



Australian Society
of Orthodontists

ASO POLICY STATEMENTS

1. SPECIALISATION POLICY

- Adopted General Meeting in Melbourne, 10 March 1972
 - Amended General Meeting in Hong Kong, 10 March 1982
 - Revised by Federal Council 1993
 - Revised by Federal Council 1999
 - Revised by Federal Council 2000
- A. The ASO recommends the recognition, at a national level, of orthodontics as a speciality in the practice of dentistry.
- B. It is therefore necessary that all State Dental Boards establish a specialist register in orthodontics. Each applicant for specialist recognition and registration shall:
- (a) Be a registered dentist in the State in which he/she wishes to practise.
 - (b) Have completed a period of two years in the practice of general dentistry.
 - (c) Have successfully gained a postgraduate qualification in orthodontics acceptable to the ASO, as a result of completing a course in orthodontics of at least three years full-time study or its part-time equivalent at a teaching institution approved by the ASO.
- C. Notwithstanding anything in the above it is recommended that no-one shall be registered as a specialist in orthodontics within five years of graduation of BDS or its equivalent.

2. THE DELIVERY OF ORTHODONTICS IN THE PUBLIC SECTOR

- Adopted 1989 replaced 'Policy on Delivery of Orthodontic Services within School Dental Services (1975)'

2.1 GENERAL CONSIDERATIONS

- 2.1.1 Malocclusion is the dental manifestation of a deviation from the expected and desired pattern of development of the dentition and the face.
- 2.1.2 The severity of malocclusion is mainly determined by an appearance conscious society, largely on cosmetic grounds. However, the psychological and functional consequences of a malocclusion need to be considered in any assessment of its severity.

- 2.1.3 The degree of handicap (ie cosmetic + psychological + functional) associated with malocclusion varies from person to person with age. Similarly, assessment of orthodontic needs tend to be subjective and reflects the values of the assessors. As a result, estimates of orthodontic needs vary. Data from the National Oral Health Survey 1987/88 suggest that dental malocclusion affects some 45 per cent of Australian children aged between 5 and 14 years, in approximately one-quarter of whom the malocclusion is severe. Freer and Olive (Australian Orthodontic Journal 4:128-36) categorised 22 per cent of children as having 'severe handicap with treatment highly desirable' and a further 55 per cent as having 'definite malocclusion, but treatment elective'.
- 2.1.4 The community has shown a growing appreciation of the need for correction of malocclusion, while increasing emphasis has been placed on orthodontic treatment by the dental profession. These changing attitudes have ensued from increased expectations by the community, clinical and technological developments in the orthodontic field, and a major decline in dental caries.
- 2.1.5 Demand for orthodontic treatment of children in societies comparable to ours is said to vary between 15 and 50 per cent of the child population. In Australia, the orthodontic labour force appears to be roughly in equilibrium with the demand for its services, with the capacity to provide orthodontic treatment to more than 20 per cent of children. Present demand at this level is largely satisfied by the private sector. There is considerable scope for improvement in orthodontic services offered to the financially disadvantaged in the public sector.

2.2 IMPORTANCE OF ORTHODONTICS IN PUBLIC SECTOR SERVICES

- 2.2.1 Where public dental services provide dental care for children, those services have a responsibility to recognise and diagnose orthodontic problems so that children with potential or actual malocclusions may be advised on or introduced to optimal orthodontic care.

This is a special responsibility of the School Dental Services under whose care the great majority of primary school children in most States are regularly examined.

- 2.2.2 Extreme dentofacial anomalies, for example cleft lip and palate, are severely handicapping and orthodontic treatment should be regarded as mandatory for them. The treatment of such conditions deserves public funding support to ensure that all affected patients have access to optimal treatment, which is usually multi disciplinary and often necessary from shortly after birth.

2.3 PRIORITY

- 2.3.1 The priorities for public funding of dental health care programs, including orthodontics, are outlined in ADA Policy Document 1, 'National Dental Health'.
- 2.3.2 Where resources are available in the public sector for orthodontic care, they should be applied first to the financially disadvantaged on a means tested basis.
- 2.3.3 Priority for orthodontic care in this group should be given to the most severe malocclusions and dentofacial anomalies, especially those causing functional problems or psychosocial handicap.

