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DENTAL HYGIENE SELF-GOVERNANCE

An Ethical and Economic Imperative

SUGGESTED CITATION: Sven, D. J. (2026, July). *Dental Hygiene Self-Governance: An Ethical and Economic Imperative*. American Dental Hygienists' Association. <https://www.adha.org/WhitePapers>.

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Dental Hygiene Self-Governance

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Executive Summary

A profession entrusted with the prevention of oral disease should not remain governed by systems that deny it authority over its own scope, standards, and future. Dental hygiene self-governance should be understood as a reform in the public interest, not merely a professional aspiration. This paper argues that preventive oral health policy cannot be fully modernized while dental hygiene remains subject to regulatory, reimbursement, and practice structures controlled outside the profession, despite its distinct education, competencies, and accountability obligations.

The paper distinguishes self-governance from self-regulation in crucial ways. Self-regulation reflects delegated authority to oversee members within an existing framework, whereas self-governance reflects inherent authority to define scope, standards, educational expectations, and the systems through which care is delivered. Building on this distinction, the paper argues that dental hygiene's current model grants the profession partial oversight responsibilities but insufficient authority to shape the structures that determine access to preventive care.

From this premise, the paper contends that governance reform is necessary to align authority with competence and public need. It argues that dentist-centered supervision rules, reimbursement barriers, and statutory control by outside professions are limiting workforce utilization, restricting patient access to lower-cost preventive services, and preserving structural arrangements that are increasingly difficult to justify on public-protection grounds alone. The paper also places this issue within a broader legal and policy context, noting that modern antitrust doctrine and health workforce policy both favor transparent, evidence-based frameworks that support access, accountability, and fair competition among qualified providers.

The proposed response is a self-governance framework grounded in independent dental hygiene regulatory authority, profession-defined scope of practice, recognition of scope-based diagnosis, direct reimbursement pathways, practice authority aligned with demonstrated competence, and public accountability through transparent standards, discipline, and outcome monitoring. Consistent with that framework, the paper recommends establishing independent dental hygiene boards, separating dental and dental hygiene practice acts, expanding direct reimbursement, removing unwarranted practice-setting restrictions, and replacing mandatory dependency models with collaborative structures grounded in competency rather than supervision.

This paper does not frame reform as unrestricted autonomy. It presents the **Dental Hygiene Modernization Act** framework as a measured model that ties expanded authority to licensure, education, experience, continuing competence, and independent oversight while preserving interprofessional collaboration and public protection. The core policy question is no longer whether dental hygienists can safely provide preventive care, but whether governance systems will evolve to reflect that reality in ways that improve access, system efficiency, and oral health outcomes.

Introduction: The Profession at an Inflection Point

Over the past five decades, the dental hygiene profession has pursued an expanded scope of practice, direct access to care, recognition of dental hygiene diagnosis, and self-regulation as mechanisms to improve public access to preventive oral health services.¹⁻³ These efforts have produced measurable gains; however, they have not fundamentally altered the underlying structures that govern dental hygiene within the broader oral health care system.

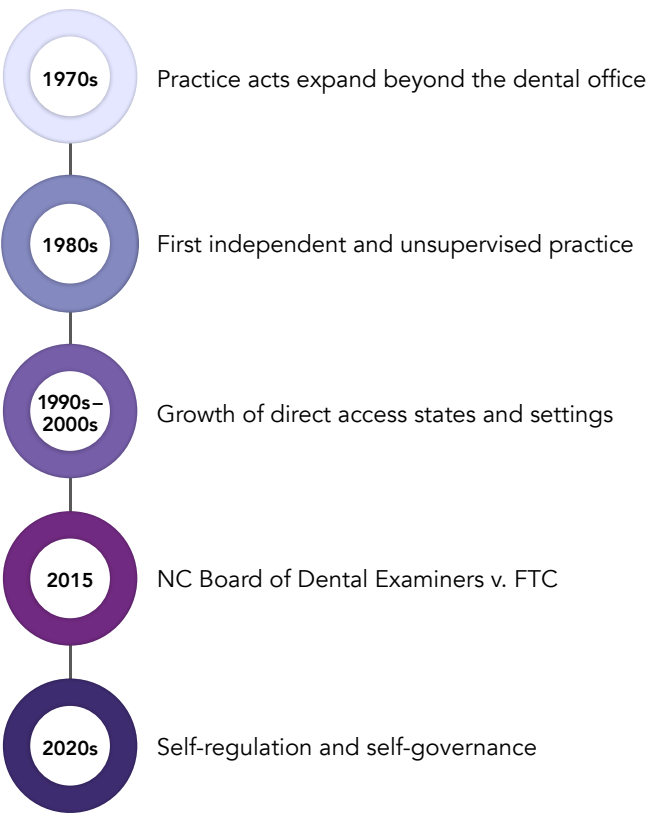


Figure 1. Five decades of expanding dental hygiene practice

Despite expanded practice acts and increased recognition of dental hygienists’ clinical capabilities, access to oral health care in the United States remains heterogeneous, particularly among rural and low-income populations.^{4,5} The National Institute of Dental and Craniofacial Research (NIDCR) has identified persistent

disparities in oral health outcomes, noting that structural barriers, including workforce distribution and regulatory constraints, continue to limit access to preventive care.⁶ Similarly, the National Governors Association has emphasized that restrictive scope-of-practice laws and supervisory requirements for dental hygienists contribute to inefficiencies in care delivery and reduced access, particularly in underserved communities.^{7,8}

