



Greater Northern Australia Regional Training Network

PO Box 6811 CAIRNS QLD 4870

Dental Board of Australia

Submission Re: Draft Scope of practice registration standard and guidelines

Introduction

Australians living in rural and remote areas are generally not as healthy as those living in the cities¹. In spite of decreased mortality rates nationally, the mortality gap has remained constant (10% higher in regional, rural, and remote areas than in major cities). The mortality gap is influenced by the higher death rates of Aboriginal and Torres Strait Islander people who represent higher percentages of rural and remote populations. Significantly, poor oral health is likely to exist when general health is poor, and vice versa². Dental caries is the most prevalent health problem among Australians and periodontal disease is the fifth most prevalent health problem among Australians (AHMAC 2001). Data from 2004-2006 show that adults living in remote/very remote areas (38%), had higher rates of untreated decay than those in major cities (24%)³.

In addition to the seriousness of health issues and poor oral health in rural and remote Australia, there is a serious problem of maldistribution of the health workforce nationally, which significantly disadvantages regional, rural and remote communities, particularly in accessing some specialists and dental and allied health services⁴. These problems are likely to increase, especially considering that the rate of population ageing is faster in rural areas, with consequent higher demand on health services. Added to this foreseeable demand are influxes of different population groups to remote communities for mining and other activities. The themes, priorities and directions emerging from the literature regarding health care and workforce provision in rural and remote Australia and in comparable countries relevant to this consultation paper include:

¹ AIHW (2010a) Australia's Health 2010 Cat. No. AUS 122. Canberra: AIHW p. 245

² AHMAC (Australian Health Ministers' Advisory Council) 2001. Oral health of Australians: National planning for oral health improvement. Adelaide: South Australian Department of Human Services, on behalf of the Australian Health Ministers' Conference.

³ Chrisopoulos S & Harford JE 2013. Oral health and dental care in Australia: key facts and figures 2012. Cat. No. DEN 224. Canberra: AIHW.

⁴ Health Workforce Australia 2011. Rural and remote health workforce innovation and reform strategy, draft background paper, August 2011 (prepared by Siggins Miller).

- A system that supports maximising scopes of practice while ensuring quality and safety for consumers
- A system that allows time and resources for addressing the specific challenges of working and providing health services in rural and remote areas
- Locally-planned, needs-based service models
- Education programs, locations and ways of teaching that will provide the skills and knowledge to deliver such care

The Northern Territory, Western Australia and Queensland experience unique challenges with explicit and extensive intertwining of issues related to both the provision of clinical education and training and the recruitment and retention of an appropriate clinical workforce. These challenges are particularly apparent in the northern rural and remote areas of Western Australia and Queensland and throughout the Northern Territory⁵. In 2011 the Australian Health Ministers Conference (AHMC) endorsed the establishment of the Greater Northern Australia Regional Training Network (GNARTN) to address the clinical education and training issues of the Northern Territory, and the northern rural and remote areas of Western Australia (north of Carnarvon) and Queensland (north of Rockhampton).

GNARTN Purpose and Governance

There are many similar issues facing all participating jurisdictions in regard to both the provision of clinical education and training and the recruitment and retention of an appropriate clinical workforce. The purpose of the formation of GNARTN is to develop the best coordination of clinical workforce, and clinical education and training effort across the Northern Territory and the northern rural and remote areas of Western Australia and Queensland.

The Chief Executive of Northern Territory is the primary sponsor of GNARTN with GNARTN Council membership comprising representatives from each jurisdiction including: Directors-General and Chief Executives; Regional Training Networks; Indigenous; and Health Workforce Australia. A requirement for Council membership is for members to have knowledge of the needs and perspectives of the following groups within the geographic area of GNARTN:

- Health professional and health educators
- Learners at the various points within the clinical education and training continuum
- Various health care settings including Indigenous, aged care, mental health, community, primary and acute health
- Higher education providers including universities, TAFE and registered training organisations
- Various health sectors including the public, private and not-for-profit sectors, particularly in rural and remote settings
- Areas of health inequity

⁵ Greater Northern Australia Regional Training Network: Concept Discussion Paper, 2011. Developed in collaboration between Queensland Health, the Department of Health Western Australia and the Northern Territory Department of Health

GNARTN Response: Draft scope of practice registration standard and guidelines

In consideration of the significant disadvantages to rural/remote Australians in accessing dental and oral health services, and particularly for Indigenous Australians as outlined above, GNARTN is supportive of Option 2 (revised standard and publishing a guidelines document) as an important way forward in addressing health workforce needs and the maldistribution of the dental health workforce and improving oral health outcomes in rural/remote Australia.

