals and political events. People express problems in terms of solutions; problems and participants move into the same setting and abrupt change can occur as new and untried combinations come into being (Kingdon 1995, Hill 1997). Considine (1994) observes that interaction between stakeholders, suppliers and users of services for example, may shape the way issues are arranged to match solutions; that supply might shape demand for services.

This mix of policy makers, suppliers and users of services combining to produce policy outputs follows pluralist thinking. However, the assumption that all will have an effect on the outcomes relies on their equal ability to contribute to the process. ‘Garbage can theory’ was developed from studies carried out in a university setting where one could assume the policy process to be accessible to most of the key actors. The other models focusing on rationality make similar assumptions. Much policy is made in circumstances where universal access to the process is more difficult, where action may be overt or covert and participation may be structured deliberately or shaped by social circumstances. Analysis of the social and structural influences on the policy process is thus an important aspect of policy analysis and is used in this study.

2.2.3 Societal influences

Smith (1993) argues that there are two perspectives from which to view societal influences: as society centred or state centred. State centred approaches incorporate corporatism and elitism to describe the notion of the state engaging with particular groups or organised interests in a selective fashion in order to govern. Society centred approaches incorporate pluralism and marxism where the state mediates between society’s interests to produce outcomes which meet the needs of the people.

Elitism, as one perspective, sees those with wealth, education, knowledge, status and capital as residing in a section of society which engages with decision makers through class connections. C. Wright Mill, an American sociologist, argued that economic and political power was becoming more concentrated as these power elites came to
control key institutions in society such as the media, education, bureaucracy and political parties (Baum 1998, Hancock 1999). This gives this group greater access to policy processes which allows them to protect and perpetuate their positions as leaders, decision makers and resource holders. Power in society is concentrated, centralised and exercised continuously (Gardner 1992 and 1995, Ham and Hill 1993). Willis (1989) used this perspective to explain the dominance of the medical profession in Australian health policy (this is addressed in greater detail later, in section 2.4.2).

Corporatism describes a perspective that sees the state, in its efforts to manage the economy, engage with business, unions and select group interests because of their capacity to provide employment, manage services and labour, and control production (Ham and Hill 1993). This relationship is interdependent but state dominated and operates to develop policy through shared decision making or 'representational monopoly' (Gardner 1992, Considine 1994). In the health sector, professional associations and insurance companies represent key participants under corporatist thinking (Hancock 1999). Such streamlining of sectional interests might facilitate the policy process but it operates at the expense of smaller and less powerful interest groups and participative diversity (Gardner 1992).

Other policy analysts describe a pluralist system with a society centred perspective. Dahl (1976, in Hancock 1999, Ham and Hill 1993, Smith 1993) was the main proponent of this thinking, describing a process that engages democratically with individuals or groups where power is dispersed or shared. Pluralist theory sees groups as central to the process of policy making, where they articulate the interests of various sectors of society to government (Smith 1993). This view holds the state as neutral arbiter that serves the common good and government agencies as one set of interest groups whose views compete with all the others. The uneven distribution of power in the process is not denied, but balance said to be is maintained in the system because different interests hold sway in each policy episode and no single group has a dominant role. Not everybody has equal capacity to influence the outcomes; each actor is either dependent, autonomous or dominant in relation to the others. Incentives to conform to these roles are strong but not irresistible and actors must choose between retaining the benefits of compliance or challenge, push for concessions and re-arrange their relationships. Policy outputs are the products of
negotiation and actors bring historically grounded preferences to the process which through compromise become components of the emergent policy. Clearly, decisions and outcomes will favour those with the most resources but no single interest is entirely satisfied. Dahl urged the analysis of overt conflicts and policy outputs to determine where power was distributed (Ham and Hill 1993, Considine 1994, Gardner 1995, Hancock 1999).

Marxism sees power as centred within the economic system, but characterises only two interests, the owners of capital (bourgeoisie) and those of the workers or labouring classes (proletariat). The state is seen as instrumental in the role of ‘...a committee for managing the affairs of the bourgeoisie...’ in that it facilitates the generation of capital (Marx and Engels 1970 in Gardner 1992). Policies and laws are made that support the interests of capitalists by protecting the ownership of property and reproducing ideas and values in society to support the values of the bourgeoisie. Health then becomes a commodity to be bought and sold and health services operate to maintain the quality of labour available. Changes in technology, separation of ownership from control and increased labour specialisation have blurred the distinctions described by Marx but the value of the theory is in focusing attention on the role of the state in a capitalist economy where the goal of capital accumulation is fundamental (Ham and Hill 1993, Gardner 1995).

The theories outlined above show that there is a range of ways of analysing social structures and their influence on policy making. All of these theories acknowledge a range of interests and that there are positions in society likely to grant greater or lesser access to decision making. Policy analysis must therefore also have an interest in how particular opinions come to be dominant and the mechanisms used to sustain them. The following sections examine the theories around how power operates to influence decision making and support the dominance of particular interest groups.

2.2.4 Power

Gardner and Barraclough (1992) argue that the allocation of values and resources always involves the articulation of interests and their mediation. It is clear that there are varying capacities for interests to be heard and varying ways in which these interests are reconciled. Policy analysis must therefore involve the examination of
which interests prevail in order to understand the way power is distributed in the system.

Foucault (1976) described power as a ‘…moving substrate of force…’ which may be exercised from innumerable points. It operates within the interplay of all relations giving effect to disequilibriums, divisions and inequalities and has a reciprocal quality dependent on its manipulation between parties. Because of its mobile and strategic nature and the resistance it generates, the effects of power need to be studied in the context of these relations (Foucault 1976, Giddens 1979). Accordingly, in the policy environment it is important to understand the individual positions and actions of each player as they relate to the others. In this way a policy process can be seen as a type of historically nested game, where individuals have more or less power according to the constraints of the ‘field’, the ‘rules’ and the quality of their support base. However, it is also the actions and interactions on the field of play that go to controlling the outputs that also require analysis.

Early process models relied upon a pluralist view which assumed similar capacities among interest groups to participate. Different groups with different interests were seen to share in the power to make decisions and the policy process became a matter of resolving the conflicts between these groups. Subsequently, recognition emerged that the ‘grand issues’ never really received policy attention because of the homogeneity of opinion within society. Such opinion, while appearing spontaneous and agreed tended to emanate from the dominant social groups supporting a conservative bias toward the status quo (Gardner 1995). Lindblom’s later work caused him to recognise that the distribution of power was less equal than he originally thought (Ham and Hill 1993), a concept explored by Alford in his work on structural dominance which will be discussed later (Alford 1975). Many authors (Alford and Friedland 1985, Gardner 1995, Hancock 1999) endorse this view and reject pluralism’s assumptions of open, accessible and responsive political systems by pointing out that under-resourced groups and those with compromised access to and competence in the policy system suffer from unequal starting positions. Ham and Hill (1993) suggest that while all groups will be heard at some stage, sources of power in political decision making are unequally distributed and achievement depends on resources and a ‘decibel rating’. Gardner observed in 1995, that power in the policy
arena can be a cumulative resource in that it has the capacity to be self-generating, sustaining the ability of particular viewpoints to be heard over time.

The analysis of power then, becomes an important focus for the examination of decision making. Early work by Dahl from a pluralist perspective urged the examination of decisions to determine whose preferences gain precedence in situations of direct or overt conflict. He observed that political actors whose preferences prevailed in conflicts are those who exercise power in a political system. Dahl, therefore urged an analysis of the decisions to determine whose will had prevailed. Lukes later referred to such power as ‘one dimensional power’ or, the power to get someone to do something they would not otherwise do (see p68); participants with the greatest number of successes out of the total number of decisions were then ‘considered to be the most influential’ (Lukes 1974).

Bachrach and Baratz (1963) criticised Dahl’s observations as simplistic on the grounds that the exercise of power can occur without overt conflict. Power can take the form of coercion, influence, authority, force or manipulation, all of which can occur in ways that avoid overt conflict but have the effect of manipulating agendas. Some issues are omitted from the decision making process by actions that support the status quo and reinforce existing beliefs and values so that decision making is confined to ‘safe’ areas. Bachrach and Baratz referred to this as the ‘mobilisation of bias’ (in Lukes 1974, Ham and Hill, 1993, Gardner 1992). For example, options may be considered ‘inappropriate’ for a range of reasons that then exclude them from consideration. Or alternatively one person may fail to act because he anticipates another’s reaction. This may result in suffocated conflict, averted discussion or failing that, de-railed implementation. Bachrach and Baratz asserted that for this reason, the analysis of what Lukes(1974) referred to as ‘second dimension power’ requires the examination of both decision making and non-decision making. Potential key issues then assume importance because of their capacity to involve:

‘...a genuine challenge to the resources of power or authority of those who currently dominate the process by which policy outputs in the system are determined.’(Lukes 1974)

Ham and Hill (1993) observe that some common strategies used to limit the scope of decision making may be to forcibly suppress demands by invoking rules or manipulating common community myths and values, for example in the mass media.
Issues may also be referred for study or review to a committee or the troublesome interest group may be co-opted into an alliance or into a participative decision making role. Easton in his policy making model (1965, in Palmer and Short 2000), also observes a ‘limitation’ role for policy processes by observing that one of the roles of the policy gatekeepers is to regulate the flow of demands in order to maintain the stability of the political system. This is similar to the ‘second dimension of power’ identified by Lukes (1974) and is widely viewed as agenda setting power. It is also recognised as one aspect of structural power (Hancock 1999).

Lukes’ (1974) criticised the work of Bachrach and Baratz’ on the grounds that it was still too ‘…committed to the study of overt behaviours and concrete decisions…’ and did not recognise the socio-cultural structures that protected the status quo. Lukes argued that the collective forces within interest groups and the social arrangements within which power is exercised both control and shape the way agendas are set, interests are expressed and decisions are scoped. This ‘third dimension of power’ so shapes peoples preferences that they contribute to the reproduction of the ‘natural order of things’; participants accept their role or can see no alternatives. The problem with identifying this form of power is that it is culturally embedded. Saunders (1980, in Ham and Hill 1993) notes that socio-cultural ideologies are largely perpetuated by the life experiences of all classes. In order to identify real interests, the costs and benefits to various groups of particular social arrangements need to be evaluated. In this way the structural aspects of the reproduction of dominance may be identified. So, an analysis of decisions to evaluate who benefits from them will illuminate the distribution of power at this level.

While Lukes criticised and extended the work of Dahl and Bachrach and Baratz, he also acknowledged this work as at least partially valid by incorporating it into a three dimensional classification of power. One dimensional power was the use of overt power exercised in observable ways described by Dahl in 1957. Two dimensional power was the covert or agenda setting power incorporating the mobilisation of bias described by Bachrach and Baratz in 1963. Third dimension power was the subliminal power he described himself requiring the examination of beneficiaries in order to make it explicit (Lukes 1974). This model for analysing the exercise of power is important because it explains several aspects of the reproduction of power and the way it can be used to control opinion and exercise policy dominance at a
structural level (Hancock 1999, Ham and Hill 1993). This study has used Lukes model in analyzing the dental policy making environment and its outputs discussed in more detail in Chapter 5.

As discussed earlier, health policy making has given a unique (and often powerful) position to the health care professions (Palmer and Short 2000). Given that the policy processes examined in this study exist in the health sector, the role of the professions and the literature related to their influence on health policy has also been examined. The next section deals with the role of expertise in policy making with particular reference to the health professions.

2.3 Expertise and Health Policy

Expertise and knowledge are crucial elements of policy making as incorporated in early attempts at rational comprehensive policy making models and more recent forays into evidence based policy making. The need for sound data combined with expert problem solving and solution generation is acknowledged by all policy systems. However, like the other aspects of policy making expertise, too, is subject to cultural and organisational influences (Considine 1994).

Experts use knowledge as a service and as such are dependent upon it as economic capital. The way it is deployed and utilised is therefore of paramount importance to their survival (Freidson 1994). It is in the interest of experts to manage this deployment and utilisation and to harness the potential power that attends its deployment (Illich 1976). Considine (1994) has identified social, occupational and organisational aspects of the use of expertise in policy making and urges the examination of its effects on both actors and outcomes. Experts who manage the deployment of their knowledge most successfully are those identified as professionals. Occupational groups such as lawyers, clerics and medical practitioners have traditionally been viewed as professions although other occupational groups (managers, academics) can lay claim to professional traits without attracting the same social value (Freidson 1994, Considine 1994, Germov 1998).
2.3.1 Professionalism

Profession can be defined as a form of work organisation or orientation incorporating the use of knowledge, an ethos or ideology and a degree of autonomy. Services provided by professionals generally involve the application of specialised knowledge, often involving personal services and high levels of trust from consumers. The ethos requires an altruistic interest in the task for its own sake, the expectation of competence, social responsibility and service to the client (Marshall 1998). A range of literature describes traits common to professionals as being the acquisition, through education of theoretical knowledge which is synthesized and used to solve complex problems, autonomous control over their own work practices, a regard for others as intrinsic to the provision of services, occupational organisation and the definition of ethical codes, and the development of collegiality and self-discipline. Considine (1994) also refers to a commitment to the discipline and career above corporate or occupational loyalties giving rise to independent judgement and a broader vision. There is also considerable reference to the capacity to develop and maintain an exclusive clientele and market for their own services (Millerson 1964 in Ham and Hill 1993, Illich 1976, Larson 1980, Turner 1995, Willis 1989, Considine 1994).

The functionalist view of professions argues that the place of professions in the social order is the result of a specialization of knowledge and skill in the provision of services which are socially valued (Germov 1998, Turner 1995). Parsons (1951) and Johnson (1972) saw professions acting as a stabilizing force in capitalist society where they balance the dominant ethos and organization of capitalism, in which the profit motive is paramount. Their concept of profession was as a vocation based upon universalism, disinterested service and affective neutrality rather than simply economic reward. In their view it was this motivation which distinguished professions from other occupational groups.

A Marxist analysis, on the other hand, sees professional groups, alongside other members of the middle class, contributing to the maintenance of production under capitalist conditions. Their role is to contribute to the management and surveillance of the working class in order that production is maintained. Professions therefore exercise control on behalf of the capitalist class under the auspices of, and with
legitimation by the state. Clerics thus support the socialisation of the working class and medical practitioners maintain their health and ability to work and control the time away from work. Their social position derives therefore from this state legitimised role and the power vested in specialised knowledge (Willis 1989).

Medicine, then, may be considered to draw power from its instrumental role in maintaining the balance between bureaucracy and capitalism via the duality of its interests in welfare and productivity (Ham and Hill 1993). Such a position benefits both government (by limiting the number of groups with which it must negotiate health policy) and the medical profession by enhancing and protecting ‘...its social and economic status and grant(ing) a measure of hegemony over the health sector...’ (O’Neill 1998).

An alternative to both functionalist and Marxist views were provided by Freidson (1970) and Johnson (1972) who saw professions and professionalisation as concerned with power and social control as mechanisms for achieving material and social benefits (in Willis 1989, Turner 1995). They argue that professionalization is achieved by the development of an esoteric body of knowledge which is protected by the preservation of an assymetry of information between patient and practitioner allowing the definition of need (demand) by the practitioner. Freidson (1994) argues that it is this authority of knowledge in a discrete field that characterises profession across many occupational areas, but the analysis of its power needs to include a consideration of the legitimization of such knowledge. Turner (1995) argues that such legitimization is vested in the ‘mystique of interpretation’ of the dual application of technical and theoretical knowledge and its exclusive ownership. Willis (1989) argues that it is the legitimation of this expertise by the state that allows professions to dominate their own markets.

2.3.2 Medical dominance

Based on his process analysis approach, Willis (1989) argued that medicine used political means to annex the declining mortality rates of the early twentieth century to its ‘scientific’ germ theory paradigm. This approach to disease placed the ‘germ infected’ individual as central to disease causality and was in keeping with the laissez
faire approach to welfare by the governments of the day. This helped to legitimate medicine’s role as the most respectable provider of health services (as opposed to, for example public health, homeopathy or Chinese herbalism).

Such a position was augmented by the establishment of university courses to replace apprenticeship style training as a means of achieving qualification to practice, thus preserving it as an occupation of the wealthy elite. The shift in medical care away from the home visiting ‘black bag’ doctor to hospitals managed by the more elite doctors with their linkages to the universities and thus to knowledge creation, further legitimated the power of the ‘educated’ doctors. University trained doctors then organised professional associations which excluded their lesser trained brothers (who came to be referred to as ‘unqualified’ or ‘quacks’) and sought government support for a register listing their names and qualifications so that the public might be able to recognise ‘legitimate medical practitioners’.

Political action on the part of the doctors eventually resulted in legislation in 1908 in Victoria to apply registration only to those who had completed five-year university qualifications. While it did not make it illegal for unqualified people to practice medicine, it conferred significant market advantages on those who were registered, protected the use of the title ‘doctor’ and the issue of death certificates to ‘qualified men’. In 1933, the right of the medical profession to set standards and to discipline their own members was enshrined via an ‘infamous conduct’ clause in the new Act. This is important because it effectively legitimated complete autonomous self-discipline for the profession by allowing them to ‘strike from the register’, without external interference, anyone who flouted their defined standards. This Act effectively defined medicine as the province of only those who had completed university medical training and finally excluded the more affordable Chinese herbalists, homeopaths, midwives and chemists from legitimate practice, thus creating a monopoly by legislative means (Willis 1989).

In 1946, Section 51 xxiii A was inserted into the Australian Constitution to confer the powers on the parliament for the “...provision of maternity allowances,...sickness and hospital benefits, medical and dental services...and family allowances but not so as to authorise any form of civil conscription” (Commonwealth of Australia 1995). This
clause enshrined medical and dental practice independence in the constitution\(^1\) thus legitimating medical autonomy at both state and federal legislative levels. Collective action and social power finally led to exclusionary state-supported shelter from competition and complete occupational autonomy through legislation (Willis 1989, Germov 1998).

Freidson (1970) noted that the monopolistic power of the medical profession was such that it could subordinate adjacent and related occupations, keeping them permanently in the status of quasi-proessions or para-medical groups (in Willis 1989). Such a view is supported by Turner (1995) who takes the position that the location of the medical profession is achieved by its control of the means of production (subordination and surveillance of ancillary and related occupations) and its contribution to the maintenance of social order. Medical dominance by the professional doctor is thus summed up by Larson (1977) who argues that professionalisation is a process by which the producers of services have attempted to constitute and manage a market for their expertise, legitimated by a state backed monopoly which has an effect on the distribution of wealth and status, thereby contributing to social inequality.

Willis showed in 1989 that the division of labour among health occupations is socially organised, and exemplified by the preservation of control over health care by the medical profession, which he described as medical dominance. He identified three mechanisms by which doctors reproduced their power over the medical market: Autonomy which involves the internal dynamic of control over the profession. Through professionalisation, doctors have attained full self-governing control over their work through legitimization by government. Australian state Medical Practice Acts provide for the establishment of Medical Boards numerically dominated by doctors with the roles of defining standards and practice boundaries, professional discipline and approving courses of education and qualifications for practice. These mechanisms protect the profession from outside scrutiny and allow it to set its own standards and discipline its own members.

\(^{1}\) The stated objective of prohibiting civil conscription was to prevent the nationalisation of medical and dental services by the Commonwealth. Judicial interpretation of this clause (in 1949 and again in 1980) refers to conscription as any sort of compulsion to engage in practice or to perform particular types of medical or dental
Until recently, doctors were also members of most of the other health practitioner boards.

**Authority** which involves subordination of potentially competitive occupational groups through task prescription, supervision of their work, limitation of the range of skills practiced and exclusion from official recognition (legitimation) by the system. Occupational groups such as nurses, pharmacists and radiologists are granted rights to practice in a limited range of services and skills or under the prescription of a doctor as in the case of pharmacists. In some cases occupational groups may practice by exemption under an Act without registration (for example orthoptists) or be completely excluded from legitimacy as in the case of chiropodists and Chinese medical practitioners who for many years were denied the legitimacy of registration. Noticeable too is the patriarchal division of labour where occupational groups with monotonous or lower status tasks are assigned mostly to women. Finally, where an occupational group develops its role through new or adopted technologies that gain legitimacy with the public, doctors will incorporate the skill into their own domain, for example spinal manipulation or acupuncture. The use of these mechanisms operate to prevent direct competition from other health care providers.

**Sovereignty** which involves the external relationships developed between medicine and the state and wider society. The development and protection of an esoteric knowledge base requiring interpretation means that at many places in the health care system, expertise is required for decision making. Medicine with its basis in science gained legitimacy over other forms of health care through professionalisation and thus a position of expertise in health. State patronage delivered a form of delegated authority to control the health system. Despite the social, economic and moral aspects of health care decision making, doctors constituted their expertise such that they filled managerial, policy and decision making positions at every level in the system. In addition, the resources available to them through remuneration, professional organisation and elite social position ensures their views are heard publicly and privately each time health is discussed. O’Neill (1998) refers to medicine’s policy monopoly providing the right to be heard on all health matters including resource and administrative issues. Medical

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services, in particular places or in particular ways, by extension thus denying the Commonwealth the power to control medical and dental practice. Mc Millan, (1992)
sovereignty, legitimated by government, is perpetuated through ownership of medical and scientific knowledge and its technologies and the ability to shape the community's perceptions about health (Hill 1997, Willis 1989).

Technological determinism (Sax 1972) provides an alternative to this view of occupational hierarchy by arguing that as technology becomes more sophisticated, the range of skills and knowledge required by each occupational group increases. The result is that segmentation and specialisation occurs and new occupational groups, often seeking professional status are born, resulting in a levelling of status of the others. Willis (1989) maintains his argument that social relations emerge to cope with technology citing the example of radiology as a para-medical specialty which has developed without displacing other groups. New technologies and occupations are absorbed, Willis argues, into the existing hierarchies strengthening medical dominance. It is possible to accept both arguments; that medicine has suffered a decline in status as discussed below, but has still managed to maintain its dominant position in health care (Lewis 2002, Germov 1998).

Such dominance, however is seen to be under threat from several aspects of contemporary society. Freidson (1994) argues that under the highly managed service delivery systems of economic rationalist societies, the proletarianisation (the decline of medical autonomy) of medicine is apparent. Increased education levels, increased consumerism and media dissemination of health promoting information has reduced the knowledge gap between practitioner and patient resulting in a decline in the mystique of medical knowledge. This cultural shift combined with advances in technology and rationalisation of service delivery has altered the position doctors hold in society (Turner 1995, Germov 1998, Annandale 1998, Hancock 1999).

Routinisation can also result in task delegation under rationalist health care, leading to the technological determinism described by Sax above (Turner 1995). Hartley (1999) in the US notes the dominant position of doctors declining in power as a result of managed care systems pressing occupational task re-distribution and a redefining of professional relationships associated with the development in particular of the nurse practitioner role. Lewis (2002) notes the changing boundaries between doctor and nurse authority arising from the development of the nurse practitioner in
Australia but also that the granting of expertise and boundary setting still remain firmly controlled by medicine.

The growth of bureaucracy and evaluative mechanisms (for example Medicare and Casemix funding arrangements in the Australian system) have intervened in doctor patient relationships reducing the autonomy of prescription, promoting evidence based decision making and increasing the authority of rules such as clinical protocols (Lawton and Parker 1999). Eligibility criteria and subsidies have similar effects. Managerialism has, in many settings replaced the doctor as manager and policy maker with the generic manager or policy maker with corporate rather than professional allegiances (Yeatman 1993, Hancock 1999). Lewis and Considine (1999) found in 1991-93 in Victoria, a shift in influence from the medical profession to senior health bureaucrats and corporate medical elites, with economic concerns appearing to be shaping the health policy agenda. O’Neill (1998) also notes the decline in policy monopoly as governments re-assert their power over health services as distributive and social policy issues.

Marjoribanks and Lewis (2002) in an examination of medical practice reform and autonomy suggested that the components of autonomy could be defined in more detail by looking at everyday work practices. Their framework for the analysis of physician autonomy is shown in Table 2.1.

**Table 2.1 Framework for the analysis of physician autonomy**

<table>
<thead>
<tr>
<th>Micro work freedoms</th>
<th>Meso work freedoms</th>
<th>Macro work freedoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical work freedoms:</td>
<td>Relations between the profession and the state</td>
<td>Acceptance of the biomedical model</td>
</tr>
<tr>
<td>• Acceptance of patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Control over diagnosis and treatment</td>
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<tr>
<td>• Control over evaluation of care</td>
<td></td>
<td></td>
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<tr>
<td>• Control over other professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and economic work freedoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Choice of specialty and practice location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Control over earnings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Control over nature and volume of tasks</td>
<td></td>
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</table>

(Source: Marjoribanks and Lewis 2002)

Research using this model has shown that while policy change has altered the role of the medical profession, the medical profession has reshaped itself to adapt. The re-definition of general practice to primary care models and altered relations between government and the profession have led to re-arranged conceptualisations of health
care, and of internal and external relationships. The shifts in the boundaries between nursing and medicine and changes to remunerative arrangements and incentives have been perceived as contributing both losses and gains to the professional autonomy of doctors. It appears however, that general practitioners are feeling the negative influences more than their elite (corporate and specialist) colleagues (Lewis 2002) but also that medicine in general has been able to largely retain its dominant position.

### 2.4 Models for analysis

Policy analysis then, requires an interest in the institutional and cultural context that sets procedural frameworks for policy making along with an analysis of how participants make themselves heard, interact and maintain the balance of the system. Lukes (1974) work is informative because it allows for the unequal distribution and accumulation of power. How this might be observed in a policy system is the subject of the next section.

#### 2.4.1 Alford and structural interests

Alford’s (1975) seminal work used a structural interests approach by examining the structures of society and how they influenced policy making. He demonstrated that interest groups fell into three main categories of dominant, challenging and repressed interests and that these interests are served by the social and economic structures of society.

Alford identified dominant interests as being those that are served by the existing structure of social, economic and political institutions. Such groups do not have to organise or act to protect their interests because other institutions act for them. Doctors are an example of a dominant group, often referred to as professional monopolists because of the embedded nature of their dominant status, legitimated by law, custom and work practices.

Challenging interests are those whose role has been created by changing technology or social organisation of society. In the health policy area, participants such as bureaucracies, hospitals, insurance companies, and newly emergent health care provider groups have this role and are often identified as corporate rationalists. These groups arise out of rationalist ideology applied to health where planning, budgets and
systems become important to the delivery of health services and planning for
corporations or communities takes precedence over individual interests.

Repressed interests are those whose interests are rarely served by the existing social
institutions or political mechanisms. Alford identified such groups (in the US) as low
income, chronically ill, disabled, non-white, and uninsured who rely upon others to
recognise and advocate for their needs because of the powerless nature of their social
position. Such advocacy groups may often only attain a ‘voice’ after excessive effort
and organisation and have been referred to generically as equal health advocates.

In Australia, Stephen Duckett (1984) has drawn on Alford’s work to show that
structural interests were evident in health policy making in the 1970s and ‘80s in
Australia and in the 1980s in Victoria. The alliance of ‘corporate rationalist’
bureaucracies and the consumer interest advocates presented a challenge to the
dominant professional interests to alter their control of the health sector (Duckett
1984). More recently, Lewis (2000) has described dental health policy actors around
the Commonwealth Dental Health Program as fitting this model. Australian health
policy making has shifted somewhat from the models applicable to the US system
because of the acceptance of a universal health insurance scheme as a driver of health
service delivery. However Alford’s model is still applicable to the dental industry
because of its market based service provision and exclusion from Medicare. Where
Medicare has strengthened the corporate rationalist and equal health advocate role in
general health policy making by enshrining government intervention, managerialism
and evaluation (Hancock 1999), dentistry has remained largely privately delivered,
fee for service and marginal to the health system. This has protected the professional
monopolist role from many of the disempowering effects of corporate rationalism that
medicine has felt over the past 20 years (Lewis 1996).

Although, as evident in the above discussion, there is a range of approaches to
dealing with the complex issues which emerge from policy analysis, most authors
agree that analysis at one level or from one approach is simplistic. Palmer and Short
(2000), Ham and Hill (1993), Davis et al (1993), Hancock (1999) and others argue
that there are interconnected layers to any policy process and the analysis of only one
layer is inadequate to explain the complexity of a policy outcome. Likewise, theory
from one perspective may have limited explanatory power for a whole policy process
but have strengths in particular domains (Ham and Hill 1993, Alford and Friedland 1985). It is therefore necessary to adopt an approach that can incorporate the social, structural and individual aspects, power, rationality and sequence to understand and explain the policy processes and outcomes.

### 2.4.2 An analytical model for combining structure and power

In 1985, Alford and Friedland asserted that ‘...individual interests, motivations and perceptions can never adequately explain individual behaviour; both organisational and societal factors must be taken into account.’ They maintain that no single model adequately explains all the layers of a policy making process and that their model allows for the combination of ‘...theoretical perspectives as modes of inquiry’. On this basis they proposed a model for analysing policy development processes which incorporated the three key theories of pluralism, corporatism and class/structuralism as being connected to the particular domains of, respectively, individual, organisational and societal levels of action. They proposed that Luke’s (1974) model for analysing the exercise of power could also be incorporated at each level.

Class theory takes a capitalist perspective relying on the social relationships between capital, the state and democracy, where class power and the modes of production maintain institutional boundaries. Alford and Friedland (1985) argue that this domain may be understood by using Lukes’ third dimension power as a basis for analysis. This identifies culturally dominant power to explain outcomes at a societal level where ‘...the normal functioning of a particular social order creates submission and intellectual subordination among one part of a population...(the labouring classes) and dominance and control among another (the owners). Elitist theory and Willis’ (1989) work on professional dominance (discussed in the next section) are explanatory at this level of analysis.

At an organisational level, corporatism becomes a stronger model drawing on bureaucratic and corporate rationality based in managerialism and technological development as key influences on government decision making. Social structure is maintained by the capacity of state and corporate organisations to negotiate with each other and set agendas, make decisions and to limit demands on the system. Lukes’ second dimension power is apparent here as the mobilisation of bias becomes a key
tool in establishing agendas and effecting non-decision making. Analysis relies on identifying corporate/bureaucratic interests and covert decision making and is informed by Alford’s earlier work (1975) identifying dominant, challenging and repressed structural interests.

At the level of functional or overt decision making, pluralism and the ideology of democracy become a stronger explanatory model. Once structural and organisational power have established the decision making arena, the interaction of individuals and small groups with concrete situations, their ability to access and influence decisions and their reciprocal actions or inactions become the focus of analysis (Considine 1994). At this level, Lukes’ first dimension of power becomes apparent where the participants with the greatest number of successes out of the total number of decisions are then ‘considered to be the most influential’ (Lukes 1974). Pluralism holds that decision making processes take place under conditions of individual political equality and freedom. Order is maintained through societal consensus developed out of participation and the tension between interest group demands and public interest are mediated by the state.

Under this combined model proposed by Alford and Friedland (1985), the actions of policy participants can be examined at three different levels allowing for contextual and organisational elements to be made explicit as well as personal actions and interactions. There is also a formalised framework to assess the expression of power in all its forms (overt, covert and subliminal) across the policy environment by examining the outcomes against the interests of particular participants.

Considine 1994, acknowledges that the examination of policy making at close quarters reveals the specific ‘...social problems, interest group struggles and government predicaments...' but argues that the consideration of larger questions of ‘...equity, fairness and power...' and the relationship to theory is equally important. This study will therefore use a combination of approaches to developing an understanding of policy process and its outputs.

At a somewhat superficial level, the sequence and formal actions will be described. In an effort to penetrate the ‘black box’ of decision making, Considine’s (1994) critical approach that identifies the components and interactions of the policy system will be used. This approach urges an examination of the linkages and interactions
between the policy history and context, the political economy, the policy institutions, actors and culture. His definition of policy culture incorporates the identification of values and assumptions, urging an examination of how these are expressed as language, myths, arguments and discourses. The expression of these interactions in his view become the outputs of the policy process. This approach to critical analysis has been used to examine the Victorian policy reform process in detail and to describe the results which comprises Chapter 4.

There has been an earlier acknowledgement that policy systems are not always equal and that particular views and values may gain expression in more or less dominant ways. This study has an interest in why dental policy making produces particular outcomes. For this reason, an examination of the findings using the wider theories of structure and power to identify the ways in which particular views become or remain dominant and shape the broader environment in which policy is made. Alford and Friedland’s combined theoretical approach to analysis of the policy making process will be used to inform a broader discussion of dental policy making. This analysis is developed in Chapter 5 as an approach to explaining the outputs of the Victorian policy process and contributing to the development of emergent hypotheses.
CHAPTER 3: METHODOLOGY AND RESEARCH METHODS

3.1 Methodology: Theoretical paradigms and perspectives

Strauss and Corbin (1998) describe methodology as ‘...a way of thinking about and
describing social reality...' and such a definition allows for a number of approaches.
The rise in logic and empiricism during the Age of Enlightenment shifted the
methods of explaining the world to what we now know as the 'scientific method'.
The qualities of this method (determinism, skepticism, empiricism and
communalism) have come to be accepted more widely than in just the natural world,
and approaches to and applications of the 'scientific method' have diversified
(Neuman 2000, Polgar and Thomas 2000). In 1968 the German philosopher
Habermas, identified three cognitive interests that human beings have in common as
being technical, practical-collaborative and emancipatory. The interests in knowing
and controlling the environment he characterised as technical; the interest in
understanding one another, communicating and collaborating were described as
practical, and emancipatory interests were those directed at removing inequalities and
distortion through awareness of our own society (in Marshall 1998). In a
classification consistent with Habermas, Neuman (2000) describes three approaches
to carrying out research arising from the three social theoretical domains: positivism,
interpretive social science and critical social science.

Positivism is grounded in empirical observation of facts on the basis that the world is
ordered and explainable through objective and value free observation and that the
accumulation of knowledge over time will improve the human condition (Neuman
2000). It recognises only observable phenomena, objective relations and the laws
determining them and bases truth on the measurement of influences and outcomes
(Grbich 1999). Positivism thus lends itself well to quantitative techniques which
control external influences and contexts. Critics of positivism argue that its
reductionist approaches fail to adequately explain subjective human experiences and
that its uses generate technical knowledge which is often used to protect the social
power of, for example, health professionals (Polgar and Thomas 2000, Neuman
2000).
Interpretive approaches do not try to be value free on the basis that all experience is subjective and open to interpretation. It is based on the view that the truth is socially constructed and context dependent and that the role of the researcher is empathic understanding (Weber's 'verstehen') of meaningful social actions. Field study and participant observer methods are thus commonly used in interpretive studies because they allow for an 'unravelling' of participants' understandings to emerge. It is therefore rich in detailed description and limited in abstraction. Its concern is with achieving an empathic understanding of feelings and world views rather than with testing laws of human behaviour (Gibich 1999, Neuman 2000, Marshall 1998).

Critical social science, in turn, takes the view that social reality has multiple layers comprised of an observable surface underpinned by deeper structures and unobservable mechanisms which shape social relations. From this perspective, subjective meaning is important but a critical process of inquiry that goes beyond surface illusions is required to uncover the real structures in the material world. The critical researcher questions social situations and places them in a larger, macro level context, assuming that there is an objective world with unequal control over resources and power on which common sense is based. It takes the view that people's actions are constrained by material conditions and cultural context (dialectical materialism) and it thus lends itself to historical-comparative techniques. The focus is on change and conflict because of their ability to reveal contradictions and explain how and why certain actions will bring about change. Its purpose is to help people change conditions and build a better world for themselves, so its findings are aimed at informing practical action (Neuman 2000, Marshall 1998).

Positivism sees social facts as objects that exist without values, situating the researcher as a detached scientist adding to the body of accumulated knowledge. Interpretive or hermeneutic sciences see meaning as subjectively created with emphasis on the subject and context giving the researcher a participant role in generating cross-cultural understanding. Critical social science views facts as existing independently but requiring interpretation within a framework of values, theory and meaning. In order to interpret facts, one must understand history, adopt a set of values and know where to look for underlying structures. The role of the critical social researcher is to be the transformative intellectual (Neuman 2000).
3.1.1 Modes of inquiry

While the 'scientific method' evolved out of positivist traditions, its rigour and systematised enquiry can be equally translated to social research, hence the term social sciences. In the social sciences, traditional quantitative methods (collection and analysis of numerical data) have been complemented by qualitative approaches. At one time the divide between qualitative and quantitative methods and their advocates was wide and rigid with each critical of the other. This is no longer so apparent. Many researchers and authors attest to the complementary nature of the two approaches and there is increasing respect and acceptance for the intellectual demands of what have been referred to as the 'soft' sciences. Further, it is accepted that the methods which are adopted should be those that are consistent with the objectives of the study (Patton 1990, Polgar and Thomas 2000, Gifford 1996, Neuman 2000, Ezzy 2001, Rychetnik 2001).

Qualitative approaches are characterised by interpretive methods using words, texts and images that describe experiences and perspectives of people in their 'real life' settings. Qualitative approaches collect rich and detailed data using the researcher as the data collection instrument. They require the researcher to become immersed in the data and to develop insight and understanding in an often inductive fashion (Neuman 2000, Polgar and Thomas 2000, Patton 1990).

Qualitative approaches are thus more limited in their ability to generalise because of the context-sensitive approaches and necessarily smaller sample sizes. They can also be more time consuming and intensive because their data are often less organised and more 'dense' or 'thick' with description, requiring more time consuming analysis. Often analytical themes develop in an iterative fashion requiring several 'rounds' of immersion and analysis rather than being made explicit in the design phase. The validity of the research and its findings are thus highly dependent on the skill and competence of the researcher. Their design therefore requires researcher reflexivity and an ability to set aside personal values and to examine the data from new angles with fresh eyes (referred to in phenomenological terms as epochè and bracketing, Patton 1999).
These subjective and responsive qualities of qualitative research give rise to criticisms over lack of rigour in comparison to quantitative approaches. Questions of validity get at the ‘trustworthiness’ of the findings and their reliability in informing for example, social policy or legislation (Lincoln and Guba 2000). Gifford (1996) and others (Grbich 1999) argue that an emerging literature supports the use of methods such as reflexivity and long immersion in the setting to overcome such problems as observer intrusion and the Hawthorne effect, and triangulation to ensure rigour in qualitative research. Triangulation can use multiple investigators working in collaboration (researcher triangulation), multiple data sources such as interviews with key informants, documents, minutes of meetings and press or newsletter articles (data triangulation), multiple data collection methods such as focus groups, individual interviews and observations or a mix of qualitative and quantitative methods (methods triangulation) and/or theory triangulation which uses alternative theoretical perspectives to interrogate the data (Gifford 1996). Finally rigour is improved when the links between the evidence and the developed findings are made explicit in the research report (Neuman 2000).

3.1.2 **Design in qualitative research**

One of the values of qualitative research is its ability to develop deep understandings of cases and contexts and ‘real life’ events and to generate explanations and theory in an inductive way. These particular qualities were consistent with the objectives of this study because the inquiry was based around complex, interactive and context-dependent policy making processes and models. It required descriptive and analytic methods and an ability to generate understanding from the events, the participants and the context, and to explore both the diversity and the generality of perspectives, processes and outcomes. Naturalistic and holistic inquiry, context sensitivity and inductive analysis were all important features of the methods required to carry out this research. These requirements led to the use of case study methods for this study (Neuman 2000, Patton 1990, Yin 1994).

Yin (1994) describes case studies as a form of empirical inquiry that investigates a phenomenon in its real life context often with the purpose of illuminating a decision or set of decisions and their outcomes. The researcher uses a number of ways of
studying the phenomenon and may look for typical, illustrative or deviant cases to examine or develop theory in a particular area (Marshall 1998). The method has been criticised for lack of rigour in data collection and analysis and a poor ability to generalise (Patton 1990, Yin 1994). However case studies may be generalised to theory rather than populations and they are important sources of explanation of the connections between the micro and macro level structures in society (Yin 1994, Neuman 2000). Developing methodological rigour requires that criteria for identifying the case or cases, the theoretical underpinnings and the convergence of data sources and their relationship to the findings must be made explicit. Case studies can be time consuming as data may be gathered over months, years or decades but they can also be short term and cross sectional as well as longitudinal. Individuals, groups, activities or events may be thought of as cases and cases may be compared using multiple case study designs (Yin 1994, Marshall 1998, Neuman 2000). The value of cross case analysis is in reconciling the specific with the universal, exploring the relationship between individual uniqueness and the generic processes at work across cases (Miles and Huberman 1994, Yin 1994). These design and rigour issues have been addressed and incorporated in this study and described in subsequent sections.

3.1.3 Data collection methods

Case studies may use a number of data collection methods including field observations such as participant-observer methods and interviewing, documentary methods including content and discourse analysis, and historical comparative studies (Neuman 2000). Many of these techniques are common to other qualitative research designs and their selection is dependent on the nature of the research questions. This discussion will focus on the use of interviews and documentary sources as these are most relevant to this study.

Interviews, as a form of data collection, offer the advantages of flexibility, focus and insight. They usually generate data that are rich in subjective explanation, allowing the interviewer to go beyond external behaviour to explore the internal states of the interviewee, their values and motivations for particular actions as well as their perceptions of events and others' actions and interactions. For these reasons they are the most commonly used form of data collection in qualitative research. They work
well with retrospective data collection, particularly if the recall period is short term or for events which are not easily observable (Patton 1990, Yin 1994, Grbich 1999, Neuman 2000).

Patton (1990) describes three types of qualitative interview, the informal conversational interview, the guided interview and the standardised open-ended interview. Standardised interviews use a set of carefully worded open-ended questions to collect the same type of information from each person and are useful when specific information is required from a large number of people. Standardised interviews also offer some flexibility to develop new or additional perspectives in response to interviewee’s comments. For this reason, many qualitative researchers refer to this approach as semi-structured interviewing. The interview guide approach outlines a set of issues as a checklist to be explored in each interview. This allows for data collection to be focused to use interview time effectively but allows the flexibility to probe and adapt questions to suit the context of the interview. The informal conversational interview allows for the spontaneous generation of questions and answers within the flow of a natural conversation without preconceived structure. This style is commonly used within participant-observer data collection. This study used both semi-structured and guided interviews as one of its data collection methods.

The quality of the data collected through interviews is highly dependent on the skills of the interviewer and qualities such as an ability to listen intelligently, be interested and enthusiastic about the topic, be compassionate, and able to remain focused for the length of the interview. Most authors strongly advocate recording interviews although others believe that tape recording can be more invasive and time-consuming when interviews are transcribed. Tape recording however does offer the opportunity for re-examination of the data beyond the initial exchange and allows for better engagement of the interviewer with the interaction. Collecting data through interviewing makes the assumption that interviewer and interviewee share common language and value systems that situate their exchange in a common social context. There are also the problems of reactivity of the interviewee to the interviewer, self-serving responses and recall error, all or any of which may challenge the accuracy of the data. Corroboration of interview material with other sources is a useful method
of increasing reliability of the data (Patton 1990, Yin 1994, Grbich 1999) and was chosen as a method of addressing these problems in this study.

Documents may be used in conjunction with other sources of information in developing a case study. Documentary sources may include archival records, legislation and parliamentary transcripts, policy and program documents, reports, budgets and minutes of meetings, letters, diary entries, newsletters and press articles and client records. They may be examined for content, theoretical perspective or discourse or for what they excluded, but must be considered, like other data as having perspective or context related orientations. Problems associated with the use of documents relate to access and completeness. Not all documents are publicly accessible because they are subject to privacy laws or parliamentary, departmental or commercial confidentiality. They must be treated confidentially as with other data. Time must also be allocated to retrieval processes within the study. Their advantages include their stability- they can be retained for re-examination and repeated review and they provide data on many things that cannot be observed in other ways. They are unobtrusive because they are not created for the study but as part of the case and can be exact with details and times (Patton 1990, Yin 1994).

3.1.4 Thematic analysis methods- grounded theory

When broad or general questions are being posed in a study without a specific hypothesis, grounded theory may be used as an analytic approach to developing theory. Glaser and Strauss and later Strauss and Corbin developed the method known as grounded theory as a technique in analytic induction: developing theory derived from and grounded in the data (Strauss and Corbin 1998). Grounded theory has been criticised for its positivist and objectivist approaches but more recent flexible approaches have incorporated interpretive methods into analysis to allow meanings to emerge as they are constructed by the interaction between, for example, the interviewer and interviewee (Charmaz 2000).

Data are systematically collected and analysed by ordering, according to concepts which emerge from the data. Concepts are developed, organised and related to one another with the use of theoretical memos (separate notes made about concepts and their connections). The data are then coded (or reduced) to develop the evidence into
explanatory theoretical frameworks. Coding is initially open (to allow categories or concepts to emerge), then axial to develop internal and external dimensions and connections of the concepts and then selective to validate the relationship between the core category and the others. While these processes have been sequentially described, they are often parallel and/or circular processes allowing iteration and reconsideration until theoretical saturation occurs.

Theoretical frameworks are then developed and refined, examined for internal consistency and tested against the data. In order to refine and develop theory, Strauss and Corbin recommend theoretical sampling which examines ‘events’ in the data to test and refine emerging theory for consistency. They also recommend broad engagement with the literature to farm as wide a range of existing theory as possible to inform grounded theory development. The process continues until theory is refined to a degree that it is a reasonable and recognisable explanation of the events that were studied (Grbich 1999, Strauss and Corbin 1998).

3.1.5 Researcher reflexivity

Patton (1990) argues that an entirely objective or detached methodology is impossible because of the interests, values and motivations of the researcher. He urges empathic neutrality as a more appropriate stance arguing that while researchers are human and social beings, they are also honest in their interest in ‘scientific’ inquiry. He urges ‘empathic neutrality’ as an important approach to collecting data which combines two interactive qualities. Empathy is a stance toward the people one encounters, while neutrality is a stance toward the findings (Patton 1990). Empathy allows the researcher to communicate interest in and care for the people and situation being studied. Neutrality incorporates an open and non-judgemental approach to collecting data and receiving information. The ability of a researcher to be non-judgemental relies of the explicit recognition of values and assumptions held by the researcher (reflexivity) and an ability to ‘bracket’ them, or set them aside in any examination of the data and findings (Patton 1990, Neuman 2000)

Researcher reflexivity has been identified by several authors as a way to improve the rigour of qualitative research and help to eliminate biases arising from the instrument (the researcher) and methods. Research is subject to the settings in which it occurs,
the methodology applied, the researcher who asks the questions and the way the
questions are asked. Reflexivity is an attempt to make explicit the values of the
researcher and her methodology, as a way of situating the research in a social context

As a researcher I am also a component of this research and its social world. I am a
dental therapist; I worked for twenty years delivering school dental services. I have
observed over many years the effectiveness and quality of dental care provided by
dental therapists and the lack of recognition this received, both within dentistry and in
the wider community. I have also observed the limitations placed on dental
therapists and the obvious gender bias in the dental occupational groups. Closer
association with dental hygienists in recent years showed that similar issues were
apparent in their profession.

Further to this perspective is the view that while dental diseases are technically
preventable, the ability of dental services to achieve this has not been adequately
developed. Dental care is often focused on technical and reductionist approaches to
treatments rather than oral health. Dental treatments (fillings and extractions) are at
best ‘Band-aids’ repairing but not curing or preventing disease and offering little
toward reducing the prevalence of oral disease in the community. Our existing oral
health care system is failing at a number of levels; it does not offer adequate care for
oral diseases and it does not adequately improve oral health status at the community
or public health level. The conceptualisation of dental therapists and hygienists was
as health care providers who would address these problems, at both individual and
community levels (NHMRC 1965, Darby and Walsh 1995).

During the period between 1996 and 1999, I became involved as a participant in the
Victorian Dental Legislation Review process as an advocate for the Victorian Dental
Therapist Association. These experiences caused me to reflect on the processes and
outcomes and generated an interest in further examining them. This participant
status offered a rare opportunity to study major policy reform of the dental industry in
detail. This led to the initiation of this study in an attempt to develop an
understanding of how policy making affects inequalities in oral health and how the
existing service models are constructed and could be improved. This study however
did not formally use participant observer methods because of its retrospective nature
and the ethical issues arising from the issue of consent. It does however draw on
these experiences in order to enrich understanding.

There are both costs and benefits to such participant/researcher status. The position
confers an in-depth understanding of the language, content, context and history, the
participants and the demands on the policy system. It avoids the time consumed by
developing familiarisation and the social problems of entry into and exit from the
field which can occur in new study settings (Patton 1990). This involvement meant
that many of the participants in the process were known to me through existing
networks and many of the documents were readily available and that diary entries and
notes and minutes of meetings could be used to enrich the understanding of the data.
It also meant that I, as a researcher was not positioned as an outsider but rather shared
the experiences and language of the Victorian policy process in particular and also
those of the other case study settings.

This insider perspective, while valuable in improving insight, posed challenges in
relation to Patton’s principle of empathic neutrality. The preservation of the
participants’ points of view and the illumination of multiple, social constructions of
meaning was an important component of the study. This required that I challenge
and confront my own biases and assumptions in order to operate from a position of
‘minimal pre-conceptions’. Immersion in the sociology, health sociology and policy
literature in the early stages of this research helped to deconstruct my socialisation as
a dental therapist, allowing me to better understand the dialectical relationship
between individual actions and beliefs, and social structures. These disciplines along
with the study of research methodology helped me identify the relationships between
the biomedical and social perspectives of health and health care and the ways in
which ideology and power are used in the conduct of research and the construction of
health care. Throughout the study, the need for empathic neutrality was apparent and
required attention during planning, data collection, description of findings, analysis
and thesis development.

A further issue for the participants and their perspectives is the nature of the personal
accounts. Interviews are interactive and affective (Patton 1990). Most of the
participants in this research were public figures, managers or advocates for particular
organisations. Each had reputations to protect and agendas to satisfy so the accounts
they presented to me were shaped by those positions. The accounts they give of themselves and their stories will be coloured by their perceptions of me and my social position and role in the process. For some, the politics of their role shaped the strategic value they saw in the research and thus the amount they revealed, the language they used and the content. For some, it meant non-participation. These aspects reinforce the view that data collection by single interview is at best cross-sectional, reliant on shared understandings and, imbued with social meaning (Neuman 2000, Patton 1990). Patton urges the development of an ethical framework to deal with these reactivity issues and this is described in the next section.

3.1.6 Ethical issues

Four key moral principles that are generally accepted as informing and underpinning our ethical decision making are autonomy (the right to self rule), beneficence (do only good), non-maleficence (above all do no harm), and justice (fair treatment). Confidentiality and veracity arise from the application of these moral principles but are generally considered to be rules rather than principles (Mitchell et al 1996).

Informed consent arises from respect for the autonomy of a person and their right to uncoerced and informed decision making about themselves. It relies on the free and willing participation of people in a study based upon their informed understanding of the nature and expectations of the research and their involvement in it. Respect for and protection of the privacy and confidentiality of information collected by a study respects both autonomy and the obligation to do no harm. Likewise, accountability and fair treatment of people, allowing them access to findings and to withdraw at any time addresses the principle of justice.

Carrying out research in a way that does not harm the participants (prevents embarrassment, emotional distress or physical harm) and works to benefit people/animals/the environment/the economy and improve society rests on beneficence and non-maleficence. Respecting cultural and social norms is an important aspect of this; a researcher who interfered with participants values or adopted paternalistic approaches would be considered unethical.

Veracity (truthfulness and honesty) is an inherent moral property of a researcher and the scientific method that translates into disinterested or honest inquiry and the honest
production of results. It also contributes to the duty of disclosure and a responsibility to communicate findings regardless of the political environment.

For some research the pure application of the rules of ethics poses disruptive problems in, for example the nature and range of disclosure as it affects unobtrusive observation, or confidentiality and non-maleficence in relation to data display where small samples are used. The obligation of the researcher however is to understand and apply the principles in the most respectful, beneficial and least damaging manner possible in order to contribute the most good (Mitchell et al 1996, Polgar and Thomas 2000, Christians 2000).

3.2 Research methods used in this study

This study, in relation to the three methodological approaches described by Neuman (2000), lies across both critical and interpretive theory in that meaning is seen as socially constructed but constrained by unequal distribution of resources and structural conditions that inhibit free activity. Individuals and groups therefore construct meaning and take actions based on their local context and experiences of the world which are nested within wider social and economic structures. Understanding therefore, needs to rely on both interpretive methods and the examination of the social structures that shape them.

3.2.1 Research aims and objectives

Aims of the project

The aim of the study was to investigate the process and outcomes of policy making around dental auxiliary practice in Victoria, interstate and internationally with a focus on the potential to increase access to dental care.

The objectives of the study were:

1. To examine the dental policy development process associated with the Review of the Dentists Act 1972 and the Dental Technicians Act of 1972 in Victoria
2. To assess associated legislative and regulatory dental policy reforms in the other states in Australia
3. To compare Australian and selected overseas countries’ dental health policy as it relates to dental auxiliary practice

3.2.2 Study overview

This project is a qualitative study of dental health policy making using exploratory procedures to identify strategies which may increase access to dental care using dental auxiliaries. It has used a multiple case study design to carry out a comparative analysis of dental health policy making and implementation in Australia and overseas to meet the study objectives.

The case study approach to this research has been taken to enable an understanding of the social and political aspects of the development and implementation of policy and their relationships to specific settings. Single cases will comprise of ‘states’ where dental policy reform around dental auxiliary practice has been, or is being undertaken. The study will use a comparative-case approach rather than survey methods because of the need to understand how the legislation is to be applied and to acknowledge local contextual differences (Yin 1994, Davis 1998). The case study of Victoria will be used to generate hypotheses which will be tested in the interstate case studies. Findings from the international cases studies are to be considered in the wider context of possible regulatory models.

Yin (1994) argues that history and case study methods overlap where a research focus is on current events. This study will draw on historical material to contextualise the policy ‘players’ and ‘positions’ and draw comparisons across contexts for the development of grounded theory.

Data collection draws on interviews as well as on documents to obtain evidence and contribute to rigour. The unit of analysis comprised legislation describing dental auxiliary utilisation in a conceptual framework incorporating power, change and regulatory innovation, and capacity to increase access to dental care. This will be carried out in a cyclic fashion (generative, constructive and illuminative) as described by Miles and Huberman (1994) to enable the generation of grounded theory.

The study methods involved a three phased approach to comparative case study design in which each stage informed the development of the next. Data collection in the interstate case studies was dependent on the emergent themes of the
Victorian case study; data collection for the international case studies were dependent on the combined findings of the Australian case studies. Table 3.1 below summarizes the methods used in data collection and procedures for the study.

**Table 3.1 Data Collection Methods**

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<th>Data collection methods</th>
<th>Reference point for further detail</th>
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| **Victorian Case Study** (purposive sampling) | • Semi structured interviews with 8 key stakeholders (face-to-face)  
  • Documentary sources:  
    o Newsletters  
    o Review documents  
    o Consultants reports  
    o Submissions  
    o Policy documents  
    o Diary entries  
    o Minutes of meetings  
    o Draft Bills  
    o Acts of Parliament  
    o Letters  
    o Mass media communications | See below, chapter 4 (p 120) and Appendix 6 |
| **Interstate Case Studies** (purposive and network sampling) | • Tracking review progress and processes  
  • Email communication with Review Project Officers in each state  
  • Websites  
  • Policy documents  
  • Group interviews at ADTA meetings  
  • Semi structured interviews (by telephone)  
| **International Case Studies** (theoretical sampling) | • Use of international data bases via websites and published literature  
  • Five face-to-face Interviews conducted at International Conference (using an Interview Guide; see Appendix 6)  
  • 1 telephone interview (using the same interview guide)  
  • 7 email conversations  
  • Documentary Sources : Policy documents, Acts of Parliament, Submissions, Letters, Conference Papers and Published Literature  
  • Websites | See Sections 6.1 Appendices 2,3,4 and 6 |
In this section, methods related to the Victorian case study will be described in detail and a brief overview of the comparative methods will be given. Detail of the methods and procedures for the interstate and international case studies will be developed below and in section 6.1 and Appendices 2, 3 and 4. This approach is taken in order to allow the logic of the sequential nature of the theoretical development to explicate the procedural approaches to data collection.

3.2.3 Selection of case sites

Victoria was selected as a case site because it offered a unique opportunity to examine a dental policy reform process in detail, incorporating the insight, understanding and access to data offered by the researcher’s participation in the process. Interstate case sites were selected for divergence from the Victorian outcomes in order to examine the range of influences, and patterns of interactions around dental policy making in Australia.

The selection of interstate comparative case sites was based on both practicality and variance. The economic and social conditions in each of the Australian states are similar and contain stakeholder groups with similar positions who were responding to agendas largely led by a federally imposed policy. There were however, variations based on local conditions. This study used investigative methods to track the progress of interstate reviews during the course of the study. Sources comprised project managers for each state’s Dental Legislation Review and health or legal branch websites, policy documents and parliamentary transcripts, group interviews with state dental therapists’ associations, and federal dental association newsletters. More detail related to the interstate data collection methods is presented in Chapter 6. Upon completion of the various stages in the review processes, policy outcomes were examined to direct what Davis (1998) and Neuman (2000) refer to as deviant case selection.

Davis (1998) and Neuman (2000) argue that deviant cases can be most useful for their power of theory development, confirmation or explanation. States where process or outcomes showed the greatest variation from the Victorian outcomes were chosen as cases in order to examine why such variance occurred and what the potential impact upon access to care might be. Three states were selected but one did not complete their review in time to be incorporated as a case. Two states were
therefore studied in greater detail using grounded theory developed in the Victorian case study to interrogate the data. The selection of case sites for the Australian state studies is discussed in greater detail in section 6.1 of this thesis.

Likewise, international case sites were selected based on (i) the similarity of the socio-economic setting, dental service delivery mechanisms and dental needs to Australian conditions, and (ii) their use of regulatory models for dental therapists and hygienists which varied from Australia and had utilised one or more of the hypothetical indicators for increased access to dental care developed earlier in the study. These international sites were selected following an examination of the international literature and databases, websites and attendance (and data collection) at an International Conference of Dental Hygienists held in Sydney in 2001.

3.2.4 Study participants

The participants approached for interview were involved in some aspect of the policy process (stakeholders, bureaucrats, politicians, practitioners) and the interviews were concerned with the participants’ roles, actions, perceptions, advocacy positions and policy outcome assessments. Following consultation with key informants, potential interview subjects were identified based upon their role in and contribution to the policy process or its implementation. Participants were selected based on having been significant contributors to the policy processes under examination and in order to obtain a diverse range of stakeholder perspectives. Bias in selection was reduced through consultation with policy project officers in each of the Australian studies and through consultation with participants themselves. In some cases, network sampling was used to identify participants, particularly interstate and overseas, but the main approaches were purposive and theoretical (Quine 1998, Yin 1994, Patton 1990). Participants were primarily dental care professionals (13 out of 18) and public servants in the roles of policy makers and professional association advocates who were involved in the dental legislative reviews. Eight subjects were interviewed in relation to the Victorian Policy Review process (based on the identified six key stakeholder groups and three representative policy actors), two or three participants in each of two selected Australian States (based on deviance of positions- two stakeholder extremes and a central policy actor) and one or two participants in each of
four overseas settings, generating a total of 18 formal interviews. Two participants selected for interview declined.

Interview data were triangulated using published literature, academic papers and theses, policy documents obtained from websites and health department sources, by email and through email 'conversations' using interrogative questions. Email conversations were used because they were more convenient and economical than telephone interviews for international data collection and involved sending questions by electronic mail which were responded to in the same way; further emails clarified responses and detail where required. These email conversations were used to add richness to documentary data and to triangulate evidence identified through initial interviews and documentary analysis.

3.2.5 Documentary data sources

Documentary data sources comprised material such as diary entries, minutes of meetings, professional association newsletters, consultants reports, policy documents, issues and discussion papers, review recommendations, drafts of legislation, transcripts of speeches and parliamentary debates, Acts of Parliament, written submissions to reviews, mass media communications and letters. These documents were public documents or were used with the permission of the authors or were already in the possession of the investigator when the study began.

Documentary sources were selected based on their ability to inform analysis and direct interview guides, and to corroborate and triangulate interview data. Sampling was conducted across the time period immediately prior to and including the review process which was from 1994 to 1999 for the Victorian case study, from 1996 to 2001 for the Tasmanian case study and from 1998 to 2002 for the New South Wales case study. Newsletter articles, submissions and media releases in particular were used to triangulate interview data and develop understanding of stakeholder positions and arguments. Where key stakeholders did not participate in interviews (the dentists' professional associations in Victoria and Tasmania) documentary sources alone were used to develop stakeholder perspectives. Semantic analysis (Neuman 2000) was used to look for meaning in the text in relation to both stakeholder perspectives (both historical and current) and to evidence based policy making.
Constructs included how evidence was used, what comprised evidence and whether the use of evidence was selective or balanced. Newsletters, minutes of meetings and diary entries were used to triangulate interview data related to the sequence of events and the reported actions that were taken. Newsletters, review policy documents (discussion papers, recommendations and consultants’ reports) parliamentary debates and speeches, draft legislation (bills) and their responses and Acts of Parliament were used to understand the policy development processes and outcomes.

Eighty-eight Australian Dental Association Inc. News Bulletins were also analysed and used to inform the Victorian, Tasmanian and New South Wales case studies. These News Bulletins and Review Discussion Papers and Review recommendations including the consultant’s report from Price-Waterhouse Cooper’s in Queensland were included in the tracking process for the Australian Reviews, along with the Bills and resulting Dental Practice Acts as they were produced and passed in each state. Parliamentary and committee debates and speeches, and draft legislation documents were also included from South Australia the Northern Territory.

In both the Victorian and interstate case studies, a key stakeholder (the Australian Dental Association) declined interviews arguing that their views were publicly available through their newsletters and submissions. The newsletters (Federal Association, Victorian, Tasmanian and New South Wales Branches and where cross referenced, the other state branches) dating from 1996 to 2002 were read and all references to legislation reviews were extracted. These provided the dentist stakeholder group perspectives and are widely quoted in the text of this thesis, in particular Chapters 4, 5 and 6. The overwhelming majority of extracted data from these newsletters was in opposition to the proposed changes and the quotes and comments in the text reflect this position.

3.2.6 Instruments

Data were collected using semi-structured interviews with people involved in the policy development processes in Victoria, interstate and overseas. The interview format was flexible and used open-ended questions to allow data collection to take a relaxed approach and generate discussion of the issues (see Appendix 6 for interview guides). Prior to conducting the interviews for the Victorian process, the interview guide was piloted with one person who participated in a support role to a stakeholder
representative. Piloting led to minor modification of questions in relation to their wording and the probing processes and interviewer skill development. The ability to pilot more extensively was limited by the number of policy participants and the potential contamination of data through previous exposure to questions.

As part of the interview, participants were asked to rank stakeholders (from one to five) according to their ability to influence the policy process. These data were not used in any quantitative fashion, but rather to generate discussion and insight into the actions and interactions of the key policy actors. Interviews ranged from 60 to 150 minutes in response to the participants' willingness to continue. In some cases (in the interstate and international cases), interviews were followed up with further contact for clarification and to check understanding, particularly of documentary data and the interpretation of legislation.

3.2.7 Procedures

3.2.7.1 The Victorian Case Study

Eight semi-structured interviews were conducted for the Victorian case study. These were of 60-150 minutes duration and were audio-tape recorded (with the consent of the subject) and transcribed by the author. An interview guide (see Appendix 6866) was used to direct questioning and discussion, and exploratory and probing questions were used to illuminate the issues under discussion (Patton 1990). Participants were not aware in advance of the specific line of questioning. Victorian interviews were conducted face-to-face in the subjects' own environment such as dental practice or offices to facilitate a relaxed approach to the interviews. Only one selected participant declined to be interviewed on the advice of the association on the basis that the views of the association had been expressed in their newsletters. These newsletters were then used to obtain material representing that perspective. Interview notes and reflections were made during and immediately after the interviews and tape recordings were transcribed verbatim, within a short time-frame, to allow for analysis. Sample transcripts and recordings were verified for accuracy by the research supervisor for validation.

Documentary analysis was carried out on systematically collected documents. Documents related to the legislation review in Victoria were already in the possession
of the researcher and their comprehensiveness was verified by the Legislation
Review Project Officer. Each of the stakeholder groups interviewed provided copies
of their submissions which were read and summarised and triangulated with interview
data. Letters and policy documents were acquired from interviewees and project
officers to enrich policy context and understanding. Print media articles were
retrieved using the Lexus Nexus electronic database search engines covering the
period 1997 to 2002.

In the Victorian case study documents comprised diary entries made by the
investigator during the course of the legislation review process, minutes of the
Victorian Dental Therapists Association's 48 Executive meetings covering the period
from 1996 to 1999 and the 20 bi-monthly professional association newsletters
covering the same period. Fifty-five Australian Dental Association, Victorian Branch
Newsletters from 1996 to 1999 were examined using the same unit of analysis as
above: articles related to or containing comment about the Dental Legislation review.

Policy documents included review guidelines, a review agenda for the health sector, a
workshop agenda and report, draft and final discussion paper, two consultants reports
and draft and final review recommendations. The Dentists Act 1972 and Dental
Technicians Act 1972, the Dentists Regulations 1972 and 1992 and the Dental
Technicians Regulations 1992, three draft Dental Practice Bills and the Dental
Practice Act 1999, parliamentary debates and the speeches from both houses of the
Victorian Parliament (1972 and 1999) were also included.

3.2.7.2 The Interstate Case Studies

Regular contact with legislation review project officers in each state gave access to
appropriate policy documents as they were produced and there were also regular
telephone and electronic mail conversations with the state dental therapy and hygiene
associations to monitor the progress of the reviews and collect documents. As
previously stated, case sites were selected according to their variance from the
Victorian outputs and a more detailed description of the case study methods and
analysis is outlined in Chapter 6.

Five interstate interviews (two in Tasmania and three in new South Wales) of 60-90
minutes duration were conducted by telephone and tape recorded with the consent of
the participants. Interviews were directed by an interview guide as for the Victorian case study to allow probing and exploratory questioning (see Appendix 6). Interview questions were related to subjects' role in and experiences of the policy making processes, policy agendas, policy outcomes in comparison to previous policy and their own agendas, their assessments of the decision making processes and its influences, alliances and problems, their assessments of how the policy would be implemented and assessments of the outcomes in relation to dental auxiliary practice and access to care for the public. Notes were also taken during interviews and the interviews were transcribed soon after. Where necessary detail was verified by email for financial reasons. Again, one selected participant declined to be interviewed so association newsletters were used to obtain data around that perspective. Newsletter articles and policy documents were also used to triangulate data.

In the Tasmanian case study, 30 Australian Dental Association Tasmanian Branch newsletters and two letters to the Tasmanian Dental Therapists Association were included in the analysis and development of stakeholder perspectives. Two health department annual reports, one dental services review report, one legislation review report and the Dental Act 1982 and the School Dental Therapy Services Act 1965, the 1999 Amendment and the Dental Practice Registration Act 2000 were also analysed. Four Parliamentary committee debates and four reading speeches (two of each being from the 1999 dental therapists amendments) were also included.

In the New South Wales case study, 44 Australian Dental Association New South Wales Branch newsletters and two submissions from the New South Wales Dental Therapists Association and the NSW branch of the Dental Hygienists Association were included in the analysis and development of stakeholder perspectives. One NSW Health (state government department) Annual Report and Legal Branch and Oral Health Branch websites were used to gain an understanding of service structure and activities around the review. The Issues Paper and Report of the Legislation Review were also analysed along with the draft Dental Practice Bill and Dental Practice Act 2001. Parliamentary speeches and committee debates during 2001 around the introduction of the Bill and passage of the new Act.
3.2.7.3 The International Case Studies

Data were also collected using semi-structured interviews (see Appendix 6 for interview guide) at an international conference of dental hygienists held in Sydney in July 2001.

Five interviews of 60-90 minutes duration were conducted. The Conference Delegate list and Program was used to identify and select interviewees based on their recent or current participation in dental regulatory policy making in their respective countries (the Netherlands, Canada, New Zealand and Washington State in the USA).

None of these interviews were tape recorded because of the opportunistic nature of their conduct and the setting which made it difficult to locate available and appropriate quiet spaces in which to record. Notes were taken during the interviews and these were augmented by elaborate notes and reflections immediately following the interviews. This material was transcribed in the week following the conference. One telephone interview was conducted with a dental therapist in New Zealand, again of 60-90 minutes duration and for consistency, was also recorded by note taking. In addition, informal data collection consisted of several electronic mail conversations to collect data and documents and to generate contextual understanding of the international settings. Documents including submissions, reports, policy documents, legislation and material from websites and the published literature in each setting were used for data triangulation and to add contextual depth to the case studies. More specific details related to each case study are included at the beginning of Appendix 2, 3 and 4.

3.2.8 Ethical issues and procedures for this study

This research used people’s experiences and knowledge as a data source to analyse dental health policy. Data were collected from people who were familiar with the topic of discussion, and in most cases, public figures or public servants who are experienced in advocacy roles. Many of them were known to the principal investigator through professional connections and appeared comfortable and confident about the prospect of such an interview.
Requests for interview were carried out in a non-coercive fashion inviting voluntary participation. Interview participants were initially approached by telephone and were then sent a plain language statement describing the research and a consent form. The consent form sought permission for the researcher to tape record the interviews and use the material. Tape recording of interviews was carried out to assist the interviewer with accurate analysis and no participants objected to the use of tape recording. (see Appendix 5ss for plain language statements and consent form).

Tape recordings and observations of interviews were stored under lock and key at the office of the primary investigator. Tape recordings and observations were transcribed and verified and coded and labelled in such a way that interviewees are not identifiable. Code lists are stored separately from tapes, observations and transcriptions.

Risk or stress to the subjects may potentially come from unauthorised attribution of material or through the broadcasting of information given as "off the record" commentary. Most of the interview material was used to direct and inform the analysis and has been referred to in a general way. Some material has been directly quoted and attributed where possible to a group of sources or a generalized citation. Coded reference numbers were not used because, given the small numbers of interviews conducted in each case study, there may have been a possibility of identifying participants. For this reason quotes are attributed just as interview data (Int), or where more than one participant expressed a similar view material is cited as (Int x2) or (Int x3) so that the multiple indicates the number of participants. In the interstate case studies where interview numbers were very small and quoted material was likely to compromise anonymity, draft copies of the sections have been provided to the subject prior to its use with an invitation to comment on both accuracy and publication. Off the record commentary has been respected as such and only used to inform analysis and to direct investigation. While the material under investigation relates to public issues, some issues were considered by participants to belong to the private or professional privacy domain and their right not to respond was respected. Directly attributed quotes have been authorised by the participants prior to their use in this thesis and attribution objected to by its subject has not been used. Due to the
restricted size of the policy environment, a decision was taken to protect the anonymity of the interviewees and their names were not listed in the appendices.

Documents that have been used in data collection were sourced from Departments of Health responsible for Review processes and organisations involved in advocating positions or were already in the researcher’s possession. Permission to use material contained in such documents has been sought from the Department of Health responsible, authors or committee chairs prior to their use.

3.2.9 Data analysis and operationalization of conceptual development

This study adopted a predominantly grounded theory approach to data analysis. While the study was initially developed around conceptual frameworks in the areas of power, policy reform, regulatory models, evidence and capacity to increase access to care, these thematic areas were subsequently augmented by other emergent themes as the analysis developed. Analysis took place concurrently with data collection in a cyclic and reflexive fashion allowing for theoretical sampling as conceptualization developed (Gifford 1998, Strauss and Corbin 1998, Charmaz 2000). Strauss and Corbin suggest that constant multiple comparison needs to continuously take place to develop theory of a general and abstract kind. The comparative and exploratory nature of this study was designed to allow for such theory development around the study questions in an inductive fashion.

The central focus of this study was the Victorian Legislation Review process which was used as a base against which comparative cases were assessed. Data were collected through semi-structured interviews with key informants which were conceptually analysed and triangulated with the use of documentary data.

Initial guiding concepts identified prior to data analysis were the context of the review, professional dominance, National Competition Policy, the use of evidence and community access to dental care. Documentary evidence was used to develop the contextual influences and identify the broad sequence of events associated with the policy review. During the interview phase, the role and positions of the various stakeholders, the community input, consultation and the actions of stakeholders and policy makers (the role of the state) also emerged as important themes. The initial guiding concepts were combined with the emergent themes to form coding frameworks. The identification of themes, concepts and analytic frameworks was an
iterative process, complicated by the multiple connections between the various themes. Coding categories were validated through an extensive examination and discussion process involving the research supervisor which established the mutually exclusive and exhaustive nature of the coding. The nature of this process was considered to be comprehensive such that inter-rater reliability of coding was not formally conducted.

The analytic themes that emerged were: the sequence of events and the influences of the policy making institution, the policy actors, their actions and the interactions (consultation, key debates) that shaped the policy development process and the outcomes. The policy actors fell into two categories, those who wanted change to occur and those who did not. These themes and sub-groupings formed a pattern that matched the theories about policy systems describe by Considine (1994) (see Section 2.2.1). Considine’s framework was therefore used to analyse and describe the results in the following ways. The sequence of events and structural influences were clustered under a heading of the ‘policy institution’. The role of the state (leadership), the influence of National Competition Policy, consultation, the use of evidence and discourses were conceived as the ‘institutional influences’ on the policy making culture. The policy stakeholders were described as ‘policy actors’ and their actions and interactions were used to examine the nature of professional dominance and the inter-relationships between their positions and the policy outcomes. There were a number of key debates that illustrated the policy actor positions and conflicts in the process. These were grouped together as flashpoints and used to demonstrate how (both actions and sequence) the negotiations occurred to produce the outcomes. The results of this analysis are presented in Chapter 4.

The broader conceptual frameworks of power, policy reform, regulatory models and capacity to increase access to care are examined in more detail in Chapter 5 which discusses the results of the Victorian study.

Analysis based on these conceptual areas resulted in the development of emergent hypotheses which were then used to examine the data collected within the interstate case studies. These themes and processes are made more explicit in Chapter 6 which develops the findings from the interstate cases. Data for the interstate case studies were collected and triangulated in the same way as the Victorian case studies.
although fewer interviews were used. This was on the basis that many of the arguments and stakeholders were similar across the states and the in-depth nature of the study of the Victorian processes was used to focus the lines of questioning for the interstate interviews. International cases were analysed against the hypothetical indicators for increased access to care developed in the Victorian and interstate case studies in order to contribute to overall theoretical development. This process is more explicitly described in Section 7.2.

3.2.10 Rigour

The combination of multiple data sources and data collection methods in this study allowed for triangulation and convergent analysis, with the use of pattern matching techniques as described by Yin (1994) to add to theoretical rigour. Davis (1998) argues that acknowledging the history of the phenomenon allows for examination of causality and can help to demonstrate the clear chains of evidence demanded for internal validity. Such historical inquiry was used to develop an understanding of policy contexts, cultures and positions in the legislation review components of the study and contribute to the development of analytic transferability across the study contexts in the development of grounded theory. The use of comparative research was designed to help eliminate or offer alternative explanations for causal relationships, and to improve conceptualisation and generality. The empathic neutrality describe by Patton (1990) was also utilised to generate an open approach to data collection and analysis. This was augmented by the deliberate selection of a range of different perspectives among interviewees and value-neutral and open-ended questioning. These approaches are made more explicit in the results and discussion sections which are presented in a manner that makes explicit the sources of data, and the evidence on which statements, hypotheses and assertions are based. This fulfills Yin’s (1994) requirement for the explicit documentation of the ‘trail of evidence’ in case study research from empirical data through to study conclusion.

3.2.11 Limitations of the study

All research studies have limitations derived from their design, sample, instruments and settings. The limitations inherent in this study are related to its qualitative case study nature and its subject matter. The findings are not necessarily generalisable to
other policy processes but rather serve the purpose of informing theoretical understandings.

The value of studying these cases is to learn about how policy processes work and how structural issues might affect processes and outcomes in dental policy settings in order to inform future policy participation. Its value was also in examining other regulatory models to inform local development and implementation however care would need to be taken in adapting findings to local cultural context.

Although each state’s dental legislation review involved the same types of stakeholders and subject matter, the history and context were different, each realising slightly different outcomes. Further, local history, leadership and participation affects policy outcomes in different ways. There were also limitations imposed by the timelines which were determined externally by political processes, and by a lack of participation by key stakeholders in two settings forcing a reliance on documentary data sources. Inherent in the use of documentary sources alone, is their public nature and their exclusion of background, covert action and contested views (Neuman 2000).

A key interest of this study was the impact upon access to dental services of the regulatory models. A limitation of this is that changes in access to dental services can only be measured as an evaluation of the new legislation in the longer term. This requires a thorough understanding and quantitative assessment of local service provision models and funding structures, participation rates and disease levels, all of which will affect service mix, supply and demand. This is something which is beyond the scope of this study given its time frame. For this reason, this study developed indicators, based on the literature and grounded theory development, to predict such outcomes. The accuracy and measurement of these indicators should be the subject of further study.
CHAPTER 4: DENTAL LEGISLATION REVIEW: A CASE STUDY OF THE VICTORIAN PROCESS

4.1 Introduction

This chapter presents an analysis of the context, processes and outputs of the Victorian dental legislation review conducted between 1997 and 1999. Victoria was the first state to complete its review under the National Competition Policy agenda. Consistent with the aims of this study, the focus is on policy change that has the potential to increase access to dental care for community members. In particular, the study focuses on the regulation of dental therapists’ and hygienists’ practice due to their capacity to contribute to this. As indicated by the Australian and international literature reviewed in Chapter 1, the preventive and primary dental care provided by dental auxiliaries has the potential to improve access to dental care for those sections of the community disadvantaged in terms of income, age, mobility and geographical location.

