



AUSTRALIAN DENTAL  
ASSOCIATION INC.

**Proposal for a  
National Dental Foundation Year Program**

**to**

**Hon Nicola Roxon MHR  
Minister for Health and Ageing**

7 September 2009

Authorised by  
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## Preamble:

The Australian Dental Association Inc. (ADA) has advocated the introduction of a dental intern or residency year to the Commonwealth Government on a few occasions, and the Federal ADA President, Dr Neil Hewson, recently gave an undertaking to the Minister for Health and Ageing, Hon Nicola Roxon, to provide a submission.

Now that the National Health and Hospitals Reform Commission has recommended a one-year internship scheme prior to full registration, the ADA takes this opportunity to offer a detailed and practical proposal for the development and implementation of such a program.

The ADA suggests that the program be titled the National Dental Foundation Year Program (the Program) because its goal should have as its prime focus, not only the development of excellent dental clinicians using strong professional development programs, but to develop community leaders with a strong sense of social and ethical responsibility. In other words it should be a program that provides dental graduates with a sound foundation for the rest of their career.

As such, the Program should be overseen by an experienced dentist with tertiary education qualifications, who answers to a committee representing the Commonwealth, States/Territories, public agencies, universities, the ADA and the community. It is imperative that the Program not compete for resources with either dental undergraduate training programs or State and Territory Government dental services. Hence, the Program should be under the control of the Commonwealth Government and the Program's evaluation should be outcomes-based.

This proposal makes recommendations for the staged introduction of the Program, proposes the Program objectives, explains the rationale for the Program, comments on its relationship with current dental undergraduate clinical placement programs, considers factors influencing the Program budget, proposes some evaluation criteria, and highlights the risks and hurdles to be overcome. This proposal concludes with an appendix that outlines the impact of the Program on the public dental workforce, and another that describes precedent dental intern programs.

# National Dental Foundation Year Program Proposal to Minister Roxon

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## 1. Purpose

The main purpose of this document is to propose the establishment of a National Dental Foundation Year Program (the Program) that will:

- provide dental graduates with a predictable and structured transition to fully autonomous dental practice;
- develop community leaders with a strong social and ethical understanding by expanding their experiences, such as in aged care facilities, hospitals, Indigenous communities, special needs dentistry, supported residential facilities, as well as in rural and regional areas;
- foster a culture of lifelong continuing professional development; and
- Consolidate the dental undergraduate clinical and education experience.

Secondary benefits of the Program will be to:

- enhance the safety, quality and efficiency of Australian dental services;
- encourage the recruitment and retention of dental practitioners to the public sector;
- encourage dental practitioners to live and practice in rural, remote and other areas of dental care need;
- improve access to treatment for Australians eligible for public dental care; and
- increase the use of preventive and evidence-based dental care.

## 2. The Program

The Program should have as its priority the development of excellent dental clinicians and community leaders with a strong sense of social and ethical responsibility. As such, the National Dental Foundation Year Program should be overseen by an experienced dentist with higher education qualifications under the guidance of a committee of Commonwealth, State/Territory, public agency, university, ADA and community representatives. Once appointed, the committee should be given six months to develop a National Dental Foundation Year Program plan and budget for Commonwealth Government consideration.

The ADA is concerned that funding allocated to the Program may be moved sideways into other expenditures and recommends that the Program be under Commonwealth Government control and that its evaluation be outcomes rather than finance-based.

### 2.1 Program introduction

Options for introduction of the Program include:

- An initial voluntary trial in the Northern Territory, Tasmania, South Australia and Victoria (around 70 dentist graduates and overseas trained dentists who have successfully completed the Australian Dental Council (ADC) examinations)
- An initial voluntary national Program which becomes mandatory after a nominated preparatory period (around 150 dentist graduates and successful ADC candidates)

- A mandatory pre-registration year for all new dental (dentist) graduates (around 350 in 2011 and 500 in 2014) and successful ADC candidates (around 150 p.a. in 2011)

The ADA recommends the first option for the introduction of the Program be an initial voluntary trial. This option will allow the staged increase and improvement of the necessary dental facilities. More importantly, it will allow the staged employment of experienced dentists and dental education staff to plan and implement the Program. Staging will also recognise that it would be unfair to existing dental students to unilaterally and compulsorily increase by one year their requirements for full dentist registration. All future applicants for Australian dentistry courses should be advised that they may have to undertake the Program before they will be able to register as a dentist in Australia.

The Northern Territory, Tasmania, South Australia and Victoria have been chosen for locations for the initial voluntary trial because these areas have the clinical facilities needed to trial the Program. On the other hand, there has been feedback received from other jurisdictions that the dental resources (infrastructure and mentors) in these jurisdictions are so inadequate that at this stage the Program could not be introduced in these areas. The Northern Territory and Tasmania were particularly selected to test if the Program will work without a local dental school. ADA representatives have been in contact with people from each of the four selected locations and received universal enthusiasm for hosting the trial.

Overseas experience shows that a well structured program will be attractive to new graduates and so recruitment for the voluntary stage should not be a problem.

Another incentive could be that universities should be encouraged to only accept dentists who have completed the National Dental Foundation Year Program into dental specialist training programs.

## **2.2 Short term objectives**

The objectives of the trial will be:

- To establish a pilot program in Victoria, South Australia, the Northern Territory and Tasmania to test the model and identify key success factors for effective implementation of a national model.
- To create a strong professional development program, aimed at developing dentists with high quality clinical skills and as community leaders with a strong sense of social and ethical responsibility.
- To bring Commonwealth, State/ Territory, public agency, university, dentists and community representatives together to plan and evaluate the trial.

Using lessons learnt during the trial, the volunteer Program should then be expanded into other areas of Australia.

If successful and resources (infrastructure and mentors) allow, after five years, the National Dental Foundation Year Program should become a compulsory requirement prior to national dentist registration for all:

- new Australian dental graduates,
- successful ADC candidates, and
- overseas-trained dentists not required to sit the ADC examinations (New Zealand, Ireland, and UK: approximately 57 per year) who graduated less than five years previously.