2.4 RESPONSIBILITIES OF PROVIDERS OF ORTHODONTIC SERVICES

- 2.4.1 Comprehensive orthodontic care implies a responsibility for retention procedures following active therapy and for long term supervision of stability of completed orthodontic patients.
- 2.4.2 Interceptive orthodontic care should be recommended where such treatment offers a real chance of avoiding or minimising more extensive treatment at a later date.
- 2.4.3 In general conformity with ADA's considered view of the rights and responsibilities that affect the duty of care in providing any type of dental service, procedures with irreversible

consequences, such as the extraction of teeth for orthodontic purposes, should only be undertaken upon the advice of a dentist who has overall responsibility for the patient's orthodontic care.

2.5 PERSONNEL

- 2.5.1 It has been shown that orthodontists provide the most cost-effective orthodontic treatment.
- 2.5.2 Paedodontists also have training in growth and development and some have expertise in orthodontics. Paedodontists along with general practitioners who have suitable experience may also provide effective services, especially for less complex malocclusions.
- 2.5.3 Appropriately trained clinical auxiliary personnel working under direct supervision can enhance the cost-effectiveness of orthodontic services.

2.6 ROLES OF PUBLIC DENTAL SERVICES WITH RESPECT TO ORTHODONTICS

2.6.1 School Dental Services

- 2.6.1.1 Children under the care of a School Dental Service should have the opportunity of being examined by a School Dental Officer, at least once during the mixed dentition period, so that advice on orthodontic care may be provided.
- 2.6.1.2 Interceptive orthodontic care might be provided where appropriate. It is desirable that such treatment be supervised by a person with sound orthodontic experience, preferably an orthodontist.
- 2.6.1.3 A School Dental Officer should consult the family's regular dentist (if any) when referring a child with malocclusion who is leaving the care of a School Dental Service, or else refer the child directly to the family dentist.

2.6.2 Dental Hospitals and Clinics

Dental Hospitals and Clinics must assume a role in providing comprehensive orthodontic care to the financially disadvantaged. This implies availability of specialist orthodontists in these institutions.

3. ALLIED DENTAL PERSONNEL IN ORTHODONTIC PRACTICE

- Adopted by Federal Council – August 1976
- Reviewed by Federal Council – 1993
- Revised by Federal Council – 1994
- Revised by Federal Council - 2005

3.1 GENERAL

The Society supports the use of highly trained preventively based allied dental personnel in orthodontic practice. The types of allied dental personnel currently recognised in orthodontic practice are Chairside Orthodontic Assistants and Dental Hygienists.

3.2 CHAIRSIDE ORTHODONTIC ASSISTANTS

Chairside Orthodontic Assistants should be recognised as being similar in duties to dental assistants, but with specific training requirements.

- 3.2.1 The duties of Chairside Orthodontic Assistants shall be:
- (i) established procedures associated with chairside assistance and practice management;
 - (ii) oral health education including dietary counselling for oral health purposes;
 - (iii) dental and orthodontic radiography and photography;
 - (iv) orthodontic pre-operative and post-operative instructions.
- 3.2 A correspondence course for Chairside Orthodontic Assistants should be established to provide training in all aspects of assisting in orthodontic practice. The Society should encourage such a course as the training of choice for Chairside Orthodontic Assistants

3.3 DENTAL HYGIENISTS

Dental Hygienists are recognised as the preventive allied oral health personnel of choice in dentistry. They are trained to provide under direct supervision dental and orthodontic care which is essentially non-invasive, or reversible.

- 3.3.1 The duties of Dental Hygienists shall include but not be limited to:
- (i) established procedures associated with chairside assistance and practice management;
 - (ii) oral health education including dietary counselling for oral health purposes;
 - (iii) dental and orthodontic radiography and photography;
 - (iv) application of rubber dam;
 - (v) pre-operative and post-operative instructions;
 - (vi) irrigation of mouth and removal of sutures;
 - (vii) topical application of solutions prescribed by a dentist or dental specialist, including etching prior to bonding;
 - (viii) removal of dental calculus;
 - (ix) debridement;
 - (x) cleaning and polishing of teeth and restorations;
 - (xi) taking of orthodontic impressions;
 - (xii) removal of periodontal packs;
 - (xiii) band-sizing and attachment selection;
 - (xiv) removal of orthodontic appliances including orthodontic cements and resins;
 - (xv) placement and removal of non metallic separators;
 - (xvi) recording of periodontal disease;
 - (xvii) routine checking for loose bands and broken appliances;
 - (xviii) application of fissure sealant;

- (xix) band-sizing and attachment selection;
- (xx) bonding of fixed orthodontic retainers;
- (xxi) administration of infiltration and inferior dental nerve block analgesic;
- (xxii) placement and removal of archwire fixation;
- (xxiii) removal of archwires.