In response to these challenges, the profession has increasingly looked to self-regulation to enhance public protection and reduce conflicts of interest inherent in dentist-dominated regulatory structures.^{2,9,10} While this represents an important advancement, it does not fully address the structural limitations imposed by a regulatory framework that keeps dental hygiene subordinate to dentistry.^{11,12}

In an era of growing corporate consolidation and the rapid expansion of private equity’s influence in oral health care, it is more important than ever for the profession to establish a clear distinction between the preventive scope of dental hygiene and the restorative scope of dentistry.^{13,14} Against this backdrop, the case for dental hygiene self-governance raises fundamental questions about organized dentistry’s asserted authority over the profession and the extent to which that authority rests on self-interested, unsupported, and legally vulnerable foundations.^{9,10,12,15}

Defining the Difference: Self-Regulation vs. Self-Governance

The distinction between self-regulation and self-governance is central to understanding how professional authority is structured. While the terms are often used interchangeably in professional discourse, they represent fundamentally different constructs within regulatory theory, professional sociology, and health policy.¹⁶⁻¹⁸

Self-regulation is a well-established concept. It is generally defined as a system in which the state delegates authority to a profession to establish standards, license practitioners, and enforce disciplinary measures in the public interest.¹⁹⁻²¹ This model assumes that members of a profession possess specialized knowledge and are therefore best positioned to regulate the competence and conduct of their peers.^{19,22} In health care, self-regulation typically operates through licensing boards or regulatory bodies that are granted authority by statute and remain accountable to the state.^{18,20,21}

Scholarly and policy frameworks consistently reinforce this understanding. Research on health workforce regulation characterizes self-regulation as a form of state-mediated authority, emphasizing that professional control exists only insofar as it is delegated and can be modified or withdrawn by legislative action.^{18,20} In this sense, self-regulation shapes how a profession operates within an existing system, but it does not determine the structure of that system itself.^{16,17}

Self-governance is less frequently defined in the context of health professions, yet it is conceptually broader and more foundational.^{16,23,24} It refers to the capacity of a group or profession to exercise authority over its own structures, decision-making processes, and normative frameworks, independent of external professional control.^{23,25,26} It extends beyond regulatory oversight to encompass the ability to define scope of practice, establish

standards of care, determine educational requirements, and shape the conditions under which services are delivered.^{11,24-26}

This distinction is supported by broader theoretical frameworks. Ostrom’s work on governance demonstrates that groups can create and enforce their own rules without relying on centralized authority, emphasizing the role of collective decision-making and internal accountability.²³ Governance theory further distinguishes between regulation as a mechanism of control and governance as the distribution of authority across actors and institutions.¹⁶ In professional sociology, Freidson argues that true professional autonomy arises not merely from the ability to regulate members but from control over the profession’s content and organization.^{22,25}

Self-regulation Oversight	Self-governance Authority
Authority delegated by the state	Authority inherent to the profession
Oversees conduct within the system	Defines the system itself
Standards applied, not set	Sets its own standards and scope
Can be withdrawn by legislative action	Structural and enduring

Figure 2. Self-regulation and self-governance compared

The difference between self-regulation and self-governance can therefore be understood as the difference between oversight and authority. Self-regulation oversees conduct within a defined system. Self-governance determines who has the power to define that system in the first place.^{16,23,25,26}

The Domains of Governance

A governance-based approach recognizes that a profession’s ability to meet public health needs depends on the alignment between its education, competencies, and the authority to apply them in practice.^{11,18,25} When that alignment is present, the workforce can function efficiently, respond to new demands, and support access to care.²⁷⁻²⁹ When it is absent, policy and practice arrangements can limit the profession’s contribution.^{12,27,30}

For dental hygiene, governance can be understood across four interrelated domains:

- **Clinical Governance**

Reflects the profession’s role in defining and delivering care. This includes assessment, dental hygiene diagnosis, care planning, preventive services, and referral.^{3,31} Aligning clinical authority with education and competency supports consistency in care delivery and reinforces accountability to patients.²⁴⁻²⁶

- **Regulatory Governance**

Encompasses licensure, standards of practice, discipline, and continuing competence.¹⁹⁻²¹ While self-regulation strengthens professional participation in oversight, governance ensures that these functions remain aligned with the profession’s full scope and evolving role within the health care system.^{2,14,18}

- **Economic Governance**

Addresses how services are recognized, reimbursed, and integrated into health care delivery systems. This includes payer recognition, contracting, and participation in public and private reimbursement models.^{8,32,33} Alignment in this domain supports the sustainability of practices and improves access to preventive services.^{4,7,33}

- **Educational Governance**

Reflects the profession’s role in defining competencies, shaping curricula, and creating its own accreditation standards.^{17,22,28} As dental hygiene expands its role in prevention and disease management, education must remain responsive to evolving practice expectations and public health needs.^{3,6}

Viewed together, these domains show that governance extends beyond oversight to encompass the systems that define how a profession functions.^{16,17,23} In the context of dental hygiene, governance serves as a practical mechanism to strengthen the profession’s capacity to meet the public’s oral health needs.^{2,6,7}



Figure 3. Where governance operates in dental hygiene

Governance Requires Alignment with Professional Scope

Effective governance in health care requires that regulatory authority be aligned with the education, competencies, and scope of practice of the profession being governed.^{18,20,25} Without this alignment, regulatory structures risk creating inconsistencies between clinical responsibility and decision-making authority.^{12,26,27}

Dental hygiene is a distinct health profession with a defined body of knowledge centered on prevention, nonsurgical periodontal therapy, caries management, and long-term disease control.^{3,31} These areas represent core components of oral health care delivery and require specialized training, clinical judgment, and ongoing competency specific to dental hygiene practice.^{2,3}