Once the compulsory stage is fully operational then the Program should be expanded to include dental hygienists and dental therapists. Again there should initially be a voluntary stage followed by a compulsory stage. The Program will need to be adjusted for the different training requirements of the allied dental personnel. The dentist, dental hygienist and dental therapist Programs should all encourage the development of a dental team culture with the dentist as the team leader.

### **2.3 Long term objectives**

The Program:

- Will offer broad general practice experience in a range of practice settings to enable Program participants to hone their skills before becoming fully registered.
- Improve access to clinical services for Australians eligible for public dental care and people with special needs.
- Promote a culture of continuing professional development.
- Promote confidence in Program participants to work in a range of clinical environments and in isolation.
- Expose graduates to different cultural and clinical settings, especially those outside major urban areas.
- Improve recruitment to, and retention in, the public sector as well as in rural and remote areas.
- Overcome practitioner isolation among overseas-trained dentists.

### **2.4 Requirements of the Program participants**

The professional development component of the Program could include aspects of the UK vocational training year (see Appendix 2), such as participants would:

- Complete 12 months working in approved training facilities.
- Attend 30 continuing professional development study days.
- Submit a professional development portfolio of evidence of achievement.
- Submit two Key Skills modules.
- Give a clinical case presentation / case-based discussion to experienced mentor dentists.
- Undergo a clinical audit by experienced mentor dentists.
- Demonstrate the required spectrum of competencies.

At the beginning of each year of the Program, each participant should be allocated patients for whose dental care they will be responsible, rather than being expected to undertake a certain number, or types, of dental clinical procedures. The Program should train dentists to care for patients in an ethical and professional manner, as opposed to becoming technicians producing “production-line” clinical output.

When dental hygienists and dental therapists are incorporated into the Program, dental teams should be formed and each dental team should be allocated patients.

## 2.5 Eligible Patients

### 2.5.1 Public Patients

Although the Program’s priority goal should be the development of excellent dental clinicians and community leaders, there will be a complementary improvement in access to dental care for Health Care Cardholders. There are about six million Healthcare Card holders and their dependents in Australia who comprise the primary target group of patients.

A recent Australian Institute of Health and Welfare report notes that

*Government-funded dental care is not accessible to many people in the community due to limited resources. There are a large number of people waiting for general dental care at public dental services. While waiting times for emergency dental care are short, waiting times for general dental care can be lengthy (for example, estimated to be between 10 and 54 months in 2000). The time that people spend waiting for general dental care indicates that there is inadequate provision of services to meet the expectations of even the minority of people who seek care from public dental services (AHMAC 2001).” (p.1)*

(Brennan DS 2009. Oral health of health cardholders attending for dental care in the private and public sectors. Dental statistics and research series no. 50. Cat. no. DEN 196. Canberra: AIHW.)

The current public dental system provides dental care to a small subset of the Australians who are eligible for publicly-funded care. It takes many years for those patients to be seen for a follow-up dental check-up or treatment. Most people obtaining care have been waiting too long, and many are in pain and require emergency attention. This explains the high level of extracted teeth amongst Australians eligible for public dental care. (AIHW Dental Statistics and Research Unit Report No.27 on Emergency care among public dental patients in Australia, March 2006 (p.4))

The Program will increase the regularity of dental visits for **all** Australians eligible for public dental care, reducing the ratio of emergency to general care visits and the proportion of teeth extracted, thereby improving the quality of life of Australians eligible for public dental care. In the process, it will improve the career satisfaction and retention rates of dental clinicians working within the public sector.

## 2.5.2 Special Needs Patients

The ADA agrees with Spencer and Harford when they argue that:

*"..... individuals with special care needs should be the target of public dental services ..... The interaction between the university education of dental providers and the public dental services represents the most fertile ground in which to positively increase the capacity and reshape the public dental services."*

Spencer, J. and Harford, J. Improving Oral Health and Dental Care for Australians, prepared for the NHHRC. Australian Research Centre for Population Oral Health (ARCPOH), University of Adelaide, December 2008, pp. 5-6.

The ADA also supports Spencer and Harford's comment that:

*.... what is required is a re-orientation of public dental services to become centres of specialised service provision to subgroups for which traditional fee-for-service dentistry does not provide an appropriate model of care."*  
*Spencer and Harford, 2009*

The Program will give Program participants experience providing dental care for Australians with special needs under the supervision of special needs specialists. This will encourage their future participation in caring for special needs patients, and hopefully in some cases, encourage them to undertake specialist training in special needs dentistry.

## 2.6 Locations for Dental Care in the National Dental Foundation Year Program

The limited number of dental facilities is the most significant constraint on the utilisation of the Program workforce. A detailed capital planning exercise will be required before deciding on the number of places to be offered (See section 10 on Barriers and Risks). Targeting of rural and metropolitan agencies with longer waiting times will help to address demand problems and will allow limits to be placed on the required budget.

Distributed networks of multi-chair clinics will be required across the nation. Some already exist, for example, in Victoria, regional training clinics have been established in Bendigo, Mildura, Wodonga, Shepparton and Melton. In other areas, new expanded facilities will need to be established, for example, in Geelong, Ballarat and Warrnambool where larger populations need to be served. Whilst in other areas facilities should be expanded, for example in Tasmania, facilities would need to be expanded in Hobart, Launceston, Devonport and Burnie. In South Australia, the facilities should be expanded to Whyalla, Riverland, Mount Gambier and Port Pirie.

## 2.7 Rotations

Rotational clinical placement options will need to include rural and remote parts of Australia, Indigenous communities, hospitals, public dental clinics, facilities for people with special needs, aged care facilities, schools, and private-sector dental clinics in areas of dental care need.

