Professor Michael Woods  
Independent Reviewer  
Accreditation System Review  
NRAS

By email:  admin@asreview.org.au

Dear Professor Woods,

Re: Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions Discussion Paper

The Australian Dental Association (ADA) appreciates the opportunity to provide feedback on the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS/Scheme) for health professions Discussion Paper (Discussion Paper).

Discussion Paper Questions

The ADA’s response to the questions posed in the Discussion Paper is outlined below.

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

Dentistry is in a unique position from the perspective of accreditation functions as the Australian Dental Council (ADC) already accredits the education programmes of five distinct professions. Therefore, a significant amount of harmonisation already exists within dental accreditation processes.

The ADC already works within the existing frameworks established under the Australian Health Practitioner Regulation Agency (AHPRA) for the development of accreditation standards. These procedures support a common approach to the development of accreditation standards. In fact other Councils have used the ADC’s Accreditation Standards.

The ADC is trialing benchmark examinations of final year students to improve their accreditation processes.

The ADA recognises that cost-benefit analysis may result in some efficiencies of accreditation processes, however, cost savings alone should not drive change. Above all, integrity and quality of the accreditation process must also be maintained.
2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

It is the ADA's understanding that the ADC already integrates the decisions of TEQSA and ASQA in its assessment of education programmes utilising documentation prepared for TEQSA as part of accreditation reviews rather than require a facility to prepare additional material under the terms of a MOU.

The ADA would not support any moves to replace professional accreditation in favour of oversight for all accreditation functions by TEQSA/ASQA as it does not believe that TEQSA/ASQA assessment is adequate.

3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

It should be kept in mind that the NRAS only came into force from mid-2010. The NRAS was established to be the single registration and accreditation scheme for Australia's almost 660,000 health practitioners across 14 professions. Essentially, the NRAS in its infancy and the ADA urges that the Independent Review only suggest options that do not disrupt the current accreditation structures and processes established by the Scheme.

The ADC is moving towards a risk-based accreditation model from late 2017 and has been consulting with education providers in developing the approach to the revised accreditation model.

Using set accreditation review cycles allows the accrediting body and education providers to plan for this well in advance. It also provides a way to manage workflow.

The differences in the length of time between routine reviews of education providers' health programmes, is because these courses vary in length. There needs to be sufficient time for students to complete the course, provide feedback on their experience, and to feed this back into the course design before the accreditation review can occur. Also, some courses are accredited provisionally due to concerns about staffing, teaching facilities, clinical placement issues and other matters. These courses need to be reviewed on a shorter cycle than those where such matters are established.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and interprofessional collaboration?

There is potential to include more common nomenclature around the naming of assessment panels. Training for panel members should be conducted. Similarly, remunerations should be based on a standard schedule of fees for assessors with an increased remuneration for team leaders.

The ADC includes a professional staff member in the assessment panels to ensure greater consistency of application of the standards between panels.

5. Should the assessment teams include a broader range of stakeholders, such as consumers?

Assessment of professional education and training programmes requires expert knowledge of the profession, education pedagogy and competency. The ADA believes that consumers are not well placed to
contribute effectively to an onsite assessment team particularly professions that involve invasive and irreversible procedures. The asymmetry of knowledge could place a consumer in an invidious position that compromises their role. The ADC initially had consumers in assessment teams and found them unsuitable for this task for reasons listed above. However, the ADC does have consumers on its Accreditation Committee where they have been valuable contributors to the committee’s activities.

**Sources of accreditation authority income**

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

Fees and levies should be based on cost recovery.

The Independent Review is asked to recognise that while the ADA provides the dental profession’s opinion to feed into ADC public consultations, the ADC’s operations are totally independent of the ADA. From this perspective, the ADA is not able to comment comprehensively about all of the ADC’s operations. A general analysis of the efficiency and effectiveness of the ADC as an Accreditation Authority (AA) should assess information about its activities and the resources it uses to perform its functions.