When governance structures do not fully reflect this expertise, a misalignment occurs between those delivering care and those defining its parameters.^{11,18,27} That misalignment has direct implications for how scope of practice is determined, how standards are applied, and how care delivery evolves over time.^{14,17,26}

Published analyses of predoctoral dental curricula have documented limited attention to the science, competencies, and purposes of dental hygiene.^{34,35} In this context, assumptions that dentists possess the requisite preparation to govern the dental hygiene profession rest primarily on their historical worldviews and organizational narratives rather than on evidence.^{8,11} When governance is grounded on such assumptions rather than in demonstrated competence, the result is a weak foundation that undermines efforts to expand access to preventive oral health care.^{7,12,33}

In broader health policy, there is increasing recognition that professions are most effectively governed by structures that reflect their own competencies and scope.¹⁸⁻²⁰ This principle

supports consistency in decision-making, improves accountability, and helps ensure that regulatory frameworks remain responsive to current evidence and practice.²⁴⁻²⁶

Within oral health care, this alignment is especially important as the system shifts toward prevention, minimally invasive care, and population health approaches.^{6,7,31} Governance structures that do not fully incorporate the expertise required for these services may limit the profession's ability to contribute at the level for which it is educated and trained.^{3,12,27}

This does not preclude collaboration across professions. Dentistry and dental hygiene share a commitment to improving oral health outcomes, and coordinated care remains essential.^{6,31} Collaboration, however, is not a substitute for appropriate governance alignment.^{11,14,26} Each profession must be supported by structures that reflect its distinct role, responsibilities, and competencies.^{18,24,25}

For dental hygiene, this distinction is critical. A profession responsible for delivering preventive oral health care must also have a meaningful role in defining the standards, scope, and systems that govern that care.^{2,3,25} Aligning governance with professional scope is therefore not only a matter of professional development, but a necessary condition for regulatory frameworks that effectively support public health.^{4,6,7}

Lessons from Nursing

Nursing provides one of the most well-established examples of how professional governance can evolve to better align authority, education, and public need.^{21,28,29} Across the United States, nurse practice acts establish boards of nursing with authority over licensure, education, scope of practice, and discipline, creating a regulatory foundation grounded in the profession itself.²¹

Over time, this regulatory framework has been complemented by broader governance developments, particularly in the recognition of full practice authority for nurse practitioners.^{28,29,36} In many states, nurse practitioners are authorized to evaluate patients, diagnose conditions, interpret diagnostic tests, and initiate treatment independently.^{36,37} These changes reflect a policy shift toward aligning scope of practice with education, training, and demonstrated competence.^{28,29,38}

Research has shown that full practice authority for nurse practitioners is associated with improved access to care, particularly in underserved and rural areas, as well as high-quality outcomes comparable to physician-led care.^{29,38-40} These findings have informed ongoing efforts to modernize scope-of-practice laws and optimize workforce capacity.^{28,37}

Importantly, this progression did not occur through regulatory reform alone. While self-regulation through boards of nursing has long been established, expanded practice authority emerged through a broader alignment of policy, education, and health system needs.^{21,28,29} This reflects a governance-based approach in which authority, accountability, and responsibility evolve together.^{24,26,41}

For dental hygiene, the experience of nursing illustrates that professional advancement is not solely a function of regulatory representation, but

Full practice authority



The authorization of licensed dental hygienists to evaluate patients, diagnose conditions within the dental hygiene scope of practice, order and interpret diagnostic tests, and initiate and manage treatments, including prescribing medications, under the authority of the state regulatory board.

- **Evaluate patients**
- **Diagnose conditions**
Within the dental hygiene scope of practice
- **Order and interpret diagnostic tests**
- **Initiate and manage treatment**
Including prescribing medications

Source: ADHA Policy Manual

Figure 4. Full practice authority, defined

of how authority is structured across the system.^{18,24,25} Aligning scope of practice with education and public need requires coordination across regulatory, legislative, and practice environments.^{18,20,29}

This model reinforces a central premise of this paper: that governance, rather than regulation alone, provides the framework necessary to support the full contribution of a health profession in meeting public health needs.^{16,23,25}

Lessons from Other Professions

Across health disciplines, there is a consistent progression toward aligning regulatory structures with professional authority.^{17,18,20} While each profession has developed within its own historical and policy context, a common pattern emerges: mature professions establish frameworks in which standards, scope, ethics, and accountability are defined from within the profession, in alignment with public need.^{19,22,25}

In pharmacy, evolving scope-of-practice models have expanded pharmacists’ roles in prescribing, chronic disease management, and preventive care, supported by regulatory and policy changes that recognize their education and clinical training.^{27,30,42} Similarly, physician associates have advanced practice modernization efforts that reduce supervisory constraints and emphasize team-based care models grounded in competency rather than hierarchy.⁴³

In medicine and law, long-standing governance structures provide additional examples of professions that define their own standards of practice, ethical frameworks, and disciplinary processes through established professional bodies and associations.^{19,44} These systems

operate with accountability to the public while maintaining authority over professional conduct and expectations.^{19,25,44}

Public health credentialing further reflects this approach, emphasizing competency-based standards, professional accountability, and alignment with population health needs.²⁰ These models reinforce the importance of integrating education, standards, and practice authority to support effective workforce utilization.^{17,18,27}

While these professions differ in structure and scope, they share a common principle: professional governance is most effective when authority, accountability, and standards are aligned within the profession and guided by a clear commitment to public protection.^{19,20,25}

For dental hygiene, these examples do not necessarily serve as templates to replicate, but as evidence of a broader shift in professional development—one that emphasizes internal alignment of standards and authority as a means of improving care delivery and advancing public health.^{2,7,18}