Due to the great need for dental care by both Australians eligible for public dental care and rurally located Australians, the priority order for rotation to clinical facilities, by sector and location, should be:

1. public sector, rural location
2. public sector, metropolitan location
3. private sector, rural location
4. private sector, metropolitan location

Secondary rotations, divided into higher priority core and lower priority non-core rotations, should include:

1. Core rotations
  - General dental practice rotation
  - Hospital clinic rotation
2. Non-core rotations
  - Emergency rotation
  - Special needs rotation

## **2.8 Impact on public sector productivity**

The priority of the Program should be on producing high quality dental clinicians with a strong ethical and social awareness. Thus, allowance will need to be made in clinical output targets for both the Program participants and their mentors. The Program participants will be inexperienced and their mentors will require time to oversee and mentor the graduates. Lower clinical productivity should particularly be expected in the early part of each calendar year.

As the proposal seeks to increase the public sector dentist workforce by over 50%, and as more Australians receive treatment, there will also be a need to increase the employment of dental assisting, reception and administration staff.

## **2.9 Exemptions for Defence Force Personnel**

The ADA recommends that dental graduates opting to work in the Australian defence services be exempt from the clinical components of the Program because they will receive mentoring and provide a public service by virtue of their enlistment. However, they should be included in the Program's continuing professional development activities and be guided by Defence Force dental officer mentors.

## **2.10 Impact on rural scholarships**

The existing main measure to address the shortage of allied and oral health professionals in rural areas is the Rural Allied Health Undergraduate Scholarship Scheme. The goal of the Scheme is to increase the number of students from rural and remote areas of Australia, who enter and complete allied health or oral health undergraduate or graduate entry tertiary studies.

*Scholarship holders receive \$10,000 each year during their entry level allied health or oral health professional studies. These funds assist scholars to cover the costs of moving from their homes and support structure in the country and settling to university study and living in the city.*

*The scholarships are not bonded. Rather, the ties to rural and remote areas of Australia are reinforced through a rural mentorship scheme as well as through membership of their university's student rural health club or nearest affiliated rural health club.*

<http://www.sarrah.org.au/site/index.cfm?display=74992>

The ADA recommends that the Rural Allied Health Undergraduate Scholarship Scheme should continue.

### 3. Rationale for the Program

#### 3.1 Benefits for Program participants

Exposure to a wide cross section of dental treatment, with the support of an experienced mentor, will ensure the Program participants become confident in their skills and ensure that their patients receive safer and better quality care. It will also enable them to be better equipped for rural practice, and to be better community citizens. For these reasons, the clinical care supplied by the Program participants should not be restricted to basic dental care. As the incomes of both participants and clinical mentors will be covered by the Program, more complex forms of dental care will become possible if eligible patients paid the dental laboratory and/or material costs of the more costly forms of dental care.

The ADA supports the following statements by Spencer and Harford:

*A national dental residency program has academic, clinical and public health merit. A period of transition between undergraduate study and autonomous practice would provide a supported transition for graduates, with an emphasis on continued professional development and consolidation of clinical expertise; and The opportunity to gain a further year of supported clinical experience post graduation would be welcomed by most graduates, and provided time was allocated to develop their proficiency and speed, new graduates would better develop their basic skills.*

The ADA also agrees with the following arguments provided by Spencer and Harford:

- A period of transition between undergraduate study and full autonomous practice reduce time pressures on the undergraduate curriculum, allowing a better paced, more predictable and possibly more varied undergraduate experience.
- It would provide a supported transition for graduates, with an emphasis on continued professional development and consolidation of clinical expertise.
- A national dental foundation year program would provide an opportunity for dental graduates to hone their skills in a learning-for-service model, engage in community service, including settings-based oral health promotion activities, and to continue their professional development in a managed way, including some teaching and research opportunities.
- Experience across the Program could be tailored to greatly extend recent graduates' competency in, special needs dentistry (including geriatric dentistry), rural services, treatment of children (especially in hospital settings), dentistry for the intellectually and physically disabled as well as routine general dental care for special subgroups of Australians.
- Such experience needs to be well supported with a mix of professional development and extension of skills into advanced areas as well as mentoring of more routine dental practice.
- A tailored continuing professional development program should assist Program participants to development, facilitate professional interaction with their peers and instil a culture of lifelong learning.

Hence, if the Program is established, the ADA undertakes to help establish social networks for the Program participants. The priority areas for the social networks will be in rural locations. These social networks will be of assistance to the new graduates in their transition into fully autonomous dental practice.

### 3.2 Benefits for the public

- The National Oral Health Plan ([http://www.adelaide.edu.au/oral-health-promotion/resources/public/pdf\\_files/oralhealthplan.pdf](http://www.adelaide.edu.au/oral-health-promotion/resources/public/pdf_files/oralhealthplan.pdf)) affirmed that "Services, including prevention and health promotion, should be accessible to all who need them, across cultures, language groups, communities of place and interest, abilities and socio-economic groups, with recognition and respect for individual needs and views"(p13).
- Improved access to care will result from the rotational assignment of Program participants to public clinics, many of which are understaffed and have difficulty recruiting and retaining staff. In some case this will require special mentoring arrangements due to the lack of senior local dentists willing and able to provide this role.
- Safer and better quality care will result from wider exposure to a full range of treatment problems and patient needs. The public will have access to higher quality care due to the enhanced skills that are engendered by a supportive and mentored approach.
- The entire community will benefit from the Program participants developing an increased awareness of and commitment to public health issues. This will generate a legacy that will last their entire working lives, even where they move into the private sector upon completion.
- Ensuring that professional development in oral health promotion and routine patient disease risk assessment are part of the Program, would engender the adoption of more effective preventive measures, which will ultimately save resources that would be required for treatment of decay and other preventable problems.
- Complex and the more costly forms of dental care will become available to eligible patients for the cost of dental laboratory services and/or materials. No longer will Health care Card holders be made to feel like second class citizens when they access public dental care.