The ADC media release of 28 February 2017 was issued for the benefit of the Independent Review and to add further information to complement the Discussion Paper. The ADC media release provides a detailed outline of the income and expenditure (Table 1), specific to the ADC’s accreditation functions and its activities (as opposed to the Discussion Paper [page 20], which focused on income and expenditure for all AA accreditation activities. These accreditation functions naturally include the assessment of overseas qualified dental practitioners.

<table>
<thead>
<tr>
<th>Australian Dental Council (ADC), all accreditation functions</th>
<th>Total Income and Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td>$6,523,125</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>$5,453,012</td>
</tr>
<tr>
<td>Total Surplus/(deficit)</td>
<td>$1,070,113</td>
</tr>
</tbody>
</table>

Source: ADC Media Release 28 February 2017

The ADA has compared the ADC’s income and expenditure as a proportion of income/expenditure of all AAs’ for their accreditation functions (Table 2).

<table>
<thead>
<tr>
<th>Differences between all Accreditation Authorities, all accreditation functions and Australian Dental Council (ADC), all accreditation functions</th>
<th>Total income and Expenditure</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Total Income (all activities)</td>
<td>16%</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>14%</td>
</tr>
<tr>
<td>Total Surplus/(deficit)</td>
<td>38%</td>
</tr>
</tbody>
</table>

Source: ADC Media Release 28 February 2017 & Accreditation Discussion Paper
The ADC’s proportion of income and expenditure as a portion of all AAs for all accreditation functions is considerable considering that dental practitioners constitute 3.3% of all registered health practitioners.

Noting that the ADC media release table extracted above disclosed three financial years’ worth of data, nonetheless, the ADC generated a surplus basis. More critically, the surplus that the ADC represented as a proportion of all AAs (Table 2) was considerable; an average of 40% of the surplus of all accreditation authorities was led largely by the ADC in 2013-14 and 2014-15. This means that the ADC was not being exceedingly costly in performing its accreditation functions.

The ADC’s media release also provided information on the accreditation of programmes activity that it has done (Table 3). There is an overall consistency of the activity performed in terms of the total number of programmes accredited and a total number of provider offering accredited programmes (approximately 62 programmes accredited and 18 providers offering accredited programmes).

The ADA notes the ADC’s total income and expenditure as a proportion of all AAs’ income and expenditure has dropped to 12% for income/expenditure in 2015/16; however, without more information it cannot be certain whether for example other AAs related to other registered health professions are increasing their share of the overall surplus.

Table 3: Summary of ADC Accreditation activities

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<thead>
<tr>
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<tbody>
<tr>
<td>Accreditation Standards Developed</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Accreditation Standards Reviewed</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>New programs accredited</td>
<td>7</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Programs re-accredited</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Programs monitored</td>
<td>10</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>58</td>
<td>61</td>
<td>64</td>
</tr>
<tr>
<td>Total Number of programmes accredited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Providers offering accredited programs</td>
<td>16</td>
<td>18</td>
<td>18</td>
</tr>
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<tbody>
<tr>
<td>Overseas qualified dental practitioners assessed</td>
<td>2,227</td>
<td>3,301</td>
<td>2,340</td>
</tr>
</tbody>
</table>

Source: ADC Media Release 28 February 2017

The Discussion Paper recognises the NRAS accreditation assessment and overseas comparison methodology must be rigorous

While the additional information provided by the ADC provides further guidance on its cost effectiveness, a more meaningful analysis can only be done if information on the number of accreditation activities performed (such as the accreditation of programmes performed, as outlined below) and number of overseas qualified health practitioners assessed is made available for all the relevant AAs across all the health practitioner types within the Scheme.
Considering the insight that the additional information pertaining to the ADC alone has provided makes it clear that the Independent review must take exceptional care in adopting an adequately rigorous methodology to assess the cost-effectiveness and efficiency of the accreditation aspects of the Scheme.

The Discussion Paper already acknowledges this need for an appropriately rigorous methodology by referring to the AHPRA Accreditation Liaison Group (ALG) Costing Paper (‘Cost of Accreditation in the National Registration and Accreditation Scheme’); which questioned the Professional Standards Authority analysis (commissioned by the NRAS Review) which argued that accreditation costs within NRAS was considerably more expensive than quality assurance of higher education programmes performed by regulators in the United Kingdom (UK); and accordingly the use of separate accrediting councils may be more costly.