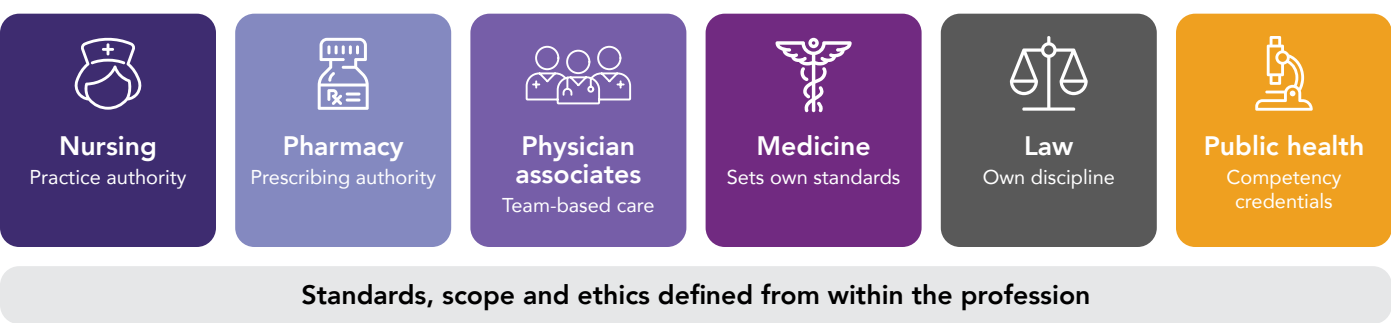


Figure 5. A shared pattern across professions

Structural Economics of Preventive Care

Health care regulation does more than allocate authority; it shapes how value is created and captured across the care continuum.^{13,15,45}

In oral health, the prevailing regulatory and payment architecture systematically favors high-margin restorative procedures over lower-margin preventive services, even when the latter are more cost-effective for patients and payers.^{7,8,33} By tying preventive care to dentist-centered ownership, billing, and supervision arrangements, the system channels revenue and decision-making toward the restorative end of the market and away from community-based, prevention-oriented models.^{8,12,33}

This configuration has several economic consequences. First, it encourages practice models in which chair time, scheduling patterns, and marketing strategies are optimized around restorative production rather than population-level risk reduction.^{13,45} Second, it weakens the business

case for standalone or hygiene-led preventive delivery systems, limiting experimentation in lower-cost settings such as schools, public health clinics, and mobile practices.^{1,7,31} Third, it blunts the incentives for payers to invest in preventive benefit design when much of the downstream savings accrue outside the entities that control scope, supervision, and ownership.^{7,8,33}

Seen through this lens, structural control is not only about professional dominance but about how the system prices risk, allocates capital, and decides which forms of oral health work “count” economically.^{9,11} A governance framework oriented toward dental hygiene self-governance would permit preventive care to be organized as its own economic domain—one in which revenue, accountability, and innovation can be aligned with prevention, early intervention, and longterm disease management, rather than subordinated to the logic of restorative production.^{2,7,33}

The Hidden Surcharge of Dentist-Controlled Governance

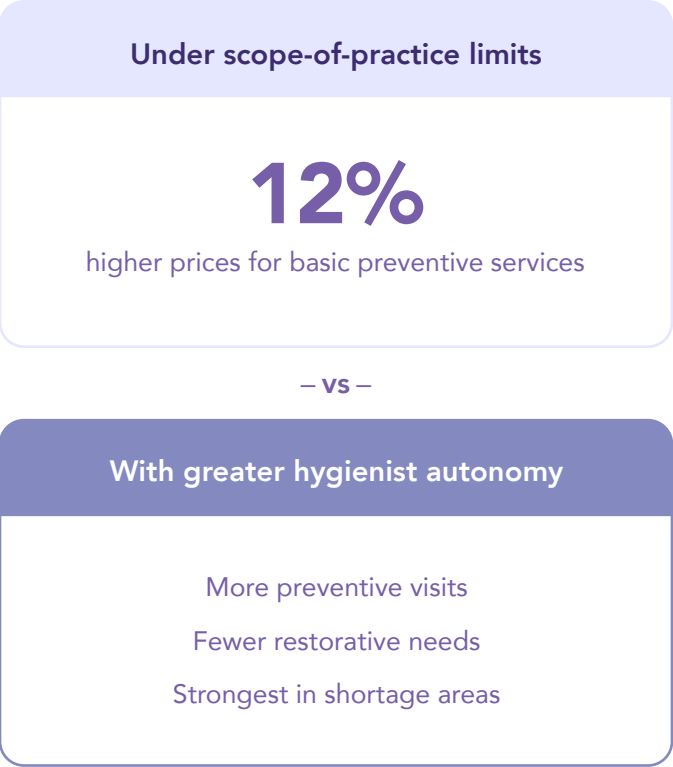
Patients possess a fundamental right to obtain preventive oral health services from qualified dental hygienists without being compelled into higher-cost treatment pathways that exceed their clinical needs, preferences, or financial capacity.⁴⁶ This principle of patient autonomy is affirmed across the major ethical codes governing medical and dental professionals and is directly violated by organized dentistry’s controls on who may provide basic services and under what conditions.^{47,48}