### 3.3 Benefits for future employment

Spencer and Harford note

*"At present recent graduates face an uncertain lottery of whom with and how they try to make this transition. Placing recent graduates in a residency program would build the dental labour force in the public dental services by over 50%, greatly increasing its capacity to provide public dental care to those eligible and targeted for such services. A residency program would provide an opportunity for dental graduates to hone their skills in a learning-for-service model, engage in community service, including settings-based oral health promotion activities, and to continue their professional development in a managed way, including some teaching and research opportunities. This would have positive implications for the graduates, the environment and culture of public dental services and the community."*

(Spencer, J. and Harford, J. Improving Oral Health and Dental Care for Australians, prepared for the NHHRC. ARCPOH, University of Adelaide, December 2008, pp. 5-6.)

- If the Program goes ahead the ADA will undertake to assist to create and publish a new graduate manual as a key resource to assist Program participants in their introduction to the profession. This should be accompanied by seminar programs involving the ADA, public agencies and regulatory bodies to equip Program

participants to deal with a wide range of professional, ethical and regulatory compliance issues. This professional developmental component will provide long term benefits for the Program participants as they enter employment relationships after the completion of the Program.

- The ADA proposes that, in addition to a new graduate manual, the Program should include courses on professional ethics within both the dental surgery and the community. Further, for overseas-trained dentists, a course should be included on Australian culture, expectations and history.
- If the Program goes ahead the ADA will also undertake to help establish social networks for the Program participants, particularly in rural areas. These networks will assist participants to move into dental practice after completion of the Program.

### **3.4 Benefits to Commonwealth Government**

- Improving the safety and quality of healthcare.
- Clearly defined annual budget item enabling the Commonwealth to assist State and Territory Governments to deliver dental care to eligible patients.
- Simple and easy to administer.
- Provides incentives to State and Territory Governments and agencies to expand and improve treatment infrastructure.
- Cost sharing with State and Territory Governments, but with control by the Commonwealth Government.
- Overcoming “The Blame Game” between State, Territory and Commonwealth Governments.

### **3.5 Benefits to State and Territory Governments**

- Cost-sharing with the Commonwealth Government.
- A subsidised dental workforce.
- Attracting and retaining public sector dental workforce.
- Addressing areas of high need and improving access to care for target populations.

All Australian State and Territory jurisdictions have similar workforce maldistribution problems and long public dental waiting times.

### **3.6 Benefits to Community Health Clinics**

- New graduate wage costs paid by the Commonwealth
- Capital improvements

### **3.7 NHHRC support for a dental education and residency scheme**

As well as various submissions from the ADA, a recommendation for the introduction of a national residency year has been presented by the National Health and Hospitals Reform Commission (NHHRC).

The Interim Report of the NHHRC made comments on the desirability of establishing a one-year dental education and residency scheme, as follows:

*"11.4 We support the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. This program would provide a solid grounding for new graduates prior to their registration in the care of complex public dental patients. In addition to routine dental care, the residency program could include the development of competencies in geriatric dentistry, special needs dentistry and dentistry for the intellectually disabled."*

*NHHRC Interim Report p269*

A similar recommendation is given in the Final report of the NHHRC (Recommendation 84). The ADA gives its support to the principle of this recommendation, though it asserts that the model should not just be based on the medical practitioner one. Rather, as dentistry is different to medicine, it should be specifically designed to suit dental practitioners.

The ADA hastens to emphasise that the other major dentally-related recommendation in the NHHRC Report, Denticare Australia, is rejected as ill-judged and unsupportable. As Denticare Australia will only provide basic dental care, it will, in direct contrast to the purpose of the National Dental Foundation Year Program, de-skill new dental graduates. The ADA advises that the clinical care delivered by the Program participants not be restricted to basic dental care. Rather, eligible patients should pay the dental laboratory and material costs of the more costly forms of dental care. Further, the dental workforce and finance that will be required to have a successful Foundation Program targeted at Australians with the greatest dental care need will make the Denticare proposal unviable (A separate submission on Denticare has been made elsewhere).

### **3.8 Other support for a National Dental Foundation Year Program**

The Public Health Association of Australia (PHAA) offered qualified support for dental education and residency scheme when responding to the NHHRC Interim Report. Their submission to the NHHRC (March 2009) noted:

- *"The scheme will need to be well funded, with a mentored clinical component, professional development, and options for research and oral health promotion.*
- *The scheme would need to be phased in as public infrastructure (capital and experienced workforce to mentor graduates) is developed."* (p.5)

Dental Health Services Victoria (DHSV) also offered support for the concept in their response to the NHHRC Interim Report:

*"DHSV supports the introduction of an intern year for registered oral health workers (therapists, hygienists and dentists), with the majority of internships to be completed within the public oral health system. DHSV is well prepared to coordinate this intern year in Victoria. However, the public sector does not want to become the sole employer of young and inexperienced dental graduates (OHT and BSc). There is a growing need for support to recruit experienced oral care providers and to provide mentoring opportunities."* (p.2)

Both the PHAA and DHSV submissions indicated the need for the Program to be introduced progressively as public dental resources increased.

## **4. Relationship to Undergraduate Clinical Placements**

### **4.1 Needs of undergraduate training**

As a result of growth in the number of undergraduate students being trained, aggregate demand for student clinical placements across both dental and oral health courses will grow. This demand involves students doing dentistry, dental therapy and dental hygiene courses in clinical placements for approximately half of their time in the final years of the course.

This means that there is already very significant pressure on the public dental system to meet demand for undergraduate clinical placements, before the Program increases demand for clinical placements from around 150 Program participants. Therefore significant infrastructure will be required to ensure both adequate clinical facilities for undergraduate training and to host the Program.

Once the dental facilities are in place and more Australians are able to access dental care, more people with conditions suitable for undergraduates to manage will become available, allowing undergraduates to manage people with dental conditions within their ability. People with more complex dental conditions will be seen within the Program by participants under the guidance of mentors. In increasing order of treatment complexity, people will then be managed by experienced general dentists, by dental specialist trainees under the guidance of dental specialist mentors, by dental specialists, and finally, within University clinical research centres.