The comparison with the UK system, which included the Health and Care Professions Council (HCPC) and seven individual accreditation bodies, and interpretation of the cost data, is questioned by the ALG. The ALG advises that accreditation fees charged to education providers increased initially with the introduction of NRAS due to multiple factors including higher expectations from a national system and a broader role for accreditation authorities.

The ALG also cites the difference in scope and intent between the two systems such as different legislative frameworks, a narrower range of functions for some of the UK authorities, and the involvement of other (uncosted) bodies undertaking the activities required of the Australian accreditation authorities. The Costing Paper claims that Australian roles, such as facilitating workforce flexibility and education innovation, are outside of the remit of comparable authorities in the UK. The ALG also claims that the respective workforces, funding models, operational process, professional risk profiles, scale and history call into question the validity of the calculations and comparability. However, the Costing Paper does not provide further detail on the cost of these (additional) factors or how they impact on the core accreditation processes.1

The financial data in the Costing Paper cannot be directly compared to the PSA work as it covers different time periods when NRAS was in distinctly different stages of maturity and activity. Further, the NRAS Review costing figures were based largely on the financial year figures for 2013/14 and data from the establishment of NRAS, whilst the ALG Costing Paper uses data from 2013/14 until 2015/16.

This Review has also undertaken a preliminary investigation into systems in other countries, including Canada and the USA. However, without a detailed analysis of each element of the accreditation process across jurisdictions (both in Australia and overseas), it is difficult to undertake a direct comparison of the cost of accreditation across international systems. These primarily relate to the differing nature of health practitioner registration schemes and accreditation arrangements, governance within those schemes and intersections with other parts of public administration (such as education portfolios).

Further exploration of accounting methods, accrual versus cash-based financial year figures, definitions of activities, income versus expenditure mapping and definitions in the UK and elsewhere, as comparators for the Australian system, will be progressively worked through with accreditation authorities.2

The ADA urges the Independent Reviewer to ensure that a rigorous explanation and rationale for the methodology used in any further comparison and efficiency/effectiveness analysis be provided for public scrutiny and input.

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7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

These fees should not be used to cross-subsidise accreditation functions for onshore programmes because these income streams may change significantly over time. Policy decisions beyond the control of the accrediting body could significantly impact this income stream. If onshore programmes become partially dependent on these income streams, their ability to continue to function effectively could be threatened if government policy decisions lead to reduced income.

An example of this is changes to the Skilled Occupations List (SOL – recently renamed as the Medium and Long-term Strategic Skills List MLTSSL). This list determines the eligibility of various overseas health professionals to apply for skilled migration visas, which is reviewed on an annual basis. Dependence of an accrediting body on particular income streams could also lead to a conflict of interest. Accrediting an increasing number of courses may generate more income for the accrediting body, but this may not necessarily be in the best interests of the workforce, or the public if that workforce is in oversupply.

**Input and outcome based accreditation standards**

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

It is appropriate to maintain the option to include some input or process-based standards. A good example is minimum number of clinical placement hours.

9. Are changes required to current assessment processes to meet outcome-based standards?

The ADA does not believe any changes to the current assessment process for dental programmes is required.

**Health program development and timeliness of assessment**

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

The ADA participated in the consultation process undertaken by the ADC related to the development of the professional competency frameworks. While they were improved, the ADA was critical of some of the competencies developed as they fail to sufficiently differentiate the abilities and outcomes expected of each type of dental practitioner – in particular, clinical competencies. The ADA would, therefore, be opposed to the possibility of dental competencies being further diluted.

There should be a clear separation between professional competencies and accreditation process of education providers for the reasons given in response to question 11.

The ADA is unsure of the benefits in having consumers involved.
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

Risk:

Over-generalisation of health profession accreditation standards could reduce the level of detail listed in the requirements. This could result in the accreditation of some courses that produce graduates who are not sufficiently prepared to practise to the high standard that the community needs and expects. The public safety aspect must be considered. Any system that has generic standards must refer to related professional competencies and so the reason for these to clearly differentiate different practitioners.