An examination of the ‘political economy’ for dental health was also carried out in Chapter 1 and, an examination of the role and development of expertise in health policy making was discussed in Chapter 2. Considine (1994) and others identify the influence of historical and cultural factors on policy making as being important to an analysis of processes and outputs (Hogwood and Gunn 1984, Ham and Hill 1993, Considine 1994, Palmer and Short 2000). Consistent with this systemic approach to analysis is the need to understand the values and assumptions that make up a policy culture and shape its context. Accordingly, the next section develops the historical perspectives on the dental policy actors and their development.

4.4 The development of dentistry

The relationship between medicine and dentistry is interesting in the light of medicine’s dominance and subordination of the other health occupations. Dentistry has maintained control over the content and conditions of its own work, has authority over related dental care occupations and has some level of broader social influence.
However it is still subject to limitation (Larkin 1980, Willis 1989). Turner 1995, Lewis (1996) and Adams (1998) assert that dentistry was able to achieve this separation because of the parallel timing of the professionalisation allowing demarcation to occur prior to rigid practice boundaries being defined resulting in limitation rather than domination. Dentists were content to limit their activities to the mouth and the technical nature of the work offered little additional prestige or competition to medicine.

The similarity in gender and social background of the practitioners, and scientific compatibilities of their methods allowed dentistry to develop in association with medical curricula although there is reference to dentistry’s inferiority complex in relation to medicine (Robertson 1989). In many cases dentists were educated alongside or as an addition to medicine, harnessing the same medical knowledge as a basis for their work (Turner 1989, Willis 1989, Adams 1998). Just as medicine developed as a predominantly male profession, dentistry was clearly a male occupation demanding strength and technical skills and arising out of the masculine occupations of pharmacy and blacksmithing (Robertson 1989, Turner 1995).

The gold rushes of the 1850s brought dentists to Australia from Europe and America and by the 1880s there were three types of dental provider in Australia. There were those who had served full apprenticeships charging fees like their social and occupational models in the medical profession. There were those who had no formal training who extracted teeth and made dentures ‘...with varying degrees of skill and showmanship...’, and there were those who carried out dental services as an adjunct to their main occupations of pharmacist, doctor or blacksmith. The result was that ‘...anyone with a modicum of training or effrontery could call themselves a dentist...’ (Robertson 1989). Victoria and New South Wales led the way in the development of dental education and the story of the Victorian development is illustrative of dentistry’s professional beginnings in Australia.

In Australia, the Odontological Society of Victoria (OSV) was formed in 1884 to establish a formal curriculum for training and to promote professional cohesion, and to raise the social status of dentists. Chief among their concerns was the practice of those they considered ‘quacks and charlatans’ on the unwitting public. Like their medical counterparts, OSV members barred themselves from advertising ‘...by
signboard, showcase or in the press...’ establishing themselves as ‘ethical dentists’ as distinct from the ‘commercial’ variety (Robertson 1989). In Victoria, the attempt to gain state patronage for this view in the form of legislation for medicine and dentistry went on for over ten years. Laissez-faire individualism stressing the non-intervention of the state in economic affairs was the predominant thinking of governments of the day. Politicians repeatedly affirmed their belief in free competition as the best regulator of professional practice. It was therefore difficult for doctors and dentists to secure market advantage over their competitors through regulation because regulation of the medical market was seen as inconsistent with open market thinking (Robertson 1989, Willis 1989).

The first Victorian Dental Act of 1887 established a list of qualified practitioners and established a Board to administer the Act. Membership included four dentists, one lay and three medical members (giving instant prestige plus medical oversight). However this Act failed to establish a monopoly for these registered practitioners as it did not prevent unlisted people providing services ‘...and anyone who extracted a tooth could be called a dentist...’ (DBV 1993).

The Australian College of Dentistry (ACD) had been formed in 1897 to develop a curriculum for the education of dentists and occupied the first floor of a building in Lonsdale Street opposite the Melbourne Hospital. The first Australian dental hospital was established in Sydney followed soon after by one in Melbourne in 1897 (Robertson 1989, Franki 1997). The first course established in 1897 by the ACD was of two years duration leading to membership of the college. Following amendment of the Victorian Act, this became a diploma course leading to a Licentiate of Dental Surgery (LDS). In 1904, the College was affiliated with the University of Melbourne, where a Dental Faculty was established and a four year Bachelor degree course began (Robertson 1989).

The Society for Unregistered Practitioners of Dentistry was formed in Victoria to lobby against proposed changes that might exclude them in the 1910 Act. The university educated dentists argued that it was unfair to students taking a degree and a danger to the public to allow unqualified operators to continue to practice. Their opponents argued that a ‘guild’ in the dental profession would restrict the number who practiced and place the public at their mercy in relation to the fees that are
charged. The government of the day was convinced to amend the Act to allow registration only for those with four years of study at the ACD or its equivalent. It also decided that it was unwilling to exclude the existing ‘non-dentists’. Practitioners with three years experience were allowed to practice as Recorded Dentists and pre 1910 registered medical doctors had 12 months grace to register as dentists if they wished. The numbers of recorded dentists in fact rose faster than the new registrations, and at the same time, dental mechanics continued to make dentures illegally, and as anonymously as possible. Both ‘ethical’ and ‘commercial’ dentists had recognised the value of strong connections with politics and had become adept at developing relationships and advocacy for their respective causes (Robertson 1989, DBV 1993, Lewis 1996).

In 1933, the first Medical Act to truly allow monopoly practice of medicine was passed in Victoria. This Act contained a section providing for the practice of dentistry as a subdivision of medicine and provided for a Dental Board containing four dentists and three doctors. This Act had developed from several much-amended attempts since the 1850s and contained clauses prohibiting advertising. Bans on advertising were another mechanism used to regulate internal competition – if doctors couldn’t advertise their prices, price-cutting wars could not occur. Advertising was thus defined as unprofessional conduct, more suited to a trade than a profession’ (Willis 1989, Robertson 1989). This Act also contained the first clause relating to ‘infamous conduct’ which was a prelude to self-regulation. This clause allowed the profession to de-register practitioners who were considered to be behaving in ways which were inappropriate to medical (or dental) practice, without recourse to the courts (outside opinion). So, like their medical brothers, dentists managed to gain control over the market by excluding ‘unqualified’ practitioners from registration.

The unregistered practitioner (mechanical dentist) developed his role to that of a dental technician, and by extension, a dental prosthodontist, who has been able to continue to mostly resist domination and exclusion by organised professional dentistry. Tasmania was the first state to legitimate their practice under separate legislation and in 1972, the Victorian parliament similarly passed a Dental Technicians Act recognising and conferring self-regulation for dental technicians and advanced dental technicians (prosthodontists) separately from the 1972 Dentists Act (Rossiter 1971).
Professional accreditation (the development of university level qualifications for practice) and domination of state licensing boards has protected dentistry from encroachment by doctors and unqualified practitioners. Association with medical curricula and the emphasis on a specialised knowledge base developed out of both study and clinical experience, have given dentists’ practice relative independence from doctors. The scope of practice however is limited to one part of the body and clauses in most Dental Acts still allow doctors to practice dentistry.

The only aspects of dentistry that have been contested by medicine are in the area of oral and facial surgery and anaesthesia. Dentists were among the first users of general anaesthesia (GA) but have since lost ground leaving doctors with a monopoly over GA use. While they have still retained their right to use it, most now call in a doctor to administer GA or admit their patients to a hospital surgical ward to receive it (Adams 1998). The performance of oral and facial surgery now requires a medical degree as well as a dental degree in most states of Australia and under these conditions, is one of the few dental services subsidised by Medicare (DPBV 2000, Spencer 2001a).

Diagnosis and prescription, an area almost exclusively retained by doctors is, however a permitted aspect of dentistry. Dentists are limited to diagnosis in the oral cavity, and the use of radiology and the prescription of drugs related to oral conditions but practice definition in most dental legislation limits it to those registered by Dental Acts, and medical practitioners. Dentists are also permitted by legislation to use the honorary title of doctor, the only health care provider other than medical practitioners and some veterinarians able to do so. It is clear that dentistry has managed to achieve the same state legitimated monopoly over its own market that medicine has achieved, with less limitation than many other health professions, although not without early medical oversight of its Boards and Acts (Robertson 1989, Lewis 1996).

4.2.1 The development of subordinated dental occupations

While dentistry has been dogged by the challenge to their dominance of the industry by the dental technicians, it has also moved to carefully develop subordinate occupations to complement their work. Advanced dental nurses and expanded function dental auxiliaries were developed to complement the work of dentists by
providing, under delegation, various low technology tasks. Most common were oral hygiene instructions and other preventive advice, exposing radiographs, cleaning and polishing of teeth (prophylaxis). These functions were soon extended into areas such as periodontic, orthodontic or surgical assistance and restorations depending on the practices they worked in. Today their most common characterisations are as dental hygienists and dental therapists, both of whom have existed for around 80 years.

4.2.1.1 The development of dental hygiene

In many cases, the dental hygienist role developed as extensions of dental nurses’ roles. Dental nurses had developed in the late 19th century as an adjunct to a dentist in the more professional surgical settings. Her role had been to assist at the chairside, clean instruments and perform some post-operative and cleaning services, under the direction of a dentist in a similar fashion to the medical nursing role.

In 1910 in Ohio, the College of Dental Surgery began offering a course for dental nurses, which was discontinued because of opposition from the dentists of Ohio. The first dental hygienists were formally trained in 1914 when a Dr Alfred Fones developed the concept of a preventive service using women trained in his carriage house in Connecticut, to deliver classroom talks, education for parents and prophylactic treatment for children in public schools. Over the next ten years, courses of training were established in several states in the US and by 1931, sixteen education programs for hygienists, of one to two years duration were in existence. In 1923, the first meeting of the American Dental Hygienists Association was held which led to the drafting of professional ethics in 1926 and a journal in 1927. By 1954, dental hygiene licensure was available in all 50 states and by 2002 in at least 23 countries world-wide including Australia (Darby and Walsh 1995, IFDH 2002).

In the US, legislation allows for three types of dental auxiliaries: dental assistants or nurses, dental hygienists and expanded function dental auxiliaries or hygienists. Each state defines the roles and regulation of dental auxiliaries in different ways but in most states they operate under the on-site supervision of a dentist. In 1968 in the US, only nine states allowed for expanded functions (beyond preventive, educative and prophylactic treatments) by dental auxiliaries, but by 1973, 44 states did so (Liang and Ogur 1987). These functions include subgingival scaling and root debridement,
the administration of local anaesthesia and in some states nitrous oxide analgesia, fissure sealants and tooth bleaching.

In Washington state, Colorado and California in the US, some provinces of Canada, the Netherlands, Denmark, Norway, Sweden and Switzerland dental hygienists are licensed to practice independently of a dentist in their own practices and in non-dental practice settings such as hospitals and residential care facilities (ADHA 1999b, Johnson 2001a, Johnson 2001b). Washington state and some Canadian dental hygienists also restore cavities which have been prepared by a dentist but this procedure may not be carried out in their off-site practices (WSL 1998, Clovis 2000). Independent practice is advocated by the American Dental Hygienists Association as a means for increasing access to care and increasing dental hygienist career options and the Association has supported research into the development of such an option (Kushman et al 1996).

In Australia, dental hygienists are licensed by or practice under exemption from dentists acts and must work under the on-site direction or supervision of a dentist. Only South Australia allows them to provide prescribed care in nursing homes where a nurse or medical practitioner is available without the on-site presence of a dentist (SADR 1988). Debate about the development of dental hygienists in Australia occurred several times between the 1920s to 1960s including a proposal by the federal Labour Government in 1943 to introduce ‘oral hygienists’ to deal with the problem of unmet dental need particularly among children. (These hygienists were described in terms that would later fit the title of dental therapist rather than the US model) (Franki 1997, Robertson 1989, Gardner 1992). South Australia was the first state to introduce dental hygienists in 1971, followed by the other states between 1989 and 2001.

4.2.1.2 The development of dental therapy

In 1913, the then President of the New Zealand Dental Association, Dr Norman K Cox proposed a system of school clinics operated by the state and staffed by ‘oral hygienists’ to address the dental needs of children between the ages of 6 and 14 years. At the time the idea was considered too unorthodox but in 1920, at a special meeting of the New Zealand Dental Association, 16 members voted for the adoption of school
dental nurses with 7 opposed to the proposal. School dental nurses were to provide diagnostic and restorative services to children ‘...in a rigidly structured set of methods and procedures which spare her the anxiety of making choices’. Leslie (1971) reports that organised opposition was considerable on the grounds that the employment of dental nurses posed:

‘...a menace to the public, (a) menace to the (dental) profession and an injustice to those seeking to enter the ranks of the (dental) profession by recognized avenues...’(Leslie 1971).

Despite the opposition, the New Zealand School Dental Nurse was born, trained initially in a school in Wellington run by the health department. After the second world war training schools were also established in Auckland and Christchurch establishing by 1990, around 900 dental therapists and a 95% participation rate by New Zealand’s school children (Tane 2002, Hannah 1998). Dental therapists in New Zealand work in mobile units and clinics attached to schools, providing diagnostic, preventive and treatment services and referring treatment beyond their skills to local dentists. Supervision was provided at a rate of around 1 dentist to 50 therapists with the purpose of ensuring therapists did not work beyond their skills and updated their practices (Leslie 1971).

This model of service delivery demonstrated considerable success and was the target of inquiry by many other countries around the world. In Great Britain, during the first world war, ‘dental dressers’ were used to carry out examinations and treatment for children in parts of England. Their role however, was eliminated by the Dentists Act of 1921 because of hostility to the role on the part of the dentist profession. They were later re-introduced, on the strength of the New Zealand scheme, as dental therapists when the high dental needs of children were ‘rediscovered’ in the 1960s1, carrying out similar services but under the prescription of a dentist who carried out the examination and care plan (Larkin 1980, Nuffield Foundation 1993). School dental services based on dental therapists were also established in other countries including Canada, South Africa, the Netherlands (temporarily), Fiji, Hong Kong, Malaysia and the Phillipines and in 2000, 28 countries around the world utilised

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1 In 1957, under instructions from the Privy Council, ‘...the British Dental Association was forced to witness the resurrection of an occupation which it had previously eliminated...’ Larkin 1980
dental therapists (FDI 2001). In some of those countries, including New Zealand, dental therapists also provide their services to adults (see Appendix 2).

As early as 1919, a Melbourne dentist advocated a state dental service which would primarily have educational and other preventive functions. He drew on the concept of the British system of ‘dental dressers’ for a new Victorian hygienist who would provide much of the care under the supervision of a dentist (Robertson 1989). In 1923, in order to make recommendations to the Victorian Cabinet for the extension of dental treatment for children, the Acting Director of Education for the State of Victoria wrote to the Principal Dental Officer for New Zealand’s School Dental Service expressing interest in the scheme to train young women as dental assistants for work in schools. Clearly, concern for child oral health was significant, but the threat of the development of another layer of practitioner, when the dentists were ‘...fending off the demands of recorded men, twlighters and mechanics...’ was too great for the Victorians (Robertson 1989).

The need to improve the dental health of children remained of great concern and a ‘fact-finding mission’ was established to look into the New Zealand Scheme in 1946 (Robertson 1989, Gardner 1992). But it was not until the 1950s and 60s that the NHMRC’s Dental Health Committee made recommendation that any instrumentality responsible for the dental care of Australian children ‘...should now give consideration to the utilization of dental auxiliary personnel in the form of the school dental nurse...’ (NHMRC 1965). The NHMRC noted the success of such schemes in other countries and in particular, the 98% participation rate and social acceptance attached to the New Zealand Scheme and also, the reluctance of the dental profession to support the concept of operative dental auxiliaries in Australia. It made recommendations that demanded systematic and regularised non-university training2, the complementary (rather than substitute) nature of dental auxiliary practice, the need to define the range of skills they could practice and the need for direction and control of their services by a registered dentist. It stressed the need for administration by a dentist of such services and for each state to train sufficient auxiliaries for their own needs to engender allegiance in its staff and to reduce the demands for

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2 The NHMRC (1965) noted several times in its report that auxiliary personnel should be trained in an appropriate government instrumentality—‘...that this is not a matter for the University Dental schools’.
reciprocity and the risks of competitive salaries and other 'undesirable developments'. Courses of training should be as short as possible in order to maintain the cost-effectiveness of the auxiliary while ensuring competence. It also suggested that such school dental nurses should be female and have their employment restricted to the government service.

As a consequence, Tasmania and South Australia established dental therapy schools to train dental therapists for their state's dental programs in 1966 and 1967 respectively (Dunning 1972, Gussy 2001). When the Whitlam government offered conditional block grants to expand the School Dental Scheme in 1973 to encourage the development of auxiliary based school dental programs, all of the other states took up the extra funding with NSW, Qld, WA establishing schools in 1974 and Victoria in 1976. All Australian courses required the completion of secondary school (university entrance level) prior to admission and in 1979 were graduating a combined total of around 280, all female students (Commonwealth Department of Health 1979).

Western Australia, which began training dental therapists in 1971, was unique in using the tertiary sector for training and allowing their dental therapists to work in private and public practice, and today is the only state allowing them to provide treatment under prescription, to adults. Their school dental service however operates like the other states with dental therapists providing examinations (radiography, diagnosis and treatment planning) and dental treatment including fillings, extraction of deciduous teeth, local anaesthesia, preventive services and health promotion to school aged children under the off-site general supervision of a dentist.

4.2.2 The Contemporary Position of Dentistry in Australia

In summary, while dentistry is dominated by medicine through limitation of practice, its autonomy and sovereignty are preserved by its self-regulation, market monopoly and its controls over practice. The profession retains significant clinical work freedoms allowing acceptance of patients, control over diagnosis and treatment planning, and provision and evaluation of care and pricing. Freedom to choose specialty and practice location in addition to control over earnings and the nature and volume of tasks carried out are preserved by the small business nature of their practice. Further, the relations between the profession and the state give them
significant policy input by way of their control over regulation, education and service delivery.

Competitive occupational groups have been largely relegated to semi autonomous (as in the case of dental technicians and prosthetists) or subordinated practice. While the dental prosthetists and technicians have retained some autonomy through separate legislation, and independent practice their regulatory and educational institutions still retain dentist input. The development of auxiliary professions under tightly regulated conditions has preserved the control over the market allowing the profits from dentistry to remain with dentists.

There is an argument which supports a gendered divide in power relations inside dentistry which favours males; around 77% of practicing dentists, 91% of practicing dental prosthetists and 2% of practicing dental therapists and hygienists are male (Spencer et al 2003). This gendered division is also evident in the imbalance in remuneration reflected by gender with dentists earning significantly more than their associate providers (Lewis 1996). It is possible that economic and social factors as well as gendered division of labour apply here. Lewis (1996) argued that the higher percentage of women in an occupation, the lower the average wage. Further, the more subordinated nature of the assistant/auxiliary roles means they are likely to be identified as ‘female’ occupations and attract more women (Burton 1991). Willis (1989) refers to the patriarchal model of medical dominance where the doctor, nurse and patient roles equate to the husband (male), wife (female) and child role. These roles may be equated with that of dentist, assistant/auxiliary and patient but becomes a little inconsistent when applied to the role of technician and prosthetist. An alternative argument is that the trade based pathway to becoming a dental technician and prosthetist may also be perceived as more ‘male’, attract more men and subsequently have a stronger male culture. Numerically, there are more dentists than any of the other occupational groups and Around 88% of the registered dental labourforce are dentists with dental prosthetists, hygienists and therapists making up the other 22% (Spencer et al 2003) however these figures exclude dental technicians and assistants. When these groups are included using data from Table 1.1, dentists (largely the employers) still number around 42% with 36% of the workforce being dental assistants (all employees). Further, dentists are the only people who may own dental practices (and dental prosthetists who may practice independently) which
preserves both their hierarchy and income status. So, while the gender divide inside dentistry is an acknowledged issue, there are structural aspects to this distribution which have been nurtured by role regulation, and that is the interest of this study.

The aim of this study, therefore is to investigate the process and outcomes of dental regulatory reform in Victoria, interstate and internationally with a focus on the potential to increase access to dental care. The policy analysis frameworks described earlier and the theories related to professional dominance will be used to examine the policy development processes and outputs. The methodological approach and research methods employed for carrying out the study have been described in the preceding chapter.

The next section of this chapter examines the policy events which preceded the Victorian Dental Legislation Review on the grounds that policy making never occurs in a vacuum (Gardner 1995) and that policy events are often components of larger developments, characterised by Hogwood and Gunn (1984) as ‘...continuous film rather than still photographs...’ and by Considine (1994) as ‘punctuation’.

Examination of the preceding events can contextualise and inform the analysis of the policy system.

4.3 The contextual background to the Victorian dental legislation review

4.3.1 Dental Auxiliary Workforce Review, March 1995 (DAWR)

In Victoria, training of dental therapists began in 1976 with the establishment of a Dental Therapy School under the auspice of the Department of Health. Female students, aged under 26 years, were offered a four year cadetship as public servants, two of which would be spent training with a stipend3, followed by two years of bonded service in Victoria’s School Dental Service. This program was accredited at Diploma level in 1988 by the Victorian Post Secondary Accreditation Board with

3 White uniforms were supplied and regularly inspected for neatness and length. Other instructions included: ‘Students must sign in and out in Duty Time Book...Prescribed shoes and ‘flesh coloured hose to be worn...hair to be clean and tied back...nails clean and short...make-up must be neat and natural...’. The course at that time included a range of health and dental science subjects, operative dentistry and clinical dentistry, preventive dentistry, dental health education as well as ‘art’ and ‘grooming and deportment’. Student Handbook, Dental Therapy School, 1976.
recommendation that it be transferred to an appropriate tertiary institution in the longer term. A departmental workforce review was established following a request from then Dean of the University of Melbourne, Professor Pennington, to define the training needs into the future, which was to inform a decision by the Department about which institution should auspice the course (DH&CS 1993). Expressions of interest were subsequently called for and responded to by RMIT, La Trobe University and the University of Melbourne.

In 1994, the ADA, which had long opposed the role of dental therapists (ADAVB April and June 1994), applied political pressure to discontinue dental therapist training and initiate dental hygienist training\(^4\). The government agreed under pressure from the ADAV\(^5\) to initiate a Ministerial Dental Auxiliary Workforce Review focussed on the workforce profile and skills of dental auxiliaries and the future treatment and workforce needs of the Victorian population. The review was chaired by the Parliamentary Secretary to the Minister for Health, Robert Doyle and included representatives of several stakeholder groups on the review panel\(^6\). The panel heard presentations from the Dental Statistics and Research Unit on dental disease patterns and trends and took submissions from interested agencies, organisations and individuals. The review reported in March 1995 and recommended that therapists should continue to work with children and that a pilot program should be initiated to examine the feasibility of auxiliaries offering dental services to adult health card holders. It further recommended that ‘...a new category of dental auxiliary should be introduced within Victoria effectively combining and replacing the categories of dental therapist and hygienist...’ and that appropriate tertiary training for this role should be carried out in a university (DH&CS 1995).

A new course was subsequently developed at the University of Melbourne following the School of Dental Science’s successful bid to auspice the existing dental therapy program. In 1996 the first students were admitted to undertake the Diploma in Oral

\(^4\) ADAV, submission to the Dental Auxiliary Workforce Review, August 1994
\(^5\) ADAV, President’s Comments, ADAV Newsletter, Vol40, No 5, June 1994
\(^6\) Membership of the DAWR Committee consisted of representatives from the Dental Technicians Association of Victoria, the Dental Board of Victoria, the Dental Hygienists Association of Australia Vic. Branch, Victorian Dental Therapists Association, the Australian Dental Association Vic. Branch, the School of Dental Science, University of Melbourne (Prof. Clive Wright) and the CEO of the Royal Dental Hospital of Melbourne (Martin Dooland) and the Manager of Dental Health Services, Vic. Dept. Health & Community Services (John MacLennan) (DH&CS 1995).
Health Therapy in either dental therapy or dental hygiene. Graduates could add the other auxiliary skills by undertaking a one year fee paying program with lateral entry into the second year of the Diploma program and graduate with two diplomas, thus meeting the DAWR recommendation for combined skills, while continuing to allow specialisation in either category.

Further, the DAWR made recommendations in relation to Advanced Dental Technicians. They would be allowed to provide partial dentures directly to patients with additional training to bring them into line with other states. However, patients seeking a partial denture from an advanced dental technician would require a certificate of oral health from a dentist (valid for only six months) prior to receiving such services. The name of the profession was to be changed to that of Dental Prosthetist but the review also recommended that their training should be suspended for five years based on reducing needs for prosthetic services (DH&CS 1995).

The DAWR also commented on the need for a strongly integrated dental workforce with close professional links and the contribution this review had made to developing these relationships in Victoria. The Ministerial Dental Advisory Committee, established in 1997, arose out of the DAWR in an attempt to continue the more positive aspects of communication across the occupational groups that had evolved from that process.

4.3.2 Future Directions for Dental Health in Victoria (August 1995)

Upon obtaining office in 1992, the Victorian state government embarked on reform in the health sector. This came to include an examination of public dental services based on a recognition that too many Victorians suffered from dental diseases and that many of them were dependent on publicly funded services (DHS Aug 1996).

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7 In a letter of reply to Robert Doyle’s DAWR recommendations dated July 1995, Marie Tehan (then Minister for Health) had included the comment that they should be allowed to specialise in either area.

8 The Dental Technicians Act 1972 was amended in May 1995 to allow for the endorsement of advanced dental technicians licenses so that they may ‘...make, fit and supply dentures to be fitted to a jaw in which there are natural teeth...’ for a person in possession of a current certificate of oral health from a dentist (s28(4 a,b)) and in order that the Advanced Dental Technicians Qualifications Board may approve courses of training for this purpose (S26A (1-7)).

9 ‘...The absence of formal links between these sectors has not contributed to enhancing a spirit of co-operation or understanding, which is a clear prerequisite for effective planning on behalf of all Victorians...’ p 2, DAWR Victoria, Report the Minister For Health, March 1995, DH&CS

10 Background Information, Public Dental Services; this document is undated but was provided as part of an information kit to Ministerial Dental Advisory Committee (MDAC) members in August of 1996.
This, combined with the DAWR led to the development of a policy document describing the projections for a public dental system to serve the community into the next century. This plan was developed internally by the department’s Dental Health Services Branch but acknowledged the need for partnerships with the private sector which provided the bulk of the services. The establishment of a Ministerial Dental Advisory Committee was to be a catalyst for this (DHS 1995).

‘Future Directions’ set out to implement the recommendations of the DAWR in relation to dental auxiliary workforce\(^\text{11}\) and improve the public dental system through the provision of efficient, integrated services and an increased focus on health promotion. A statewide strategy for oral health promotion and support for integrated and flexible dental education were part of the plan. Targets included a reduction in tooth loss among 35-44 year olds and edentulism among 65 year olds along with an increase in the numbers of decay free preschoolers and 12 year olds. Services (specialist, general, child and adult) were to be increasingly provided through larger multi chair clinics offering integrated services managed by a new lead dental agency. Dental Health Services Victoria (DHSV) was to amalgamate the previously separate Royal Dental Hospital of Melbourne, the School Dental Services, the Victorian Special Dental Services and Denture Scheme and co-ordinate the services provided by other agencies such as local government, hospitals and community health centres through contractual arrangements. The organisation was to have the status of a public hospital, be managed by a Board of Directors and provide services as defined and purchased by the state government (DHS 1995).

The new organisation had all the features of corporate managerialism and the new public management agenda of the Kennett government (Alford and O’Niell, 1994, Lewis 1996, Zifcak 1997, Hancock 1999). It used purchaser - provider arrangements that created an internal market and provided service delivery external to the Department of Health and Community Services. It used output funding and focused on efficiencies, market type competition and a corporate approach to service delivery. It also maintained the separateness of dentistry by retaining a single centralised

\(^{11}\) Introduce formal dental assistant training course, change of name and allow dental prosthetists to provide partial dentures, introduce a new category of dental auxiliary, conduct a pilot project using auxiliaries with other age groups and introduce an intern year for dentists plus transfer dental therapy education to a tertiary institution, DHS August, 1995:p16,33
organisation to deliver dental services rather than integrating it into the existing regional public health structures. The role of government became one of legislation and regulation, workforce planning, setting policy direction (defining the ‘vision’) and developing and evaluating service contracts along with support for oral health promotion within the broader health context (DHS 1995). DHSV was thus established in January 1996 with the goal of optimising the planning, integration, management and co-ordination of public dental services in Victoria.

4.3.3 The AHMAC Pilot Proposal (1996)

At the Commonwealth level, in 1994, government representatives on the National Community Services and Health Industry Training Advisory Body (NCSHITAB) facilitated a national meeting of directors of state public health dental programs. The meeting considered the skill and training issues influencing the delivery of quality, cost effective and accessible public dental services. The following issues were identified:

- Despite the introduction of the Commonwealth Dental Health Program (CDHP), a growing proportion of the population including groups generally regarded as disadvantaged were not receiving adequate dental care. High costs were considered to be limiting access to dental services for many public sector clients especially from rural, remote and dispersed communities.

- The difficulty experienced in attracting dentists to work in the public sector and in particular, to areas with high numbers of disadvantaged people most at risk of dental diseases.

- That dentists, whose training equipped them with competencies to undertake complex functions were spending a significant amount of time undertaking low level technology based functions.

- That inflexible work structures in public dental teams prevented some team members from fully utilising the skills they possessed and that there is a need to minimise the costs through maximal use of auxiliary skills.

The Dental Directors concluded that it was imperative to explore the concept of translating the successful utilisation of dental therapists and dental hygienists to develop a new auxiliary to meet the needs of the public sector. They developed a
proposal to put to the Australian Health Ministers Advisory Council (AHMAC) to
establish a pilot program. The program was to test whether a dental auxiliary with
additional training could provide a specified range of dental care services to adults in
a more cost-effective manner while maintaining standards of care consistent with
existing service provision. The proposal was accepted by AHMAC in 1995 and
jointly funded by both AHMAC and state Health Departments.\(^{12}\)

The project commenced in March 1996 with the appointment of one of the Public
Dental Directors as Chair and a Project Management Committee with membership
drawn from the various dental professional associations, representatives of the State
Dental Directors Group, the ACTU and the NCHITAB. There were three parts to the
project:

1. To undertake consultation in order to develop options for roles and training

2. To train for and trial the role (with Victoria and NSW as pilot sites)

3. To evaluate and report on the project.\(^ {13}\)

From the outset, the project was vigorously opposed by the Australian Dental
Association which ran media campaigns\(^ {14}\) and advocacy designed to prevent its
implementation\(^ {15}\). Their members wrote letters to parliamentarians\(^ {16}\) and directly to
members of the project management committee\(^ {17}\) and their advocates spoke publicly

\(^{12}\) AHMAC: Project to Pilot a Dental Auxiliary, Background Paper, September 1996; Tehan M, Minister For
Health, Open letter to all dentists, February 1996

\(^{13}\) Australian Dental Therapists Association (ADTA), Letter to ADTA members from the President of the ADTA
re: the AHMAC Dental Auxiliary Pilot Project, November 1996

\(^{14}\) "Non-dentists to treat poor patients" Helen Carter, Herald Sun- 19.2.1997, and 'Should non-dentists be used
as a cost cutting measure to provide (dental) treatment to the disadvantaged?'. Vote-Line Question February 19,1997
Patients could die if the role of dental therapists was extended, dentists claimed yesterday, Death fear in dental
row", Helen Carter, Herald Sun 20.2.97

'Pull the other one', Editorial comment Herald- Sun Feb 20, 1997

\(^{15}\) ADTA President's letter to ADTA members (see above), also ADAVB newsletter, Feb 1996 Vol 42 No7

'...the use of this mini-dentist poses a more serious threat to dentistry and the dental health of the public than the
partial denture issue ever did...', and ADAVB Newsletter March 1996. '...this is an assault on one of the pillars
of our profession and we have to maintain a steadfast resistance to any move that has the potential of undermining
the quality of care for the people of Victoria...the Association wonders why the Minister is listening to non-
practicing dentists and bureaucrats who do not understand the clinical shortcomings of the proposed
program...', and ADAVB Newsletter April 1996. "...the Branch believes that there is absolutely no need to have a
pilot project to test the obvious (people don’t put their hands in a flame to see if it will burn). Unless of course
there is another agenda...the idea of using therapists who don’t know what they don’t know for initial patient
contact is a sham..."

\(^{16}\) ADAVB newsletter, March 1996 Vol 42, no7

\(^{17}\) Letter (6 March 1997) from Anne-Marie Vincent, President of the ADAVB to Sue Loftes, ADTA
representative to the AHMAC Pilot Project PMC outlining the ADA’s objections to the project, dated October
1996
against the program, sometimes using less than accurate language\textsuperscript{18}. In May 1996 a project officer was appointed (after arguments from the ADA that it should not be an ex-dental therapist\textsuperscript{19}) and in September 1996 a new project manager was appointed from within the staff of AHMAC. In March 1997 an options paper dealing with the first stage was produced which was subsequently leaked to the press by the ADA attracting criticism from the project manager. The ADA in turn, criticised the project for lack of consultation and for taking ‘...shortcuts driven by some sort of cost-cutting agenda...’\textsuperscript{20}. By June 1997 the project had apparently founded for lack of recurrent funding\textsuperscript{21} and was relegated to inactive status on the AHMAC agenda despite commitment to re-invigorating the project from the Victorian Health Ministry\textsuperscript{22}.

4.3.4 National Competition Policy (NCP)(1996)

The application of the principals of industry competition to the health sector as recommended by the report of the Independent Committee of Inquiry into a National Competition Policy (the Hilmer Review) formed the basis of the need, Australia- wide to review the various Acts and Regulations applicable to the provision of health care. Encouraging competition is intended to

\begin{quote}
The guiding legislative principal of Competition Policy is: Legislation should not restrict competition unless it can be demonstrated that;
\begin{itemize}
  \item[a)] The benefits of the restriction to the community as a whole outweigh the costs
  \item[b)] The objectives of the legislation can only be achieved by restricting competition.
\end{itemize}
\end{quote}

The following set of principles have been developed specifically for regulation of practitioner groups:

\begin{itemize}
  \item[a)] The system of regulation must be in the public interest (ie. regulation is for the benefit of the public, not the practitioner group)
  \item[b)] The system of regulation must be the most effective means of achieving the desired outcome (ie. regulation by Act of Parliament is not a given; legislation must be clearly more effective than alternative non-legislative systems of regulation).
  \item[c)] The system of regulation should take the least restrictive form possible...
  \item[d)] The benefits of regulation must be greater than the costs...
\end{itemize}


\textsuperscript{18} 'Experimental Dental Program' ‘...an experiment will commence shortly to provide ...as little as 19 hours training for non-dentists to undertake injections, fillings, tooth extractions... in the trial pensioners, unemployed, low income earners will serve as guinea pigs for an experimental dental care program not seen before in developed countries...’ ADAVB Media Release(18.2.97),

Also ADTA President’s letter to ADTA members, November 1996

\textsuperscript{19} ADAVB newsletter April 1996

\textsuperscript{20} Newsbits, ADA Inc, News Bulletin, April 1997 Number 243

\textsuperscript{21} Newsbits, ADA Inc News Bulletin, June 1997, No 245

\textsuperscript{22} Notes of meeting between VDTA president and Robert Doyle, Aug 1997
"enhance Australia’s economic performance into the future" (Industry Commission 1995) by reducing prices and enabling more effective competition in a global market. This is aimed at increasing exports and the influx of revenue from external sources which in turn increases taxation revenue and helps to ‘...counter the calamity of falling revenue and rising costs...’(Gardner 1992) as experienced by the Australian economy during the 1990s.

Reducing health care costs was seen to be achievable if the barriers to effective competition could be reduced among health professionals. A national policy to encourage competition and the creation of a “level playing field” agreed with this way of thinking by creating a market for health which works to reduce the barriers to effective competition (such as monopolistic behaviours) and stimulates more cost-effective outputs.

In this environment, the Hilmer Review recommended the implementation of National Competition Policy and amendments to the Trade Practices Act to include application to the previously exempt health industry. In April 1995, at a Meeting of the Council Of Australian Governments (COAG), agreement was reached by all states and territories, to unilaterally apply National Competition Policy to all areas of industry, including the health sector, beyond the jurisdiction of the Commonwealth. All states have made commitment, through COAG, to complete the legislative processes by June 2002. The process has been administered and supported by the Australian Competition and Consumer Commission (ACCC) which has the power to apply pecuniary penalties or seek litigation for non compliance (Kennedy 1996). Victoria passed the Competition Policy Reform Act, 1995 on 16 November 1995, which came into effect in Victoria on 21 July 1996.

The Victorian state government set a legislative review agenda with some early emphasis on health regulation which had not previously been subject to the Trade Practices Act. Responsibility for the reviews was devolved to the departments responsible for each Act with oversight from the Department of Treasury and Finance which developed generic Guidelines for the Reviews (DP&C 1996). The final form of the reviewed Acts had to satisfy the demands of the National Competition Council (NCC).
The Dentists Act of 1972 and its companion, the Dental Technicians Act of 1972 were slated for early attention because of the view that they were outdated and the concurrent agenda of bringing all health regulatory legislation in Victoria under a common framework also drove the policy making environment. The department of Premier and Cabinet had, in its Timetable for Review of Legislative Restrictions on competition (DP&C 1996a) considered the review of dental legislation to be a major review of high priority. At its inaugural meeting, the Victorian Ministerial Dental Advisory Committee was informed of the intention to review the two dental Acts in August of 1996 (Satur 1996).

The market failures which were acknowledged to exist in this environment were:

- information asymmetry (where the consumer has less knowledge than the provider about the service, making it difficult to judge the quality of care provided),

- experience goods (goods whose quality only becomes apparent after purchase)

- negative externalities (flow on negative effects of service provision to others eg. with infection control breaches) and,

- transaction costs (costs incurred by consumers in locating a competent provider with the appropriate mix of quality and services) (DP&C 1996, DHS 1998).

Regulatory responses to such problems might include accreditation, prescribed minimum standards, self-regulation (eg codes of ethics), business licensing or occupational regulation. Legislative mechanisms are generally seen to be the most costly (in terms of both administration and competition) way of imposing behaviour modification on private companies or individuals (DP&C 1996). The Industry Commission had identified the restrictions in the dental industry as anti-competitive, particularly those applied to dental auxiliaries (limited numbers, limited duties and supervision) and the ownership and advertising restrictions (Industry Commission 1995).

4.3.5 The policy culture: a summary

Considine (1994) contends that ‘...each policy system contains a culture of its own, made up of values, preferences and habits of interaction...’ and that it is the interaction inside the system of negotiation and agreement that shapes policy. The
preceding section describing the policy context reveals a policy culture for dental policy making with particular values, assumptions, languages, organisational methods, customs and conventions, and authority (Considine 1994). It is this culture that contextualises the next policy episode, providing a basis for negotiation.

In the dental policy environment, dentists dominate, defining and shaping both resource allocation and the community’s perceptions and beliefs about oral health problems (Lewis 2000) and providers. They conceive of themselves as the exclusive professionals, holders of dental knowledge and expertise, as the only educated and ethical providers with exclusive right to make policy.

Their conception of the auxiliary professions (dental hygienists and therapists) is of trained and complimentary ‘hand-maidsens’, working under delegation, using routinised knowledge (shaped and interpreted by dentists) under supervision. In their view these providers are trained, without a distinct expertise or ability to diagnose and with little understanding of their own limitations. Naturally they are submissive but also subject to exploitation by ‘unscrupulous dentists’ (who must be disciplined under self regulatory models) and therefore must be protected from that exploitation and limited to supervised and prescribed practices for their own good. Dentists must therefore be held personally responsible for their practice because of the limitations of their knowledge, the community’s inability to choose appropriately and to ensure that dentists are less able to exploit them.

The Australian Dental Association’s (ADA) support for the hygienist as the ‘auxiliary of the future’ is grounded in this conception because of the preventive (non-interventionist) approaches and routinised treatment tasks carried out under prescription (dentist as decision maker) and on-site supervision (referred to as ‘team dentistry’). Dental therapists, on the other hand are the antithesis of this position, demonstrating over many years, their ability to diagnose and work more independently of dentists, and carrying out invasive procedures such as restorations and extractions. In an era of reduced need for services among children, dental therapists are portrayed as an ‘anachronism’ to be phased out (ADAVB 1995,

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23 ‘...there are a number of problems associated with the use of auxiliaries...include[ing] their lack of adequate skill...their relative inflexibility arising from their limited duties, their potential to over-service in the areas in which they are qualified to provide treatment...’ ADAVB 1994:69
ADAVB April 1994). The ADA refers to therapists as ‘tooth cutting auxiliaries’ (tooth mutilating) in a discourse which promotes dentists as ‘primary care’ providers promoting prevention and providing complex and high technology restorative services because of the needs and demands of consumers (patients).

The domination of market based delivery of services in a small business model protected from external interference fostered the conception of the private sector as the ‘real world’. Dental technicians fit into this paradigm because of their free market orientation, and their supplier relationships to dentists. Dental prosthetists, as independent providers, on the other hand are less acceptable to the dominant view which argues a declining need for dentures and poor quality training for future high technology and complex needs of the aging patient (ADAVB 1994). Dental prosthetists however, also supported the market-based nature of the ‘real world’ because of their small business orientation. This cultural authority of market-based dentistry is exacerbated by the low funding, poorer perceptions and low profile of public sector dental services which sees 85% of dental services delivered through the private sector.

In summary, the policy context comprised several components. The dominance of private sector dentists’ conceptualisation of the industry and their ability to reproduce the power to define its structure, supply and demands had resulted in significant policy inertia (Lewis 1996). The cessation of the Commonwealth Dental Health Program (CDHP) funding had put oral health onto the political agenda in the states in ways that gave state administrators greater legitimacy and authority to shape dental service delivery (Lewis 2000). Waiting lists for dental care were increasing in both length and profile and proposals to address these problems had been opposed through dentists’ structural dominance of the regulatory and policy environments. As we have seen, the two earlier dental policy processes had supported reform of the dental workforce and public sector service delivery (DH&CS 1995, DHS 1995). At the same time, the Kennett liberal government’s economic rationalist approaches and health sector reform agendas had set the scene for change in other areas, and the federal National Competition Policy agenda had established the need locally, to review the dental legislation.

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24 "The role and skills of the dental laboratory technician are highly valued at the present time." (ADAVB 1994)
Sabatier and Jenkins-Smith (1999) assert that for policy change to occur ‘…some shock originating outside the policy subsystem alters…the views of coalitions (actors) within the subsystem…’. In this case the ‘shock’ came from two Commonwealth policy initiatives. One was the abolition of funding for the CDHP in 1996 which applied pressure on the state to increase spending on public sector dental services and the other was the Competition Principles Agreement which provided incentives to increase competition and apply Trade Practices legislation to the health sector. Further, the experiences of policy makers arising out of previous policy episodes had resulted in the ‘policy oriented learning’ described by Sabatier and Jenkins-Smith (1999). Robert Doyle, as a policy broker had been subjected to policy oriented learning through increased understanding of problem parameters and the factors affecting them through these earlier processes (the A HMAC Pilot Proposal and the DAWR). The Kennett government embrace of competition and free markets offered systemic political incentives to support change and move away from the status quo.

Emerging from this policy context was the Victorian dental legislation review. As discussed in detail in Chapter 3, this case study is based on data collected through semi-structured interviews with key participants in the policy development process which were conceptually analysed and triangulated with the use of documentary data. The following section describes the sequence, outcomes and process of the review, which ran from 1997 to 1999, in greater detail. Eight semi-structured interviews with key policy participants including stakeholders, members of the reference group and review panel were conducted (cited as Int, Int xn, where n= number of interviews)\(^{25}\). Data collected from these interviews reflect the perceptions, observations and understandings of the process of review and policy development by these key players. These data were conceptually analysed and triangulated with the use of documentary data. This documentary evidence is from sources such as discussion papers, consultants’ reports, policy documents, submissions, reports, speeches and parliamentary debates reported in Hansard, material published in the press, letters, professional association newsletters, minutes of meetings and diary entries.

\(^{25}\) In order to protect the confidentiality of participants, these are cited in the text as (Int) or, where multiple interviews reflected a position, the number of interviews is included, for example Int x3 would indicate that three interviews reflected a particular view.
The case study adopts a predominantly grounded theory approach to data analysis whereby emergent themes are developed and interpreted by drawing on relevant policy development and analysis models and frameworks. Considine’s framework (see Section 2.2.1) was used to analyse and describe the results. The sequence of events and structural influences are clustered under a heading of the ‘policy institution’. The role of the state (leadership), the influence of National Competition Policy, consultation, the use of evidence and discourses were conceived as the ‘institutional influences’ on the policy making culture. The policy stakeholders were described as ‘policy actors’ and their actions and interactions were used to examine the nature of professional dominance and the inter-relationships between their positions and the policy outcomes. There were a number of key debates that illustrated the policy actor positions and conflicts in the process. These were grouped together as flashpoints and used to demonstrate how (both actions and sequence) the negotiations occurred to produce the outcomes.

This study and presentation of data deals with the first two phases of the policy cycle from the agenda setting phase to policy adoption. Interviews were carried out in December 1999 and January 2000 in the period prior to implementation and evaluation, so these later phases of the policy process will not be dealt with here.

4.4 The sequence, outputs and policy institution of the Victorian Dental Legislation Review

Considine (1994) suggests that policy outputs are the results of shifting and contested patterns of belief inside a system bounded by the political economy (described earlier), the institution in which the policy is made, the policy actors and the policy culture. The policy culture in existence at the beginning of this process has been described (see Section 4.2). The next sections describes the institutions and actor positions followed by their interactions and the cultural aspects made that emerged from the data collected through interviews and documents.
4.4.1 The review sequence

In mid 1997 a project officer\(^1\) was appointed to manage the task of reviewing the Dentists and Dental Technicians Acts, 1972 from within the Department of Human Services. A panel, chaired by Robert Doyle (Parliamentary secretary to the Minister for Health) was appointed by Minister for Health (Knowles) to conduct the Review. It consisted of two other members; Dr Graeme Ryan\(^2\), and Dr Chea Wa Chea, Assistant Director of Policy Reform for the Victorian Department of Treasury and Finance\(^3\).

The Review was classified as a Model Two Review under the government's Guidelines For Legislative Review (DP&C 1996, Int) which meant that it must be an independent review incorporating public notification, call for submissions and may include targeted consultations with interest groups. Under these guidelines, the Minister also had the discretion to release a draft report prior to finalising the recommendations. The Review began by identifying and writing to stakeholder groups informing them of the review and its terms of reference. At this stage, a Reference Group\(^4\) was established to undertake the task of developing the Issues Paper.

Table 4.1 below, summarises the time-line of the policy process with the formal stages, policy makers and processes outlined in the upper half of the table and the debates and stakeholder actions outlined in the lower half. Consultation, which formed an integral part of the process is also identified in Table 1 and will be discussed later in this chapter.

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1 The project officer had a background as a dentist, had worked for several years as a dental officer for the School Dental Service and was at the time a project officer for the Department of Human Service's Dental Policy Unit (interview data, Dec 1999).
2 Chief of Clinical Services of the Inner and Eastern Hospital Network and former Dean of the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne and registered medical practitioner
3 Dr Chea's PhD research was in market competition
4 The reference group comprised the project officer for the Review, a Department of Human Services legal officer, Dr. Chea Wa Chea from the Review panel and Dr. Rohan Storey, then president of the Dental Board of Victoria and specialist dental practitioner.

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### Table 4.1: TIMELINE AND ACTIVITIES FOR REVIEW OF THE VICTORIAN DENTAL LEGISLATION

<table>
<thead>
<tr>
<th>AGENDA SETTING PHASE</th>
<th>POLICY DEVELOPMENT PHASE</th>
<th>POLICY ADOPTION PHASE</th>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kennett Liberal Government; R Knowles Minister for Health; R Doyle Parliamentary Secretary</td>
<td></td>
<td>Nov 1999: Change of Govt- Bracks Labour govt elected, J Thwaites Minister for Health</td>
<td></td>
</tr>
<tr>
<td>Stakeholder consultations</td>
<td>Stakeholder consultations</td>
<td>consultation</td>
<td>consultation</td>
</tr>
<tr>
<td><strong>1997</strong></td>
<td><strong>1998</strong></td>
<td><strong>1999</strong></td>
<td><strong>2000</strong></td>
</tr>
<tr>
<td>Wrote to &amp; meetings stakeholders</td>
<td>Legislation Review Workshop (attend all stakeholder groups)</td>
<td>Discussion Paper Published Formally announced Panel appointed</td>
<td>Submissions Accepted</td>
</tr>
</tbody>
</table>

### ARGUMENTS ABOUT DE-REGULATION PER SE, REGISTERING HYGIENISTS AND TECHNICIANS, SINGLE ACT & BOARD

### ADAVB ACTIONS

- **Petition circulated, presented to Parliament**
- **Media campaign: ‘Open wide and cross your fingers’**
- **Group/regional Meetings with Robert Doyle**
- **Kit distributed to members Letters to Minister, Press**

Lobbying (formal and informal)

Articles in ADAVB newsletters

Media continues, radio, Press, submission on website

Definition of dentistry lobbying with DBV & DHSV News-sheets to MPs

### VDTA

- **Womens trust grant, Oct 1997**
- **Ref group meetings Aug-Nov. Letter protest dentist on Ref Group to Minister. Meet with Calsa P/L, March/Exec meet with R Doyle**

April: Kit to members May: Media campaign:

‘Spread the Smiles’ including launch, radio, TV, press

Submission circulate x 100

June: met with R Doyle, Sept: met with Minister

### DIIAABV

- **Meet with other groups, attend ADAVB group meetings, Meet with Board, Ref group meetings**

Meet with Robert Doyle

- **April 1999 Wrote to all MPs, Met with Oppn’n Health**

Written response to regs

- **Submission to Codes**

- **Submission to Codes**

- **Submission to Codes**
The reference group placed two tasks out for tender as part of this work: an investigation of the registration of dental professionals and processes for regulation of unprofessional conduct and impaired practitioners (Calsa, 1997a, 1997b). Calsa Pty Ltd were the consultants engaged to carry out this work. They also conducted some consultations to develop a new structure for a dental practice Board. Some features of the 1988 New Zealand dental legislation review and the British General Dental Council were included in these discussions. The project manager and Dr Chea Wa Chea then conducted meetings with all the stakeholder groups and in some cases, invited representatives of stakeholder groups met with the Reference Group to discuss specific issues.

In October 1997, a Legislation Review Workshop (LRW) was held. This workshop included around 40 invited participants from across 13 stakeholder groups and others with legal and NCP expertise (DHS 1997a). This workshop included presentations and small group discussions across ten specified areas in mixed groups. The findings of this workshop were published and contributed to the production of the Discussion Paper published in December 1997 (DHS 1997a). In November 1997, advertisements were placed in the press announcing the Review of the Dentists Act 1972 and the Dental Technicians Act 1972.

The Discussion Paper, published in December indicated that the review, driven by NCP would also examine the applicability of three key policy documents – the Review of Registration for Health Practitioners (DOH 1990), the recommendations from Future Directions for Dental Health in Victoria (DHS 1995) and the Dental Auxiliary Workforce Review (DH&CS 1995). It also noted the potential to incorporate ‘...efficiencies through modernisation and integration of legislation across dental professional groups and the removal of any regulatory duplication’.

This paper, which was widely circulated, invited submissions by March 1998 and indicated that the review panel would report its findings to the Minister for Health in April so that legislation could be introduced into the Spring 1998 parliamentary session (DHS 1997b). The panel received written submissions from approximately 80

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30 The key person involved (also a director) for Calsa Pty Ltd was John McLennan who had a background in dental policy and health administration and had been the manager of Dental Health Services, the department’s public sector dentistry arm, prior to it being out-sourced under purchaser/provider arrangements in 1996 (Department of Health and Community Services Ministerial Briefing: School Dental Service, Dental Health Services, Primary Care Division, March 1994).
individuals and groups. Table 4.3 summarizes stakeholder positions. During this time Robert Doyle (the panel chair) met with a wide range of people and made himself available to stakeholder groups’ professional association meetings (Int x6).

4.4.2 The review outputs and outcomes

In June of 1998, the panel circulated a draft of its recommendations to stakeholder groups and conducted another round of meetings to discuss its findings. In July 1998, the panel published their final report and was disbanded. Between July 1998 and April 1999, four drafts of the legislation were produced culminating in the presentation of the Dental Practice Bill to the Victorian Legislative Assembly for first reading in early May 1999. The Bill had its second and third readings and was passed in the lower house on May 12, 1999 without amendment and with bipartisan support. On May 13, it received first reading in the upper house and its second and third readings on the May 25 and was subsequently passed, also unopposed. It received Royal Assent on June 1 and was expected to commence on or around January 1 2000 but did not do so until July 2001.

Table 4.2 below summarizes the outcomes of the review comparing the 1972 Act with the new 1999 Act and the implications of the changes. The Dental Practice Act 1999 (VDPA 1999) registers dentists, specialists, dental therapists, hygienists and prosthodontists and students, protecting both titles and the practice of dentistry. It establishes the Dental Practice Board to administer the Act and standing committees to give advice to the Board in relation to the practice of specialists, auxiliaries and prosthetists and technicians. It describes standards for professional conduct, procedures for inquiry and discipline and for dealing with impaired practitioners. The new Act also defines the twin objectives for the Board of protecting the public and promoting access to dental care (State Government of Victoria 1999).

Regulations which accompany the legislation were then drafted by the Office of the Parliamentary Council in consultation with the Minister for Health. This work was begun in mid 1999 but due to the announcement of a State Election, was held over until after the election due to the government’s caretaker role during this time. Regulations were finally developed during December 1999 and circulated to
### Table 4.2: Summary of the changes made in the Victorian Dental Practice Act 1999.

<table>
<thead>
<tr>
<th>Dentists Act 1972(^{31}) and Dental Technicians Act 1972(^{32}) (Old Acts)</th>
<th>Dental Practice Act 1999 (New Act)(^{33})</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Acts, two Boards, one licensing committee</td>
<td>Single Act, Single Board</td>
<td>Technicians &amp; prosthetists loss of autonomy, Mixed membership Board</td>
</tr>
<tr>
<td><strong>Practice protection</strong></td>
<td><strong>Dentistry</strong></td>
<td><strong>Definition less restrictive than previous eg. allows people to look into mouths, identify need for dental attention, and oral health education to occur</strong></td>
</tr>
<tr>
<td>Restrictive definition included examination and giving advice as well as treatment &amp; prosthetics</td>
<td>Definition retained(^{34}) Exclusions (medicos and emergency care) as for old Act</td>
<td>Employment limits lifted</td>
</tr>
<tr>
<td>Specific practice regulation for auxiliaries in regulations (^{35}) but no title protection or participation</td>
<td>No employ limits, DHs 1:1 ratio &amp; DTs public sector limits removed. Other limits to be dealt with in Codes of Practice.</td>
<td>Dental Therapists (DTs) and Dental Hygienists (DHs) status improved – participate in regulation via Board</td>
</tr>
<tr>
<td><strong>Registration Title protection</strong></td>
<td>Only dentists, specialists, technicians and Advanced D Techs</td>
<td>Dentists, specialists, therapists hygienists, prosthetists (name change)</td>
</tr>
<tr>
<td>Students excluded</td>
<td>Students registered- impaired practitioner applies</td>
<td>All registered equally but, dental technicians de-regulated. DTs &amp; DHs have disciplinary procedures, title protection</td>
</tr>
<tr>
<td><strong>Board</strong></td>
<td>Seven members, all dentists, five elected by dentists, two appointed by Minister for Health</td>
<td>11 members- all appointed 5 dentists (including 1 specialist), 2 prosthetists, 1 auxiliary, 2 lay, 1 lawyer. Dentist President, with casting and deliberative vote for president where tied vote</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Not defined- public protection implied</td>
<td>Protect the public against risks in dentistry Promote access to dental care</td>
</tr>
<tr>
<td><strong>Committees</strong></td>
<td>Specialists Board, no other prescribed committees</td>
<td>3 standing advisory committees Specialists, Auxiliaries and Prosthetists</td>
</tr>
</tbody>
</table>

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\(^{31}\) State of Victoria, Dentists Act 1972, No 8287/1972

\(^{32}\) State of Victoria, Dental Technicians Act 1972, No 8366/1972

\(^{33}\) State of Victoria, Dental Practice Act 1999, No 26/1999

\(^{34}\) “Dentistry” means the diagnosis or management of conditions of the mouth of a person, the performance of any invasive or irreversible procedure on the natural teeth or the parts of a person’s body associated with their natural teeth or the provision to a patient or the insertion or intra-oral adjustment of artificial teeth or dental appliances for a patient. s 3, VDPA 1999

\(^{35}\) Licenses were subject to any terms and conditions the Board thought fit and could be cancelled at the Board’s discretion; appeal of Board’s decisions was to the Magistrates Court. Hygienists and therapists were not able to enter into contractual relationships with members of the public. The regulations contained prescribed lists of duties for dental therapists and hygienists, requiring that they work under supervision, direction and control of a dentist. Dental therapists could only be employed in public sector, and their patients were limited to school aged children. Each practice could only employ only one dental hygienist for each dentist employed enabling 1:1 supervision.
<table>
<thead>
<tr>
<th><strong>Dentists Act 1972</strong>(^{31}) and <strong>Dental Technicians Act 1972</strong>(^{32}) (Old Acts)</th>
<th><strong>Dental Practice Act 1999</strong> (New Act)(^{33})</th>
<th><strong>Implications</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulations detailed – contained DT &amp; DH prescriptive regulation Policies defined by all dentist Board</td>
<td>Regulations more generic Practice boundaries and standards to be defined in Codes of Practice promulgated by the Board</td>
<td>Less in regulation. Codes of practice to be more flexible and responsive. Will include consultation and input from DTs and DHs through member and Dental Auxiliary Advisory Committee</td>
</tr>
<tr>
<td><strong>Discipline</strong></td>
<td>Investigation &amp; formal inquiry- all complaints Dentists sit on all inquiries</td>
<td>Investigation, informal &amp; formal inquiries, prof misconduct &amp; impaired practitioners dealt with differently. Mixed panels Parallel practitioners on panels</td>
</tr>
<tr>
<td><strong>Advertising</strong></td>
<td>Limits on signage &amp; media</td>
<td>No limits- trade practices applies, no testimonials</td>
</tr>
<tr>
<td><strong>Business ownership</strong></td>
<td>Dentists and specialists only, no partnerships</td>
<td>No limits</td>
</tr>
</tbody>
</table>


The appointment of the new Dental Practice Board was also held up by the change of government. The Department of Human Services under Liberal Minister Knowles initially advertised for expressions of interest from persons wishing to be appointed to the Board in August 1999. The new Labor Minister Thwaites placed a second advertisement after the state elections, in February of 2000 because of the view that a change of government may attract other applicants. Around 99 applicants were short-listed and interviewed by an all dentist panel who made recommendations to the Minister\(^{36}\). The Minister then made his nominations to the Governor in Council who formally appointed the Dental Practice Board on June 13, 2000 (VDTA April 2000 and June 2000). The Act was subsequently commenced on July 2000, some three and a half years after the Review had begun.

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\(^{36}\) This panel comprised the chief dental policy adviser to the Minister for Health, a private practitioner and past president of the ADA and, a public dental health academic and former head of the School of Dental Science at the University of Melbourne.
4.4.3 The institutional influences

As shown in Table 4.1 above, there were four distinct phases in the Review of the Victorian dental legislation. The first was the phase, from mid 1997 until March 1998 when acceptance of submissions closed, that could be described as the agenda setting phase as identified by Anderson (1984) and described in section 2.2. In this phase, debate was narrowed from the broad range of possibilities available under NCP to an area within which the policy makers were prepared to debate; so a sort of bounding of the rationality occurred (in Ham and Hill 1993). This ‘range’ was described formally in the Discussion Paper which was published in December 1997 (DHS 1998). The policy formulation or development phase followed, running from March 1998 to May 1999. During this phase the Review Panel appointed by the Minister for Health received submissions and developed recommendations in relation to the development of new legislation. This was followed by the policy adoption phase as recommendations were then used to develop a Dental Practice Bill which was passed into new legislation. The implementation phase began in July 2000 when the Dental Practice Act 1999, with its subordinate legislation was proclaimed and the new Dental Practice Board of Victoria was appointed.

Considine (1994) describes the practical devices for solving problems using routines and standard approaches as policy institutions. He includes the machinery of government such as Cabinet rules and bureaucratic norms; devices apparent in this process and described above. That these institutional processes are influential is also apparent. The publication by the state government of a set of procedures for NCP Reviews (DP&C 1996) shaped the framework and philosophy of the review. It also defined the nature of the review panel which was to exclude dental professional participation, but included a doctor (health expertise) and an economist (market expertise). The agenda setting phase was also deliberate as the reference group consulted in an effort to understand all the issues (Int) and the resulting Discussion Paper (DHS 1997b) described the ‘range’ of the debate. Formal written submissions, considered in private and reported to the Minister, meant that decision making was a private affair and subject to controlled advocacy inside the arena of government. The nature of consultation and participation (discussed later), driven by government norms and community expectations are also within the control of the institution. The delegation of policy leadership also occurs as part of the institution. In this case, the
appointment of a Parliamentary Secretary as Chair of the Review panel formally conferred the constraints of government policy but also considerable institutional power to develop the outputs (Recommendations), and the outcomes (Act). These too, will be examined later. The next section looks at the positions taken by the stakeholders as policy actors and the way they defined their policy expectations.

4.5 The policy actors and their positions

Policy is produced from a range of options. Rational analysis suggests that there are various ways (rational comprehensive, incrementalism, mixed scanning) in which these options are considered and that these are generally defined by the policy institution (Hogwood and Gunn 1984, Ham and Hill 1993, Considine 1994). However policy options arise from a number of sources including government, bureaucracies and stakeholders. Interactions between these various actor positions make the policy outcomes possible. Considine (1994) suggests an examination of speeches, submissions and documents along with interviews as ways of making actor positions explicit. Here, the positions advocated by the stakeholders (as a subset of the policy actors) is described.

4.5.1 Stakeholder positions

Interview data and documentary evidence was used to establish the views of the various stakeholders or policy actors in the review process. Submissions were received by the Review Panel from 51 individuals and 35 organisations, seven of whom were considered key by interviewees. There were submissions from 13 organisations of dentists or dental specialists, plus the School of Dentistry and the Australian Dental Council, two Dental Boards, two public sector organisations and two health funds, and five dental auxiliary associations. The Health Services Commissioner was the only apparent consumer advocacy organisation that was involved (DHS 1997b). Table 4.3 below presents their positions. Each tick represents material collected in an interview (multiple ticks indicate multiple interviews reflecting this position) and footnotes identify documentary sources of evidence corroborating these assertions. The Australian Dental Association Victorian Branch declined an invitation to participate in an interview.
<table>
<thead>
<tr>
<th><strong>Table 4.3: Victorian dental legislation review: Stakeholders Views</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced Dental Technicians Qualifications Board and Dental Technicians Licensing Committee (DTLC/ADTQB 1998)</strong> 37</td>
</tr>
<tr>
<td>Advanced Dental Technicians (ADT) and Dental Technicians (Dtechs) should be licensed/registered  ✓ ✓ ✓ Retain separate Act &amp; Board for ADTs &amp; technicians ✓ ✓</td>
</tr>
<tr>
<td>Change ADT title to Dental Prosthetist</td>
</tr>
<tr>
<td>Ministerial Dental Advisory Committee to formally bring all dental occupations together</td>
</tr>
<tr>
<td>CORA38 to have federal advisory/affiliation role as Aust. Medical Council</td>
</tr>
<tr>
<td>Wanted to adjust (strengthen) Dental Technicians Act 1972 to provide more powers to regulate and discipline 39 ✓ ✓ and include title and practice regulation</td>
</tr>
<tr>
<td>Oppose suspension of training for ADTs</td>
</tr>
<tr>
<td>Certificate of oral health for ADT patients removed ✓ ✓</td>
</tr>
<tr>
<td>Retain prescription of duties for Dtechs and ADTs</td>
</tr>
<tr>
<td>Lift restrictions business ownership but ensure owner responsible for offences</td>
</tr>
<tr>
<td>Support 'fitness to practice' provisions from model legislation</td>
</tr>
<tr>
<td>Oppose mandated continuing training as condition of registration</td>
</tr>
<tr>
<td>Inappropriate to separate registration and disciplinary functions 40</td>
</tr>
<tr>
<td>Capacity to co-opt disciplinary panel members</td>
</tr>
<tr>
<td>Remove restrictions on employment and age groups for dental therapists ✓</td>
</tr>
<tr>
<td>Remove 1:1 ratio for hygienists Maintain adequate supervision for hygienists</td>
</tr>
<tr>
<td>Low degree of supervision for dental therapists ✓</td>
</tr>
<tr>
<td>Retain prescription of duties for dental therapists and hygienists</td>
</tr>
<tr>
<td>Consumers have right to appeal Board decisions</td>
</tr>
<tr>
<td>Independent Board chair (non dentist) ✓ Opposed dentist presidency/deputy role ✓</td>
</tr>
<tr>
<td>Education represented on the Board ✓</td>
</tr>
<tr>
<td>Certification for dental assistants (DAs), under jurisdiction of a Dental Auxiliaries Board ✓</td>
</tr>
</tbody>
</table>

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37 Submission to the Legislation Review Panel from the Dental Technicians Licensing Committee and Advanced Dental Technicians Qualifications Board (5/3/1998)  
38 (CORA) Council of Regulating Authorities is convened as a national body by AHMAC to set and monitor standards and address Mutual Recognition in relation to training and practice for dental technicians and dental prosthetists in Australia (Int).  
39 Such as providing for effective and inexpensive remedies for consumers to address malpractice among Dtechs and ADTS, increasing the range of disciplinary options including powers to deal with unprofessional conduct and impaired practitioners, stronger penalties including power to suspend registration, guilty party to bear costs of hearings and retaining appeal to the Supreme Court  
40 Based on cost, consistency in experience of panel members and precedent set by Medical Practice Act
Australian Dental Association Victorian Branch (ADAVB 1998)\textsuperscript{41}

Opposed de-regulation of dentistry and application of competition principles to dental industry\textsuperscript{42}✓

Retain Protection of title and protection of practice (definition of dentistry)

Support registration of all operatives including Specialists

Registration fees to be the same for all occupations

English language requirement for registration

Supported professional indemnity insurance

Support establishment of a single Board

Board to enforce practice standards and information standards, make Codes of practice

Board to have powers to enforce infection control standards, search and inspection powers. Board could administer Radiation Licensing

Board to conduct formal and informal inquiries and have powers to fine, suspend, de-register. Penalties of at least $20,000 for illegal practice. Costs of formal inquiry awarded against guilty party

Dentist to serve on all panels. Parallel practitioner to serve on panels but No auxiliary to serve on panel investigating dentists ✓ Appeals of Board decisions to VCAT

Board membership should have a majority of dentists and dentist president✓

Three advisory committees (specialists, auxiliary and prosthetist/technicians)

No Partnerships between specialists and GP dentists

Only dentists can own practices (with exception of public sector, local govt. and health funds) ✓

Advertising restrictions to be retained, Oppose ownership of intellectual property

Dentists and staff not permitted to market health insurance products

Support National Oral Health Survey

Oppose unrestricted entry of overseas trained graduates or tooth cutting auxiliaries into market

Limit number of operatives to protect against over-servicing (esp therapists)

Cessation of training of dental therapists and the conversion of existing to dental hygienists

Opposed to moves to extend dental therapists into adult area

Retain Supervision, direction and control of auxiliaries; Dentist must carry out diagnosis and treatment planning and delegate tasks to auxiliary; Dentist has responsibility for

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\textsuperscript{42} "The deregulation of dentistry as proposed has not been supported by any sound arguments. We are placed in the French defence position; i.e. We are guilty and must prove our innocence. We are told there is a blank sheet of paper on to which we must craft our Act, guided by the principles of competition law. A law untested in the health professions, administered by an unelected and unaccountable body. We quote Michael Wooldridge in our summary "...you could hardly call health a marketplace. Health is one of the most highly regulated areas in government...it doesn't follow the normal rules when you just focus everything on the consumer. You've got to look at the behaviour of the supplier in health." A person in pain is not a consumer." President's Comments, ADAVB Newsletter May 1998, Vol 44, no 10
auxiliary actions
Dental hygienist kept separate (no hybrid auxiliary)
Dental hygienists to work in nursing homes under general supervision of dentist and on-site doctors and be allowed to do fissure sealants
Dental therapists to remain in public sector only (oppose move into private sector)
Dental prosthetists to be renamed denturists. Dental laboratories to use ‘denturist’ in business name
Support retention of certificate of Oral Health for patients seeking partial dentures from a dental prosthetist
Opposed mandatory continuing education
Supported compulsory refresher programs for workforce re-entry at discretion of the Board
Opposed the use of terms dental professional and dental practitioner by auxiliaries

<table>
<thead>
<tr>
<th>Dental Board of Victoria (DBV 1998a)43</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title protection and Practice protection including definition of dentistry</td>
</tr>
<tr>
<td>Retain restrictions on dental therapists employment to public sector and school aged children</td>
</tr>
<tr>
<td>Retain supervision direction and control of dental auxiliaries</td>
</tr>
<tr>
<td>Remove defined ratio of hygienists to dentist (1:1 ratio)44</td>
</tr>
<tr>
<td>Retain Certificate of Oral Health and Prescription of duties for ADT</td>
</tr>
<tr>
<td>No licensing for dental technicians</td>
</tr>
<tr>
<td>Practice ownership by Dentists only</td>
</tr>
<tr>
<td>Single Board for all dental occupations, include lay and legal membership of Board</td>
</tr>
<tr>
<td>Full, specialist and provisional registration for dentists</td>
</tr>
<tr>
<td>Supports Victorian model legislation for unprofessional conduct</td>
</tr>
<tr>
<td>Supports structured approach to dealing with impaired providers</td>
</tr>
<tr>
<td>Support professional indemnity insurance ‘for privately funded’ patients</td>
</tr>
</tbody>
</table>

---

44 Interview data suggests that their early position was to support retention of the 1:1 ratio but that this shifted later
**Dental Health Services Victoria (DHSV 1998)**

Title and practice protection (minimalist definition: ‘...surgical operation on teeth and supporting structures and associated parts...’) Opposed complete de-regulation ✓

Codes of practice to define services, infection control, education standards, supervision of therapists & hygienists ✓

Opposed registration of dental assistants or dental technicians ✓

Reduced prices for oral health services for the community ✓

Registration of practitioners ✓

Reduced control of the system by dentists ✓

Combined single Board with wider representation ✓

More flexible decision making processes ✓

More flexibility to use auxiliaries, more internal competition ✓ Wanted to test therapists with adults ✓

Dental therapists in private practice ✓

General (off-site) supervision for auxiliaries ✓

No practice ownership restrictions including allowing therapist owners ✓

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**Dental Hygienists Association of Australia Victorian Branch (DHAAVB 1998)**

Remove one-to-one ratio (dentist:dental hygienist) for supervision ✓ Retain supervision (general) ✓

Wider use of skills in off site supervised settings ✓ Did not support independent practice ✓

Registration of hygienists ✓

Supported title protection, practice protection (definition of dentistry) and list of duties specific to hygienists ✓

Wanted to broaden skill range to include local anaesthesia (LA), fissure sealants and some orthodontic procedures (to include competencies practiced in other Aust. states) ✓

Dental hygienist seat on Board and for discipline of hygienists ✓

Supported professional indemnity insurance (but opposed to mandated because gives too much control to insurance companies) ✓

National Association argued for retention of regulatory status quo ✓

Opposed to merging of auxiliaries (hybrid) ✓

Supported removal of ownership limits?

Did not oppose therapists in private practice ✓

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45 Dental Health Services Victoria (DHSV), Submission to the Review of the Dental Act, March 1998

46 DHSV Submission, March 1998

The positions advocated by the various stakeholder (interest) groups represent the raw components of eventual policy. The decision making process requires the analysis of the interactions between these policy actors as they struggled to have their views.

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48 Prosthetists were described under the 1972 Act as Advanced Dental Technicians but used their preferred term in this document.
(cultural definitions) take precedence. Data collected in this study showed that there were seven key stakeholder or interest groups (the dentists (ADAVB), the Dental and Dental Technicians Boards, the Technicians and prosthetists, the public dental provider agency (DHSV), the dental therapists (VDTA) and the dental hygienists (DHAAAVB) and that they fell roughly into two ‘camps’ – those who wanted to change the system and those who wanted it kept the same.

The section that follows reports the results of the conceptual analysis of the data under the headings of the actors (stakeholders) and the policy culture, and the interactions between the institution and the attempts to shape policy culture. Flashpoints, will be described as exemplars of these interactions followed by an analysis of the policy system and how its components contributed to the policy outputs.

### 4.6 Shaping the policy culture: the actors

This group of themes and evidence comprises the actions and positions of the policy stakeholders, referred to by Considine (1994) as actors (often also referred to as interest groups) in their attempts to shape the policy culture.

#### 4.6.1 Dominance of dentists

A strong theme emerging from all interviews was that policy participants recognised the power of the dentists in and over dentistry. Dentists were numerically dominant\(^{50}\) and had more representation at all levels and stages of the process\(^{51}\), more resources\(^{52}\), and an expectation that their views would be important. Of note from the submissions is the content; dentists commented on all aspects of dentistry while many

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\(^{49}\) *Oral Health, A Right Not a Luxury; Victorian Dental Therapists Association (VDTA) Submission to the Review of the Dentists Act 1972 and Dental Technicians Act 1972, March 1998*

\(^{50}\) The Discussion Paper indicates that there were around 2400 dentist in Victoria in 1997, compared to 64 hygienists, 234 therapists, 371 technicians and 333 prosthetists (DHSV Dec 1997)

\(^{51}\) Around 16 of the 33 submissions came from dentist professional groups and organisations. There were also a number of individual dentists who made submissions (estimated to be around 35 of the 51 received) (DHSV July 1998)

\(^{52}\) The ADAVB spent over $127,000 in 1997 alone on media advertising compared to for example the VDTA which spent $11,000 from 1997 to 1999. (Essential Media Communications, VDTA Media and Lobbying Campaign, April 1998). The ADAVB also have a salaried executive officer and staffed office at both state and federal levels compared with the other associations who use voluntary labour.
of the other groups restricted their views to their own sector or area of expertise (see Table 4.3 showing content of submissions).

Dentistry has been regulated by state legislation in Victoria since 1888 when the first Act was passed establishing the first Dental Board. The Boards have had a history of drafting dental legislation and regulations and of setting the standards of practice and discipline for the profession. Dental Boards, since their inception have been comprised of a majority of dentists (doctors and lawyers have been included from time to time). Since 1972, all members of the Dental Board have been dentists, the majority of whom are male and have been elected by registered dentists (DBV 1993). In this process, dentists were represented on four of the key stakeholder groups, the Dental Board of Victoria, the ADAVB, the University of Melbourne’s School of Dental Science and DHSV. They also participated via their specialist societies and academies, student body and as dental policy officers for the Department of Human Services (DHS 1998, Int x2). The key advocate for dentists’ interests was the ADAVB whose membership comprises of 95% of Victoria’s dentists (ADAVB 2002).

Interviews showed that there has been a view that dentists have protected their own interests over the long term through control of the boards, the Australian Dental Council (ADC) and the professional association (ADA) (Int x3). Interviewees felt that the control they exerted over the whole environment made it difficult for progress to occur or more flexible service delivery to occur (Int x6):

‘...dentists have control of the system, and I wanted that control reduced. This is a mixed society and it was never going to be removed, they’re powerful people. But I wanted it reduced, so that for instance the combining of the two Boards, and representation of auxiliaries on the Board, it doesn’t get rid of the dentists’ power, they’re still going to sit there with a lot of power, but it’s reduced. And I wanted the framework within which decisions were made, flexible enough for progress to take place...’ (Int)

‘...within the dentist profession when you ask people to self regulate, it’s like putting “Dracula in charge of the blood bank...”’ (Int)

A key example of this dominance was apparent in the debates around practice definition. The dentists argued that dentistry should be defined so that only people with dental qualifications could practice dentistry. They wanted the supervision and duties of dental therapists and dental hygienists defined and they wanted the practice,
partnership and referral arrangements of specialists defined. They wanted a defined
range of duties for dental prosthetists, and for technicians to work under prescription
of a dentist (ADAVB 1998, DBV 1998a). In short, they argued to retain or
strengthen the existing regulation. There was no evidence of debate or discussion
about the range of skills or practice areas of a dentist. There is also no Board
subcommittee for dentists as there is for the other occupational groups (DPA 1999).

4.6.1.1 Relationship with the other occupational groups

Interviewees described the relationships inside dentistry as hierarchical rather than
collaborative or peer relationships, referring in particular to dentists and technicians
or dentists and auxiliaries (Int x2). The subordination of therapists and hygienists
was so well accepted that independent practice for these professions was not given
consideration, in some cases even among their own ranks (Int x2).