Under many traditional supervisory models, patients seeking routine preventive care are routed through dentist-centered examination and treatment-planning processes that structurally favor higher-priced restorative, elective, and cosmetic procedures that the patient may not have sought or clinically

required.^{8,33,45} Empirical evidence shows that task-specific scope-of-practice restrictions on hygienists drive up the prices of basic services by roughly 12%, inflating consumer costs for prophylaxis, periodontal therapies, caries control, radiographs, and similar procedures that hygienists are fully qualified to provide independently.³³ In ethical terms, this configuration magnifies financial conflicts of interest: it embeds profit maximization into the clinical gateway for preventive care, and when hygienists are marginalized or overruled within such systems, patients and the broader public bear the economic and health consequences.^{9,12,15}

Research also demonstrates that expanding dental hygienist practice autonomy not only increases access to preventive services but shifts utilization

away from costlier restorative care.^{4,7,33} Using national Medical Expenditure Panel Survey data, Chen and colleagues found that states moving to higher levels of hygienist autonomy see more preventive visits and fewer restorative needs, with



Sources: References 33 and 49 (see page 18)

Figure 6. The economic effect of scope-of-practice restrictions

effects especially pronounced in dental provider shortage areas and low-income populations, where reliance on hygienist-delivered care rises measurably.⁴⁹ These findings situate organized dentistry’s resistance to hygienist autonomy as not merely a matter of professional turf, but as a driver of avoidable consumer spending on restorative and cosmetic services that could, in many cases, have been prevented or deferred through timely, lower-cost preventive care.^{8,11,12}

These studies underscore the policy stakes of dental hygiene self-governance. When restrictive, dentist-controlled scope-of-practice and reimbursement rules are relaxed, prices for basic services fall, preventive utilization increases, and demand for invasive, expensive treatment contracts, especially in underserved communities, where cost is the dominant barrier to care.^{4,7,33} As oral health policy continues to emphasize prevention, minimally invasive care, and cost containment, ensuring that patients can access preventive services directly from dental hygienists is not only a matter of professional role definition; it is a core issue of patient autonomy, consumer protection, and the public’s right to affordable preventive oral health care free from structurally induced over-treatment and price inflation.^{6,12,31}

Antitrust, Competition, and Public Protection

Regulatory frameworks in health care are intended to protect the public by ensuring that professionals meet established standards of education, competence, and ethical conduct while also supporting access to care, workforce efficiency, and fair competition.^{18,20} In dentistry, however, this balance has been distorted by governance structures in which dental boards are dominated by active market participants, with either no dental hygiene representation or at most hygienist members whose influence is structurally limited.^{9,10,15} Over time, this pattern has

functioned as a form of regulatory gerrymandering, enabling organized dentistry to retain control over the rules governing a separate, distinct profession and to shape its scope of practice, mandate its supervision, and reimbursement policies to protect their economic interests.^{8,11,45}

The U.S. Supreme Court’s decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission* underscores the antitrust risks of such arrangements, holding that state licensing boards composed of active market participants are

subject to federal antitrust law when they restrain competition without active state supervision.¹⁰ The Federal Trade Commission has likewise warned that professional boards may not deploy scope-of-practice restrictions, supervision requirements, or limits on care delivery as tools to suppress competition from qualified providers, emphasizing that such policies can reduce access, raise prices, and stifle innovation without demonstrable gains in quality or safety.^{12,50,51} Together, these principles highlight a central concern in oral health care: when dentist-dominated boards exclude or marginalize dental hygienists, they blur the line between legitimate public protection and anticompetitive control over preventive services.^{8,12,52}

In this context, distinguishing between policies that genuinely safeguard patients and those that functionally limit the availability of services is critical.^{33,45} Health workforce research shows that scope-of-practice rules are heavily shaped by historical hierarchies and professional power

dynamics, not solely by evidence of risk.^{11,14} For dental hygiene, this means that a century of dentist-controlled regulation has constrained the profession's ability to practice to the full extent of its education and competencies, particularly in underserved communities where hygienists could expand access to preventive care.^{1,4,7,31}

Antitrust jurisprudence does not weaken professional regulation; it clarifies that regulatory power must be exercised transparently and with accountability to the public rather than to the economic interests of incumbent providers.^{10,52} For dental hygiene, aligning board composition and regulatory authority with the profession's scope, education, and demonstrated safety record is therefore not merely a matter of internal governance reform, it is a response to longstanding antitrust concerns about organized dentistry's willful use of state power to suppress competition and maintain control over preventive oral health services.^{2,8,12,33}

Policy Recommendations

Advancing toward a self-governance model in dental hygiene requires coordinated policy actions that align professional authority with education, competence, and public need. The following recommendations outline key areas for consideration by policymakers, regulators, and professional organizations.

- **Establish Independent Dental Hygiene Regulatory Bodies**

Support the development of dental hygiene boards or commissions with appropriate public representation. These entities can strengthen professional oversight while ensuring that regulatory decisions reflect both subject-matter expertise and the public interest.

- **Separate Dental and Dental Hygiene Practice Acts**

Separating the Dental and Dental Hygiene Practice Acts clarifies that dentists and dental hygienists are distinct professions with separate scopes of practice, reducing the legal and ethical conflicts arising from overlapping regulatory authority.

- **Align Scope of Practice with Education and Competence**

Authorize dental hygienists to perform assessment, dental hygiene diagnosis, preventive services, nonsurgical periodontal therapy, and referral based on education and clinical competency. Aligning scope with training supports consistency in care delivery and enhances access to preventive services.

- **Expand Direct Reimbursement Pathways**

Enable dental hygienists to enroll directly as providers in Medicaid and commercial payer systems. Direct reimbursement supports sustainable practice models and improves access to care, particularly in underserved and community-based settings.

- **Remove Unnecessary Practice Setting Restrictions**

Reevaluate facility-based limitations that restrict where dental hygienists may provide care. Expanding allowable practice settings can improve access to preventive services in schools, long-term care facilities, community health settings, hospitals and other underserved environments.