Proposed Change	GNARTN Comments
1. Support the team approach to dental care	
<p>Insert additional point under Requirements: All dental practitioners are members of the dental team who work together within their particular areas of competence, to provide the best possible care for their patients.</p>	<p>A team approach to dental/oral health care is consistent with health service delivery/primary health care services in rural/remote areas – public and community controlled services. An expectation of all health professionals as per their professional code of conduct is to work within their particular area of competence and scope of education and training, and to provide the best possible care for their patients.</p>
2a. Reflection of practice	
<p>Amend to: Dental hygienists, dental therapists and oral health therapists are members of the dental team. They practise in a range of activities included in the definition of dentistry in which they have been formally educated and trained. They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners.</p> <p>Key deletions:</p> <ul style="list-style-type: none"> • They may practise in a range of environments that are not limited to direct supervision. • The definition of supervision. 	<p>As above, all practitioners must by law, registration and professional code of conduct, practice within the range of activities in which they have been formally educated and trained.</p> <p>Within the context of a rural/remote team approach to dental care, it is important that a dental hygienist, dental therapist and oral health therapist be able to practice independently within a structured professional relationship within the health team, and as required would seek professional advice and/or refer patients to the dentist and other health professionals as appropriate where there is need for advice or for direct referral when the problem is outside the scope of their formal education and training.</p> <p>It is the view of GNARTN that the structured professional relationship with a dentist in a rural/remote context includes provision of advice via telephone/telehealth facilities etc and does not require a dentist to be available on site. This is consistent with supervision models across other disciplines working in rural/remote contexts, and consistent with the proposed change below (2b).</p> <p>The standard needs more clarity around the concept of independent practice as defined within a structured professional relationship with a dentist who may or may not be on site.</p>

2b.	
<p>Insert a definition under Definitions of a structured professional relationship: Structured professional relationship means the arrangement established between a dentist and/or specialist dentist(s) or group of dentists, and a dental hygienist, dental therapist, oral health therapist, and/or dental prosthetist to provide professional advice, in relation to the management of patients within their scope of practice. It provides the framework for the referral of patients from the dentist and/or specialist dentist to the dental hygienist, dental therapist, oral health therapist and/or dental prosthetists, and referral to the dentist and/or specialist dentist when the care required falls outside of the scope of practice of the dental hygienist, dental therapist, oral health therapist and/or dental prosthetist.</p>	As above
2c.	
<p>Amend the definition to: Independent practitioner means a practitioner who may practise without a structured professional relationship.</p>	Change supported
3. Reduce the prescriptive nature of the standard	
<p>Amend to: Dentists and/or specialist dentists work as independent practitioners who may practise all parts of dentistry included in the definition of dentistry. Where there is a structured professional relationship or referral relationship then the dentist and/or specialist dentist is the clinical team leader.</p> <p>Key deletion: Dentists may supply and fit dental appliances for the treatment of sleep disorders. They must work in cooperation with the patient's medical practitioner who is responsible for the medical aspects of the management of sleep disordered breathing.</p>	<p>This change is consistent with comments above and therefore supported by GNARTN</p>
<p>Amend to: Dental prosthetists are members of the dental team. They work as independent practitioners in a range of activities included in the definition of dentistry.</p>	<p>While it is acknowledged that dental prosthetists are members of the dental team, dental hygienists, dental therapists and oral health therapists are also members of the dental team, and particularly within a rural/remote context, it is important that they are recognised as independent practitioners who may and must only practice and perform treatments for which they have been formally educated and trained in programs of study approved by the Board and in which they are competent.</p> <p>As per 2a above, the standard needs more clarity around the concept of independent practice as defined within a structured professional relationship with a dentist who may or may not be on site – as per the amendment for dental prosthetists (left)</p>

4. Further clarification of the standard

Publish a guidelines document that includes the following.

- **A description of the dental profession**
- **Education and training requirements** for oral health therapists and dental therapists on the treatment of patients of all ages
- **National Board approved programs which may extend a dental practitioner’s range of practice.**

The proposal that the current add-on program list becomes a historical document from 31 December 2013;

The range of skills listed in the guidelines form a new list of programs which lead to an extension of scope and will be effective from 1 January 2014.

Only programs which fit the range of skills and which lead to an extension of scope will be included in the Extension of scope of practice list of programs

Agreed

Contact:

Scott Davis

Senior Director GNARTN

0410 477 166