‘...It's not going to happen, just at the moment... it is not in the interests of public health and safety for
(hygienists) to be working without a dentist... So in a way (they) weren't badgering for
unsupervised... weren't badgering to be able to hang up (their) own little sign and work on (their)
own... there has only been one spot where they're ... doing that and that's California. And they've had
a hygienist there since 1903. You know, they're way grown up. They know what they are, they know
what the concept is... ’ (Int).

It was also apparent both inside and outside dentistry that the dentists have the
highest public profile and that not enough is known about the other professions (Int
x5).

This higher public profile is also possibly related to the 85% provision of dental
services through the private sector. There was a view among interviewees that
private sector dentistry represents the ‘real world’ and that the public dental sector is
‘...sort of out on the edge- not mainstream... ’ (Int x2). For that reason, some
stakeholders viewed the opinions of policy makers and public sector providers as less
relevant to the debates:

‘...the Labor party stood up in Parliament and supported the Bill, and they understood it so little that
that Brumby went off talking about School Dental Services... ’ (Int)

‘...I'm not talking about the public service here, I'm talking about the real world... ’ (Int)

This view had been advocated in earlier policy episodes:

53 Only two women were ever appointed to the Dental Board of Victoria, the first in 1987, the second in 1997.
...the association wonders why the Minister is listening to non-practising dentists and bureaucrats who do not understand the clinical short-comings of the proposed program...’ ADAVB April 1996.

In some cases the ADAVB had been openly opposed to the public sector dentists and critical of their agendas but more recently the two factions had made more effort to work together in the public interest (Int, ADAVB Feb1999). Despite this environment, the traditional image of the profession as an unselfish service provider rather than profit making business still pervades and was protected by the ADAVB (ADA VB 1998, Int).

The dominance of the dentists means that their relationships with other dental professions are mostly antagonistic. The dental prosthetists and technicians have a history of hostility although the relationship is perhaps more collegial now than at any time in the past (Int x2). The ADAVB still argued for retention of the Certificate of Oral Health for prosthetists’ patients and supported the embargo on their training (ADA VB 1998). They also supported the single Board model which re-instated some control over the prosthetists but they did not support the de-regulation of technicians (ADA VB 1998, Int x2). Interview data show that the technicians and prosthetists were unhappy about the loss of separate regulation and also that the dentists were quite pleased about it (Int x3).

The dentists’ relationship with the therapists and hygienists was disparate. The ADAVB continued to oppose the existence of dental therapists arguing that ‘...there is no longer a need for a tooth cutting auxiliary...’, and arguing for the ‘cessation of their training and conversion to hygienists’ as soon as practicable (ADA VB 1998). On the other hand they supported the hygienists’ role referring to them as the only ‘preventively oriented auxiliaries’ and the ‘auxiliary of the future’ (ADA VB 1998). The hygienists accept their place in the team and the hierarchy and have retained the support of dentists (Int x2).

4.6.1.2 Policy participation

The actions taken by dentists in this review included overt and covert actions designed to strengthen the internal capacity of the organisation to be influential and to mobilise external support for their views. The ADAVB used their newsletters to regularly provide considerable amounts of information to their members, although interviewees questioned its quality (Int x3). They also provided a kit of information to
each of their members which included signage and petitions for their surgeries, pamphlets for their patients and material for inclusion in letters to MPs protesting the review and its proposed changes. They also encouraged individual members to submit their views to the review panel and in letters to the press, and by visiting members of parliament (ADAVB Dec 1997, ADAVB 1998). Regular monthly Dental Updates were sent to members of parliament and in July 1998, a petition opposing deregulation of practice and ownership containing 29,000 signatures was presented to parliament (ADAVB June 1998, ADAVB July 1998).

The ADAVB also engaged public relations expertise to develop a corporate marketing campaign called ‘Open Your Mouth and Cross Your Fingers’ which headlined their press releases and included media training for their spokes-people (ADAVB June 1998). Newspolls were also commissioned to gather consumer views. This media action to discredit the review upset the panel, including Robert Doyle, because of the ‘scare-mongering’ misinformation being published and because it circumvented the review process (Int x6):

"...we would have preferred the ADA to come to us and talk to the issues rather than talking to the media..." (Int)

Robert Doyle himself was also invited to several branch meetings to discuss the review where the opposition to de-regulation, practice ownership and practice protection were constant topics, with the Ballarat and Geelong meetings becoming quite vitriolic (Int x3). There was also a suggestion of the use of a private investigator and personal attacks on Robert Doyle (Int x2).

The Dental Board of Victoria (DBV) was in a curious position in this review. Historically, it had been they who were responsible for drafting legislation but NCP said that the review process had to be impartial and exclude direct participation of the professions, except as stakeholders. The DBV had considerable expertise in administering the act but in many ways this review was about undoing the power of the DBV (Int x2). During the agenda setting phase, the appointment of the DBV chairman and specialist dentist, Rohan Storey to the Reference group was defended on the grounds that he was to:

"...provide some guidance as to what were the issues we needed to address when we were drawing up the issues paper..." (Int).
The apparent concern of the DBV over its distance from the policy making process was alleviated by this appointment, an opportunity not offered to any other stakeholder group (Int). There is evidence to show that Dr Storey used this position to argue that hygienists could not practice safely on their own. The hygienists also felt that the DBV had ‘leaned on’ them to make particular arguments favouring the retention of supervision and the one-to-one ratio (Int).

It is clear that the dentists (represented by the ADAVB) possessed considerable power in the process and exercised it continuously and in a number of ways and that it was quite effective despite the assertions from the review team that all stakeholders were equal:

‘...The ADA clearly had a lot of power, and my impression was that they used the right style in the formal arenas a lot ... but look they’re establishment dentistry and they have establishment power, they met people at parties. I got the distinct impression that positions changed between meetings, with no explanation other than influence from the ADA. Also, my impression was that Robert had influence brought to him from above in government too, I assume as those dentists got to higher people...’ (Int)

4.6.1.3 ADAVB Relationship with the Chairman of the Panel

Interview data show that some actions of the ADAVB clearly upset the panel and in particular Robert Doyle (Int x8). Several of the interviews cited a particular Robert Doyle remark indicating he made no secret of the fact:

‘... “when people get up my nose, I tend to sneeze”... and the ADA certainly had got up his nose...’
(Int)

Panel members felt that any criticisms should be made inside the process rather than to the media and that the criticism came too early, resulting in a stifling of debate in certain areas such as broadening auxiliary practice (Int x3). Of course the alternative view might be that it was clever and effective agenda setting:

‘...But it annoyed Doyle, that’s right. But they were saying things outside that were untrue and he knew it was untrue, and they knew it was untrue, and he knew that they knew it was untrue and he was cross about it...’ (Int)...

There was also a question about the ethics of scare mongering among patients to generate signatures for a petition (Int).
The assertions made by the ADA VB that dentists were the only ‘professionals’ in the area and that none of the other occupational groups should be referred to as professional also annoyed him (ADA VB Sept 1998, Int x2):

'...He also said at that same meeting that he would change it to providers or whatever they changed it to, on the clear understanding that this had nothing to do with saying the other providers weren’t professionals, weren’t professions...He actually used those words. He was actually cross about that as a pathetic tactic, pathetic thing to watch. The words they suggested, he said, ... It was what was a clearly self-seeking power, my impression was that he was seeing that as revealing their true motives. He didn’t mind changing the words, he didn’t give two hoots, but I think he learned a bit about them and what they were really after in the process...' (Int)

4.6.1.4 The outcomes

Despite the apparent change agenda and the challenged relationship between the panel chair and the ADA VB, the dominance of the dentists was clearly reflected in the outputs. The majority of practitioners on the new Dental Practice Board are dentists and the new Act preserves the presidency and deputy presidency of the Board for dentists alone. The supervision of dental therapists and hygienists has been retained despite its anti-competitive nature and the Act contains, against all predictions, a definition of dentistry. There is also no Board subcommittee dedicated to dentists, and prosthetists and technicians have been brought back into a single regulatory arena. Despite the loss of numerical control over the Board there are indications that the dentists were reasonably satisfied with their positions:

'...there are the little whispers around (among the dentists). You know, how we’re going to get back in charge. How we’re going to take charge of the profession and do what we should, we’ve always done it, run it the way (we) want it run...' (Int)

'...the professional associations chief among whom was the ADA, probably because they were the biggest, best funded and among the most vocal. They would have seen themselves as the ones with the most to loose. I don’t know, perhaps they’re congratulating themselves that they didn’t lose that much...' (Int)

4.6.2 Corporatism and the role of the public sector provider agency

In 1995, Dental Health Services Victoria (DHSV) was established to co-ordinate the delivery of public sector services through the Dental Hospital, the School Dental Services and a range of community health services. Dr Martin Dooland, author of the National Health Strategy (Dooland 1992) document which had proposed the Commonwealth Dental Health Program (CDHP) and ex Director of the South
Australian Dental Services, was appointed as CEO of the new organisation (DHS 1995, DHSV 1996).

Martin Dooland, with his background as a dentist, had both a personal and corporate interest in the Review. His official role was to represent and advocate for the interests of DHSV- public sector dental services. He had a career interest in public health, supported the AHMAC Pilot proposal (AHMAC 1996) and had been active as an advocate at federal level for public dental services (Lewis 2000). His role in South Australia and to a lesser degree in Victoria, had however brought him into conflict with the ADAVB over, for example the AHMAC pilot, support for therapists and prosthetists and fee scales for purchased private sector services (ADAVB April 1996, May 1996, Int). He had also been a member of the DAWR team chaired by Robert Doyle in 1995. Interview data show that he was considered by some to be outside mainstream dentistry (the ‘real’ world) but nonetheless a dentist in an influential position (Int x6).

DHSV supported the removal of the public sector only employment limits for dental therapists, a broad definition of supervision to protect the ability of the school dental services to continue its service provision model, a single multi-disciplinary Board and the inclusion of a definition of dentistry (DHSV 1998). Dr Dooland’s support for the definition of dentistry was such that he joined forces with the then president of the ADAVB to jointly discuss the issue with the panel and actively contributed to the debate around its wording (Int x3).

His views on many issues appear to have prevailed and there are a number of possible reasons for this. His support for competition and therapists and opposition to dentist dominance seemed to agree with the government agenda (Int x2). Public sector services were important to Doyle because of the public profile they had and Dooland had proven himself to be someone with some solutions, such as implementing co-payments as a solution to the loss of the CDHP (DHSV 1998). The purchaser-provider arrangements meant that Dooland could have a voice separate from the bureaucracy, adding a public sector stakeholder distinct from the professional associations. Because of their corporate/consumer advocate position they were possibly seen as less self interested than the representatives of the professions. These factors appear to have combined to make him influential. An alternative perspective
is that Martin Dooland and DHSV’s corporate interests happened to agree with the direction that the government wanted to take.

4.6.3 Development of the auxiliary professions

The process of this review established some conditions that gave greater voice to the auxiliary professions than they had had before. The demand that the review panel be independent and use a consultative approach meant that the auxiliary professions became stakeholders with equal conditions of participation to the dentists. This forced them to engage with the process and learn how to participate. The whole experience meant that the two professions rapidly developed advocacy and policy making skills at a time when their members were ready to do so.

4.6.3.1 The dental hygienists

Interview data show that the DHAA had little understanding of National Competition Policy and its implications in the beginning but that they worked at informing themselves and meeting with other groups to discuss its implications (Int x2). Previous policy experience with the DAWR had seen them aligned with the ADA because of their inexperience, low numbers and congruent agendas (Int, Lewis 1996). There was also a need for the Review team and some of the other stakeholders to learn more about their role and skill range (Int x3).

Their meetings with other groups left them feeling manipulated by the DBV and concerned about the attitudes of the ADAVB.

'...the ADA originally (said to them)... don’t even worry about it. Don’t even write a submission. They are making you jump through hoops!...(the DHAAVB) met with them first of all and they were no help whatsoever.... except (they) walked out of that meeting frightened...' (Int)

Their relationship with the dental therapists however, which had been poor in the past, blossomed during this time (Int, VDTA July 1997).

There was however some disquiet inside their association about the potential movement of dental therapists into the private arena and the threats this might pose to their position (Int x2 1999). Their early concerns were that the ‘hybrid’ or combined auxiliary recommended by the DAWR was on the agenda but they were re-assured by the project officer that this was not the case. Once they had developed an understanding about NCP, their chief concern became de-regulation; that hygienists
would not be registered and they set about making arguments to oppose that (Int, DHAAVB 1998). They were generally happy with their existing professional relationships with the exception of on-site supervision and the one-to-one ratio because this prevented them from working when their dentist was away from the practice. They were also keen to be able to work in nursing homes as the South Australian Act allowed. They felt that their profession was not mature or well known enough to develop independent practice. The issue of two auxiliary board seats was important to them but they were told early that this would be unlikely and they were happy to have representation and a role in a subcommittee where there had been none previously (Int).

Their relationship with the dentists was perceived by others to be strong and the ADAAVB actions support this, referring to hygienists as the ‘auxiliary of the future’ (Int x3)

‘...I think the dental hygienists to a certain degree have an unholy alliance with the ADA, so I don’t think they fear … no that’s not true, they do fear change and they do fear challenges to their position and their private practice, but I think they’re a fairly… secure group…I think they perceive themselves as the chosen dental auxiliary, in the real dental world, I’m not talking about the public service here, I’m talking about the real world…’ (Int)

‘...You see they don’t push themselves. They seem to sit in meetings, often with the ADA, and seem to say, “...and we agree with him”. As in, we agree with the dentists. And it puts them in a situation where they’re not representing any interests except the dentists’, in my view...’ (Int)

The hygienists however felt that they had developed independent views in this policy process and were taking some risks by expressing them. They came under pressure from their federal association whose submission supported a strong alliance with the dentists and expressed more conservative views (Int x2).

‘...We learned a lot, it brought out the, “how far are you going to go?” You know when you have that time when somebody pushes your values, how far... are you going to go on the bandwagon or are you going to risk standing out on your own, with the heavies coming down on you after the fact for doing it... because it becomes a public document... I went to the meeting, I listened to what they had to say, and then I went back to research and said, is there anything physically documented anywhere to support the position they would like me to take. If there was, I would consider it; if there wasn’t then I would move on. For most of the things they would know there was no founding... no international models, there was nothing to support what they were telling me. That just told me, look well I’ve got all this support telling me that it doesn’t have to be that way so... ’ (Int)

The actions they took mostly involved the consultative meetings and interactions with other stakeholder groups and the development of their submission. There is evidence to show that there was respect for the work and position put by the DHAAVB and
while they were heard, they were considered to be one of the less powerful stakeholder groups (Int x5).

4.6.3.2 The dental therapists

The therapists were in a slightly more advantageous position in terms of understanding NCP than the hygienists as one of their colleagues had undertaken post graduate study in the area (Millsteeed 1996, VDTA Dec 1996). They recognised the opportunity this Review was presenting and the resources they would need to be heard and acted to achieve this. They were successful in the Victorian Womens’ Trust Granting round of 1997 which enabled them to engage expertise to help develop their submission and their media and advocacy work (VDTA August 1997, VWT 1997).

They too participated in the consultation process as well as running a launch of their submission which achieved some media coverage in May 1998 (Gray 1998, McLagen 1998, VDTA April 1998). Their campaign, “Spread the Smiles” promoted therapists' capacity to increase access to dental care through lower cost dentistry. This process also included the development of press releases and media skills in their executive members. They engaged their membership through their newsletters and produced an advocacy kit for their members to use with local newspapers. The VDTA also circulated 170 copies of their submission to community, health policy and professional groups and members of the Victorian Cabinet (VDTA April 1998, May 1998). They also wrote to all MPs in April 1999 and met with the Opposition (EMC 1998, VDTA Sept 1998).

Unlike the hygienists, the therapists wanted the opportunity to compete with dentists within their skill range (ie no employment or client age limits), to have a voice in their own regulation and to have their relationship with dentists defined in a more collaborative way. They felt the existing regulation did not reflect current practice and was designed to protect the dentists dominant position. They did not seek to expand the range of skills they used, but rather to use them with fewer restrictions

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54 The ADAVB response: ‘...the panel will be weighing up the risks of allowing less qualified people to perform dental procedures on the lay public. They must assess the risks of disease transmission in a less regulated practice environment. Will somebody die? How many? I hope compassion and reason will prevail...please could we have a little reason and logic based on science; are the rationalists winning this debate? I recently had to respond to a “launch” by the dental therapists of their submission to the review. They are making an ambit claim to perform most acts of dentistry on adults as well as children in both public and private sectors...’ ADAVB Newsletter, Presidents Comments, June 1998
(VDTA 1998). They had support from the prosthetists who felt they should be able to practice with more autonomy and also from DHSV (their major employer and traditional support base) who saw their employment limits as a moral issue (Int x3). There was a perception that Robert Doyle knew more about therapists than hygienists and that they had developed quite a good relationship with him (Int x2).

Interview data show that the therapists too were considered to have made a good submission and were seen to be more effective than the hygienists but less so than the prosthetists; and as well organised but not as well resourced as some other groups (Int x5):

‘...I think the low number of therapists and their situation of currently being in the public sector meant (they) were never going to be influential ... It’s a bit of hygienists scarcely on (their) side, it’s being in the public sector and not known, (they) don’t have high powered contacts like the dentists do, (they) aren’t as street wise as the (prosthetsits, who are) more used to lobbying, there’s a lot more of them, they’re very effective at it too...’ (Int).

The outcomes of the review support these views. Independent practice and adult clients were never seriously debated and both supervision (albeit a broader definition) and the age limits were retained. The therapists and hygienists had a shared board seat and, with title protection and registration and the application of disciplinary procedures to their professions, were brought into mainstream health practitioner status55. A standing committee comprising dental therapists, hygienists and assistants (dental nurses) was to provide expert advice to the Board on matters pertaining to dental auxiliary practice (DPA 1999).

The therapists themselves had learned a great deal about a range of things thorough this process. They gained an understanding of how legislation works and how policy is made and how to participate in that process. They recognised the value of resources and expertise;

‘...Without this VWT Grant, we may have made some legislative gains but the learning, the wider application, the confidence (empowerment), the visibility and the credibility of our arguments and thus their effectiveness would have been so much less. We learned so much that was irreplaceable from our consultants...our Association is now more powerful than it was two years ago...’ (VDTA Nov 1999).

55 They had previously been licensed under the act with no title protection or representation at board level.
They also developed better relationships with many people in and around dentistry and, like the hygienists, found that they could and should participate in the dental policy environment (Int x2).

The period of the Review saw the development of better relationships between dental therapists and dental hygienists which had been long overdue although this was possibly a result of the personalities and the combined educational environment as well as the review itself. Both groups began by believing that the process was genuine, open and anything was possible but they became more cynical as it progressed. Some of their members became disillusioned and felt manipulated (Int x3). What is common to both is that they developed more skills as the process went along - learned how to ‘play the game’ and also gained confidence in their own opinions.

4.6.3.3 Dental nurses

While dental assistants or nurses participated in the review, it really didn’t engage them in the same way it did other groups. Their practice is regulated by delegation and supervision as they are not permitted to perform any invasive procedures at all (Int). While they have an important infection control and chair-side role, are indispensable in most dental practices and are widely recognised as part of the ‘team’, their issues were not seriously discussed by the review (Int):

‘...I think they’re universally accepted as a fairly powerless group in the dental world...that’s the history of dental nursing ...I think it’s got to do with their rung on the ladder, in the dental world, I think it’s to do with their work relations, with the relationships with employers, I think it’s to do with their gender, I think it’s to do with their non-professional status, a lack of recognition of skills... ’ (Int)

Their arguments that regulation should demand that dentists only employ qualified nurses and that they should be more formally regulated were also difficult to sustain in an environment of de-regulation (Int). They were however formally given a role in the new Board’s Dental Auxiliary Advisory Committee (DPA 1999).

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56 In 1996, the University of Melbourne auspiced the first course educating both dental therapists and dental hygienists in one setting. The course has a combined (core) first year with streamed second year culminating in a Diploma in Oral Health Therapy in either dental therapy or dental hygiene. Prior to this dental therapists were mostly trained in state government auspice programs and the only course for dental hygienists was at Gillies Plains College of TAFE in South Australia.
4.6.4 The community

Despite the public nature of the review, there was very little engagement from the community. The perception among interviewees was that they were not very interested because it was complicated and people generally trust the government to set up proper protective mechanisms (Int x4). There were indications that individuals met with or wrote to Robert Doyle about particular concerns they had as consumers but they did not otherwise participate in the consultations (Int x2). There was some interest from formal consumer advocates such as the Health Services Commissioner’s office and some community health centres but it was largely the professions that engaged (DHS 1998). The tone of the Discussion Paper may have contributed to this as it was ‘pitched up’ because of the nature of the participants who had engaged and the complexity of the issues (Int).

Anecdotal evidence suggests that organisations such as the Brotherhood of St Laurence and the Health Issues Centre felt they were not qualified to comment on issues of a clinical nature because they lacked expertise. It is interesting to speculate, but impossible to assess whether strong advocacy on behalf of population groups with low access to dental care could have influenced the policy outcomes in any way.

At the level of the media, there was also little engagement. Both the ADAVB and the VDTA sought media attention and while there was some television and radio coverage including some talk back, around the time of the VDTA launch (VDTA May 1998) and one or two other episodes triggered by the ADAVB activities (Herald Sun, 1997, ADAVB March 1998, June 1998) the media did not debate the issues in any depth.

In summary, the combination of interview data and documentary evidence has shown that the key policy actors were the various dental professional associations and boards, the review panel and bureaucracy supporting the process and the public dental service provider agency. Analysis of this range of actors shows that while initiative in the process was provided by National Competition Policy and several pre-existing policy documents, leadership was provided by the parliamentary secretary to the Minister for Health. The ADAVB, representing organised dentists was clearly the
strongest player but the process demanded input from the other dental occupational groups.

The preceding section has looked at the interests and actions of these groups and individuals along with the policy outputs and key arguments made in an effort shape them. The following section continues the results section by examining the role of the institution as it interacted with the policy actors. This includes consultation, the interactions and mechanisms that were used to influence how the decisions were made and some of the key flashpoints in the process.

4.7 Shaping the policy culture: the institution

4.7.1 Consultation framework

In this policy process, the ‘institution’ refers to the government and its branches responsible for the legislation review; this includes the Department of Premier and Cabinet and the Department of Human Services and its Minister (the Minister for Health).

The Department of Premier and Cabinet had established Guidelines for Legislation Review that indicated that a Model Two Review should include an independent panel, public notification, call for submissions and targeted consultations with interest groups. Under these guidelines, the Minister also had the discretion to release a draft report prior to finalising the recommendations. (DP&C 1996, Int). Both interview and documentary data show that consultation was an integral part of the review process. As shown in Table 4.1, there were three formal phases of consultation although there is evidence to show that lobbying and advocacy occurred throughout the entire process.

4.7.1.1 Consultation phases

Consultation began early in the process with letters inviting identified stakeholders and the Ministerial Dental Advisory Committee to meetings with the Reference
group. The purpose of this consultation was to ensure a good understanding of NCP and the review process, and to develop the issues for debate (Int x4). The Chair of the review panel, Robert Doyle also made himself available at this stage for meetings with the professional associations, consumer groups and individuals (Int x6).

Following receipt of submissions in March 1998, the Review Panel met to develop recommendations which were circulated in draft form in June 1998. This triggered another round of consultations. In July 1998, the Recommendations were published and work began on drafting a Bill. During this phase the stakeholder consultations to discuss the Draft Bill were conducted by Robert Doyle and the Dental Policy Unit, although some groups met with Minister as well (Int x6).

In May 1999 when the Bill was presented to parliament, all stakeholders were invited to attend the Lower House to hear debate, and afterwards to the Speakers Room at Parliament House to celebrate its passage with the Minister and his Parliamentary Secretary (Int x3, VDTA June 1999). Consultation also occurred in January 2000 around the development of the regulations (VDTA April 2000).

While consultation was organised and constant throughout the process, it had different agenda setting role in that they provided information to the stakeholders about Competition Policy and the framework for the Review including the earlier policy documents (Int x4). They allowed debate of particular issues to ‘...capture participants’ ideas, arguments and suggestions about relevant issues...’ (DHS 1997a) and to test ideas such as disciplinary models and regulatory frameworks (Calsa 1997a, 1997b).

The submissions which represented a formal presentation of stakeholder views, developed after the agenda setting stage, reflected positions which had undergone some discussion and were closer to the more competitive model the government was proposing. For example, the DBV had initially verbally supported the retention of supervisory ratios for hygienists (Int) but in their submission, they did ‘...not support

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57 The Reference group had the task of developing the Discussion Paper and comprised the project officer for the Review, a Department of Human Services legal officer, Dr. Chea Wa Chea from the Review panel and Dr. Rohan
any ratio…’ (DBV May 1999). Interviewees also reflected a shifting of the ground during the earlier phases resulting in more focused written submissions (Int x2).

‘...We had our first draft before that (the Discussion Paper) and we...ripped it up. Deleted everything and started over. And we re-wrote, because from then we knew what they were talking about.... Well it was more...about what they were trying to achieve and how to position your arguments for legislation... and regulation, in the fact that it had to... it was not to support your profession... it was to support...public health and safety and access to care. ..’ (Int)

Written submissions were not accompanied by verbal presentations or public forums but were privately considered by the panel who deliberated for around three months before producing draft recommendations. This draft was considered in another round of consultations with stakeholder groups prior to being submitted to the Minister and government.

The phase following the recommendations was more intensely negotiated as the recommendations were translated into legislation and some wording and implementation issues were considered. Interviewees considered this phase to be more overtly political in the nature of its decision making as stakeholders engaged their networks, lobbied across the political environment and applied ‘wearing down’ strategies (Int x3).

These differing phases of policy making reflect Anderson’s (1984) model of policy making processes. This model makes distinctions between the phase where problems are defined and the policy agenda is set (agenda setting) and the phase where new policy is designed or developed (formulation). Policy formulation is followed by policy adoption where policy is enacted or formalised into, for example, legislation (in Palmer and Short 2000). The actions of and consultation with policy participants in this process were separated deliberately by the nature of its management processes. In this process, the agenda setting phase was clearly the phase up to the publication of the Discussion Paper in December 1997; consultation was focused on identifying the range of views and issues in order to develop the frameworks for the process. The policy formulation phase occurred without direct interaction as formal views were put in writing and considered privately by the panel. The policy adoption phase occurred following the release of the recommendations during the time that they were

Storey, then president of the Dental Board of Victoria and specialist dental practitioner
converted into and passed as legislation. At this time stakeholder actions varied from those internal to the process to those external to the process, for example directed toward the public or other politicians in order to apply external pressure where the outcomes of policy formulation were considered unacceptable.

### 4.7.1.2 Consultation functions

Two perspectives about the consultation process emerged from the interview data, that of the bureaucracy and of the stakeholders. From the bureaucratic (Review Panel) perspective, consultation was important because it increased their understanding of the policy environment. In the early stages, consultation helped to develop the details and issues. For example, the role and skills of dental hygienists and their relationship with the dentist, the dentist to specialist referral mechanisms and how disciplinary models had worked in this industry, were all explored (Int x4). The submissions were equally of value and there is evidence to suggest that each submission was read in detail and used to inform decisions as they were made (Int). The consultation process also allowed the panel to go back to people to explore their ideas, further develop the thinking and look for more evidence or detail to inform their decision making. An example of this is the definition of dentistry, where consultation around this issue shifted the decision making away from the outcome expected under NCP and model legislation (Int x2). The development of the functions and role of codes of practice was also a product of the consultations; this gained strength and depth as the consultations progressed (Int x4).

There was also a sense of consultation being used to negotiate outcomes with suggestions about ‘deals’ being done to bring opposing views into consensus or to develop agreement about the outcomes. The review panel supported this because in their view the process demanded a negotiation of opposing views in order to reach an outcome everyone could work with:

‘...well maybe the ADA did a deal and accepted ownership of practice in return for maintaining the restriction on supervision, because they knew that would kill off potentially independent practice...’ (Int).

‘...Consultation means, we will listen carefully to your arguments and then we will make a decision...of course no-one got what they wanted because there were so many conflicting interests in this...the reason it takes three years is because that's how long it takes to talk to all of those groups...’ (Int).
The review team asserted that all the stakeholders were considered equal under the review process and given the same opportunities to contribute and be heard. From this perspective, consultation was important to the process because it also increased the transparency of the decision making process (Int x4).

Among stakeholders there were two views about the purpose and use of consultation. On the one hand there was a view that consultation was genuine and openly seeking opinions and developing details. While there was a framework in place and some ideas about what the outcomes should be, the consultations had the role of testing the model and looking for weaknesses in it and alternatives:

'...I actually thought the government was asking, I didn't think they were pushing their preferred position very, very hard. I thought they were challenging us to see if the de-regulated model really was a goer...'. (Int)

The alternate view among other stakeholders was that consultation was a type of game playing; that stakeholders were all playing a part in an orchestrated process and that there was a sense of manipulation. This view held that consultation was carried out to publicise the preferred model and people's views were ignored where they didn't fit with that model (Int x3):

'...he consulted with all the various sectors that he wished to consult with, he ran these meetings which I suppose we all attended diligently .... I would be not very surprised if he hadn't written the bill before he even started the consultation process because in all honesty it was a sham, the whole consultation process was a sham, because once the bill was issued many, many of the areas I would imagine would have been raised and sorted out weren't represented...'. (Int)

There was an acknowledgment that consultation (and support) was widespread and continuing but that it was designed to keep particular stakeholders engaged with the process because of their ability to develop particular arguments and find the evidence to support them (Int x2):

'...I think the input of particular groups was valuable, and was used extensively ...I became much more cynical about the reasons for these particular types of processes, the real reasons beyond the espoused reasons... you know the spirit of consultation, and stuff like that... maybe it's my cynicism, the consultative process means letting other people do all the work,...'. (Int)

Also of interest is the way that the various stakeholder groups approached consultation. For those with greater experience with policy processes, consultation meant an opportunity to defend strategic positions rather than explore new options and they used multiple engagements to do this. For example, the ADAVB and the Technicians/Prosthetists identified what they viewed as the agenda early and treated
consultation as a lobbying opportunity; as the time to wear down opposition and protect historical positions. Both their state and federal associations, networks and individuals were engaged in this process (Int x3, ADAVB 1998, DP&DTAV 1998, DHS 1998). This approach reflects Considine's (1994) views of policy as 'punctuation' where each policy output is a step in a continuous process of development and evaluation, refinement and re-development. The more experienced policy participants recognised the ongoing nature of policy making and the contribution that their history had made and that this process would make to their future. They defended existing positions with less regard for the current political agendas and incorporated broader arguments than the process demanded. For example the ADAVB argued in support of a national oral health survey and the DP&TAV argued for the repeal of the five year suspension on the training of dental prosthetists. They were also relatively unconcerned concerned about appearing self interested.

The hygienists and therapists took more naive, trusting view, accepting at face value the concept of developing new legislation from a 'clean sheet of paper' as put forward by the review team. They saw it as genuine exploration of options and an important opportunity to be heard, but also as a more discrete event (Int x3).

DHSV (representing the dental public health view) took the middle ground. Their approach acknowledged the given frameworks and ideas about what the outcomes should be and were aligned with much of this agenda and genuinely engaged in debates around what they perceived as the uncertainties and details. They were also prepared to work across stakeholder boundaries to develop consensus to take to their consultations rather than have it imposed upon them by the process (with the definition of dentistry for example) (Int x3).

It is useful to apply Arnstein's (1969) ladder of participation to the consultation process in this policy setting. The policy makers (bureaucrats) and stakeholders saw the consultation as having different functions. An analysis of those functions in relation to the levels on the 'ladder' shows that while consultation was important, it did not represent power sharing or participatory approaches to policy making. Arnstein’s model explicitly recognised that public institutions may subvert
participatory mechanisms and challenged the view that these processes provide citizens with a real opportunity to make a difference.

In conclusion, these data suggest that consultation was of value to the policy makers because of its ability to generate consensus and acceptance, to increase transparency and because wide consultation generates a wide range of views. It therefore offers the opportunity to support any argument because almost all views will have been expressed by one or more stakeholders. In this case there was a need to have particular viewpoints supported, so the process ensured that those players who would support particular views were engaged and there was an attempt to introduce some equity into the process. It is apparent that the policy makers were using consultation to explore the environment for options, to generate supporting evidence and positions and to negotiate the preferred outcome.

Considine (1994) describes stakeholders as ‘quasi- proprietors’ in a policy process because of their strategic role in the provision of services and their power of veto. Further, the added power of expertise and professional status has given dentists in particular, institutionalised and recognised power in this policy environment. One of the important tensions in this policy process was the need to shift the institutionalised position of the ADAVB as the key stakeholder in dental policy processes. Ensuring broad consultation was a strategic tool in achieving this.

4.7.2 Leadership

This section of the data has been categorised under the heading of leadership and is included under institutional interactions because of the source and nature of the leadership.

Leadership may have several meanings ranging from authoritarian to instrumental or expressive. Leaders may act as a surrogate for individual responsibility (Rowitz 2001) or may be managerial with delegated authority. A leader may be a visionary and a strategic
planner, a ‘captain’ steering or mediating a process through to outcome or as motivator generating group action toward a particular goal (Ham and Hill 1993). Leaders may also appear as focal points, spokespersons or advocates for a particular community (Rowitz 2001); they may also act as network connectors (Considine 1994).

Considine (1994) asserts that leaders are always group performers and in any environment, require particular supports. His conception of policy leadership is as policy actor with an institutional role in achieving policy outputs arguing that the role is made possible and limited by the web of connections in a policy system (Considine 1994). It is this conception that is used here.

Government institutions may be seen as organised structures for policy making and implementation which both regulate (by imposing constraints on policy systems) and enable change. An important regulatory mechanism is that of party loyalty- the subservience of individual over collective interest in government that establishes a shield or barrier to the veto power of individual interests (Gardner 1995, Considine 1994). Thus ministers charged with the role of developing policy have a responsibility to ensure loyalty to the collective interest by ensuring consistency across the policy environment with the directions set by government. Initiative in this policy process came from the state government which had committed itself to implementation of federally developed National Competition Policy. Interview data show that responsibility for implementing NCP was devolved to the departments responsible for each piece of legislation (Int x2). The processes and mechanisms involved in that responsibility are the subject of the next section.

Leadership in this policy process clearly came from Robert Doyle, the parliamentary secretary to the Minister for Health and Chair of the Legislation Review panel. The government, through the Minister for Health had formally delegated this role to him in both this and a number of other health practitioner reviews. Interview data indicate that he brought both a personal political agenda to this review and also a sense of direction about what was needed in dentistry (Int x6). He had learned about how the political economy of dentistry worked from his earlier policy role as Chair of the Dental Auxiliary Workforce Review (DAWR) in 1995-6 and as Chair of the Ministerial Dental Advisory Committee. He not only led the Review team and
process but also the consultative process where he was widely viewed as listening, but also promoting particular views and working to achieve consensus. He was also widely viewed as effective and determined (Int x6).

The legislative review process had the potential to be quite difficult politically given the government agenda of de-regulation and competition and the difficulties this posed in the health sector (Int x2). A ‘drier’ outcome would attract more political kudos but professional monopolists in many fields (for example, barristers and solicitors, veterinarians, optometrists) had been quite opposed to de-regulation and there was a recognition that the health sector presented its own problems, particularly in relation to information asymmetry (Int). Achieving consensus would reflect well on its architect. Interview data suggest that the outcome was actually more de-regulated than was thought possible at the beginning (Int x2), and fairly widely accepted by all stakeholders in the end (Int x3, ADAVB June 1999, VDTA June 1999).

4.7.2.1 The agenda

Waiting lists for public sector dental services had been a problem for the government because of the media attention the issue had received, particularly since the demise of the Commonwealth Dental Health Program in 1997. As a result of this, co-payments for public sector dental services had been introduced in Victoria in 1997 (DHS 1996) but the government’s ability to trial other service delivery models (eg the AHM PAC Pilot) had been blocked by the ADAVB (ADA June 1997). The dental policy environment had been dogged by inertia for some time (Lewis 1996) and required strong leadership to enable change. The increase in profile provided by Commonwealth attention gave state policy makers more authority to challenge the existing service delivery models (Lewis 2000). There was an imperative to alter the policy making environment to allow more flexible and responsive services to be delivered in a more collaborative, team oriented way:

‘...He knew he had to sort of bludgeon the dentists a bit because they were getting out of hand and there is no doubt about that...’ (Int)

The political environment was also believed to favour privatisation of public sector service delivery (Int x2). Interviews indicated that Robert Doyle saw access to dental services as a key issue for this policy process. He also felt that the inter and intra professional relationships were not reflective of modern health practice and that this
policy process needed to challenge the dentists’ dominance of the environment (Int x3):

‘... (he was) quoted as saying, “In this particular clinical area, you do work of enormous clinical and technical sophistication but you’re still organised like medieval guilds...”, and that was a real problem...’ (Int)

### 4.7.2.2 Leadership mechanisms

Several mechanisms were used to lead or steer the process including that of the public interest, the national agenda, and the sense of ongoing evaluation. Protecting the interests and safety of the public as the key purpose of the legislation was useful to force the professions to set aside (or at least conceal) professional self-interests. It was also used to justify decisions that were difficult to attribute to NCP such as retaining supervision of auxiliaries or having a dentist as chair of the new Board. Robert Doyle also argued that the public ‘wanted’ a definition of dentistry included in the Act; an argument that was difficult to refute because of the ill-defined identity of ‘the public’ and the political role he had in representing their interests given his democratically elected role (Int x2). The discourse of access to care had a similar effect because it became difficult for its opponents to argue against it without appearing self-interested.

The need to satisfy the competition policy agenda (set at a federal level) and as a consequence, Victorian Treasury and Cabinet, was also a useful tool; the ‘collective interest shield’ described by Considine (1994). In the beginning this was used to develop the concept of the ‘clean sheet of (legislative) paper’ which forced advocates to justify the need for any regulation on public benefit grounds thus removing all precedent set by earlier legislation:

‘...one of the things that (we) had to get over was the presumption on the part particularly of dentists, that because there had been a definition in the Act before, ipso facto, there would be a definition in the new Act...’ (Int)

Dr Chea Wa Chea was very effective in this respect because he brought an economist’s view to the process that challenged existing structures and mechanisms. He was a ‘logical sceptic’ who was portrayed as the representative of both Treasury and Cabinet and who must be ‘convinced’ if they were to accept the final decisions (Int x4).
The sense that this was an on-going process with an impermanent outcome was also a useful tool. People were assured that this ‘would be reviewed in the short term, that legislation is not ‘set in concrete’ and that it was not possible to get to a final conclusion with the ‘first cut’ (Int x3):

‘...He certainly said that to us, on every occasion he met with us, he said that he wanted to put something up try it, see how it was going and modify if necessary...’ (Int)

This had the effect of calming both those who thought it had gone too far and those who felt it had not gone far enough (Int x2).

When the difficult area of practice boundaries within dentistry came up there were two mechanisms used to resolve the anxieties. The first was the ‘...audit snapshot of where we are now...’(Doyle 1999). This was a concept applied to assuage fears among dentists that the role of therapists would be increased to address access to care issues and among therapists and DHSV that their role would be contracted. The ‘audit snapshot’ meant that existing occupational boundaries and referral relationships would not change; that the appearance of ‘no change’ was constructed.

The other mechanism used was to delegate the more complex clinical decisions to the Codes of Practice. Decisions such as who could carry out which procedures for which client groups and under what arrangements were some of the most contested (Int x6). Robert Doyle’s philosophy was to allow clinicians to make the clinical decisions on the basis that governments should not interfere with clinical autonomy and that clinicians have the most expertise in their own field (Int x2, Doyle 1999). This had the effect of removing these arguments from this policy process and also of satisfying all the occupational groups because they all had representation on the Board, whose task it would be to devise them. The dentists felt they would control the Board and the other professions felt that they would not be allowed to so (Int x2).

When all else failed, Robert Doyle used his position as a policy mediator to generate acceptance. Negative comments were cast as opposition to change:

‘...he said, “Look, we’re proposing radical reform and we going to do this, do that, we’re progressive and all that sort of stuff. Of course you’re going to have negative views”...’ (Int)

He also drew on his experience with reviewing legislation and reminded the participants of the gains they were making and that it was really the role of the government to mediate, and to make the decisions:
'...he was telling us how fabulous all of the changes were going to be... and some of the group got quite excited... and that was fine. I mean... there were exciting changes that were happening ...and that he had made all of these things possible and that he had done these things and he had the power. He suggested.... he suggested subtly that he had the power to take them away again...’ (Int)

The strong message that came from all interviews was that Robert Doyle was the key influence on the outcomes. It was he who chaired the Review Panel, it was he who had to satisfy the government’s needs in relation to both NCP and the ability of the legislation to protect the public and it was he who had to steer the recommendations into legislation. To achieve the wider agenda of industry reform he required vision and strong political skills in negotiation and consensus management. That he could do these things and receive endorsement from most of the stakeholders is testament to the effectiveness of his ‘leadership’.

4.7.3 Decision making and the myth of the ‘clean sheet’

As we have seen, the review occurred within formally identified frameworks which had been defined by the Department of Premier and Cabinet (1996). National Competition Policy (NCP) had the lead role as it was this agenda which had precipitated the review. Local policy documents including Future Directions for Dental Health in Victoria (DHS 1995), the Dental Auxiliary Workforce Review (1995), and the Victorian Health Practitioner Registration Model were to be incorporated as were the AHMAC findings on mutual recognition (DHS 1997b).

The policy actors held various views about the role of regulation. Interview data revealed that the policy makers perceptions were that its role was to protect the public while allowing for flexibility in the dental industry to utilise skills appropriately (Int). There was also the widely held view that it should mediate market failures (such as information asymmetry) but not prevent competition (Int x4). There was also a concern about the ability to deal with poor quality service delivery among both practitioners and owners (Int x4, ADAVB 1998). Among some stakeholders was the view that it should be quite prescriptive and specific (Int x2) but others felt that the more prescriptive it was, the less flexibility there would be to do ‘sensible things’ (Int x3). The bureaucratic view was that the legislation should lay a broad framework and that detail, particularly the clinical decision making, should be the responsibility of
the professions because of their expertise in this area (Int x2). The outcome also had to meet the competition tests; that the benefits of regulation should outweigh the costs and that the objectives of the legislation could only be achieved by restricting competition (DHS 1997a, 1997b).

In laying the groundwork for the review, the Chair of the Legislation Review Panel, Robert Doyle talked of the need to build legislation from the ‘ground up’ characterising the starting point as a ‘clean sheet of paper’ (Int x3). Indeed the NCP agenda demanded that regulation be imposed only where it could be justified and was necessary (DP&C 1996). This placed the onus on the proponent of regulation to demonstrate a need for it (Int x4, ADAVB June 1997):

‘...The clean sheet of paper was very difficult for people to understand, we were not amending an Act. We were looking at a clean sheet of paper and saying what should be put on that piece of paper now that doesn’t overly restrict the competition but protects the public...’(Int)

Interview data revealed that there were different perceptions about how the decisions were made within this broad framework. The panel and others assert that the decisions were all made based on the merits of the arguments, that they treated all stakeholders equally and had an open mind about the outcomes. They placed great value on the written submissions and looked for evidence where it was available (Int x4). They stand by the concept of the ‘clean sheet of paper’:

‘...We started by looking at what we had, what are the issues, what are the reasons, what are the arguments that would be of relevance and then... we decided on the approach that we would take...’ (Int3)

Some stakeholders supported this view, indicating that they felt that the panel were ‘asking’ and were on a mission of genuine inquiry (Int x2).

An alternate view emerged from the interviews, with some stakeholders suggesting that the decisions had all been made before the process began (Int x3). Some stakeholders felt that ‘...it was all spelled out, the directions it would go...’ at the Legislation Review Workshop held in October 1997 (Int x2). There was a view that panel members were listening to argument and testing their ‘model’ for weaknesses and alternatives and also to see how much opposition there was to their ideas (Int x2). The directions set in earlier policy episodes and the model legislation principles (DHS 1995, DH&CS 1995, DHS 1997b) support this view. Analysis of the outcomes against these policies shows that a majority of the decisions had been flagged earlier (see table in Appendix 7 for decision analyses).
NCP also influenced some decisions although not as many as the early agenda suggested it would. The states had an incentive to satisfy NCP because of the payments attached (suggested to be $14.5 billion in total\(^{58}\)) and some stakeholders considered that the government also wanted to use this opportunity to out-source public sector dental services to the private sector (Int x2). There were stakeholders who were relatively pleased that in the end, NCP had less influence than they expected although there was widespread opposition to the de-regulation of dental practice ownership and de-licensing of dental technicians (Int, ADAVB June 1999, Aug 1999).

There were some decisions made that flew in the face of NCP and this led to some stakeholders feeling cynical about its influence (Int x2). They felt that where NCP suited the purposes of the review or the direction that key decision makers wanted it to take, then it was important. But there were times that it was discarded in favour of other policy agendas:

‘...when he was pushed further, really about the objectives of National Competition Policy which was my impression that that’s what the whole thing was about, he denied...I mean he sort of...I don’t know, in that moment, the whole National Competition policy thing was thrown out the window...’ (Int)

Supervision and continued limits on dental therapists’ and dental hygienists’ practice are an example; with a number of stakeholders interpreting the NCP guidelines as being very supportive of removing those limits (Int x3, VDTA 1998):

Despite the bureaucratic view that during the panel’s deliberations, all stakeholders were considered equal, interview data suggests that the stakeholders themselves did not have this view. Interviewees saw Robert Doyle, chair of the Review Panel and parliamentary secretary to the Minister for Health as being the most powerful person, and the leader of the process (Int x 5). There was also an almost universal view that the dentists’ professional association (the ADAVB) was also a key player in terms of their influence, connections and resources (Int x 7). The Technicians and Prosthetists Association (DT&DPA) was seen to have power in the process based on their past and their well established links to political parties (Intx3). The dental therapists (VDTA) were seen to have made good arguments but as lacking resources to ensure their visibility (Int x6). The dental hygienists (DHAABV) were seen to often argue

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\(^{58}\) ADAVB Newsletter, Executive Director’s Comments, October 1998
for the same things as the ADA and to be compromised by a lack of internal consistency despite the efforts of some strong individuals (Int x5). So while all the stakeholders made a contribution (and the panel argues that dissatisfaction among all is evidence of that) they key decisions were seen to be made by Robert Doyle, government public sector advisers, and the ADAVB:

'...I think in reality, the decisions were made between upper government and Doyle, Treasury and Finance and Doyle, they may have been roughly the same but not quite, Department advice and Doyle, it wasn’t a pushy thing but it was advice, ADA and Doyle, and to a lesser extent, DHSV and Doyle...’ (Int)

This raises the question of the role of the bureaucracy. Considine (1994) identified the value of bureaucratic expertise in parliamentary systems of government. The nature of ministerial recruitment from among the ranks of elected members means that ministers become generalist policy makers dependent upon their bureaucracies for specialist support. Further, the nature of policy making leadership relies on bureaucratic supports. In this instance, interview data supported this position, revealing a covert role for the bureaucracy, advisory and secretarial but not without influence (Int x3). The continuity of the bureaucratic role means that it is involved historically and brings previous policy experience to bear on the current process (Ham and Hill 1993).

So, in summary the influences brought to bear on the policy culture by the policy institution have included the NCP framework giving rise to the concept of ‘the clean sheet’, a demand for consultation incorporating key stakeholders, the appointment of a policy leader from within parliamentary ranks (incorporating political power and cabinet discipline) and the explicit inclusion of previous policy documents. The next two sections examine components of the policy culture, again supported by the policy institution, but which were more contested; the language or discourses used to shape the values of the policy process and the use of evidence. The use of research material or evidence was important because of its intrinsic value in a scientific setting such as health care and its value to contemporary policy making (NHMRC 1998, UK Cabinet 1999, Neisson et al 2000, Paton 1999, Lock 2000, Davies et al 2000, Davey-Smith et al 2001). Evidence here was defined as empirical or research evidence which has been derived from systematic investigation aimed at increasing the sum of knowledge (Davies et al 2000).
4.7.4 The role of evidence

This policy process sought to take an evidence-based approach by asking stakeholders to provide evidence to support the arguments they were making in their submissions (DHS 1997b). There is, however, no indication that this process used any systematic approach or structured schema for evaluating evidence. What is apparent from interview and documentary data is that most participants in the process respected the value of evidence and the contribution that science might make to decision making and many supported their positions with the use of evidence (Int x3). The following discussion separates the users of evidence into two categories: the stakeholders and the policy makers.

4.7.4.1 Stakeholders use of evidence

Interview and documentary data revealed that there were several different ways that evidence was used by the stakeholders in the policy development process. Some submissions provided material to support the status quo such as regulatory material from other settings (comparative material) and case studies of regulatory breakdown, for example in infection control protocols (ADAVB 1998, DHAAVBA 1998). Some proponents argued strongly that there was evidence to suggest that title protection alone, which had been used with other professions, would not be enough to protect people against unqualified practitioners (ADAVB 1998, DHSV 1998). The dental hygienists used evidence of regulatory failure in the area of infection control to argue that they should be registered (DHAAVBA, 1998) and the advanced dental technicians used precedent to argue for a tile change to prosthetists (DP&DTAV 1998). One area that used research evidence, as defined above, was in the arguments around the practice of dentistry by dental therapists and hygienists. There were two main sets of arguments advanced in this area.

1. Arguments made in support of the need for change

There was a range of published evidence to show that the oral health outcomes among those treated by dental therapists or dental hygienists was equal to or better than that provided by dentists alone (Barnes 1983, Gaughwin et al 1996, Baltutis 1997). It also showed that there are other similar settings internationally that utilise dental therapists and hygienists in more independent (less restricted) practices.
without any increased risk to the public (Wang 1994, Orhn et al 1996, Freed et al 1997) and that legislative restrictions on their practice increases the costs of providing dental services (MacBride and Owen 1974, Douglass and Lipscombe 1979, Liang and Ogur 1987, Rogers 1995, Millsted 1996, Perry et al 1997). Much of the evidence supporting change was presented by the dental therapists’ professional association and the public dental health organisations and some consumer groups also supported this in their submissions and advocacy (VDTA 1998, DHSV 1998, Int x2). The dental therapists association also generated new evidence that demonstrated cost savings to the community of lifting restrictions on their practice. The key focus of their arguments was around the high levels of unmet need and the costs of providing dental care (VDTA 1998).

2. Arguments made to oppose change

The dentists’ professional associations and the Board, in an effort to protect the status quo supported their arguments against change by:

- discредiting the existing evidence by arguing, for example, that evidence that existed was not relevant, that it was too old or too small a study, too specific, too generic, not local, badly designed or biased:

  ‘... just because there was a bit of research to say this, that and the other thing, ... how did it apply to Australia? How does it apply to us, where are we now? Because at the end of the day you’ve got to get something that works ... ‘ (Int)

  ‘... any introduction of additional operatives capable of performing irreversible procedures on adult teeth should be based on accurate information... ’(ADAVB 1998)

  ‘... there is a need for unbiased research before we make changes... ‘ (ADAVB April 1996).

- generating mistrust of the evidence. It was also argued that there was not enough evidence or research and that more was required before an informed decision could be made. Again there was argument that it was dangerous to use existing evidence on the grounds that there was not sufficient understanding of the effects:

  ‘... insufficient data is available on which to base an assessment of the current restrictions as they are perceived... ‘ (ADAVB 1998)

  ‘... That was essentially it, they (the ADAVB) were scare-mongering about who might do the dentistry and how un-qualified and what nasty things might happen as a result... ‘ (Int)

These same stakeholders had however, worked to prevent the generation of new evidence prior to this policy process by acting to prevent trials of less restrictive
models which had been proposed and backed by the Australian Health Ministers Advisory Council (AHMAC):

"...the Branch believes that there is absolutely no need to have a pilot project to test the obvious ...people don't put their hands in a flame to see if it will burn." (ADAVB April 1996).

"...Patients could die if the role of dental therapists was extended, dentists claimed yesterday..." (Death fear in dental row, Helen Carter, Herald Sun 20.2.97).

The end result of that process was that the trial foundered for lack of funding and has been relegated to inactive status by AHMAC (ADA 1997).

These data identify a profession that purported to be grounded in science actively opposing the generation and incorporation of scientific knowledge. Indeed, the ADAVB in their submission to government in relation to the Regulations supporting the new Dental Practice Act, gave explicit support to the concept that Codes of Practice should be evidence based and recommended the use the NHMRC Guidelines (1998) as a basis for their formulation (ADAVB June 1999).

The third way that evidence was used by the ADAVB dentists to influence policy making involved an attempt to focus attention on a particular type of evidence by:

- reframing the definition of 'evidence' and redirecting debate. The data that was produced referred to existing patient to dentist ratios and visit data to demonstrate that supply of services was meeting demand. However, it failed to acknowledge the gaps in services provision.

"...there is sufficient supply of dental occupations to satisfy community demand and generate a healthy competition for consumer attention. This is based on normal dentist-population ratios around the world... members of the ADAVB report via the dental practice survey that they are booked no more than two to four weeks in advance..." (ADAVB 1998)

"...we request that the panel accept the strengths and proven record of the existing structures which have been developed over 100 years..." (ADAVB 1998)

There was no evidence or empirical material produced to support the claims that dentists provided better 'quality care' or to support the need for supervision or lists of 'duties' for auxiliaries. The other key strategy was an attempt to redirect the debate to funding and quality. It was argued that improving access to care meant increasing funding to provide for more public sector services delivered by dentists and an intern program, and that dentists were the only safe and ethical providers of dental care (ADVB 1998).
These findings illustrate the selective and functional use of evidence in this policy arena, the control of evidence-generating research and appeals to non-research based ‘sources’ of evidence such as history, tradition and ‘common sense’.

4.7.4.2 Policy makers’ use of evidence

Policy makers including those involved in reviewing the legislation, also used evidence in a number of ways:

- To inform decision making: Interview data show that the submission process was used to generate and expose evidence. In some cases the review panel went to the original material and in others they relied on what was presented in submissions. Interview data also showed that panel members were aware of the evidence supporting change, including the competition arguments that supported it (Int x4).

‘...Yes...(research evidence) was pretty important. It was. Particularly to people like...(one panel member)... because at the end of the day (the panel) had to stand by the recommendations and...(he) had a lot of experience in the states. He was based in the states for a long time so he saw the world quite differently. And he was an academic as well...’ (Int)

- To support their decisions: Some material was cited in support of their recommendations and some was ignored where it conflicted with the recommendations. The panel’s recommendations were carefully written to indicate that some of the limitations on auxiliary practice were anti competitive (the one-to-one ratio for hygienists and the employment limitations on therapists) but that there was not sufficient evidence to support removal of supervision, prescribed duties or the client age limit for therapists (DHS 1998):

‘...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...(and therefore)… the restrictive one-to-one ratio for dental hygienist-to-dentist (should) be removed from the Regulations.’


‘...yes I think the presumption was it (supervision) should go. The definition (of supervision) ...we made up would be anti-competitive but it’s a matter of degree,...In an ideal environment...we would not have had supervision...if you are clever enough in defining what supervision entails or does not entail, then you might actually be more liberal and end up in a more liberal environment,... what [0]we came up with was not as bad as in the old Act. (Int)

‘...All dental auxiliaries (are) to continue to work under the supervision of a dentist until clinical evidence indicates that autonomous practice does not endanger public health and safety...’


Evidence then became just one aspect of the basis for decision making. In some cases the policy makers also re-defined their definition of ‘evidence’ to include existing practice and opinions:
In other instances the policy makers acknowledged the political role they had in ‘walking a line of best fit’ between conflicting views allowing them to ignore or reframe evidence to suit their purposes (Int x3).

Despite the existence of evidence supporting change, the National Competition Policy agenda and the recommendations of earlier policy processes, the legislation review made very few changes to the practice of dentistry by dental therapists and hygienists other than to register them and afford them one seat out of eleven on a new Dental Practice Board. The policy process used evidence much as it had NCP, where it suited the purposes of the agenda. The dentists’ (ADA) preferred model was largely retained despite the evidence supporting an alternative model. Evidence was valued as a component of the normative aspect of decision making in a process which also included the political, economic and social dimensions.

Even if evidence were re-defined to include a broader definition as advanced by the UK Cabinet Office (1999), the issue for this policy environment essentially remains. This UK document treats ‘information’ as the raw material for evidence and encourages the use of a variety of sources of information. This includes traditional research as well as professional workforce experience, stakeholder consultation and comparative material as ‘evidence’ to inform policy making. In the dental care setting, the dominance of the private sector as a provider lends a market oriented focus to oral health and an invisibility to unmet need. Further, the dominance of the dentist profession that has captured policy institutions such as dental boards, dental faculties, research institutions, and bureaucratic advisory units means that most stakeholder, comparative and expert advice is skewed to the structurally dominant or sovereign view. The subordinated stakeholder challenging the professional monopoly and advocating a health promoting ethos remains a minority voice. Even this broader definition of evidence incorporating a more grounded approach is still dominated by the dentist and the biomedical model.

This use of evidence to inform policy decisions is consistent with observations within the literature. Several authors have observed that while policy responses should be shaped by technical and scientific evidence they may not stand up to the rigour of evidence based assessments because of the culture and political economy of health
resource allocation. Policy outcomes are influenced by complex political processes including the manipulation of public opinion by pressure groups and it may be naive to expect evidence to be a panacea for policy making (Sax 1999, Lin 1999, UK Cabinet 1999, Neisson et al, 2000, Paton 1999, Lock 2000, Davey Smith et al 2001).

4.7.5 Discourses

Considine (1994) describes the combination of values, assumptions, categories and stories woven together in a characteristic policy language as discourses. These discourses become the language of the policy culture which shapes the outcomes. The discourse of the ‘clean sheet’ is illustrative of this, as is the discourse of evidence-based policy making. There were two further key pieces of language or discourse which were used to achieve consensus because of their multiple interpretations and meanings. One (access to care) was devised by the bureaucracy to shift the agenda and the other (team dentistry) by the dominant stakeholders to protect their dominance.

4.7.5.1 Access to care

Concerns about access to dental services appear to have emerged as public health issues from the National Health Strategy (McLelland 1991a, McLelland 1991b, Dooland 1992) and became the driving issue behind the establishment of the CDHP. The loss of Commonwealth funding for this program in 1996 shifted the problem back to the states but with a higher profile (Lewis 2000). State policy processes such as the AHMAC Pilot project, the DAWR and ‘Future Directions’ had placed unmet need for dental care firmly on the state agenda (AHMAC 1995, DH &CS 1995, DHS 1995) generating the impetus for change. From the beginning of this policy process the availability of affordable, accessible and quality dental services was to be given consideration (DHS 1997b).

For the bureaucracy, the discourse was used to position the debate around regulatory issues by identifying that there was unmet need for services and placing the emphasis on structural reform rather than funding.

‘...the government’s key role is to establish the appropriate legislation, regulation and licensing framework to support an efficient, effective and affordable public and private dental system for all Victorians...’ (DHS Aug 1995)

‘...From the state’s point of view you have to address those needs in a way that the patient is entirely safe and you are able to prosecute those who make them unsafe. But at the same time we need maximum flexibility so that we can treat that patient with the appropriate professional...’ (Int)
For DHSV, increasing access to services meant being able to use dental therapists with wider client groups and use available resources to provide more services. This also suited the therapists’ agenda because it recognised their value to the community and the contribution they had made to public dental health. Broader utilisation of their skills would also generate more diverse employment and career options (VDTA 1994, 1998).

‘...the challenge for the community is to find better ways of delivering quality dental care to all members of society in a responsive and cost-effective manner...dental therapists have skills which can help to make dental care more accessible, reduce waiting lists for public dental care and reduce prices for private dental treatment...dental therapists can provide less expensive high quality dental care...’ (VDTA 1998)

The problem for the ADAVB with this agenda was that it was difficult for them to argue against it without appearing self-interested. Their approach to the access to care discourse was to also support it by advocating for an increase in government funding for public sector services and to promote their profession as the only one that could provide the quality of care the community required.

‘...our case focuses on public interest arguments...the need for high standards of dental treatment and patient care and the need for invasive procedures to be completed by dentists with advanced levels of study and committed to ethical and safe treatment of patients in both the public and private sectors... the biggest single factor affecting access to 'cheap' dental care for the disadvantaged is lack of government funding...' (ADAVB 1998)

The government’s view prevailed, enshrining in the legislation as the Board’s objectives, ‘...to promote access to dental care and to regulate dental professionals for the protection of the public...’ (DHS 1998, DPA 1999). The ADAVB objected to this on the grounds that it ‘...politicised the Board...’ (ADAVB Sept 1998) and maintained that the Board’s practical ability to implement this outcome remains vague (ADAVB April 1999).

4.7.5.2 Team dentistry

The concept of team approaches to achieving health care tasks is not new, with the term denoting a ‘set of persons working together, of combined effort and organised co-operation’ (Oxford 1995). ‘Team dentistry’ likewise has been used to denote the combined efforts of a multi-disciplinary group of dental care providers originally a
dentist and dental assistant but broadening to include specialists, technicians, hygienists and therapists. Of interest in this debate are the interpretations of the concept and the way it facilitates agreement.

The ADAVB interpretation applies a more hierarchical interpretation to the concept where team dentistry means a dentist as team leader diagnosing and treatment planning and delegating some tasks to others. Within this interpretation is the subordinated dental auxiliary carrying out prescribed tasks under close supervision (ADA VB 1998).

For DHSV it meant ‘least cost’ approaches to care with therapists and dentists delivering more collaborative services. In their model, dental therapists examine, recognise, diagnose and treatment plan, provide treatment within their skill range and refer patients beyond their skills to a dentist. Dental prosthetists directly design, manufacture and supply dental prostheses to the public and dentists provide only higher technology or complex services. The provision of clinical services is thus carried out by the team on a least cost basis.

For hygienists, there are a combination of interpretations depending on the practice environment. In some practices, for example orthodontic practices, the orthodontist carries out all diagnosis and treatment planning, prescribing all tasks for the hygienists with the possible exception of oral hygiene tasks. A hygienist working in a general dental practice may be expected to develop ‘periodontal care plans’ or ‘treatment sequencing’ (including periodontal diagnoses and treatment planning) in collaboration with a dentist who would carry out the initial examination. This represents a more collaborative model somewhere between the other two (Darby and Walsh 1995).

There is evidence to show that most stakeholders in this process supported the team concept and that there was support for, or acceptance of the DHSV interpretation in relation to dental therapists:

‘...I think Robert actually, thinks team practice is genuinely a good thing. The ADA and the board (DBV) seem to have accepted that the operational definition that the School Dental Service used was acceptable...’ (Int)

The value of the team concept to the process is that due to wide acceptance for the concept of team dentistry and the multiple interpretations of the term it can be used to
negotiate compromise and retain flexibility in application. For example the following statement allows dentists to remain in ‘control’ by choosing the way their ‘team’ operates according to their clinical and business judgements, and also to remain in charge:

‘...a registered dentist should be able to freely choose the team arrangements in accordance with their clinical and business judgement about the practice...the panel strongly supports a team approach to dentistry with dentists offering guidance and advice to dental auxiliaries. (DHS 1998)’

For dental therapists and hygienists, the terms ‘direct and control’, which denote entrenched subordination, have been replaced with ‘guidance and advice’ implying a higher level of autonomy in their practice. Similarly:

‘...A modern definition of supervision should be cast in terms of the collegial arrangements that characterise a team approach to dentistry...’ (DHS 1998)

The term ‘supervision’ which, under the old regulations had meant ‘...oversight of the performance of duties requiring the on-site physical presence...’ of the dentist (DBV 1997) which both hygienists and therapists had opposed, was to be defined in ‘modern’ terms. This gave latitude to the interpretation of ‘modern’ allowing it to mean ‘the way I currently practice’. One could argue that in fact nothing, or everything, has changed.

These discourses were key expressions of the policy culture used to shape and negotiate the outcomes between the contesting views. The next section demonstrates how these key discourse were woven into the negotiations that produced the policy outputs.

4.8 Flashpoints; the resolution of contested cultural views

There were several debates or flashpoints in the review process that participants saw as being key to the outcomes. These are illustrative of the way the policy culture was negotiated and shaped to define the outputs as they show the interactions between actors, institution and political economy.

Early in the process the application of competition policy with its accompanying threat of de-regulation was a high profile argument. This included arguments about practice and title protection and business ownership. Later arguments focused more on power structures, the composition of the regulatory authority and the mechanisms for internal regulation.
4.8.1 De-regulation and the application of NCP

Some stakeholder groups accepted the NCP agenda and others opposed it. The therapists for example accepted it and began actively exploring alternative regulatory models and less costly ways of regulating dentistry as the NCP agenda suggested (Int x2, DP&C 1996). The hygienists had the perception that this agenda meant their profession would not be registered (would be de-regulated) and made arguments to oppose this (Int x3, DHAAVB 1998). The dentists actively opposed the whole concept and did so vigorously and early in the process (Int x3):

"'How do you know your dentist is qualified?' '...the State government is changing the laws that have protected you and your family for the last 26 years...Don't wait until August 1998 to take action, by then it will be too late...' ' (ADAVB Pamphlet circulated to private patients, Dec 1997).

'...the review is trying to apply commercial competition principles to health care...it effectively argues for patients to buy dental services in the same way they buy goods and services from variety stores or supermarkets...' ' (Letter to community organisations, re-printed in ADAVB Newsletter March 1998).

This had the effect of generating fear in the minds of the public and stifling some of the debates that were possible, for example around auxiliary practice (Int).

4.8.2 De-regulation of dental technicians

The technicians and prosthetists also opposed the idea of de-regulation although they supported the concepts of competition within dentistry (Int x2). Their main concerns were to retain the regulation of dental technicians and a regulatory structure that remained separate from the dentists thus preserving their autonomy. They were given indications early that it was difficult to support both of these arguments under competition policy because of the need to reduce regulation (Int x4). Indeed, the consultant’s report indicated that AHMAC had considered in 1992 that there was no case for registration and that some dental technicians currently practiced without registration (Calsa 1997a). This was hotly opposed by the association and the Dental Technicians Licensing Committee who argued that although dental technicians construct appliances on the prescription of a dentist, there were quality assurance and infection control issues intrinsic to their practice that posed a threat to the public (DP&DTAV 1998, DTL&C&ADTQB 1998).

The dental technicians and prosthetists had a history of successful political activism which had produced a separate Dental Technicians Act in 1972 and Board,
independent practice for prosthetists and the provision of partial dentures (DH&CS 1995). Their relationships with the ADAVB had been abrasive over many years, however the ADAVB gave support to the arguments for the regulation of dental technicians (Int x2). Concern interstate about the intention to de-regulate dental technicians because of the precedent it set for their own reviews also led the national association to Melbourne to meet with Robert Doyle (Int x2). Despite the lobbying, political connections and national involvement, the panel took the view that there were less restrictive ways of regulating dental technicians and chose not to protect their titles or register them (DHS 1998).

4.8.3 Title and practice protection

The protection of title and practice was another key debate arising out of NCP and the Victorian Health Practitioner Legislation Model. The 1972 Act contained very specific and restrictive practice protection in the form of a definition of dentistry. Competition theory said that such a protection was anti-competitive and a clear message had come out of the early discussions that it was unlikely that practice protection would be maintained as none of the other health practitioner Acts contained it (DHS 1997a, DHS 1997b, DP&C 1996). There was also the view among policy makers that it was an illusory protection in that only law-abiding practitioners took any notice of it; ‘backyard’ operators existed despite its presence in the Act (Int x3). Robert Doyle had, in several settings, indicated that title protection alone was the most likely outcome (Int x4).

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59 The provision of partial dentures had been achieved in 1996 through the DAWR which recommended that advanced dental technicians (as they were then known) would be allowed with additional training to provide partial dentures directly to patients to bring them into line with other states. However, patients seeking a partial denture from an advanced dental technician would require a certificate of oral health from a dentist (valid for only six months) prior to receiving such services. The name of the profession was to be changed to that of Dental Prosthetist but the review also recommended that their training should be suspended for five years based on reducing needs for prosthetic services (DAWR 1995).

60 For example, clinicians who deal with dental technicians will have an incentive to provide high quality services to their patients and therefore to deal with suitably trained dental technicians who provide appropriate services (DHS 1998).

61 "The practice of 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 dental treatment or advice to any person or the examination of the natural or artificial teeth of a person for any purpose..." Dentists Act 1972

62 The messages coming from DHS in the earlier parts of the review indicated that education and qualifications (competence) would determine areas of practice and that only qualified people (identifiable by registration) would be able to practice dentistry under the legislation. Therefore, anyone who was not qualified would not be registered and could not therefore, legally provide dental care (Int x3). This model also allowed for providers to add competencies and develop innovative complimentary or substitute models of care; the dynamic efficiency encouraged under NCP to reduce prices and enhance access to services (DP&C 1996).
Almost unanimously, the stakeholders opposed this outcome. Many submissions contained a definition of dentistry and many argued that it ought to be included by virtue of precedent set under the old Act (ADAVB 1998, DBV1998, DHSV 1998, DHAAAVB 1998). The submissions contained various arguments around public health and safety which indicated that existing common and civil law was inadequate; that the police would have neither the time or resources to devote to the pursuit of unregistered providers (Int). Martin Dooland (CEO of DHSV) and John Matthews (then president of the ADA) went together to discuss the problems with Dr Chea Wa Chea (member of Review panel). They asked him to explain how the proposed framework would protect against unqualified people providing dental care and it seems the discussion left Chea Wa concerned (Int x2). The Boards\textsuperscript{63}, used to dealing with complaints felt that it was not enough to rely on title protection\textsuperscript{64} and complementary legislation\textsuperscript{65}. The ADA also took this view and their submission makes the argument that specific practice definition was also required for specialist practitioners and dental auxiliaries (ADAVB 1998).

Interview data indicates that the panel became convinced that because dentistry had carved a separate niche for itself, the protections that existed around the other more integrated parts of the health care system did not exist in this area\textsuperscript{66}. They finally, reluctantly agreed to its inclusion on these grounds and because they felt that the legislation had to have the confidence of the profession and the public. The argument that apparently convinced Cabinet that such a departure from the ‘norm’ was appropriate was around information asymmetry; that in dentistry this was of such concern that the government had to step in with regulation to protect the public (Int x2).

The problem became then, whether and how dentistry should be defined:

\textsuperscript{63} Submissions: DBV 1998, DTLC&ADTQB 1998
\textsuperscript{64} Title protection allows only registered persons to use the titles listed in the act (eg dentist, dental hygienist etc)
\textsuperscript{65} For example Drugs Poisons and Controlled Substances Regulations which prevents the purchase or use of S4 drugs by unregistered people, the Radiation Safety Act which allows only licensed practitioners to take radiographs and the other health practitioner acts which restrict the services to those which a provider is educated to provide eg. physiotherapists are not trained to provide dental restorations therefore, under the Physiotherapists Act such provision would be considered unprofessional conduct.
\textsuperscript{66} For example Medicare provider numbers limit the providers who can be remunerated for medical services, hospital protocols define practices and referral arrangements.
...because definitions by their nature, tend to be constraining, and the entire vision of what we were going to finish up with was certainly constraints, but not artificial ones, not ones that were determined by semantics rather than good dental practice.' (Int)

The panel members allowed the professions to engage with this because they viewed them as having the most expertise. At one end of the range was the ADA view that only dentists should do dentistry and the other end was the view that there was a need for many health care workers to be able to identify and refer dental disease (Int). The two boards sat somewhere in between”

‘...the two Boards, DHSV and the ADA all had definitions of dentistry that were on a continuum, which were compromised on. It was a bit more than (DHSV) wanted and a bit less than (the others) wanted and so everyone was happy... ’(Int).

There is a view that the adopted definition is not completely adequate because it is still reliant on interpretation and intention and may not be flexible enough in the long term (Int x3).

4.8.4 Practice ownership

Practice ownership was another key argument. NCP again said that limiting practice ownership to dentists alone was anti-competitive and could not be justified (DP&C 1996). From the beginning the ADAVB dentists opposed this on the grounds that non-dentist owners would be more likely to exploit the profit making capacity of a dental practice and interfere with treatment decision making.

‘...Professional ownership of dental practices should be retained to avoid commercial owners setting practice policies which may over-ride the practitioners' clinical judgements...the confidentiality of the dentist patient relationship would also be subject to threat where the dentist did not own and control the practice...' (ADAVB 1998)

This argument was initiated early and continued throughout the process. The alternate view had some support from other stakeholders (VDTA 1998, DHSV 1998, DTLC & ADTQB 1998) who saw benefits to the community in wider ownership. NCP and model legislation thinking prevailed, removing ownership limits and potentially opening the way for managed care arrangements. The potential threat to service provision standards was addressed by defining as an offence the practice of ‘...directing or influencing an employee to practice in a fashion detrimental to the welfare of a consumer...’ and the use of unprofessional conduct standards as a component of the Act (DHS 1998, DPAct 1999).
4.8.5 Board structure

Interview data revealed that most stakeholders believed that arguments about a single Board and Act were ‘settled’ early (Int x3). This is supported by the Final Report of the DAWR that had recommended the merging of the two dental technician regulatory bodies (DH&CS 1995) and the Consultants Report (Calsa 1997b). The report of the Legislation Review Workshop held in October 1997 shows that most of the presentations favoured this model and the workshop findings reported support for a single Board although some reservations were raised by the dental technicians (DHS 1997a). It appears that the option of more than one Act and Board had essentially disappeared by this time:

'A single Board would produce administrative savings, would be representative and produce the synergy of a team approach to dentistry...committees consisting of the respective categories would be delegated responsibility for registration, discipline and education...a separate disciplinary committee would be linked with the Board...' (Report of group discussion: Structure of a Regulatory Authority, Legislation Review Workshop October 1997).

'...But it was fairly obvious from the discussions that we had with them in the initial stages, the government had a view that they would only..., in fact they did say so, I mean its not that it was a hidden agenda by the government, it was the government’s agenda, they were only coming to us with a proposal that there would be one Board, and they were determined that that was how it would be....' (Int).

Once this single Board model had been decided, the next difficulty for the panel was determining its composition. Model legislation suggested the inclusion of non-dental or lay members and a lawyer and ‘Future Directions’ (DHS 1995) had supported representation of all the professional groups on a board (DHS 1997b). Interview data indicates that while stakeholders supported the inclusion of non-dental practitioners on the Board, there was concern about the mix of dental practitioners.

'(there were)...a number of competing interests. Dentists who wanted to control the Board and a fear of the other professions that dentists would control the Board. Some natural antipathies between dentists and the other professions that they would consider as not as trained as them. The prosthetists and technicians who saw that they were losing not only their own Act but two of their own Boards, and therapists and hygienists who had not had a seat at the table but who...should be registered professionals and have a seat at the table. So it was an act of compromise.' (Int)

The Recommendations made by the panel allowed for a nine member Board with four dentists, one prosthettist and one ‘auxiliary’ (dental therapist or a dental hygienist) along with three other members (DHS 1998). Almost immediately, arguments were made by each group for greater representation. The dentists argued that the workload would be too great for a board with only four dentists and that:
"...the potential exists for non-dentists to outvote the four members who actually know what they are talking about on a clinically significant issue..." (ADAVB 1998).

The prosthetists argued that it would be too difficult for a single prosthesis to contribute to decision making because he would need a colleague to confer with (Int x2). The therapists and hygienists argued that they should have one seat each on the basis that they were two distinct professions and that worldwide trends in the delivery of dental care have indicated increased roles for dental auxiliaries into the future (Int x3):

'... the capacity to increase access is likely to depend on the careful...evolution of their roles. Dental auxiliaries also spend more time working with low income and disadvantaged people who have poorer dental health and ... their capacity to advocate for these people is an important dimension of the board’s role... (VDTA Nov 1999)

There was also the issue of discipline. The disciplinary model included the use of parallel practitioners as disciplinary panel members and the appointment of only one auxiliary would pose a problem with implementation of this provision (VDTA Nov 1999).

When the draft Bill was released, the number of dentists on the Board had increased to five and the number of prosthetists had increased to two resulting in an eleven member Board. Interview data showed that while there was some discussion around the numerical parity of auxiliaries and dental prosthetists, no-one was really surprised at the outcome although several people questioned the appointment of a second prosthetist (Int x3). Some took the view that they had made a gain as compensation for the loss of their own Board and to invalidate the view that this was designed to take them back to the days when they were frozen out of the decision making process (Int x2). Some stakeholders had also expressed the view that putting a hygienist onto the Board was paramount to giving another vote to the dentists whereas the prosthetists were a more independent group who would balance the extra dentist.