Benefit:

Alternatively, providing consistency between accreditation standards could be used as a tool to ensure that certain expectations of newly graduated health professionals are consistently addressed through the alignment of education programmes, such as the need for interprofessional collaboration, and cultural responsiveness.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

Currently, dentistry is in the unique position of producing more graduates than Australia requires to meet the demand for services. Even if additional funds were injected into the public dental systems, there are more than sufficient graduates entering the workforce and existing capacity in the private sector to absorb the workload.

This current and projected workforce oversupply must be a consideration by the ADC should an education provider wish to have a new programme of study accredited. Current analysis indicates projected workforce oversupply until at least 2025.

Interprofessional education, learning and practice

13. How best could interprofessional education and the promotion of interdisciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

The ADA believes that interdisciplinary practice is a quintessential aspect of modern dental practice and requires educative aspects within the formal degree process. The current standards and professional competencies address this issue.

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

The ADA does not have a position on this matter.
15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

Accreditation processes should expect to see evidence that contemporary education pedagogy approaches underpin curricula. However, given the nature of the invasive and irreversible procedures regularly performed as acts of dentistry, there cannot be a reliance on simulated care training. There must be procedures performed and assessed upon real life patients.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

Yes, if the period of supervised practice is related to the level of responsibility held by that practitioner, the complexity of the work expected of them, and the risk profile of that profession. Each health profession would have a different risk profile. For example, the ability to prescribe and dispense medications, the level of invasiveness of procedures, or the types of patients that would typically be treated, and the role of that category of health professional in the healthcare team (team member or team leader), would all contribute to the risk profile of that profession.

This is becoming an increasingly important issue now that more dental practices are owned by non-registered persons and corporations. Whereas historically young practitioners could expect to obtain mentoring support in their first job after graduation, the availability of this support can no longer be assumed.

The ADA supports the concept of one-year post-graduate programmes provided that they are based on mentoring and continuous professional development to enhance the knowledge and skills of the graduates and not just the provision of services. In particular, they should be developed in conjunction with a range of stakeholders including recent graduates, education providers, experienced practitioners and professional bodies and provide:

- participants with a predictable and structured first year of post-graduate practice that offer exposure to areas of practice which will build on the experience and education provided in entry to practice training;
- exposure to a range of settings in major cities, inner regional, outer regional and remote areas and across specialist services;
- placements which are separate and do not compete with student clinical practice placements, and
- participants with appropriate recognition of their participation.

In addition, there must be, for each placement, a formal agreement which clearly defines the roles and responsibilities of all parties and participants must be engaged under an employment arrangement.
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Dentistry is a clinically based profession by and large. The onus of competency at the completion of a course should be derived from assessment over the years of the course. The ongoing assessment must include both diagnostic and clinical execution of skill sets being examined by competent and suitably qualified and experienced teaching staff as each competency level is met.

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

The ADA believes that there is little if any evidence to suggest that this provides better outcomes and as such does not support national examination and that no further educational assessment shall be required for any student graduating from a course accredited by the ADC to gain registration with the Board.

A student is better assessed over a whole course than just at one examination where they will be examined in a limited area of knowledge. Courses leading to registration as a dentist aim to produce a graduate with a broad range of knowledge and the necessary critical thinking skills to apply their knowledge in a clinical setting. There is a risk that education providers will teach only to an examination rather than offer a variable experience.

However, trialing the use of benchmarking examination as the ADC is doing is supported.

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

Within these questions, the discussion paper appears to assume that National Boards are either not empowered, or not equipped to take the evolving needs of health consumers into consideration when making decisions about accreditation and registration, or that this is not their role. What evidence is there to support this?

The ADA understands that since the establishment of AHPRA and the National Boards, accrediting bodies have been brought together for workshop programmes designed to address these issues. Such practices are supported and should be encouraged into the future. Representation at such forums should be expanded to include the profession more broadly.

This issue is the reason the ADA supports discipline specific boards as is the case currently.