### **4.2 Lessons from reviews of undergraduate clinical placements**

Just as clinical placements programs for undergraduates require a best practice model to ensure positive outcomes for the students and the agencies in which they are placed, the National Dental Foundation Year Program will need similar best practice arrangements if it is to be effective and sustainable.

This will require:

- Sufficient dental facilities, Program participants and mentors for a sustainable placement program;
- A grouping of four Program participant chairs in a clinic with 8 – 10 chairs provides the minimum critical mass to justify a mentor position without the need to carry a clinical load. A minimum of four chairs also makes it more feasible to have part-time university staff on site to provide support.
- Ensuring that the Program participants are available to Community Health Services for a specified component of the calendar year. Otherwise the dental facilities will not be fully utilized forcing community dental clinics to either close down dental facilities or attempt to engage short-term contracted dental clinicians.
- As over 85% of the dental workforce work in the private sector, experienced private-sector dental clinicians will need to be encouraged to take a mentor role in the Program, and in some areas, as the Program develops private dental clinics will need to be included in the Program.

## 5. Budgetary considerations

### 5.1 . Costings for the National Dental Foundation Year Program

Spencer and Harford said:

*Infrastructure could be developed under a matching contribution from states and territories. In order to build the capacity of the hubs (i.e. dental teaching hospitals) a new hub would be required each year for five years. The spokes, or academic oral health service centres, barely exist at present. Some 10 such centres would need to be established each year for five years to build the capacity toward the 700 graduate residents. These developments would require some \$150 million p.a. The full operating cost of the residency program would be \$152 million p.a. Just less than half this cost is for residents' salaries and the remainder for appropriate support for the residency program and their service provision."*

Spencer, J. and Harford, J. Improving Oral Health and Dental Care for Australians, prepared for the NHHRC. ARCPOH, University of Adelaide, December 2008, p. 19.

The Government should expect a cost in the region of \$200,000 per dental chair and associated building costs.

The budget to fund participant salaries of around \$60k p.a. for over 500 participants plus support staff across the nation will require new funds. A specified number of Program participants including international dental graduates and successful ADC candidates will need to be accommodated with long term projections based on close monitoring of enrolments.

To make the Program attractive to potential participants, tax relief and Higher Education Contribution (HECS) forgiveness will need to be costed in the Program budget.

### 5.2 National Dental Foundation Year Program salary / package

- \$60k p.a. plus superannuation: This compares with an average of \$70k new dentist graduate salary (Graduate Careers Council survey, 2008)
- \$15k bonus if Program participant stays in the Program for the full year (during the voluntary stage of the Program)
- Retention reward to be given if the Program participant is employed by State public dental service for a year after completion of the Program - paid by State.

### 5.3 Support staff for the Program participants - at agency expense

Budgetary adjustments will need to be made to provide for employment of reception, dental assistants and other support staff. For each Program participant, a full time dental assistant will need to be employed.

### 5.4 Salary overheads

Apart from the remuneration package offered to the resident, on-costs of approximately 30% will be required to cover superannuation, Workcover, professional indemnity, payroll tax, and human resource administration costs.

## **5.5 Administration**

Program administration costs will also need to be covered. In each jurisdiction, there will need to be staff and facilities assigned to coordinate Program implementation. Refer 8.6 below.

## **5.6 Continuing Professional Development (CPD)**

- Travel and accommodation allowances for rural postings
- 30 days minimum. - 180 hours +
- Academic staff and facilities say \$2k / intern i.e. \$100k
- ADA Branches and/ or dental schools

## **5.7 Mentor training and time release**

- Half day per week allowance
- Debriefing time with Program participants
- Higher Duty Allowance for mentors for extra responsibility say \$10k
- Reimbursement to CHC when mentor is not working half a day per week \$10k
- For the pilot Program, the normal ratio recommended is 1 mentor to 5 Program participants, therefore if 70 Program participants, at least 20 mentors are required. This will be affected by the number of clinics in which space permits this many residents to be assigned. Recognising that some clinics may only be able to accommodate smaller numbers, a provision for an extra 10 mentors should be made.
- For the full Program accommodating 500 new graduates, at least 100-120 mentors will be required.

## **5.8 Rural allowance**

- In the event a voluntary Program is utilised, a tiered rural allowance is proposed according to remoteness e.g. \$5k, \$10k, \$20k

## **5.9 Dental Advisory Group - honorary members**

- Travel
- Accommodation
- Administration support

## **6. Staged Implementation**

### **6.1 Phase 1**

#### **6.1.1 Pilot trial in Victoria, South Australia, Tasmania & Northern Tasmania**

- 12 months duration
- Rotation through specialist areas e.g. hospital dental units, nursing homes / domiciliary care, Indigenous communities.
- Competitive entry (voluntary) - by application
- The introduction of a mandatory Program should be considered depending on the outcomes of the voluntary stage of the Program
- 70 graduates p.a. across four States initially Victoria (30) South Australia (25) Northern Territory (5) and Tasmania (10)
- A formal agreement would need to be drawn up between the entity running the Program and agencies / clinics
- Option out provisions should be available for the Program participants but if they do not complete the year, they should forfeit any bonuses.

### **6.2 Phase 2**

- Other States included as public sector capacity allows

### **6.3 Phase 3**

- Include other operatives e.g. dental hygienists and dental therapists

### **6.4 Phase 4**

- Mandatory national Program

## **7. Stakeholder contributions**

### **7.1 State and Territory Government Departments**

- Fund infrastructure to accommodate expansion of the Program over time
- Act as employer
- Administer placements

### **7.2 Registration Boards**

For the compulsory Program

- Registered as dentists specifying that can only work in the Program.

For the voluntary Program

- If Program participants are to sacrifice income and to provide public service while serving in the Program, they should not be obliged to pay registration fees but should be treated in the same way as student registrants.

### **7.3 Public Clinics**

- Provide access to treatment facilities
- Provide mentor release and facilities
- Ensure mentor avail in clinic 80% of time
- Day to day administration and direction for Program participants
- Release Program participants for CPD days
- Where outside metro area, arrange accommodation and travel subsidies for CPD
- Provide and remunerate mentors
- Support mentors and Program participants
- Liaise with State and Territory Dental Agencies re placement rosters and identification of issues requiring attention.