“Strengthening governance requires not only expanded authority but expanded accountability.”

- **Substitute “Supervision” Frameworks for Collaboration**

Substitute outdated “supervision” frameworks with collaborative practice models that recognize the distinct education, licensure, and clinical competencies of dental hygienists as autonomous healthcare professionals.

- **Incorporate Public-Interest Review in Regulatory Decision-Making**

Encourage periodic review of scope-of-practice policies to ensure alignment with current evidence, workforce needs, and public health priorities. Incorporating public-interest considerations supports balanced, transparent policymaking.

- **Align Regulatory Frameworks with Workforce Utilization**

Ensure that regulatory structures support the full utilization of the dental hygiene workforce. Policies should reflect contemporary education, training, and evidence of safe and effective care, promoting both access and system efficiency.

Considerations and Common Concerns Regarding Governance Reform

Discussions surrounding professional governance reform in health care are often accompanied by important questions regarding patient safety, care coordination, educational consistency, and system integration.^{18,20} These considerations warrant careful examination and should be addressed directly within the discussion of dental hygiene self-governance.

One commonly cited concern is that expanded professional authority could contribute to fragmentation within oral health care delivery.¹⁴ Dentistry and dental hygiene have historically operated in collaborative practice settings, and coordinated care remains essential for

maintaining continuity, referral relationships, and comprehensive patient management.^{7,31}

As the longstanding collaboration between nurse practitioners and physicians illustrates, increased professional autonomy need not undermine integrated care; rather, it can coexist with and even strengthen team-based models when roles are clearly defined.^{29,39} In the same way, a governance-based model in oral health does not eliminate collaboration between professions; it seeks to ensure that collaborative relationships are structured around competence, accountability, and patient needs, rather than mandatory dependence.^{25,26}

The Dental Hygiene Modernization Act framework endorsed by the American Dental Hygienists' Association (ADHA) reflects this balanced approach. Rather than diminishing professional collaboration, the model preserves structured referral and consultation relationships through a collaborating dentist framework while allowing qualified dental hygienists in advanced practice to deliver preventive services independently within clearly defined parameters. This structure recognizes that collaboration and autonomy are not mutually exclusive concepts.



Figure 7. The Dental Hygiene Modernization Act components

Questions are also frequently raised regarding patient safety and quality of care.^{18,20} However, evidence from health workforce research consistently demonstrates that appropriately educated and licensed health professionals can safely provide services aligned with their training and demonstrated competence.^{29,38} Similar concerns accompanied the expansion

of practice authority in nursing, pharmacy, and other health professions, yet subsequent research has shown that these reforms have improved access to care while maintaining high standards of quality and patient outcomes.^{27,29,38}

Importantly, contemporary governance proposals in dental hygiene are not based on unrestricted practice authority without standards or preparation.³¹ The Dental Hygiene Modernization Act framework incorporates layered competency requirements, including active licensure, substantial clinical experience, minimal baccalaureate education, advanced post-licensure training, continuing competence requirements, and formal disciplinary oversight through an independent Board of Dental Hygiene.² These provisions reflect a governance model grounded not only in expanded authority but in increased responsibility.^{19,24,25}

Another consideration involves variability in educational preparation and regulatory consistency across jurisdictions.¹⁸ As scope and practice authority evolve, governance structures must ensure that educational standards, competency assessment, continuing education, and disciplinary systems remain rigorous, transparent, and evidence based.^{20,21} Strengthening governance, therefore, requires not only expanded authority but expanded accountability.^{19,24}

The ADHA-supported modernization framework addresses this concern directly by aligning educational and regulatory standards with Commission on Dental Accreditation (CODA) requirements while establishing profession-specific oversight mechanisms for licensure, ethics, discipline, and continuing education.² The framework further recognizes that advancement toward autonomous practice should occur through structured pathways tied to education, demonstrated competence, and professional responsibility rather than through abrupt or unregulated expansion of practice authority.^{2,21,26}

Finally, some stakeholders may view governance reform primarily through the lens of professional autonomy.^{25,26} While professional development is an important aspect of these discussions, the central issue raised in this paper is not independence for its own sake. The primary question is whether regulatory and practice structures are appropriately aligned with contemporary workforce capabilities and public health needs.^{4,7,33}

The Dental Hygiene Modernization Act reflects what may be characterized as a steady and balanced model of governance reform.² It preserves interprofessional collaboration, incorporates public accountability, establishes graduated

competency requirements, and maintains clear distinctions between preventive dental hygiene services and restorative dentistry. Rather than functioning as a departure from accountability, this approach represents an effort to modernize oral health workforce policy in a manner consistent with evidence-based care, public protection, and improved access to preventive services.^{4,20,33}

Governance reform is therefore best understood not as a shift away from accountability, but as a framework for aligning authority, responsibility, competency, and public protection more effectively within the modern oral health care system.^{2,18,19,26}

Conclusion: From Permission to Authority

The question facing dental hygiene is no longer whether the profession is capable of providing safe and effective preventive care. Decades of workforce research, expanded practice models, and public health outcomes have demonstrated its capacity to do so.^{4,49,53} The question is whether regulatory and governance systems will evolve to reflect that reality.