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

The discussion paper asserts that “The current subsidiary relationship of accreditation authorities to National Boards has the potential to constrain the most appropriate education and training of health
practitioners. National Boards, by virtue of their role and composition, may institutionally (and arguably appropriately) be risk-averse and also not necessarily have the expertise in education approaches and the changes needed for a rapidly evolving health system.”

The ADA is not aware of such constraints being placed on the ADC.

Student health practitioners should be trained in evidence-based treatment that is current best practice rather than emerging techniques or philosophies that are yet to be fully tested or accepted as best practice by the professions. Since accreditation standards define the minimum standard practitioners must reach to be eligible for registration, and the two functions are closely linked, it is reasonable that the National Boards be responsible for approving these standards.

Approval of programmes of study against the accreditation standards including professional competencies however, does appear to be a process that would be more appropriately assigned to accreditation bodies. It does not seem necessary to assign this responsibility to the National Boards, unless they take additional criteria into consideration that the accreditation bodies do not, and this should be avoided so that time and effort are not wasted by the accrediting bodies.

Query about discussion paper comments on p.52:

“The Corporations Act 2001, Australian Securities and Investments Commission Act 2001 and various standards or guidelines issued by the Australian Securities and Investments Commission or the Australian Charities and Not-for-profits Commission may not always be in sync with a council’s obligations in running a scheme for public benefit.”

Does this mean that there could be a conflict of interest at the governance level, because it is important to be financially solvent, and thus there would be pressure to cut costs while increasing the number of programmes that are accredited?

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?

The ADA believes that the current mix of community representation on the ADC Board and committees is appropriate. As indicated previously, it is more important that those involved in making accreditation decisions have the necessary expertise and knowledge of accreditation processes and purpose.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

The board of a Dental Accreditation Authority should be composed of persons with the appropriate skill set to carry out its function. It should include dental practitioners (a diverse mix of academics and clinicians) and lay persons but only include one Head of School who must not be the President or Chair. They should be selected based on the capacity of there not being potentially any conflicts of interest.

Both the examination and the accreditation committees must include dentists as members.

The examination committee and accreditation committee should be composed of persons with the correct skill mix including dental practitioners (a mix of academics and clinicians) and lay persons.
23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

The ADA does not have a position on this matter.

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

The ADA does not have a position on this matter.

What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

The ADA does not support the establishment of a single accreditation authority.

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

The ADA does not have a position on this matter.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

The ADA does not have a position on this matter.

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

The ADA believes that the Ministerial Council should not have any role on this matter.
29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

The ADA does not have a position on this matter.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

As a minimum, the ADA believes regular engagement and consultation with stakeholders is essential as a governance and transparency requirement. Workforce requirements must be driven by demand and ADA is unsure what "INNOVATIVE" workforce models encompass and what work redesign means with respect to dentistry.

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

The ADA does not have a position on this matter as it relates to specialist medical training and practice and not dentistry.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

It is in the interests of both the dental profession and the public that appropriate, clearly defined and transparent standards and appropriate workforce requirements should be in place to govern the assessment, recruitment and training of overseas qualified dentists (OQDs).

The ADA believes that where there is a workforce oversupply that the recruitment of OQDs should cease except for research and academic positions but where such assessments are conducted, the National Board should be responsible and they must ensure that the skills and knowledge of OQDs are of the same standard as Australian-trained dentists.

33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

Assessment of OQDs is currently done by the ADC on behalf of the Dental Board of Australia and the ADA supports no change.
34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

The ADA believes there is potential to achieve such an outcome however, given the risks vary from profession to profession there will always need to be specific assessments e.g. dentistry is invasive and so higher risk than more consultation based professions.

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

The ADA does not support any lowering of standards of registration and so supports that OQDs must be of the equivalent standard and have the same competency as local graduates. Currently OQDs who have passed the ADC examination do not requires supervised practice.

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

The ADA supports the current system for registration of OTDs and is of the opinion the current system adequately covers grievance/appeals related to accreditation of OTDs.

37. If an external grievance appeal process is to be considered:

- Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
- Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

The ADA does not have a position on this matter.

Yours sincerely,

Dr Hugo Sachs
President