[67] Where an informal or formal hearing is being conducted by the Board, the panel must contain one member who is from the same profession as the practitioner who is facing the disciplinary proceedings (hearing) to satisfy the requirement for peer assessment of professional conduct. (s3, unprofessional conduct (b), s37(1)(b), s44(1)(b) Dental Practice Act 1999)

[68] During the DAWR in 1996, the hygienists had made many of the same arguments as the ADAVB:

'... there was only one (advocate) ... and (she) got steamrolled by the DBV and the ADA. 'Stick with us dear because we're the people who employ you and this is what we're gonna do', [0] And at the time I think there were 24 registered hygienists in Victoria... what are you going to do, what are you going to be saying, you've only just got registration for god's sake. You've only just got a license to practice legally, and now we're looking at where hygiene's going to be in the next ten years, ... shut up and ... stay with the people that you know and work your base out through them...' (Int)
The decision to appoint a dentist chair of the new Board outraged the dental prosthetists and technicians. Their Boards had been chaired by independent people, most recently a lawyer and they vehemently opposed it on the grounds that it gave the dentists too much power (Int x3). The dental therapists also opposed the dentists having the presidency (and deputy presidency) and pressed for it to be decided by a vote of the Board members.

'... such appointments should be made on merit, based upon experience and skills and, to assert that only dentists would ever posses these skills is elitist and discriminatory and does not serve the best interests of the public... ' (VDTA Response to the Second Draft of the Dental Practice Act, Jan 1999)

Both groups also felt that to give the Chair a deliberative and a casting vote meant that the dentists, in the absence of a Board member would have a majority in their own right. Robert Doyle argued that this was not important as Boards ‘don’t vote’ as such, and that this Board had to have the ‘confidence of the professions and the public’. Interview data also shows there was a view that it would have been too radical for dentistry to have it any other way and that the government may not have supported it (Int x3).

4.8.6 Regulation of dental therapists and hygienists

From the beginning the dental therapists argued that practice limitations on dental auxiliaries ought to be removed on the grounds that they were anti-competitive and reduced access to dental care. They argued that therapists ought to be able to compete with dentists to provide services while retaining a collegial relationship providing for referral of cases beyond their capacity to dentists. They felt that National Competition Policy clearly did not support continued limits on employment, client age or supervision, direction and control of dental therapists or dental hygienists by dentists (VDTA 1998).

This position, while opposed by the ADAVB, had support from some of the other stakeholder groups. The technicians and prosthetists supported greater autonomy for therapists on the grounds that they already worked in a fairly independent fashion and

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69 '...there is a risk of over-serving if there are too many operatives, especially among those performing a limited range of irreversible procedures...continued restriction of dental therapists to the public sector may be contrary to competition policy but...a public interest case can be made for this to occur... ' (ADAVB Submission to the Dental Legislation Review, March 1998)
should be allowed to apply their skills to the adult population (DP&DTAV 1998). Martin Dooland\textsuperscript{70} and Dental Health Services\textsuperscript{71} had been instrumental in establishing the AHMAC proposal and DHSV were keen to apply therapists’ skills to their adult public sector waiting lists. They also supported wider employment for dental therapists because they supported greater competition as a way of improving access to care, and on the grounds that it was ‘immoral’ to restrict employment to one setting. DHSV wanted to protect current levels of supervision (which allowed for therapists to diagnose and treatment plan referring to dentists who were off-site) which allowed them to provide cost-effective services. They were also content to allow the client groups (age range) issue to be dealt with in a way that allowed for deferred decision making (Int).

The hygienists were of the view that the practice of dental hygiene in Victoria was not sufficiently mature to move to independent practice but that the one-to-one supervisory ratio should go. They believed general supervision should be required to allow hygienists to continue to work when the employing dentist was temporarily away from the practice, and to allow them to provide care in nursing homes. They were also very comfortable with their existing arrangements requiring the care they provided to be prescribed by a dentist (DHAAVB 1998, Int x2).

There is some evidence to suggest that the panel also supported a more autonomous role for dental therapists (Int x2):

‘...The supervision protocols which exist now, I would argue, are not reflective of the mind of the parliament which drafted direct supervision, but clinical practice and common sense dictated that it was no longer a dentist standing over the shoulder of a therapist, that therapists do work, and let’s be blunt, they do work in the majority of cases autonomously and it was our intention that that continue...’ (Int)

The ADAVH however expressed concern that therapists would deliver care beyond their listed ‘duties’ unless they were to continue to work under direction, supervision and control (ADAVB 1998). This view was also supported by the DBV who argued that supervision levels must be retained along with age limits, practice prescription and employment limits (ADAVB 1998, DBV 1998a):

\textsuperscript{70} then Manager of SA School Dental Services

\textsuperscript{71} the Department of health’s public dental health branch prior to the creation of DHSV under purchaser-provider arrangements
‘...The Board believes that there is a clear public benefit in restricting the work of dental therapists to the public sector with particular emphasis on school-age children and special needs groups within that population...’ (DBV 1998a)

‘...supervision needs to be carried out by a dentist who performs the patient diagnosis and treatment planning, then directs and controls the work of the auxiliary. Direction and control require the presence of a dentist on site at all times... the preventively oriented dental hygienist should be maintained as a separate auxiliary since this is required for future needs...the ADAVB recommends the cessation of training and conversion of dental therapists to hygienists as soon as practicable... the profession believes it is irresponsible for two-year trained auxiliaries to perform tooth-cutting procedures on permanent teeth...if dental therapists were permitted to perform work normally done by dental surgeons, this would flood the market with practitioners and most likely lead to over-servicing...’ (ADAVB 1998)

‘...the School Dental Service requires a dedicated workforce able to focus on the need of school children up to the age of 15 years...until recently, school dental therapists were restricted entirely to junior primary age children...this work has been mainly simple and prevention oriented ie sealants...there is inadequate training currently provided to equip dental therapists to treat adolescents, much less to deal with the adult population...’ (ADAVB Response to the Dental Legislation Review, Supplement to the September 1998 Newsletter)

The option of developing different supervisory arrangements for the two auxiliary professions does not appear to have been considered although different arrangements for public and private sector practice was raised.

Interview data shows that it became obvious to the panel that the public sector employment limit for therapists had to go, but that not enough support had been generated to provide debate over independent practice (Int x3). The debate then quickly narrowed to employment and supervision levels. DHSV were not prepared to engage in arguments about the age range for therapists other than an extension to 18 years, and the removal of the supervisory ratio for hygienists seemed to be generally accepted. Interview data indicates that the supervision levels used by DHSV in the School Dental Service became the compromise (Int x2). It meant that on one hand, the gate-keeper role was retained and on another there was a clear instruction that the old legislated subordination was no longer appropriate. It was also a pragmatic acceptance that the legislation would not go through without the ADA’s acceptance:

In an ideal environment ‘...we would not have had supervision...what [0]we came up with was not as bad as in the old Act. (Int)

‘...The only risk is an inappropriate definition of supervised...a too tight definition. If you can own a practice, you just have to have a dentist to supervise you clinically, I think it’s a very minor concession... without it... it would have been hard to get the Act through...’ (Int)

The ADAVB and the DBV wanted these limits prescribed in the Act and the panel made firm recommendations:
"...All dental auxiliaries (are) to continue to work under the supervision of a dentist until clinical evidence indicates that autonomous practice does not endanger public health and safety..." (p iv, Executive Summary of the Recommendations of the Review, DHS July 1998)

Similarly, the recommendations said that the age limit for dental therapists’ patients would be up to and including 17 years ‘...until evidence based on sound clinical research shows that removing the restriction will not endanger public health and safety...’ (DHS 1998). This decision brought Victoria into line with several other states whose school dental services provided care for secondary school students but also flagged the possibility of extending this boundary in the future.\footnote{72}

The first draft of the new Dental Practice Act included both of these provisions but they were omitted from later drafts and excluded from the Regulations. This meant that the relationship, in the end, was left to the Codes of Practice to define.

These debates, or flashpoints described above are illustrative of the way the policy culture was shaped and negotiated. There was an early assertiveness about National Competition Policy that laid the ground for a shift in the relationships of supply and demand. The concept of new policy justified against NCP criteria created an environment of ambit claim that meant protection of the existing policy framework was not possible. The de-regulation of dental technicians and business ownership and the single Board model were early examples of this intention. However, the dominance of the dentists quickly re-asserted itself in the debates over title and practice protection where the outcome resembles the initial position. The structure of the Board sums up this negotiated culture in that there was a significant reduction in the dominance of the dentists over dental regulation, but inside the occupational mix, they remain the dominant profession. Interestingly, this was defended on the grounds that ‘public confidence’ must be maintained. Public sector interests and access to care shaped the approach to dental therapists’ and hygienists’ regulation although the dominance of dentists meant that only small changes were made. The assertion of the ‘team approach’ and further developments pending the development of ‘evidence’ were good examples of the use of discourse to achieve outcomes acceptable to most stakeholders.

\footnote{72} ‘...There is the possibility for therapists to upgrade skills and qualifications to expand duties into the future. The project of the Australian Health Ministers Advisory Council is one avenue for evaluating whether a dental auxiliary with additional training could provide a specified range of high quality care for adults in a more cost-effective manner...’ Final Report of Legislation Review, DHS July 1998
4.9 A summary, using a cultural analysis approach

‘...there is no such thing as a completely de-regulated market. Neither is there a perfectly centralised system...it's somewhere in the middle...it's just a degree of whether it's a bit more towards the de-regulated regime or a bit more towards the regulated regime...’ (Int)

Considine (1994) has argued that policy is the product of the interactions between actors in particular kinds of systems consisting of a political economy, a policy institution and actors, and a policy culture. He sees policy making as ‘...a form of intentional action in which new ideas are socially cultivated and refined into negotiated strategies.’ It is the contest over the nature of the policy culture and the institutional approach to increasing the value of a particular cultural view that effects policy innovation (Considine 1994). This model of policy making is valuable in explaining the policy outputs of this study.

4.9.1 The institution

The policy process began with a strong culture of professional dominance supported by an all-dentist Board and arising out of a chain of previous policy episodes. Frustration with the most recent of these episodes and the increasing demands for public sector dental services meant that there was a cluster of past policy actors in the dental policy environment keen to see change occur. Lewis (1996) identified a group she called ‘equity rationalisers’ comprising the public dental service managers and providers and some dental academics as challenging the professional monopoly in the earlier policy episodes. She also suggested that efficiency and de-regulation may be more important influences on dental policy innovation than social justice.

It is apparent that leadership in this policy environment came from within the government where a ‘mixed scanning’ (see section 2.2) approach to the policy outputs was taken. A fundamental decision was made to alter dentist professional dominance to create a more rational dental policy environment in order that the incremental decisions outlined in earlier policy documents could be brought into play. Institutional influences were brought to bear on the policy environment to construct particular values that would support the desired outcomes. Strategies and mechanisms used to achieve this were:
• The use of the National Competition Policy framework and the supposed ‘clean sheet’ of policy paper

• Institutional leadership with parliamentary authority (providing the substantive power to make change combined with the shelter of higher order deciding consistent with party policy)

• A perception of outdatedness (the ‘medieval guild’) of existing regulation

• A demand for consistency across the health sector (denying ‘dentistry as different’)

• An objective of protection for the public (a mobilisation of altruism)

• Broad and continued consultation (to engage particular values and provide for all decisions to belong to the democratic process)

• The discourse of impermanence and ongoing evaluation (‘nothing is set in concrete’)

• An agenda of increasing access to care that focused on market and regulatory rather than fiscal mechanisms (support for private sector as the ‘real world’)

• An expectation of evidence-based policy making (scientific decision making)

• The assurance of no change (the ‘audit snapshot’ of existing conditions)

4.9.2 The actors

Considine (1994) refers to the second component of this model as being the ‘expert networking of key social groups’ in negotiating a policy culture. In this dental legislation review, there were two broad groups promoting opposing cultural views in support of and opposed to change as follows:

In support of the status quo:

• The dentists (ADA VB) who wanted to protect and support the pre-existing culture (and thus their positions) and argued vehemently against NCP as a framework. They used the discourses of team dentistry, public safety, quality of care and information asymmetry to defend their position. They used early agenda setting, public fear tactics, petitions, the media, continual lobbying and advocacy through multiple advocacy groups to put pressure on the government from a number of sources. Their actions defended key attributes; the higher education, morals and expertise of dentists, their right to autonomy and sovereignty over the dental
policy and market (private sector as the ‘real world’), and the need to limit the activities of the other occupational groups on the basis of their limited training.

- The hygienists (DHAARB) who were fairly comfortable with their position because of benefits that flowed from a secure position (auxiliary of the future) in market based service delivery and financial rewards including career options supported by dentists. They argued for minor change in a substantially unchanged environment.

- The Dental Board of Victoria also supported the existing culture and a highly regulated environment which provided good access to power over the industry for dentists.

- The Prosthetists were mostly comfortable with the status quo because the market bestows benefits on them which include autonomy and independent practice. They argued to retain regulation but with greater autonomy (separation from dentists) and,

- The technicians who were similarly satisfied because of their supplier relationship with private and public dental practices as autonomous businesses.

Embedded in this broad cultural view is a measure of opposition among dentists to both prosthetists and dental therapists. Both of these groups represent challenges to dentists’ cultural view of dentistry because they;

1. siphon the profits of dentistry away from dentists (prosthetists) and
2. challenge the notion of exclusive expertise (therapists)

They further challenge the market role of dentists because they offer substitute services as opposed to the more complementary roles of the dental hygienist and technician.

**Seeking change**

- the public sector providers (DHSV) contested the dominant culture through rationalist arguments in support of access to care (support for competition, rationalist and corporate agendas and technical efficiency). Strategies used were early agenda setting, continual lobbying and negotiation, and the discourses of
evidence, team dentistry and access to care. They were advocating the strengths of a manageralist model of service provision incorporating efficiency, evaluation and equity for the community.

- The dental therapists (VDTA) contested dentist dominance using rationalist arguments about access to care, more ‘sensible’ (de-regulated) use of their skills and participation in regulatory structures; their dissatisfaction flowed from poor remuneration and limited employment options despite clinical autonomy. Their arguments were around technical efficiency and equity and they also used media and lobbying strategies.

In this cultural view, both prosthetists and therapists are supported because of their ability to provide dental services of the same quality but at lower cost than dentists. Their positions therefore support both rationalism and equity because of their stronger substitution roles.

4.9.3 A compromised policy culture

Considine (1994) observes that policy outcomes are the products of negotiation and that actors bring historically grounded preferences to the process which become compromised components of the emergent policy. Where there is an institutional system for increasing the cultural value of a particular preference, innovation may occur.

In this case the institutional influences produced an ambit claim for total change. This, combined with the actions of stakeholders, effected a cultural change to allow a negotiated compromise that resulted in decreased professional dominance and modified competition. The outcome was part NCP (de-regulation of ownership and dental technicians) and part professional dominance (retained definition of dentistry, retained auxiliary supervision and prosthetists were brought back under dentists’ regulatory authority). The agreement over the private sector as the ‘real world’ and the ‘team dentistry’ concept are further evidence of the dominant position of the dentists. The registration of therapists and hygienists and broader Board membership came from previous policy directions and can be seen as incremental, and useful in the new policy environment. The discourses, consultation and evidence were shaped
and used selectively to justify particular outcomes and, documented in order to shape policy implementation.

There is a view that the actions of the less powerful groups such as dental therapists and hygienists made little difference to the policy outcome. Considine (1994) however, points out that actors are either dependent, autonomous or dominant and must choose between retaining the benefits of compliance, or challenge, push for concessions and re-arrange their relationships. The hygienists in this process sought only a small shift in the boundaries of their practice and thus took the position of largely supporting the dominant culture. The therapists, on the other hand, sought a change and argued for an altered cultural view. While they were not a powerful group, their visibility was important as evidence of the availability of alternative service provision models and the viability of the corporate rationalist view. Their decision to act rather than be compliant meant that there was a more extreme position than DHSV’s on the continuum of options, allowing negotiation to occur in a broader range. That they were of value to the policy institution is apparent as consultation ensured their continued engagement with the process and support for the contesting position.

The important aspects of this policy system that allowed change were the combination of alliances ranged in opposition to the dentists, the values in the policy institution that sought change combined with a range of actors ready to engage and, a broader political environment supportive of, and giving legitimacy to, a key discourse (NCP). While the new Victorian Dental Practice Act 1999 met the demands of NCP in only a few areas, the conditions under which other changes could occur were considered to have been created (Int x2). The process enabled an important policy leadership role for the state in altering the policy making environment around dentistry in order to bring it closer to the models of service delivery occurring in other health settings. More importantly for government, the capacity to apply more rationalist approaches to public sector service delivery was created. The cultural dominance of the dentists via the ADAVB however, remained clearly effective as reflected in their ability to reproduce power in the dental market place and policy environment. How and why this occurs will be explored and discussed in greater detail in the next chapter where the broader structural influences on the policy system are discussed.
CHAPTER 5: THE VICTORIAN CASE STUDY; DISCUSSION

5.1 Introduction

In the early 1990s, Australian federal governments again returned to the neo classical theories of economic rationalism; of increasing efficiency by increasing market competition and reducing bureaucratic intervention (Carroll 1992). Smaller government and less intervention, it was felt, would improve economic efficiency through competition. In 1995, this thinking was formalised with the development of the National Competition Policy (NCP), implemented by COAG and requiring the review of all state and federal legislation for compliance. In Victoria, the Kennett government enthusiastically embraced this direction through bureaucratic restructuring and contractualism (Alford and O’Neill 1994, Stanton 2001) and the systematic review of legislation. When applied to the health sector it was thought that reducing the barriers to effective competition among health professionals would create further potential to improve quality, efficiency and reduce costs (Wooldridge, 1996). A national policy to encourage competition and the creation of a “level playing field” fitted with this way of thinking by creating a market for health which worked to reduce the barriers to effective competition (such as monopolistic behaviours) and stimulate more cost-effective outputs (DP&C 1996).

The key issues at the interface of health policy and the economy are the high and ever rising costs of health care and the moral arguments related to its rationing. Governments have faced increasing health budgets with little ability to alter the demands for and costs of care because of constitutional protection of the medical and dental professions, self regulation and their limited ability to control supply of and demand for services (Gardner 1995, Palmer and Short 2000). Medicare, casemix funding and corporatisation have had the effect of reducing but not eliminating the influence of health professionals in the medical sector but dentistry has remained largely untouched by these developments because of its market based delivery (Lewis 1996). Dentistry is not included in Medicare and around 85% of dental services are delivered by the private sector from small group or solo practices to consumers with the means to pay for them.
Access to dental services emerged as a public health issue as data showing the costs
to the community, prevalence of disease and inequality of access to care made it
visible to the National Health Strategy (McLelland 1991a and 1991b, Dooland
1992). The Commonwealth Dental Health Program was implemented in 1993 to
improve adult access to public sector services but funding was withdrawn in the first
Costello budget (in 1996) and responsibility for funding adult dental services was
again devolved to the states. The proposed AHMAC trial\(^1\) was an attempt to develop
other service provision models based on ‘...the successes of the School Dental
Service...’ in order to extend the efficiency of and access to public dental services,
but was scuttled by the Australian Dental Association. In Victoria, the Health
Department produced its key dental policy document Future Directions for Dental
Health in Victoria 2010 (DHS 1995). This outcome focused document outlined the
vision of increasing access to dental services for low income people through an
appropriate legislative framework, a well planned flexible and adaptable workforce,
quality lower cost dental services and closer co-operation and links within dentistry.
The department had also recently reviewed its dental workforce and made
recommendations that increased demand for dental services pointed to a need for
more dentists and/or auxiliaries. It also recommended the implementation of a dentist
intern program, greater educational integration, and, that a trial to examine the
viability of auxiliaries offering dental services to adults be conducted. (DAWR
1995). The key barrier to achieving the outcomes identified by these policies was the
legitimised dominance of the market and of educational and regulatory structures by
dentists which had maintained the status quo or ‘inertia’ identified by Lewis (1996)
over many years.

Changing the composition of the Dental Board of Victoria, reducing the barriers to
competition and defining dental care as a product within a market would all feed into
the ability to manipulate the health market in favour of the economic philosophy
embraced by the Victorian Government. National Competition Policy was used as
the mechanism for reviewing the Victorian Dentists Act by setting as objectives the

\(^1\) The proposal which was supported by AHMAC was to establish a pilot program to test whether a dental
auxiliary with additional training could provide a specified range of high quality care to adults in a more cost
effective manner than the existing model using dentists, while maintaining standards consistent with existing
service provision. Funding for the pilot came from the state Health Departments and it had the support of all the
state public sector Dental Directors who together, acted as consultants to the project. Victoria and NSW agreed
wider goal of making the Australian economy more competitive. This agenda demanded that regulation should only be imposed where the costs to the community were too high to allow for market failures. The onus of proof of need for regulation lay with the proponents of regulation. The Review team had an espoused ‘clean sheet of paper’ to devise ‘new’ rules only where a demonstrated need existed. This agenda was also grounded in existing policy documents; the Mutual Recognition Act 2, Model Legislation Principles (DOH 1990), the Dental Auxiliary Workforce Review (DH&CS 1995) and Future Directions (DHS 1995). This policy making environment created an atmosphere of 'ambit claim' or cover for the unspoken aims of reforming the dental policy environment and also served to raise many issues for debate at once. It was also closely aligned with increasing efficiency which was an identified vision for the dental industry in Victoria arising out of the demise of the CDHP (Lewis 1996).

Considine (1994) observed that policy outcomes are produced from the combination of positions policy actors bring to the process nested in the political economy. The negotiation between the state as an actor and the stakeholders creates a policy culture. The policy culture then defines and shapes the outcomes. In the previous chapter, I have argued that changing structural power was one of the key objectives of the Review of the Dentists Act and Dental Technicians Act of 1972 and that this was in line with the outcome focused philosophy of the Department of Human Services at the time, and its objective of increasing economic efficiency in the health sector. I have also shown that dentists recognised this challenge to their power and acted to limit the scope of the discussion and protect the status quo by discrediting the government agenda in public and using their elite connections to shape the outcome. That the dentists held and retained a dominant position in the dental policy environment is also apparent. The following discussion takes a broader view of this environment in order to examine the mechanisms and structures that allow this position to be protected and reproduced.

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2 At a special Heads of Government meeting in May of 1992, the Mutual Recognition Agreement was reached between all State and Territory governments and the Commonwealth. The Commonwealth Mutual Recognition Act 1992 contains the requirements for mutual recognition of qualifications in order to facilitate interstate practice. Each state has now passed legislation adopting the provisions in the Act.
Alford and Friedland (1985) assert that policy making events cannot be adequately understood through an analysis of decision making as a simply pluralist or ‘institutional conflict’ event. They assert that social systems create ‘…historical conditions in which certain institutions exist and therefore decision making situations become more or less probable…’. They assert that there are several ‘layers’ in a policy process which require the use of more than one approach to analysis. The following analysis therefore draws on Alford and Friedland’s (1985) combined theory model for analysing power and decision processes. This combined theory model incorporates elitist, corporatist and pluralist theories and asserts that at each level or layer, different types of power are exercised which reflect Lukes’(1974) three dimensions of power (these theoretical models were discussed in greater detail in Section 2.2). At the society or class level, elitism and structurally supported and exercised power is most evident (Lukes third dimension power). At the organisational level, where corporate and government agendas engage, agenda setting power and the mobilisation of bias are evident which Lukes described as second dimension power. At the level where individuals engage in a more pluralist fashion, Lukes first dimension of power, the use of power to influence decisions in an overt fashion are most evident.

5.2 Structural power

Alford (1975) argued that the difficulty in achieving reform in the health sector was grounded in the benefits that powerful interests derive from the health care system in its existing form. Dentists reap both financial and social benefits from the existing system. They have control over capital through legislation protecting the ownership of dental practices and the supervision (gate-keeping) of other providers of dental services. They therefore have control over prices and the supply of services. This market control is further protected by the ‘small business’ and often solo practitioner nature of their practices making population level evaluations of service output and quality difficult to achieve. Alford also suggested that proposals for reform are unlikely to achieve changes because they are so readily and effectively resisted by the institutionalised and legalised control exercised by dominant structural interests. Such structural interests need only act to resist change in order to maintain the status quo rather than generate the ‘extraordinary political energies” required to achieve change.
An important question is, how did dentists manage to achieve such control over the market and then maintain it? Turner (1995) argued that professionalisation should be regarded as a strategy of occupational control between experts, patrons and clients and that doctors and dentists actively sought to become ‘professionals’. Larson (1977) argues that professionalisation is a process by which the producers of services have attempted to constitute and manage a market for their expertise. This requires a monopoly backed by the state and has an effect on the distribution of wealth and status thereby contributing to social inequality by protecting for dentists, the profits from dentistry. Section 2.4 has developed this thinking in more detail and has described the events and actions that have produced the professional dominance evident in today’s policy environment.

Willis (1989) has also argued that the division of labour among health occupations was socially organised and largely related to the preservation of control over health care by the medical profession. While he acknowledged that occupations form the technical division of labour and classes form the social divisions in society, his view was that the relationships between the two were dialectical; occupational control or dominance maintains and develops social position, which in turn contributes to occupational control in a circular fashion. Indeed, one could argue that the formerly middle class role of doctors has been elevated in post-industrial society because of their control over the ownership and production of knowledge. Willis identified the three mechanisms by which doctors produced and reproduce their power over the medical market as being autonomy, authority and sovereignty. While dentists have been subjected to professional medical dominance within health (Willis 1989, Turner 1995, Lang 1999), they have also used these strategies to good effect to dominate their own market (Larkin 1981).

5.2.1 Autonomy

As discussed in section 2.5 dentists ‘professionalised’ in the early 1900s (like medicine) and through legislation by government, with the 1972 Act, achieved virtually complete autonomy with the establishment of an all-dentist Board to administer the Act. This has allowed them to exercise all regulatory, disciplinary and standard setting functions for their own profession. Dentists undergo five years of university training prior to achieving registration under a state Dental Act in order to be allowed to practice (effectively limiting market entry). They have attained full
control over their market by limiting practice ownership to dentists and preventing competitive advertising, and by defining dentistry under the Act and limiting its diagnosis to dentists and its practice to those registered under the Act (State Government of Victoria, 1972). As the Layton Report (MBRC 1996) showed, dentists have convinced governments that dentistry is too costly to include in Medicare. This has had the effect of keeping oral health services in the private sector, off the mainstream health agenda and largely out of the medical dominance arena, all of which have served to retain autonomy.

5.2.2 Authority

Willis (1989) argued that dominance in medicine over potentially competitive occupational groups was achieved through limitation, subordination and exclusion. Early dental practice legislation excluded apprenticeship trained ‘mechanical dentists’ from the market by ensuring legislation recognised only university qualified practitioners. Dental technicians have since been limited to providing prosthetic (technical/mechanical role) services under the prescription of a dentist. Dental prosthetists (advanced dental technicians) have only been allowed to practice since 1972, and their practice has been limited to prescribing, supplying and fitting prostheses and mouthguards. Although they have been licensed\(^3\) under a separate Act, their Boards have contained two or three dentist members.

When dental therapists were introduced in 1972, they were all female\(^4\), licensed rather than registered, and without title protection\(^5\). They were excluded from regulatory and policy areas, worked in a limited range of skill areas under ‘direction, supervision and control’ of a dentist in the public sector, and only with children\(^6\). They were effectively subordinate to dentists, limited in their range of skills and

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\(^3\) Under the 1972 Acts, dental therapists, hygienists, technicians and advanced dental technicians were all licensed to practice aspects of dentistry rather than registered as health care practitioners. Only dentists and dental specialist were registered and although there is little difference in practical terms, it served to retain a separation in status. Dentists’ and specialists’ practice was limited only by their training and competence and the definition of dentistry contained in the Act (practice protection) and were trusted to recognise their own limitations as professionals. The licensed practitioners had lists of ‘duties’ defined by the Regulations which they could practice which were strictly applied regardless of their competence or training. They were not considered by dentists to be professionals.

\(^4\) Only young women under 26 years of age were offered places in the training course.

\(^5\) Title protection refers to the protection of certain titles by an Act for registered practitioners alone (eg dentist, nurse, medical practitioner, dental surgeon). It is therefore an offense for a person not registered by that Act to use the title or give the impression that they are registered under the Act.
clients and excluded from legitimate professional status and self-regulation. Dental hygienists too, were subject to subordination, limitation and exclusion from professional legitimacy. When finally allowed to practice in Victoria in 1989, almost 100 years later than their US contemporaries, they were also all female and licensed (DBV 1989). The legislative requirement for on-site, one dentist-to-one hygienist supervision and restricted skill range meant that dentists retained the role of diagnosing and prescribing the treatment they could carry out. With these conditions on their practice, dental therapists and hygienists were permitted to provide aspects of dental care but in a way that ensured dentist authority over their practice.

The differentiated division of labour in dentistry has seen the more mundane, messy and time consuming tasks delegated to the auxiliary occupations with gatekeeper controls ensuring the profits from their work flow back to the dentist (with the exception of the prosthetist). In 1996, the DAWR imposed a suspension on the training of dental prosthetists (on the grounds that demand for their services was diminishing) and required that clients obtain a certificate of oral health from a dentist prior to having a denture or partial denture inserted by a dental prosthetist. With this change dentists thereby re-imposed a form of gatekeeper control over this occupational group.

5.2.3 Sovereignty

Medical doctors achieved sovereignty in health care initially by alignment with the scientific approach to cure, unifying themselves against their competitors, developing university training and harnessing their social connections to develop political legitimacy. Willis (1989) argues that the most important aspect of legitimization of medicine was that its claim to an esoteric knowledge was utilised politically to develop state patronage for self-regulation.

Dentistry too recognised the value of this position and quickly moved to take the same path. It moved itself from a technical to a scientific basis and made similar claims revolving around the ‘oral sepsis’ theory prevalent at the time, to develop political support for the scientifically trained professional man as the expert in this

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6 The irony is that children are often considered more difficult to treat because their mouths are smaller and they are often less tolerant of dental treatment adults. They often require gentler, more persuasive and patient care which makes them time consuming and potentially less profitable.
important field (Robertson 1989). The long university training required to gain such knowledge ensured the perpetuation of elite participation in the profession. Dentistry, like medicine, gained further legitimacy based on its ability to develop in a corporate fashion engaging with the business elite and capitalism. State patronage extended a sanctioned monopoly over the market, providing self-regulation and conferring legitimacy, allowing dentists to become institutionalised experts on all matters related to dental health (including conferring the honorary title of ‘doctor’). Out of the first Odontological Society developed to socialise the behaviour of the newly emerging profession (Robertson 1989), university dental schools, State Dental Boards, professional associations and the Australian Dental Council have developed, providing institutionalised orthodoxy – a single voice of dentistry- over all dental matters.

Society is now so accepting of the specialized nature of the knowledge required to perform dental procedures that it has been convinced of the need to have dentists provide expert advice on all dental matters. Dentists lead and teach in university dental schools and auxiliary education settings, they participate in dental technicians regulatory boards and dominate dental nursing education organisations. Dentists manage dental hospitals and public sector organisations which provide dental services, and their boards, dentists staff policy units advising health ministers on dental matters and devising state policy, carry out dental epidemiological research and workforce reviews, all of which position them to perpetuate the sovereignty of their own profession. Lewis (2000) noted that:

'...the dental profession's concept of practice has generally dominated both resource allocation and society's beliefs about oral health problems and they have successfully guarded their independence.'

5.2.4 The role of professional dominance in the Dental Legislation Review

The sovereignty of dentists was evident in the Review decision making process. There was an acceptance throughout the review of the dental legislation that clinical issues needed to be decided by those with expertise and that the expertise of the dental professions in dental legislative reform was paramount. The political view was that it was important to keep politicians and the legal system separate from the regulation of professions because of the expertise required in deciding clinical issues.
There was also a view from the professions that there ought to be enough flexibility in the legislative outcome to enable changes to be made without having to engage the interest of politicians in dental issues. Therefore, issues defined as clinical in nature such as auxiliary duties and client groups, infection control protocols and specialist roles were deferred for decisions to the new Board via Codes of Practice. It was also very clear throughout the process that the role of setting standards and disciplining the professions should belong with the professions. The right of the professions (and here I include all the dental occupational groups) to exercise autonomy was never questioned; rather it was supported by the model legislation principles (DOH 1990). None of the actions within the review challenged the right of the dentists to autonomy or sovereignty over their own practice but rather challenged their sovereignty over the whole of dentistry.

Despite being commissioned as an independent review (with ‘impartial and detached’ reviewers independent of the industry or profession under review (DP&C 1996), the NCP review of dental legislation had dentists as the project officer and in several other roles. The functions of the project officer were to draft documents and speech notes, as an executive function to the review panel, to provide clarification and interpretation of dental matters, to identify stakeholders and develop meeting agendas. The then president of the Dental Board of Victoria (DBV) was appointed as a member of the Reference Group, whose role it was to identify issues for the Review and shape the Discussion Paper, an opportunity not offered to the President of the Dental Technicians Licensing Committee or Qualifications Board. One third of the 40 members of the Dental Legislation Review Workshop were dentists, (only two dental therapists and two dental hygienists were invited) and four out of ten discussion groups were chaired by dentists, again positions not offered to other dental occupational groups (DHS Oct 1997). The consultations designed to inform the review about options for registration and regulatory processes for impaired practitioners and unprofessional conduct (Calxa 1997a and 1997b) were based on other dental models and it was acknowledged by the panel that dental regulation ‘…everywhere is tradition based…’ and that this review was not likely to throw up anything new. The chief policy advisor to the Minister for Health who had the role of taking the recommendations to legislation was also a dentist. While there may be a view that this comprised agenda setting or second dimension power, it is my
contention that it is structural power because the roles of these people were hardly contested and none of the other stakeholder groups, including consumers had this level of input. Dentists were in positions which gave them greater access to the process as a result of their sovereignty over the industry (in policy, education, management and administrative roles). They did not need to actively seek appointment (with the exception of the Reference group) because the system perpetuated their influence as ‘...part of the natural order of things...’ (Lukes 1974).

This review also served to highlight the tension between the consumer as sovereign in a market and the sovereignty of dentists over their domain. The nature of health service delivery allows practitioners to define the nature and amount of services required by each consumer (patient) thus controlling both supply and demand (Playle and Keeley 1998, Hancock, 1999). Esoteric knowledge is thus used to protect professional sovereignty (Willis 1989). Where market thinking positioned the consumer as sovereign, professionalism has kept them submissive and retained sovereignty through information asymmetry (unevenly distributed knowledge). Thus sovereignty is perpetuated through the ownership of scientific knowledge and its technologies and through elite social positioning (Willis 1989).

National Competition Policy identified information asymmetry as a significant market failure because it prevents consumers from judging the quality of dental care and making informed choices about providers and their own needs. Consumers could be protected from this market failure either by improving consumer skills or adding regulation. Regulatory layers are however, considered to be more protective of monopoly because they limit market entry and consumer choices (DP&C 1996). At this point the contested ground of market based health reform becomes evident as regulation protects consumers but compromises market efficiency.

In this review, there was never serious discussion about alternative methods of protecting against information asymmetry; the debate centred on the type of regulation that should be applied and to which practitioners (DHS 1997b). The rhetoric surrounding consumers was that of patronage- defining consumers of dentistry as patients who are ‘...unable to make informed choices regarding their treatment... ’ and ‘the profession protecting the public’, (ADA VB 1998). Rather than develop mechanisms to empower consumers to make informed choices, the rhetoric
served to support the use of regulatory mechanisms that would protect the holders of esoteric knowledge.

There is a further conflict in the relationship between the state and the providers of dental services. On the one hand, dental service provision has been left to the ‘invisible hand of the market’ to distribute, where private capital and profit have been the motivation and professionalisation (education, socialisation, regulation) has provided the means of ensuring quality. However this professionalisation of the provider has meant that the power to control the market has resided in the hands of one occupational group. Where the market has failed to provide equitable distribution (an acknowledged problem in the health sector (Rydon, McKay, Sax, *in* Gardner 1995)), this same professionalisation has meant that governments’ power to intervene to, for example, develop innovation or apply evaluation has been limited. Legislation has vested power in all dentist ‘Boards’ to control market entry, occupational behaviour, education standards and task distribution. It has therefore allowed complete market monopoly which has protected the social position of dentists, and created a tension between the power of the professional monopolists and government responsibility for equitable distribution of health services. This review acknowledged the problems with access to services and attempted to adjust components of the system to allow for internal changes. The provision of dental care using market based mechanisms however, was a ‘given’ that was not challenged.

The arguments around practice protection (ie. the definition of dentistry) were also grounded in professional sovereignty. National competition policy and the model legislation principles had both identified practice protection as redundant because of the difficulty in defining practice to allow for development and flexibility. Practice regulation had also been described as a tool for resolving demarcation disputes between practitioners (Carlton 1997). Regulation of other professions (eg medicine, nursing, physiotherapy) had shown registration and title protection capable of limiting practice to qualified practitioners and the intent of health practitioner regulation was to be in the interests of consumers rather than professions (DHS 1997a, DP&C 1996, DOH1990,).

All the dentist stakeholder groups however, argued for practice protection on the grounds that it protected the public from unqualified operators. ‘Backyard’ or illegal operators were mostly overseas trained dentists who had not been able to achieve
registration in Victoria or who had been de-registered rather than other health care providers who had encroached on the dentists’ territory. Such providers were usually identified by the Dental Board of Victoria through complaint or inquiry or through the Office of the Health Services Commissioner (DBV 1999).

It had been argued under model legislation and NCP, that the real threat to the public of illegitimate practice could be addressed by title protection alone (DHS 1997b). Any person illegally using the title of, or holding themselves out to be a dentist or dental surgeon etc. could be prosecuted and, as was the case under the previous Act, would have criminal proceedings brought against them (DBV 1999). The underlying threat to dentists though, was that without a definition of dentistry (defined practice boundaries) other health care providers would legally be able to provide dental care, given the appropriate training, and the sovereignty of the dentist over oral health would be threatened. In this case, despite the overt government agendas, they successfully argued that such sovereignty should remain in place and protected by legislation; that is that the legal ‘limitation’ of dental practice should be maintained.

Further, given the acceptance of practice protection for dentistry within health using a definition of dentistry, practice protection within dentistry was then legitimated. The roles of dental therapists, hygienists and prosthodontists could be prescribed (restricted) and the threat of internal occupational encroachment could be resisted. Interestingly, there was never any discussion of defining the role, skills or practice areas of dentists or the boundaries between what constitutes general and specialist dentist practice tasks. They could do anything within their self assessed skill range that was considered to be dentistry. Their sovereignty within and outside of dentistry was thus maintained.

The sovereignty of the dentist profession also benefits from the de-regulation of dental technicians because removing them from the professional environment alters their status and a large section of the support base for dental prosthodontists is therefore excluded from the policy environment. The 1999 Act has achieved once again, the exclusion of dental technician, an outcome the dentists had sought since the early days of the profession (Robertson 1989, Turner 1995). The other arm of the occupational group, the dental prosthodontist has, by contrast been legitimised but the regulation of this group has been downgraded from self-regulation to combined
occupational board regulation with greater dentist domination than before (see section 4.7.2).

5.3 Organisational power

"When institutions and laws continuously serve dominant structural interests, challenge must come from elsewhere." (Alford 1975)

While interest groups will legitimately operate in any policy environment, the pluralistic view that power is diffused, that all groups have an equivalent capacity to participate and that processes are democratic, is a simplistic explanation of policy outcomes (Alford 1975, Gardner 1992, Marshall, 1998, Hancock, 1999). Lukes (1974) proffered the view that conflicts exist and are resolved at both an observable and an unobservable level through the exertion of influence, non decision making and through agenda setting; power he described as second dimensional (Lukes 1974, Ham and Hill 1993, Hancock, 1999). Alford (1975) argues that the ability to exert second dimensional power in this way is often supported by social structures which allow interest groups to hold either dominant, repressed or challenging positions.

As discussed in Section 2.3, Alford defines dominant interests as those served by the existing structure of social, economic and political institutions and notes that such interest groups do not need to act to defend their interests because other institutions will do that for them. Repressed interests are those who will not be served by the existing structures because there are no social institutions or political mechanisms which do so. Examples of repressed interests would be homeless, disabled or poor people who lack resources to participate in a market or political process and often rely on others to advocates for them. Challenging interest groups are those that are created by the changing structures of a society, for example administrative arrangements, funding mechanisms or technological developments. Hospital managers may be thought of in this way; the organisation of health care services into hospital based delivery requires management; managers have become powerful because they must mediate between service providers (health professionals) and governments who purchase services on behalf of the community. The shift toward output funding and managerialist models has strengthened the position of these hospital managers. As a result, these challenging interests are often well organised because of the role they have in the corporatised delivery of health services. Alford
also noted that professional monopolists can maintain the dominant structural position and also support division or ideological factions within it without challenging the principle of professional monopoly. The policy process around this legislation review evidences this observation as the positions argued by dentists were in the majority that of dominant interests, but there were also dentists who argued in the interests of both challenging and repressed positions.

Alford’s work showed that in the case of health policy, the dominant interest groups were generally doctors and others who held a monopoly over the provision of services. While the position of medical doctors as professional monopolists as evidenced by Alford’s work in the 1970s has shifted from the small solo practice model, the practice of dentistry has not. It can therefore be argued that this model still holds explanatory power for dental health policy (Lewis 2000).

At this level of analysis, the power of organisations is important. Alford and Freidland (1985) contend that identifying the composition of stakeholder networks, the capacity of politically biased state and corporate organisations to dominate one another, and the mechanisms they use in order to influence decisions become important. Using the structural interests model, the positions of the dominant, challenging and repressed groups should be identified. In addition the actions these groups take to promote their interests should be examined and the bias and controlling mechanisms used in the policy process need to be identified. Second dimensional power becomes important because of its ability to set agendas, limit debates, mobilise bias and narrow the scope for change (Lukes 1974, Alford 1975, Hill 1997, Hancock 1999)

The discussion that follows take this approach by identifying the organisational distribution and the characteristics and actions of each of the interest groups.

5.3.1 Dominant interests

The Australian Dental Association Victorian Branch (ADAVB) and the Dental Board of Victoria (DBV) had both operated from a position of structural power vested in them by the state through the protection of market based delivery of dental services and the all-dentist Board (Lewis 1996). While the DBV and the ADA perform different functions and technically maintain their independence from one another, there is and has historically been overlap between their leadership and
members (DBV 1993, Robertson 1989, Lewis 1996). Since 1972, five of the seven members of the Board had been elected by the registered dentists in the state. In Victoria, around 95% of dentists are members of the ADA (ADAVB 2001) and over 85% of dental services are delivered by private sector dentists. This has helped deliver a practice and policy culture dominated by private sector dentist views; where the private sector is the ‘real world’.

Unlike medicine, this independence has remained protected from government intervention by being external to Medicare and has resulted in a lower level of interaction between dentists and the bureaucracy (Lewis 1996). This dominant hegemony was acknowledged by the bureaucracy in both its planning and in the development of adult public dental programs where successful delivery was seen to rely on the co-operative incorporation of the private sector, as set out, for example, in Future Directions (DHS 1995) and the Commonwealth Dental Health Program (Dooland 1992, Lewis 2000).

The documentary and interview data show that, in a predictable fashion, the ADA and DBV argued against change in order to protect the existing benefits of their professional monopoly. They argued that NCP ought not to be applied to health care and argued vehemently against de-regulation. Their communications, petitions and media coverage spoke of the danger to the public of any alteration to the existing regulation (Herald-Sun October 1997, DBV 1997, 1998a). There was the inference that in proposing de-regulation, the government cared so little about its citizens that it would make a decision based on economics that would harm them. In the government’s view, ‘…some of the good stuff was lost…’ because there was then no consideration by the public of the wider issues such as alternative service models, access to care and consumer issues (see section 4.5). With these actions they were able to stifle debate on the issues that challenged their dominance and shift the agenda toward ‘protection’ of the public creating both the perception of a threat and its solution.

To a degree, the technicians and prosthodontists also behaved as a structurally dominant group, protecting the status quo, arguing for a strengthening of their existing regulatory processes and against de-regulation. They had largely been owners of their own businesses supplying services either to dentists, the public sector or in the case of prosthodontists, directly to patients, having achieved a degree of market
autonomy despite the limitation imposed on their scope of practice. They had
developed political strength and strong organisational abilities which had grown out
of the historical contests with organised dentistry, strong political associations
particularly in the post-war period, and had achieved some momentum during the
their lack of complete autonomy, they have always had a business interest (‘real
world’ legitimacy) with access to resources and often positioned as owners of capital.

5.3.2 Repressed interests

Those whose interests were repressed were those low to middle income consumers
without access to public sector waiting lists and unable to afford dental care in the
private market; many adults from families with children, the aged and housebound,
people with disabilities and, increasingly, rural residents. The private sector had
little interest in serving their needs because of their inability to pay for dental
services. Neither the Commonwealth nor the states have completely taken
responsibility for, or adequately funded, dental services (other than child services)
resulting in rationed and often ad hoc public sector services (AHMAC 2001). Of
those who were eligible for public sector services, there were often long waiting
times before receiving care. Both the Layton Committee (Medicare Benefits Review
committee 1986) and the National Health Strategy (McLelland 1991, Dooland 1992)
had identified the unmet needs of this group. The CDHP had improved this situation
considerably (Brennan et al 1997) creating, however, greater demand and attention to
their needs upon its cessation.

Extraordinary political energies must be mobilised to draw attention to the needs of
repressed interest groups (Gardner 1995, Alford 1975), and this is evidenced by the
low profile of unmet dental care needs within the health policy arena. Alford (1975)
described groups who advocate on behalf of repressed interests as equal health
advocates. Lewis (2000) in a study of the CDHP policy process had identified the
Brotherhood of St Laurence, ACOSS and the Consumers Health Forum as acting in
concert with the National Health Strategy (NHS) in filling the role of equal health
advocates to achieve funding for adult public sector dental services. The results (see
Section 4.5.4) show that in the current review the consumer advocacy groups were
largely silent, possibly on the basis that the review was seen to be concerned with
clinical issues that needed to be decided by the professions or alternatively, that the
way the review was framed made it too difficult for those other than the professions to debate. It is also possible that there were stakeholders who used their network relationships with these groups to reinforce the perception that the dental legislation review would not affect consumers. As a result, it fell to the public sector providers (community health centres, DHSV and the dental therapists) to fill the equal health advocate role.

The interests of the auxiliary occupational groups in achieving professional status had also been repressed because of the political, legal and organisational interests in retaining their inferior status. Legalised subordination, limitation of tasks and exclusion from regulatory and policy areas were all mechanisms for maintaining this. Dental therapists and hygienists were almost all female and worked under the direction, supervision and control of dentists (Szuster and Spencer 1997a, 1997b, State Government of Victoria 1992). Their value to their employers was as low cost workers who would carry out messy (scaling and cleaning teeth), time consuming (children’s services, root debridement) and monotonous tasks (oral hygiene instruction) at lower cost than dentists (Palmer and Short 2000, Rafferty 1991 Lewis 1996). Because of their low levels of remuneration7 and employment limited to the School Dental Service, dental therapists had been a means to providing lower cost, flexible and responsive public sector services (DH&CS 1995). So long as the School Dental Service relied on government funding, it was in the interests of the government to retain a cheap and compliant workforce (Rafferty 1991).

Dental hygienists too are paid substantially less than dentists, were not allowed to be identified on practice stationary or notice boards, nor directly contract with members of the public to provide services (State Government of Victoria 1972). The credit for and profits from their services were therefore accrued by their employing dentist. The structural power of the dentists in the hygienists’ realm was even greater than in the therapists’ as hygienists also operated under a direct employer/employee relationship with them, carrying out prescribed tasks under individual supervision. This relationship was defined by legislation and was therefore inflexible. While the private sector could reap profits from hygienists as substitute providers of certain

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7 Dental therapists salary rates in 1999 averaged around $33,000 pa. (DHSV 1999) compared to an average return (sum of wages profit and salary) per dentist of $76,600 pa for 1997-98 in private practices (ABS, Dental Services:8551.0, 1999)
dentists' tasks, there had been no interest in developing their role or autonomy because of the threat they might pose as competitors. Subordinated dental auxiliaries therefore suited the interests of both public sector managers and funders, and the private sector practice owners.

Dental assistants, the largest occupational group in dentistry have also been a repressed group. They too have been largely female and subordinated to dentists and auxiliaries, poorly paid and often of limited working life with 81% being under age 34 in 1991 (ABS 1995 in Lewis 1996). Dental nurses generally have a limited working life because of poor career progression prospects and low salaries (Lewis 1996, AIHW DSRU 2000c). The interests of the dentist profession (and, it may be argued, consumers) has been served by limiting this component of their production costs. In this legislation review process, this situation was perpetuated by the NCP agenda that sought less a regulated and potentially more innovative environment.

Several authors (Willis 1989, Burton 1991, Rafferty 1991, Grant and Tancred 1992, Short and Sharman 1995) have noted the gendered division of labour which places women in roles that equate with extensions of their domestic roles and relationships. Palmer and Short (2000) note that 64% of women in the dental workforce are employed at the lower end of the hierarchy as dental assistants, hygienists and therapists compared to less than 1% of men. Both Short (1987) and Lewis (1996) have recognised the applicability of these observations in relation to dentistry by noting that not only are the auxiliary occupations dominated by women, but that they were designed for women and that contemporary trends to equal employment opportunity have had little impact.

Hygienists were often dental assistants who had undertaken further training so their subordinated role had undergone longer and more vigorous socialisation into the mother/daughter role described by Willis (1989) and others. The hygienists had aligned themselves strongly with the ADA during the DAWR, arguing that they were the 'auxiliary of the future' and opposing the existence of dental therapists (Lewis 1996). At the time, they had only recently been granted the legal right to practice in Victoria and were reliant on private practice employment, and therefore the good will of the ADA. Despite their espoused independence, they were perceived during this review, to hold views that were similar to the ADAVB (see section 4.5.3).
Their state association’s submission argued that their practice posed such risk to the public that they required registration, title and practice protection and that they were not sufficiently skilled or profitable to practice independently (DHAAVB 1998). In this review however, the state association declined to comment on therapist roles on the basis that they were not sufficiently informed to do so. Their federal body once again argued against the existence of dental therapists, against their move into the private sector and fiercely guarded the ‘preferred auxiliary’ position, arguing against any blending of the roles (DHAA 1998). This political division between hygienists and therapists has assisted the dentists’ dominance because it has undermined their ability to organise as a group.

Conversely, the therapists have operated under greater independence where their employers have been public servants who have worked off site allowing the development of greater occupational independence. They had shown signs of adopting a challenging role as they matured as profession and increasingly questioned the subordinated status of their occupational group and recognised the value of their skills within a public health service (VDTA 1994). Their submission to this review openly challenged the status quo and criticised dentist domination while advocating for greater access to care, aligning themselves with the corporate and bureaucratic agendas (VDTA 1998). They recognised the efforts that would be required to have their voice heard and sought extra resources in the form of funding, media and networks to enable this and there is evidence that they had some impact. Chapter 5 discusses the changing bureaucratic cultures with their outcome focus, privatisation and small government agendas that have provided the necessary technological and corporate change to shift the dental therapists’ position.

A parallel with the dental therapists’ position is that of the nurse practitioner. The emergence of the Nurse Practitioner has arisen out of local and international trends which have recognised the capacity for nurses to develop skills to provide primary medical care, and as consequence of the shortage of doctors in rural areas of Australia (DHS 1999). The American Nurses Association defined nurse practitioners as registered nurses with a graduate degree in nursing who conduct comprehensive health assessments, and diagnose and treat health and wellness issues for individuals, families and communities with a high degree of autonomy. They function in a collegial relationship with their peers, physicians and other health professionals.
(American Nurses Association Congress of Nursing Practice 1991 in Hartley 1999). The potential of the nurse practitioner to provide the same types of services in a range of settings in a cost-effective manner has led to the wider trialing of this role and its implementation through legislation in Victoria in 2001 (DHS 1999, Nurses Board of Victoria 2000b).

This role has been allowed to develop under outcome focused government policies which have challenged the professional monopoly of doctors over the delivery of medical services (Davies 2001). Similarly, dental therapists have been able to provide high quality, cost-effective services to children in the School Dental Service. Outcome focused rationalist government environments have encouraged public sector dental providers' interest in developing this role to address unmet adult needs for dental care. Dental therapists have aligned themselves with this position because it has recognised their skills and provided the potential to utilise them with other client groups and in other settings. This altered policy environment coupled with increased recognition of unmet need for dental care, and the demand for greater professional autonomy has shifted the dental therapists' position closer to that of a challenging interest.

5.3.3 Challenging interests

Not all dentists were aligned with the professional monopolist view. Public sector and community dentistry advocates from within the public sector and parts of the tertiary education sector (Lewis’ ‘equity rationalists’ (1996)) had long upheld the value of the auxiliary professions. The DAWR and AHMAC pilot proposal had, under a shift in government philosophy from process to output or outcome focused programs, sought their wider and less regulated utilisation. As we have seen in section 5.1.3, this proposal met with such vigorous and scathing opposition from the ADA (ADAVB April 1996, Lewis 1996, Carter 1997) that it failed to proceed. These public health dentists had identified the access to care issues in the community (Wright 1991, Dooland 1992, Lewis et al 1995) and sought to develop responses, but were a minority voice in the ADA and alone, could not generate sufficient public interest to achieve change.

Alford (1975) asserted that challenging interests arise out of the changing structure of society. Where changing technologies and redistribution of occupational tasks in
the production of health services occurs, a redistribution of power results which rewards different groups. The need for organisation to co-ordinate differentiated health service providers gives rise to the need for management and evaluation of services. This gives power to managers and administrators over health practitioners and develops organisational (corporatized) agendas and interests which are distinct from those of health professionals and consumers (Alford 1975). Alford’s work found that challenging interests were often corporate rationalists and that their ability to challenge the professional monopolists is vested in the interests of the efficiency and effectiveness of the organisation.

Lewis (1996) argued that the outcomes of the Dental Auxiliary Workforce Review (DAWR 1996) demonstrated the ability of the ‘equity rationalisers’ to challenge the dentists’ monopoly in Victoria, but that it was a fragile outcome. In the same period, economic rationalist reforms, the trend within the Victorian government toward ‘steering not rowing’ (Alford and O’Neill, 1994) which resulted in, among other things, the contracting out of government services also led to the creation of DHSV, a non-government service provider agency as an umbrella for all public health dentistry activities in Victoria (DHSV 1996). These organisational arrangements meant that planning, integration and management of such public sector services as the School Dental Service, the Royal Dental Hospital, the Community Dental Programs and the Victorian Denture Scheme were aggregated under a corporate umbrella and distanced from government. This aggregation meant that for the first time in Victoria, public sector dental services were not competing with each other for a small bucket of government funding and attention but rather were combined into a larger and more unified organisation with the status of a public hospital and a discrete budget. It was this strengthening of the economic rationalist philosophy in government and the aggregation of public sector providers into a corporatised agency that created the changing social conditions necessary to empower the challenging role.

This purchaser-provider arrangement has allowed a much stronger voice for public sector dentistry because its independence from government has allowed access to the media and more freedom of lobbying and the development of a corporatised public health agenda. DHSV’s CEO, Martin Dooland also had some links with ACOSS and the Brotherhood of St Laurence through his work with the National Health Strategy
and the Commonwealth Dental Health Program (Lewis 2000). As such, he brought to the policy system both a challenging corporate rationalist view as well as the equal health advocate perspective of the public health dentist. Dr Dooland’s background with the South Australian School Dental Service had given him direct experience with the dental therapist’s role and he recognised the cost-effectiveness of the work they did with the school dental services. He had been instrumental in developing the proposals and support for the AHMAC pilot (AHMAC 1996). As discussed in Section 4.6.2, Dr Dooland, Dr Dooland had both a personal and a corporate interest in furthering the public sector capacity to increase access to dental care. This combination of a more united and independent, corporatised public sector lead by a dentist-manager with policy advocacy experience had the effect of providing a measure of counter-balance to the ADAVB’s monopolist position.

The removal of employment limits on dental therapists did not however, outwardly fit with the corporate interest of DHSV and raised questions about why DHSV might have provided support for such a policy outcome. Allowing broader employment opportunities in the private sector for dental therapists was considered likely to create higher earning potential based on current dental hygienist rates\(^8\). This would create a salary inequity which would favour the private sector attracting therapists away from public sector employment, leaving DHSV both short of staff and spending more on salaries. Martin Dooland had argued that there was a moral imperative for allowing freedom of employment creating somewhat of a dilemma given that DHSV was already suffering a shortage of supply of dental therapists for a range of historical reasons (AIHW DSRU 2000c).

However, some of the longer term outcomes of such a decision may have held strategic value for DHSV. Broadening the market for dental therapists’ services by allowing them to work in the private sector would naturally increase the demand for graduates in the short term as more job opportunities opened up. This would help put pressure on the training environment to increase its undergraduate intakes to better meet market demand and course viability requirements. In the longer term it might also change the ADA culture of opposition as more individual private sector dentists worked with therapists and came to recognise their value. It may also mean that

\[^8\] In 2000, dental hygienists were earning approximately $35-$45 per hour in the private sector (DHAA 2002) compared to dental therapists’ public sector salaries at $15-$21 (average around $17) per hour (DHSV1999).
demand for dual-skilled auxiliaries\(^9\) increased because the private sector may only use a limited amount of people with therapist-only skills (because the wide availability of School Dental Services limits the demand for child services in individual private general practices). A combined dental therapist/hygienist can provide children’s restorative services, orthodontic, preventive and health promotion services to all age groups and adult periodontal services which makes them a more attractive option for general practices and orthodontic practices. Because of the financial and career rewards that arise out of wider employment options, therapists and hygienists are likely to add skills at their own expense and gradually increase the number of dual-skilled auxiliaries. (Dental Practice Board data shows that this has already happened in that several dental hygienists who began their careers as dental therapists have redeveloped their dental therapy skills and registered as both. There is also a number of currently practicing dental therapists who have undertaken studies to add hygienist skills (see Table 1.1, Calache 2002)). This development suits the ‘adult trial’ agenda where a dual-skilled auxiliary would be the dental auxiliary of choice because of the required combination of adult and restorative skills (AHMAC 1996). The government would thus be spared the expense of training practitioners for an AHMAC type adult trial and their role will have already gained broader societal and industry acceptance.

In supporting the employment of dental therapists in the private sector, it can be seen that both the competitive and the DHSV corporate agendas (increasing cost effectiveness and access to services) were served. Dental therapists would move into the private sector and provide the potential to develop alternative providers of school dental services (allowing DHSV to purchase school dental services in difficult-to-service areas). They would gain wider industry acceptance and have the incentive to develop additional skills at their own cost and create an environment more likely to support their utilisation with adults. These developments would all contribute to DHSV’s ability to provide more ‘…accessible and affordable dental health services...’(DHSV 1998a).

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\(^9\) The dual-skilled auxiliary (one qualified as both a dental therapist and hygienist) represents a step toward the combined auxiliary that the DAWR had recommended. This type of practitioner was supported by both government and public sector but opposed by the ADA and the DHAA.
5.3.4 The state

The state’s role in policy processes has been variously described as neutral arbiter (pluralist where democracy is the central interest that must be served), as a committee for managing the affairs of the bourgeoisie (instrumentalist view where capital accumulation is the interest being served), or as a supporter of the economic order (democratic elitism where social stability is being protected) (Alford and Friedland 1985, Ham and Hill 1993, Hancock 1999). Corporatist theory holds that as capital accumulation has slowed (with its accompanying industrial concentration and international competition), the state has come to adopt a more directive and interventionist role with decision making occurring between government, business elites and labour organisations (Hill 1997). The important aspect of corporate theory is the greater emphasis on the role and autonomy of the state as a key player, a view supported by Considine (1994). Nordlinger (1981) argues that, under corporatism, the state exercises and acts on preferences of its own, sometimes in opposition to the preferences of powerful groups. He identifies three types of state autonomy: Type 1 autonomy where the state acts on its own preferences where they diverge from societal preferences; Type 2 autonomy operates where state and societal preferences diverge and the state, through its officials acts to bring about societal change; and Type 3 autonomy where the preferences of the state and society agree (in Ham and Hill 1993). It is the role of the state and its directive capacity to achieve policy outcomes through negotiation between labour and capital that is of interest here.

In addition, the rise of the ‘new public management’ agenda in Victoria with its emphasis on entrepreneurial management, contractualism and privatisation has seen a shift toward more centrally controlled policy making and a bureaucracy which was more responsive to government agendas. When the Kennett government came to power in 1992, the state’s health sector was seen to be in a crisis of inefficiency and neglect, inflexible and provider dominated. The managerialist agenda combined with output funding and competition were seen to be able to improve efficiency, protect quality, encourage innovation and increase consumer choice. The role of government had become one of ‘deciding rather than providing’ and the focus was on ‘outcomes rather than processes’ (Gardner 1995, Zificc 1997, Hancock 1999, Smith 1999). The splitting of clinical decision making from that of market oriented regulatory processes fits with this agenda by allowing the regulatory framework to be
defined by the review process (the bureaucracy) and the detail of implementation by the new Board’s Codes of Practice (the professions). Further, the appointment of Board members by the government means that government policy agendas are influential.

As the preceding chapter has shown, the Victorian government, in this policy process clearly had an agenda of dental policy reform but in the case of dentistry had found barriers in the form of professional dominance. Medicine had already seen a shift in structural power with the alliance of corporatised health bureaucracies and equal health consumer advocates, in both the federal arena and in Victoria in the 1980’s (Duckett 1984). This had resulted in a shift to more rationalised approaches through a range of management principles including universal health insurance, output funded hospital services and in Victoria, large hospital networks (Smith 1999, Lewis and Considine 1999). Dentistry, operating largely outside these mechanisms, could only be influenced via regulatory regimes. Increasing efficiencies in dental service provision relied in part, on the more rational utilisation of personnel, a change which had been resisted through capture of the regulatory process by an all dentist Board.

The bureaucratic agenda was grounded in pressure on the state to control health spending (Hancock 1999) and growing waiting lists for public sector dental services (Daley 1997, Brown and Wright 1998, Nancarrow 1998). At around the same time, following the fallout from the discontinuation of the CDHP, oral health was receiving federal government attention through the Senate Community Affairs References Committee Inquiry into public dental services (1998). This report had indicated that public dental services were the domain of the states. At that time, Victoria was making the lowest per capita investment in public sector dental services (AIHW 2000). The state government had also made a commitment to the National Competition Policy agenda and the financial rewards attached to compliance. If private sector access could be improved through greater competition and reduced prices and public sectors could apply less costly models, including the capacity to offer services for tender, the pressure to increase state spending could be reduced.

There was a bureaucratic view that dentistry had rigid task delineation attached to job titles that did not reflect the competencies of the people practicing or the needs of patients and the need to create a more modern regulatory framework for dentistry had been identified (DHS 1997b). The NCP demand to review all the state’s
legislation provided the impetus to open the Act and rearrange the structural
dominance which had previously prevented change.

Robert Doyle, as the representative of the state and driver of the process exercised a
special sort of power in an overt way; he also clearly had a personal agenda beyond
the political arising out of his policy history in the dental environment. Nordlinger’s
(1981, in Ham and Hill 1993) type two autonomy was evident as Robert Doyle
worked to bring divergent agendas together, however the managerialist culture of his
government used type one autonomy and corporatised commitment to secure the
competition agenda. This reflected the centralised control and entrepreneurial style of
the Kennett government which placed competition and government agendas ahead of

Considine (1994) describes stakeholders as those who contribute services essential to
delivering a program and whose veto power is often out of proportion to the roles of
other groups for whom the policy is created. In this case however, veto power itself
was altered because of the nature and culture of the policy making. In this case the
government was threatening to alter the level of autonomy exercised by practitioners
over their own market. For some practitioners, their autonomy was under threat of
reduction and for some, autonomy could be increased. For the dentists in particular,
the legitimation by government of their monopoly power over the market was
threatened. Their power to make policy decisions had been diluted by the NCP
policy making guidelines excluding interest groups from review panels and the
contract state thinking aimed at guarding against labour interests dominating policy
environments (Alford & O’Neill 1994, DP&C 1996). For this reason, the
government had more power and stakeholders, particularly the dentists, less than
they would in a less liberal policy environment.

Also of interest here is the widening of the range of stakeholder groups participating
in dental policy making; namely the recognition that dental therapists and hygienists
were stakeholders. The DAWR in 1994 had, for the first time, included them
formally in the policy process by appointing them to the task-force group. It had also
recognised the divided nature of the dental policy making environment and had
recommended the establishment of a Ministerial Advisory Committee with broad
membership, including a dental therapist and hygienist in an effort to broaden
participation (DH&CS 1995). Their elevation into participative legitimacy was
therefore a relatively new experience likely to give them increased policy making power thereby shifting the balance of power.

Both the state government and its bureaucracy and the corporate rationalisers (DHSV) wanted to see a more pluralist system in operation. In order to achieve that, the state had to take the role of change agent to engineer the system away from the elitism that had dominated the policy environment for many years. The structural interests model described by Alford (1975) had only recently become apparent in dental policy making because of the almost complete dominance of the professional monopolists. The changing conditions which provided challenging interests with their power had only gained momentum in the 1990s (not really evident until the creation of DHSV in 1995) and the equal health advocates had been almost invisible until the NHS policy process had raised their profile. The strong Kennett government economic rationalist agenda demanded a more outcome focussed approach to resolving the public health dentistry issues and one that did not focus increased attention on government funding. The creation of a policy environment that could allow for technological development and a more rational task distribution with respect to occupational boundaries and health outcomes could achieve this. There was an acceptance of the right to self regulation among health professionals but the resistance of the dentist profession had demanded structural changes to strengthen the corporate rationalist position. The de-professionalisation (as described by Friedson 1994) which had largely been prevented by the dentist profession was being applied by fiat.

5.3.5 The role of organisational power

'...second and third dimensions of power point to a limiting of the policy agenda to consideration of only those issues deemed acceptable, and to an exercise of power by certain elites to get others to hold the preferences deemed appropriate.' (Lewis and Considine 1999).

This section draws on the previous discussion which identified the policy participants in terms of Alford’s (1975) structural interests model based on their organisational separation into dominant, repressed and challenging interests. The discussion that follows identifies the way that these structural interests affected and were affected by the review of the legislation. Alford and Friedland’s (1985) model suggests that second dimension power or the power to manipulate agendas and shape the policy discourses, is most relevant at this level of analysis.
The composition of the new Board may be viewed in organisational terms because of the distribution of structural interests across the stakeholder groups. The majority of dentists took the dominant role but there were also dentists whose agendas matched the government position in a challenging/equal health advocate role. Those dentists involved in the bureaucracy (the Department, DHSV, public health) were keen to see a less dentist dominated Board in order to further their public health aspirations. Those operating from within the ADAVB and DBV (referred to here as the 'professional monopolists') were keen to retain structural dominance. The initial decision to have a nine member Board with only four dentists represented a significant loss of power for these professional monopolists. They argued that while they accepted the government's desire to include non-dental persons on the Board, it should consist mainly of dentists and be led by a dentist (ADA 1998, DBV 1998). These dentists were also very concerned that those they termed 'non-dentists' should not be involved in disciplining dentists (ADA 1998, DBV 1998). But the more consumer oriented approach of the Model Legislation Principles which had resulted in the inclusion of non-dental people on the Board meant that they also had a role in inquiry and discipline. The extra sting for the dentists in this decision was that auxiliaries and prosthetists would also have this role and that dentist professional behaviour would now be subject to much broader intra-occupational scrutiny.

Retaining the presidency and the deputy presidency of the Board for dentists because ‘...the public had to have confidence in the Board...’ and that ‘...it would have been too radical for dentistry to have it any other way...’ (Int x2) however, represented a 'win' for the professional monopolists. This demonstrates the power dentists retained over dentistry, despite the government agenda. A pluralist analysis of this decision would suggest that the government arbitrated between particular interests to generate a workable outcome but the bureaucratic agenda becomes apparent with an examination of the composition of the Board and its effect on structural interests.

Organisational analysis suggests that while the structure of the Board changed to allow for another dentist it actually strengthened the challenging role. With the appointment of a second prosthetist alongside the second dentist, there was more room for a public sector dentist appointment. (Four dentists may have meant a struggle for a public health/sector dentist appointment given the need for a mix of old and new, metro and rural, male and female, and specialist appointments).
prosthetist was also much more likely to promote a rationalist approach to dental service delivery (given their largely substitute role) and support a competitive environment based on their history of opposition to dentist domination and support of competition. Had a second auxiliary been appointed, the dentist vote may have been strengthened because a hygienist would certainly have had a seat, a position supported by the ADA and DBV. Previous policy making (DAWR 1996, DHAA 1998) had demonstrated that the hygienists would be likely to align themselves with these dentists based on their employment relationship and their subordinated situation, although there is evidence to suggest that the Victorian Branch were growing in independence. (In the longer term, many people are of the view that the second prosthetist seat will become a second auxiliary seat.) This decision reinforces the view that the structure of the Board was driven by a need to alter the structural dominance of the dentists and their power over policy making. This single, mixed membership Board outcome was clearly identified early in the review process and appears as an important strategic action to meet the government agenda.

The dominance of the dentists was also challenged by a change in the relationship with dental prosthetists. The Certificate of Oral Health, required under the DAWR (1995), which had imposed gatekeeper controls on their practice was rescinded in this review on competition grounds and for lack of evidence of benefits (DHS 1998). The independence of the dental prosthetist was legitimated even though their self-regulatory status was removed. An analysis of the technician position shows that their de-regulation occurred because earlier policy action (Calsa 1997a) had raised questions over the need for their regulation and under the NCP agenda, the need for reduced regulation was satisfied. However, the bureaucratic agenda required a strong challenging faction; the market and political strength of the technician/prosthetist lobby was important to reducing dentist professional monopoly. Dental prosthetists were registered as equals thereby creating three (therapist, hygienist and prosthetist) potentially challenging professional occupations.

Agenda setting power was also evident around the issue of supervision of dental therapists and hygienists. It may be argued that it was actually third dimension power that produced this outcome but there is evidence to show that it did come up for debate in the early stages and it can be seen as a combination of both third and second dimension (agenda setting) power. The Industry Commission Report (1995)
and the local NCP agenda promoting a more competitive environment both
supported a reduction in gatekeeper controls over auxiliary practice (DP&C 1996).
There was also a significant body of evidence attesting to the quality and safety of
their practice and the economic and social benefits of reducing the barriers to
competition (Barnes 1983, Freed et al 1993, Millsted 1996, Perry et al 1997,
VDTA 1998).

The hygienists however, ‘knew’ they were never going to get independent or
unsupervised practice and didn’t bother to argue for it; in fact they supported the
retention of supervision (DHAA 1998). Lukes’ (1974) work with the three
dimensions of power identifies the third dimension of power as culturally embedded;
as being ‘...so pervasive that people contribute to the reproduction of the ‘natural
order of things’; participants accept their role or can see no alternatives...’.
Even though the hygienists had criticisms of the way that ‘supervision’ was interpreted
by the DBV and came to see that it limited access to dental care among certain groups
(in particular hospital and nursing home patients) and their own patients when their
supervising dentist was on leave, they still argued for its retention for public health
and safety reasons.

Interview data also showed that ‘...nobody really wanted anything different...’ (Int),
but the therapists had certainly argued for the removal of supervision and assembled
evidence that independent practice was not a threat to quality (VDTA 1998). Clearly
then, those who supported the retention of supervision had been successful in having
it removed from the agenda. Bachrach and Baratz (1963) describe this as a
mobilisation of bias and argued that the work of regulating demands in this way
operates against those disadvantaged by the status quo or seeking a reallocation of
where the benefits flow to illustrate structural interests, will show that the
preservation of dentist authority through supervision of auxiliaries bestowed benefits
on dentists as practice owners and public sector managers where auxiliaries have
been a cheap source of labour. The actions of Rohan Story (DBV President) on the
reference group asserting that hygienists could not work unsupervised is an example
of this type of power. DHSV emphasized the need to maintain ‘the current high
standards of supervision...of the current public sector program’ (DHSV 1998). The
Legislation Review Workshop minutes noted that with ‘...auxiliaries there is
implied, a relationship with the principal practitioner and teamwork...' (DHS Oct 1997) and the Discussion Paper asserted that '...generally there is a strong view from the industry- locally and overseas- that a team approach is required in dentistry' (DHS 1997b). All of these actions or statements occurred prior to the submissions and the work of the Review Panel suggesting that the decisions about auxiliary supervision were made prior to any pluralist engagement with the issues, and regardless of the NCP agenda. This then, is evidence of the exertion of second dimension power; the deliberate and covert use of power to reinforce existing cultural bias.

Lukes (1974) urged an examination of the outcomes to assess where the benefits flow in order to illuminate the use of power in its less covert forms. This is an important task for the analysis of second and third dimension power which has been discussed in the previous sections. A matrix detailing a full analysis of the Review's decision making using Lukes' approach is included as Appendix 7. It shows that the majority of decisions went in the direction the government wanted to take but that there were still a large number of important decisions that conferred benefit on the dentists. It also shows the areas in which there was no decision making (prosthetists training embargo, independent or broader practice for therapists and hygienists, a dentist advisory committee on the board) which benefited the dentists and demonstrated their agenda setting power. However there were also a number of 'non-decisions' which benefited the government agenda (elimination of dental therapists, the combined or 'hybrid auxiliary') demonstrating their determination to retain some previous policy decisions.

5.4 Pluralist power analysis

The combined theory model (Alford and Friedland 1985) also urged the examination of decision making for the overt exercise of power (Lukes (1974) first dimension) and the open negotiation between policy participants from a pluralist perspective. Gardner (1995) describes pluralism as '...a socio-political system in which the power of the state is shared with a large number of private groups, interest organisations, and individuals represented by such organisations...'. Governments will act as arbitrators but will have interests that lead to a more active bargaining and negotiating role. Pluralist theory holds that the government's role is to regulate and
co-ordinate the debate so that no one group dominates the process in all policy events.

Considine (1994) asserts though, that policy actors may have uneven ability to participate in the process and articulate their positions which has been seen in the previous discussion of structural and organisational power. It has already been shown that this policy environment had structural supports in place that allowed dentists to dominate the process and that they had done so for a long period of time. It has also been demonstrated that a key objective for the government was to make the policy environment more pluralist.

Review panel members however, argued that the process in the case of the legislation review had been pluralist based on the outcomes. No group had been completely satisfied by the outcomes and the government too had given ground in the competition area by allowing a definition of dentistry to be included in the legislation. Some policy mediators see evenly distributed dissatisfaction with outcomes as evidence that the policy process was equitable because everyone had to compromise. In this case, it has been observed that not everybody was happy with the outcomes (Int). This may, however simply indicate that those who are used to being powerful did not get their own way and that the re-arrangement of policy actor networks gave greater voice to those who are usually repressed. The repressed groups were also dissatisfied because they had a wide range of concerns and many remained unmet. This analysis therefore challenges the somewhat simplistic argument that a lack of satisfaction with the policy outcomes among key stakeholders necessarily reflects a pluralistic process.

Few decisions actually came down to individual level debate (as shown by the table in Appendix 7) as most had been made prior to the decision-making process during the agenda setting phase. Some fine tuning of the legislation occurred during the drafting phase but the range and impact of these decisions was limited. Advertising limits, which had been removed were reapplied with less restrictions but this arose out of high public profile problems the Medical Practice Board were having with plastic surgeons at the time. Students were registered in response to concerns about impaired practitioners- this was supported by the ADAVB and opposed by the therapists and DHSV on the grounds that it would give the Board the power to determine curricula. The ADAVB also won the argument to describe registrants as
dental care practitioners rather than professionals. Supervision and client age limits shifted from the legislation to the codes of practice, a decision which was opposed by the ADAVB and supported by the government, the therapists and DHSV. In a simple analysis of overt power over these few decisions, the dentists and the government were mostly aligned, except for supervision; and on this the government prevailed.

As shown by the power and leadership exerted by the government, it was the bureaucratic agenda to shift the dental policy environment to a more pluralist model. In order to achieve this the government had to address entrenched structural power and create an environment that engaged the other groups in a ‘more equal’ way. Registering a wider range of dental practitioners and creating a combined multi disciplinary board with consumer members should have the effect of creating a more equitable environment. There is also, however a need for cultural change to occur in the regulatory environment so that power sharing and the occupational autonomy of all groups is considered the norm.

5.5 The effects of the review on structural power

The structural power of dentists over dentistry has been discussed in the literature (Larkin 1980, Robertson 1989, Turner 1995, Lewis 2000, Millsteed 1995, Lewis 1996) and covered at length earlier in this chapter. It is my contention that the challenge to dentists’ power was a fundamental direction for this legislation review and that while many of the policy changes were incremental, the most important ones altered structural power and were addressed through changes to the composition of the Board which was to administer the new Act. The following section outlines the structural changes that were made in the Dental Practice Act 1999 and their implications.

The 1999 review of the dental legislation addressed structural change in the following ways:

1. It has allowed groups other than dentists to have a voice in the policy arena and in regulating the dental professions through the Dental Practice Board. The title of the new Act reflects the diversity of providers.
2. It has given the government more power over the profession by appointing Board members rather than having them elected by dentists.

3. It has increased the professional status of the other providers by registering them on an equal basis with dentists. Although subordination of other providers still likely exist, its nature is to be defined under Codes of Practice. Common law is also likely to now recognise therapists, hygienists and prosthetists as autonomous practitioners (MacFarlane 2000).