Self-regulation represents an important advancement in professional accountability and public protection, but regulation alone cannot fully resolve structural limitations that restrict how the profession defines its scope, participates in care delivery, and responds to public health needs.^{2,16,18} Governance addresses these broader questions by aligning authority with responsibility, education, and demonstrated competence.^{23,25,26}

As health care systems continue to emphasize prevention, access, workforce efficiency, and evidence-based policy, governance structures must also evolve.^{6,7} Professions are most effective when they are accountable for the standards, systems, and responsibilities associated with the

care they provide.^{19,24,25} For dental hygiene, this alignment is increasingly necessary not only for professional development, but for improving access to preventive oral health services and strengthening public health outcomes.^{4,7,33,49}

The future of dental hygiene will ultimately be shaped by whether the profession continues to operate within systems built upon permission, or advances toward systems grounded in authority, accountability, and professional responsibility.^{25,26}

Self-regulation asks whether dental hygienists may regulate themselves. Self-governance asks whether dental hygiene will be recognized as a profession with the authority to define, direct, and be accountable for its own future.^{16,23,25}

References

1. American Dental Hygienists' Association. *Direct access states*. American Dental Hygienists' Association; 2025. Accessed June 7, 2026. <https://www.adha.org/wp-content/uploads/2025/02/ADHA-Direct-Access-Chart-02-2025.pdf>
2. Gadbury-Amyot, C.C., Martel, S., & Rowley, L.J. (2025, December). *Dental Hygiene Self-Regulation: How Self-Regulation Strengthens Public Protection and Expands Access to Care*. American Dental Hygienists' Association. <https://www.adha.org/WhitePapers>
3. Swigart, D.J., Beaty, K.L., McLeroy, T. (2026, February). *Dental Hygiene Diagnosis: Defining the Essential Role of Diagnostic Decision-Making in Dental Hygiene*. American Dental Hygienists' Association. <https://www.adha.org/WhitePapers>
4. Akinlotan MA, Ferdinand AO, Maxey HL, Bolin JN, Morrissey MA. Dental hygienists' scope of practice regulations and preventable nontraumatic dental emergency department visits: A cross-sectional study of 10 U.S. states. *Community Dent Oral Epidemiol*. 2023;51(2):274-282. doi:<https://doi.org/10.1111/cdoe.12737>
5. Chou C-F, Vallin T, Rogers S, et al. Impact of the Health Resources and Services Administration's state oral health workforce grant program on dental workforce density and access to oral health care. *Eval Program Plann*. 2019;75: 43-53. <https://doi.org/10.1016/j.evalprogplan.2019.04.004>
6. National Institutes of Health. *Oral health in America: Advances and challenges*. National Institute of Dental and Craniofacial Research; 2021. Accessed June 7, 2026. <https://www.nidcr.nih.gov/research/oralhealthinamerica>
7. National Governors Association. *The role of dental hygienists in providing access to oral health care*. National Governors Association; 2014.
8. Kleiner MM, Park KW. *Battles among licensed occupations: Analyzing government regulations on labor market outcomes for dentists and hygienists*. W.E. Upjohn Institute for Employment Research; 2010. <https://www.nber.org/papers/w16560>
9. Carpenter D, Moss DA, eds. *Preventing regulatory capture: Special interest influence and how to limit it*. Cambridge University Press; 2013.
10. *North Carolina Bd of Dental Examiners v Federal Trade Commission*, 574 US 494 (2015).
11. Abbott A. *The system of professions: An essay on the division of expert labor*. University of Chicago Press; 1988.
12. Gilman DJ, Fairman J. Antitrust and the future of nursing: Federal competition policy and the scope of practice. *Health Matrix*. 2014;24:143-201.
13. Havighurst CC. Health care as a (big) business: The antitrust response. *J Health Polit Policy Law*. 2001;26(5):939-955. <https://muse.jhu.edu/article/15613>
14. Nancarrow SA, Borthwick AM. Dynamic professional boundaries in the healthcare workforce. *Sociol Health Illn*. 2005;27(7):897-919. doi:<https://doi.org/10.1111/j.1467-9566.2005.00463.x>
15. Stigler GJ. The theory of economic regulation. In: *The democracy sourcebook*. MIT Press; 2003:393-397.
16. Bevir M. *Governance: A very short introduction*. Oxford University Press; 2012.
17. Dent M, Bourgeault IL, Denis J-L, Kuhlmann E, eds. *The Routledge companion to the professions and professionalism*. Routledge; 2016.
18. Leslie K, Moore J, Robertson C, et al. Regulating health professional scopes of practice: Comparing institutional arrangements and approaches in the United States, Canada, Australia and the United Kingdom. *Hum Resour Health*. 2021;19(1):15. doi:[10.1186/s12960-020-00550-3](https://doi.org/10.1186/s12960-020-00550-3)
19. Bauchner H, Fontanarosa PB, Thompson AE. Professionalism, governance, and self-regulation of medicine. *JAMA*. 2015;313(18):1831-1836. doi:[10.1001/jama.2015.4569](https://doi.org/10.1001/jama.2015.4569)
20. Gershuni O, Orr JM, Vogel A, et al. A systematic review on professional regulation and credentialing of the public health workforce. *Int J Environ Res Public Health*. 2023;20(5):4101. doi:[10.3390/ijerph20054101](https://doi.org/10.3390/ijerph20054101)
21. Russell KA. Nurse Practice Acts guide and govern: Update 2017. *J Nurs Regul*. 2017;8(3):18-23.
22. Freidson E. *Profession of medicine: A study of the sociology of applied knowledge*. University of Chicago Press; 1988.
23. Ostrom E. Beyond markets and states: Polycentric governance of complex economic systems. *Am Econ Rev*. 2010;100(3):641-672. <https://www.aeaweb.org/articles?id=10.1257/aer.100.3.641>
24. Porter-O'Grady T, Rollins S, Bailey KD. Nursing professional governance: The structure to enable professional practice. *Nurse Leader*. 2025;23(6):102512.