### **7.4 Australian Dental Association (ADA) support**

Initially:

- The Federal ADA (ADA Inc)
- The Victorian Branch of the ADA (ADAVB)
- The South Australian Branch of the ADA (ADASA)
- The Tasmanian Branch of the ADA (ADATas)
- The Northern territory Branch of the ADA (ADANT)

Later:

- All ADA organisations

### **7.5 Universities**

Various approaches to clinical training are evident in current university courses across the nation. The ADC accreditation guidelines might usefully be reviewed in the light of the National Dental Foundation Year Program.

## 7.6 State and Territory dental agencies

Administrative support for the Program will desirably be provided by State and Territory dental agencies. This will include:

- Placement coordination
- Budget control
- Professional development program planning and coordination
- Problem resolution
- Guidance to participants and participant 'hosts'
- Evaluation (see 9 below)

## 7.7 Advisory group membership

- ADA nominees
- State agencies nominees
- University nominees
- DOHA nominee
- Community nominees

## 8. Evaluation

The ADA is concerned that funding allocated to the Program may be moved sideways into other expenditures and recommends that the Program be under Commonwealth Government control and that its assessment be by outcomes rather than finance-based. A way of collecting the data required for the Program evaluation should be collected by upgrading the current software that is currently used in most State public dental services called "Titanium."

Some suggested evaluation outcomes are given below:

### 8.1 Against objectives

Need to identify at the outset the data required to make judgements about the effectiveness of the Program in meeting the objectives.

### 8.2 Actual outcomes for Program participants

- As the key purpose of the Program is to provide a professional development experience for Program participants, their views will be important
- Assessments of the Program participant performance will need to be part of the mentor duties
- Exit surveys
- Professional development outcomes
- Skill development

### **8.3 Stakeholder feedback**

- All key participants must have clear and simple mechanisms available to them for feedback on how the Program is progressing. This will be necessary to address operational problems as they arise, but also to underpin the overall evaluation of the effectiveness of the Program in achieving the long term objectives.

### **8.4 Administrative elements**

- Evaluation of the efficiency and effectiveness of the administrative measures and the extent to which they helped or hindered in achievement of Program objectives will need to be undertaken independently of the Program administration.
- Engagement of an independent agency to perform this role will require a suitable budget.

### **8.5 Incentive components**

- Whatever incentives are offered to encourage voluntary participation, their effectiveness should be evaluated with a view to targeting only effective measures when the Program is extended nationally.

### **8.6 Community benefits**

- Given that the primary rationale in support of the Program is for community benefit, stakeholders in the community should be invited to participate in evaluative feedback mechanisms.
- Budget provisions need to be made for this also.

### **8.7 Costs – alignment with estimates**

- Programs such as this are complex and so require careful budgeting
- Once the Program is in place successive budget predictability should be reliable.
- Evaluation will need to closely assess the alignment of estimates with actual expenses for all key dimensions.

### **8.8 Differential measures rural Vs metro**

- Additional support measures will be required for rural placements including accommodation and travel assistance.

## **9. Barriers and Risks**

### **9.1 Constitutional and legal issues**

Some have suggested that the mandatory stage of the Program could not be contemplated because Section 51 of the Constitution prohibits conscription of the medical and dental workforce.

Section 51 of the Constitution states that:

*“The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:*

*(xxiiiA) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances."* (emphasis added)

Given that similar intern and residency schemes have been used from many years in medicine and psychology, we assume that this argument is specious. If the Program is conducted in liaison with the universities and occurs before full registration, i.e. with special or specific registration status involving support and supervision for residents, then there should be no Constitutional issue.

The current State and Territory legislation and the proposed Bill B for the National Registration and Accreditation Scheme would appear not to present any legal impediment for the Program being established for dental graduates.

## **9.2 The Program being perceived as a cheap source dental labour for the public sector**

Barriers to effective use of clinical placements in undergraduate training have been identified in recent reviews, and some of the lessons suggested for improved clinical placement outcomes will need to be applied to the Program also. After all, the Program concept is really only another form of clinical placement albeit with new graduates, if it is to precede full registration.

Currently there is little emphasis on identifying learning outcomes to be achieved from clinical placements and no assessment or feedback is provided to undergraduates with any bearing on their academic results. To avoid the criticism that the Program is merely a workforce initiative and a 'workaround' by which to avoid conflict with Section 51 of the Constitution (which prohibits the civil conscription of dentists), the Program will need to have genuine professional development merit and substance.

## **9.3 Program participants become emergency practitioners**

ADA support for this measure is qualified by recognition that the Program will only be beneficial for Program participants if attention is paid to their needs as young professionals. If they are asked to treat patients with complex conditions without adequate support and mentoring, then the experience will be entirely negative and may serve to discourage them from seeing it as a basis for continued public service beyond the year. Spencer and Hanford do make the point that such a program needs to be well supported and managed. This requires the enthusiastic commitment of the public dental system at all levels rather than half-hearted or reluctant participation under pressure from above.

As Spencer and Harford rightly point out:

*If well supported and managed, greater numbers will choose to extend their transition by joining the public dental services. A resident needs a competitive salary package with support for travel and accommodation on rotations. Consideration might be given to HECS relief as recognition for 'community service'. Their activities need mentoring and an adequate level of administrative support. Clinical activities also need a good level of dental assistant and reception support, and a more open approach to supplies and the scope of services provided. Finally, continuing professional development should be formally structured and should be rewarding. While such support will be at a cost, the expansion of the public dental services is likely to be achieved in a cost-efficient manner in comparison to all other approaches.*

#### 9.4 Burning out Community Health Centre staff

Mentor fatigue  
Constant turnover of new grads

#### 9.5 Insufficient clinical facilities (capital budgets)

Participation in one year of public service would encourage Program participants to consider longer term employment in the public sector. The Program therefore offers a possible solution to public sector difficulty in recruiting and retaining graduates. Additional chairs should be built into public facilities where demand is highest.