4. Access to dental services has been acknowledged as a problem for the community and placed on the Board agenda for resolution, which mitigates against protecting monopoly power. (the problem of access to care now belongs more with the professions rather than solely with the government)

5. The inclusion of consumer advocates will strengthen the ‘equal health advocate’ role in policy making and dissipate the ‘single policy voice’ of dentists. It also recognises the rising status of health consumer rights.

6. The ‘mystique of interpretation’ (esoteric expertise) has been retained with the professions through the Board’s role in interpreting and administering the Act but membership diversity on the Board means a wider range of interpretations may apply.

7. Market entry limits through business ownership have been removed allowing people other than dentists to profit from dentistry. This alters the structural position of dentists as the exclusive owners and producers of capital potentially altering the dynamic of ‘class struggle’ (Juredini et al 1997, Annandale 1998) in this industry. Registration and overseas entry limits remain, as do limits on training numbers of auxiliary (competitive) professions.

8. The Act allows insurance companies and others as purchasers of services which opens the door to managed care arrangements which reduces market monopoly power of dentists/owners and develops external evaluative mechanisms.

9. Allowing therapists to practice in the private sector increases competition where child services are provided, but retaining supervision means gatekeeper controls will prevent complete vertical competition. However it
does allow for competitive tendering for public sector services and increases their profile and potential demand for their services. An increase in market demand will increase demand for training places putting pressure on artificially imposed limits.

10. Therapists in private practice are likely to earn more than they have in the public sector, which potentially increases their capacity to engage politically and offset dentists’ power.

11. Dental therapists’ and hygienists’ participation at Board level increases their networks at the policy making level. Therapists have more potential to capitalise on this as the equal health advocate role seeking increased access to dental services will be strengthened (where previously private sector interests dominated).

12. Advertising restraints have been lifted; auxiliary professions can now be included in advertising as trade practices standards now apply (limits on signage and the medium of advertising has been freed up). This provides the opportunity to increase the public profile of auxiliaries and increase competition. This may reduce prices (extend the market) and is most likely to occur in middle to low income suburbs (market margins) where practice building is important.

13. Many of the other states are using the Victorian Act as a model or basis for discussion for their own reviews so many of the changes may flow on to other states.

14. The allocation of one board seat to therapists and hygienists should develop a more communicative (and potentially more aligned) relationship and greater collaboration between the two groups.

Other areas independent from but coinciding with the legislation review that have the potential to augment the structural changes include:

1. The auspicing of the dental therapy and hygiene courses by Universities and their accreditation will alter their status (Wright 1995, DAWR 1996) with the likelihood of eventually reaching degree level. It is interesting to note that dentistry has moved to develop graduate entry models and intern year programs which serve to lengthen dentistry’s training time. Several policy
documents and overseas settings (see Appendix 4) support the need for such extra training time but professional dominance theory (Willis 1989, Friedson 1994) suggests that as subordinate occupational groups attain professional status and tertiary qualifications, dentistry must respond by increasing its educational status.

2. Oral health is now on several health agendas (NPHP 2000, Labor Party Health Policy 2000, AHMAC 2001). It is increasingly being defined as a 'need' rather than a demand, increasing its political profile. Oral health promotion has support with the current federal Liberal government (which abolished the CDHP), and oral health treatment programs have some support with the Labour opposition (which implemented CDHP) (NPHP 2000, Spencer 2001). Both however, have acknowledged that oral health requires policy attention.

As a result of the changes brought about by the Dental Legislation Review, together with the concurrent wider influences, the ability of dentists to reproduce power is reduced and the potential for further dental sector reform has been created in Victoria.

5.6 The capacity to increase access to dental care

Outcomes will take time to develop and are still reliant on the interpretation of the Act, the actions of Board members and the application of Codes of Practice. At the time the interviews were conducted, the Dental Practice Act 1999 had been passed but the Board was yet to be appointed and codes of practice developed. Interview data showed that stakeholders felt there would be very little effect felt at consumer level because for all intents and purposes, middle to upper income people would continue to purchase dental services from private dental practices and the standards of care and pricing would remain much the same. This view is supported by the Commonwealth government response to the findings of the Senate Community Affairs References Committee maintaining that the federal government does not have a role in funding dental services and that responsibility therefore lies with the states (SCARC 1998).

In the period since the data for this study were collected, the Dental Practice Act 1999 has been promulgated and the new Board has been appointed. Codes of
Practice for dental therapists and dental hygienists have been promulgated via a further, very contested process which lasted from July 1999 until March 2002 (see Appendix 8 for Victorian Codes of Practice). The discussion below incorporates these developments and makes predictions about the longer term outcomes.

5.6.1 Outcomes

Over time, dental hygienists and therapists are likely to become more visible as advertising restrictions allow their names and professions to be identified on practice promotional material and therapists move into private sector employment. There is also a likelihood that the two roles will become less distinct as the two work side-by-side in the private sector and more people add the skills of the other stream to broaden their utility. This role blending is likely to be supported by the movement in Queensland (since 1998), South Australian and possibly Melbourne universities toward offering a dual outcome degree qualification. It is also likely that as more dentists work with therapists, there will be a greater acceptance of their skills and role which may lead to an increase in demand and subsequently supply.

At the market margins, it is likely that pricing may reflect the lower costs of providing services utilising therapists and hygienists, but given the retention of the dentist in the gatekeeper role (as clinical team leader and for hygienists, prescriber of care) there is limited potential for true competition. The capacity to reduce prices relies on the ability of auxiliaries to genuinely compete with dentists in the provision of services in an open market. Private practices located in low to middle income areas are more likely to pass on cost savings to consumers in order to increase their market share and may be more likely to alter service mix. It is unlikely that practices with higher income client groups will do the same. This has the potential to make practices in higher income areas more profitable than those in lower income areas thus supporting the inequitable distribution of services.

The capacity to increase access to services is also reliant on the interpretation of ‘team relationship’ and its impact on therapists’ and hygienists’ practice autonomy. This is true in public sector services such as preschool services where it is usual for a

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10 The codes of practice promulgated in 2002 by the Dental Practice Board of Victoria require a consultative and referral relationship where the therapist or hygienist must be employed in a team relationship with a dentist as the clinical team leader. It also requires hygienists to provide services within the context of a treatment plan devised by a dentist (DPBV, 2002).
single practitioner to be employed to provide preventive, diagnostic and treatment services all within the range of a therapist. The demand for dental therapists and hygienists to be employed in a team relationship with a dentist may limit the capacity to just employ, for example a therapist and refer the dentist tasks on to another service or practice. The retention of prescription of services for dental hygienists would also prevent a hygienist providing services to nursing home or hospitalised patients and the homebound without them also seeing a dentist. A shortage of dentist services has created difficulties in access to care for these groups to date and the existing regulation offers little capacity to alter this. It has also traditionally meant that when the dentist is not present (for an hour, a day or a week) in a practice employing hygienists, they have not continued to see patients. The codes of practice devised by the new Board have loosened requirements for on-site supervision but its application is yet to be tested.

The key potential for change in access to care was in the scope of practice, which has been defined by the board under its powers to make Codes of Practice. Previously, the scope of dental therapists’ and hygienists’ practice was rigidly defined by a ‘list of duties’. If this list were to be dispensed with and scope of practice defined by education as with other health care providers, the potential for innovation in service mix would be created. US studies of the impact of input regulation on dental service provision showed that placing legal restrictions on the use of a complementary input (that is the hygienist or therapist) results in a decline in the productivity of the unrestricted input (the dentist) and a decline in practice efficiency. It not only prevents dentists using auxiliaries for tasks they are qualified to perform but raises the prices of procedures and the overall price of a dental visit (De Vany 1982, Liang and Ogur 1987). Where therapists and hygienists can provide services appropriate to their training in response to local needs, the potential to reduce the costs of services and develop more innovative models (dynamic efficiency) is increased. The new Victorian scope of practice, while more loosely defined and incorporating the words ‘educational preparation’ has not significantly altered the capacity for innovation (see appendix 8). It still limits the range of services to those prescribed by the Code and prevents the development of the roles in new directions.

Where limits are retained on therapists’ client groups the capacity to increase access to care will also be impeded. Epidemiological data show that low income consumers
often receive more extractions and lesser amounts of preventive services (Brennan et al 1997a, 1997b). The utilisation of therapists to provide adult services could result in lower cost restorative and preventive services being made available to these consumers, altering their service mix. Moreover, the ability of therapists to provide their services to adults in the public sector would reduce waiting lists through greater cost efficiencies, improving access to services for many who are currently excluded. Indeed, an increase in the provision of preventive services over the long term has the capacity to improve the oral health of the community rather than just treat oral diseases. The Review’s recommendations indicated that age limits should be retained until ‘…evidence based on sound clinical research shows that removing (them) will not endanger public health and safety …’ (DHS 1998). It is therefore up to the Board to determine the nature and quality of evidence required and to negotiate a model which satisfies the demands of the professions and needs of the public.

The deregulation of business ownership has allowed dental therapists and hygienists to own dental practices. Under existing arrangements, they would need to employ a dentist to provide ‘clinical team leadership’ but it is interesting to speculate on the potential changes to the political economy of dentistry. Firstly the tension between the management and subordinate roles for the auxiliary would force the development of altered intra-professional relationships separating professional competence from health service management needs. Secondly, from a Marxist view, the redistribution of capital alters class relationship where the auxiliary becomes the owner and the dentist the worker. This has the long-term potential of providing more resources for therapists and hygienists to improve their political influence and social standing. This may also mean that existing political alliances would become less important as professional independence increases. Under Alford’s (1975) model, therapists and hygienists may move into the professional monopolist sphere, weakening the equal health advocate position and increasing the remunerative base. Economic analysis suggests however, that were incomes for therapists and hygienists to increase too far, they would be likely to price themselves out of the market because new graduate dentists would become more competitive service providers due to their wider scope of practice.

Some entrepreneurial models are likely to evolve using School Dental Service type arrangements but without external evaluative mechanisms or other incentives to pass
on cost savings, it is likely that the profits from these practices will stay with the owners. Such models could (and were envisaged to) compete with public sector providers (such as DHSV) to provide school, preschool and other public sector services, thus satisfying the economic rationalist agenda. There is also the potential for organisations such as friendly societies and insurance companies to both own practices, and engage in managed care schemes.

Managed care models in the US have seen wider utilization of auxiliary staff to allow captitation and indemnity schemes to remain profitable (Meskin 1995, Christensen 1999, Hartley 1999). The Dental Practice Act of 1999, unlike its predecessor, has not prohibited the ‘selling on’ of dental services by a third party, thus opening the way for managed care schemes to operate in Victoria. Private health insurance rebates account for about 32% of dental services and are covered in most policies as extras. They are thus outside of mainstream health insurance packaging (AIHW 2000, AIHW DSRU Mar 2001a, PHIACa 2002). In the US, health care in large degree is privately funded often through employment packages that may or may not include dental insurance. Because health insurance in Australia is largely covered by Medicare which excludes dentistry, the capacity for insurance companies to underwrite the costs of dental diseases, which are more prevalent and recurrent, with the general health fund payments is reduced. The majority of Australians currently purchasing private health insurance are middle to upper income earners who already participate in the dental market so the ability of insurance companies to contribute to increased access to dental care through capitation schemes is more limited than in the US.

The capacity for the legislation review outcomes to have an impact on access to dental services hinges on the people who make up the Dental Practice Board. This in turn is dependent on the appointment of Board members and the political will and agenda of the government of the day. The appointment of progressive people willing to work together and alter the prevailing dominance of dentists over the market has the potential to make a great deal of difference to those who currently cannot access care. There is also a requirement for further injection of public funding for dental services and an alteration of the training mix to allow for an increased supply of therapists and hygienists to meet existing demand and to address the projected future workforce shortages (AIHW DSRU 2000c).
5.6.2 Regulatory criteria that indicate a capacity to increase access to dental care

As described in Chapter 1, there is economic, legal and dental research evidence that regulatory arrangements for dental therapists and dental hygienists can increase or decrease utilisation of the skills of dental therapists and hygienists and consequently the costs of dental care. The discussion in Section 5.6 above, in relation to the outcomes of the Victorian dental legislation review is predicated on, and further develops the evidence. Arising from the literature evaluating and reporting the utilisation of dental therapists’ and hygienists’ skills, the economic literature assessing barriers to competition and the pre-existing dental practitioner regulation from Australia and overseas and the results of this study, a group of indicators of the capacity for legislation to increase access to dental services have been developed. These are outlined below.

- Formalised access to dental policy making for people other than dentists. Where Boards are comprised of all dentists the capacity to protect the interests of the profession is increased (MacBride 1974, DOH 1998). Broadening of membership should therefore include both consumers and the other dental occupational groups. Self regulation for dental therapists and hygienists has the greatest capacity to develop their roles because it formally removes dentist dominance of their professions.

- Registration of dental therapists and hygienists under a Dental Practitioner Act places the onus of professional practice on the practitioner with rights to practice as an assurance of public protection. This reduces the need for other potentially anti-competitive mechanisms (such as limiting or prescribing practice, supervision etc) and allows freer movement of these practitioners into diverse and needy settings.

- Gatekeeper controls on service provision increase costs where services provided by one dental care provider are tied to services provided by another (Liang and Ogur 1987, DP&C 1996). Least cost models where therapists and hygienists are allowed to act as primary care providers referring patients who require more complex care on to other providers are likely to offer cost savings and increase utility of public funds (AHMAC 2001). Gatekeeper controls also limit the
provider choices consumers have and the range of health service settings that may utilise dental therapists and hygienists.

- Access to services is restricted where limits are placed on the employment settings of therapists and hygienists. This limits the range of clients and dental service providers who have access to their services. Costs of care are increased where regulation limits the number of dental therapists or hygienists a dentist works with—ie ratios are defined (Liang and Ogur 1987, Industry Commission 1995). Limits on employment also prevent competitive tendering arrangements using for example dental therapists.

- Tightly prescribed (or bundled) skills or services reduces dynamic innovation and the capacity to reduce costs (MacBride 1974, DP&C 1996). The more specific the regulation of skills is, the greater the limits are on portability, practice and innovation. It also prevents appropriate responses to new technology. Most health occupations rely on educational preparation to define skill areas allowing the development of locally responsive practice. (eg. Nurses Act 1993, Medical Practice Act 1993, Podiatrists Registration Act 1997- the key exception in Victoria being the Optometrists Act 1996 which lists four practice areas)

- Limits on client groups also has the effect of restricting access to lower cost services and more preventive approaches to care for both public and private patients (Millstead 1995, AHMAC 1996, Baltutis and Morgan 1998, Baltutis and Gussy 1999)

- Practice ownership restrictions can protect monopoly pricing arrangements, increase the costs of running practices and inhibit innovation (Industry Commission 1995, DP&C 1996). It also prevents service delivery by community agencies and health insurance companies and retains the profits from dentistry with dentists alone creating a market monopoly.

- Advertising limits have the effect of restricting the information a consumer has available, and increasing transaction costs associated with making dental service purchasing choices (DP&C 1996). They also reduce the visibility of complementary or substitute services (for example, dental therapist and hygienist services) where regulations prevent for example, practice stationery, print media and noticeboards promoting their services.
Outlined below in Table 5.1 is a summary of these indicators and their regulatory interpretations mapped against the Victorian legislative outcomes and a predication of their impact in Victoria.

### Table 5.1: Indicators of capacity to increase access to care and the Victorian legislation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Increase access</th>
<th>Decrease access</th>
<th>Victorian outcomes</th>
</tr>
</thead>
</table>
| Policy Access      | • Develop separate self-regulating therapist and hygienist practice Acts and Boards  
• Broaden membership of combined practitioner Board to include other dental care providers and consumers  
• Alter balance of power so that dentists are not numerically dominant                                                                                       | • Board members all dentists  
• Elected or appointed by dentists                                                                                                                                                                           | • Mixed membership Board  
• Appointed by Minister for Health  
• 2 public members  
• dentists hold 5/11 seats  
• 1/11 auxiliary seat  
• dental auxiliary advisory committee to provide expert advice to the Board  
Access to care: some potential ↑                                                                                                                                                                                  |
| Market Entry       | • Registration of dental hygienists and therapists  
• Allow mutual recognition of qualifications across state borders                                                                                                                                               | • Allowed to practice under exemption from the Act  
• Limits on training numbers                                                                                                                                                                                  | • Dental therapists and hygienists registered  
Access to care: some ↑, depends on other layers & supply                                                                                                                                                            |
| Gatekeeper controls | • Consumers allowed to choose which practitioner they will see  
• Therapists and hygienists allowed to directly compete with dentists  
• No definition of inter-professional practising ratios or relationships in regulation  
• No limits on billing relationships so that therapists and hygienists may directly contract with the public, the public sector, hospitals or insurance companies | • Dentist must examine all patients and refer to hygienists or therapists before/after treatments  
• Dentists must prescribe treatment  
• Dentists must supervise therapists and hygienists  
• All patients must see a dentist first or within a set time period (eg 6 months, 1 year)  
• Provisions preventing direct billing of therapist or hygienist services                                                                                     | • Therapists and hygienists may only be employed in a team that includes a dentist as clinical team leader  
• Relationship defined in employment agreement  
• Dentist examines hygienists’ patients  
• No independent practice  
• Services billed under dentist’s name?  
• Off site practice allowed  
Access to care: miniscule ↑                                                                                                                                                                                      |
| Employment settings | • No limits; Therapists and hygienists may work in independent practices, hospitals, outreach services etc wherever there is a need for their skills                                                                 | • Therapists and hygienists may only work where a dentist is on site  
• Only dentists may employ therapists and hygienists  
• Regulation defines how many therapists or hygienists a                                                                                           | • No limits                                                                                                                                                                                                      |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Increase access</th>
<th>Decrease access</th>
<th>Victorian outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client groups</td>
<td>• No restrictions on client groups - skills applied according to needs of client</td>
<td>• Age limits or client groups limited</td>
<td>Access to care: ↑ (but limited by other mechanisms)</td>
</tr>
<tr>
<td>Scope of Practice</td>
<td>• No definition of skill range- therapists and hygienists use skills according to their educational preparation and work context</td>
<td>• Skills/tasks prescribed and limited by regulation</td>
<td>• Skills loosely prescribed, defined by educational preparation and defined in employment agreement Access to care: minimal ↑</td>
</tr>
<tr>
<td>Business Ownership</td>
<td>• No limits</td>
<td>• Practice Ownership limited to dentists</td>
<td>• No limits Access to care: potential for some ↑</td>
</tr>
<tr>
<td>Advertising</td>
<td>• No limits</td>
<td>• Prescriptive limits on signage and promotion of skills and services</td>
<td>• Limits apply to false and misleading advertising and full disclosure of conditions of offers, no testimonials Access to care: minimal ↑</td>
</tr>
</tbody>
</table>

### 5.7 Conclusions

This discussion has shown that the change in the dentists’ sovereignty and autonomy was deliberate. The Review of the Victorian dental legislation made significant changes to the power of dentists over the dental market largely through re-structuring the Dental Board. It is evident that this was the key agenda item for the government in its move to provide the opportunity for outcome focused policies around dental care delivery and greater competition within the health sector. In this way, the focus of unmet need for dental services could be shifted to the market place and away from government funding. Prior to the formal beginning of the policy process, the government deliberately shaped a policy agenda to create a policy culture which would produce change. NCP and the creation of a broader policy playing field ensured that support for reform existed. Support for reform also came from actors who challenged the notion of exclusive expertise, arguing for more rational approaches to service delivery and focused on health outcomes and increased
consumer power, the very things which had led to de-professionalisation in the medical sector.

This policy agenda of de-regulation posed a significant threat to the private sector dentists’ monopoly of the market and policy environment. Their response was a strategy with multiple components designed to protect their position of professional dominance. They engaged in a fear campaign in the public arena arguing that public health and safety was under threat if changes were made. They ignored cost effectiveness and existing evidence, focusing the debate on processes of care, arguing that dentistry was far too complex and dangerous for anyone other than dentists to carry out or regulate. They also argued that the government’s only concern was cost. Their actions were taken to reinforce the ideology of profession; the mystique of knowledge, altruistic service and monopolistic practice and to preserve the mechanisms of autonomy, authority and sovereignty. This proved effective in that regulation was retained, subordination of the other dental occupations was retained and practice definition was retained (protecting against both internal and external competition). However, the conditions supporting complete autonomy, authority and sovereignty were altered to allow for the participation of the other occupations and consumers.

This shift was tied to the wider pressure on governments, both state and federal over the rising costs of and demands for health care. Neo-liberal political agendas have brought with them market focused reforms based on managerialism and marketisation (Hancock 1999). Reducing health care costs was seen to be achievable through the application of the National Competition Policy to the health sector and the application of private sector management techniques to health service delivery. Creating a market for health which works to reduce the barriers to effective competition (such as monopolistic behaviours, price setting by professional associations) and stimulate more cost-effective outputs was seen to be able to ease health spending pressure while protecting quality. Such a position also has the effect of reducing the power of the professions over their own markets as professional protective measures and capture of regulatory processes have been diluted (Willis 1989, DP&C 1996). Thus through managerialism and the application of NCP, the government regained some power over health practitioner regulation and set the scene for dental sector reform.
These trends are also consistent with the observations of health sociologists about the changing role and nature of the professions. Marx and Engels (in Annandale 1998) theorized that capitalist expansion will gradually convert every occupational group into proletariat or paid wage workers, and by this process strip them of their status and reverence, and their control over their work. State sponsored capitalist reforms of health care have seen the increasing development of complex organisational structures which have reduced the control of doctors in particular, over their own work (Marjoribanks and Lewis 2002, Lewis 2002). Health care has been rationalised and divided into numerous specialised tasks which can often be undertaken by less qualified workers (eg nurses, radiographers, pathologists) leading to domain encroachment (Willis 1989, Annandale 1998, Turner 1995). Friedson (1994) has observed that the narrowing of knowledge gap between client and doctor has served to challenge the ownership of specialised knowledge and the mystique of interpretation. The trend toward greater client questioning of professionals and, reduction in unquestioned authority has contributed to de-professionalisation (Friedson 1994).

As discussed by Lewis (2000), dentistry has largely resisted these changes because it has remained market based and largely outside government funding mechanisms. Despite the recent shift to purchaser-provider arrangements and the assertions from the ADAVB (1998) that dentists compete with one another, consumers are still largely disempowered. There is still little effective choice among providers in the private sector and purchasing decisions in the public sector are made by a centrally administered organisation on behalf of the community. Dentists have, however, lost a degree of corporate control in that individuals and businesses other than dentists may now provide dental services, offering the potential to apply external evaluative scrutiny. While there has been some occupational diversity in service delivery, hierarchical professional controls have mostly limited flow-on benefits to consumers or government. Dentists still mostly retain control over the other occupational groups and have also moved to occupy managerial roles which provide control over organised service delivery. The key changes here then, are in the loss of complete authority over the industry through policy control, and the loss of business ownership. This legislation review in Victoria has served to facilitate the shift for
dentistry by altering the legislative framework to support the types of changes that managerialism has achieved with medicine.

The key findings arising from this case study of the Victorian legislation review process can thus be summarised into seven areas:

1) There are regulatory indicators of capacity to increase access to dental services
2) The professional dominance of dentists has limited the re-structuring of dental service delivery to meet community needs
3) The government has an interest in reducing the power of dentists in order that costs of service delivery could be reduced.
4) Economic rationalism and corporatised health service delivery has altered the power of challenging and repressed interests in dental policy making
5) It is much harder to generate change than to protect the status quo
6) Empirical evidence is less powerful than structural dominance but it does strengthen the case for change
7) Leadership is emerging as an important tool for generating change

Further examination of these findings will occur in the next two chapters.
CHAPTER 6: THE INTERSTATE COMPARATIVE CASE STUDIES

6.1 Introduction: interstate case study methods

Both Robson (1993) and Yin (1988) talk of multiple case studies as replicating and extending the work of a single case study in a way that attempts to support or challenge the theory generated by it. The purpose of using a multiple case study design here is to build on the grounded theory generated by the Victorian case study and extend it through analytic generalization.

The areas of theoretical development that have emerged from the Victorian Study are summarised in Table 6.1.

Table 6.1 Victorian case study: Emergent hypotheses

<table>
<thead>
<tr>
<th>Victorian case findings: emergent hypotheses</th>
<th>Policy theory areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>The professional dominance of dentists has limited the re-structuring of dental service delivery to meet community needs</td>
<td>Effects of structural determinism on health service delivery, (Willis 1989)</td>
</tr>
<tr>
<td>There are regulatory mechanisms that indicate capacity to increase access to dental services</td>
<td>Regulatory models</td>
</tr>
<tr>
<td>The government has an interest in reducing the power of dentists as a step toward reducing the costs of service delivery.</td>
<td>Impact of regulation on costs and quality of health services</td>
</tr>
<tr>
<td>Economic rationalism and corporatised health service delivery have altered the power of challenging and repressed interests in dental policy making</td>
<td>Tension between professional dominance and managerialism/corporatism</td>
</tr>
<tr>
<td>It is much harder to generate change than to protect the status quo</td>
<td>Influence of NCP- neo-liberal economics</td>
</tr>
<tr>
<td>Empirical evidence is less powerful than structural dominance but it does strengthen the case for change</td>
<td>Structural power of dominant interests</td>
</tr>
<tr>
<td>Leadership is emerging as an important tool for generating change</td>
<td>Rational comprehensive policy making models</td>
</tr>
<tr>
<td></td>
<td>Contribute to theory on evidence based practice</td>
</tr>
<tr>
<td></td>
<td>Policy making and leadership in public health</td>
</tr>
</tbody>
</table>

6.1.1 Rationale

Health practitioner legislation is used by governments to mediate the asymmetry of information between consumers and providers of health services in order to protect
public safety. It generally uses mechanisms such as registering qualified providers (limiting service provision to those with adequate training), protecting the use of titles for registered providers and providing mechanisms to deal with breaches of standards. Governments have largely delegated the power to regulate the behaviour of practitioners to the professions themselves by providing for the establishment of health practitioner boards to administer their Acts and set practice standards. In many cases it has also allowed them to define the roles and practices of complementary occupational groups in ways that allow some occupations a measure of control over the practices of others. For example physicians have control over the work of nurses, pharmacists and radiographers (Larson 1977, Larkin 1980, Willis 1989, Turner 1995). As discussed in the previous chapters, this has occurred in dentistry with dentists exercising significant control over the work of dental hygienists and therapists, and to perhaps a lesser degree, dental technicians and prosthetists.

The ability to reduce costs of health care while maintaining quality has been an issue for governments and funding agencies for some time. One way of achieving this is by improving technological efficiency. This involves distributing tasks across occupations so that lesser trained occupational groups carry out lower technology services and more highly trained occupational groups carry out more highly technical or complex tasks. Existing occupational groups within dentistry have evolved in this way but regulatory mechanisms have often limited their utilisation (MacBride, 1974, Liang & Ogur 1987, VDTA 1998, Morgan & Baltutis 1999). There is empirical evidence to support wider utilisation of the skills of lesser trained occupational groups in dentistry (dental therapists and dental hygienists) without a reduction in quality of care (Douglass and Lipscombe 1979, Barmes 1983, Gaugwhin et al 1996, Millsteed 1996, Lewis 1996, VDTA 1998).

The National Competition Policy initiated reviews of dental legislation have been conducted between 1996 and the present in all states in Australia. These reviews have sought to give explicit attention to the effects of regulation on competition. As at October 2002, all but one state have completed their reviews but not all have promulgated new Dental Practice Acts. The outcomes of these reviews and their progress toward legislation is summarised in Appendix 9. Without exception, all states have regulated dental therapists and hygienists under the same piece of legislation as dentists. The impact of these regulatory changes on the delivery of
dental services will take some time to evolve and be evaluated. For this reason, this study has identified empirically based indicators for increased access to care, against which new legislation can be assessed. These indicators were identified in the previous chapter that discussed the results of the Victorian case study. They have been used in Table 6.2 below, as a basis for summarising changes in policy in the remaining states and territories. These data were used as a basis to select case sites for the multiple case study analysis.

6.1.2. **Procedures**

Table 6.2 was constructed using the following procedures.

Material from the Australian states was collected in four ways;

1. Baseline data were collected by analysing pre-existing dental legislation from each state. Key information related to dental auxiliary regulation was compiled. The accuracy of this material was verified by each state’s Dental Therapy Association and the Dental Hygienists Association of Australia.

2. In September 1999, 2000, 2001 and 2002, group interviews were conducted at the Australian Dental Therapists Association Annual General Meetings (see Appendix 6 for interview framework). These meetings are attended by two delegates from each state Dental Therapy Association. These delegates are members of the state association’s executive and have knowledge of the legislation reviews in their own states through the advocacy role of the associations. The review of dental legislation was on the agenda of each of these meetings (ADTA 1999, ADTA 2000, ADTA 2001). Data were collected which identified the progress of the reviews from this stakeholder perspective. Documentary materials supporting the reviews and their sources, and contact people in each state health department responsible for carrying out the reviews were also identified.

3. As they were published, the Discussion Papers, Review Recommendations and Legislation from each state were collected and read.

In July 2001, the legislation review project officer in each state was interviewed by telephone to assess progress. A table was compiled summarising the progress at
<table>
<thead>
<tr>
<th>Criteria</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
<th>QLD</th>
<th>NSW</th>
<th>ACT</th>
<th>TAS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Access</strong></td>
<td>13 members 6 dentists 1 DT &amp; 1 DH 1 DP &amp; DTech 2 Consumer 1 lawyer</td>
<td></td>
<td></td>
<td>7-11 members 4 + registrants 2 consumer 1 lawyer</td>
<td>12 members 7 dentists 1 auxiliary, 1 public health employee, 1 education 2 consumer</td>
<td>8 members 4 dentists 1 DT &amp; 1 DH 2 consumers</td>
<td></td>
</tr>
<tr>
<td><strong>Market Entry (DT/DH)</strong></td>
<td>registered</td>
<td></td>
<td></td>
<td>registered</td>
<td>Registered</td>
<td>registered</td>
<td>registered</td>
</tr>
<tr>
<td><strong>Gate-keeper controls</strong></td>
<td>Control- in regs</td>
<td></td>
<td></td>
<td>Not specified</td>
<td>Subject to the practice oversight of a registered dentist. (In Act)</td>
<td>none2 - in Codes</td>
<td></td>
</tr>
<tr>
<td><strong>Employment limits</strong></td>
<td>DT &amp; DH must be employed by dentist</td>
<td></td>
<td></td>
<td>Proposed none</td>
<td>Therapists public sector only</td>
<td>None - Independant practice allowed- in Codes</td>
<td></td>
</tr>
<tr>
<td><strong>Clients restricted</strong></td>
<td>Yes</td>
<td></td>
<td></td>
<td>Therapists 0-18 yrs</td>
<td>Therapists 0-16yrs + trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scope of Practice</strong></td>
<td>Process underway3</td>
<td></td>
<td></td>
<td>Not defined in Codes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ownership restrict’ns</strong></td>
<td>Retained, only dentists and Prosthetists as owners</td>
<td></td>
<td></td>
<td>Likely to be lifted</td>
<td>Restricted to dentists, all dentist corporation s and health funds</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Advertising</strong></td>
<td>As Vict. but omits testimonias</td>
<td></td>
<td></td>
<td>Only limits misuse of titles</td>
<td>As Victoria plus can’t disparage another provider</td>
<td>None, Fair Trading Act applies</td>
<td></td>
</tr>
<tr>
<td><strong>Key differences</strong></td>
<td>Competitive Limits mostly retained</td>
<td>Awaiting Bill</td>
<td>Awaiting Bill</td>
<td>Different process, NCP review out sourced, Incomplete</td>
<td>Least change, most restrictive</td>
<td>awaiting completion of review process</td>
<td>Least restrictions</td>
</tr>
</tbody>
</table>

1. Qld- awaiting completion of NCP review incorporating PWC public benefit test. Policy process has indicated registration and a Board seat for therapists but no more details as yet.
2. Tasmania has ‘in principle’ agreement on Codes of Practice ratified by the Board
3. SA- the definition of auxiliary practice in regulations currently being negotiated, except practice ownership/employment as neither therapists nor hygienists are able to own practices as there is the expectation that they would be employed by a dentist.
this time and was subsequently updated as developments occurred (see Appendix 9) through electronic mail contact with project officers. Project officers were also asked to identify key stakeholders in each state and to make predictions about the time-lines for completion their reviews.

The resulting dental practice legislation in each state has been analysed and summarised using the set of regulatory indicators developed in the Victorian case study (See Table 6.2).

6.1.3 Comparative case studies; Selection of sites and methods

Two case sites were selected for study based on variance among these outcomes. Tasmania has shown the greatest variation from Victoria by imposing the least restrictions on the practice of dental therapy and hygiene and New South Wales has shown the least amount of change. These two sites were therefore selected as case study sites.

Phase 2: Data collection and analysis for interstate case studies

Following selection of case sites data collection was carried out using three methods:
1. Examination and analysis of legislation following NCP Review processes
2. Analysis of interpretive documents and parliamentary transcripts
3. Semi structured interviews with key policy actors

Cases studies of the New South Wales and Tasmanian reviews have been developed and examined using the themes developed from the Victorian case study (see Table 6.1). Table 6.3 summarises the data sources, data collection methods and key questions to be addressed within the New South Wales and Tasmanian case studies.

This participant selection was based on the likelihood that they would offer a broad range of perspectives. Interviews were carried out by telephone and tape recorded, with extensive notes also taken. These interviews were then transcribed as soon as possible following the interviews. They were then triangulated with the use of documentary material from government websites, policy documents, discussion papers, parliamentary transcripts and legislation, stakeholder submissions, newsletters and press articles. This material was then analysed against the theoretical areas
developed by the Victorian Case study. The results of the Tasmanian and New South Wales case studies are presented in the following sections.

<table>
<thead>
<tr>
<th>Emergent hypotheses</th>
<th>Methods</th>
<th>Data sources</th>
<th>Key questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional dominance</td>
<td>Semi-structured interviews with key stakeholders*</td>
<td>Review project officer ADA, DTA, DHA</td>
<td>How were agendas set? Who benefited from the outcomes? What structural mechanisms are still in place?</td>
</tr>
<tr>
<td>Access to care</td>
<td>Documentary sources</td>
<td>Measure regulatory outcomes against access criteria as above (and NCP)</td>
<td>What capacity is there to increase access to dental care?</td>
</tr>
<tr>
<td>Technical efficiency and structural dominance</td>
<td>Semi structured interviews with key stakeholders*</td>
<td>Examine legislation- Board structure, participation Review project officer, ADA, DTA, DHA</td>
<td>Has professional dominance of dentists been altered by this? Are corporatists/equal health advocates more apparent? How does this contribute to theories of de-professionalisation?</td>
</tr>
<tr>
<td>Generate change vs protect the status quo</td>
<td>Documentary sources</td>
<td>Analyse old &amp; new legislation, Issues papers, submissions Recommendations, Hansard Board registrars or project officers to develop detail of interpretation</td>
<td>What does this tell us about policy making models? Does it support/discredit incrementalist models?</td>
</tr>
<tr>
<td>Evidence based policy making</td>
<td>Documentary sources Semi structured interviews with key stakeholders*</td>
<td>Look at key submissions, stakeholder web sites, newsletters, submissions Review project officer, ADA, DTA, DHA</td>
<td>How has evidence been used? Is evidence important to policy making? Rational comprehensive policy model supported/discredited?</td>
</tr>
<tr>
<td>Leadership</td>
<td>Semi structured interviews with key stakeholders*</td>
<td>Review project officer, ADA, DTA, DHA</td>
<td>Garbage can model? How important is leadership? Which actions are important? What can we learn from this?</td>
</tr>
</tbody>
</table>

*Interview participants were representatives of the respective state branches of the Australian Dental Association (with exception of one state where the invitation to participate was declined), and the Dental Therapists Associations and a more neutral participant such as the review’s project manager.
6.2 A case study of the Tasmanian Dental Legislation Review

6.2.1 Introduction

Prior to the dental legislation review, Tasmanian dental care providers were regulated under three Acts. The Dental Act of 1982 regulated the practice of dentists and specialists. The School Dental Therapy Services Act of 1965 allowed dental therapists to practice under exemption from the Dental Act as employees of the School Dental Services. Dental prosthetists were regulated under the Dental Prosthetists Registration Act 1996 and dental hygienists could not practice legally in Tasmania. Both the Dental and Dental Prosthetists Acts were administered by separate boards. The Dental Services Advisory Committee, established by the School Dental Therapy Services Act 1999 had a training oversight rather than regulatory role. The Poisons Act and the Radiation Safety Act also intersect with dental legislation in order to allow for the use of certain drugs and radiography for dental procedures.

The National Competition Policy (NCP) initiated review of Tasmania’s Dental Act began formally towards the end of 1999 (Int, ADTA 1999). The Department of Health and Human Services (TDHHS) had however, already met with the Australian Dental Association Tasmanian Branch (ADATB) and the Dental Board’s CEO in early 1998 to discuss the review (ADATB April 1998). Discussions about a review of dental legislation in Tasmania had occurred several times since the early 1990s. This had been mostly related to amending the existing legislation to allow for the employment by dentists of dental hygienists (Int1 x2, ADATB Oct 2001).

The process was less formal than the Victorian one in that it was delegated to the state Health and Human Services Department’s legislation unit and largely consisted of discretionary consultations. Also, like the New South Wales processes, the Dental Technicians and Prosthodontists Act was not included in the review. The review’s

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4 Government of Tasmania, School Dental Therapy Services Act 1965, also Jackson J, Hansard, April 13 1999, debate, School Dental Therapy Services Act Amendment 1999
5 "The Dental Prosthetists Act was not listed for NCP review: the only issue would be advertising controls but they are relatively simple... (and) ...the review would really have been about justifying the registration of dental prosthetists which is pretty self-evident." Personal communication with Tasmanian Department of Health and Human Services, Feb 2002
manager had been responsible for all NCP reviews of health practitioner legislation in the state and there was a template or model in place upon which the dental legislation was based. There was no issues paper but policy documents drawn from other states (Victoria and South Australia) and informal submissions served as a basis for discussion and development of legislative frameworks which were progressively refined through consultations (Int x2). Consequently, little documentary evidence is available other than the legislation and the report to the Minister making recommendations for legislative change arising out of the review. Evidence presented here comes from two interviews (Int) with key participants, the previously mentioned documents and ADATB publications. The Australian Dental Association Tasmanian Branch declined an invitation to participate in an interview.

6.2.2 Context of the review

In November 1997, following the withdrawal of federal funding of the Commonwealth Dental Health Program, a review of the Tasmanian Dental Services was commissioned to consider the delivery of dental services in the state ‘...in the context of national best practice’. This review recommended that legislation be amended to allow for the practice of dental hygienists in Tasmania, dental therapists in the private sector and the introduction of a new ‘combined’ dental auxiliary to the public sector to provide treatment to adults. In 1999, an amendment was made to the School Dental Therapy Service Act 1965 to create the conditions under which a dental therapist could provide services to people over the age of 16 years and to allow for the provision of additional training of dental therapists to enable a trial. This came to be referred to as ‘the adult trial legislation’. The trial was to test the use of dental therapists with adults in an effort to address adult public sector waiting lists as recommended by the Dever review (TDHHS Nov 1997). Under this legislation, dental therapists working under the direct supervision of a dentist could provide

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6 Interview material indicates that the dentists disciplinary model was different to the template and was later incorporated because it was considered to be a better model (Int)

7 Legislation will be amended to enable the introduction of a dental auxiliary who combined the skills of a dental hygienist and a dental therapist. The auxiliary will only be able to practice in the public sector, on prescription and under the direct supervision of a registered dentist when treating patients 16 years and over.’ JG Dever (1997) Review of Publicly Funded Dental Services in Tasmania, November 1997 (Dr Garth Dever, at the time was the Director of Westmead Hospital Dental Clinical School, Sydney NSW)

8 State Government of Tasmania, Dental Amendment Regulations 2000
services prescribed or directed by a dentist. This legislation was to expire five years after its commencement.

This legislation had been developed under contested conditions. Dental therapists in Tasmania had not previously been regulated in this way. They had practiced under the School Dental Therapy Services Act 1965 which was administered by a seven member committee, three of whom were Australian Dental Association members. It did not prescribe the relationship between a therapist and a dentist nor a scope of practice for dental therapists. In fact school dental service procedural policies had specifically instructed dentists not to interfere with the diagnosis and treatment planning of therapists, and had always allowed for therapists to practice within the range of their training (TSDS 1965). Dental therapists had been unhappy with the demand for supervision and prescription under the ‘Adult Trial’ amendments, while dentists had been unhappy with the concept of therapists treating adults (ADATB Jan 1998, Int). To date, this trial has not been held although since 1998, the competencies required by dental therapists to provide adult services have been identified, a project officer appointed and a business case has been developed to invite tenders for the training portion of the project.

6.2.3 Stakeholders’ positions

Interview data and documentary evidence was used to establish the views of the various stakeholders or policy actors in the review process. Table 6.4 below presents their positions. Each tick represents material collected in an interview and footnotes identify documentary sources of evidence corroborating these assertions.

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9 'Under plans presented to the Tasmanian Government, it is proposed that adults seeking dental care in the public sector will be treated by non-dentists in a callous disregard for the high dental standards enjoyed by the rest of the Australian community... described by (the federal) President of the ADA as “a brave but foolhardy experiment on the disadvantaged members of our community...”'(and by the Executive Director of the ADA as a)’...“bizarre attempt at providing what will be second class dental treatment...in a misguided attempt to save money”...‘(and by) the president of the Tasmanian Branch of the ADA...who says he is “shocked to learn that the government would actually contemplate such a measure”’ (ADATB Media Release, Feb 1998)
10 School Dental Therapy Services Act 1965
11 Researcher’s personal engagement with policy process in 1998-99, also Interview Data Oct 2001
12 Personal communications, Dr. Rosemary Cane, September 2001, ADATB Newsletter June/July 2000
Table 6.4  Stakeholder positions in the Tasmanian dental legislation review

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Position</th>
<th>Source</th>
</tr>
</thead>
</table>
| **Australian Dental Association Tasmanian Branch (ADATB)** | Single Dental Act<sup>3</sup>  
Retention of title and practice regulation, including specialist titles<sup>14</sup>  
Support introduction of hygienists in Tasmania<sup>15</sup>  
Dental therapists continue to be restricted to the public sector<sup>16</sup>  
Oppose therapists treating adults/ retain age limits<sup>17,18</sup>  
Opposes new public sector auxiliary but if introduced, should be restricted to public sector<sup>19</sup>  
Dental auxiliaries work under direction, and supervision of a dentist<sup>20</sup>  
supervision must be written into the Act<sup>21</sup>  
Dental auxiliaries to be employed by dentists (no independent practice)<sup>22</sup>  
Wanted a prescriptive list of duties for auxiliaries<sup>23</sup>  
Specified levels of training for auxiliaries should be adopted<sup>23</sup>  
Penalties for illegal practice increased<sup>24</sup>  
Dental board should consist 5 dentists and 2 consumers, elected chairperson<sup>25</sup>  
dentist chair<sup>26</sup>  
no auxiliaries<sup>27</sup>  
Partnerships between dentists and specialists restricted<sup>28</sup>  
Retain practice ownership limits with dentists<sup>29</sup>  
All practice owners to be registered by the Board<sup>30</sup>  
                                                                 | "...The ADA has influential people all over the place, their practices are next door to minister’s offices...they mix in the same social circles...they are a significant lobby group...a senior profession..." (Int) |
| **Tasmanian Dental Therapists Association (TDTA)**  | Practice according to educational preparation (no lists)<sup>31</sup>  
Age limits removed<sup>31</sup>  
No supervision- collaborative model allowing referral where needed<sup>32</sup>  
Registration<sup>33</sup>  
Remove employment limits<sup>33</sup>  
Retain existing capacities and autonomy<sup>33</sup>  
Wanted separate Board seat for each auxiliary<sup>33</sup>  | "...(they) were very green in the beginning but ...learnt a lot...did the leg work, developed the networks, asked for help from experienced people..." (Int)  
"...they don’t have the power of the ADA, but they did have more clout than the Board..." (Int) |

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<sup>13</sup> ADATB Newsletter Dec 1998, Vol 6 No 6  
<sup>14</sup> (ADATB) Australian Dental Association Tasmanian Branch Inc., Feb 1999) Newsletter, Vol 7 No 1 discusses ADATB submission, includes all the points listed below  
<sup>15</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>16</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>17</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>18</sup> ADATB Newsletter, homeless, from the President; Sept/Oct 2000, vol 8 No 4  
<sup>19</sup> ADATB Newsletter Dec 1998, Vol 6 No 6, ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>20</sup> ADATB Newsletter Feb 1999, Vol 7 No 1 ‘... with the dentist responsible for the actions and consequences of treatment by a dental auxiliary...’  
<sup>21</sup> ADATB Newsletter, homeless, from the President; Sept/Oct 2000, vol 8 No 4  
<sup>22</sup> ‘...she kept wagging her finger at me and saying, “You’ll have a list of duties or we’ll make you; the Board will make you”...’ (Int) also ADATB Newsletter Dec 1998, Vol 6 No 6  
<sup>23</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>24</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>25</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>26</sup> ADATB Newsletter, homeless, from the President; Sept/Oct 2000, vol 8 No 4  
<sup>27</sup> ADATB Newsletter Dec 1998, Vol 6 No 6  
<sup>28</sup> ADATB Newsletter Feb 1999, Vol 7 No 1  
<sup>29</sup> ADATB Newsletter Dec 1998, Vol 6 No 6  
<sup>30</sup> ADATB Newsletter, homeless, from the President; April 2000, vol 8 No 2  
<sup>31</sup> ADATB Newsletter, homeless, from the President; April 2000, vol 8 No 2  
<sup>32</sup> ADATB Newsletter, homeless, from the President; April 2000, vol 8 No 2
| Dental Hygienists Association of Australia Inc (DHAA) | "...because there are no hygienists here they were harder...we had to go through their national body...they didn't really engage there were not sufficient issues... 'Int' |
| Wanted hygienists to be able to practice in Tas✓✓ | |
| Wanted separate Board seat for each auxiliary✓✓ | |
| Not concerned about supervision?✓33 | |
| Registration?✓ | |
| Opposed one-to-one ratios for supervision✓ | |

| Dental Board of Tasmania | "...Members often had more than one hat on... 'Int' |
| Supported introduction of hygienists✓ | |
| Wanted to control what therapists and hygienists did in a prescriptive way✓✓ | |
| Opposed to independent practice for auxiliaries- they should only be employed by dentists✓ | |

| Womens Advisory Lobby | |
| Wanted to fight inequality and anti-discrimination issues✓ | |

| ACROSS | |
| Sympathetic to the needs of people with unmet needs for dental care✓ | |

| Department of Health & Human Services (TDHHS) (Oral & Dental Services) | "...The department didn’t really engage formally...but if the outcome had been unacceptable to them they might have... 'Int' |
| Retention of adult trial legislation (1999 Amendment) ✓✓ | |
| Wanted to address shortages of services to adults, growing public sector waiting times, increases in emergency services✓✓38 | |
| Concerned about potential loss of DTs to private sector if legislation allowed it✓ shortages of therapists35 | |
| Shifting some demand for dental services into private sector36✓ | |
| Equity, access to services, rural access✓37 | |

### 6.2.4 Policy Outputs

Note that the bracketted initials and numerals (eg S33(2)) in this section refer to parts (P), divisions(D), sections (S) and sub-sections of the Tasmanian Dental Practitioners Registration Act 2001.

In March 2001, TDHHS made recommendations to the Minister about the Review of the dental legislation. In April 2001, the Parliament of Tasmania repealed the Dental Act 1989 and the School Dental Therapy Services Act of 1965 and replaced them with the Dental Practitioners Registration Act 2001. It was also necessary to amend the Poisons Act 197138 and Radiation Control Act to allow for dental therapy practice.

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33 Some interview data indicated that the hygienists agreed with the therapists' approach to supervision and some indicated that they weren't concerned about it. In their April 2000 newsletter The ADTATB President stated, "...Interestingly in my discussions with the president of the Australian Dental Hygienists Association there have not been any areas of disagreement."


35 as above
36 as above p34
37 as above p36
38 The regulations attached to this Act required amendment because of the repeal of the School Dental Therapy Services Act; see (Poisons Amendment (Dental Therapists) Regulations 2001, Parliament of Tasmania)
The key outcomes from this review were the decisions related to dental auxiliary practice. Dental hygienists’ practice was enabled, the employment limits on dental therapists were removed and both may own practices. The intent of the Dental Practitioners Registration Act 2001 (TDPR Act) is to allow both auxiliaries to practice independently in their own practices so long as they have established, with an identified dentist, mechanisms for consultation and referral of patients who have needs beyond their skills. Dental therapists and hygienists are to be registered and each profession will have a seat on the eight member Board along with four dentists and two consumers, all of whom are to be appointed by the Minister (TDPR Act 2001).

The legislation relating to the Adult Trial was retained as a Schedule to the Act with a life of three years from commencement39 and as a consequence, the age range for dental therapists’ clients was retained in the short term. Definition of practice (dentistry) is included in the Act with practical guidance in relation to scope of practice and referral arrangements to be developed in by-laws under a Dental Code (S11, TDPR Act). The wording of the Act in this area is not specific to dental auxiliaries but refers to dental practitioners40 including specialists.

The new legislation does not restrict dental practice ownership but does require that services be under the control of and provided by registered persons (S64) and may require corporations providing dental services to provide information about shareholdings, management or operations (S74). Section 65 also makes it an offence to ‘...direct, induce or allow an employee...to provide a dental service...in a way that is or is likely to be detrimental to patient welfare.’ These provisions were put in place to address concerns about commercial interests overriding the standards of care in importance (TDHHS March 2001, Jackson 2001).

Under the 1989 Dental Act, the board had the power to make regulations about how dental practices could advertise their services. This power has been removed under

39 Schedule 4: Savings and Transitional, S 9(1) states that ‘During the three year period following commencement day, a person who is registered as a dental therapist may practice dentistry on persons who have attained the age of 16 years...’ under the same conditions as the previous amendment (employed in the public sector, with qualifications or expertise determined by the Minister, under direct supervision and prescription)
40 S11(2) states ‘...the by-laws may provide practical guidance and direction to ensure that practitioners
(a) carry out procedures and, provide advice, within the scope of their training, acquired skills and competency; and
(b) have in place satisfactory consultation and referral arrangements.’
the 2001 Act. Fair trading controls have been applied using the provisions of the Commonwealth’s Trade Practices Act and the Tasmanian Fair Trading Act (TDHHS March 2001, Jackson 2001)

A further outcome was the drafting of an agreement between the professions which was to form the basis of a Dental Code. This ‘Dental Practitioners Code of Practice; Working Draft’, dated March 2001 was ratified by the new Dental Practitioners Registration Board in December 2001\(^4\). This code contains a series of by-laws for the purpose of providing practical guidance to practitioners in the practice of dentistry in Tasmania\(^2\). It did not prescribe the skills or ‘duties’ a dental therapist or hygienist could practice, it did not restrict their ability to practice independently or prescribe the practicing relationships they must have with a dentist (eg supervision). It did require them to practice within their training, acquired skills and competence (Dental Board of Tasmania 2001).

6.2.5 Who benefited from the outcomes?

Lukes (1974) argued that the distribution of power in a policy process can be gauged from an analysis of who benefits from particular policy outcomes or decisions (see section 2.2). Table 6.5 below assesses the outcomes of the Tasmanian Legislation Review in these terms.

The overall picture of where the benefits flow suggests that therapists, hygienists and consumers served to gain more from this legislation review than dentists. There is no doubt that these groups will benefit from the removal of gatekeeper controls over practice and the potential competition it creates. Dentists have lost monopoly control over the dental market but have retained control in other areas such as over the Board and through a loss of separate legislation, the regulation of dental therapist’s

\(^4\) Personal communication with Tasmanian DPR Board member, January 2002
\(^2\) It requires that a dental auxiliary practice dentistry ‘...within the scope of training, acquired skills and competency of the auxiliary.’ It also requires that an auxiliary provide to the Board, the name and practice address of the employing dentist(s). Where an auxiliary is not employed by a dentist, they must enter into a formal agreement with at least one dentist who acts as a dental consultant and accepts referrals for treatment and advice beyond the scope of the dental auxiliary. The code also provides for an agreement to be made between a dental auxiliary and dentist, ‘...which could include, depending on their negotiated preferences, references to each parties’...responsibilities...procedures to be undertaken and advice to be given...an undertaking to comply with the Act in relation to the Auxiliary’s scope of practice and other terms and conditions including supervision as may be agreed to. The code also allows for a dental auxiliary to appeal to the Board where ‘...a dentist may have unreasonably withheld consent to enter into an arrangement...’ as referred to above. (Dental Board of Tasmania, March 2001)
practice. Further, there was no challenge to the dominant model of private practice dominated and market based service delivery

Table 6.5 Outcomes of the Tasmanian Dental Legislation Review and their implications

<table>
<thead>
<tr>
<th>Tasmanian Dental Practitioners Registration Act 2001</th>
<th>Who benefited?</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board</strong>: 8 members 4 Dentists 1 Dental Therapist 1 Dental Hygienist (later) 2 Consumers</td>
<td>Therapists, Hygienists &amp; consumers Dentists</td>
<td>Achieved a voice at policy level Policy dominance of dentists altered Power to make codes of practice at Board Lost exclusive membership but still have a majority especially initially prior to appointment of a hygienist Therapists now regulated under same Act</td>
</tr>
<tr>
<td><strong>Registered</strong>: Dentists, Specialists, Therapists Hygienists</td>
<td>Therapists &amp; Hygienists Consumers</td>
<td>DT &amp; DH status increased- responsible for own acts. Less need for other limits on practice Better access to service choices</td>
</tr>
<tr>
<td><strong>Gatekeeper controls- eg supervision</strong> May be in Codes- prelim agreement excludes them</td>
<td>Consumers</td>
<td>Reduced costs of services if no supervision, prescription etc. allowing primary care role Outreach, nursing home, isolated practice service opportunities increased for hygienists</td>
</tr>
<tr>
<td><strong>Employment limits</strong> None, Independent practice allowed-</td>
<td>Therapists &amp; Hygienists Consumers</td>
<td>Wider employment opportunities, autonomy Reduced costs of services More service choices, potentially more competition</td>
</tr>
<tr>
<td><strong>Client Groups; Therapists</strong>:0-16yrs + trial</td>
<td>Dentists</td>
<td>Kept lid on client groups of therapists in short term- adult trial may not happen</td>
</tr>
<tr>
<td><strong>Scope of practice; defined in Codes; preliminary agreement says ‘...based on education, competence and acquired skills...’</strong></td>
<td>Consumers Therapists &amp; Hygienists</td>
<td>More flexibility to utilise skills, respond to change and be innovative- greater potential to provide responsive services and reduce costs of service More diversity in roles- raises profile</td>
</tr>
<tr>
<td><strong>Ownership limits</strong>: none</td>
<td>Therapists &amp; Hygienists Consumers</td>
<td>DTs, DHs and other non-dentists may own practices May introduce more competitive pricing Opportunity for external evaluative measures where multi-practice corporate owners</td>
</tr>
<tr>
<td><strong>Advertising limits, None- Fair Trading Act applies</strong></td>
<td>Consumers Therapists &amp; Hygienists</td>
<td>More information available Raises profile of these providers- increases consumer choice May increase transaction costs: Increased costs of advertising passed on. Sometimes more difficult for consumers to get good information because of ‘marketing’ language</td>
</tr>
</tbody>
</table>

6.2.6 Shaping the policy culture

As discussed earlier, Considine (1994) argues that policy outputs are the result of a policy culture negotiated between policy actors and mediated by the policy institution. The culture of the policy system is shaped by deliberate actions and
discourses so that particular policy outputs are produced. This section develops the analysis to show the way the culture in the Tasmanian policy system was shaped to deliver the outputs described above.

There were key differences to the Victorian review outcomes related to independent practice by dental therapists and hygienists and the separate regulation of dental prosthetists and technicians. The new Tasmanian legislation treated dentists and dental therapists and hygienists equally, registering them and allowing them to own practices. There is the intention to allow them to practice independently and to provide those services that their education, acquired skills and competence allows and this is outlined in the recommendations to the Minister for Health (TDHHS March 2001) and the draft Dental Codes. These different outcomes suggest that the shape of the policy culture in Tasmania was quite different to those of the Victorian and NSW reviews (discussed later).

The reasons for this appear to be connected to the position taken by the policy institution including the manager of the legislation review, the Minister and Treasury (ADATB Oct 1999, ADATB April 2000, ADATB June/July 2000). Interview data indicate that there was a view from within government that regulation should be about determining who was competent to provide dental services and not how they should be provided. Under the NCP agenda, business ownership was not to be protected. Therefore, the only interest the Act needed to have was in ensuring that only competent and safe providers were registered; their business and employment arrangements were not part of its remit.

"...this was not an issue for the legislation because it is not about who employs you but about protecting the public- we register these people and where they work is not an issue for the regulation so long as the protections are there in relation to safe service provision. The codes need to put in place the appropriate structures for therapists and hygienists to have advice and support when they need it- (the type of practitioner) is an issue for the consumer to decide as they do already with specialists..." (Int)

Under this thinking, the Act could not be used to define inter-professional relationships and the acceptance of a qualification for registration meant that registered persons then provided the services they were educated and competent to provide:

"Our therapists have always been trained in different places with different skills, especially since the school closed at the end of the 80s, having a list of things they could or could not do was not logical. ' (Int)
This same thinking meant that the retention of employment boundaries and age limits for therapists was also not defendable.

‘...they had worked with a significant degree of independence, without dentist supervision that is in some of the other states legislation...they provide free standing services to children in schools and community clinics often with dentists very far away- they effectively operate their own practices (clinics)...’ (Int)

From the Review’s perspective this thinking shaped the agenda in that the control that the dentists wanted to have over the practice of therapists and hygienists could not then be part of the debate. The review’s outcomes had to be argued on competitive and public protection grounds and be consistent with the other Acts. These concepts had existed in the Victorian environment but had not survived the political process in the same way they did in Tasmania. This may have been due to the less public nature of the review and the control the project officer had over it.

Further, there was a clear challenge to the dentists’ sovereign expertise over dentistry. An aspect of professional dominance that is used to protect the position of the professions is the deliberate use of a mystique of knowledge; the aura of complexity and expertise that is created and reinforced around the discrete knowledge of a discipline (Larson 1977, Larkin 1980, Willis 1989, Turner1995, Considine 1994). Professions use their specialised knowledge and experience as a basis for maintaining power over their clients and managers by insisting that only they have the expertise to interpret and apply esoteric knowledge in the exercise of their discipline. This mystique of interpretation was challenged in this case by firstly, the Dever Review (TDHHS 1997) and then by the therapists with the Minister for Health:

‘...I remember at one meeting we had (the Minister) was quoting... a lot of ADA phrases about cutting auxiliaries and irreparable damage.... I said, ’For goodness sake , it isn’t that hard- it’s just a technical skill- anyone can learn it, there’s no big mystery about it’. She looked a bit stunned at that and I think I convinced her that perhaps the dentists weren’t as expert, and we weren’t as big a risk as they were making out... ’ (Int )

When faced with the dentists’ arguments that they were the only ethical and qualified people who should be allowed to practice dentistry, an alternative view was in place. This has had the effect of raising questions about the unique expertise of dentists and has replaced their single policy voice (sovereignty) with a more fragmented and contested model.
The shortage of dentists in Tasmania had been an identified and accepted policy issue. The government had already moved, through an earlier policy process, to develop the role of dental auxiliaries in the provision of adult services. The ADATB had opposed this legislation arguing that an increase in dentists could resolve the problem.

"In talking to dentists you really get, I guess, a picture of the industry in Tasmania and, to a person, every single one of them bemoans the fact there are not enough dentists in Tasmania. A lot of the questions have been about what the State Government is doing to get more dentists here because we all know the length of time that people on health cards are waiting for dental treatment in Tasmania." (Cheek (Opposition Spokesman for Health, Tasmanian House of Assembly) March 2001)

They had argued that using therapists to treat adults would result in two tiers of dental services. However both the government and the opposition (who, as the previous government, had initiated the Dever Review and supported its findings) had endorsed the quality of services provided by dental therapists and supported the concept despite ADATB opposition. The process of developing the amendments for the ‘adult trial’ in 1999 had given the parliament a good understanding of the role and skills of dental therapists and had elicited significant support for their role. Second reading speeches and debates in both chambers make reference to the ‘…absolutely reject(ion of) the statement that dental therapists’ work is somehow inferior to dentists’…’ and ‘…absolutely wonderful…’ work of dental therapists, and of ‘…entrust(ing) one of our most vulnerable groups - the children - to the acknowledged skills and competencies of a dental therapist …’ and ‘…I believe that our young and our aged will feel confident with the dental therapists…” (Jackson 1999, Madill 1999, Squibb 1999). Further, the dentists had come in for some criticisms during this debate that apparently diminished their standing with the government:

‘…The dental action group has some concerns about comments made by the Minister during the debate and in committee, in that they indicate we may not be well heard, particularly with the Dental Act to be reviewed in the next few months…” (ADATB April 1999);

Recall also, that dental therapists in Tasmania had never had their practice prescribed by lists of duties or been required by the Act to work under supervision as had the other states. This, combined with the reputedly diminished standing of the ADATB and the approach the government had taken to legislation under NCP,

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43 See Hansard, School Dental Therapy Services Act Amendments, second reading speech and debates April 1999. See also, TDIHHS Annual Report 2000-2001
44 School Dental Therapy Services Act 1965. Referral mechanisms had been defined under management procedures (Personal communication with TDTA, 2001).
resulted in a perception within government that change should occur, and a policy environment that would challenge the dentists’ conception of dentistry.

This was demonstrated by the actions related to subordinate legislation. The making of Codes of Practice for dental auxiliaries became a defacto part of the legislation review despite the fact that the new legislation delegated it to the new Board. In practical terms, the negotiation was achieved by the key stakeholders during the Review of the Act at the suggestion of the review’s project officer (Int x2, ADATB April 2000). Despite a difficult and prolonged process\(^45\), the stakeholders achieved agreement on a draft document which was apparently mediated by the registrar of the old Board\(^46\). This draft was adopted by the newly appointed Board as a working document in October 2001\(^47\). This suggests a directive approach by the government in order to achieve an outcome that matched their agenda. Had a resolution not been achieved, there was a suggestion that decision making power may have been retained by government and defined through regulations rather than codes of practice (Int).

Bachrach and Baratz (1962) described coercive power and observed that it was often exercised to effect non-decision making (Lukes 1974, Ham and Hill 1993, Hancock 1999). The effect of this is to limit the scope of decision making to only those issues which do not represent a challenge to the resources of power of the ‘elites’ (Lukes 1974). The ADATB attempted to exercise this type of two dimensional power by refusing to negotiate over the Codes, relying on their power as the dominant stakeholders in the process to force their views to prevail. In this case, they wanted to ensure that there was a list of ‘duties’ and prescribed dentist supervision of dental

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\(^45\) Interview data indicates that representatives of the TDTA began to meet with the ADATB and the Board in an effort to develop agreement about a code of practice. It became apparent fairly quickly that this was a difficult task because both the Board and the ADATB were determined to have therapists and hygienists working under the direction and supervision of a dentist carrying out tasks from a prescribed list of duties. This did not reflect what had been happening in practice, nor in the view of the therapists did it fit in with the thrust of the legislation. They sought other models and made some proposals about wording which were rejected outright by the dentists and the meetings soon ceased. (see Dental Board stakeholder position, ADATB newsletter April 2000 Vol8 No21 In a letter from the ADATB (Dec 1999b) to then president of the TDTA, the ADATB stated that ‘...the Dental Board has requested ADA input in developing guidelines for dental auxiliaries. Attached please find a list of duties based on the Federal ADA Guidelines and Codes of practice for dental auxiliary personnel, for your information and comment...’. The ADATB newsletter of Dec 1999 similarly stated that the president and CEO of the ADATB ‘...are having meetings with ...the registrar of the Dental Board on the proposed duties and qualifications for dental hygienists. We hope to have recommendations for our respective bodies by February 2000.’

\(^46\) ‘...the Registrar had previously offered his help in developing this code but had not been involved in the negotiations because of his role in administering the Act rather than being a stakeholder...In the end he) drafted it in a way that reflected what the legislation was doing... negotiated the minor adjustments and got agreement...’

\(^47\) See also, Jackson, J (Minister for Health and Human Services) committee stage, Second Reading of the Bill, March 2001
therapists and hygienists and that negotiation should occur around the wording. They overestimated their power in the process and were circumvented when the therapists worked with other people (in this case, agents of government) to develop an option which excluded this, and that suited the government agenda.

The composition of the Board however, is illustrative of the continuing attempts of the dentists to alter the policy environment. The original composition of the Board had seven members three of whom were dentists. Continued pressure from the ADATB saw the number of dentists increased to four in an eight member Board (TDHHS March 2001, ADATB Sept/Oct 2000)\textsuperscript{48}. The other feature is that while the dentists technically lost numerical dominance at Board level, they gained more power over dental therapists than they had previously had through the creation of a single Act. The argument that there were such small numbers of practitioners that it was impractical to have two Acts\textsuperscript{49} has merit however it is inconsistent with other Tasmanian legislation\textsuperscript{50}. There are currently 47 practising dental therapists and while there are no dental hygienists there is an expectation that their numbers will grow fairly rapidly once they are legitimated. It seems that the potential to amend the School Dental Therapy Services Act to include the practice of dental hygiene and deregulate the practice of dental therapy was not discussed. It is also interesting to note that the original intention was to also incorporate the Dental Prosthetists Act into the Review and develop a single piece of legislation\textsuperscript{51}. That this did not happen raises questions, about the power of the Dental Prosthetist lobby.

The age limits on dental therapist’s client groups was also illustrative of the contested nature of the policy culture. TDHHS’ Oral and Dental Services argued that the ‘adult trial’ legislation had to be retained in order to allow a trial to evaluate the provision of adult dental services by dental therapists in order that unmet demand for adult services could be addressed (Int). Under the NCP agenda, the adult trial legislation could simply have been repealed, making the new Act silent on the age limits for dental therapists’ clients which would allow a trial to go ahead anyway. Therapists’

\textsuperscript{47} personal communication with Board member, Dec 2001
\textsuperscript{48} “... (the ADATB) wanted to keep adding to the Board to make sure they had the numbers...” (Int)
\textsuperscript{49} “...there are only about 200 practitioners- it almost pre-determines a single act...” (Int)
\textsuperscript{50} The Annual Report for 2000-2001, Tas Dept Health and Human Services records the Chiropractors and Osteopaths Registration Board as having 55 registrants, the Dental Prosthetists Registration Board as having 52 registrants and the Podiatrists Registration Board records 60 registrants in 2000.
client groups could then be defined under a code of practice and adjusted in response to the trial, or remain undefined allowing the ‘dental market’ to determine the boundaries naturally. Retaining that legislation allowed the age range for dental therapists to be retained in the Act thus meeting the ADATB agenda. There is still a view that the ADATB believes it will be able to control the Codes of Practice based on their numerical dominance of the Board (Int) and one could take the view that, based on past experiences, there may be difficulties in ever establishing the adult trial. Evidence suggests that the ADATB were opposed to a trial but ‘…didn’t fight it too much’. The argument from the public sector to retain the ‘adult trial’ legislation effectively achieved a ‘non-decision’ in the area, allowing the status quo to be retained.

The amendments to the Poisons Act however, seem designed to prevent independent practice being possible\(^{52}\). Concurrent to the final stages of the review, amendment was made to the Poisons Act in order to complement the new dental legislation. Effectively, the wording of this amendment re-applied gatekeeper barriers to dental therapist practice as it prevents dental therapists from purchasing and administering local anaesthesia, and providing some other procedures including fluoride treatments and fissure sealants without the supervision of a dentist. This amendment serves to benefit the dentists because it reinstates a mechanism they sought to have in the dental legislation and a barrier to direct competition. It appears that an attempt was made to manipulate one part of the legislative environment to thwart the changes being made by another part. Of interest is the effect it may also have on dental hygienist practice as they seem to have no capacity to use the prescribed drugs at all.

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\(^{52}\) ADATB Newsletter April 1999, Vol 7, No2

\(^{52}\) The repeal of the School Dental Therapy Services Act 1965 forced amendment of the Drugs and Poisons Act 1971 to allow dental therapists to legally purchase, store and use local anaesthesia under the new dental legislation. The 2001 amendment to the Poisons Act says that ‘…dental therapists…may administer… (local anaesthesia) under the supervision and general direction of a dentist…’ (Poisons Amendment (Dental Therapists) Regulations 2001). These words effectively prevent them purchasing, storing or using it as independent practitioners because the regulations have retained the need for supervision and general direction of a dentist. This is in conflict with the Dental Practitioners Registration Act 2001. The wording was developed by the Manager of Dental Services under delegation from the Department of Health (Int). The TDTA was not consulted about the wording and are now in a position where the legality of their practice is under a cloud. Under the same regulations, they are also unable to administer fluorides, and use some other commonly utilised dental treatment materials without dentist supervision.
6.2.7 The use of evidence

Interview data indicates that evidence-based policy making was not an important part of this review. The only evidence used in the decision making process was that related to past experience rather than empirical material. Like the other states, the Tasmanian Review decided it would retain registration of dental practitioners. This was based on the ‘evidence’ that dental services present a danger to the public ‘...if undertaken by unqualified or untrained persons’ (TDHHS March 2001). Dental therapists had safely and reliably provided dental services to children in the state for thirty years providing ‘evidence’ that they should have their employment limits removed (Int). They and dental hygienists performed invasive procedures much like a dentist and therefore required registration. That some other states were already proceeding in this direction offered further ‘evidence’ and, after examining alternatives there didn’t seem a more effective way to protect the safety of the public. There was a view that it wasn’t the task of the legislation to look at evidence and technology- that was the role of the dental code (Int). In this case, little use was made of empirical material leading to the conclusions that the precedents set by other legislation and the practical and political aspects of the policy environment were more important.

6.2.8 Has the professional dominance of dentists been altered by this review?

The composition of the Board has altered the dentists’ position with only four out of eight members being dentists (where previously all members were dentists). There are two consumers and positions for both a dental therapist and a dental hygienist (S6(1) DPRAct 2001). Where split vote occurs, the matter is to be adjourned to the next meeting requiring negotiation to resolve the impasse rather than being decided by the president’s casting vote as in the Victorian Act (Schedule 2, S4,Tas DPR Act). Also unlike Victoria, the role of president of the Board is not protected for dentists. Committee debate in the lower house had indicated that while the new act gave the Minister for Health the power to appoint a chair, that this would be a reserve power and that the intention is to allow the Board members to make a recommendation (Jackson 2001). In the areas of membership, leadership and veto power, the dominance of the dentists has been diminished.
As in Victoria, broadening board membership has the effect of increasing the diversity and transparency of decision making and its ability to protect the interests of the public. The inclusion of consumers strengthens the equal health advocate position (described by Alford in 1975) and develops a mix more reflective of the community (DOH 1990). Ministerial appointments of board members (rather than election by dentists) increases the power of government over the profession because of the ability to select individuals with specific interests and experiences (and potentially supportive of government policy). Having therapists and hygienists registered and appointed members of the Board means they are no longer 'excluded' from legitimacy in the dental market and increases their networks and experience at policy level. This in turn increases their capacity to influence policy and decreases dentist sovereignty over the industry. The Board still has the capacity to apply the mystique of interpretation for dental matters but the interpretation can be challenged and must be explained to others which diminishes somewhat, its ability to be used as a tool of power. The autonomy, authority and sovereignty of dentists over dentistry has been reduced by altering the mix of people responsible for administering the Dental Practitioners Registration Act.

Of interest in this policy process is the alliance of dentists. In Victoria, there was a distinct split between the ‘professional monopolist’ dentists represented by the ADAVB and the ‘corporate rationalist/equal health advocate’ (public sector) dentists. The Tasmanian dentists however remained more organisationally aligned, with public sector services being managed by a dentist who was also a member of the ADATB Executive and the Dental Board and apparently acting in the profession’s interests.  

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53 There was overlap in membership of the Dental Board and ADATB. There are small numbers of dentists in Tasmania compared to other states and their leaders tend to fill roles on the professional association executive as well as the Board (Int). For example, the Manager of the Tasmanian Dental Services was also a Dental Board member and a member of the ADATB executive. Another member of the Board was an office bearer for the federal branch of the Australian Dental Association. (ADATB newsletters in 1999 and 2000 and the TDHHS Annual Reports (1999-2000 and 2000-2001) show common membership of the ADATB executive and the Tasmanian Dental Board (five members) and management of Oral and Dental Services Branch of the TDHHS)  

54 Interview data suggests that the Manager of Dental Services made it quite clear to the TDTA that, in this instance the TDTA would have to advocate for the needs of therapists. It seems there was an attempt to separate the resources of the department from the TDTA. They were no longer allowed to have meetings on school dental services premises, therapists who were managers were discouraged from participating in the TDTA executive, clerical staff were discouraged from assisting and inaccurate accusations of misuse of work time and resources and personal criticisms began to circulate about the TDTA president and secretary. Eventually, harassment of executive members caused a resignation forcing a rearrangement of the association’s executive. At the time this was a great loss to the association’s expertise. The fallout from this was a tension within the association’s membership with some therapists questioning whether their loyalties should lay with the professional association or with their employers, the state Dental Services. There was also talk of ‘getting the therapists under control’. The Therapists’ Association then agreed to meet formally with the Dental Services management to develop
leaving the therapists to take the opposing policy positions of advocating for underserved interests. These relationships demonstrate an historically developed policy environment reproducing dentist sovereignty. While members of this profession were able to fill roles at public sector management, on Boards and as professional association advocates, the dominant policy position is heard and becomes so pervasive that it is difficult to challenge\textsuperscript{55}. This was the case until the Dever Review in 1997 in which an out-of-state public health dentist made recommendations to alter the status quo, drawing the attention of policy makers to alternative service models (TDHHS 1997).

At the time, the support of both sides of parliament for the amendments to dental therapy legislation to allow for the ‘adult trial’ laid the foundations for the current reforms. Despite several meetings with ministers, letters sent to parliamentary members, speeches made in parliamentary council, phone calls to the leader of the opposition on the day the legislation was to be debated, the ‘adult trial’ legislation was passed without amendment (Jackson 2001, ADATB April 1999). The Second Reading Speeches related to this legislation suggest that the lack of support from the ADATB for this proposal may have been partly responsible for the current policy culture of reduced support for the dentists’ position. So the reduction in sovereignty of dentists over dentistry had begun prior to this legislation review.

This reduction in professional dominance is also illustrated by the loss of protection of dental practice ownership. One effect of this can be to reduce the market monopoly power of dentists as owners by allowing people other than dentists to profit from dentistry. This alters the structural position of dentists as the exclusive owners and producers of dental services and diminishes their ability to ‘...\textit{constitute and manage a market for their own expertise...}’, one of the defining features of a profession (Larkin 1980, Turner 1995). In the longer term, it also alters the sovereignty of dentists because of the capacity for corporate interests to be introduced into the dental policy environment. There is also the flow on effect of redistributed financial resources arising from the ability of dental therapists and hygienists’ to

\textsuperscript{55} Lukes (1974) described third dimension power as that which so shapes the environment that people cannot conceive of other ways of doing things.
profit from dentistry and strengthen their own professional positions as discussed in section 5.3.

6.2.9 Has economic rationalism and technical efficiency altered the policy culture?

In Tasmania there had been incremental progress toward a more rationalised (outcome focussed) approach to resolving the problems of unmet need among adults. National competition policy provided the ammunition to make further changes and the government was supportive of a less protected industry. In this environment, there was an opportunity to challenge the structural dominance of the dentists but there was no corporate stakeholder or organised equal health advocate position in existence. In previous policy processes, the public sector had been the advocates for the role of dental therapists but this policy process presented challenges to traditional industry structures and professional power that altered this position.

Considine (1994) argues that there are structural supports for power that may determine the policy environment but the decision of participants to act or not will depend on their perception of the incentives to conform or react to the exercise of that power. In his view, action is a ‘double deal’. On the one hand structural power puts pressure on actors to conform in order that they retain the benefits this confers. On the other, all actors retain the capacity to push for concessions, and form new relationships and negotiate on their own terms. Both the dental therapists and the public sector dentists were forced to determine which position they would take. The evidence suggests that some public sector dentists chose to conform to traditional positions.

The therapists however, were forced into a position of acting in their own interests through the separation of their professional interests from the public sector interests in keeping them repressed. When they began to apply their own rationality to the problems a clear path emerged. They were also required, probably for the first time to draw entirely on their own resources to develop arguments and plans for action which required them to also learn ‘how to play the game’. They were subjected to pressures to conform to their old role but an assessment of the benefits of doing so indicated that while there were benefits in conforming, the risks of not doing so were not great.
Dental Services needed the co-operation of the therapists to provide services and the goals of the profession in this case agreed with the needs of the community and the policy incentives operating on the government. In this case, they formed new relationships and effected for themselves a legitimacy in the policy process which had previously been the domain of the dentists alone.