3.3.2 With respect to the prescriptive duties list described above a Dental Hygienist's duties may not be limited to this. A Dental Hygienist's clinical conduct is acceptable provided always that any procedures undertaken and advice given is within their acquired skills and competency, and does not exceed the scope of training applicable to the curricula leading to a qualification entitling a certificate of registration.

3.3.3 Any course of training for Dental Hygienists shall include an appropriate component of training in orthodontic duties.

3.3.4 The Society encourages and supports the establishment of upgrade courses for Dental Hygienists who have not been trained in orthodontic duties. Such courses could involve an element of in-service training.

3.3.5 The Society supports the establishment of conversion courses to train School Dental Therapists to be Dental Hygienists.

3.4 SUPERVISION

3.4.1 The orthodontic allied dental personnel must be supervised by an Orthodontist who is on the premises at the time of treatment, except in the case of orthodontic treatment provided by a Dental Hygienist on the premises of long term residential care, either government or licensed under local government legislation, for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call.

3.4.2 The Society encourages a maximum supervisory ratio of 4 Dental Hygienists per Orthodontist as it is considered that a ratio greater than this is not in the public interest.

3.5 CAREER PATH

Orthodontic allied dental personnel should be facilitated to enter dental workforce training courses that are at a higher level than their current qualification. This establishes a career path within the orthodontic workforce that is based on appropriate training.

3.6 FUTURE

The Society supports the introduction of a Clinical Dental Assistant (Diploma level qualification) whose training would include orthodontic duties.

The orthodontic duties that may be expected to be carried out by a Clinical Dental Assistant are:

- (i) established procedures associated with chairside assistance and practice management;
- (ii) oral health education including dietary counselling for oral health purposes;
- (iii) dental and orthodontic radiography and photography;

- (iv) taking of orthodontic impressions;
- (v) placement and removal of non metallic separators;
- (vi) removal of archwire fixation;
- (vii) removal of archwires.

The career path to become a Clinical Dental Assistant would preferably be from a Certificate IV Dental Assistant who would train further to a level of Diploma.

From a general perspective the utilisation of Clinical Dental Assistants in orthodontic practice would decrease the demand for other allied dental personnel (eg. Dental Hygienists) and thus allow their greater involvement in other work areas where they are needed (eg. long term residential care).

4. POLICY STATEMENT ON THIRD PARTY ORTHODONTIC PROGRAMS

- Adopted by Federal Council - February 1978
- Revised by Federal Council - 1993
- Revised by Federal Council - 1997

- 4.1. Dental health programs should be formulated with the professional advice of authorised representatives of the Australian Dental Association and its affiliated bodies and be compatible with their Codes of Ethics.
- 4.2. The Australian Dental Association should seek consultation with its affiliated bodies whenever dental health programs are being formulated which affect the interests of these affiliated bodies. Orthodontic treatment should be included in dental health programs only after the priorities of basic dental care are established.
- 4.3. The major portion of the delivery of orthodontic treatment should be by recognised specialist orthodontists. The performance of complex treatment should be limited to these recognised specialists.
- 4.4. Third party programs must not interfere with the orthodontist's right to prescribe for patients under his care.
- 4.5. To preserve a fundamental professional relationship, the patient must retain the right of free choice for selection of the orthodontist and the orthodontist the right to accept or reject any patient for treatment.
- 4.6. To preserve the contract between patient and orthodontist, the patient should be responsible to the orthodontist for all fees. Third party rebates are part of the contract between the patient and the third party.
- 4.7. To maintain the mutual responsibilities of the patient and the orthodontist a reasonable part of the fee should be paid by the patient.
- 4.8. To be efficient, operation of third party programs, especially coding procedures, should be simple.
- 4.9. When rebates are based on a percentage of the fees paid by the patient a total maximum rebate limit should apply. An objective of rebate systems should be the elimination of detailed appliance coding procedures.