Spencer and Harford's argument for increasing the public dental infrastructure to jointly serve the needs of an expanding professional development program and a higher level of service to public patients is well made. Infrastructure issues are a major impediment to delivering improved access to dental care, which is now almost universally accepted as necessary. Investment in infrastructure for a National Dental Foundation Year Program will be an enduring investment in facilities for treatment of Australians eligible for public dental care and so should be considered not a cost of the Program.

Spencer and Harford have proposed:

*New arrangements between education and public dental services might involve some form of hub and spokes model. Such models involve the identification of key academic oral health service sites or dental teaching hospitals which form a hub in the system and linkages from these to dispersed smaller oral health service centres in urban and rural areas. These arrangements should encourage the building of oral health service centres with a strong integration of education into public dental service delivery. This is analogous to the University rural health schools which have been developed in medical education.*

*Integration of education with the public dental services will greatly assist with the provision of clinical teaching services. A hub and spokes model can be used to provide effective undergraduate experience in under-serviced locations through rotations or electives. Such undergraduate teaching clinics need direct support so that public dental services do not face an opportunity cost for their involvement. However, there is a reciprocity that also needs emphasis. The clinical teaching provides a valuable dental service back to the community.*

To ascertain whether there will be sufficient clinical placement facilities in public agencies to permit a Foundation Year for all new graduates, a comprehensive audit is required of the number of placements required in each jurisdiction and the number of places / chairs available. This audit will need to address physical accommodation matters such as the number and location of chairs, but also whether there will be enough dentists and support staff in the public sector to provide the mentoring, supervision, treatment support and administrative backup required.

Spencer and Harford note that:

*Australia is rapidly expanding its number of university dental schools, but there are substantial issues in appropriately supporting existing dental schools which have expanded graduate numbers and the new schools which will struggle to develop infrastructure. A key element is how dental education integrates with the state/territory public dental services. This might be aided by a hub and spokes model for clinical teaching facilities and a new national dental residency program.*

*The greatest barrier to such a program is the needed infrastructure. A program of matching capital expenditure between the Commonwealth and the states and*

*territories is needed to expand the multi-chair clinics, co-located with other health services, where residents can practise. As this infrastructure will take time to build, a phased voluntary residency might be required across initial years with a set target year for full implementation of a residency program. "*

The single biggest impediment to the effective implementation of the Program will be the availability of sufficient accommodation in public dental agencies. Clinical placements for undergraduate students are already under extreme pressure and with yet another cohort of young dentists to be accommodated, there may be significant difficulty in accommodating them. Innovative approaches to the use of facilities, including split shift measures and weekend rosters may be required to achieve the desired targets. There will be industrial implications and costs in any such arrangement and these will need to be accounted for in the implementation budget.

Implementation of a foundation year must not lead to competition with under graduate clinical placements

#### **9.6 Lack of new graduate interest**

If the Program only operates in some jurisdictions, then the more attractive income offered in non-Program jurisdictions would become a drain on the Program workforce.

#### **9.7 Universities may perceive this as a criticism of their courses**

The dental schools already conduct clinical placement and training programs which have been considered satisfactory preparation for hundreds of graduates in recent times.

There may be some resistance from the schools if they perceive that the additional clinical training being provided via the Program is to compensate for shortcomings in the present arrangements. However our consultation with the Adelaide and Melbourne dental schools indicates this will not be a problem.



Dr N D Hewson  
President  
Australian Dental Association Inc.

7 September 2009

## Appendix 1 - Impact on public dental workforce

While the Program is primarily an professional developmental one offering support to new graduates, there will clearly be significant impact on the public dental workforce and this should be understood both in terms of its supplementation of the permanent workforce with short term resident personnel, but also on increased support staffing levels and reduced productivity for mentors and mentees.

Advice from public dental agencies to the ADA Inc suggests that the current public sector dentist workforce (as at 2007/08) is 1025.17 full-time equivalents (FTE), distributed as follows:

| State | Number   |
|-------|--|
| ACT   | 8.67 FTE Dentists  |
| NSW   | 238.9 FTE as at 30 June 2007   |
| NT    | NT has 17 FTE positions, currently there are 11.5 FTE positions occupied |
| QLD   | est. between 280 & 300 FTE's   |
| SA    | 93.4 FTE (+3)  |
| TAS   | 20 FTE   |
| VIC   | 250.2 FTE Dentists & Specialists   |
| WA    | 102.5 FTE  |

The ADA realises that currently there are not enough dental facilities to accommodate all current dental students to partake in the Program. However, to give an indication of potential figures, if all new graduates from Australian dental schools in 2011 were to undertake the National Dental Foundation Year Program, an additional 350 graduates would be available to participate. By 2014, that number will rise to around 500 p.a.


*Total capacity to supply dental services will increase by some 7 million visits per year by the early 2020s and will allow for population growth, a transition away from edentulism and some real increase in per capita visiting.  
Spencer and Harford, 2009*

The Public Sector Dental Workforce Scheme, in which 99 overseas-trained dentists are currently participating, should continue. Once the dentists under the Public Sector Dental Workforce Scheme have successfully completed the Australian Dental Council Examinations, and all contractual arrangements have been fulfilled with their respective State dental services, they should be transferred to the National Dental Foundation Year Program.

Rounding the numbers the dentists and residents participating in public dentistry would rise to 1375 in 2011 and to over 1,500 by 2014 – an increase of almost 50%.

International dental graduates would also be included and thereby gain valuable local experience. This would assist them in gaining employment in either the public or private sector at the end of their Program year. Given their need to develop improved understanding of Australian language and customs especially as regards the clinical and professional relationships desired between practitioners and their patients, a year of directed and supported clinical experience would be enormously valuable to them.