The structural power of professional monopolists which subordinates, limits and excludes particular actors can be difficult to overcome because the subordinated actor has little opportunity to develop skills, accumulate resources and be well enough informed to be an effective participant. The TDTA is a small organization of women who work for the government relying entirely on volunteer participants with little policy or advocacy experience. Pitting their resources against the ADATB which is a well resourced and staffed organization with political experience, elite connections and national resources along with historically legitimized power is not an even contest. To argue that each organization can make choices about the actions it takes, choosing to be compliant or assertive, does not adequately accommodate the social and organizational aspects of professional dominance. Certainly, actors can make choices about their participation and the role they will take but challenging the status quo is much more difficult for relatively powerless groups alone. In this case, the position taken by the therapists had support with the policy imperatives of the day, the government and the opposition. It also moved a pre-existing agenda forward incrementally.

Some policy mediators see widespread dissatisfaction with outcomes as evidence that the policy process was equitable. In this case, it has been observed that not everybody was happy with the outcomes (Int). However, like Victoria, this may simply indicate that those who are used to being powerful did not get their own way and that the re-arrangement of policy actor networks gave greater voice to those who are usually repressed.

56 The ADATB has membership comprising 95% of dentists in Tasmania (Int) and according to their 1998/99 Annual Report, had an income of $66,659 and assets of $192,000. They engaged a ‘professional political adviser and lobbyist and asked members for a special contribution of $100 per head in 1998. The federal association also generously supported the state branch to the tune of a $4,000 donation to the ‘Defence Fund’ (ADATB Newsletter Oct 1999 V7No5, and April 1999 Vol 7 No2, Dec 1998 Vol 6 No.6 and ADATB Annual Report 1998-99).

57 The Imperial Government Dental Act was proclaimed in Tasmania in 1878 giving title protection to dentists, the 1884 Act gave a local Board powers to examine and register dentists and the 1919 Act produced a Board to
6.2.10 Was leadership important?

Leadership in this case study takes in policy leadership as well as the more personal aspects. As in Victoria, leadership from the state was also very important in shaping the policy culture. It was the actions of the bureaucracy in support of NCP, a consistent approach to health practitioner regulation and a more rationalised approach to dental service delivery that shaped the institutional approach. The state’s experiences with dental therapists were cited as evidence of the need for change and the government had made an attempt to establish a new regulatory model. Further, earlier policy contact with the dentists’ association, and their inability to provide solutions to the problems the state was facing, seems to have developed a commitment to increasing the cultural value in favour of change. This set the scene for a similar contest over the policy culture, as the dentists’ association moved to protect their conceptualisation of dentistry and the therapists association moved to support a shift.

Interview data showed that the therapists’ group had reasonable power in this process for a number of reasons. Their president was a person with industrial experience (Int x2):

'...saw all this from a number of angles because she wears a number of hats- you see (she is) also a union rep and attends meetings on behalf of therapists with the unions and with management...' (Int).

She also had some observational experience of politics based on personal connections. There is evidence to show she did not use her personal connections but had some familiarity with the political process and was thus comfortable talking to politicians:

'...I have to say though that she did not, as far as I could see, use her political position to do things. As (someone connected with a) politician she could have manipulated the system to suit her own ends but I never saw her do it. From what I could see she went through the normal channels talking to ministers and so on. She was very capable...' (Int).

She had not had any dealings with legislation prior to this process and characterised herself as ‘very green’. She was however, prepared to ask for help and to work hard and closely with the small but active group of members of the association. This group was prepared to advocate for the outcomes that would suit the public interest and to challenge the dominant interests. They also worked to develop networks and administer the Act comprising ‘...a Government nominee and five qualified dentists elected by all dentists on the
relationships that would support the cause and to strengthen the dental therapy organisation so that it made best use of its resources. Tasmania is a small state with a relatively small population. The networks and systems of government are therefore smaller and more accessible, with more connected social circles:

'...down here doors are open more than say in (Victoria) - we are much smaller and our ministers are more accessible. Our minister has an open door policy anyway so anyone can see her to talk about things...' (Int).

The therapists’ association capitalised on this by ensuring that they made personal contact with all of the sitting members of parliament (Int)\textsuperscript{58}.

Without this leadership, there was potential for the therapists’ organisation, when put under pressure to conform, to do so and not oppose the changes the dentists wanted. This leadership while timely, is possibly a product of a public sector workforce that is numerically dominated by dental therapists and short of dentists (TDHHS 2001). It is less costly to the public dental sector to develop and promote dental therapists into management roles and retain dentists for clinical roles, thus giving therapists management and policy exposure. In a workforce that is now thirty years old, well connected to the unions and forced into a position of acting separately from the public sector corporate interest, there was a capacity for organisational development. Olson (1956, in Considine 1994) identified non-economic or social incentives as likely to only be valuable in small groups and that the larger the group, the smaller the value of participation by individuals. These features were certainly evident in this situation; the TDTA is a small organisation (47 members) capable of mobilising its numbers and maintaining its motivation through its sense of opportunity and vulnerability. This feature may well represent a strength for the organisation. The ability of a leader (or small leadership group) to motivate and organise such a group would seem to be an important feature of its ability to contribute to the policy process.

In this environment, the actions of the public sector dental provider were of mixed value and not as influential as in Victoria, but the therapists’ position had a greater role in supporting change than in Victoria. Bachrach and Baratz (1963) point out

\textsuperscript{58} This is supported by Hansard as all members of parliament who spoke to the Bill had knowledge of the therapists’ association and their role.
that one of the mechanisms for the exercise of two dimensional power is through anticipated reactions:

"...that is, an actor...may be deterred from pursuing his or her preferences because he or she anticipates an unfavourable reaction from another actor..." (Ham and Hill 1993).

This may account for the stronger position of the therapists in Tasmania. The political connections of the TDTA president, while not utilised, may have created a perception of power among other policy actors which altered their actions, giving greater cultural value to the views of the therapists than they may otherwise have had. Considine (1994) claims that policy innovation occurs where there is an institutional system for increasing the cultural value of a particular preference. In this setting, the institutional system for increasing cultural value came from the state and was supported by the dental therapists who, in deciding to act and challenge their previously dependent position and re-arrange their relationships, were possibly perceived as aligned with and supported by the government. This combination would have given greater strength to the voice for policy cultural change.

6.2.11 What capacity is there to increase access to dental care in Tasmania?

This thesis has developed a number of regulatory indicators which point to an ability to increase access to dental services through the broader utilisation of dental therapists and hygienists (see section 5.6.2). The policy outputs have been examined against these indicators to assess potential to increase access to dental care in Tasmania.

1. **Policy Access**: the inclusion of dental therapists and consumers on the Dental Board will shift the focus toward access to care issues but the numerical dominance of the dentists may still make change difficult.

2. **Market Entry**: Registration and overseas entry limits remain, as do limits (interstate) on training numbers of auxiliary (competitive) professions so the amount of change will be limited in the short term. There is a shortage Australia-wide of dental therapists and hygienists (AIHW DSRU 2002) and as Tasmania relies on out-of-state institutions for graduates, their capacity to expand their workforce is limited.
3. **Gatekeeper Controls**: There is quite good potential to increase access to dental services in Tasmania because of the intention to allow independent practice for dental therapists and hygienists. The removal of the gatekeeper role of the dentist as 'supervisor' or prescriber of care and, owner of practices effectively allows consumers to go directly to a dental therapist or hygienist for dental care and be referred on to a dentist where required. It effectively allows people to make their own choices about the type of provider they want and removes the cost of a dentist's services being applied to every person's care. Freed Perry and Kushman (1996) in California showed that after two years, hygienists in independent practice had increased contact with clients who were not regular dental attenders and that they were able to charge lower prices for their services than dentists. In Colorado it allowed the provision of mobile dental hygiene services to nursing home residents (Astroth and Cross-Poline1998). It also means that outreach services can be provided and that dental hygienists can be employed directly by hospitals and nursing homes and domiciliary dental services, significantly reducing the costs of providing such care and increasing efficiencies. Under these conditions, only those clients who require the more complex care of a dentist need receive it. However should the Poisons Act Amendment (2001) remain in place, it is likely to restrict access to services more than the previous legislation. However, there will also be a need for cultural change to occur in the therapy and hygiene professions before entrepreneurial behaviours become the norm as these professions have been subordinated since their inception in Australia.

4. **Employment Limits**: these have been removed allowing the skills of dental therapists and hygienists to be used more broadly allowing innovative service to occur. This offers the potential for prices to be reduced and services provided at the market margins in settings that are currently without market incentives, such as domiciliary and rural care. Salary rates for dental therapists in Tasmania however, are among the highest in the country so the lure of private sector practice is possibly not as great as in some other states. There is also a view that so long as School Dental Services\(^{59}\) continue to deliver universal care, private dental therapy practice viability will be limited (Int)

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\(^{59}\) Tasmanian School Dental Services provide all school children with dental examinations free of charge and any required treatment under a co-payment of $35 per course of care.
5. **Clients restricted:** the age limits on dental therapists’ clients has been effectively retained because the legislation prescribing the conditions under which they can treat adults has been retained as a Schedule to the Act with a life of three years from proclamation. This amendment was retained ostensibly to enable a trial to occur to test the use of dental therapists with extended skills in the treatment of adults. Implementation of the trial is an important aspect of increasing access to dental services and experience with other policy processes suggests that this is still contested ground. Should the life of the schedule lapse without the trial occurring, the client age range for dental therapists will again require attention.

6. **Scope of practice:** The skill range is to be defined by education allowing context to determine the types of services provided and for dynamic innovation (DP&C 1996) in service provision and provider mix to occur. Wider and more flexible application of therapists’ and hygienists’ skills has the potential to reduce the costs of care and independent practice is more likely to develop models that will mount those challenges particularly at the market margins.

7. **Ownership limits:** Removing practice ownership limits has the capacity to increase competition in the dental market, offering opportunities to broaden the nature of owners, service models and evaluative mechanisms. Removing limits on practice ownership also allows insurance companies and others to become owners of dental businesses, increasing competition and potentially access. It also opens the door to ‘managed care’ arrangements (see section 1.2.4) Managed care arrangements in the US market have led to much angst among health professionals (including dentists) because of the third party introduced into the ‘doctor-patient’ relationship. This third party often has the effect of forcing more efficient use of service ‘inputs’ (such as auxiliary personnel) but is also criticised for limiting treatment to less costly and sometimes less optimal choices. It may also develop external evaluative mechanisms in relation to pricing, supply and demand for dental services where generic management or purchasing structures are used allowing cross-practice comparisons. These comparisons may in turn

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60 Schedule 4, s9; Government dental therapists: continuation of trial, see footnote 39 for detail
61 ‘Managed care’ involves the purchase and re-selling of dental services by a third party such as an insurance company and is prevalent in the US. See chapter 1 for a more detailed explanation
produce more innovative service models and pricing structures, again particularly relevant at the market margins.

The removal of ownership limits may pose a threat to treatment options in some cases, but the challenges posed to quality of care by the profit motive probably exists among some dentist owners in the existing environment. The ability to apply professional discipline to these owners is an important tool that is not available outside the health professional environment. The Tasmanian Act requires notification of corporate owners and includes a clause making it an offence to '...direct, induce or allow...a dental service provider [to] provide dental care...in a way that is detrimental to patient welfare.' (Government of Tasmania, TDPR Act July 2001) This is an attempt to protect the consumer from the potential challenge to quality of services posed by the profit motive in a less regulated market (TDHHS March 2001, Jackson, 2001).

8. Advertising: there are no limits so increasing access to care will relate to the ability of therapists and hygienists to alert the public to the presence of their services.

On face value, the market has a greater capacity to put downward pressure on prices because of the creation of a more competitive environment and more capacity to increase access to dental services through more flexible utilisation of auxiliaries. In practice, however, it will require developments in several other areas to encourage the potential to be explored. These developments include the resolution of the restrictive wording in the newest amendments to the Poisons Act, the establishment of the ‘adult trial’ and development of the new public sector auxiliary role and their associated legislative changes, the appointment of a Board willing to see change occur, and promulgation and effective management of the Codes of Practice.

6.2.12 Tasmanian Conclusions

The Tasmanian government had taken a broad review of the field in 1997 with the Dever Review which had set particular agendas. Early policy development processes had thrown up some barriers to these agendas in the form of professional dominance. Like Victoria, the government developed a policy environment of reform using NCP as its initiative. Again, the dentists’ association contested this approach and made arguments in support of the status quo about expertise and quality of care. However, the government had already made legislative commitment to broadening the role of dental therapists and the key policy actors (the bureaucracy and the dental therapists) ranged in support of change gave impetus to a fundamental change. The deregulation of, in particular, dental therapy practice, practice ownership and the Board
composition have long term implications for the dental industry and alter the structural dominance of dentists.

Ham and Hill (1993) among others, described the mixed scanning model as one which makes the distinction between fundamental and incremental decisions where fundamental decisions are taken via a broad review of the field allowing long term outcomes to be assessed. Incremental decisions lead up to and follow on from the broad review and allow for more detailed analysis of specific options (Ham and Hill, 1993, Palmer and Short 2000) (see section 2.2.2.). The fundamental decisions relate to the creation of a more rational and less monopolized dental care sector. The incremental aspects of this process relate to the legislation governing dental therapy practice in Tasmania. This was already less prescriptive than in other states and the outcome of the legislation review is also less prescriptive than other states. While these changes were strongly opposed by dentists, the policy culture of National Competition Policy and economic rationalist government agendas meant that the wider utilisation of dental therapists and hygienists was supported. So in terms of content, these changes are smaller in that the previous amendments re-defining age limits on dental therapists’ client groups were retained, therapists were registered rather than allowed to practice under exemption and their employment limits were removed; all things that fit with the general thrust of earlier policy developments.

Also in broader terms, the professional dominance of dentists, which had been much greater prior to the review, has been reduced at a number of levels. Their claims to esoteric knowledge and exclusive expertise had been challenged, their monopoly over the market had been removed and their claims to altruistic service had been questioned. Their sovereignty over dentistry has been reduced although their autonomy over their own practice remains largely unchanged. It is their authority that has suffered the greatest blow with the subordinated occupations no longer excluded or subordinated by regulation and limited only by their educational preparation rather than the pre-existing lists of duties.

This legislation review outcome was the most de-regulated in Australia and provides an interesting contrast to the outcomes in New South Wales. The NSW review is the subject of the next section.
6.3 A case study of the New South Wales dental legislation review

6.3.1 Introduction

As in the other Australian states, the Competition Principles Agreement initiated a review of the New South Wales Dentists Act 1989. NSW Health’s legal branch was delegated responsibility for carrying out the review of all health practitioner legislation. The Branch appointed as project officer, a lawyer who had been involved in reviewing three Acts prior to the Dentists Act, to conduct the Review and make recommendations to Cabinet. The Dental Technicians Registration Act 1975, which regulates dental technicians and prosthetists however, as in Tasmania, was not reviewed\(^6^2\) (NSW Health 1999).

According to the Legal Branch, there was an interest in consistency across health practitioner legislation and the Medical Practice Act which had already been reviewed, was used as a broad template which was adapted to suit each practice area. The department had moved to a ‘core practices model’ for practice regulation. This model sees practice of specific activities which are identified as having the potential to cause harm to patients, restricted to individuals with appropriate training. These practices and the occupational groups that may provide them are defined by the public health act (NSW Health 1999, NSW Health 2001b) The disciplinary model used by the Dental Board however, was considered by NSW Health to have merit and was incorporated into the template (Int).

In September 1999, in order to facilitate public consultation, the department called for submissions via the release of an Issues Paper (NSW Health 1999). Stakeholder groups were identified by the Legal Branch and invited to make submissions outlining their views. The submissions were received until 31 November 1999 and processed by the branch prior to formulating recommendations to Cabinet. Recommendations were made to Cabinet in March 2001. In early 2001, representatives of NSW Health’s legal branch met with each stakeholder group to go through the Bill in detail and seek written comment while it was still ‘cabinet confidential’. The recommendations were then published in August, just prior to the

\(^{6^2}\) …I think that those prosthetists were very clever in that they just didn’t get their act reviewed… ’ (Int)
Bill’s presentation. The Bill was presented to Parliament on September 4, 2001, passed through both houses and assented on October 16, 2001 (NSW Health Legal Branch Jan 2002, NSW Parliament Hansard 2002). The new act will be commenced when the regulations have been written, a process which began in January 2002 and is, as yet, incomplete.

6.3.2 Stakeholder positions

Interview data (Int) from three interviews conducted between November 2001 and February 2002, and documentary evidence was used to establish the positions taken by the various stakeholders or policy actors in the review process. It is not clear whether the review was publicly advertised but NSW Health’s Legal Branch had a role in identifying and establishing dialogue with the various stakeholders. Submissions were received from nine individuals and 14 organisations, six of whom were considered key by interviewees. There were submissions from three dental associations, plus a University Faculty of Dentistry and the Dental Board, two public sector organisations and two health funds, three dental auxiliary associations and a dental students’ association. The NSW Council of Social Services (NCOSS) was the only apparent consumer advocacy organisation that was involved. Table 6.6 below presents their positions. Each tick represents material collected in an interview and footnotes identify documentary sources of evidence corroborating these assertions.

Table 6.6 Stakeholder positions in the NSW dental legislation review

<table>
<thead>
<tr>
<th>Australian Dental Association New South Wales Branch (ADANSWB)</th>
<th>’...you deal with oral health you deal with the ADA...’ (Int)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retain the status quo of old act, ✓✓</td>
<td></td>
</tr>
<tr>
<td>Existing disciplinary mechanisms retained and reinforced ✓✓</td>
<td></td>
</tr>
<tr>
<td>Dentists initially opposed to registration for Dental Therapists(DT) and Dental Hygienists(DH) ✓✓ but later supported statutory recognition of hygienists ✓✓</td>
<td></td>
</tr>
<tr>
<td>Retain employment limits for DTs ✓✓</td>
<td></td>
</tr>
<tr>
<td>‘preventive focus not tooth-cutting’ ✓✓ therapists continue in public sector while there is a need and then eventually ‘cross training’ to hygienists ✓✓</td>
<td></td>
</tr>
<tr>
<td>Supervision of DTs and DHs by dentists be retained ✓✓ ✓✓</td>
<td></td>
</tr>
<tr>
<td>Ownership limited to dentists and health funds, probity arrangements ✓✓ ✓✓</td>
<td></td>
</tr>
<tr>
<td>Advertising limited ✓✓</td>
<td></td>
</tr>
</tbody>
</table>

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65 ADA NSW Branch Inc. Newsletters
66 ADA NSW Branch Inc. Newsletters (Feb 2000, Oct 2000)
67 Early newsletter material is silent on this with the exception of a statement in the April 1999 newsletter identifying ‘...registration of providers other than dentists...’ as a major issue.

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<table>
<thead>
<tr>
<th>New South Wales Dental Therapists Association (NSWDTA)</th>
<th>‘...they got their act together quickly, they were also internal (to the department)... their role in public health programs placed imperatives on addressing their concerns...’ (Int)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration of DTs✓</td>
<td></td>
</tr>
<tr>
<td>Private sector employment✓✓</td>
<td></td>
</tr>
<tr>
<td>Board seat✓</td>
<td></td>
</tr>
<tr>
<td>Requirement for dentist supervision should be removed✓✓69</td>
<td></td>
</tr>
<tr>
<td>Range of skills adjusted to meet national standards✓ 70</td>
<td></td>
</tr>
<tr>
<td>Age range client groups✓</td>
<td></td>
</tr>
<tr>
<td>Concern about education, quals, grandfathering, access to education, continuation of undergraduate training✓✓71</td>
<td></td>
</tr>
<tr>
<td>This group did not associate with DT Organisation (see below) either publicly or privately because of illegal nature of the work of DTO members and would not allow them to be members as only practising therapists may be NSWDTA members✓</td>
<td></td>
</tr>
<tr>
<td>Oral Health Branch, NSW Department of Health -</td>
<td>‘...they offered) independent expertise-a touchstone for the legal branch – advisers ...an important factor in the employment issue for DTs...’ (Int)</td>
</tr>
<tr>
<td>Educational upgrade of DT quals✓</td>
<td></td>
</tr>
<tr>
<td>Retain employment limits on DTs✓✓72</td>
<td></td>
</tr>
<tr>
<td>Dental Hygienists Association of Australia NSW Branch (DHAANSWB)</td>
<td>‘...tend to blend in with the dentists a bit, and the private sector perspective comes from the ADA... ’ (Int)</td>
</tr>
<tr>
<td>Registration ?✓✓✓73</td>
<td></td>
</tr>
<tr>
<td>Alter requirements for supervision-✓✓74 (not so strong as the DTA on this)</td>
<td></td>
</tr>
<tr>
<td>No change?</td>
<td></td>
</tr>
<tr>
<td>? expanded duties✓</td>
<td></td>
</tr>
<tr>
<td>Independent orthodontists &amp; Australian Society of Orthodontists</td>
<td></td>
</tr>
<tr>
<td>Orthodontic auxiliary role75?</td>
<td></td>
</tr>
<tr>
<td>Dental therapists in private practice✓76</td>
<td></td>
</tr>
<tr>
<td>Retain supervision of dental therapists and hygienists by dentists77</td>
<td></td>
</tr>
<tr>
<td>Dental Therapists Organisation (nswDTO);</td>
<td></td>
</tr>
<tr>
<td>about 6 DTs qualified -thought to be illegally working in orthodontic practices or as dental assistants; not associated with NSWDTA</td>
<td></td>
</tr>
<tr>
<td>Wanted private sector employment rights✓87</td>
<td></td>
</tr>
</tbody>
</table>

71 NSWDTA Submission to the Review (Nov 1999) argued that there were five specific practices which should be added to the permitted range for therapists- stainless steel crowns, use of elevators for extractions, mouthguard construction for children, use of OPG x-ray equipment and removal of orthodontic bands and associated processes- all procedures performed in other Australian states by dental therapists
72 all of the above arguments are supported by the NSWDTA Submission to the Review (Nov 1999).
74 Report refers to arguments made by the DHAANSWB Branch in support of title protection
75 NSW Health, Report of Review of the Dentists Act 1989, March 2001. The DHAANSWB supported the development of guidelines to allow a hygienists to provide services in nursing homes under prescription but otherwise broadly supported the existing arrangements for on-site supervision by a dentist.
76 NSW Health, Report of Review of the Dentists Act 1989, March 2001-the ASO wanted an extension of hygienists scope to include orthodontic skills. The Health Funds of NSW also supported a relaxation of the ‘controls’ on hygienists.
77 NSW Health, Report of Review of the Dentists Act 1989, March 2001 shows support for this position coming from the independent orthodontists
78 NSW Health, Report of Review of the Dentists Act 1989, March 2001. The ASO and the HCF submission supported the need for supervision. A Dr A.A.Mills’ submission also supported the need for supervision while also supporting the role of therapists.
79 NSW Health, Report of Review of the Dentists Act 1989, March 2001 DTO also argued that supervision should reflect practice

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6.3.3 Policy Outputs

Note that the bracketted initials and numerals (eg S33(2)) in this section refer to parts (P), divisions(D), sections (S) and sub-sections of the NSW Dental Practice Act 2001.

While the costs and benefits of de-regulation of the dental industry in NSW were debated, the outcome was the retention of a model incorporating title and practice regulation for dentists, dental specialists, dental therapists and dental hygienists. Dental therapists and hygienists however, are only registered to carry out dental auxiliary acts, whereas dentists are registered to carry out dentistry and dental auxiliary acts are to be defined by regulations (NSW Health 2001). Therapists and hygienists must only carry out ‘...dental auxiliary activity...subject to the practice

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79 NSW Health, *Report of Review of the Dentists Act 1989*, March 2001, also supported by Faculty of Dentistry’s Continuing Education Committee and the ADANSWB
83 NSW Health, *Report of Review of the Dentists Act 1989*, March 2001. This view was also supported by the Hospital Contribution Fund (HCF) on the grounds that there were risks that therapists would over-supply conservative services, an argument that also appears in ADAVB policy documents (ADAVB March 1998,)
85 NSW Health, *Report of Review of the Dentists Act 1989*, March 2001; NCOSS argued that division of roles should be based on the complexity of treatment required in order to increase access to services.
86 NSW Health, *Report of Review of the Dentists Act 1989*, March 2001. This was also advocated by the NSWDTA
87 Although contested, this decision was made on the grounds of the services they provided and the risks they posed. This argument seemed to be consistent across all the states.
oversight of a registered dentist...’ (S33) which replaces the ‘supervision’ required under the 1996 regulations. Dental therapists’ employment is restricted to the ‘...Department of health, a public health organisation or a body or organisation prescribed by the regulations for the purposes of this section...’ (S 33(2)).

The registration of dental hygienists and therapists meant that they would be entitled to Board membership:

‘...Enacting regulatory controls to cover the practice of auxiliaries will allow the maintenance of standards and the professional development of both groups...' (MacDonald 2001, Second Reading Speech.)

As a result, the Board was expanded by three members from nine to twelve members. One seat out of 12 was reserved for a dental auxiliary, one extra consumer and one extra dentist bringing the number of dentist members to seven. Of the dentist members, five are to be elected by dentists, one is to be appointed by the Minister for Health and one is to be an academic involved in the education of dentists.

‘...In order to meet the demands on the Board for participation in committees and other activities an extra dentist member was needed to ensure that sufficient professional expertise was available to the Board...’ NSW Health, Report of Review of the Dentists Act 1989, March 2001:80.

The new Act also provides for the Minister for Health to appoint two consumer representatives (an increase of one), a lawyer and an employee of the Department of Health to the Dental Practice Board (S108).

Disciplinary matters are to be dealt with by the Dental Care Assessment Committee (DCAC) consisting of four dentists and one consumer with no provision for the appointment of a dental auxiliary as a parallel practitioner. There is however, provision for such an appointment to the Impaired Practitioner Panel which deals with health issues. The Dental Care Assessment Committee has the powers to require a practitioner to undergo competence testing and medical examinations (P5, D3) and there are provisions for more constructive approaches to deal with impaired practitioners. More serious breaches of the Act are dealt with by the more independent Dental Tribunal which is to be chaired by an experienced lawyer and

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88 The 1996 regulations required the supervising dentist to be available within a reasonable time and to be aware that they may be called upon to provide such assistance. (Dentists General Regulations 1996, part 5, S 18 (1-2), Dentists Act 1989

89 Interview data indicated that it was the intent of the Board that where a panel were dealing with a dental therapist or dental hygienist, a panel member of the same profession (parallel practitioner) would be appointed, however the Act refers to the appointment of 4 registered dentists and 1 consumer as members of the DCAC (NSW Dental Practice Act 2001:Part 9).
consists of three other non board members, two of whom are dental care providers. (Parts 5, 9, 10 and 11)

There are also restrictions on practice ownership and the employment of dentists. Dentists must practice in their own name only and dentists may only work for, or in partnership with, another dentist, or for the crown or a registered health fund (S 34, S4190). Directors of incorporated practices are obliged to comply with the Act. Directors or shareholders of incorporated practices must be registered dentists or their family members and must have their controlling interest owned by a registered dentist(s) (S34). This would prevent a therapist or hygienist entering into a business arrangement such as owning a practice or practising in partnership with a dentist unless they were a family member or unless they could convince the Board to approve the arrangement under section 41(2)(g). S 139 allows for the board to approve someone as a non-dentist owner if it is considered to be in the public interest. It is interesting to note that under S139, the public interest excludes the interests of registered dentists, and that this clause arose out of a judicial interpretation of the previous act (Int).

6.3.4 Analysis of power: where did the benefits flow?

Lukes (1974) argued that the distribution of power in a policy process can be gauged from an analysis of who benefits from particular policy outcomes or decisions. Table 6.7 below assesses the outcomes of the NSW Legislation Review against the criteria established to assess potential to increase access to care and in terms of the beneficiaries.

As can be seen from the table above, for almost every decision, the benefits flow to the dentists because of their ability to maintain monopoly control over the dental industry. Dentists retain the profits from dentistry by effectively retaining control over ownership, by retaining gatekeeper controls over and thereby preventing competition from subordinate practitioners and through their numerical dominance of the Board. Even registration of dental hygienists and therapists91, while of benefit to

90 The exception to this is spelled out in S41(2) which excludes ‘...(a) the Crown...(b) a public health organisation...(c) local council...(d) incorporated practice...(e) registered health benefits organisation...(f) friendly society... or, (g) any person or body that has been approved by the board for the purposes of this paragraph.’
91 Dental therapists and hygienists previously practiced under exemption from the Act.
these professions because of the legitimacy and inclusion it confers, serves to increase the power of the dentists over these professions through their dominance of the

Table 6.7 Outcomes of the New South Wales Dental Legislation Review of their implications

<table>
<thead>
<tr>
<th>NSW Dental Practice Act 2001</th>
<th>Who benefited?</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board: 12 members; 7 Dentists (5 elected, 1 minister appt, 1 Dentist educator) 1 Dental Auxiliary (DT or DH) 1 Dept Health member 1 Lawyer 2 Consumers</td>
<td>Dentists</td>
<td>Numerically dominant = retain authority and Dentists able to elect members = autonomy over practice There is one auxiliary voice where there wasn’t previously ↑ consumer voice</td>
</tr>
<tr>
<td>Registered: Dentists, Specialists, Therapists Hygienists</td>
<td>Therapists &amp; Hygienists Dentists Consumers</td>
<td>DT &amp; DH professions brought into legitimacy and into policy arena (Board seat) Increases dentists formal control over therapists Offers statutory protection from risks inherent in undertaking dental treatment from all providers of invasive procedures</td>
</tr>
<tr>
<td>Gatekeeper controls - Practice oversight for auxiliaries</td>
<td>Dentists</td>
<td>Retain practice monopoly over market through ‘practice oversight’ and prescription of services for hygienists</td>
</tr>
<tr>
<td>Employment Limits: Therapists only employed in public sector, hygienists only employed by a dentist</td>
<td>Dentists</td>
<td>Retains dentist monopoly over market- and gatekeeper controls, prevents service provision competition</td>
</tr>
<tr>
<td>Client Groups: not defined</td>
<td></td>
<td>To be dealt with in regulations following workforce review</td>
</tr>
<tr>
<td>Scope of practice: Defined in regs</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Ownership limits: dentists and health funds</td>
<td>Dentists and health funds</td>
<td>Retain profits of dentistry with dentists</td>
</tr>
<tr>
<td>Advertising limits</td>
<td>Consumers</td>
<td>No change - based on consumer protection legislation and consistent with other Acts</td>
</tr>
</tbody>
</table>

Interview data (Int x3) shows that the therapists in particular were unhappy with both the review’s Final Report (NSW Health 2001) and the draft Bill in relation to their employment limits and the shared Board seat. They took every opportunity to express their dissatisfaction but consultation in this case seemed designed to pacify rather than provide opportunity for negotiation (Int). They had some encouragement from back bench politicians who took up their cause following the first reading of the Bill
but to no avail as both the government and the opposition voted against the amendments:

‘...The Government opposes the three amendments moved by the Hon. Richard Jones. The Dental Practice Bill provides for a dental board of 12 members. Of these members seven are to be registered dentists and one is to be a dental auxiliary. There is no justification for increasing to two the number of dental auxiliaries on the board, given that there are more than 4,000 registered dentists in New South Wales compared with some 350 dental auxiliaries. Reducing the number of registered dentists on the board would cause an increase in the workload of board members and would be of significant concern to both the board and the dental profession in general. Consequently, the Government cannot support the amendments...’ (Macdonald (Parliamentary Secretary) 2001).

‘...The Opposition is familiar with the submission put forward by the President of the Dental Therapists Association and has some sympathy for the association’s position with regard to the appointment of auxiliaries to the Dental Board. We understand the dilemma the association faces with regard to the fact that a choice must be made between dental therapists and hygienists. However, given the argument that the Government has put forward we do not find ourselves able to accept the amendments moved by the Hon. Richard Jones, but we shall watch with interest to see how the board functions...’ (NSW Hansard, Dental Practice Bill Committee debates, 25.9.2001) Sovereign power, the autonomy and authority of dentists over dentistry was thus preserved, demonstrating significant political power (Jobling (Opposition) 2001)

6.3.5 Shaping the policy culture

As discussed in the Victorian case study, Considine (1994) argues that policy outputs are the result of a policy culture negotiated between policy actors and mediated by the policy institution. Certain mechanisms and discourses are used to shape the culture so that particular policy outputs are produced. This section develops the analysis to show the way the culture was shaped to deliver the outputs described above.

The data and policy outputs in this case study suggest that enthusiasm for the NCP agenda, which had been vigorous in Victoria in 1997-98, was less so in NSW in 2000-2001. This was supported by interview material indicating that the Minister seemed to have ‘...gone a bit cold on the idea...’ and that there had been a public questioning of the benefits of competition to the health industry in general (Int x2). Unlike Victoria which took a ‘clean sheet of paper’ approach to developing a new Act, the issues paper for NSW suggested that there was a possibility of no change or of ‘amending’ the Dentists Act (NSW Health 1999). Although the recommendations had identified the Dentists Act of 1989 as the most restrictive and anti-competitive in NSW92, many of the anti-competitive aspects were retained (NSW Health 2001b).

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92 Practice and title regulation, ownership and employment restrictions on dentists which prevented non-dentists owning practices, supervision requirements for auxiliaries and public sector employment restrictions on therapists,
On the issue of ownership of dental practices, the NSW legislation also differed significantly from the Victorian Act which had removed ownership limits. This was an important issue for the ADA in every state and no less for the NSW Branch whose Newsletter (April 1999) argued that the profits from dentistry should remain with dentists. This argument developed into concerns with what were referred to as ‘probit issues’ and the ability to look ‘behind the corporate veil’ and trust that corporations would not allow commercial gain to override professional practice (NSW Health 2001):

‘...concerned about probity issues...the corporate ethos may not be something which is of benefit to the community generally. The other important thing about probity is sanctions. If there was a breach of the act, and this was a philosophical question that seemed to be of concern to the department and therefore the government of NSW, not just in a dental context,...how do you deal with corporate entities and make sanctions flow on to the corporate entity... and further, if you did have a corporate entity owning a dental or a medical practice, how can you stop the commercial entity putting pressure on the health care providers to provide treatment which is perhaps inappropriate or perhaps engage in treatment which is unconscionable... ’(Int)

Despite a lack of evidence supporting the need for practice ownership limits and the NCP agenda requiring that the onus of proof lay with the proponents of regulation, the outcome was much tighter regulatory control than in Victoria. This was attributed partly to government concern with some recent adverse outcomes in the area of cosmetic surgery (Int). The development from a position of no limits to one that reapplied limits appears to have occurred after the recommendations were made to Cabinet in March 2001 but before the Bill was presented to parliament. In May 2001, the then president of the ADANSWB commented that

‘...we are fortunate to have an excellent relationship with Craig Knowles, the NSW Health Minister who obviously has a very pragmatic approach to dental issues. This branch has expended significant resources on the Review of the Dental Act of NSW and it is gratifying to know that this Minister will be applying his ‘if it ain’t broke don’t fix it’ attitude to dental legislation... ’(ADANSWB May 2001)

This outcome is also consistent with a view that enthusiasm for NCP was waning.

The ADANSWB also argued strongly that dental therapists should be phased out of practice as they were not ‘well enough trained’ to perform tooth cutting procedures (Int):

‘...Dental therapists are no longer relevant in the future delivery of dentistry as the services they provide are limited, and can now be more effectively and efficiently performed by dentists without disciplinary procedures which have effect on commercial behaviours (eg advertising rules) and entry barriers were all identified as being anti-competitive (NSW Health, March 2001)

91 This article, by the NSW Legislation Review Working Party of the ADANSWB, also noted that, ‘...the medical profession which operates under this model, seems unconcerned by these problems.’ ADANSWB Newsletter, April 1999
supervision. Also the changing trends in disease patterns indicate that the people most a risk of
dental disease are outside the scope of training of dental therapists...’ (ADANSWB Submission
1999, in ADANSWB Feb 2000)
‘Clearly it became evident that the anti-competitive argument was being used as a means for
circumventing the requirements for academic achievement at secondary school level and didactic
and clinical instruction at the tertiary level. That National Competition Policy could be used as a
means for setting clinical training standards is alarming...’ (ADANSWB 2001)

This former argument is based on the “Dental Team for the Millennium” policy of the
ADA which sees hygienists as the auxiliary of the future in both public and private

These same arguments had been made by the ADA in Victoria in an earlier policy
process (ADAVB August 1994). The 1995 Dental Auxiliary Workforce Review
(DAWR) in Victoria had been asked to ‘...identify the skills and composition of a
future dental workforce...’ and this extra policy process prior to the legislation review
had endorsed the need for dental therapists’ skills (DH&CS 1995). By the time of
the Legislation Review, the main arguments to be made were about their regulation.
In the NSW case, the ADANSWB argued that the skills of therapists were no longer
relevant and their training should cease, combining the issues of their existence and
their regulation (ADANSWB Feb 2000, Oct 2000).

The role of the public sector dental providers and their advocates was important to
this debate. Unlike Victoria, the Chief Dental Officer (CDO) of the Oral Health
Services was opposed to private sector employment for dental therapists (Int x3).
Interview material indicated that the public sector argued for therapists’ employment
to be restricted because their training was funded by the state in order to staff state
funded dental programs94. It appears from interview material that the relationship
between the CDO at NSW Health and the ADANSWB was quite good95 (Int). It is
also clear that their positions on dental therapists’ employment became congruent.
The ADANSWB later argued that while the School Dental Services needed dental
therapists then they should remain, but be restricted to public sector employment and
then phased out and given the opportunity to ‘cross-train’ as dental hygienists (Int).

The Oral Health Branch and the Review has subsequently suggested to the NSWDTA

94 NSW is the only state that still auspices dental therapy training directly from the state health department. The
Westmead College of Dental Therapy opened in 1976 and is an annexe of the Westmead Hospital. Originally, the
qualification (like all the Australian states) was at certificate level and was accredited at Diploma level in 1994.
NSW does not offer dental hygiene training although there is some advocacy in support of this.
that not all of their currently practising members could expect to be registered as their training would first need to be upgraded (Int x2). As the review progressed, it became clear that the issue was quite contested and that it did not have to be decided in order to pass the Act:

‘...there were a lot of ‘hot’ issues in that whole review and this was probably one of the more difficult ones. Initially (they) thought (they) might try to resolve it in this process and then (they) realised that (they) would have to try to resolve all these other issues...and this was clearly a matter that didn’t have to be in the act...if (they) had tried to resolve all those issues we would never have got our new legislation...’ (Int)

In light of public sector advocacy, a decision to retain the status quo was easy to make.

This issue of workforce mix and ‘training competencies of dental therapists and hygienists’ was however, successfully given a profile in the policy environment and is to be addressed by a ‘comprehensive review of training and service needs’ (NSW Health 2001). This review is to be carried out by the Oral Health Branch and will address public sector needs and consideration of current courses offered for dental therapists and hygienists (NSW Health March 2001). The members of the review panel include the CEO of the Oral Health Branch, nominees of the Dental Board and the ADANSWB, the Dean of the Faculty of Dentistry at the University of Sydney and an Area Health Services manager but no dental hygienists or therapists. (Again this differs from the 1995 Victorian DAWR panel which included a therapist and a hygienist and a prosthetist.) The ADANSWB supports the need for dental hygienist training (which does not currently exist in NSW) but not that of dental therapy (ADANSWB Oct 2000). This review is to develop a stronger view on the role of dental therapists and provide further data on the appropriate form of guidelines for practice oversight (NSW Health 2001). This type of action (referring issues to committees for detailed study, imposing new ‘rules’ on aspects of the policy process) are described by Bachrach and Baratz (1963) as ‘non-decisions’. Achieving non-decision making is an identified strategy of agenda setting, and evidence of the exercise of second dimension power (Lukes 1974, Ham and Hill 1993).

93 This is supported by comments made by the CEO of Oral Health Branch in the April 1999 ADANSWB newsletter (vol 48, No5) and by the then president of the ADANSWB in October 2001, Vol 50, No 10
Funding arrangements in New South Wales are also different, with devolution of service provision to Area Health Services. The role of the Chief Dental Officer of the Oral Health Branch, as an employee of NSW Health, not only has a policy role but is also the key central advocate for public oral health services and adviser to the Minister on oral health matters (NSW Health 2002, Int x2). The devolution of service provision to area health boards shifts and fragments the responsibility for dealing with oral health to local agencies. Their ability to advocate for public sector dental services is thus more diluted. This differs to the Victorian situation where the Department of Human Services dental policy unit provides similar planning and policy advice to the minister, but service provision is out-sourced to a single, public sector dental provider agency. This arrangement meant that the interests of public health dentistry are advocated by a single agency, separate from government. Further, the devolution of the agency of responsibility for providing school dental services could be met directly, or by purchasing their provision under sub-contract. Monopoly over the employment of dental therapists was therefore less important in this environment of privatisation. Moreover, supply of dental therapists had already been shifted into the University sector in 1996. Increasing demand for their services by widening their employment opportunities would fuel pressure on the University to provide more graduates. NSW Health however was directly funding the training of dental therapists and school dental services from one budget establishing a more introspective, and controlled approach. The question that is raised by this is why NSW Health continues to fund dental therapy training when the other states have moved it into the tertiary sector.

Access to care and adult service provision by therapists did not develop as an issue because the review was successfully narrowed to regulation issues. For dental therapists’ and hygienists’ this meant refining the limits applied to their practice.

96The NSW Minister for Health, through his department, has responsibility for the provision of health services in NSW. The Department (NSW Health) has responsibility for funding public health services along with a variety of regulatory functions and statewide responsibilities for policy development, system wide planning, performance monitoring and management. The various branches of the department, including the Oral Health Branch, carry out these functions. The NSW Health Services Act 1997, collectively describes the 17 Area Health Services and other entities in the NSW Public Health System as public health organisations. Area Health Services play a major role in the planning, delivery and coordination of local health services and resource management in their geographic areas. The Director General (NSW Health), and the Health Services Administration Corporation has a pivotal workforce co-ordination role and is the legal employer of health system staff and responsible for the negotiation of wages and other conditions of employment and for industrial purposes. (NSW Health, Annual Report, 2000/2001)
rather than debating the potential to utilise their skills more widely. Despite some early agenda setting by the therapists and NCOSs who raised it in their submissions, and a push by the hygienists to be able to work in nursing homes with off-site supervision, it was not really debated (Int). The ADANSWB newsletters acknowledged it early but successfully reshaped the concern to mean access for rural and remote communities and increasing public sector funding:

‘...the ADANSWB Branch has always been of the view, that... there is equity and accessibility of dental services in the community generally and the branch has been quite specific in recommending initiatives in rural and regional NSW. (They) have been extremely aggressive in pursuing the need to have increased federal funding into state dental programs... (Int).

Unlike Victoria where access to care remained a live issue and was incorporated into the Act as an objective for the Board, the discourses of the NSW review excluded auxiliary utilisation as a mechanism for increasing access to care, successfully shifting it off the regulatory agenda. Rather, the NSW government chose to act by investing in a new ‘Fee For Service Scheme’ involving private practice dentists in delivering public sector services, along with an incentive program for graduates to undertake rural practice, thus embedding the ADANSWB concepts into policy actions (Int, ADANSWB July 2001).

By the time the NSW review occurred, the ADA had also learned from the other states. Victoria had led the country in these reviews. The federal office of the ADA Inc. acknowledged the contribution of the Victorian Branch’s strong stand and allocation of considerable funds in running a campaign that served as a model for all the states. (ADA Inc July 1999, ADANSWB Dec 1999). The agenda setting carried out in NSW that redefined the issue of ‘access to care’ may well have arisen from the Victorian review experience. The Presidents Message column in the October 2001 issue of the ADANSWB Newsletter, contained these comments;

‘A disaster has been averted in this state. In Victoria, they haven’t been so fortunate. As the first state to undergo such a review, they encountered the lobby groups and economic rationalists in their fervent early days. As a result dental therapists have full private practice rights in...’

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97 Of interest is here is anecdotal evidence that NSW Health also provides financial support for dentist education to the University of Sydney without imposing employment restrictions on those graduates.

98 ADANSWB newsletter April 1999, Vol 48 no 3; In an outline of what the ADA saw as the important issues prior to the publication of the issues paper, the ‘...concern among stakeholders that there are people unable to access dental services...’ was identified as a major issue. However later issues referred to shortages of dentists in rural and public health areas and to working with the Oral Health Branch to advocate for more funding (May 1999, Vol 48 No 4, June 1999, Vol48 No 5) and to a preventive approach for the future dental team (Oct 2000, Vol49 No9)
Victoria and virtually anyone can open a dental practice. Only time will tell what the fallout will be.' ADANSWB, October 2001).

NSW is also the home of the federal office of the ADA and this central organisation was also active in its support for the states and is said to empower the local organisation through the effects of two sets of networks. By this time, the Commonwealth Senate had also held an Inquiry into the effects of National Competition Policy giving the professions and the public sector opportunity to express their more negative views at a national level and consolidate their arguments at state level (ADA July 1999). In addition, the ADANSWB seem to have developed a more positive relationship with their Minister than their Victorian counterparts.

6.3.6 The use of evidence

Both the review documents and interviewees identified evidence as important. Arguments had to be supported and stakeholders were told by the Legal Branch that:

'...they weren't going to accept history...vacuous statements or filibuster...' (Int).

Evidence was apparently important in demonstrating the need to regulate practice (NSW Health 2001, Int). Evidence was presented and acquired in relation to the invasive nature of dental services, infection control issues, the complexity of providing treatment to ageing and medically compromised patients, ill fitting dentures, infections and incidence of oral cancers, from the published literature and the Centre for Disease Control in the US (NSW Health 2001, Int). Once the Review was convinced of the risk factors and potentially irreversible side-effects of poor dental treatment, a recommendation was made to retain practice restrictions99. The ‘core practices’ approach was seen to meet this requirement in a less restrictive way that would satisfy NCP100.

99 '...if you proved that these practices were inherently dangerous if done inappropriately, then whoever does them has to be registered...' (Int)

100 This is considered to be a less restrictive form of practice regulation because it only limits the performance of risk prone activities (for example invasive procedures) rather than the ‘total practice restriction’ model which includes the entire range of activities belonging to a profession. A definition of dentistry would have included all procedures performed in the oral cavity as being ‘dentistry’. including toothbrushing instruction, oral inspection, flossing teeth, photography, surgical assisting etc. WA, Qld also chose to apply core practices models to their new legislation. The core practices defined by the NSW Dental Practice Act 2001 includes, ‘...any operation on the human teeth, jaws or associated structures, ...correction of malpositioned teeth, ...oral radiography, ...construction, renewal or repair of artificial dentures or...dental appliances (and) performance of operations preparatory to... (the latter).’
For this reason, the NSWDTA engaged a lawyer to help them develop their submission and also carried out research\(^{101}\) to demonstrate that the prevailing approaches to supervision did not reflect current practice or the assertions being made by the ADANSWB (Feb 2000). This evidence was convincing enough to generate support for debate over the wording. It is clear though, that this was very contested ground and that it took some time to find wording that satisfied all the stakeholders (Int x3). The outcome despite the evidence, was a change from ‘supervision’ to ‘practice oversight’ (NSW Health 2001).

The NSWDTA submission also presented evidence about the on-going need for dental therapists’ services and the ability of dental therapists to meet the needs of other client groups. This, and the evidence supporting reduced costs of providing services to private sector patients if therapists’ employment restrictions were lifted, and supporting their arguments about the quality of the services they provided, appears to have been ignored (NSWDTA Nov 1999). The review concluded that there was little evidence of public benefit flowing from the limitations on dental therapists’ employment, but still declined to remove the restrictions (NSW Health 2001).

This was also the case with business ownership; according to legal branch, there was little or no evidence to support restrictions on ownership or limits on the employment of dentists. The Report recommended that the employment and practice ownership limits were anti-competitive and should be removed and replaced with legislative provisions directed at protection of the public and placing corporations on the same regulatory footing as practitioners (NSW Health 2001). Following publication of the report, a decision was made to retain ownership limits and the existing limits from the 1989 Act were modified and included in the 2001 Act (NSW Health Sept 2002).

So, in summary the mechanisms (mobilised bias) used to shape the policy culture arose largely from the dentists’ position and were endorsed by the policy making

\(^{101}\) In 2000, the NSWDTA carried out a telephone survey to identify the level of supervision provided by dental officers for dental therapists on a daily basis in the workplace. Their data showed that while the assistance of dentists (from both public and private sectors) was generally readily available when required, it was not on site, it was never used on a daily basis or for every patient and that dental therapists mostly developed treatment plans and provided clinical services to child patients without the presence of a dental officer. They concluded, based on the absence of any ‘...malpractice cases against the profession...’ in the 25 years they had been practising, that dental therapists’ practice under existing conditions provided negligible risk to the public, demonstrated appropriate training levels and that existing referral mechanisms and pathways were appropriate. (NSWDTA, August 2000)
institutions. These were expressed as concern with de-regulation in the health sector, apparently endorsed by the government and underpinned by a waning of enthusiasm for competition policy; concern about corporate intrusion into the health sector shaped as a ‘mistrust’ of the ethics of certain types of commerce; a reshaping of the perceptions of how access to dental services might be defined (rural) and addressed (more dentists); doubt over the need for a ‘tooth cutting auxiliary’ outside of the school dental service; support for increased preventive services provided by hygienists and questions about the adequacy of training for therapists. These last three were successfully shifted from the regulatory review agenda and flagged for future policy attention under a further dentist dominated review process.

6.3.7 What impact did the review have on the professional dominance of dentists?

The dentist profession in NSW was singularly successful at preventing changes to their legislative frameworks. They have retained a sovereign position with authority over subordinated professions and autonomy over their own professional practice. Their well developed networks enabled their views to be supported in a number of ways and there is also evidence of effective advocacy in the political arena with a positive relationship between the dentists’ professional association and the Minister for Health.

‘...This Branch expended significant resources to ensure that the NSW and ACT Dental Acts were not decimated by the process of economic rationalism. In NSW our efforts were successful...we would like to publicly acknowledge the support of both political parties in ensuring the safe passage of the legislation...’ (ADANSWB Sept 2001)

That the profession was happy with the outcomes and had good relationships with the Minister, the legal branch and the oral health branch suggests that their sovereign position has been reinforced in this process. (ADANSWB May 2001, October 2001)

Their dominance of policy making was evident. Business ownership limits were largely retained despite the recommendations that they were anti-competitive and should be replaced with legislative provisions directed at protection of the public (NSW Health 2001):

‘...The Government supports the continuation of restrictions on the ownership of dental practices in the new Dental Practice Bill. In this regard, the Government recognises the strong concerns put to it by the dental profession. These concerns were particularly directed at the potential for large corporate dental practices to establish regional monopolies which may reduce access to services in rural areas, as well as concerns that removal of the ownership restrictions may reduce the
Employment limits for dental therapists were also retained and the ability of therapists and hygienists to compete directly with dentists to provide services was prevented.

Numerical dominance of the Board by dentists is almost unchanged from the previous Act thus also preserving their autonomy. That five of these dentists are still to be elected reinforces that autonomy and it appears that the concept was not even questioned\(^{102}\). Where six out of nine members were dentists under the 1989 Act, seven out of twelve are, in the 2001 Act. Even the academic appointment is defined as one involved in the education of dentists. The authority of dentists over the auxiliary professions is such that they are considered to also be experts in the education of auxiliaries whether or not they are participating in this activity\(^{103}\). That the DHAANSWB did not challenge their dominant views is further evidence of that power. The capacity to alter the subordination and limitation of these occupational groups is dependent on a dentist dominated Board’s interpretation of the legislation and a dentist dominated workforce and training review.

Their ability to have practice definition retained where medicine could not is even more interesting. The arguments for retaining practice definition focused on infection control and invasive procedures giving rise to greater risk of poor quality services (NSW Health 2001). These risks also apply for example, to medicine, nursing and podiatry. It supports the thesis that while medicine has undergone some de-professionalisation in NSW, dentistry has not. Even in the definition of practice the distinction is made between dentists and their subordinated occupations. The Act defines the work of dentists as ‘dentistry’ and the aspects of dentistry carried out by therapists and hygienists as ‘dental auxiliary acts’. This effectively maintains the mystique of interpretation around dentistry and implies a more task oriented (and less ‘professional’) description to practice definition for dental hygienists and therapists.

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\(^{102}\) The Issues Paper (August 1999) raised questions of cost involved in conducting elections however the Report (March 2001) does not make mention of any debate on this point.

\(^{103}\) The existing appointment to the Board in this capacity is the Dean of the Faculty of Dentistry at the University of Sydney. The College of Dental Therapy is auspiced by the Department of Health and is not connected to the University other than through shared clinical space at the Westmead Dental Hospital.
6.3.8 How important is leadership?

Leadership was also important in this case although leadership appeared to come from the dentists- the traditional dentist sovereignty model was unchallenged and government actions served to support this. The outcome of this was a no change environment despite the NCP agenda. The key issue for Victoria (and as previously discussed, Tasmania) had been recognition by government of the access to care issues. In NSW, leadership from within the ADANSWB successfully shifted this issue to one of increased funding for dentists pushing responsibility back onto government. There is evidence to suggest that in fact the government did not acknowledge the deficiencies of the existing system\textsuperscript{104} in terms of meeting the community’s need for dental services. This too reflects the dominance of the dentists. Clearly their agenda setting power was so effective that the traditional low profile of dental issues was maintained. Policy leadership, the province of government, was therefore in support of the status quo.

The ADANSWB argued that theirs was not a dominant profession and that it was the fact that their views were supported by most of the other stakeholders that contributed to achieving the outcomes that they wanted (Int). It is interesting to speculate on why this is the case. It is possible that the sovereignty of the dentists is so complete that others don’t question their view of the world. For example, when dentists hold positions of power in most settings that make dental policy (government, practice board, professional association, education) and exclude the other occupational groups from participation, theirs is the only view that is expressed. It may also be because of the strong network of connections that the ADA has developed. In NSW, the ADANSWB has relationships with advocacy groups such as the Pensioners and Superannuants, Council Of The Aging, the Brotherhood of St Laurence and other welfare advocacy groups, refugee and ethnic advocacy organisations, the Coalition of Health Professionals\textsuperscript{105}, the health funds and the insurance companies (Int, ADANSWB May 1999). Considine (1994) argued that alliances and networks are pivotal in policy outcomes because of the multiple opportunities they provide to support a particular view. He described them as the ‘...sociological sub-system

\textsuperscript{104} "(...the) Minister will be applying his ‘if it ain’t broke don’t fix it’ attitude to dental legislation..." (ADANSWB May 2001).

\textsuperscript{105} The dental hygienists (DHAA), but not the dental therapists, are also members of this coalition.
which governs a policy sector’. In this case the ‘sociological sub-system’ was largely in accord, leaving the therapists and NC OSS as the only groups seeking real change.

**6.3.9 Has economic rationalism and technical efficiency altered the policy environment?**

The actions of the health funds appeared to present the only serious challenge to the dentists’ dominance of the process. Health funds have had an important role in NSW as owners of some dental practices and the power of insurance companies, as in other states, is becoming increasingly visible, particularly to the ADANSWB (July 2001). Both preferred provider schemes and rebated services offer companies the opportunity for price monitoring and evaluation. The ADANSWB has expressed concern about the levels of rebates, the ability of companies to de-recognise providers and to directly provide services (ADANSWB Oct 2000, July 2001, September 2001). The inclusion of health funds as legal owners of dental practices under the new legislation offers the only real ‘loss’ for the dentists.\(^{106}\)

Despite the concerns of the Greens and individual members of the government\(^{107}\), this legislation review has enhanced the ability of these companies to own dental practices under the law (Rhiannon 2001, Chesterfield-Evans 2001). Clearly the dentists are concerned about the challenges these companies are making to the autonomous practice of dentistry, its profits and the implications of third party influences over pricing. The ACCC (at federal level), has also encouraged competition of this type and limited the ability of the dentists’ associations to resist their influences under fair trading laws (ADANSWB August 2001).

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\(^{106}\) ‘...Health funds are however already regulated under the National Health Act, and under that legislation are already subject to a public interest test before they can be registered as a “health benefits organisation” and so be entitled to carry on a health insurance business. Given this regulatory system already oversees the activities of health funds and requires consideration of public interest issues, it is proposed to revise the restrictions under dental legislation to allow health insurance funds which are “registered health benefits organisations” under Part VI of the National Health Act to employ dentists...’ (MacDonald, Second reading Speech, 2001)

\(^{107}\) ‘...By giving dentists a hard time at least the health funds will push costs down in those areas. However, that will only help people who are privately insured. Initially, the funds will raise the fees to dentists to encourage them to join and as the funds gain more control of the market, as happened in general practice, they will then lower the fees. I believe that if the fees to dentists are lowered sufficiently this will influence dental practice....I do not agree with the suggestion that the bill contains only a little clause that will not do any harm. Once a powerful lobby has control it is almost impossible to take away that control... This bill has a fundamental flaw and I regret that I do not have an amendment to move in Committee, although from the reaction of the Government and the Opposition it would make little difference...’ (the Hon Dr Chesterfield-Evans, for the government, Second Reading debates, 2001)
At present, the dentists’ association appears to be aligned with the health funds and has negotiated rebates for hygienists’ services at the same rates as those of dentists, thus retaining the profits with the dentists’ practice. Also, hygienists’ services must be charged via a dentist’s provider number protecting the gatekeeper charging arrangements. Should health funds move to treat hygienists as separate providers and rebate their services differently, the incentive for dentists to employ them may change. Should health funds however move to offer capitation schemes as in the US, the incentive to employ hygienists (and indeed therapists) will increase. Where health funds are direct owners of practices, (now more likely to occur in NSW) the incentives to employ auxiliaries increases because their services are both more preventive and of lower cost. At this point, the only challenge posed (and won) was over ownership, and it was clearly an effective challenge. Interestingly, the health funds chose not to act over the employment limits of dental therapists. In NSW, it may well be these organisations (ie. the health funds) that will move into the corporate rationalist or challenging role in dental policy making if their ability to remain viable is limited by professional dominance.

6.3.10 The capacity in NSW to increase access to dental services

This thesis has developed a number of regulatory indicators which point to an ability to increase access to dental services through the broader utilisation of dental therapists and hygienists (see section 5.6). The NSW Dental Practice Act 2001 can be assessed against these indicators to in the following ways;

1. **Policy Access**: there is little potential to change the culture in which policy is made and legislation interpreted because the Dental Practice Board has seven dentist members out of twelve. Five of these dentists are to be elected by registered dentists, the majority of whom are private practitioners making it likely that the interests of private practice dentists will be best served. The likelihood of removing practice boundaries applicable to dental therapists and hygienists and allowing innovative models of service delivery to be applied are slight based on past experience.

2. **Market Entry**: while dental hygienists and dental therapists are to be registered it is unlikely that the market advantages that should flow on from this will occur.
This is because other regulatory controls (employment limits, supervision, limitation of skills) on their practice have been put in place. It is therefore unlikely that they will be allowed to have normal market access and be able to practice the full range of skills they have been educated for, allowing registration alone to regulate practice. The application of registration alone could be viewed as a more restrictive regime because it places dental therapists’ practice under greater control of the dentist profession via the Board than they had as employees of the School Dental Services working under exemption from the Act.

3. **Gatekeeper controls:** requirements for supervision (practice oversight) have been retained however it appears likely, given ADANSWB support for the concept, that the controls over hygienists may be relaxed a little to allow for their services to be utilised in nursing homes under prescription. This would increase access in one small area but does not address needs of other disabled people, rural and regional, aboriginal, low or middle income people or the issues of reducing costs of services through input flexibility. So long as there is the need for prescription and on-site presence of a dentist for hygienists, the costs of their services must incorporate the cost of a dentist. With this gatekeeper control in place there is little prospect of input flexibility or reduced prices.

4. **Employment limits:** retaining public sector employment limits on dental therapists prevents the cost efficiencies generated by their utilisation to be applied to private sector services. At the market margins where price sensitivities occur (such as in lower income areas) there is no capacity to increase consumer purchasing power.

5. **Clients restricted:** at this point, dental therapists’ services are restricted to children in the public sector. Given the dominance of the dentist profession in NSW evidenced by the Review’s outcomes, it is unlikely that application of their skills to the needs of older client groups will occur. There is therefore little prospect of increasing access to services among other client groups.

6. **Scope of Practice:** this is yet to be defined in Regulations. It seems possible that hygienists would be able to extend their range of skills to include some orthodontic procedures. Other states have acknowledged the need for a ‘national’ range of skills to be applied for therapists (ADC 2001b) which could see the five
extra ‘duties’ sought by the NSWDTA added (see stakeholder positions above). This however, would be dependent on the ability of the public sector to utilise these services given therapists’ practice restrictions. It is also unlikely, given the demonstrated needs of the public sector for school dental services, that there would be any contraction of the range of skills for therapists.

7. **Ownership restrictions**: this is still to be tested. The clause allowing the Dental Practice Board to approve other owners if it is in the public interest to do so, and the ramifications of the NIB case\(^{108}\) may have broad flow-on effects. The ability of health funds and others to employ therapists and hygienists may see some of the effects of managed care schemes such as external evaluations and production efficiencies flow on to the Australian setting. This is reliant on the regulations and the attitude of the Board to such developments. However the view of the dominant dental profession is that ownership should not be relaxed and given the numerical dominance of dentists on the Board there is likely to be resistance.

8. **Advertising**: increasing access to care relates to the ability of therapists and hygienists to alert the public to the presence of their services. There are no barriers to this however retention of therapists in the public sector and the on-site supervision and prescription likely to be applied to hygienists means that consumers generally won’t have the free choice of providers that needs to accompany broader marketing of their skills.

6.3.11 **New South Wales conclusions**

In this NSW legislation review the strategic actions and negotiation of policy preferences resulted in a perpetuation of the dentists’ dominant culture. Despite the overt NCP agenda, there was little real threat of change as both the government (and its bureaucracy) and the dentists opposed its application and acted to protect the status

\(^{108}\) In 1995, NIB (a health fund) appealed a Dental Board decision to deny them the right to establish a dental practice on the grounds that it was anti-competitive to do so unless the applicant was of poor character. The Court of Appeal found in NIB’s favour, arguing that it could not consider the interests of dentists in denying ownership, substantially opening up the market. The interest in practice ownership has remained limited however with only 17 practices being owned by health funds, friendly societies, unions and universities. NSW Health, *Report of Review of the Dentists Act 1989*, March 2001 and interview data.
quo. Challenges to this dominant culture came from two sources: dental therapists, and in a limited range, health funds. The challenge posed by the health funds over ownership had been decided in a prior civil action, and was therefore an incremental response to judicial precedent. That they were able to achieve change in this area at all, against both the dentists and evidently the government agenda, demonstrates their policy power. The ability of the therapists (a repressed and largely powerless group with few network connections, supports or resources) however, to challenge the entrenched dominance (authority, autonomy and sovereignty) of the dentists was reduced to arguments over the nature of their subordination.

As seen from the examination of the outcomes against the regulatory indicators for increased access to care, little change occurred. No questions were effectively raised about how the increasing demands for restorative services that come with an ageing population, and the shortage of dental services for low to middle income people (Spencer 2001a) would be met. The organisations who, in other policy settings might have taken the equal health advocate role, were largely silent, apparently supportive of the dentists view. The ability of dentists to meet the needs of rural communities and increasing funding for public sector services effectively replaced arguments about internal efficiencies, dynamic innovation and restructuring the industry. The professional monopolists, in the face of little opposition retained the upper hand.

The ability of repressed interests to challenge the status quo was stifled by both the policy environment and stakeholder alliances. In NSW there was no significant balance to the dominance of dentists, no effective corporate rationalists or equal health advocates or challenging organisational circumstances that would provide support for a challenge to the status quo. Significant efforts were exerted in order to have alternative views heard (Int x2, NSW Hansard 2001), but without supporting networks and structures in place, the dentists’ third and second dimension power protected the status quo with little apparent effort. The result is a dental policy environment dominated by dentists and little changed by the NCP agenda and offering poor capacity to increase access to dental services. The next policy episode that engages the health funds, however may see a shift in this network structure.
6.4 Interstate Case Study Conclusions

As can be seen from the previous case study, little has changed in NSW. While this state has to date, shown the least amount of change, it can be said of most states that little has changed in terms of dental therapy and hygiene regulation across Australia.

Tasmania is the only state prior to the legislation reviews that had separate legislation regulating dental therapy practice (see Appendix 10). Victoria, NT and WA licensed dental therapists by amending the Dentists Acts and defining practice in regulations; hygienist practice was later established in the same way. South Australian therapists practiced under exemption from a dental act as did NSW and QLD dental therapists. In those states dental hygienists were enrolled via a dentist’s application to the Board. All these regulatory structures had the effect of excluding therapists and hygienists from legitimacy and from participation in self-regulation via the Boards. Although Tasmania allowed dental therapists to practice under exclusion from an Act, they were the closest to legitimacy because their Act was separate and they participated in a statutory body which had oversight of training standards. In some ways, their registration under combined dental legislation has reduced their autonomy.

South Australian dental therapists could make similar arguments; while they were not afforded legitimacy under an Act, their exclusion from it meant that their employer determined their scope of practice. South Australia in recent years has included dental therapists in management and policy making roles and on their public dental services board of management. Their scope of practice was able to respond to the needs of the community and was, therefore flexible. Their status as dental care providers was however, like NSW, marginalised and poor in terms of the external relationships described by Willis (1989) as critical to professionalisation. While there are corporate rationalist arguments for retaining this, there are also arguments supporting the shift. A more ‘professional’ status for dental therapists and hygienists is likely to give voice and visibility to them adding to the capacity (through public acceptance) to develop more innovative models for delivering dental services.

In all states, following legislation reviews dental therapists and hygienists are already, or are likely to be registered bringing them into legitimate health practice and into participation in self-regulatory models. No state, however has developed separate
legislation for therapists and hygienists affording them clearly autonomous professional status. The NCP agenda has contributed to this outcome by pressing reductions in regulation, but third dimension power is also responsible. In each state, the idea that dental therapy and hygiene are inseparable from dentistry was never really contested; the team dentistry concept was so pervasive that it shaped, mostly without challenge, the regulatory environment.

Table 6.8 below summarises the findings of the two interstate case studies in relation to the emergent hypotheses from the Victorian case study.

<table>
<thead>
<tr>
<th>Victorian case findings</th>
<th>Tasmania</th>
<th>New South Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>The professional dominance of dentists has limited the re-structuring of dental service delivery to meet community</td>
<td>This has been the case in the past although small changes pre-review</td>
<td>Yes, both in the past and in this legislation review</td>
</tr>
<tr>
<td></td>
<td>Previous structures in place to protect dentists position (ie all dentist board, ownership, advice to minister etc) New model is less supportive of dentists</td>
<td>Structural power of dentists retained - 7 out of 12 of new board members are dentists, market dominance and service delivery structures not challenged</td>
</tr>
<tr>
<td>There are regulatory mechanisms to indicate capacity to increase access to dental services</td>
<td>Regulatory indicators show greater capacity to increase access to care in this state because gatekeeper controls mostly removed (not clear about hygienists), independent practice allowed, scope of practice based on education, ownership and employment limits removed</td>
<td>Little or no capacity to increase access to services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Only real change is off-site supervision for hygienists in nursing homes. 1 shared (DT/DH) board seat out of 12 and registration not likely to make any difference here because all other limits retained</td>
</tr>
<tr>
<td>The government has an interest in reducing the power of dentists as a step toward reducing the costs of service delivery. Economic rationalism and corporatised health service delivery has altered the power of challenging and repressed interests in dental policy making</td>
<td>Yes; shortage of dentists in Tasmania was important. Technological efficiency already an issue- previous policy in place for adult trial Codes developed alongside review process Environment created which altered repressed interest behaviour → challenging Corporate interests not apparent NCP influence helped by pushing ownership, advertising limits &amp; gatekeeper controls This is a more competitive environment for dentistry than exists (or is likely to) in any other state</td>
<td>No. Access to care issues not on agenda as an efficiency issue NCP not influential- 'gone off the boil' Little change to ownership laws Corporate interest not apparent other than as aligned with dominant interests Repressed interest were heard but not influential Area health service structures appear to have dissipated public sector dental advocacy Future potential for health funds to take up challenging role-corporate interests</td>
</tr>
</tbody>
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313
<table>
<thead>
<tr>
<th>Victorian case findings-</th>
<th>Tasmania</th>
<th>New South Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is much harder to generate change than to protect the status quo</td>
<td>Not really - but bureaucracy/govt was supportive of change here Structural power of dominant interests reduced but not eliminated: eg. Rearguard action on the Poisons act, Board numbers Market based system still in place and no external evaluation of prices Mixed scanning policy making model</td>
<td>Yes - govt/bureaucracy not supportive of change. Mobilisation of bias evident re repressed interests Despite 'enormous energies', status quo retained Incremental policy making model</td>
</tr>
</tbody>
</table>

| Empirical evidence is less powerful than structural dominance but it does strengthen the case for change | Research evidence of little influence in this case-comparative/experiential evidence used Mixed scanning model-structural reform fundamental, policy elements significant but incremental | Evidence of use but much less powerful than structural dominance. Evidence acknowledged where it didn't challenge the dominant view. Evidence ignored where it did not support policy direction |

| Leadership is emerging as an important tool for generating change | Leadership critical to behaviour of repressed interests Also government/bureaucratic (agenda & knowledge) leadership important Organisation skills important to be heard- how to 'play the game' | Yes-govt/bureaucratic leadership stifled change. Dominant interests too strong & pervasive Repressed stakeholder leadership important in a pluralist sense, but not enough alone |

Willis (1989) observed that the mechanisms of medical dominance included subordination, limitation and exclusion. These dental legislation reviews have had the effect of removing exclusion of dental hygienists and therapists across the board, albeit in a token fashion in some states. With the exception of NSW, most states’ legislation alone does not protect the other two mechanisms (subordination and limitation), although regulations and/or codes of practice can, by retaining requirements for supervision and a defined scope of practice. So far, only Tasmania has managed to avoid both subordination and exclusion. Therapists’ and hygienists’ practice will still be limited by their educational preparation and the Dental Code will require identification of referral pathways; whether this translates into subordination will be interesting to watch.

In the past, governments have allowed dental practice boards to advise them on the mechanisms required for defining the roles of dental auxiliaries. Dentists have seen this as their role and therapists and hygienists have been excluded from these processes. The current round of policy making in this area has not only included the
dental therapists and hygienists as stakeholders but in many states has also imposed a level of support for their participation that has not occurred before. This development in itself increases the power of these groups because of the growth inherent in participating in such processes. While exclusion of these groups has limited their policy making experience, their increasing maturity and experience (both within and outside dental practice) has delivered emergent professional groups with growing capacity and self-esteem. Their formalized participation in regulatory structures, however small, continues this development and adds the benefit of access to information. In all states, this emergence alters the culture of dental policy making, and establishes challenge to their continued subordination.

The Victorian review delegated the task of determining the scope of dental auxiliary practice to the Board, but added an objective related to increasing access to dental services. In South Australia it is the role of regulations\textsuperscript{109} to 'prescribe the conditions’ under which therapists and hygienists should work and both therapists and hygienists have been formally included in the working party developing these regulations\textsuperscript{110}. In New South Wales, the Act has retained the limits on therapists’ employment and will also determine scope of practice in regulations to be developed with leadership from the Department of Health (Int). In each of these cases, governments have retained a degree of control over the way auxiliaries are regulated despite their registration and the delegation of statutory responsibility to Dental Practice Boards. These decisions combined with the appointment rather than election of Board members indicates that some governments are taking a more directive approach to dental auxiliary regulation than in the past.

A further discussion of the findings of the case studies and development of the hypotheses will be carried out in the concluding chapter.

\textsuperscript{109} Regulations are required to be accompanied by regulatory impact statements and are usually made by the Minister responsible for the legislation

\textsuperscript{110} personal communication, SADTA, Jan 2002
CHAPTER 7: CONCLUSIONS; THE REGULATION OF DENTAL THERAPISTS AND HYGIENISTS

7.1 Introduction

This research project sought to analyse and gain insight into the dental health policy process with a focus on increasing access to dental care. Given that dental care in Australia is provided through a market based system of delivery and there is little immediate prospect of this changing due to pressures on health spending, the study was interested in how the market suppliers (in particular dental therapists and hygienists) could be regulated so as to provide for increased access to care.

The aim of the study was:
To investigate the process and outcomes of policy making around dental auxiliary practice in Victoria, interstate and internationally with a focus on the potential to increase access to dental care.

The objectives of the study were:
2. To assess associated legislative and regulatory dental policy reforms in the other states in Australia.
3. To compare Australian and selected overseas countries’ dental health policy as it relates to dental auxiliary practice.

In order to meet these aims and objectives, the policy making process around the National Competition Policy review of the Victorian dental legislation has been studied. This has been augmented, through comparative case study methods, with analysis of legislative and regulatory dental policy reforms in the other Australian states. Further, the regulation of dental therapists and hygienists in international settings has been examined for variance and evidence of models that may increase access to dental care.

One of the components of policy analysis is evaluation of the impacts of the policy. The timing of the policy review processes examined by this thesis has limited the
ability to evaluate the impacts of the policy changes on access to care. Any such impacts will occur in the longer term. However in lieu of assessing the impacts, and given the focus of this study on access to care, it was important to develop a number of indicators of capacity to increase access to dental care. These indicators have been developed through the dental policy analysis conducted in this study together with input from the relevant research, historical and policy literature in Australia and overseas (described in sections 1.2, 2.5, 4, 5.6 and 6).

These indicators have been used to analyse regulation in the Australian and international settings examined in this study. They are described and used in the following section to draw conclusions about the outcomes of the policy reforms.

The second section of this chapter presents concluding arguments around the dental policy making processes that delivered the outcomes which have emerged from this study. The themes discussed in this section provide an explanation for the inability of dental policy reform to achieve the changes which are predicted to increase access to dental care.

7.2 Dental policy reform outcomes and indicators for increased access to dental care


This evidence was applied to the models most commonly used to regulate the dental industry (especially in relation to dental therapists and dental hygienists) in order to
develop indicators that could be used to assess regulatory outcomes. Eight key indicators were identified as follows:

- Increasing access to regulatory policy making for dental therapists and hygienists (reducing or removing dentists dominance of the policy environment)
- Using registration to manage market entry requirements and practice standards
- Removing gatekeeper controls over dental hygienists and therapists’ practice (rather than for example prescribing vertical relationships such as prescription, supervision, direction and control by dentists in regulation, and defining billing relationships)
- Removing limits on client groups (eg. school aged children, or patients previously examined by a dentist, or living in community-controlled areas)
- Removing limits on employment for dental hygienists and therapists (eg public sector, dentists only)
- Allowing scope of practice to be defined by education, acquired skills and competency (rather than for example lists of duties or services prescribed in regulation or tight practice definition)
- Removing limits on business ownership
- Removing limits on advertising (particularly for hygienists’ and therapists’ services)

The outcome of applying these indicators to dental hygienists’ and therapists’ regulation would be that they would be registered, subject to professional conduct standards (and sanctions for unprofessional conduct), self-regulating and able to provide their services in collaboration with and in competition with dentists in any environment where patient needs match their skills. Standards of professional conduct would require that referral pathways be established for patients whose needs are beyond the skills and competence of dental therapists and hygienists and that they would be responsible for their own practices. In many settings they could become the primary dental care provider, assessing need, providing care and referring on where appropriate to more highly skilled practitioners. Equally they would be responsible for recognising the boundaries of their skills and maintaining their professional competence, and able to develop further skills in relation to local needs. Course approvals (or alternatively licensing examinations) by regulatory bodies would allow education, acquired skills and competence to determine practice areas which may
vary between individual practitioners. Dental therapists and hygienists would be able to own practices and supply their services when and wherever there is a need for them, directly charging whichever organisation or individual is responsible for the fees. Advertising within professional boundaries would allow dental hygienists and therapists to provide information for consumers to make choices about which provider is appropriate to their needs. This model allows the flexibility to utilise the health promoting, preventive and low to medium technology clinical services in whichever practice setting and combination is required to best meet local needs at lower cost than most existing dental practitioner regulation currently allows.

An examination of regulation in each Australian state, New Zealand and some international settings selected for their variance with Australian models in relation to these indicators has shown that while many settings incorporate some, no settings have combined all of them. Table 7.1 below summarises these indicators, their empirical supports and their application in legislation in a range of states, provinces and countries.

