Submission to Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

MAY 2017
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INTRODUCTION

The Australian Dental Council (ADC) is the appointed accrediting authority under the *Health Practitioner Regulation National Law Act 2009*. The ADC welcomes the opportunity to respond to the Accreditation Systems Review, commissioned by the Australian Health Minister’s Advisory Council (AHMAC), as it is acknowledged that there are many opportunities in the National Registration and Accreditation Scheme (NRAS) which should be highlighted. Some of these opportunities are naturally evolving through the maturity of the NRAS and would benefit from promotion, funding and a reassessment of the governance of such opportunities.

The ADC notes the Independent Reviewer has grouped the discussion paper into three themes being:

1. Improving efficiency;
2. Relevance and responsiveness; and
3. Producing the future health workforce.

The ADC has chosen to respond to each question posed by the Independent Reviewer and, where possible, has provided evidence or commentary to support our comments. In addition, the ADC has provided in its Preface to this submission, a vision of the opportunities that exist in accreditation which would start to better address the future health workforce need.

We would welcome further opportunity to engage with the Independent Reviewer should there be occasion to further support or provide explanation of any part of this submission.

Professor Michael Morgan  
President  
Australian Dental Council

Mrs Narelle Mills  
Chief Executive Officer  
Australian Dental Council
PREFACE

National Oral Health Strategies in the Australian Health System

The effectiveness and efficiency of accreditation of Australian dental practitioner programs needs to be considered in the context in which the practitioner will work. The Australian Health System is funded for treatment rather than prevention. There are acknowledged national initiatives which offer the hope of prevention and/or early intervention, such as the Child Dental Benefits Schedule (CDBS), but frequently these programs are simply not getting to the root of the problem because of a number of issues including a piecemeal approach which is not integrated with broader health outcomes and a lack of continuity of such programs. As at September 2016 only a third of eligible children had accessed the CDBS since its introduction in January 2014 and it was almost scrapped by the Turnbull government in favour of a Child and Adult Public Dental Scheme. Furthermore, whilst public dental services are largely the remit of individual states and territories which may provide opportunities for innovative solutions to manage the burden of dental disease (e.g., a common risk factor approach to promoting dental health), the majority of dental services are provided through private dental practitioners where funding for interdisciplinary approaches is limited despite an evidence-base which demonstrates an interprofessional approach is successful (e.g., caries management system which involves psychology intervention See: The Caries Management System: are preventive effects sustained post clinical trial? Evans et al., Community Dent Oral Epidemiol 2016).

The National Oral Health Plan 2015 – 2024 ‘Healthy Mouths Healthy Lives’ is clear in its articulation of the national goals, guiding principles, foundation areas and priority populations. It also provides a summary of progress against the first National Oral Health Plan (2004-2013) which includes some acknowledged significant achievements. The fine print in the front of this publication tells us that the Plan was prepared by the Oral Health Monitoring Group, a sub-committee of the Community Care and Population Health Principal Committee reporting through AHMAC to the Council of Australian Governments (COAG) Health Council; but who is really responsible for the accountability of all identified entities within that Plan which have roles in relation to the achievement of these goals? Accreditation entities sit alongside other entities and cannot be considered in isolation.

Social determinants of oral health include many factors such as social, economic, environmental, behaviour, biological in addition to access to care and oral health literacy.1

Professor Sir Michael Marmot in his 2013 UCL Institute of Health Equity publication ‘Working for Health Equity: The Role of Health Professionals’2 states that this paper was produced in response to its precursor publication now known as the Marmot Review or Fair Society Healthy Lives which looked at, in part, whether doctors should be involved in understanding the ‘causes of the causes’ or to better understand their role in prevention. Working for Health Equity called on professions to define ‘statements for action’ which were written and endorsed by education providers or professional associations and outlined the role of the practitioner in addressing social determinants of health.

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1 Australian’s National Oral Health Plan 2015 - 2024, page 6, accessed 20 April 2017
For the dental team this included the following observations:

*Given the close links between oral health and other indicators such as family income and educational attainment of children and parents, a wholesystems approach to improving oral health in the context of general health is required. Some of the principles that must underpin action include:*

- Tailoring the response to the level of oral and general health need;
- Building on community assets and strengthening family competence to self-manage health, including oral health;
- Placing emphasis on early years and early intervention;
- Taking a family focus; and
- Taking a personalised approach to delivering services.³

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### What is Oral Health?