Engaging all new graduates to work in public dental settings for one year would increase the public sector workforce by almost 50%. This suggests that considerable allowance will need to be made in the productivity targets set for these current personnel as they will need to spend many hours supervising and supporting the residents who come into the Program each year. This will be a particularly intensive commitment in the early



months as the new practitioners become acquainted with provision of treatment on a professional level. The 50% increase in personnel may therefore only equate to about a 35%-40% increase in productivity, and this needs to be accepted and supported by State and Federal Treasuries as well as health departments and dental agencies.

It is not acceptable to propose a Foundation Program as a professional developmental and 'safety and quality' measure, and then to only resource it on the basis that the additional personnel were only wanted for their treatment output. To do so would give credence to the charge that the Program was merely a form of civil conscription – thus contravening the Constitution.

## Appendix 2 - Precedent programs

### UK NHS prep

All UK graduates must undertake 12 months vocational training in a Deanery approved practice in order to be able to work as an NHS Performer.

For new graduates, the vocational training year has 30 day release professional development days at a local postgraduate centre and for experienced non UK dentists, a 10 day NHS Introduction course is available. (See also NHS Introduction Course)

Vocational Training introduces newly qualified dentists to NHS dentistry and helps them make the transition from undergraduate to independent practitioner in a supportive environment.

Participants are expected to:

- Complete one year working in an approved training practice
- Attend the 30 Vocational Training study days
- An educational portfolio of evidence of achievement
- Submit 2 FGDP Key Skills modules
- Clinical case presentation / Case Based Discussion
- Clinical Audit
- Demonstrate a broad spectrum of skills (clinical and non-clinical)
- Complete a wide range of foundation assessments

The intern is salaried throughout the year, with a fixed income determined nationally and is an employee of the training practice with a 12 month contract. The trainer supervises the intern and provides a well equipped surgery, experienced nursing support, hands on teaching, regular tutorials and a wide range of patients and clinical experience to ensure they can have a broadly based introduction to practice.

See also:

[http://www.nesc.nhs.uk/primary\\_areas/dental\\_school/dental\\_vocational\\_training.aspx](http://www.nesc.nhs.uk/primary_areas/dental_school/dental_vocational_training.aspx)

### New York

Since 2007, all applicants for initial dental licensure must complete an approved residency of at least one year's duration. The US Commission of Dental Accreditation (CODA) and the residency programs it oversees are independent and objective. A residency program is a clinical exam based on performance over an entire year rather than on one clinical exam.

The New York State Education Department administers licensure arrangements for dentists, and their website (<http://www.op.nysed.gov/dentlic.htm>) states:

"The Department must receive, directly from the residency program director, verification of completion of an approved residency program accredited for teaching purposes by an acceptable national accrediting body. **You should confirm with your residency program director that the residency program is participating in this route to licensure.**

If you participate in a residency program in New York State, you must obtain a limited permit to practice within the residency program.

You may complete a residency program in either a clinical specialty or in general dentistry. The dental residency program requirements are:

- Specialty Clinical Dental Residency Program

The dental resident applicant must complete a clinical specialty residency program in one or more of the following specialty areas: endodontics (root fillings), oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics (gum treatment) or prosthodontics (crown, bridges and removable dentures). If the specialty residency program is not in one of these specialty areas, 50% of the program completed by the resident must include clinical training in one or more of these specialty areas or general dentistry to meet New York State requirements.

- General Dentistry Residency Program

The dental resident applicant must complete a general dentistry program. During the residency program, the dental resident applicant must complete 9 dental procedures - 2 full crowns, 2 endodontically treated teeth (root canals), 4 restorations (2 anterior, 2 posterior), and 1 periodontal case (Type 1) - independently and to generally accepted professional standards. See the Reference Guide included with [Form 4B](#) or further information."

## Indiana

The Indiana State Board of Dentistry (<http://www.in.gov/pla/dental.htm>) publishes the following advice regarding its provisions for internships for dental graduates:

*"The Board may, at its discretion, issue a dental intern permit to any person to whom it has not issued a license, but who is a graduate of a dental college recognized by the board and is otherwise qualified to take the regular examination for licensure. An applicant for a dental intern permit shall furnish to the board satisfactory evidence that the applicant has been:*

1. *appointed to a dental internship in a hospital, or similar institution operated under the laws of the State of Indiana; or*
2. *employed as:*
  - A. *an instructor in a dental school recognized and approved by the Indiana State Board of Dentistry; or*
  - B. *a teacher or operator in a clinic in a public or parochial school, college or university.*

*Any person receiving a dental intern permit may practice dentistry only in a hospital or other institution designated in the permit and only under the direction of a licensed dentist who is a member of the dental staff of the hospital or other institution. The intern's practice shall be limited to bonafide patients of the hospital or other institution.*

*The holder of an intern permit may not engage in private practice. Practice is limited to the internship site. It is not valid for engaging in faculty practice.*

***The permit is valid for only one (1) year from the date of issuance and is renewable at the discretion of the board upon the payment of a fee of one-hundred dollars (\$100.00). The Board may recall the permit at any time. You are responsible for notifying the board if you wish to renew your permit. "***

## **Cincinnati**

Cincinnati has popular dental residency (intern) programs including the general dental one run at the University Hospital, which has the following goals and objectives:

- 1. Provide high quality comprehensive general dental care, and resident education beyond that achieved as an undergraduate, for healthy and medically compromised patients, integrating all phases of dentistry in providing that care.*
- 2. Make sound judgments in examination, diagnosis, treatment, planning and decision-making during the course of patient treatment, incorporating good patient and staff management principles.*
- 3. Act as the primary dental care provider for healthy and medically compromised patients; coordinate the service of dental specialists and other health care professionals.*
- 4. Function efficiently in the hospital setting, providing care for individuals with complex medical and social backgrounds.*
- 5. Understand the oral health needs of the community and engage in community service.*

## **Previous Victorian dental intern program 1995-1998**

A voluntary dental intern program operated in Victoria during 1995-98, details of which are available from the Victorian Government Department of Human Services. The major problem faced by this program was that the participants did not find it attractive. This reinforces the importance of the education and professional development component of the National Dental Foundation Year Program.