In Australia, following legislation reviews, most states have moved to registering dental therapists and hygienists under dental practice legislation and including them in mixed membership dental practitioner boards. Only Victoria and South Australia have removed dentists' numerical dominance of the board. While this seems a small change, the potential for wider reform of the industry has been created because a broader range of views will now permeate the regulatory environment. The limitations however, are that dentists still hold more seats on both Boards than any other group and the market based model of service delivery is unchanged. The dentist profession's concepts of practice have generally dominated society's beliefs about oral health and service delivery and this is unlikely to change in the short term (Lewis 2000). This entrenched expertise and authority over dentistry means that dentists' cultural perceptions are still likely to dominate the Boards unless public health appointments alter the balance of power. As this decision in both states resides with health ministers, political pressures are likely to prevail.
Table 7.1 Summary of indicators and their application in regulation in Australia and overseas

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale &amp; Supporting Evidence</th>
<th>Increase access by...</th>
<th>Settings using this approach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Broaden membership of combined practitioner Board to include other dental care providers and consumers</td>
<td>Most Australian states New Zealand, Some Canadian provinces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dentists are not numerically dominant on mixed Boards</td>
<td>Victoria, South Australia</td>
</tr>
<tr>
<td>Registration as market entry</td>
<td>Ensures adequate education, rights to practice as protection of standards, reduces the need for other potentially anti-competitive mechanisms DP&amp;C 1996, Industry Commission 1996</td>
<td>Registration of dental hygienists and therapists Allow mutual recognition of qualifications across state borders</td>
<td>Most Australian states and New Zealand (local variations) Some Canadian provinces and American states (National Licensure exam) UK 2002</td>
</tr>
<tr>
<td>Remove gatekeeper controls</td>
<td>Decrease input costs &amp; prices because removes the need for clients to see a dentist unless needed Therapists and hygienists in primary care role (less costly, more technological efficiency). Practitioner relationships develop as needed Allows consumer choice of provider Liang and Ogur 1987; De Vany 1982; Industry Commission 1995; Milsteed 1996, DP&amp;C 1996; VDTA 1998 Baltutis and Gusey 1999, Orhn et al 1996; Barmes 1983; Gaughwin et al 1996 Other health professionals eg nurses in Victoria do not have gatekeeper controls in regulation</td>
<td>Public allowed to choose which practitioner they will see Therapists and hygienists allowed to directly compete with dentists</td>
<td>British Columbia, Canada (365 day rule) Netherlands: new hygienist in primary care role Netherland California, Colorado</td>
</tr>
<tr>
<td>Remove employment limits</td>
<td>Limits prevent application of skills where they match need: Liang &amp; Ogur 1987; Freed, Perry and Kushman 1998; Industry Commission 1995; DP&amp;C 1996 Astroth and Cross-Poline 1998; VDTA, 1998</td>
<td>No limits; Therapists and hygienists may work in independent practices, hospitals, outreach services etc wherever there is a need for their skills</td>
<td>Dental Hygienists in Canada (some provinces), Netherlands, some US states Dental therapists in WA, Tasmania, Victoria, Saskatchewan (no employment limits but independent practice not permitted- employer must also employ a dentist)</td>
</tr>
<tr>
<td>Remove limits on client groups</td>
<td>Limits prevent application of skills where they match need: AHMAC 1996; Baltutis and Morgan 1998; VDTA, 1998</td>
<td>No restrictions on client groups - skills applied according to needs of client and setting- complex care referred to dentist or other health practitioners Hygienists and therapists work remote from dentists (off-site) hospitals, outreach services etc wherever clients need their skills</td>
<td>No age limits for Dental hygienists, No age limits for Dental therapists in New Zealand, Western Australia, Netherlands new hygienist, UK, Canada First Nations All dental therapists. Dental Hygienists in Canada, Netherland, some US states, Victoria and, South Australia under prescription of a dentist</td>
</tr>
<tr>
<td>Scope of practice not prescribed</td>
<td>Tightly prescribed (or bundled) skills or services reduce dynamic innovation and the capacity to reduce costs (MacBride 1974; DP&amp;C 1996) Most health occupations rely on educational preparation to define skill areas allowing the development of locally responsive practice</td>
<td>No definition of skill range-therapists and hygienists use skills according to their educational preparation and work context Registration (professional practice) demands that they work within their competence</td>
<td>Dental hygienists in British Columbia, Alberta (Canada) Dental therapists: New Zealand uses broad description of practice, UHC no defined list but services provided under dentist delegation) Saskatchewan, Netherlands core (restricted) practices defined</td>
</tr>
<tr>
<td>Remove business ownership limits</td>
<td>Restrictions can protect monopoly pricing arrangements, increase the costs of running practices and inhibit innovation; Industry Commission 1995 DP&amp;C, 1996</td>
<td>No limits</td>
<td>Victoria, Tasmania, Netherlands, British Columbia Canada, Washington, Colorado, California</td>
</tr>
<tr>
<td>Advertising</td>
<td>Limits reduce visibility of therapists and hygienists</td>
<td>No limits</td>
<td>Tasmania, Victoria</td>
</tr>
</tbody>
</table>
New Zealand will move to a self-regulating model for dental therapists (also proposed for dental hygienists) in the near future under omnibus health practitioner legislation currently before parliament. The Dental Council of New Zealand will comprise mixed dental occupational membership and will delegate powers to individual occupational Boards. The Dental Therapists Board is to consist of five dental therapists, two dentists, one dental therapy educator and two public members. The New Zealand Dental Therapist Association has been involved in a considerable amount of policy development in the lead up to this change to establish codes of practice and clinical competence standards and annual practice certification requirements (see Appendix 2).

This move will bring New Zealand into line with several other countries around the world that have passed separate legislation covering dental hygienists and established dental hygiene and therapy boards or colleges. Several Canadian provinces, for example, moved to self-regulating models during the 1980s and '90s, developing Colleges of Dental Hygiene out of their Hygienist Associations with responsibility for developing practice standards, educational and competency standards, registering practitioners and administering the legislation. The provinces have developed locally appropriate mechanisms and policies to suit their own needs, some of which have now been in existence for around 20 years. Dental hygienists in Quebec have been self-regulating since 1975 and dental therapists and hygienists in Saskatchewan since 1981 (see Appendix 3). These models demonstrate that where dental hygienists and therapists are regulated separately from dentists, more flexibility in service provision is enabled.

The Netherlands has also moved to this model under omnibus legislation which has placed responsibility for regulating practice with the Netherlands Dental Hygienists Association (NDHA). The NDHA has chosen to offer two types of registration, Standard and Quality. In order to achieve and maintain Quality Registration, hygienists are required to demonstrate continuing professional development, recency of practice and undergo workplace performance assessments or, for independent practitioners, peer review assessments. The NDHA has also been involved with government in defining a hygienists' schedule of fees in order that hygienists can be
directly remunerated for their services by government and insurance agencies (see Appendix 4)

Clearly, based on these findings, dental hygienists and therapists are capable of administering regulation of their own practice and defining professional and educational standards at a level which provides appropriate protection of the public. It may be argued that dental hygiene and therapy practice in all of these countries has a longer history than in Australia and was therefore ‘ready’ to manage these tasks. I argue that the movement to self-regulation is not predicated on the needs of the profession and therefore not reliant on its maturity, but driven by the need to maximise the utility and effectiveness of these professions in the public interest. Retaining dentist dominance over the regulatory environment has prevented these reforms from happening, both in Australia and overseas. It is therefore in the public interest to draw on the experiences of other settings (local and international) and to develop appropriate models, provide appropriate resources and opportunities that allow these developments. Subordination is the problem, not a lack of maturity.

As discussed in Chapter 6.2, Tasmania has to date, shown the most liberal approach to regulation of dental therapists and hygienists in Australia. Regulation there has relied upon registration alone without the other historically imposed controls. Independent practice has been enabled and practice ownership limits removed. Education and competence define their scope of practice. Skills and responsibilities, and the relationship between dental therapist or hygienist and a defined dentist are to be described by individual agreements. The capacity in this state to increase access to dental care is greater than in any other Australian state because the flexibility to provide services according to local needs has been enabled.

The Canadian provinces of British Columbia and Alberta have shown that where hygienists are registered, education can safely be relied upon to determine practice. This kind of regulation already occurs with the regulation of many other health practitioners in Australia including nursing (ANCI 2000, 1995,1993, NBV 2001a) and dentistry. Dentists can practice any aspect of dentistry within their considered capabilities; dental therapists and hygienists have also been doing so in practice and there is evidence to demonstrate that they appropriately refer clients with needs beyond their competencies (Barmes 1983, Gaughwin et al 1996, Freed et al 1997). It
is clearly unnecessary and costly (DeVany 1982, Liang and Ogur 1987, DP&C 1996) to define skills in regulation, an assertion supported in Victoria by model legislation (DOH 1990, DHS 1997b).

It is also unnecessary and costly to impose routine supervision on dental therapy and hygiene practice. The presence of a dentist in the same room or building as a hygienist or therapist will not prevent mishaps (Dunning 1972); appropriate standards of education and training and a self-recognition of competency will do that. These are aspects of both the administration of registration and the moral agency developed by educational socialisation into a health profession, including dental therapy and hygiene (University of Melbourne 2002b, ADC 2001b). Clearly a new practitioner in any profession will require higher levels of support than an experienced practitioner, equally with some patients, care is complex and requires greater levels of skill and collaboration between practitioners, both inside dentistry (vertically) and across health professions (horizontally). Individual competence will also demand individual levels of support and collaboration. Dental therapists in Australia and New Zealand have been practising safely and effectively (Barmes 1983, Dooland 1992, Gaughwin 1996) in collaborative, referral relationships with dentists who have been available but not present on the premises for many years (despite the presence of regulation requiring direction, supervision and/or control). They have effectively managed their own practices in all but name, demonstrating that independent practice does not pose a risk to the public. Kushman et al (1996), Freed et al (1997), Perry et al (1997) and Astroth and Cross-Poline (1998) in the US have demonstrated that independently practising hygienists can do so safely, refer appropriately, offer no threat to quality of care and increase access to dental services. Both experience and research have demonstrated that such gatekeeper controls are unnecessary encumbrances and yet, as demonstrated in this study, regulatory models continue to impose these costly barriers to access.

Removing client limits also has the capacity to increase access to dental care. The limit imposed particularly on dental therapists in relation to the age of their clients is particularly restrictive. The imposition of age limits has had little foundation in empiricism and more to do with historical policy decisions around service delivery. Indeed, on what basis can an arbitrary age limit be imposed that defines treatment
needs or complexity? Child patients have adult teeth and there are adult patients who have similar treatment needs to child or adolescent patients, particularly in settings where fluoride is more accessible and dental caries rates have decreased. Victoria has recognised this and made an incremental shift in the age limit to 18 years with a capacity for dental therapists to provide adult services on prescription of a dentist for patients aged between 18 and 25 years (DPBV 2002). Tasmania has made similar compromises by retaining an amendment allowing for a trial to test the use of dental therapists with adults, albeit under the close supervision of dentists.

In both these situations the ground was contested and involved debate around extending dental therapists’ education to include hygienists’ skills. No such debate appears to have occurred in New Zealand however, where age limits on dental therapists’ patients were removed in 1988. As a consequence, there are dental therapists working in community health and Maori provider organisations providing dental care for low income adults and adults of Maori and Pacific Islander backgrounds (See Appendix 2). Dental therapists in Manitoba and Saskatchewan in Canada have been working for First Nations Community provider organisations treating adults for over 20 years. It is clear that dental therapists have the capacity to provide these services and that there are significant public health gains to be had from such a model because the services they provide come at a lower cost than those of dentists alone.

This raises questions about inconsistent perceptions of risk across community groups. It is possible that extensions of the roles of dental therapists and hygienists in these communities show that dentists may be prepared to allow broader therapist and hygienist roles with communities that are not profitable to market based private sector models. Indigenous, elderly, low income, disabled and homebound people and children are often not viable consumers of dental services in a market based system because their treatments may take longer, require more patience or more repetitive treatments, are more difficult to treat or require domiciliary services. While some dentists are prepared to work with these communities, many are not because market incentives do not exist there.

Indeed there is evidence to suggest that dental therapists in particular were seen as a temporary solution to the problem of child dental caries that could be dispensed with
once the problem was under control (Leslie 1971, NHMRC 1965, ADAVB 1994). In Saskatchewan, Canada, for example, once the caries levels in children appeared to be reduced to manageable levels the School Dental Service was dismantled in favour of a private practice dentist delivered capitation scheme (Croucher 1988, See Appendix 3 for the Canada case study). Experiences in international settings show that dental therapists can provide dental services at appropriate standards to adults with resulting increases in access to care (Assembly of Manitoba Chiefs 1997, NZMOH 1998, NZDTA 2002.). The arguments about such a model posing a threat to the health of the public is inconsistent with these experiences and raises questions about other motivations for making them.

In the light of these arguments the new model Netherlands dental hygienist, providing diagnostic, preventive, restorative and periodontic services look very interesting. This extended dental hygienist is to become the primary care provider of dental services for all age groups who refers on to the six year trained oral physician, a practitioner with more highly developed treatment and surgical skills (see Appendix 4). This hygienist is to spend four years in a bachelor program to equip them with appropriate skills. However this development in turn raises questions about whether this practitioner is really just a dentist in another, less costly incarnation. In addition, the development of the prophylaxis assistant to provide prophylactic and preventive services under delegation begins to look like the dental hygienist in her original conception.

The advantage of this model however, is that the hygienist is a preventive practitioner first and an interventionist second. It shifts the whole thrust of oral care to a preventive model and one that is more technically efficient because the oral physician role does not engage in low to medium technology services. The challenge for this model will be to keep prices down if it is to increase access. This model is similar to that proposed by the WHO Expert Committee for the Educational Imperatives for Oral Health Personnel (WHO 1990). The concept of using a combined dental therapist/hygienist also has support in the UK (Nuffield Foundation 1993) and in Australia (AHMAC 1996, DAWR 1995) but the same level of support for a primary care role is not evident.
As with the new Dutch hygienist and the AHMAC ‘adult auxiliary’ proposal, the independence of dental prosthetists has posed similar threats to dentists. Their role is now reasonably well accepted in most states in Australia, they practice independently, in their own practices and without threat to quality of care and with demonstrated reductions in costs of care (Dooland 1992). There is evidence that this ground was hard fought (Robertson 1989), but expanding services and reducing costs has proven irresistible to governments and consumers alike. It is inconsistent to argue that where dental prosthetists are safe providers of dental services under these conditions, that dental therapists and hygienists are not capable of doing the same.

An important consideration in relation to these indicators is that all eight are required to increase access to care. Selected combinations may improve the situation marginally, but single indicator changes may be detrimental. For example, the use of registration alone without removal of lists of duties, client limits and supervision of practice only serves to add an extra layer to regulation and has the effect of increasing control over hygienists’ and therapists’ practice by dentists, as in NSW. Removing ownership and advertising limits alone serves only to shift the flow of profits. However removing ownership and advertising limits and allowing dental hygienists or therapists to practice independently according to their competencies allows new practice types to develop in low income, remote or domiciliary settings with lower input costs and lower prices. It also allows therapists or hygienists to provide public sector services under subcontract or in combination with other employment. It also allows them to work in hospitals and residential settings that may not need or be able to afford to employ a dentist.

The need to increase access to dental services is apparent in every setting examined by this study. There is also strong international and local evidence to support the contention that market based distribution of dental services is inadequate as a means of meeting the full range of community needs. All settings have identified aging populations, workforce shortages and unmet need in low income communities as issues for future dental services delivery (AHMAC 2001, Locker and Matear 2001, Van den Heuvel 2002, Hannah 1998). Re-orienting health services to more preventive and primary care models has also been recognised as an important aspect of reducing demand for treatment services and improving health (WHO 1990). The
regulation of dental practitioners has been shown here to have important influences on the capacity of communities to address these issues and this study has set out to establish mechanisms by which this might be achieved. Retention of regulatory barriers to broader utilisation of dental therapists and hygienists skills cannot be justified on public safety grounds. Indeed the above discussion has shown that every one of these regulatory barriers has been dismantled in various settings in Australia and around the world without posing risks to the quality of oral health care provided to the public. Indeed the only barrier to their removal has been the dentist professions themselves and they, it seems are the only beneficiaries of their retention.

7.3 Understanding the outcomes: the dental policy development process

As discussed above, regulatory indicators for increased access to care have been developed from the literature and from the findings of this study. These indicators have been used to examine the outcomes of the dental policy reform processes in this study. The study has found that in almost all settings examined (with the exception of Tasmania and possibly the Netherlands) the regulatory models have failed to match these indicators. The following section of the conclusions discusses the broader policy system influences that have contributed to these policy outputs. The discussion below is based on the close examination of the policy reform processes in Victoria, and to a lesser degree, Tasmania and New South Wales. It uses the hypotheses generated by the case studies to form conclusions about how dental policy was developed and why, given the need to increase access to care, there has been little regulatory change.

7.3.1 The professional dominance of dentists has limited the re-structuring of dental service delivery to meet community needs

Power structures within dentistry reflect those of medicine as described by Willis (1989), Turner (1987), Freidson (1994) and Short and Sharman (1995) with structural supports for professional dominance maintained by legislation, market monopolies and education. This was particularly evident prior to the dental legislation reviews
initiated by NCP in Australia (see Appendix 10). Several states had made attempts to shift the practice of dental therapists and hygienists into new settings and configurations (AHMAC 1996) but had been impeded. Willis (1989) identified the three mechanisms for establishing and protecting professional dominance as being autonomy, authority and sovereignty. While these legislation reviews challenged all three aspects of the dentists’ dominance, none were particularly successful.

The control that dentists have over their own work in areas such as price setting, diagnosis and treatment planning, clinical decision making and evaluation, the nature and volume of tasks and earnings has remained largely unchanged. Thus the autonomy of dentists over their own practice as defined by Marjoribanks and Lewis (2002) has been retained. However autonomy in relation to their professional standards and the industry has been changed in some settings. It has been challenged by the trend to ministerial appointment (rather than election by dentists) of board members and diversifying board membership. For some states (for example NSW), this change is small, as the proportion of non-dentists to dentists and ministerial appointments has hardly altered although overall membership has increased. For Victoria and South Australia though, the shift is significant, as numerical control over the board has been removed, although dentists still hold more seats than any other occupational group. Thus in some states, through the appointment of non-dentists to dental boards, dentists’ professional behaviour will come under the scrutiny and judgement of consumers and other dental occupational groups. Policies, practice standards and discipline will all be subject to non-dentist opinion and the development of subordinate regulation such as codes of practice will have broader input than in the past, reducing the internal aspects of dentist autonomy.

Authority in most states has also been reduced but only slightly. The control that dentists have over other occupations has been a feature of their professional dominance. Their ability to retain subordination (through prescription, direction, supervision and control of practices), limitation of practice and exclusion from regulatory and policy making of dental therapists and hygienists in particular has been almost complete in Australia.

Legislation review processes have made little change to this authority except that subordination is less prescribed in some settings, having been reduced to what are
described as collaborative relationships or general oversight. This has recognised the autonomy of dental therapists over their own practices in relation to diagnosis and treatment planning, evaluation of care and organisation of practices and a degree of control over their dental assistants. This is not the case for hygienists (except in Tasmania) who are still working largely under the prescription of dentists although the requirements for on-site supervision have been reduced.

Other gatekeeper controls have been retained though, with the exception again, of Tasmania. Dental therapists and hygienists can also own practices in Tasmania but in Victoria they must be employed in conjunction with a dentist. In South Australia and New South Wales they can only be employed by dentists or governments. Limitation of practice remains, as a subset of dentistry but the ability to add competencies has been created and the barriers to portability across state borders are being reduced in Victoria, Tasmania and are likely to be reduced in South Australia.

In all states dental therapists and hygienists are no longer excluded from legitimacy and policy making as all states have or are likely to register them and afford them at least a shared seat on a multi-disciplinary board. While this is a significant shift given Australia’s regulatory environment, it is a small change compared to many international models. No state gave consideration to separate legislation or self-regulation which would have conferred real legitimacy and autonomy of practice. In fact in two states, Victoria and South Australia, prosthetists suffered a reduction in their autonomy by being brought back under dental practice legislation.

So dentist autonomy and authority have been only slightly reduced, and their sovereignty over the whole dental industry is also little changed. In every state, private practice dentists are still the most prominent providers of dental services and the ones who define dentistry (Lewis 2000). They retain most of the structural power by way of well resourced and politically connected professional associations, well remunerated employment, controlling positions in public dental health organisations and educational settings and as ‘usual sources’ for the media. In those states where dentists are not numerically dominant on the board, they hold the chair conferring a degree of sovereignty even in settings where there is potential for change. Some momentum has been achieved in the Commonwealth policy arena in raising the profile of oral health and challenging existing service and public health models but
these too are dominated by dentists and exclude policy participation by therapists, hygienists and prosthetists (AHMAC 2001).

Further, the dominance of the biomedical model of dental care which Lewis and Marjoribanks (2002, section 2.2.4) identified as a macro work freedom, remains. The emphasis on high intervention, reductionist treatment technology remains in place, taking precedence over minimal intervention, preventive and health promoting models. Funding arrangements and market oriented service delivery support this model in every state protecting the independence and financial rewards of dentistry for dentists. Lewis (2002) showed that despite redefined roles and structures, medicine has not shown generalised losses of authority and autonomy. In the dental field also, despite the structural changes to regulatory administration, dentists maintain their role as state sanctioned professional and market monopolists, defining practice boundaries and retaining oversight of other dental professionals’ work.

7.3.2 State governments have an interest in reducing the power of dentists as a means of reducing the costs of service delivery.

Globalisation and neo-liberal economics have created an environment where all sectors of the Australian economy have been challenged to become more rational and competitive (Hancock 1999). Further, the spiralling costs of health care and the profile of unmet dental needs has fed into the struggle of governments to regain control over health service costs (Dooland 1992, SCARC 1998, Lewis 2000). The distribution of responsibility for health care and the resulting tensions between state and federal governments has allowed each state to deal with these demands in their own way (Hancock 1999, AHMAC 2001). The result has been a chequered approach to dental policy which has delivered different outcomes in each state. Victoria and Tasmania, and to a lesser degree, South Australia embraced the NCP agenda and used it to generate changes in the dental regulatory environment that may not have occurred without it. In these states the will of the government to see structural change in the dental industry was greater than in many of the other states. The NSW government on the other hand had little apparent interest in altering the dental policy environment. So, while this theory was well supported in the Victorian and Tasmanian contexts, it did not hold for New South Wales.
While threatening to many public health agendas, somewhat ironically National Competition Policy offered opportunities to improve public access to dental services with the economic rationalist agenda forcing greater consideration of costs and outcomes and giving less respect to traditional professional monopolies. In most health settings, a neo-liberal agenda of market based reform poses a threat to equitable distribution of health services (Hancock 1999). In this case, however, where market based delivery, complicated by a professional monopoly, was the mainstream provider, market reform offered an opportunity to improve equity of access by challenging the monopoly.

Where markets are so regulated that a monopoly exists then prices may be artificially inflated because there is no challenge to them. Further, the incentives to use innovative and technically efficient service delivery mechanisms are absent (DP&C 1996). For some markets, regulation mediates this (for example price regulation in the postal industry, Medicare in the health sector) but because in this case, the people responsible for regulating the market have a vested interest in protecting its monopoly and profits, a conflict of interest exists. Further, allowing this same group to regulate the practice of subordinated providers extends the conflict of interest because of the ability to profit from that subordination. The demands of NCP to increase competition challenge this monopoly and expose its accompanying conflict of interest.

While complete de-regulation in the health sector would pose significant problems because of information asymmetry, there is clearly room for less regulation and greater challenge to the remaining conflicts of interest in the dental regulatory environment. In each state, the will of governments to challenge the will of professional dominance was tested and in most cases the sovereign power of the dentists was retained. Dentistry in Australia, with its practice definition, legitimated subordination and entrenched authority, is still one of the most highly regulated, monopolised and dominant health professions.
7.3.3 Economic rationalism and corporatised health service delivery have altered the power of challenging and repressed interests in dental policy making

De-regulation and rationalism have altered the health policy environment. Where dental policy was once the premise of governments and dentists with power delegated via dental boards to dentists, the development of competition has altered this environment. Lewis (2000) identified the changes that the rise and fall of the Commonwealth Dental Health Program (CDHP) had made to the federal policy arena, however these changes did not all flow on to the states other than to confer greater legitimacy on state governments for dental policy intervention. Some states chose to act on this, others did not and it is this fragmented approach to policy that makes generalisation across the states problematic.

In Victoria, this loss of funding was combined with the Kennett Liberal government’s enthusiasm for purchaser-provider arrangements in the public sector (Zifcak 1997, Hancock 1999) and the fragmentation of dentists into public health ‘equity rationalists’ (Lewis 1996) and professional monopolists. These changing conditions, along with a greater attention to output focused service provision created a faction taking a challenging position to the professional monopolists with the support of government. The existence of a corporate public dental entity and broader practice ownership provisions allowing corporate health sector involvement underpin both the corporate rationalist and equal health advocate roles described by Alford (1975).

In Tasmania, a pre-existing shortage of dentists plus the loss of CDHP funding generated earlier policy changes in a rationalist direction and a greater profile for unmet dental needs. Government support for this position combined with politically astute dental therapist participation took this stakeholder group from the position of a repressed interest to that of a challenging interest. Their potentially expanded role in the delivery of public sector services and as practice owners in the light of a shortage of dentists in that state, may provide the supports to sustain the role.

In NSW there is less fragmentation of organised dentistry’s views and less of a profile with government for unmet dental needs (NSW was the only state that did not attempt to respond to the loss of the CDHP). It was also apparent that the NSW labour government had less enthusiasm for NCP than some of the other states. As a
result there was less opposition to organised dentistry’s views and therefore less change in the structural environment. The key change that occurred here was in the area of practice ownership that was opened up to the health insurance industry. This has the potential to create a corporate sector that will challenge the professional monopolists in the future. Change of this nature has also occurred in Victoria, Tasmania, and Queensland.

The key changes to the dental policy environment then, have arisen from the loss of the CDHP funding giving greater profile to unmet dental needs, and the impact of neo-liberal economics and competition on dental regulation. In Victoria and Tasmania, there were stakeholders ready to advocate the needs of under-served populations and rationalist approaches to dental service delivery so that the monopoly dentists have protected over many years was challenged. In NSW it was the corporate health sector capitalising on the policy environment. That dentist professional dominance still overpowers rational regulation and use of dental hygienists and therapists is clear. However, the changes to legislation may well have developed the tension between professional dominance and corporatism necessary to alter the dental policy environment in all three states over the longer term. The insurance industry is a sector that may exert key influences in the future.

7.3.4 It is much harder to generate change than to protect the status quo

Considine (1994) observed that policy outcomes are the products of negotiation and that actors bring historically grounded preferences to the process which become compromised components of the emergent policy. Not everybody has equal capacity to influence the outcomes because of their positions and power. Each actor is either dependent, autonomous or dominant and must choose between retaining the benefits of compliance with this position or challenge, push for concessions and re-arrange their relationships (Considine 1994).

The issue for those who choose to ‘challenge, push for concessions and re-arrange their relationships’ is that enormous energies must be generated and sustained to do so. Single efforts in policy engagement contribute very little to the debates, particularly during the visible part of a policy process. These case studies have shown that it is second and third dimension power that is the most influential- pluralist
engagements on a level playing field were either non-existent or had little influence; by that time the decisions had mostly been made. The ability of the ADA in each state to shape the perceptions of what dentistry should be, define the policy agenda, mobilise bias in support of the status quo, generate fear of change, discredit the existing evidence, generate multiple advocates for their position and continually apply pressure was overwhelming. The structural supports, networks and resources available to this powerful group mean that support is generated without much effort. They hold most of the positions of power so they are invited to participate in policy making. They are members of many of the stakeholder groups and inhabit social circles common to the decision makers. They are asked to contribute their expertise which is given weight because of the sovereignty of esoteric knowledge. The services they provide are to middle to upper income people who can afford them, so the needs of this group, which are adequately served by the market, are the most visible and dominate the policy environment.

The ability of other stakeholder groups to challenge these views was much more limited. Dental hygienists and therapists in particular, relied on volunteer organisations, had little policy and advocacy experience and little opportunity to engage with government and with regulation. The efforts involved in generating the resources, time and expertise to advocate for their causes were considerable, particularly over the long term. For professions comprised largely of women, the competing demands of home and work, subordination and professionalism generated further tensions. Further, the way dental hygienists and therapists are employed often creates greater pressures on their advocacy role because the stakeholders they are forced to advocate against may be their direct employers. Their position as repressed interests has benefited these employers over the long term. In some states, these groups had support from other stakeholders and experiences that helped their positions, but in others they were forced to act alone, sometimes even in isolation from their colleagues. Dentistry is a relatively small industry and the repercussions of acting can be costly.

In NSW, where relatively little change occurred, it can be seen that for a repressed interest with few other supports, generating change was almost impossible. Also, the review in this state talked of modifying an existing act, therefore offering little
opportunity to make change or rationally consider other models. Under this model of policy making the mobilisation of bias easily and effectively supported the status quo. Incremental policy making models such as this have a greater capacity to protect the status quo because they allow the dominant ideas to prevail without significant challenge (Ham and Hill 1993).

In Victoria and Tasmania however, the overt agenda was of developing new legislation. This mixed scanning model enabled an ambit claim approach providing the opportunity for change because at some point a broad view of the field was undertaken to make fundamental decisions. In both states the intent of government was to alter the environment so that more rational models of service delivery could be established. Once these fundamental changes (board structure, registration and ownership) were identified then incremental change to existing models occurred to develop outcomes more consistent with other health practitioner regulation.

7.3.5 Empirical evidence is less powerful than structural dominance but it does strengthen the case for change

This study took an interest in how evidence was used to inform policy making in light of recent trends to evidence based practice. The claims of dentistry to a basis in science would suggest that evidence would be important to decision making in this field. In two of the Australian case studies, evidence based approaches were sought by the policy processes. The existence of research evidence that could inform the decision making has already been demonstrated (see section 1.24). As we have also seen, international settings also demonstrated models which could be used as comparative evidence (Appendix 2, 3 and 4). But the policy outcomes in these two states did not reflect this evidence. Ironically, in the state that did not seek evidence, (Tasmania), the outcomes were closer to the evidence.

The processes in Victoria and NSW clearly demonstrated that evidence can be subordinated to the dominant view. Professionals have expertise and apply it as part of their roles and one of the ways dominant professions protect their position is to claim ownership of knowledge and the unique (but impenetrable) ability to apply it (Willis 1989, Considine 1994). Therefore expertise can be authoritative because it can reconstruct ‘evidence’ to suit the dominant paradigm and equally has the ability to
discredit that evidence that challenges its dominance. For example, dentists generated mistrust of the evidence in support of less regulation for therapists and hygienists and fear of more rational approaches.

Stakeholder groups used the available evidence to manipulate public opinion and to support the outcomes they wanted to achieve. The strategic use of evidence means that some will be ignored, interpreted and dissected out, be subjected to ‘spin’ and incorporated into discourse in an attempt to shape the policy culture and support the preferred direction of the decision making. This selective use of evidence has also been described by other authors (Lin 1999, Niesson et al 2000, Black and Donald 2001).

The Victorian process also showed that evidence must be salient and well understood by a range of people around the policy process, particularly the policy makers. Presenting new evidence during the policy process was not particularly useful because of the incremental and cumulative nature of the policy making, and the competition for attention. Many of the policy directions had been developed prior to the active process and the narrowing of the field that occurred during the agenda setting phase was critical to the negotiation that occurred during the active policy making phase. Evidence therefore needs time for digestion and incorporation into the accepted discourses. It should be presented continuously and re-presented during the policy formulation phase to maintain its salience.

Policy makers also used evidence selectively. In both Victoria and NSW, the policy makers were aware of evidence that supported less regulation and also had an NCP agenda to support it. That the outcomes were inconsistent with these supports demonstrates the political nature of policy making. The result was that where the policy outcomes agreed with the evidence it was used and where it did not it was ignored. Research, therefore, was just one ‘tool’ in the armory the policy makers had available to them to gain acceptance for the proposed policy. Weiss (1979) who proposed a number of uses of evidence in policy making, described this model as the political model where evidence is used to justify a pre-determined position.

The generation of evidence can also reflect dominant discourses as it depends upon the questions that have been asked. Research funding sources, political support and
publication can also select the evidence that is available for use in policy making (Black and Donald 2001). The ADA argued in all three states through this policy process that there was not enough evidence to support change. However, in 1996 when the AHMAC pilot project was proposed they actively suppressed the generation of new evidence which would investigate whether dental therapists could be utilised with adults. In Tasmania, this idea eventually gained acceptance in 1997 (Dever) but the research trial is yet to be implemented.

While evidence is important to policy decision making it has not prevailed in a pluralist sense; political agendas and structural power (the contextual aspects) have carried more weight. Of interest here is the strength of the dominance of the process by one particular view which led to evidence being ignored. In health policy making there is often the problem of lack of specifically relevant evidence, where human nature and context validity are not well addressed by the research evidence (Lin 1999). There is also an acknowledgement of the role of governments in constraining the range of options with cost limitations, timelines and ‘fit’ with existing policies and platforms (Davey Smith et al 2001). In this case, in relation to broadening the scope of auxiliary practice, there was existing evidence, it was specific and generalisable to the problems at hand, and in agreement with broader policy positions applied to the process. The values and attitudes of a dominant ‘normative’ stakeholder group subverted the application of this evidence to the policy outcome resulting in a greater weighting of political rationality over technical, economic or social rationality. This may reflect the agenda setting power of particular interest groups rather than a lack of commitment to evidence based practice (Alford 1975, Marmour 1982 in Palmer 2000). The view is reinforced that, despite the evidence, dentist professional dominance and power is still alive and well in the dental policy making environment.

7.3.6 **Leadership is important as a tool for generating change**

While professional dominance, NCP and the loss of the CDHP (which raised the issue of unmet dental need) exerted significant influences on the policy outcomes, there are still aspects unexplained by these influences. An important additional ingredient appears to be the leadership of particular policy actors. It is apparent that
individuals also make a difference to policy outcomes but they need structural support too. This is consistent with Considine’s (1994) assertion that policy leaders may represent the public face of a policy position but that the position is still a product of the groups and the system. Policy systems confer on particular actors the power to make decisions and this power is the product, in relation to regulation, of government authority. How the particular representatives of government mediate the demands of the policy processes will have a bearing on the outcomes.

In Victoria, for example the key policy maker had, through previous policy processes and a government ideology in support of competition and change, an imperative to reduce the dominance of dentists. As a result there were some determined actions (an ambit claim environment, targeted consultations and the exercise of authority) to achieve an outcome that met this agenda. Leadership in this state was strong and overt and also supported by rationalist and equal health advocate stakeholders.

In Tasmania, that task was delegated to a section of the bureaucracy with a change agenda, which also engaged with particular stakeholders to achieve the required support. In this case strong leadership from the dental therapists group meant that there was a counterbalance to the opposition to change. If the dental therapists had not actively sought regulatory change and been prepared to explore and develop alternative models, it may have been difficult for the bureaucracy to make the changes they did.

In NSW leadership also came from the policy making unit but it did not attempt to generate change or challenge the dominance of the dentists lobby. No strong opposition to these views came from any sector other than the dental therapists, although the dental therapists had good leaders with similar vision to that in the other states. This process demonstrates the importance of context and institutional support to the direction of regulatory reform.

In New Zealand, leadership has been particularly important in generating change. While legislative reform was on the agenda, the movement of a dental therapist into a political role created an environment where the dental therapist lobby could become a challenging interest. The policy process still engaged with all the stakeholders but the therapists were elevated into policy roles from which they had previously been
excluded. The authority of the minister was able to overcome the dominance of the dentists and ensure a more rational approach to regulation. Similarly, in the Netherlands, policy direction has come from the Ministry on the back of a number of broader reforms despite the opposition of organised dentistry (Hovius 2001, Okma 2001, Karlsbeek et al 2001).

In some ways the evidence around leadership in these studies agrees with Cohen, March and Olsen's (1972) garbage can theory of policy making which asserts that policy outputs are the products of the policy primeval soup - the random intermingling of choices, problems, solutions and energised participants in the policy environment at any given time. While this appears somewhat random and accidental as an explanatory framework, there is a degree of randomness to the rise of leaders with particular interests, connections and energy at particular times. Critical to their ability to be effective, though, is the support provided by those around them and the context in which the policy is being made.

7.3.7 Development of the dental therapy and hygiene professions

Certainly for the dental therapists and hygienists, personal leadership, vision, energy and relationships were important aspects of their ability to participate. Again though, these attributes are products of the context and not just the result of individual action. A number of changes were occurring in their environments. Rationalist approaches to technical efficiency and in some cases political support were offering them opportunities for participation they had not had before. The internal dynamics of their profession were also contributing, as the average age of the professions shifts upwards into the 30s and 40s (in 2000, 70.6% of therapists and 55.2 % of hygienists were aged between 30 and 44 yrs; AIHW DSRU 2002) giving more experience and confidence to their members. Many members of these professions were recognising and questioning the subordination and lack of respect for their abilities that have been enshrined in legislation. They were prepared to generate resources, develop their arguments, argue for challenges to the status quo and push for concessions. Emerging internal development meant that there was a recognition of the mechanisms of subordination and dominance and the need for development of their advocacy roles, networks and their separation, as a profession from their employment.
This identity separation is particularly relevant in the case of dental therapists. Dental therapists have been a product of their environment, developed and trained for school dental services and solely employed by them, in New Zealand for around 80 years, and in Australia for around 30 years. Their self-conception has been bound up in the delivery and management of school dental services. Indeed, the original conception of a dental therapist was of one delivering standardised and routinised procedures (Leslie 1971). School dental services over many years have relied upon this using centralised planning, resourcing and evaluation which, of necessity in a large organisation, limits individual professional freedoms. This has posed problems, not only for the internal development of the profession, but also for the dentists conceiving of their regulation. Further, the information the dentist profession has received about dental therapists from their professional associations has been mostly sparse and negative, leaving many dentists under-informed about their roles and abilities (Atkinson 1993, ADAVB April 1994, June1994, ADAVB April 1996, ADATB Feb1998, ADANSWB Oct 2001). Separating the role, skills and intra-professional relationships of the generic dental therapist from the school dental services model has been a challenge for many involved in the debates around their regulation.

Their separation from the dental hygiene profession has also contributed to this. Hygienists, despite their greater subordination have always had greater freedom of employment and diversity in their roles. They have provided care on the prescription of a dentist rather than diagnosing and treatment planning for themselves but this has meant far greater diversity in employment settings and skill development. Dental hygienists have been able to work in general practice, periodontic and orthodontic practices and for many, in a combination. Their closer relationship with dentists has allowed them more access to professional development and developing technologies. There are also broader international networks and role models providing pre-existing concepts of a generic hygienist role, and greater support for their role among dentists (IFHD 2001, ADANSWB Feb 2000, Oct 2000, ADAVB Aug 1994, Mar 1998, ADATB Dec 1998, Feb 1999). The separation of the dental therapy and hygiene professions has been both a product of their separate employment settings but also deliberately nurtured by dentists.
This separation has diminished the ability of dental hygienists and therapists to work together but also to recognise the commonality of their roles as preventive, low to medium technology providers of dental care. The current trend to combined education (initiated in 1996 at the University of Melbourne, in 1998 at the University of Queensland, and at the University of Adelaide in 2002) and the ability to add competencies to 'dual skill' is beginning to generate a wider understanding and greater collaboration between the two professions. In Victoria, this process was beginning during the legislation review and has progressed as education and legislation brings the two closer together. Further, the lifting of restrictions on therapists' employment will increasingly bring them into closer contact in dental practice environments. In Queensland, legislation is considering protecting the title of oral health therapists in recognition of the dual skilled practitioner (PWC 2000). In the states where there is a shared board seat greater recognition of the common ground between the two groups and potentially greater collaboration is likely to develop. It is also possible that the functional affiliations of dental boards will contribute to some policy contamination (or borrowing of regulatory models) into the future (Considine 1994). Whether this is in a direction that benefits dentists or the community will depend on the interests around the board tables.

The issue for these groups however is that their ability to challenge their entrenched subordination is difficult to sustain without structural supports (Alford 1975). The new policy environments that include them contribute to, but are constrained in several states by numerical dominance of the boards by dentists. Further, the affiliation of the state dental boards as the Australian Dental Council (ADC) to advise on matters concerning the uniformity of education and occupational regulation of dentistry adds an extra layer (ADC 2001a). The recent move by the Australian Dental Council (ADC 2001b) to accredit dental therapy and hygiene education programs might be perceived as positive if it were not for the membership of that body- all dentists. So the structural supports for subordination are still in place and dentists remain, mostly unlikely to support their dismantling.

What membership of boards does do is give dental therapists and hygienists access to information. Further, their education in university settings contributes to their ability to synthesise and apply information, make decisions and develop their own expertise.
Corporate and rationalised approaches to dental service delivery are also likely to contribute supports. These interests in driving greater technical efficiency will maintain the profile and utility of dental therapists and hygienists into the future. It is also likely to continue to put pressure on the barriers to accessing dental services and drive greater examination of their full potential. This contributes structural support as service provision models shift and demand for their services drives an increase in their numbers, adding skills and resources to their organisational base.

Broader employment opportunities are also likely to contribute to workforce retention. As broader employment opportunities and greater utilisation of dental therapists and hygienists occurs their profile in the community will grow and their position as participants in and advocates for oral health will be enhanced. Sax (1972) referred to this as technological determinism arguing that it produces a levelling of status among the occupational groups. Willis (1989), however argued that newly emergent professions can be simply absorbed into the existing hierarchies in ways that do not threaten dominance as dominant professions respond by altering their own support mechanisms. More recently Lewis (2002) has supported this position by noting that while there are losses and gains in autonomy and authority for medicine, its ability to maintain and define boundaries remains. This can be observed in dentistry as dentists upgrade their education to graduate entry and include internship programs which serve to maintain the knowledge gap between the occupational groups.

### 7.4 The implications for public dental health

There can be no system of policy making without policy participants and the outcome of a policy process is the product of the interactions, conflicts and negotiations that occur along the way (Considine 1994). It is important therefore to ensure that whatever position public health advocates are in, they participate and ensure their views are heard. Policy credibility and power can be cumulative (Gardner 1995) and dental therapists and hygienists, despite their less powerful positions, are important participants in the dental policy arena in terms of their preventive approach to dental services, their ability to advocate for underserved populations and because of the culturally different views they have of dentistry.
Indeed, it was this culturally different approach to dental care that was the key to the establishment of dental therapists and hygienists. Their ability to meet the need of undeserved groups and to increase preventive services to clients was the cornerstone of their development. Indeed, so long as they are prepared to remain in the role of a complementary provider, many dentists are supportive of them. The provision of preventive and therapeutic services to a selected range of clients who under market conditions may not receive such care, maintains a complementary occupational position. The contests occur when hygienists and therapists challenge their subjugation and their limitations and threaten to move into more substitute and competitive roles. Indeed, part of the problem lies with the demand that they provide services as part of a professional paradigm and behave as professionals, but are denied the legitimate autonomy of a professional.

This problem is consistent across the Australian and international settings examined in this study. In each setting, the quality of care provided and the professional attributes of dental therapists and hygienists is established. Further, the existing market mechanisms for delivering dental services have also consistently been shown to be unable to meet the needs of the community. The likelihood of low taxation, minimalist neo-liberal governments investing sufficient funds to alter this distribution is small. Given this combination, the most effective reform that could occur in dentistry is to develop more cost-effective treatment systems and place a greater emphasis on prevention of oral diseases. Wider utilisation of dental therapists, dental hygienists and oral health therapists as primary care providers is an appropriate way to meet this need. This will require some dismantling of the mechanisms of dentist dominance of the oral health care environment. Evidence exists that such a dismantling process poses no threat to public protection and quality of services.

Dental treatment is not always synonymous with oral health. While access to services is an important aspect of achieving oral health, and this thesis has dealt in detail with the issues surrounding access to care, it is not the treatment alone that is important. Access to care and in particular primary care, incorporating health promotion in all its facets, is important. Increasing access to preventive services and advice is also important. Allowing the health promoting approach to oral health to be incorporated as a full and critical component of oral care is also important. Shifting the heavy
emphasis from the technical and biomedical toward the social is also critical to the improvement of oral health in the community. Dental therapists’ and hygienists’ education incorporates a much greater proportion of this theoretical area than does dentist education and as such, a greater emphasis is placed on public health. Shifting funding and service access is important but shifting dentistry philosophically toward public dental health is critical to developing better oral health for all sectors of the community.
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PART 5-DENTAL AUXILIARIES
Division 1- School Dental Therapists

502. Duties of a school dental therapist

A school dental therapist may, under the supervision, direction and control of a dentist, do the following, in the provision of school dental services:

(a) carrying out of established procedures associated with chairside assisting; and
(b) dental health education; and
(c) dental examination, including the taking of dental radiographs; and
(d) removal of plaque, extrinsic staining and calculus from teeth; and
(e) topical application of solutions to teeth or oral tissues; and
(f) administration of infiltration or inferior dental nerve block local analgesia; and
(g) application of rubber dam; and
(h) preparation of cavities in teeth; and
(i) restoration of teeth by dental amalgam, cement or composite resins, excluding endodontics; and
(j) recontouring and polishing of dental restorations; and
(k) restoration of deciduous teeth by preformed crowns; and
(l) forceps extraction of deciduous teeth under local analgesia; and
(m) pulp capping of teeth and pulpotomy of deciduous teeth; and
(n) placement of pit and fissure sealants; and
(o) pre and post operative care.

505. Duties of a dental hygienist

A dental hygienist may, under the supervision, direction and control of a dentist, do the following:

(a) carry out established procedures associated with chairside assisting and practice management; and
(b) dental health education; and
(c) topical application of solutions to teeth and oral tissues; and
(d) pre and post operative instructions; and
(e) measurement and recording of periodontal disease; and
(f) removal of plaque, extrinsic staining and calculus from teeth; and
(g) root planing; and
(h) cleaning and polishing of teeth and restorations; and
(i) application and removal of periodontal packs
(j) orthodontic band selection; and
(k) removal of orthodontic archwire; and
(l) removal of non-metallic separators; and
(m) preparation of teeth for bonding by scaling and polishing, but not etching; and
(n) routine checking for loose bands and broken appliances; and
(o) taking of impressions for study casts; and
(p) taking of peri-apical and bitewing radiographs.

507. Maximum number of hygienists per dentist

In a dental practice there must be one supervising dentist for each dental hygienist employed.
APPENDIX 2: CASE STUDY: NEW ZEALAND

The data for this case study were collected via two semi-structured interviews with the Presidents of the New Zealand Dental Therapy Association and the Dental Hygienists Association of New Zealand; electronic mail interviews with the Policy Officer of the New Zealand Ministry of Health, Policy documents from the Ministry of Health and Dental Council of New Zealand, Conference Papers from the 15th International Symposium of Dental Hygiene held in Sydney in 2001 and material from the published literature.

New Zealand (NZ) is an island nation east of Australia with a population of 3.84 million people. Eighty-five percent of people are concentrated in urban areas and the main ethnic groups are European (71.7%), Maori (14.5%), Pacific (4.8%) and Asian (4.5%). As in many Western countries, the population is ageing. It is projected that, in 2031, twenty two percent of the population will be aged 65 or over, compared to only 12 percent in 1998. Maori and Pacific populations show a younger population structure with roughly twice the proportion of children under 15 compared to the rest of the population. The unemployment rate in March 2000 was 6.4 percent (NZMOH2001a).

The organisation of health and disability support services within New Zealand has gone through a number of changes within the last decade. Area Health Boards established in the late 1980s, came to have responsibility in the 1990s for delivering health services purchased by regional health authorities in a competition oriented environment. In 2001 a more community-oriented model has been implemented with policy and funding functions and the administration of pharmaceutical benefits done at Ministry level and service purchasing and delivery devolved to Regional Health Boards. New Zealand spends around 8.4% of GDP (compared to 8.6% in Australia) on health care and 77.5% of health services were publicly funded in 1998-99, through taxation with the rest funded through private health insurance, the Accident Rehabilitation and Compensation Insurance Corporation or direct consumer payments. Most health care in New Zealand is provided free of charge – the one exception to this is primary care where a fee-for-service system exists (NZMOH2001a).

Maori issues and health services

The New Zealand Health Strategy acknowledges the special relationship between Maori and the Crown under the Treaty of Waitangi. In New Zealand it is recognised that health outcomes are enhanced when services are delivered in ways that meet the cultural needs of Maori and there has been a drive to increase the provision of culturally appropriate services. A minimum of two members of each regional health board must be Maori and there are funded structures in place to increase the number of Maori health workers, to increase traditional healing practices and support Maori
provider services. There is currently around 10 years difference in the life expectancy of Maori and Non-Maori people in New Zealand (NZMOH 2001a). Whilst the majority of the population has experienced improvements in oral health, Maori, low-income and isolated New Zealanders tend to carry the greatest burden of dental diseases and tend to have poorer access to dental treatments.

**Dental service delivery**

Dental services are provided in New Zealand via a mix of private and public sector provision with the majority provided by dentists in private practices funded directly from patient payments. There are 16 regional, dental therapist based, school dental services which meet the preventive, educative and restorative needs of around 90% of eligible school children via direct public sector service delivery with referral to private practice dentists for complex needs. Table 1 shows the number and mix of practitioners in the New Zealand workforce.

**Table 1 - the New Zealand Dental Workforce- mix and numbers**

<table>
<thead>
<tr>
<th>Year</th>
<th>Dentists</th>
<th>Dental therapists</th>
<th>Dental hygienists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>1364</td>
<td>510</td>
<td>95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ratio:</th>
<th>1:2724 total pop</th>
<th>1:1120 children (0-12yrs)</th>
<th>1:4052</th>
</tr>
</thead>
<tbody>
<tr>
<td>population</td>
<td>1:2285 adult pop'n</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(source: DCNZ 1998)

In the mid-1950s the New Zealand government introduced the General Dental Benefits Scheme. Private dental providers were offered a contractual relationship with the government to supply a defined range of services to New Zealand adolescents, a scheme to bridge the transition between the school dental program and the responsibility of adulthood within the private dental market. Around 68% adolescent (up to 16 yr olds or 18 if still at school) needs are met by this scheme via capped fee-for-service (with a restricted range of services) which varies from region to region. Preschool services also vary from region to region and participation rates range from 56%-81%. Changes to the health and education systems during the early 1990s saw a fragmentation of service delivery arising out of regional level purchasing arrangements which has altered the universal nature of the child and adolescent dental public services.

Services for hospital in-patients and institutionalised and disabled adults are also provided under public sector funding. Adult services are provided under an Emergency Scheme for some Community Card Holders under central policy requirements but in some localities, more generalist services are provided to low income earners under local service funding arrangements. These services are provided through a mix of private fee-for-services arrangements, hospital and Maori community provider organisations. Maori Healthcare Providers also administer and
deliver preschool, primary and adolescent dental services to their own communities (Hannah 1998, NZHFA 1999, NZMOH 2001a, NZMOH 2001b).

Caries experience in children range between 1.44 in 5 year olds in fluoridated areas and 1.88 in 12 year olds in non-fluoridated areas with Maori children suffering almost twice these average rates (NZHFA 1999). In adult populations, caries experience among 35-44 year olds averages 20.6 DMFT with 11.7% edentulous. This rises to 58.6% edentulousness among 65-74 year olds (Hunter et al 1992). Cost is considered to be a significant barrier to adults accessing dental care which exacerbates socio-economic differences in oral health status which are apparent despite water fluoridation, particularly in Maori populations (Hannah 1998).

**History**

New Zealand pioneered the systematic introduction of an operative dental auxiliary\(^1\) to assist with the management of dental caries. The School Dental Service introduced the School Dental Nurse (who later came to be called the dental therapist) in the early 1920s as the principal dental service provider to New Zealand school children. The NZ School Dental Service grew with the NZ primary school educational system to be considered, along with the School Medical Service, as a key part of an integrated education and health service. Approximately 60% of schools have dental clinics and can accommodate visiting dental services on either a full or part time basis. The dental therapist was accountable to a local Dental Officer in an administrative role, and services outside the range of the dental therapist’s competence are referred to private dentists participating in the provision of the Special Dental Benefits scheme (NZMOH 2001b).

According to Leslie (1971), the spark which eventually produced the school dental nurse was ignited by the president of the NZ Dental Association, Dr Norman K Cox in 1913. In response to the ‘disturbing condition of children’s teeth’, he proposed a system of school clinics operated by the state and staffed by ‘oral hygienists’ to address the dental needs of children between the ages of 6 and 14 years. At the time the idea was considered too unorthodox but following recognition of the poor oral health of WW1 recruits, the idea was raised again. In 1920, at a special meeting of the New Zealand Dental Association, 16 members voted for the adoption of school dental nurses with 7 opposed. Leslie (1971) reports that organised opposition was considerable on the grounds that the employment of dental nurses posed:

‘...a menace to the public, (a) menace to the (dental) profession and an injustice to those seeking to enter the ranks of the (dental) profession by recognized avenues…’


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\(^1\) Dental ‘dressers’ had existed in the UK slightly earlier but had worked in a limited number of clinics providing services under the prescription of a dentist for a short time (Nuffield 1993)
The structured safeguards built around the scheme, it was argued, addressed these concerns. School dental nurses were to provide diagnostic and restorative services to children:

‘...in a rigidly structured set of methods and procedures which spare her the anxiety of making choices... they would be supervised by graduate dentists...they would be trained, not in a university but in a school conducted by the Department of Health...and permitted to treat only pre-school and primary school children... organised and directed by the State...’

under monopoly employment arrangements. Further, only young women, ideally aged around 17 years, would be trained for the role (Leslie 1971). The debate about the training setting showed that some favoured the university environment along-side dentists, but the view prevailed that:

‘...it is better that she be trained...in an institution where the curriculum and conditions have been specially designed to prepare her for the responsibilities she will be required to assume...’. This required ‘...absolute standardisation of techniques and rigid uniformity of instructions. Student dental nurses are taught only (school dental) Service methods and procedures and these must be strictly adhered to...each school dental nurse is issued with a copy of ‘Standing Instructions’ covering in great detail, every conceivable subject relating to her work...the need for personal judgement is (therefore) reduced to the barest minimum...’ (Leslie 1971).

It was recognised that a university setting was designed to encourage a broad approach, the exercise of judgement and selection of alternatives, an education which was considered wasteful if applied to these school dental nurses. In this way, school dental nurses would provide no competition to dentists, they would be safe and reliable providers of dental care working in a limited environment, under supervision and be unable to illegally pretend to being dentists. Leslie (1971) acknowledged the need for dentistry to ‘protect its status and retain its responsibilities’ and exhorted his readers to ‘...remember that well trained, well disciplined auxiliaries are more likely to conform than are the dentists themselves’.

As a consequence, beginning in 1921 the NZ Health Department offered a course from a school in Wellington, and then in additional schools in Auckland, and Christchurch after the second world war until the late 1970s. At this time the additional schools closed leaving just the Wellington school graduating around 30 students per year (Tane 2002, Hannah 1998).

Leslie concludes his review of the 50 years experience of the school dental nurse scheme in New Zealand by asserting that they had proven invaluable in delivering education and dental services which had contributed to improvements in dental health, in lifelong dental attendances and service flexibility.

“Within a planned system, they can provide excellent services which...in the happy event of a major breakthrough in prevention, could be gradually curtailed without adverse effect on anyone, least of all independent practitioners.” (Leslie 1971)
Dental therapists today

New Zealand’s dental therapists currently practise under employment with Crown Health Enterprises (CHE), and contracted to regional health authorities for the delivery of primary dental services to children and adolescents and in some settings, adults. Like Australian dental therapists, they provide examination, diagnosis and treatment planning, restorations, extraction of deciduous teeth and preventive dentistry including, health education fluorides and fissure sealants. They work under the supervision of dentists (average of 1 CHE dentist : 62 therapists NZ wide) referring children with complex clinical needs to dentists in the private sector. The responsibilities of supervising dentists is to ensure that dental therapists do not practice outside of, and that they maintain, their competencies (NZMOH 1998). Dental therapists are currently not registered but practise under exemption from the Dental Act 1988².

Adolescents are commonly treated by dentists through the private sector although there are proposals to move this aspect of service provision into the dental therapist based school dental services (Hannah 1998, NZMOH 2001b). Age limit restrictions on dental therapists’ clients was removed in the Dental Act 1988 on the basis that they would offer the same services to all age groups utilising referral mechanisms for complex services in the same way they had traditionally done with children. Some Regional Health Authorities and Maori Healthcare Providers utilise dental therapists to provide basic dental services for low income adults, older adolescents on benefits or in training programs and for the elderly³ (Hannah 1998, NZMOH 1998, NZDTA 2002). Dental therapists have only recently in some districts begun to work with dental assistants. Workforce predictions are indicating that this is a positive development which is likely to offer an increased patient caseload of up to 1450 children per dental therapist (compared to current caseload of 950 children per therapist) (Hannah 1998).

In 1998, there were approximately 569 (equivalent of 510 full time) dental therapists practicing in New Zealand, a significant decline from around 900 in 1990. The majority are female and 45.8% are aged over 45 years of age. Around 5.7% are of Maori background although student data indicate that 15% of students in 1998 were male and 36% were of Maori or Pacific Islander backgrounds. A 1998 workforce analysis indicated that an ageing workforce, poor retention of graduates, poor career

² S7; Exemption in respect of dentistry carried on by persons employed by School Dental Service or hospital boards or area health boards---Nothing in section 4 of this Act prevents the carrying on, in accordance with conditions approved by the Director-General of health, of the practice of dentistry by any person employed by the School Dental service or a hospital board or an area health board. (NZ Dental Act 1988)
³ At present dental therapists who treat adults mostly work within Iwi health groups (Maori) or as in Taranaki, low income adult groups. Taranaki area is one where dental therapists treat adults within the Dental Service and are totally integrated with the hospital dental service. There are three clinics that treat adults part of the time and children the other part of the working week with the same level of dentist 'supervision'. (personal communication NZDTA, 2002)
development and occupational regulation are all issues requiring attention in order to meet future workforce needs (Hannah 1998).

In 1991, training was transferred from the Department of Health to the Ministry of Education, under auspice of the Wellington Polytechnic which offered a two year diploma course (Hannah 1998). This program was having difficulty in attracting students and seen to be not catering for the needs of tertiary students or employers. In 1999, the University of Otago offered a Diploma program from its School of Dentistry (TAGDT 2001) and in 2002, took students into the first year of a three year Bachelor of Health Sciences in Dental Therapy. In 2002, the University of Otago has also offered dental therapists the opportunity to undertake post-graduate education. The Postgraduate Diploma in Dental Therapy is offered over two years part-time in recognition of the capacity and need to develop clinical expertise for special needs populations, as well as management and educator roles (Kardos 2001, Tane 2002, University of Otago 2002).

An identified shortage of dental therapists to meet workforce needs (Hannah 1998) has also led to a three year Bachelor of Health Science in Oral Health (Dental Therapy) being developed and offered at the Auckland University of Technology in 2002. This program is being delivered through a health sciences campus with a first year which is integrated with nursing and other allied health undergraduates. This has arisen out of a proposal from Waitemata Health, identifying problems related to attracting dental therapists from northern and Pacific Islander communities to education settings in the South Island (Otago) along with local workforce shortage and retention issues. Waitemata Health is the largest provider of public dental services in New Zealand, and will collaborate to enable the clinical aspects of the course to be delivered (TAGDT 2001, Shaw 2002, Horne 2002).

**Dental hygienists**

The employment of dental hygienists in NZ is relatively new having only been formally recognised under legislation in 1988. Their scope of practice includes removing deposits and stains from tooth surfaces, application of fluorides and other preventative agents, polishing teeth and restorations, some root planing and periodontal maintenance and ‘...other services delegated by a registered dentist...’ (NZMOH 1998, New Zealand Dental Act 1988). They may only provide services prescribed by a dentist when a dentist is on the premises. In 2001, there were approximately 120 dental hygienists practising in NZ, around 45% of whom work full time and 77% of whom are under 35 years of age (NZ Dental Hygienists Association (NZDHA), Hannah 1998). Dental hygienists are currently not registered and practice under Section 11 of the 1988 Act.

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4 This was a finding of the 1997 Report or the Academic Review or Dental Therapy and Related Programs at Wellington Polytechnic, cited in TAGDT report 2001.

5 S11- Exemption in respect for removing deposits from teeth and certain other work---Nothing in this Act prevents any person---
Formal training commenced in 1995 when Otago Polytechnic offered a 15 month Certificate in Dental Hygiene which developed into a two year Diploma program in 1998 (Hannah 1998, NZDHA 2001). In 2002, the University of Otago commenced a three year Bachelor of Health Sciences in Dental Hygiene program from the same campus as the dental therapy and dentistry courses (University of Otago 2002).

Prior to that time, there were several sources of ‘training’ for dental hygienists. On three occasions during 1989-90, the NZ Dental Association delivered a three week course through the Wellington Polytechnic to ‘convert’ dental therapists into dental hygienists. This was not compulsory for practice and there are also dental therapists working as dental hygienists who have had no extra training other than on-the-job or preceptorship training. There are also dental assistants who have developed dental hygienist skills in this way to meet the needs of their current employer.

The NZ Armed services also trains dental hygienists in a two year program to meet their own needs; some of whom have taken up employment in private dental practices upon service exit. Further, there are also overseas trained dentists, who have been unable to meet NZ registration requirements for practice as a dentist, who have taken up employment as dental hygienists. There are also dental hygienists who have graduated from overseas programs working in New Zealand, some of whom are teaching into the new course at the University of Otago (NZDHA 2001, University of Melbourne 2002).

The wide range of sources of education and training for dental hygienists has meant a wide range of competence and skill in their practitioners. This has been exacerbated by a lack of regulatory recognition resulting in diverse practice standards and employment conditions. There are arguments in support of protecting title under regulation in order to exclude ‘unqualified people’ from practising dental hygiene. The NZDHA has identified the financial incentives dentists have in employing inadequately trained hygienists although dentists argue that as they are responsible for the quality of services provided, the financial incentives are weak (NZMOH 1998, NZDHA 2001). The NZDHA has chosen to accept as members, only those who have completed formal training as hygienists from the Polytechnic or University settings (including those dental therapists who ‘converted’ in 1989-90) and graduates of overseas Dental Hygiene programs (NZDHA 2001). Currently, a small but growing number (around 14% in 1998) of dentists employ hygienists (Hannah 1998).

Policy and Legislation Review

In 1998, a labour government was elected in New Zealand and among its new appointments was a Minister for Health with a background as a dental therapist. The new labour government recognised, as one of the 13 population health priorities, the

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(a) removing deposits from teeth, (b) applying materials to teeth for the purpose of preventing disease or (c) giving advice on oral health or (d) carrying out any other similar work—under the direction of a dentist who is present on the premises at which the work is carried out. (NZ Dental Act 1998)
improvement of the oral health of New Zealanders in its overall Health Strategy. Specifically the Government identified six strategies for improving the oral health of New Zealanders, namely to:

- re-establish a nation-wide oral health system for children and adults;
- allow dental therapists to provide a greater range of services;
- upgrade training and registration of dental therapists;
- investigate access for low income adults;
- review the Dental Benefit Scheme; and
- review the Dental Act. (NZMOH 2001b).

In order to address some of these strategies, the NZMOH established a Technical Advisory Group for Dental Therapy (TAGDT) to make recommendations about training, regulation and scope of practice of dental therapists. The group \(^6\) meet several times over the period of four months and together with the Ministry of Health developed a paper containing a number of recommendations relating to the dental therapy workforce (NZMOH 2002). This report recommended that:

- Dental therapists be registered and have their employment restrictions removed. They would still work as part of a dental team but would be responsible for their own practice.

- A combined dental council be established with proportional membership from each dental occupational group including at least two dental therapist members.

- Committees for each workforce group be established with delegated powers to register practitioners, advise on education, review competence and consider applications for annual practising certificates and, consider the cases of impaired practitioners in that workforce group.

- The proposed dental council have the functions of providing uniformity between workforce committees, advise the minister in relation to dentistry and promote high standards of education and training. The separation of registration and disciplinary functions was also supported, endorsing the HPCA proposal including peer membership of a tribunal.

- Dental therapists’ existing scope of practice \(^7\) should be endorsed initially and thereafter be subject to adjustment by the combined DCNZ via the dental therapists workforce committee. A named dentist would be designated to provide clinical guidance and the NZ Dental Therapists Association (NZDTA) and NZ Dental Association (NZDA) would together develop a code of practice defining inter-

\(^6\) TAGDT membership comprised representatives from the New Zealand Dental Council, the NZ Dental Association, the District Health Board Managers and the NZ Dental Therapists Association

\(^7\) Dental therapists’ scope of practice includes examination and the preparation of a treatment plan, the provision of uncomplicated care for dental caries and minor periodontal conditions, preventive dentistry and the recognition and referral of conditions that they are unable to treat, and individual oral health education. (TAGDT 2001)
occupational interface. The report also considered that dental therapists should not treat patients as sole operators.

- That appropriate educational options for future dental therapy would be a three year degree and should be urgently explored (TAGDT 2001).

The Minister for Health endorsed these recommendations in July 2001. In response to these recommendations, both the University of Auckland and the University of Otago have developed degree programs of education for dental therapists as discussed above. The NZMOH has also established a Transitional Working party to develop these recommendations and the implementation of the new HPCA Act in relation to dentistry (see below). In March 2001, the Minister also appointed a dental therapist to the Dental Council of New Zealand (NZDTA 2001).

Early in its term, the new government also proposed a new framework for omnibus health practitioner regulation that was introduced as the Health Practitioners Competency Assurance (HPCA) Bill in June 2002. The Bill repeals 11 Health Practitioner Acts (including the Dentists Act 1988), provides consistent processes for the registration and ongoing competence of practitioners who are currently regulated, and a process for the inclusion of new health professions if appropriate. Registration authorities will certify that practitioners are qualified and competent to practise within a scope of practice, which will describe the activities practitioners are qualified to perform and the conditions under which the activities may be performed. Some activities, where there is a risk of serious or permanent harm, will be restricted to those who are competent to perform the activity. The Bill requires demonstration of on-going competence via annual practising certificates. Complaints and discipline procedures will be dealt with through the establishment of a common Health Practitioners Disciplinary Tribunal which includes peer representation. It also establishes mechanisms for the establishment of Quality Assurance Activities to facilitate practitioners’ learning from patient outcomes, improving their competence and reducing adverse outcomes through collaboration. This legislation is to be complemented by the Health and Disability Commissioner Act which has been established to deal with consumer complaints outside of professional conduct and impairment issues (NZMOH 2002).

Under the proposed legislation, dentists, dental therapists, dental hygienists and dental technicians are to be registered under a combined membership Dental Council of New Zealand. It is also being proposed that the current employment restrictions on dental therapists will be removed (however their client groups are likely to be limited to publicly funded patients) and that therapists will be responsible for their own professional practice within their scope of practice (NZDC 2002). In addition a named dentist will need to be designated for each dental therapist to provide clinical guidance. Dental hygienists’ practice will be limited to treatments prescribed by a
dentist but the requirement for on-site supervision is to be removed (NZDC 2002). Workforce committees, referred to as workforce Boards, proposed under the TAGDT have been accepted and are expected to meet more regularly than the DCNZ and to have fully delegated regulatory functions for their respective occupational areas. It has also been proposed that there would be cross membership of these Boards in order to maintain consistency (Eden 2001). These outcomes all rely on the passage of the HPCA Bill into legislation and establishment of the Boards. In the meantime, NZDTA and the DCNZ have been working together to establish registration and annual practicing requirements for dental therapists in order that implementation can be streamlined upon passage of the Bill (NZDTA 2002, DCNZ 2002).

There is some evidence to suggest that the dental technicians’ Board and the Dental Hygienists Association have some concerns about the Bill. Both the issues of a combined council model and its membership have generated objections (Dunbar, 2002). The Bill apparently has the support of the NZ Dental Therapists Association, the Dental Council and the NZDA who have had significant consultative input (Caddie 2002). Initially, there was concern that the dental hygienists were to be excluded from this regulatory model but recent developments suggest that they too will be registered and included in the new combined dental council (NZDHA 2001, NZDC 2002).

**Conclusions**

Dental therapists and hygienists have been initially dealt with quite separately but have come to have similar outcomes in terms of regulation. Their scope and autonomy of practice however are quite different, with dental therapists having responsibility for their own practice and hygienists more subordinated. This may be related to the longer history (and acceptance) of dental therapy profession as autonomous practitioners conferring greater industry credibility in NZ. Further, the referral model in NZ which uses private practice dentists for treatment needs beyond the capacity of a dental therapist has served to develop a stronger team approach than the Australian model which has used employed public sector dentists to provide referred treatments. This has given dental therapists’ skills and role wider exposure inside dentistry and the high participation rate over many years has meant wide exposure in the community.

The notion that dental hygienists can be trained on-site by a dentist may contribute to the perception of a less ‘professional’ and autonomous role. Further, even though the role is well understood in international settings, it is relatively new to NZ and the inconsistency of skills and training may contribute to their lower visibility. It also means that the internal organisation of this profession is less developed making it more difficult to contribute to external developments such as policy and education issues. Anecdotal evidence suggests that the NZDA supported the distinct separation of the two professions and that the NZMOH knew less about the hygiene profession.
The notion of self-regulation is also interesting. There seems to be industry acceptance of the concept of separate boards with delegated authority to regulate each profession (or workforce group). This is quite distinct from the models being applied in Australia and may be related to the perceived maturity of the dental therapy profession. It may also be related to the need to retain protection for professional territory using the existing model which has had separate boards for dentists and dental technicians under the umbrella of the DCNZ. The existing NZ model makes the move to self-regulation for dental therapists appear more incremental. The use of omnibus health practitioner legislation also has less intra-dental professional dominance implications for the dental technicians than the Australian de-regulation models.

The removal of age limits is also quite radical when compared to Australia. The translation of dental therapy skills into the adult environment has been achieved with little apparent fuss (although it is not widespread). A clear distinction is that in Australia, the utilisation of therapists’ skills with adults has always been attached to the notion that dental hygiene skills are essential to retain the quality of services. New Zealand dental therapists seem able to provide the same services to adults as they provide to children without additional training.

Finally, the difficult of achieving professional development for dental therapists in New Zealand has historically been little different to elsewhere. Governments and dentists have benefited from therapists’ inability to challenge the monopoly of dentists over dentistry and public sector organisations over therapists’ employment. The difficulty in retaining therapists and attracting students to the profession, combined with access to care issues and a small decline in oral health status in the community has contributed to a policy profile for oral health within the ministry of health. The leadership provided by a minister with a dental therapy background though, has also clearly had an influence on both the profile of oral health and the capacity to achieve policy change, particularly for dental therapists.

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APPENDIX 3: CASE STUDY: CANADA

The data for this case study were collected via an interview with an Associate Professor at the School of Dental Hygiene, Dalhousie University, Halifax and a Lecturer and Clinical Instructor in Dental Therapy and Dental Hygiene at the College of Dentistry, University of Saskatchewan. This was augmented by electronic mail communications with the Registrar of the Saskatchewan Dental Therapists Association and Registrar of the Yukon Dental Therapists Association, Presidents of the Canadian and Manitoba Dental Therapists Associations, and Canadian Dental Hygienists Association. This was further augmented by web site material and documents kindly provided by these participants and Conference Papers from the 15th International Symposium of Dental Hygiene held in Sydney in 2001, and material from the published literature.

Introduction
In 2001 Canada had a population of around 31 million people living in nine provinces and two territories. Each province and territory manages its own health care plan under a federally implemented universal health insurance scheme. This scheme is augmented for Canada’s Aboriginal populations (known as First Nations and Inuit communities) with a special benefits scheme and movement towards self-administered programs and resources. These schemes, with the exception of First Nations and Inuit, largely exclude dental services which are predominantly delivered through private dental practices (offices) (Health Canada 2002). There are 17,000 practicing dentists representing a dentist to population ratio of ratio of 1:1824. Water fluoridation is widespread in municipal water supplies (Canadian Dental Association 2002).

Dental disease rates and service delivery patterns are similar to Australia with oral diseases being more prevalent among lower income groups and the elderly. The majority of dental services are provided through the private sector including most public sector services which are funded largely under capitation or voucher schemes for low income earners and their dependents (Canadian Association Public Health Dentistry 2002).

A study which aggregated research on Canada’s oral health and quality of life by Locker and Matear indicates that dental caries affects 60% of 5-17 year olds and early childhood caries about 6-8% of children under 5 years of age. In disadvantaged communities such as the Inuit populations of the Northwest Territories up to 65% of 4 year old children are affected. In 1990, 17% of Canadians were edentulous with the highest rate of tooth loss in Quebec, at 28%, while Ontario had the lowest, at 11%. Severe periodontal disease (6 mm or more loss of attachment at one or more tooth sites) increases with age and affects one in seven of those in middle age and almost one in three elderly. Needs for dental care are higher in the elderly age group than any other, and particularly high in institutionalized elderly. Over half of the latter have been found to need restorative care and one fifth, surgical treatment. Oral cancers account for 3 to 4 percent of all cancers and 2 to 3 percent of all cancer deaths. The oral health status of low-income individuals of all ages is markedly worse.
than that of high-income subjects. New immigrant adolescents in Ontario for example were four times as likely as their Canadian-born counterparts to need dental treatment (Locker and Matear 2001).

Only 53 percent of the Canadian population are covered by dental insurance. Almost 80 percent of high-income individuals aged 25 to 44 years are covered compared to only 11 percent of low-income elderly. Canadians with dental insurance were 2.7 times more likely to report a dental visit in the previous year than the non-insured. Within Canada’s predominantly private system of dental care, dental visits are largely determined by the ability to pay. Annual dental visits mirror dental insurance rates with around 59% of Canadians (35% of Newfoundlanders and 69% of Ontarians) reporting annual dental visits. Seventy-eight percent of Canadians in the highest income group reported a dental visit, while only 41% of Canadians in the lowest income group did so (Locker and Matear 2001, CPHDA 2001).

In 1996/7, private dental insurance companies paid $2.3 billion for dental plans covering 13.6 million beneficiaries. In 2000, total expenditure on dental care in 1999 has been estimated at $6.4 billion. Only 14 percent of these costs were paid by public funds. This varied from 3% in Ontario to 28% in Manitoba and 75% in the Territories. In Canada in 1986, dental disorders ranked third in terms of treatment costs, after cardiovascular diseases and mental disorders (Locker and Matear 2001). This is comparable with Australia where around 85% of dental services are privately funded and dental disease ranks third among illness expenditure items with around half the population regularly accessing care (AHMAC 2001). Australia however, spent only $2.6 billion in 1998/99 on dental services (AIHW 2001).

Canadian dental services are delivered largely by dentists and specialist dentists as in Australia. These are augmented by dental hygienists and dental therapists, dental assistants and certified dental assistants, and dental technicians and denturists (CDA 2002, Clovis 2000). Although dental hygiene and dental therapy evolved separately in Canada, their roles overlap and in some settings have become combined. British Columbia allows hygienists to restore cavities in a role referred to as the Expanded Function Dental Auxiliary and there are some states where dental therapists have added some skills to register as dental hygienists (Clovis 2001, Clovis 2000).

**Dental hygiene and dental therapy in Canada**,

Dental hygiene was first legally recognised in Canada in 1947 in response to a demand for dental hygienists in the public sector. The first dental hygiene education program was established in Canada in 1951 with a class of less than 10 students; today there are approximately 14,000 dental hygienists across the country (CDHA 9.8.01). Dental therapists were first employed in 1962 in the Yukon (known there as dental nurses) and early 1970’s in Manitoba and Saskatchewan in schemes based on the New Zealand School Dental Service. There are around 350 dental therapists in Canada and they too arose out of a recognition that the health of the population relied
on people being better able to access dental services (Croucher 1988, MDTA 1999, CAPHD 2001)

Combined Canadian government and professional association data on dental therapists and dental hygienists indicate that over 14,000 people were employed in these professions in 1998, an increase of 46.3% from 1988. Thirty-six per cent work part-time, well above the average of 19% for all occupations which is a significant increase over the last ten years. Ninety-nine per cent of dental hygienists and therapists are women, well above the average of 45% for all occupations and only 7% of are self-employed, compared to an average of 17% for all occupations across Canada. The unemployment rate averaged 2.3% from 1996 to 1998, compared to the national average of 6%. This rate is among the lowest for technical, para-professional and skilled occupations. At around $40-50,000 Canadian per annum, the average earnings are among the highest for technical, para-professional and skilled occupations but are comparable to those for other occupations in the health sector (CHDA 2002, HR Canada 2000).

Dental hygienists now work in private dental practices, hospitals, clinics, educational institutions, government agencies and private practices. Dental hygienists provide dental hygiene assessment and treatment and information related to the prevention of diseases and disorders of the teeth and mouth. They assess tooth and gum health, take dental impressions, remove stains and deposits from teeth, take X-rays, clean and stimulate the gums and apply fluoride treatment. They also carry out root debridement and in many provinces administer local anaesthesia (LA), and some restore teeth which have been prepared by a dentist. In clinical practice, dental hygienists most often work with general practitioner dentists or specialty practice dentists. In British Columbia and Ontario they are able to own their own practices although they still practice in a collaborative and referral relationship with a dentist. The CDHA describes hygiene practice as encompassing clinical and preventive therapy, health promotion, administration, education, and research. Although 85% of dental hygienists work in the private sector there are roles in residential and hospital settings along with public health focused community dental hygiene (CDHA 2002, Clovis 2000).

Dental therapists mostly work for the federal government and the governments of Newfoundland, Manitoba, Saskatchewan, Yukon and the Northwest Territories to provide services in rural and remote communities and practice in private practices in some provinces. Dental therapists provide dental services related to the prevention and treatment of diseases and disorders of the teeth and mouth. They examine patients and develop treatment plans, take dental impressions and X-rays, remove stains and deposits from teeth, mange minor periodontal conditions, administer local anaesthesia, fill cavities, extract teeth (both deciduous and permanent), place and remove sutures, and replace portions of tooth crowns. They also engage in community and preventive dentistry including oral health education and promotion (NDTWG 2001). They work in a consultative and referral relationship with a dentist
and must be licensed to practice. Dental therapists are now mostly employed throughout the First Nations communities across Canada, although they originally provided school dental services in Manitoba and Saskatchewan and still do in Yukon. They now provide community-based services such as fillings and extractions, as well as preventive care and health promotion for both children and adults (HR Canada 2000, SIFC 2000, MDTA 1999, Croucher 1988).