- 4.10. In order to encourage efficient delivery and maintain the highest standards of treatment, rebates for treatment performed by an orthodontist should be higher than the rebates for orthodontic treatment performed by a general practitioner. Rebates for complex orthodontic treatment should be payable only when this treatment is carried out by a recognised orthodontic specialist.
- 4.11. When services are provided by both a general dentist and specialist orthodontist, the Health Insurance Industry should provide a rebate to their members commensurate to at least 20% more than the rebate provided when the service is provided by a general dentist or nonorthodontic specialist. This would assist to reflect the additional educational and clinical skills and thus the standard of care, provided by specialist orthodontists.
- 4.12. Specific item numbers for specialist orthodontic services should be available to and utilised by registered specialist orthodontists.
- 4.13. Pre-existing conditions rules are inappropriate in any system of rebating for orthodontic services. Health funds should apply adequate qualifying periods of membership before granting orthodontic rebates. Otherwise the third party will effectively discriminate against those in the community with the most handicapping malocclusions and treat favourably those whose treatment priority is lower.
- 4.14. Any system of peer review must be implemented by the Australian Society of Orthodontists.

5. SOCIETY POLICY ON TREATMENT FOR CLEFT LIP & PALATE PATIENTS

The Australian Society of Orthodontists pledges its Members to support that disadvantaged group within the community with severely handicapping deformities, and particularly the children with cleft lip and palate anomalies. The Society wishes to assist this group in every way.

5.1 PRINCIPLES

- 5.1. The Society believes the specialised skills involved in overall management of cases suffering from Cleft Lip & Palate abnormalities require a multi-disciplined team approach.
- 5.2. Such a multi-disciplined team should include specialists in plastic surgery; ear nose and throat surgery; children's dentistry; orthodontics; oral surgery; prosthodontics; speech pathology; psychology and audiology.
- 5.3. The prime objective in establishing these specialised teams must be the continuing developing of the specific specialised skills required in providing treatment for these children.
- 5.4. These specialised teams should be confined to specific units situated in closely populated areas - eg capital cities.
- 5.5. Ideally, all treatment for patients with these abnormalities should be within these Units, to assist in the continuing development of specialist expertise, to facilitate the continuing overall treatment planning and for comprehensive record requirements essential to fostering allied research.
- 5.6. The cost of establishing or upgrading existing specialised Units should receive direct governmental assistance.
- 5.7. Units should employ full time or part time orthodontic specialists, or alternatively orthodontic specialists on a sessional basis.
- 5.8. The remuneration for specialist orthodontists should be equal to the hourly rate paid to visiting medical and surgical specialists.
- 5.9. The Society supports the principle of a Cleft Lip and Cleft Palate Scheme administered by Medicare to provide financial support for patients who have severely handicapping congenital or

acquired conditions such as cleft lip and cleft palate and who choose private orthodontic care. The list of such conditions or disease so covered should be determined by the Society from time to time.

- 5.10. The Society recognises that Medicare has never funded such a scheme to fully cover usual orthodontic fees and so the Medicare fee should be treated as rebates claimable by the patient.

6. POLICY ON CONTINUING EDUCATION IN ORTHODONTICS FOR THE GENERAL PRACTITIONER

- 6.1. The Society undertakes to support and assist in the establishment of courses in orthodontics for the general practitioner by medium of the University Dental Schools.
- 6.2. The objectives of such courses shall be to enhance the practitioner's understanding of orthodontic diagnosis and treatment planning, provide information on the advances in orthodontic methodology and promote understanding on the relative roles of general practitioners and specialists in providing orthodontic services.
- 6.3. The Society emphasises that such courses should not be designed to teach general practitioners complicated diagnostic or treatment procedures. They should teach the general practitioner to competently manage patients within the general practice environment and to refer patients for specialist orthodontic treatment when required.

7. EMPLOYMENT OF GENERAL PRACTITIONERS AND POST-GRADUATE ORTHODONTIC STUDENTS IN SPECIALTY ORTHODONTIC PRACTICE IN EITHER THE PUBLIC OR THE PRIVATE SECTOR

- Revised by Federal Council 1999

The ASO has a responsibility to the profession and the public to ensure that the orthodontic service delivered by its members is of the highest possible standard. The orthodontic training program and periods of clinical experience are formulated to meet this requirement and are reviewed regularly. Full-time graduate programs have been offered for many years by Australian Dental Schools. Many overseas dental schools also have similar courses of a high standard that are available to Australian Dental Graduates.

The cost effectiveness of this service is also important and the ASO believes that the most cost effective service is provided by specialist orthodontists.

7.1 POLICY

The ASO recommends that general practitioners only be employed within specialist orthodontic practices if they hold registrable orthodontic qualifications.

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