25. Freidson E. *Professionalism: The third logic: On the practice of knowledge*. University of Chicago Press; 2001.
26. Weston MJ. Defining control over nursing practice and autonomy. *J Nurs Adm*. 2008;38(9):404-408.
27. Adams AJ, Weaver KK. Pharmacists' patient care process: A state scope-of-practice perspective. *Innov Pharm*. 2019;10(2):1-10.
28. Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The future of nursing: Leading change, advancing health*. National Academies Press; 2011. doi:<https://doi.org/10.17226/12956>
29. Xue Y, Ye Z, Brewer C, Spetz J. Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systematic review. *Nurs Outlook*. 2016;64(1): 71-85.
30. Kumar A, Ray AB, Blanchard C. Use of research evidence varied in efforts to expand specific pharmacist autonomous prescriptive authority: An evaluation and recommendations to increase research utilization. *Health Res Policy Syst*. 2022;20(1):1.
31. Gadbury-Amyot CC, Simmer-Beck ML, Lynch A, Rowley LJ. Dental hygiene and direct access to care: Past and present. *J Dent Hyg*. 2023;97(5):24-32.
32. O'Brien JM. How nurse practitioners obtained provider status: Lessons for pharmacists. *Am J Health Syst Pharm*. 2003;60(22):2301-2307.
33. Wing C, Marier A. Effects of occupational regulations on the cost of dental services: Evidence from dental insurance claims. *J Health Econ*. 2014;34:131-143.
34. DeStaffany AM, Gurenlian JAR, Bono LK. Investigating periodontal diagnosis and treatment at one dental school. *Eur J Dent Educ*. 2023;27(3):535-540.
35. Dhar V, Glascoe A, Esfandiari S, Williams KB, McQuistan MR, Stevens MR. Should PGY-1 be mandatory in dental education? Two viewpoints. *J Dent Educ*. 2016;80(11):1273-1281.
36. Slade EP, DePriest K, Commodore-Mensah Y, Samuel L, Hanson GC, D'Aoust R. State full practice authority regulations and nurse practitioner practice autonomy: Evidence from the 2018 National Sample Survey of Registered Nurses. *Med Care Res Rev*. 2025;82(1):68-78.
37. American Association of Nurse Practitioners. *Literature on quality of nurse practitioner practice*. American Association of Nurse Practitioners; 2024.
38. Newhouse RP, Stanik-Hutt J, White KM, et al. Advanced practice nurse outcomes 1990–2008: A systematic review. *Nurs Econ*. 2011;29(5):230-250.
39. Barnes H, Richards MR, McHugh MD, Martsolf G. Rural and nonrural primary care physician practices increasingly rely on nurse practitioners. *Health Aff (Millwood)*. 2018;37(6):908-914.
40. Fitzpatrick JJ, Mehlman MJ, Plemmons A, et al. The impact of nurse practitioner full practice authority on chronic condition–related readmissions and emergency department visits in the United States. *Med Care*. 2026;64(4):192-197.
41. Potratz E, Bushaw A, Weston MJ. Strengthening clinical practice through professional governance. *Nurse Leader*. 2025;23(2):196-200.
42. Forsyth P, Baker J, Saadat W, Radley A. Professional autonomy in pharmacists: Independence within interdependence. *Res Social Adm Pharm*. 2026;22(1): 178-183.
43. American Academy of Physician Associates. *PA practice modernization*. American Academy of Physician Associates; 2024. <https://www.aapa.org/advocacy-central/pa-practice-modernization/>
44. Levin LC. The politics of lawyer regulation: The case of malpractice insurance. *Georgetown Journal of Legal Ethics*. 2020;33(4):969.
45. Kleiner MM, Kudrle RT. Does regulation affect economic outcomes? The case of dentistry. *J Law Econ*. 2000;43(2):547-582.
46. Beemsterboer PL. *Ethics and law in dental hygiene*. 3rd ed. Elsevier; 2016.
47. Ozar DT, Sokol DJ, Patthoff DE. *Dental ethics at chairside: Professional obligations and practical applications*. 3rd ed. Georgetown University Press; 2018.
48. Varkey B. Principles of clinical ethics and their application to practice. *Med Princ Pract*. 2021;30(1):17-28.
49. Chen J, Meyerhoefer CD, Timmons EJ. The effects of dental hygienist autonomy on dental care utilization. *Health Econ*. 2024;33(8):1726-1747.
50. Federal Trade Commission. *Anticompetitive practices*. Federal Trade Commission; Accessed June 7, 2026. <https://www.ftc.gov/enforcement/anticompetitive-practices>

51. Federal Trade Commission. *Federal Trade Commission doesn't investigate Texas Medical Board after agency receives law expanding competition among telehealth providers*. Federal Trade Commission; 2017.
52. *North Carolina State Board of Dental Examiners v FTC*. *Harv Law Rev*. 2015;129:1670-1679. <https://harvardlawreview.org/print/vol-129/north-carolina-state-board-of-dental-examiners-v-ftc-2/>
53. Langelier M, Continelli T, Moore J, Baker B, Surdu S. Expanded scopes of practice for dental hygienists associated with improved oral health outcomes for adults. *Health Aff (Millwood)*. 2016;35(12):2207-2215.

American Dental Hygienists' Association

The American Dental Hygienists' Association (ADHA) is the only organization representing the professional interests of the more than 220,000 dental hygienists in the United States. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support whole-body health through the promotion of optimal oral health. To learn more about the ADHA, dental hygiene or the link between oral health and general health, visit adha.org.

*"Advancing toward a self-governance
model in dental hygiene requires
coordinated policy actions"*