Dental therapists are required to have completed the two year dental therapy diploma program offered by Health and Welfare Canada or an approved college program in dental therapy such as that offered by the Saskatchewan Indian Federated College in collaboration with the College of Dentistry at the University of Saskatchewan (SIFC 2000). Presently this is the only school of dental therapy, the National School of Dental Therapy, located in Prince Albert, Saskatchewan (formerly in Fort Smith, Northwest Territories). The only other school of dental therapy was Saskatchewan Institute of Applied Science and Technology (SIAST) in Regina, Saskatchewan, which graduated its last students in 1988 (Reed 2002). Dental therapists are registered under the Dental Profession Act in the Yukon, under their own legislation by the Commissioner in North West Territories and Newfoundland, and self-regulating in Saskatchewan. In Manitoba they are registered by the Manitoba Dentists Association (MDA) if they work privately and under the Health Workers Act where they work in public or community settings although this is currently under challenge (MDTA 1998).

There are 27 dental hygiene educational programs offered across Canada, five of which are at bachelor degree level and three at diploma level and the rest offered through community colleges. There are also ‘one-plus-one’ programs where the first year qualifies the graduate as a certified dental assistant (who performs x-rays, tooth polishing and fluoride applications) and an additional second year qualifies them as a dental hygienist (Clovis 2000). The National Dental Hygiene Certification Board offers credentialling via examination based on national standards that provides portability between jurisdictions. It is recognised by five of the eleven provincial regulatory authorities (NDHCB 2002). Dental hygienists are required to be licensed to practice in all provinces and territories. Between 1994 and 1999, five provinces granted self-regulation to dental hygienists under their own Acts, Boards or Colleges and discussions about self-regulation are occurring in most other provinces (Clovis 2000). Each province and territory regulates its dental care providers slightly differently although in contrast to Australia, there are no limits on client age groups and the main variations lie in supervision and regulation. Table 1 below summarizes the range and types of regulation for the two professions in each jurisdiction based on available information.

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8 The Manitoba Dentists Association does not recognise the education program delivered by the SIFC program and requires certification by SIAST prior to registration for private practice (MDTA 1998).
<table>
<thead>
<tr>
<th>Practitioner type</th>
<th>Policy access regulation</th>
<th>Gatekeeper controls</th>
<th>Employmnt Pub/Priv?</th>
<th>PO</th>
<th>Clients</th>
<th>Scope of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta 9</td>
<td>Hygienist</td>
<td>Self: Registered by Alberta DHA Council of 7 hygienists</td>
<td>On and off site supervision</td>
<td>Both- by dentists the state</td>
<td>no</td>
<td>all</td>
</tr>
<tr>
<td>British Columbia 10</td>
<td>Hygienist</td>
<td>Self: DHyg Act 1994 Self-reg through DHCollege Since 1995</td>
<td>Off &amp; on site Supervision 365 day rule Public health exempt (with advanced licence)</td>
<td>Both and independent practice</td>
<td>yes</td>
<td>all</td>
</tr>
<tr>
<td>Manitoba 11</td>
<td>Hygienist</td>
<td>MDA under Dental Act</td>
<td>On site</td>
<td>both</td>
<td>no</td>
<td>all</td>
</tr>
<tr>
<td>Therapist</td>
<td>No consistent licens'g. Priv Prac: One-off license MDA but have no direct represent'n Public: Health Workers Act</td>
<td>Supervision: Private-on-site Public &amp; First Nations-General off site, referral by DT</td>
<td>Both SIAST- both National School of DT- public and First Nations</td>
<td>no</td>
<td>All ages services differ public private</td>
<td></td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Hygienist</td>
<td>New Brunswick Dental Society</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West Territories</td>
<td>Hygienist</td>
<td>Dental Auxiliary Act administered by Commissioner registers both</td>
<td>Direction &amp; control dentist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td></td>
<td></td>
<td>Dental health program approved by commissioner</td>
<td>Childre n</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newfoundland</td>
<td>Therapist</td>
<td>Dentist Act</td>
<td>General supervision</td>
<td>Geographically restricted</td>
<td>no</td>
<td>Public only- o FN reserve land only</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Hygienist</td>
<td>Dentists Act 1992 2 DNs on 14 member board</td>
<td>On site But Board can allow offsite for cmyt residential</td>
<td>Both Only work in employ/ under supervision of a dentist</td>
<td>no</td>
<td>all</td>
</tr>
<tr>
<td>Ontario 12</td>
<td>Hygienist</td>
<td>Self: Regulated by HP Act 1991 (omnibus legis) DH Act 1991 administered by College of DH Ontario</td>
<td>Practice on 'the order of a dentist' which is broadly interpreted as on or off site supervision</td>
<td>Public &amp; priv and independent practice</td>
<td>yes</td>
<td>all</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

9 Dental hygienists cannot practice in Alberta until they meet professional qualification standards and are registered with the ADHA. The Registered Dental Hygienist (RDH) designation assures the public that a dental hygienist is trained and educated in knowledge and advancements in oral hygiene. In order to receive an RDH designation, a dental hygienist must: be a graduate of an approved dental hygiene program, either a Diploma in Dental Hygiene or a Baccalaureate in Dental Hygiene, successfully complete the Canadian National Dental Hygiene Certification Board Exam, meet continuing education and competency requirements, work a minimum number of hours per year, be a member in good standing of the ADHA. The ADHA also issues an Annual Certificate to all qualified members. It assures patients that their RDH is meeting continuing education requirements and holds a current CPR (cardio-pulmonary resuscitation) certificate. It is illegal for dental hygienists to work without a Certificate of Registration and a current ADHA Annual Certificate. (source Alberta Dental Hygienists Association, Aug 2002) Similar requirements apply in British Columbia, Ontario
10 Clovis 2009
11 Manitoba DTA 1998, 1999

391
<table>
<thead>
<tr>
<th>Practitioner type</th>
<th>Policy access regulation</th>
<th>Gatekeeper controls</th>
<th>Employment Pub/Priv?</th>
<th>PO</th>
<th>Clients</th>
<th>Scope of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince Edward Is</td>
<td>Hygienist Since 1953</td>
<td>Dentists Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>Hygienist</td>
<td>Self: since 1975</td>
<td>On and off but DHs can only plan perio</td>
<td>No limits but Must be employ’d by or established referral paths with dentist</td>
<td>No</td>
<td>all, depend on employer needs</td>
</tr>
<tr>
<td>Saskatchewan¹³</td>
<td>Hygienist Therapist</td>
<td>Self: DT since 1981 Dental Disciplines Act 1997. Administered through D, DT, DH, DA Prof Associations</td>
<td>Can diagnose &amp; plan all their care</td>
<td></td>
<td></td>
<td>Both DT &amp; DH have broad list relying on educ preparation</td>
</tr>
<tr>
<td>Yukon</td>
<td>Hygienist Therapist</td>
<td>Dental Auxiliary Act By commissioner (no board)</td>
<td>Under direction</td>
<td>Mostly priv but both OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultation</td>
<td>School dental service only</td>
<td>no</td>
<td>2-14 yrs</td>
<td>As per Aust range</td>
</tr>
</tbody>
</table>

For the purposes of this study three states will be looked at in more detail given their alternative regulatory models.

**Saskatchewan**

Dental hygienists have practiced in Saskatchewan since 1948 and dental therapists since 1974 when the Saskatchewan Dental Plan (SDP) was introduced. The SDP was introduced as a result of a number of studies showing high levels of decay among children and poor access to dental services among rural residents. The Canadian Dental Association (CDA) argued for increased patient loads for existing dentists and the use of hygienists (then only 20 in number) to address these unmet needs, but manpower was still considered insufficient. A pilot program based on the use of the New Zealand style dental therapists was conducted successfully in a single community and led to the proposal for a universal service for children aged three to twelve years. Services were delivered through school based clinics by therapists as the primary care providers who would refer children requiring care beyond their competence to a dentist. From the beginning the proposal was opposed by the CDA on the grounds that dentists should be carrying out diagnoses and treatment plans and delegating work to dental therapists under in-office or intermittent supervision (Croucher 1988, MDTA 1999, CAPHD 2001).

Despite the misgivings of the CDA, the SDP went ahead along with local training of dental therapists at the Saskatchewan Institute of Applied Science and Technology and the National School of Dental Therapy. In 1976, the program was evaluated, finding that fillings ‘...placed by dental nurses (therapists) were significantly

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12 Source: Website of the college of Dental Hygienists Ontario, http://www.cdho.org/newsletter.htm, 22.8.02
13 Saskatchewan Dental Disciplines Act also personal communication with Registrar (Reed C, Oct 2002)
14 Dental Professions Act of the Yukon 1982, Dental Hygienists Association of the Yukon
superior to those placed by dentists working in private practices...’ and that on the issue of supervision, ‘...it would be difficult to insist that direct supervision of dental nurses take place without making the same suggestion in the case of dentists...’ (Ambrose et al 1976, in Croucher 1988). In 1980, a second evaluation was conducted which favourably demonstrated higher utilisation and lower costs of care than any other Canadian child dental scheme, with an important finding that a child receiving treatment in the SDP also had better long term oral health outcomes (Lewis 1981, in Croucher 1988).

In 1982, the Journal of the Canadian Dental Association (McDermott & Oles 1982) reported that growth rates in dentists in the province was giving rise to a situation where supply of dentist manpower would exceed demand. Croucher (1988) takes the view that this situation, combined with a government sympathetic to the concerns of dentists, may have been responsible for the decision to develop the SDP to include adolescents aged 14 years and over. These young people received their care in private dental practices under a modified capitation plan, funded by the province and administered by the College of Dental Surgeons of Saskatchewan (thus preserving the autonomy of dentists’ practice).

In 1987, despite the demonstrated successes of the SDP, the provincial government of the day effectively eliminated the plan, re-allocating the funding to provide less services on a fee-for-service basis through the private sector (Croucher 1988, Clovis 2000, CADPH 2001). Upon the cessation of the program, the government provided financial support for therapists to undertake a nine-month program to re-train as hygienists (Reed 2002). Both authors attribute this outcome to the dominance of the dentist profession and its concerns with control of the dental divisions of labour and market monopoly (Croucher 1988, Clovis 2000).

Dental therapists today continue to practice in Saskatchewan despite their ‘overnight’ redundancy as a result of the changes made to the SDP in 1987. In 1987 there were around 400 dental therapists practising which has reduced to around 200 in 2002 with 178 holding practising licenses (Clovis 2001, Long 1998, Reed 2002). They carry out examinations, x-rays, preventive and educative services, restorative services and extractions in a consultative relationship with a dentist much as they do in Australia but without limits on the age of their clients. They are employed by the medical services branch of the provincial government, First Nations boards and health organisations. They also work in private practices, some providing both dental therapy and hygiene services and anecdotal evidence suggests that since 1987, many have opted to provide only hygiene services and are no longer licensed as dental therapists (HR Canada 2002, Reed 2002, Clovis 2001).

Saskatchewan’s dental therapists have had separate legislation since 1973 and have been self-regulating since 1981 when the Saskatchewan Dental Therapists Act 1981 came into effect. The Dental Professions Act 1978 allowed dentists to hire dental therapists in private practice since the existing legislation only allowed public sector
practice, however this act did not regulate their practice as it only applied to dentists and dental hygienists (Reed 2002, Manitoba DTA 2001). In 1994, the dental hygienists also sought self-regulation (SDHA 1994) which culminated in new umbrella legislation for all the dental professions.

Regulation of dentists, dental therapists and dental hygienists in Saskatchewan is currently achieved via the Saskatchewan Dental Disciplines Act 1997 (SDDA) which delegates the responsibility for administering the Act to the respective associations, including the Dental Assistants Association. Under the Act, these four associations are to be managed and administered by a Council of at least five members, three of whom are appointed and funded by the government. The Dental Hygienists Council for example has nine members, including five elected hygienists, the president of the association and three appointed public members (SDHA 1998). The respective councils are responsible for registration and setting standards for qualification, conduct, competency, professional indemnity and advertising, managing professional discipline and complaints, approving educational programs for qualification and developing by-laws for approval by the Minister (SDDA). Issues that were still to be resolved in 1998 were direct billing of therapists’ and hygienists’ services, particularly by insurance companies (Long 1998).

Of interest here is the degree to which the needs of the public for dental care came into conflict with professional ideology of the private practice dentists. It is clear that tensions between the need to maintain profitable practices and the professional ideal of ‘patients’ best interests’ may not always translate to broader public interests. The demise of the SDP may also have had another unanticipated outcome that of combining the skills of dental therapist and dental hygienist to produce a blended oral health practitioner similar to the Australian oral health therapist. It is unlikely that any of the occupational groups would have supported such a blending (given the responses to such a suggestion in other settings) but attitudes to and value of such a role is clearly worthy of further research.

Manitoba

In similar fashion to Saskatchewan, a dental therapist based, public sector children’s dental program was established in Manitoba in the 1970s. In 1978 when the program was discontinued under dentist opposition and new government ‘free enterprise’ policies, the Manitoba Dental Association (MDA) recognised dental therapists in order that they could be employed in private practice settings to provide children’s services (MDTA 1998). The CAPHD (2001) asserts that the resultant private fee for service scheme proved too costly for government and was eventually dismantled.

Since that time, dental therapists have continued to work with First Nations, Inuit, rural and remote comminutes and in some private dental practices. Their regulation, however is fragmented and inconsistent. Dental therapists who work in private practices, employed by dentists are licensed under a one-time application to the MDA
which uses its delegated legislative powers under the Manitoba Dental Association Act 1970 to regulate them. The MDA thus regulates practice using a task oriented list of procedures, limiting the preparation of cavities for restoration to children under 14 years of age and requiring direct, on-site supervision of services. Further, the MDA recognises only graduates of the SIAST program for registration and does not include dental therapists as members of their Board, and has no jurisdiction to discipline dental therapists (MDTA 1998, MDTA 1999).

Dental therapists employed by the government of Canada and First Nations communities are regulated under the Dental Health Workers Act 1975. Services are provided under a work description based on education under general supervision (off-site), a broad scope of practice dependent on local need with no age restrictions. Graduates of SIAST and the National School of Dental Therapy are recognised for this public practice. They are however limited to practice on First Nations Reserve land which has prevented their utilisation with metropolitan First Nations communities. The MDTA maintain that quality of care, client satisfaction and cost-effectiveness of these services have all been well documented (MDTA 1999, MDTA 1998, AMC 1997).

The MDTA is currently seeking regulatory reform and has proposed a model based on the Saskatchewan Dental Disciplines Act (MDTA 2001).

**British Columbia**

For most of its history in Canada, dental hygiene has been regulated by Dentists Acts or Colleges which largely excluded participation by hygienists in their own regulation. In 1975, Quebec became the first state to allow self regulation for hygienists but it was not until 1990 that other states began to follow suit. Dental hygienists have been practicing in British Columbia (BC) since 1951 and there are currently around 1900 holding provincial registration (BCDHA 2002). Health sector reform in the late 1980s saw omnibus health practitioner legislation enacted, overseen by a Health Professional Council. This Act determined a process for seeking designation as a profession and established umbrella legislation describing the role of Colleges in administering the occupationally specific regulations, disciplinary procedures and processes for registration and assessing the competence of practitioners. The Health Professionals Council was also given the role of ratifying the legislative framework for each profession.

Prior to that time dental hygienists were regulated as an auxiliary body by the British Columbia College of Dental Surgeons under the Dentists Act. Their services were defined and limited to provision under the general supervision of a dentist. In 1991 the British Columbia Dental Hygienists Association (BCDHA) sought designation as a profession from the province’s Health Professionals Council. Professional status was accepted but the council was concerned about the levels of supervision required for safe practice and the level at which regulation was required (risks posed by the
practice) and the capacity of the profession to self-regulate. In 1994, the Dental Hygienists’ Regulations were proclaimed and in 1995, upon establishment of the College and acceptance of the Dental Hygiene By-Laws, the profession became self regulating (Clovis 2000).

Title protection was included in the Regulations and the By-Laws defined dental hygienists’ scope of practice to ‘...assess of the status of teeth and adjacent tissues and to provide preventive and therapeutic dental hygiene care for teeth and adjacent tissues...’ Practices reserved (core practices) for dental hygienists are supra and sub-gingival scaling or root planing and local anaesthesia; these practices are also reserved for dentists. The only limitation on their practices is the requirement for a dentist to supervise local anaesthesia and the ‘365 day rule’ that ‘...permits dental hygienists to practise independently provided the patient has been examined by a dentist within 365 days...’ (BCCHA 2002, Clovis 2000). Public health dental hygienists, subject to special licensing arrangements requiring advanced dental hygiene skills in diagnosis and treatment planning, are exempt from this law where they work in residential care units as part of multi-disciplinary health care team, however they are required to notify the BC College of Dental Surgeons of the need for dentist examinations of these patients (BCCHA 2002).

While the regulation of dental hygienists in BC has met many of the criteria applied to other health care professionals, it has not quite achieved parity. The imposition of the 365 rule still limits provision of dental services to those not prepared to also pay for the services of a dentist and implies that a dental hygienist cannot reliably recognise the need, independently for referral to a dentist. Clovis (2000) in a study of dental hygiene regulation in Canada concludes that this rule has been retained more in the interests of dentists’ professional dominance than public need.

Conclusions

It is apparent that despite the self-regulating status of dental hygienists and therapists in five provinces, there is still opposition from the dentists professional associations. In Ontario, for example the task of examining and self-initiating treatment has been recognised by the Health Professions Regulatory Council but is still contested by the College of Dental Surgeons (Clovis 2000, CDHO 2002). In other provinces, the work of dental therapists is largely limited to First Nations communities where it poses little threat of direct competition, although in Nunavut in the New Territories, a private dental practice has contested the exclusive delivery of services by therapists (Bell 1997). Clovis (2000) notes that dentists in Canada are still largely able to delegate the roles and responsibilities of a range of other occupations including dental hygienists, dental therapists, dental technicians and denturists and dental assistants. The high proportion (85%) of dental hygienists in Canada who still work as employees of dentists contributes to both the ‘in practice’ and policy control that dentists have over definition, pricing and remuneration of their services. Other
authors note the entrenched nature of the policy dominance and the opposition to the development of dental hygiene education beyond the undergraduate level as all being consistent with dentists’ need to retain their power and control over the market (Croucher 1988, Brownstone 1999 in Clovis 2000).

In the provinces where self-regulation has been achieved, it has generally been a decision of an independent arbiter such as British Columbia’s Health Professionals Council or the Saskatchewan provincial government. The arguments made by the professions (dental hygiene and therapy) to achieve this were related to the conflict of interest posed to dentists in managing profitable practices and regulating dental therapists and hygienists (MDTA 1999, Long 1998, SDHA 1994). In both cases, the chief concern of the decision makers were related to the professions’ ability to manage and sustain the infrastructure required to adequately protect the public. They were required to demonstrate adequate definition of practice and practice standards, explicitly defined codes of ethics and a capacity to define educational standards in order to contribute to credentialing processes (Clovis 2000, SDHA 1994, ADHA 2002).

Although total spending on dental services is almost double that of Australia, access to dental care is still an issue for Canadians. Unlike Australia, universal school dental services do not appear to exist and the oral health of children is marginally worse with an average DMFT in all 13 year olds at 1.1 and 3.9 for First Nations 13 year olds (CAPHD 2001). The settings that do provide children’s services are First Nations communities and they almost routinely use dental therapists’ services, often including adult care. It appears that the key reasons for this are the remote nature of the settlements and difficulty in attracting dentists to them, the cost-effectiveness of services provided by dental therapists and culturally appropriate service delivery under First Nations self-governing models (CAPHD 2001, MDTA 1998, AMC 1997). It is interesting that dental therapists services are used more widely and with less restrictive regulation in these settings. This raises questions about the cultural value to First Nations communities of the biomedical model as compared with more preventive approaches utilised in these communities. Also, that the likely absence of contemporary elite political connections such as professional monopolists in self-governing First Nations communities may alter the nature of health policy making. It also suggests that private practice dentists argue strongly for ‘quality of care’ but only in communities where they choose to work.

It is beyond the scope of this study to evaluate the effects of local legislation on access to dental services given the complexity of socio-economic influences and service delivery mechanisms at a local level on oral health. What this study has shown is that it is possible, safe and potentially advantageous to the delivery of dental services to allow dental hygienists and therapists to operate in autonomous regulatory environments, which are consistent with other health professional models despite the opposition of dentists. Indeed the Canadian Association of Public Health Dentistry
has endorsed the utilisation of dental therapists and hygienists and suggested that 
independent practice has the potential to increase access to services and increase 
referrals to dentists (CAPHD 2001). As regulatory models in Manitoba have shown, 
where dental therapists are regulated away from dentists dominance the services they 
provide are broader in range, more responsive to local needs and less prescribed - 
therefore offering better access to care.

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APPENDIX 4: CASE STUDY: THE NETHERLANDS

The data for this case study were collected via an interview with the Director of the Dental Hygiene School at the University of Professional Education Hogeschool Holland; electronic mail interview with the Chief Dental Officer of the Netherlands Ministry of Health Welfare and Sports, Policy documents from the Netherlands Ministry of Health Welfare and Sports (NMHWS), Conference Papers from the 15th International Symposium of Dental Hygiene held in Sydney in 2001 and material from the published literature.

Oral health status in the Netherlands has been improving over the past decade with young people in particular showing decreases in caries experience and edentulousness (Truin & Bronkhorst 1997). In 1993, 53% of 11 year olds were caries free (up from 38% in 1987), as were 19% of 17 year olds (8% in 1987) and 6% of 23 year olds (1% in 1987). In 1992 the WHO found caries indices in 12 year olds to be 1.7 DMFT (Hovius, 2001). In 1999, 18% of people aged 45-64 had full dentures, a reduction from 54.3% in 1981 (Truin says 44.1% in 1987). Periodontal status has also improved. Average scores for plaque, calculus, bleeding after probing and number of buccal root surfaces exposed to the oral cavity were lower in 1995 than in 1983, among Dutch adults aged between 25-54 years (Karlsbeek et al, 2000, National Health Services 1987 and 1993 in Hovius 2001).

These data show that while the oral health of young Dutch people is comparable to that of young people in Australia, the oral health of their older age groups are better, possibly due to greater access to dental services prior to 1994. (In 1990, around 85% of dentate adults visited a dentist each year). In 1994 a decision was made at the Ministry of Health Welfare and Sports (HW&S) to remove most dental services to adults from the national health insurance scheme (Okma 2001). Dutch health care is supported by a social health insurance scheme funded via a mix of public and private contributions indexed according to income levels. There are three funding compartments-two of which are administered by the National Health Services (NHS). Chronic or long term care in institutions (including nursing homes, rehabilitation etc) is funded through income related contributions and the Sickness Fund covers short term and acute care which is jointly funded by individual and employer contributions. This fund is compulsory for all employees in low to middle income brackets representing around 64% of the population in 2001. The third compartment is comprised of private insurance for those whose incomes have exceeded the level set by the government and for those who wish to augment the basic services covered by the Sickness Fund. The provision of services is thus market based and delivered through private practices and non-profit or charitable hospital and health care institutions. Dental services are delivered predominantly through privately owned practices (Okma 2001, Hovius 2001, Truin & Bronkhorst 1997).
Dutch dental services: funding

Dental services are provided through the Sickness Fund free of charge to all those under 19 years of age with examination and oral hygiene services available to adults and dentures available with a 25% co-payment. All other dental services are now out-of-pocket or covered by supplementary private health insurance. The NHS sets remuneration rates for services by negotiation with the professional associations and the insurance companies. Insurance covers dental treatment for people up to 19 years of age and for periodontal treatment for adults which includes oral hygiene instructions. Dental treatment for medically compromised patients and severe dental problems such as cleft palate, are provided from the Long Term Care fund. Many people take out additional insurance for dental care but rebateable services differ widely across insurance companies (Hovius 2001, Okma 2001, Truin & Bronkhorst 1997).

Dental hygienists

At present, hygienists must work under referral from a dentist, where a dentist would first examine the patient and refer them to a dental hygienist who may be an employee of the practice, working under a subcontract or practising independently in his or her own practice. Hygienists also work as staff in hospitals helping patients with systemic diseases achieve good oral health prior to for example, surgery or chemotherapy or where poor oral health would pose a risk to compromised immune systems. Hygienists also work for specialists (only oral surgeons and orthodontists are specialists) and in nursing homes. They are paid via the referring dentist where a dentist would bill the NHS or insurance company for the treatment provided and pay the hygienist for the treatments he or she provides. Some private insurance companies pay hygienists directly for their services. Existing hygienists take medical and dental histories, collect data and indices, provide prophylaxis, scaling, root debridement, apply fissure sealants and preventive solutions including fluorides, take intra-oral and extra-oral radiographs and photographs, and do individual and group oral health education. Local anaesthesia (infiltration and block) is permitted also, under a special by-law because it is defined as a core practice of dentists and physicians. Depending on where they work hygienists may perform other tasks such as banding teeth in orthodontic practices (Hovius 2001). Hygienists may also finish restorations previously inserted by a dentist and cavity preparation was reported by Johnson (2001a) as being carried out in an experimental children’s program.

History

During the second world war the Dutch Air Force came into contact with dental hygienists in Britain and in 1948 several hygienists were trained in Great Britain to meet the needs of the airforce. In the post war period when sugar became freely available once again and the population increased substantially, the need for dental care outweighed the availability of dentists. The government sought foreign dentists to meet the needs of the child population, but their lack of local language skills and
inexperience with children limited the success of this program. A decision was taken to establish a dental hygiene program and in 1965 the Dutch government sent a group of students to the US, Canada and Great Britain to train. This program was costly and many of these students did not return to work in the Netherlands resulting in a dental hygiene school being established in Utrecht in 1968 followed by schools in Amsterdam (1972), Nijmegen (1974) and Groningen (Hovius 2001, Truin and Bronkhorst 1997).

The four schools currently train between 35 and 80 students each per year, for example graduating 117 in 1997 (Johnson 2001a), and it is intended to increase this number to 300 per year (Hovius 2001). There are currently around 2000 registered dental hygienists in the Netherlands representing a hygienist:population ratio of 1:10,000 and a dental hygienist to dentist ratio of 1:4 (Johnson 2001a). Around 99% of the existing hygienist workforce is female. At present, the demand for dental hygienists is greater than the supply, so enforced unemployment is rare; around 90% of graduates found one or more jobs within a week of graduating in 1997 (Luciak-Donsberger 2000).

**Dental Therapists Trial**

In the 1970s, the Netherlands government accepted a recommendation of the Netherlands Dental Association to train dental therapists to deal with unmet need among children. The New Zealand and Australian School Dental Therapists’ model was used for the project which ran from 1972 to 1977. Dental hygienists who had recently graduated received 950 hours of additional instruction in local anaesthesia, cavity preparation and restorations, pulpotomy and extraction of primary teeth and orthodontic assessment. Two separate programs were conducted, one in the School Dental Service in Amsterdam and another in Nijmegen. The Nijmegen project utilised six dental therapists in the treatment of pre-school children at a fixed clinic. The Amsterdam project (which was the subject of the 5 year study) utilised two dental therapists in mobile School Dental Service vans providing treatment to primary school children. The study concluded that the performance of the dental therapists was on par with that of dentists and that dental therapists can contribute considerably to the preventive and restorative dental care of children (Houwink et al 1977). While the findings from this study were apparently positive there was no wider implementation of the program (Nuffield Foundation 1993). Truin and Bronkhorst (1997) attribute this partly to the increase in availability of dentists due to increases in training numbers (approximately 460 graduates per year during the 1960s).

**Practice regulation**

In 1997, the regulation of health practitioners in the Netherlands changed from a model which regulated each practitioner separately under twelve different Acts to an omnibus model regulating core practices only. This was designed to reflect the widening scope of health service provision incorporating alternative therapies and to
allow consumers to make choices about the type of practitioner they wanted to consult. In order to prevent unacceptable health risks to consumers, certain procedures are specifically excluded and may only be performed or delegated by authorised practitioners. The Professions in Individual Health Care Act 1993 registers eight professions; physicians, dentists, pharmacists, physiotherapists, clinical psychologists, psychotherapists, midwives and nurses. The Act protects titles, lists the specified protected procedures (such as surgical and obstetric procedures, punctures and injections, radiation, general anaesthesia etc) and makes it an offence to act in a way that is injurious to a person’s health as well as providing mechanisms to deal with discipline and practitioner incompetence (NMHWS 1997).

Each practitioner is allowed to practice only those procedures in which they are competent and has the responsibility to maintain their competence and to delegate tasks only to those competent to perform them. Under this model only dentists are allowed to ‘remove hard dental tissues’. Separate regulation applies to dental hygienists, dieticians, podiatrists, speech therapists and others under ‘Article 3 Paramedical Professions’. This is an Order in Council which contains rules about training and areas of professional competence and allows the use of a professional title. The government does not formally register these paramedical professions but allows the professional bodies to do so if they wish. The main feature of these changes for service provision is that any person who is competent may perform delegated procedures (NMHWS, 1997). Thus specialized nurses may perform minor surgical procedures, dental assistants may carry out cleaning and polishing of teeth (prophylaxis) (Hovius 2001).

There are other laws which support this legislation and as a consequence also define the way a registered or paramedical professional (ie. dentists and dental hygienists) performs their work;

- Registration of the Individual (guarantees the privacy of the patient)
- The Medical Treatment Agreement (informed consent) and
- The Right of Complaint for Public Sector Patients (obliges complaints mechanisms)

Other laws apply to services provided in institutions and public health centres (NMHWS 2000, Okma 2001, Hovius 2001).

The Netherlands Dental Hygienist Association (NDHA) has initiated a registration and quality assurance program in response to this Act with two tiers of registration—‘standard’ and ‘quality’ registration. Members of the association may be placed on the quality register from 2005 onwards by demonstrating continuing professional development through credit points earned at post graduate courses and professional development and seeing patients a minimum of two days per week during five years. These hygienists must also participate in workplace performance assessments or for independent practitioners, a peer review process. Quality of Care study groups have been formed to develop these processes and skills in their members. Around 10% of
the workforce are already part of the study groups and will be able to seek registration with the Association in 2005 (Hovius 2001).

**Workforce issues, political and regulatory changes**

At present in the Netherlands there is a shortage of dental ‘manpower’. In an effort to find a ‘new equilibrium between supply and demand for dental services the Dutch government made a decision to increase the annual intake of dental students from 260 to 300 per year. This may be increased by a further 30 students if there is the practical capacity of dental schools to accommodate them. The intake of dental hygiene students is also to be increased from 210 to 300 per year to meet growing demand for dental hygiene services (Van den Heuvel 2002, Hovius 2001).

Hovius (2001) has observed that hygienists have also sought more autonomy in planning and scheduling courses of treatment. They have also demanded higher salaries and due to the shortage of hygienists have generally had their own way; hygienists, along with physiotherapists and optometrists are the highest paid paramedical workers in the Netherlands. This has made them less popular with the Dentists Association who have moved over the past several years to develop a new dental care provider, the Prophylaxis Assistant (PA). The PA is an extended duties dental assistant who provides scaling (officially supra gingival) mostly with ultrasonic devices and preventive services. Where hygienists and PAs work together the workload of the hygienists has altered but generally demand for their services is still high (Hovius 2001). It appears that government policy has moved to incorporate all of these issues in an effort to increase services and efficiency.

The combination of unmet demand for dental services, the implementation of the new Professions in Individual Health Care Act and the interest in market competition has produced changes to the way dental care is to be provided into the future. The government is keen to keep health expenditure to a minimum and their policy position is that where services can be provided at the same quality for lower cost by lesser trained or qualified practitioners, then it should occur. This approach has been formally referred to as Task Delegation and allows the more specialised education of the physician and dentist to be used for more difficult work (Borst-Eilers 2001, NMHWS 2000). Task delegation in relation to dental hygiene means that the dental hygienist is to become a primary care worker who is the first dental professional a patient sees who would then refer a person to a dentist or specialist for treatment beyond their skills. (Van den Heuvel 2002, Hovius 2001). Dentists are to be educated as a more generalist health care provider in the role of an oral physician with an emphasis on complex dental diagnosis and treatments utilising their more specialised skills for more complex care. Further, steps have been taken to expand the training and redesign the curriculum of both dentists and dental hygienists in order to produce a six year trained oral physician and more widely skilled hygienist in a four year Bachelor Degree program (Kalsbeek H et al, 2001, Hovius 2001, Van den Heuvel.
This model is similar to that proposed by the WHO Expert Committee for the Educational Imperatives for Oral Health Personnel (WHO 1990).

This new hygienist will have skills in the fields of diagnosis, prevention and treatments for periodontal disease (the traditional skills), public oral health, simple restorative treatments and clinical dental prosthodontics (Hovius 2001, Van den Heuvel 2002). In order to allow the health system to work with this model, the Netherlands Dental Hygienists Association along with the NMHWS has been required to define all the tasks of a dental hygienist in detail using prescriptive language. This is known as the Dental Hygienist Classifications and will operate as a schedule of fees so that the National Health Service and the insurance companies can directly remunerate their work (Hovius 2001).

The implications for the existing members of the dental hygienist profession are that they will have to upgrade their skills in order to fit in with this new model of care. The Higher Education Board have recommended that in order to develop research, evidence based treatment, reflective practice care and multi disciplinary integration and entrepreneurship, a four year program is required. The aims of the four year program are to develop a practitioner with clinical competence, communication skills, problem solving and a capacity for initiation, reflection and review enabling them to develop and respond to change (Hovius 2001, UPEHH 2002).

The role of the chairside dental assistants is to be explored by improving and extending their education in order to trial their ability to perform superficial procedures such as fluoride applications, removal of calculus and patient education and instructions. Implementation of this will formalise the role of the prophylaxis assistant which has evolved in practice. Government policy also supports the development of the team concept of dental service provision so that the most effective and efficient combinations of personnel inputs occur and quality is maintained. Within the dental team, agreement must be reached about patient treatment plans through written protocols focusing on the welfare of the patient (Van den Heuvel 2002, Hovius 2001, NMHWS 2001).

**Conclusions**

Independent practice among dental hygienists is an accepted role in Netherlands and is not perceived to be a threat to public safety. Furthermore, the ability of dental hygienists to perform hygiene diagnoses and restore teeth does not appear to be under challenge. These practices make the move to the new model more incremental than they may be elsewhere. Further, the outcome is quite similar to the Australian oral health therapist role without the age limits and the dual qualified dental hygienist/therapist practitioner in existence in Canada and Australia. The interesting move is that of policy development which supports the primary care role of this practitioner.
It is difficult to assess the level of controversy created by the proposals and movement toward the new Netherlands dental hygienists role as local dental journals and websites are all published in Dutch. Anecdotal evidence however suggests that there has been opposition to the role from dentists and periodontists and that there is now a recommendation that restorative work should be conducted under the supervision of dentists (Hovius 2001, Knevel 2002, Sanz 2002). However as the proposal has come from the Ministry of Health Welfare and Sports and implementation of the new four year dental hygiene program and work on the Dental Hygienist Classifications has begun, the change appears to be underway. Experience with dental therapists in the Netherlands shows that despite a trial demonstrating effectiveness, the role was not implemented. Experience in other settings (eg trial, Canada- see Appendix 3) has shown that even after a changed mode of service delivery has been established and demonstrated to be effective, dentist opposition is capable of reversing the process. The difference this time appears to be the process of implementation where regulatory policy was altered by omnibus approaches to task delegation that treated dentistry the same as other health practice. This may have shifted the dental policy environment enough to allow education to dictate practice rather than professional dominance.

This move raises the question of whether, given the development of the prophylaxis assistant, this new hygienist is not just a dentist in new garb. The difference is that the hygienist is primarily a preventive practitioner and this new model is an attempt to shift the philosophy of dental care into a new re-oriented service delivery mode. The new, more highly developed oral physician has a secondary care role demanding high technology skills to meet the needs of more complex care, which is increasing given the reduction in edentulism in the Dutch population. Unlike existing dentists, this practitioner would not spend time on low technology services such as fissure sealants, simple restorations or fluoride treatments. The boundaries between roles are to be more clearly separated reducing overlap and increasing technological efficiency.

There is a potential loss of professional dominance for dentists inherent in this model so the resultant inter-professional relationships will be interesting to observe. Given the observations of Willis(1989) and Lewis (2002) it is likely that dentists will alter their position to retain dominance. For example, the prophylaxis assistant replaces the subordinated dental hygienist and retains for dentists, a degree of occupational control. The move of dentists to a six year program protects esoteric knowledge, conferring greater expertise and protecting sovereignty. The freedom to determine work content, evaluation, pricing and practice type will still exist although the gatekeeper role has been lost. The oral physician role possibly brings oral physicians (dentists) closer to medical practice because of the more specialised nature of the role, creating greater challenge to the limitation of dentistry and the dominance of medicine. Medicine’s response to this challenge will also be interesting.
The other aspect of this move that is interesting is the costs and prices issue. Movement to a four year degree program has the potential to increase costs because the cost of developing this practitioner are greater. Hovius (2001) maintains that the move from a three year to a four year degree was related to the standards of education programs among other para-professionals rather than directly to the needs of the hygienist. This aspect however, remains an input cost that the market must absorb. Given the shortage of supply of hygienists and that their current remuneration rates are seen to be high, it may be argued that the effect on prices will be negligible. The need however for the NDHA and the government to negotiate price scales for insurance purposes, and the strong role of the insurance industry in the Netherlands, means that there are mechanisms in place for external evaluation of pricing. One would assume that the government’s interest in expanding the capacity of the dental care system to increase access to services would ensure adequate price control.

References


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Sanz M (2002) Letter to E Borst-Eiler Minister for Health, Welfare and Sports, and LMLHA Hermans, Minister for Education from Professor Dr M Sanz, Secretary-General, European Federation of Periodontology re: the EFP’s concern about the development of dental hygiene in the Netherlands. March 5, 2002


(UPEHH) University of Professional Education, Hogeschool Holland, Curriculum for Bachelor of Dental Hygiene Students 2002-2003, Dental Hygiene School, Hogeschool Holland, Amsterdam, Netherlands

My name is Julie Satur. I am a Doctor of Philosophy Student from the School of Health Sciences at Deakin University. I am conducting research into the dental legislation reform process in Australia and some other selected international sites, looking in particular at dental auxiliary practice. My supervisor in this work is Dr. Jan Garrard.

I would like to invite you to participate in this study by being interviewed by me, about your experiences and views related to the dental legislation policy reform process that you have been involved in. I will be seeking interviews with people who have been involved in the review processes and whose work will be affected by their outcomes. My questions will be related to the role you played in the process, how changes were made, what you think the outcomes will mean to dental care delivery and what sort of influences you think were important to the process. The interview will be about the dental legislation, how and why it was framed in a particular way and what the intentions behind the wording were.

The interview should take about 40 to 60 minutes.

Most of the interview material will be used to direct and inform the analysis and will be referred to in a general way. Some material may be quoted and attributed to a group of sources (for example 'many dentists believe...' or, 'public sector agencies hold the view that...') and a small amount of the material may be directly quoted and attributed to individuals. Draft copies of the sections containing material that is directly quoted by you will be provided to you prior to its use with an invitation to comment. Any material that you object to will either be revised to your satisfaction or will not be used. There will also be a list in the appendices of the thesis which includes the names of the people I have interviewed for this work. If you do not wish to have your name included in this list, please let me know by indicating this in writing on the consent form attached.

Agreeing to be interviewed places you under no obligation whatsoever. At any time before, during or after the interview, you are free to stop, and also to withdraw your permission for any information you may have given me or comments you may have made, to be used. If you decide that your material should not be included, you have only to inform my supervisor or me. (please see below for contact details)

With your permission, I would like to tape record the interview to make it easier for me to be accurate about your views. Tapes and transcripts from the interview would not be made available to anyone other than my research supervisor and will be stored in a locked cabinet in my office, as required by Deakin University ethical standards, and destroyed after six years. Their labels will also be coded to make them unidentifiable to other people, and stored separately from consent forms and other lists which may identify you.

Further information about this study may be obtained from my supervisor whose contact details are listed below. If you would like to hear about the results of this study, please let me know and I will arrange for this to occur.

If you agree to being interviewed, I will arrange a time and place for an interview that suits you. Thank you for giving this consideration.

Julie Satur
Researcher
7 Buckingham Close, Somerville 3912
Phone (03) 5977 6046
Email: satur@deakin.edu.au

Supervisor
Dr. Jan Garrard
School of Nutrition and Public Health
Deakin University,
Burwood Hwy, Burwood, Victoria Tel: 9251 7263
Fax: 9251 7301
Email: garrard@deakin.edu.au
DEAKIN UNIVERSITY ETHICS COMMITTEE : CONSENT FORM:

I, of

Hereby consent to be a subject of a human research study to be undertaken by Julie Satur

and I understand that the purpose of the research is designed to meet the following objectives:

- To conduct a comparative analysis of dental health policy as it relates to dental auxiliary practice
- To evaluate legislative and regulatory dental policy reform outcomes in Australia
- To document the dental policy development process around the Review of the Dentists Act 1972 and the Dental Technicians Act of 1972 in Victoria

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the research study, have been explained to me.

2. That I voluntarily and freely give my consent to my participation in such research study.

3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals.

4. I understand that any comments attributable to me for use in the final report will only be used subject to my approval.

5. Individual results will not be released to any person except at my request and on my authorisation.

6. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used, unless explicit permission to do so is given.

I give/ do not give permission for my name to be listed in the final document as a source of data for this research (cross out whichever is not applicable)

Signature: Date:
APPENDIX 6: INTERVIEW QUESTIONS

Victorian Case Study Questions

In general terms, why was the legislation review set up?

What did the government hope to achieve from the review?
How / why did you become involved in the process? What was your role?
What did you hope to achieve?
Did you achieve it? Why/why not?
Do you think there were any pre-determined outcomes?

Was there anything not up for change?

Generally speaking, was there anything surprising or unexpected?
Were there any triggers or turning points and what were they? Eg. events that changed the nature of the debate or triggered compromises?

The next group of questions is about the processes that shaped the review

Who were the key players in the review process?
What were they hoping to achieve?
What actions did they take?
Formally
Informally or behind the scenes? eg. did anyone employ professional lobbyists?

Could you rank these key players for me from one to five according to their ability to influence the outcomes, where one equals little or no influence and five equals the most influence?

Did the formal submissions have any influence?

Which ones? Can you give me an example of how something in a submission influenced the outcomes?

What role did research evidence play?

What evidence or data was important?
Did the panel seek independent data, other than what was in the submissions?
Did they try to verify what was in the submissions?

What role did community’s view play?

How were the consumer groups involved? Were they active?
Do you think the media had any influence?
Do you think anyone was excluded from the process? For example, I know the dental nurses felt they were a bit marginal?

Who or what groups had the most influence over the process of the review

Were they equal in their ability to influence the process?
Could you give each group or alliance a power rating from 1-5 based on their ability to influence the process or outcomes
What actions did each take?
What did they do behind the scenes, do you think?
Were there times when they deliberately did nothing? Or something negative?
What activities do you think were important in terms of influencing the outcome?

What role did the department (bureaucracy) take?

Do you think the process was controlled? By whom and how? Why?

What happened in the debate around the definition of dentistry?
(Why was it so important? who was most concerned, why?)

And what about the structuring of the board?
What arguments were made and by whom?
How did they arrive at the end result?
Why was it important to have all the providers covered by one act? Where did that come from?

Were there any issues that dropped off the agenda or ceased to be important to the review? Why?

Who or what groups had the most influence on the outcomes of the review? Why do you think this was the case? Eg were they more in tune with what the government wanted? were they a more forceful or credible lobby group? Were the other groups weaker because they were less visible, ineffectual, naive, inexperienced, powerless?

Were you satisfied with the end result?
What do you think were the best things to come out of it?
Was there anything you were concerned about?
Was there anything that wasn’t done or addressed that you thought should have been? Why?

What changes do you think we’ll see as result of this review?

Would you like to add anything? Is there anything we haven’t talked about that you would like to mention?
**Interstate Case Study Questions**

Who were the key players and what outcomes did they want? What actions did they take?
How have technicians & prosthetists been regulated?
Who were the dominant group/stakeholder in this process? (Rank 1-5 like Victorian data set) Where were the alliances?
How important was evidence to the outcome? How was it used?
What did the government want?
Detail Checkpoints: consumer participation, use/influence of media, key actions, role of NCP (overt/covert), leadership activities

**Interview Guide: International Case Studies**

Can you tell me how health services are funded in your country?
Are dental services included in this? If not, how are dental services funded?
What are the current issues around provision of dental services in your country?
What types of dental care providers are there and what are their relationships/boundaries of practice?
How are dental therapists and/or hygienists regulated? (Explore indicator areas)
Can you tell me about any recent legislation or policy reform that has affected the way dental therapists/hygienists practice?
What have the arguments been?
What have the outcomes been?
How do you think this will affect dental service delivery?
Can you suggest
- other key people I could talk to?
- policies or other documents I should look at?

### PROGRESS OF LEGISLATION REVIEWS

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APPENDIX 7; VICTORIAN POLICY PROCESS- OUTCOMES AND DECISION ANALYSIS

See over page
### APPENDIX 7: VICTORIAN POLICY PROCESS - OUTCOMES AND DECISION ANALYSIS

<table>
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<tr>
<th>Decision</th>
<th>Who supported it</th>
<th>Who opposed it</th>
<th>Outcome</th>
<th>Policy influences</th>
<th>Who benefitted from decision?</th>
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<td>Apply NCP to health sector</td>
<td>Federal Govt</td>
<td>ADAVB</td>
<td>Yes</td>
<td>✓ NCP</td>
<td>Governments, Consumers</td>
<td>Reduce power of professionals, attention shifted to markets rather than funding</td>
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<td>Review Dentists Act under NCP</td>
<td>State govt VDTA, DHSV</td>
<td>ADAVB, Techs/Prosth</td>
<td>Yes, partly</td>
<td>✓</td>
<td>Government</td>
<td>Competition policy nurtured a culture of reform - produced a change agenda</td>
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<td>Increase competition</td>
<td>NCP, fed &amp; state govt, DHSV, VDTA</td>
<td>ADAVB, DBV</td>
<td>Yes partly</td>
<td>✓</td>
<td>Consumers, fed and state govs</td>
<td>Potential to reduce dentist monopoly through reduced regulation ↓ prices, ↑ access to care ↓ Pressure on govt. spending</td>
</tr>
<tr>
<td>Impartial process</td>
<td>Government DHSV, VDTA</td>
<td>ADAVB, DBV</td>
<td>No practitioners on review panel</td>
<td>✓</td>
<td>All non ADAVB &amp; DBV stakeholders</td>
<td>Reduced formal power of dentists in review process</td>
</tr>
<tr>
<td>Integrate Acts to single Act &amp; board</td>
<td>ADAVB, DBV</td>
<td>Tech/prosth, VDTA</td>
<td>Yes</td>
<td>✓ part</td>
<td>Dentists, Govt</td>
<td>Dentists regained power over techs/proths, retained power over therapists &amp; hygienists Altered structural power</td>
</tr>
<tr>
<td>Register dentists and specialists</td>
<td>ADAVBVB, DBV</td>
<td>Yes</td>
<td>✓</td>
<td>Dentists, Specialists</td>
<td>Consumers identify specialists, protects market entry</td>
<td></td>
</tr>
<tr>
<td>One register with divisions</td>
<td>ADAVB</td>
<td>Yes</td>
<td>✓</td>
<td>Dentists</td>
<td>No occupational creep, no power to create new auxiliaries</td>
<td></td>
</tr>
<tr>
<td>English language competence</td>
<td>DBV, ADAVB</td>
<td>Yes</td>
<td></td>
<td>Existing practitioners</td>
<td>Protects market entry from non-english speakers</td>
<td></td>
</tr>
<tr>
<td>Protect Title</td>
<td>all</td>
<td>Yes</td>
<td>✓</td>
<td>Practitioners community</td>
<td>Entry barriers protect market Quality of care - qualifications for practise</td>
<td></td>
</tr>
<tr>
<td>Protect practice (Definition of dentistry)</td>
<td>ADAVB, DHAA DHSV, Techs/Prosth</td>
<td>NCP, ML, Govt</td>
<td>Yes</td>
<td>x</td>
<td>Dentists</td>
<td>Retained control over their practice - able to limit competition. Precedent to define (limit) subordinate practice</td>
</tr>
<tr>
<td>Register Students</td>
<td>Government</td>
<td>DHSV, VDTA</td>
<td>Yes</td>
<td></td>
<td>Consumers</td>
<td>↑ Board Power over training setting capacity to discipline students, Board potential to interfere with training</td>
</tr>
<tr>
<td>Register Dental Therapists &amp; Hygienists</td>
<td>DHAA, VDTA, DHSV</td>
<td>Yes</td>
<td></td>
<td>Hygienists, therapists</td>
<td>Increased status/ recognise role, self determination through seat on board,</td>
<td></td>
</tr>
<tr>
<td>Decision</td>
<td>Who supported it</td>
<td>Who opposed it</td>
<td>Outcome</td>
<td>Policy influences</td>
<td>Who benefitted from decision?</td>
<td>Why?</td>
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</tr>
<tr>
<td>Limit therapist training numbers</td>
<td>ADAVB</td>
<td>DHSV, VDTA, VDAW (DAWR)</td>
<td>Not addressed</td>
<td>✗ ✗ ✗</td>
<td>Role of therapists apparently supported by government</td>
<td></td>
</tr>
<tr>
<td>Convert all therapists to hygienists</td>
<td>ADAVB</td>
<td>DHSV, VDTA, (DAWR)</td>
<td>Not addressed</td>
<td>✗ ✗ ✗</td>
<td>As above- DAWR position retained</td>
<td></td>
</tr>
<tr>
<td>Remove Therapist employment restrictions</td>
<td>VDTA, DHSV, Tech/prosth</td>
<td>ADAVB, DBV</td>
<td>Yes</td>
<td>✓ ✓ ✓</td>
<td>Therapists, community</td>
<td>↓ subordination, greater potential to ↑ dynamic efficiency, ↓ costs. More competition. ↑ profits for practice owners or reduce prices. ↑ therapists profile</td>
</tr>
<tr>
<td>Prescribe Auxiliary duties</td>
<td>ADAVB, DBV, DHAA, VDTA, Techs/prosth</td>
<td>DHSV</td>
<td>Not in Act; up to Board in Codes of Practice</td>
<td>✗</td>
<td>Limits capacity for dynamic innovation More room to move as Board now has power to determine under Codes of Practice- relies on Board appts</td>
<td></td>
</tr>
<tr>
<td>Retain Auxiliary: direction, supervision &amp; control</td>
<td>ADAVB, DBV, DHAA,</td>
<td>VDTA, Techs/prosth</td>
<td>Not in Act but Recoms said supervision only</td>
<td>✗</td>
<td>Dentists More potential for change but Board now has power Reduces competition (gatekeeper role retained for dentist)</td>
<td></td>
</tr>
<tr>
<td>'Hybrid' (combined) Auxiliary</td>
<td>DHSV</td>
<td>DHAA, ADAVB, DBV</td>
<td>Not addressed</td>
<td>✓ ✓</td>
<td>Consumers, DHSV Separate divisions of register for therapists &amp; hygienists preserves separation</td>
<td></td>
</tr>
<tr>
<td>Independent practice for therapists &amp; hygienists</td>
<td>VDTA, Techs/prosth</td>
<td>ADAVB, DBV</td>
<td>No</td>
<td>✓</td>
<td>Dentists Limit competition, protects dentist monopoly, prevents subcontracting or alternative services</td>
<td></td>
</tr>
<tr>
<td>Remove 1:1 supervision ratio</td>
<td>DHAA, VDTA, DHSV Techs/Prosth</td>
<td>DBV, ADAVB</td>
<td>Not in Act but recom Yes</td>
<td>✓</td>
<td>Community, Dentists, Hygienists ↓Prices and greater potential for wider use of hygienists- depends on Codes of practice dentists/practice owners can profit from multiple hygienists</td>
<td></td>
</tr>
<tr>
<td>Retain age limit for therapists</td>
<td>ADAVB, DBV</td>
<td>VDTA, DHSV, Techs/prosth</td>
<td>Not in Act, recoms up to 17yrs</td>
<td>✗ ✗</td>
<td>Dentists Prevents competition, In Codes of Practice means DPBV now has power to decide. If retained Access to care limited</td>
<td></td>
</tr>
<tr>
<td>De-regulate dental technicians</td>
<td>NCP (govt), DBV, DHSV</td>
<td>Techs/Prosths</td>
<td>Yes</td>
<td>✓</td>
<td>Government, dentists Met NCP =payments. Remove from Board (dental policy environment)</td>
<td></td>
</tr>
<tr>
<td>Change ADT name to Prosthetist</td>
<td>Techs/prosth</td>
<td>ADAVB, DBV</td>
<td>Yes</td>
<td>✓ ✓</td>
<td>Prosthetists Greater distinction (separation?) from Technician</td>
<td></td>
</tr>
<tr>
<td>Decision</td>
<td>Who supported it</td>
<td>Who opposed it</td>
<td>Outcome</td>
<td>Policy influences</td>
<td>Who benefitted from decision?</td>
<td>Why?</td>
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</tr>
<tr>
<td>Register prosthetists</td>
<td>DBV, Techs/Prosth</td>
<td>Yes</td>
<td>DAWR FD NCP ML</td>
<td>Prosthetists</td>
<td>Improve status/recognise role</td>
<td></td>
</tr>
<tr>
<td>Prescribe Prosthetist duties</td>
<td>DBV, Techs/Prosth</td>
<td>No debated</td>
<td>×</td>
<td>Prosthetists, consumers</td>
<td>In Codes of Practice</td>
<td></td>
</tr>
<tr>
<td>Repeal Certificate Oral Health</td>
<td>Techs/Prosths NCP, ADAVB, DBV</td>
<td>Yes</td>
<td>× ✓</td>
<td>Prosthetists, consumers</td>
<td>↓prices, removes gatekeeper role of dentist</td>
<td></td>
</tr>
<tr>
<td>Separate &amp; improved Act for Techs/Prosth</td>
<td>Techs/prosth</td>
<td>No</td>
<td>×</td>
<td>Dentists</td>
<td>Bringing prosthetists into a single Act = more effective regulation for them but greatly reduced autonomy</td>
<td></td>
</tr>
<tr>
<td>Repeal training embargo for Prosthetists</td>
<td>Techs/Prosths ADAVB</td>
<td>Not discussed</td>
<td>× ✓</td>
<td>Dentists</td>
<td>Embargo retained-benefits dentists</td>
<td></td>
</tr>
<tr>
<td>De-reg Business ownership</td>
<td>NCP (govt), DHSV, VDTA ADAVB, DBV</td>
<td>Yes</td>
<td>✓</td>
<td>Government, Consumers Therapists &amp; Hygienists</td>
<td>Met NCP, more competition ↓ prices Therapists &amp; hygienists can profit as owners providing they employ a dentist to ‘supervise’ them</td>
<td></td>
</tr>
<tr>
<td>Maintain Partnership limits</td>
<td>ADAVB, DBV NCP, VDTA</td>
<td>No</td>
<td>×</td>
<td>consumers</td>
<td>Potential spread of profits from dentistry away from dentists</td>
<td></td>
</tr>
<tr>
<td>Two Boards</td>
<td>Techs/Prosth, VDTA ADAVB, DBV</td>
<td>No</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Board- all dentist</td>
<td>ADAVB, DBV DHSV, VDTA, DHAA, Techs/Prosth</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Board – mixed membership</td>
<td>DHSV, VDTA, DHAA ADAVB, DBV, Techs/prosth</td>
<td>Yes ✓ ✓ ✓</td>
<td>All non dentists, community</td>
<td>↓power of dentists over policy environment-structural change Maintain regulatory control by dentists over other occupational groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointed Board members</td>
<td>Model legisl (govt) ADAVB, DBV</td>
<td>Yes ✓</td>
<td>Government Community?</td>
<td>↓power of dentists over policy environment ↑govt control of policy environment- ↓vested profession interests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist majority</td>
<td>ADAVB, DBV VDTA, DHSV, Techs/prosth</td>
<td>No</td>
<td>Non dentists-change agenda</td>
<td>↓power of dentists over policy environment-structural change – marginal numerical minority only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More Dentist</td>
<td>ADAVB, VDTA, Techs</td>
<td>Yes</td>
<td></td>
<td>Dentists</td>
<td>maintains dentist dominant presence on</td>
<td></td>
</tr>
<tr>
<td>Decision</td>
<td>Who supported it</td>
<td>Who opposed it</td>
<td>Outcome</td>
<td>Policy influences</td>
<td>Who benefitted from decision?</td>
<td>Why?</td>
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</tr>
<tr>
<td>numbers on Board than other groups</td>
<td>DBV</td>
<td>&amp; Prosth</td>
<td></td>
<td></td>
<td></td>
<td>Board- &quot;dentist as leader&quot; increases agenda setting power, and over Prosthetists.</td>
</tr>
<tr>
<td>Dentists Advisory Committee</td>
<td>ADAVB, DBV</td>
<td>VDTA, Tech/Pros</td>
<td></td>
<td></td>
<td>Dentists</td>
<td>Retains dominance of dentist issues at Board (others deferred to subcommittees)</td>
</tr>
<tr>
<td>Board president and VP dentist</td>
<td>VDTA, DHAA, ADAVB</td>
<td>DHSV, Govt. Tech/prosth</td>
<td>Yes</td>
<td></td>
<td>Dentists</td>
<td>Kept agenda setting power (Board) with dentists</td>
</tr>
<tr>
<td>Two auxil members</td>
<td>VDTA, DHAA, ADAVB</td>
<td>ADAVB, DBV</td>
<td>No</td>
<td></td>
<td>Non dentists Government</td>
<td>Balance of power less likely to support dentist dominance</td>
</tr>
<tr>
<td>Autonomous Subcommittees</td>
<td>VDTA, DHSV, DHAA</td>
<td>ADAVB, DBV</td>
<td>No, Advisory</td>
<td></td>
<td></td>
<td>▲ power of auxiliaries compared to past but ▼ power of prosthetists &amp; techs and retains Board power over policy</td>
</tr>
<tr>
<td>Non dentists on discipline panels</td>
<td>ADAVB, DBV</td>
<td>Yes</td>
<td></td>
<td></td>
<td>community</td>
<td>▼ power of dentists over profession</td>
</tr>
<tr>
<td>Dentists on all panels</td>
<td>ADAVB</td>
<td>Not defined</td>
<td></td>
<td></td>
<td>Dentists</td>
<td>Depends on Board allocation – likely, retains dentist sovereignty &amp; authority over committees (other groups)</td>
</tr>
<tr>
<td>Inquiry models; formal &amp; informal hearings</td>
<td>All, DBV, ADAVB, Techs/prosth</td>
<td>Yes</td>
<td></td>
<td>✓ consumers</td>
<td>✓</td>
<td>Costs of regulation- Less punitive model, more opportunity to be remedial &amp; educative where appropriate</td>
</tr>
<tr>
<td>Increase penalties</td>
<td>DBV, Govt</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Board consumers Govt</td>
<td>More disciplinary power for Board, more income for self funded board, profession bears cost of discipline</td>
</tr>
<tr>
<td>Guilty party to bear costs of inquiry</td>
<td>ADAVB, Techs/prosth</td>
<td>no</td>
<td></td>
<td>×</td>
<td></td>
<td>Not in spirit of model legislation because punitive</td>
</tr>
<tr>
<td>Looser advertising rules</td>
<td>NCP, Model legisl (govt)</td>
<td>ADAVB, DBV</td>
<td>Yes</td>
<td></td>
<td>Consumers, auxils</td>
<td>Increase provision of information Raise awareness of therapists &amp; hygienists, ▼ transaction costs may ▲ costs &amp; prices</td>
</tr>
<tr>
<td>Mandatory professional indemnity insurance</td>
<td>Govt, DBV for privately funded patients</td>
<td>DHAA</td>
<td>Yes</td>
<td></td>
<td>Consumers, govt., insurance companies</td>
<td>Industry self-funded compensation mechanism for regulatory failure Allows insurance company control over prices and possibly registration</td>
</tr>
<tr>
<td>Mandated Cont Education</td>
<td>VDTA</td>
<td>ADAVB, Techs/prosth</td>
<td>No, but implied under renewal</td>
<td>✓ consumers</td>
<td></td>
<td>Seen as too difficult to monitor and ineffective- is encouraged but not</td>
</tr>
<tr>
<td>Decision</td>
<td>Who supported it</td>
<td>Who opposed it</td>
<td>Outcome</td>
<td>Policy influences</td>
<td>Who benefitted from decision?</td>
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</tr>
<tr>
<td>Directing another to act unprofessionally</td>
<td>VDTA, ADAVB</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td>Possibly protects consumers against profit overriding quality. Also practitioner autonomy &amp; competence boundaries, Retains clinician autonomy</td>
</tr>
<tr>
<td>Dental care providers rather than 'professionals'</td>
<td>ADAVB</td>
<td>VDTA, DHSV</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Dentists believe it protects their status</td>
</tr>
<tr>
<td>Promote Access to Care as objective of Board</td>
<td>DHSV, VDTA</td>
<td>ADAVB, DBV</td>
<td>Yes</td>
<td>✓</td>
<td>✓</td>
<td>Consumers, Auxils</td>
</tr>
<tr>
<td>Codes of practice</td>
<td>All, esp ADAVB,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↓ prices, mitigates against dentist market monopoly in future decision making, because of imperative to consider innovative delivery models</td>
</tr>
<tr>
<td>Board to administer radiation licensing</td>
<td>ADAVB, VDTA</td>
<td></td>
<td>No</td>
<td>×</td>
<td>Radiation safety</td>
<td>Revenue, external control over dentist radiography practice standards</td>
</tr>
<tr>
<td>Register dental assistants</td>
<td>Techs/prosths, VDTA, DAAA</td>
<td>NCP, govt</td>
<td>No</td>
<td>×</td>
<td>Dentists, consumers (cost)</td>
<td>Protects dynamic innovation, keeps practice costs down. Maintains low remuneration and standing of DAs,</td>
</tr>
</tbody>
</table>
APPENDIX 8- CODES OF PRACTICE VICTORIA

DENTAL PRACTICE BOARD OF VICTORIA

CODE OF PRACTICE (effective August 1 2002)

PRACTICE OF DENTISTRY BY DENTAL HYGIENISTS AND DENTAL THERAPISTS

PREAMBLE

This code has been developed, pursuant to s.69 (1)(e) of the Dental Practice Act 1999, to provide a framework for the practice of dentistry by dental therapists and dental hygienists. In exercising its obligations, the Board will use this code to determine if a practitioner is acting within or outside the framework approved by the Board.

The Code will be subject to continuing review in the context of:

- evolving dental workforce needs;
- new technological developments; and
- the objectives of the dental practice Board of Victoria.

There will be a formal review process within five years. In further developing the boundaries of this Code the Board will promote and support appropriate research into the scope of practice of dental auxiliaries, including into the utilization of dental therapists for the provision of dental health care to persons over the age of 18 years.

It is fundamental to this Code that, within the defined range of skills, dental therapists and dental hygienists must practise only those skills for which they have been formally educated (in courses approved by the Board) and in which they are registered and competent. The Board requires registered dental care providers to possess at least a level of competence expected of a graduating final year dental auxiliary student in a course of study approved by the Board. It may take into account such matters as educational preparation, acquired skills and within the parameters set out in part 3, recency of practice and continuing professional development.

Part 1

This Code requires a team approach in the delivery of dental services, with a registered practising dentist or dentists adopting the role of clinical team leader(s) with overall responsibility for patient care. The dental therapist and dental hygienist work with the dentist(s) in a consultative and referral relationship to provide any or all of the following; preventive, periodontal, restorative and orthodontic dental services. A dental auxiliary may not engage in independent practice.

A dental auxiliary must only practise:

- in the employ of a registered practising dentist or dentists who shall be team leaders(s); or
- in the employ of a registered practising dentist or dentists who employ a registered practising dentist who shall be team leaders; or
- in an entity that employs a registered practising dentist or dentists who shall be team leaders(s)

The parties mentioned in the preceding paragraph must enter into a written agreement that outlines the professional relationships and activities that affect clinical care. That agreement must specify:
• roles and responsibilities of the auxiliary;
• roles and responsibilities of the dentists or dentists;
• competencies achieved within the areas listed in Part 3 of the Code or Practice;
• working relationships between the team leader and auxiliary, including procedure and protocols for the operation of the dental team and quality assurance systems.

All parties must ensure that the written agreements are consistent with the terms and conditions of their professional indemnity insurance.

Part 2

Dental therapists may provide dental care, as specified in Part 3, for persons up to and including 18 years of age and, on the prescription of a practising dentist, for persons between the ages of 19 and 25 years of age. There is no age restriction on the provision of orthodontic procedures by dental therapists within the parameters set out in Part 3.

Part 3

Dental hygienists and dental therapists may perform only those tasks for which they have been formally educated (in courses approved by the Board) within the following areas:

DENTAL THERAPISTS AND DENTAL HYGIENISTS

• Oral examination including intra-oral dental radiography
• Extra-oral dental radiography on the prescription of a dentist
• impression taking (for other than prosthodontic or prosthetic treatment)
• local anaesthesia for dental procedures
• application of therapeutic solutions to teeth, but not including in-surgery bleaching of teeth
• orthodontic procedures under the supervision of a dentist, except for
  o diagnosis and treatment planning for orthodontic treatment
  o initial fixation of bands and brackets
  o design of orthodontic appliances
  o activation and adjustment of orthodontic appliances

DENTAL THERAPISTS

• preventive dental procedures including fissure sealants and removal of deposits from teeth;
• the restoration of coronal tooth structure damaged by or at risk from caries, or damaged by trauma, including pulpotomies, but excluding indirect restorations and endodontics;
• extraction of deciduous teeth.

DENTAL HYGIENISTS

• management of periodontal disease (except surgical management) within the context of and overall treatment plan undertaken by a dentist;
• preventive dental procedures including, on prescription of a practising dentist, fissure sealants.
APPENDIX 9: AUSTRALIAN AND NEW ZEALAND LEGISLATION REVIEWS PROGRESS: OCT 2002

See over page
## APPENDIX 9: AUSTRALIAN AND NEW ZEALAND LEGISLATION REVIEWS PROGRESS: OCT 2002

<table>
<thead>
<tr>
<th>State</th>
<th>Act</th>
<th>Progress on Auxiliary Regulation</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>Dental Practitioner Registration Act 2001 Passed in May, not yet promulgated-waiting on Regs to be written. Separate Act for Prosthetists and Technicians No change to DT &amp; DH as yet Make up of Board still being discussed but likely to be a mixed Board with representation including dental therapists, oral health therapists and dental hygienists.</td>
<td>DTs, OHTs &amp; DHs as is and will be addressed under amendment. This was such contested ground that the Qld Govt put the process out to tender for independent report. Price Waterhouse Coopers engaged to carry out public benefit test and make recos. This report published June 2000, released June 2001, stakeholder comments received Dec 2001, currently under discussion - some policy issues still be to be resolved. Dept expected draft legislation to be ready (?) by June 2002 (to meet NCP timelines) Not yet completed, dispute over definition of dentistry and scope of practice for DT, DH and OHTs</td>
<td>PWC Recommendations as follows: 1. Limited supervision should apply and be defined by a Code of Practice which addresses referral relationships, dentists’ quality assurance roles and supervision of hygienists 2. Dental therapists and Oral health therapists should be permitted to treat adults under the supervision of a dentist 3. Public sector restrictions on therapists and numerical restrictions on hygienists employment serve no public benefit and should be removed</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Dental Practitioners Registration Act 2001, Passed in May. Two Acts- retained separation of dental practitioners and technicians. Therapists &amp; hygienists registered Employment restrictions lifted to allow independent practice by dental therapists &amp; hygienists. Business ownership freed up. Board consists of 4 dentists, 1 therapist, 2 community reps and 1 hygienist (when appropriate numbers of them are registered)- Board appointed Oct 2001,</td>
<td>All parties (ADATB, the old board, the TDTA, DHAATB and the Department of Health) developed draft ‘Guidelines for the practice of dentistry and delivery of dental services and Scope of Practice for dental auxiliaries’ dated Aug 2000 which has come to comprise a draft code. Age limits not specified because of adult trial (2000 SDT Act amendment allows for this- dental therapists may treat people over 16 yrs under certain conditions) and status quo remains in place until after trial. Board has met, draft Code has been accepted as a ‘working doc’ but needs to be ‘built on’ to include infection control, radiography etc. as it is a code applicable to all dental practitioners not just DTs &amp; DHs</td>
<td>This code applies to all dental practitioners registered by the Dental Board of Tasmania. It does not define a range of skills but requires practice within the scope of training, acquired skills and competency. There is a requirement for dental therapists and hygienists to provide the Board with the name of the dentist who acts as consultant and accepts referrals and gives advice outside the scope of practise of the dental auxiliary. A dentist and an auxiliary ‘may’ make an agreement defining each parties’ responsibilities. This may include a general or detailed description of procedures to be undertaken and advice to be given by the auxiliary and undertakings by the dentist not to direct care beyond scope of auxiliary practise and by the auxiliary not to perform procedures outside scope of practise.</td>
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<tr>
<td>State</td>
<td>Act</td>
<td>Progress on Auxiliary Regulation</td>
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<tr>
<td>South Australia</td>
<td>Dental Practice Act 2001 passed in May. Allows for registration of DT &amp; DH Mixed board; 6 dentists, 1 D'Therapist, 1 D'Hygienist, 2 consumers, 1 Prosthodontist, 1 Technician and 1 Lawyer Employment restrictions lifted? DTs and DHs ‘…provide prescribed care under prescribed circumstances. Ownership limits retained.</td>
<td>A working party was appointed (Jan 2002) to develop Regulations prescribing practice of DTs and DHs. It was expected that the working party would form the new Board when the Act is proclaimed but this is now unclear</td>
<td>Previous govt subcommittee made recommendations re regulations. New govt undertook further consultations re these. <em>Anticipated that new draft regs released to stakeholders for consultation soon.</em> Hope to see Act proclaimed late 2002</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Review complete. Bill passed October 2001. Therapists and hygienists to be registered, otherwise existing arrangements retained (employment limits, age etc), ownership limits also retained Single auxil board seat out of 12 (7 dentists-2 appointed, 5 elected, public sector rep, 2 consumers, lawyer)</td>
<td>Therapists and hygienists practice boundaries to be defined by regulations- process to include consultations and regulatory impact statement- began Jan 2002 expected to take 6 months. No outcome yet (Oct 2002)</td>
<td>Therapists and hygienists are to be registered, employment and age restrictions on therapists will be retained. Ownership limits retained-limited to dentists and Health Funds A workforce and education review also being undertaken by Oral Health Branch is underway</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Omnibus legislation- held up Draft Bill released for comment but is generic given omnibus nature</td>
<td>Dental Schedule to be written later, was looking promising re; DT and DH practice but now? because of NSW outcomes</td>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Cabinet has approved Omnibus legislation; Review begun in late 2001, discussion paper published calling for submissions. Public forums held December 2001. Report is published. Consultation will occur on a draft Bill with completion (legislation) expected late 2002</td>
<td>Omnibus Health Practitioners Bill before Cabinet-to be released for comment in next month</td>
<td>Bill provides for Registered DTs, &amp; DHs, a shared board seat (one seat out of 7) between prosthetists, therapists and hygienists. Removes employment and age limits for DTs (requiring additional educ for adults) Board to devise practice definition</td>
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<tr>
<td>Western Australia</td>
<td>Govt has approved the drafting of legislation; projected for presentation next parliamentary session? Consultations Dec/Jan 2002 re recommendations No progress since, Bill still to be drafted Oct 2002</td>
<td>Status quo remains in place until review of schedules occurs. Bill removed the public sector employment restrictions on school dental therapists and the requirement for a one-to-one ratio for therapists and hygienists in private practice</td>
<td>NB: WA has three categories of auxiliary: School Dental Therapists (public sector, school aged children), Dental therapists (private sector- all ages treated under prescription) and dental hygienists (all ages treated under prescription). Existing regulations have five parts and individ DT/DH practise under a mix depending on skills</td>
</tr>
<tr>
<td>State</td>
<td>Act</td>
<td>Progress on Auxiliary Regulation</td>
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<td>New Zealand</td>
<td>Health Practitioner Competency Bill has been accepted by cabinet and introduced to Parliament in June 2002 and is expected to be passed in early 2003 following committee stages late 2002. This is omnibus health practitioner legislation covering 11 health practitioners that has schedules attached specific to practitioner streams which will describe 'restricted' acts (core practice model) and scopes of practice. Discipline will be by HP Disciplinary Tribunal. The Bill provides for the registration of dentists, dental therapists and dental hygienists, dental technicians (and advanced dental technicians) and the establishment of Boards for each practitioner group.</td>
<td>Technical Advisory Group (ADA, NZDC, MoH, DTA) on dental therapy regulation report to ministry has been signed off. Transitional Working Party is developing implementation of the new HPCA in relation to dentistry. The agreed model is to retain the New Zealand Dental Council as an umbrella organisation and establish two Boards which report to it, the Dentists Board and the Dental Therapists Board. The NZDC is be comprised of 5 dentists, 2 dental therapists, (unsure about other occupational group membership yet) 2 consumers and 1 educationalist. Two members of the NZDC will sit on each of the Boards. The Dental Therapists Board will have 5 DTs, 1 dentist, 1 educator and 1-2 consumers. The Dentists Board will have 5 dentists, 1 dental therapist, 1 educator and 1-2 consumers. The functions of the Boards will be to deal with registration, competency, scope of practice and education issues for each profession and reports to the NZDC.</td>
<td>Dental therapists work as part of a dental team with a designated dentist providing clinical guidance/general oversight. Employment restrictions removed. The functions undertaken by dental therapists must be commensurate with their formal training and scope of practice which includes; examination and treatment planning the provision of uncomplicated care for dental caries and minor periodontal conditions preventive dentistry and the recognition and referral of conditions that they are unable to treat individual oral health education No restriction on patient groups- &quot;they are merely undertaking the same work on different age group&quot; - generally speaking those providing services to an older age group have had an additional two weeks training in diagnosis and perio. This change made in 1988 Act. Dental Hygienists operate under the direction (prescription) and supervision of a dentist Removing deposits from teeth Applying materials to the teeth for the purposes of preventing disease Giving advice on oral health Carrying out other similar work</td>
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APPENDIX 10: DENTAL PRACTICE ACTS PRIOR TO REVIEW COMPARED
See over page
# APPENDIX 10: DENTAL PRACTICE ACTS PRIOR TO REVIEW COMPARED

<table>
<thead>
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<td>No, but Act allows practise</td>
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<sup>*</sup> under direction where a dentist is to prepare the written treatment plan—ie treatment provided under prescription

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1 NT also has an aboriginal health worker registered under the Health Practitioners and Allied Professional Registration Act to practice under direct or indirect supervision of a dentist to provide relief of pain (analgesics, antibiotics, removal of soft debris with hand instruments and placement of temporary dressings, simple extraction of periodontally involved teeth under LA) and prevention (OH education, prophylaxis and plaque control), apply topical fluorides and fissure sealants, chairside assisting & interpretation.
2 WA School dental therapist (SDT)- limited to public sector work with children
3 WA dental therapists (DT) are those allowed to work in the private sector with all ages but are not allowed to prepare cavities in adults, only fill them. Those wishing to work in orthodontic or periodontic practices must gain additional skills in those areas under the amendments introduced in 1996
4 Also Tutor Dental Therapist; duties same as School Dental Therapist plus assisting School DT training
5 Queensland dental hygienists may only be employed by a dentist or specialist with prior approval of the Board under ‘immediate personal supervision’
6 Tasmanian School Dental Therapy Services Act allows employees approved by the Minister to practise dentistry under exemption from the Act in the provision of school dental therapy services. Also establishes a Dental Health Services Advisory Committee of 7 persons (3 are ADA nominees) to make recommendations to minister in relation to the provision of school dental therapy services.
7 NSW for hygienists specifies ‘treatment to be carried out that does not involve cutting of oral or dental tissue’
8 Tasmanian adult trial – legislation passed in 2000 to allow dental therapists to participate in a trial under the direct supervision of a registered dentist providing prescribed treatment to adults
9 NSW dentist employed by, or authorised by the Department available within a reasonable time to assist the dental therapist
10 NT, both therapist and hygienists work under direct or indirect supervision and in accordance with guidelines set by a dentist
11 WA; for dental therapist (private practice) and hygienist dentist must examine the patient before and after treatment
12 ACT registered dentist must be available to the therapist within ‘a reasonable time’
13 WA dentist must be reasonably available. Dental therapists and dental hygienists in WA may also work in hospitals
14 In South Australia, dental hygienists may provide prescribed services to patients in Nursing homes provided a doctor or nurse is at close call. The treatment plan must be prepared and signed by a dentist, less than 6 months old and checked following completion.