The widely accepted definition of oral health is that which was adopted by the FDI World Dental Federation in late 2016 which states that oral health:

- Is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex;
- Is a fundamental component of health and physical and mental wellbeing. It exists along a continuum influenced by the values and attitudes of individuals and communities;
- Reflects the physiological, social and psychological attributes that are essential to the quality of life; and
- Is influenced by the individual’s changing experiences, perceptions, expectations and ability to adapt to circumstances.⁴

This definition emphasises the enormous affect poor oral health can have on an individual and how important the role of good oral health is to the overall well-being of Australians. According to Dr Michael Glick, co-chair of FDI’s Vision 2020 Think Tank, this new definition adopted in September 2016, “…moves dentistry from treating disease to treating a person with disease”.⁵

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³ *Ibid., Page 93*


Dental Professions in Australia

Under the Health Practitioner Regulation National Law Act 2009 (National Law), the dental professions are broken into five (5) divisions; dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists. Dentists with specialist qualifications can be registered as a dental specialist in one of 13 recognised dental specialties. All dental practitioners are members of the dental team who exercise autonomous decision making within their particular areas of education, training and competence, to provide the best possible care for their patients. The Dental Board of Australia (DBA) further describes the relationship of the various roles within the dental team with the dentist being the ‘clinical leader’ when a structured professional or referral relationship is in place. This model relies on all dental practitioners working within their own individual scope; that is in accordance with their education and competence.

Education providers delivering dental programs in Australia range from TAFE to universities and private providers (specialist colleges). This results in dental programs being delivered across a range of settings and levels in the Australian Qualifications Framework (AQF) as well as outside of the AQF in the case of specialist colleges. The range of providers may be structured or operate in very different ways, and may be subject to regulation by the Tertiary Education Quality and Standards Agency (TEQSA), the Australian Skills Quality Authority (ASQA) or, in the case of specialist colleges, neither.

Accredited programs work in collaboration with the public dental health services in each jurisdiction. Most have specific agreements in place which outline contractual requirements between the provider and the public dental health service regarding the use of public dental facilities and patients for students under supervision and funding relationships and assurance of provision of exposure to clinical experiences required to achieve the competencies of a newly qualified practitioner by graduation. These relationships vary from state to state and can, at times, influence the ADC assessment of the viability of a program and the suitability of clinical experience (in both patient mix and capacity). More than 80% of dental practitioners work in private practice and an increasing reliance on public health patients being treated in private practice; and with that an increasing burden on the assurance of the private practice standard and funding models which are dependent on Commonwealth funding with no certainty of continuation beyond 2019.

Admissions to dental programs are a mixture of direct entry and post-graduate with the current average ATAR score to enter dentistry in Australia being in the high 90’s, and most schools have selection criteria in addition to academic achievement. Although variation exists across programs with the introduction of direct patient care by students, typically students are introduced to clinical practice through simulation learning prior to commencing dental treatment with patients, under supervision, as the operator. The transition from the simulated environment to direct patient treatment is tightly managed with education providers including barrier examinations and tests that must be passed before this transition is allowed. The ADC, through its Accreditation Standard, requires education providers to demonstrate that all of their students are deemed to have acquired the necessary competencies prior to providing care to patients.

Dental therapists are educated to work with children and young adults. A Dental Hygienist will also see children and adults. Oral Health Therapy is a newer profession and this dental practitioner has dual qualifications in dental hygiene and dental therapy. In some cases Oral Health Therapists may also see adult patients. This is dependent upon the undergraduate program they undertook, or if they have done a post-graduate qualification in adult scope of dental therapy practice.

**Transition to the National Registration and Accreditation Scheme**

When the National Registration and Accreditation Scheme (NRAS) was introduced in 2010, transitional arrangements included “grandfathering” in of existing processes and entities which were previously undertaking these roles. The ADC was such an existing entity and therefore already had in place accreditation standards and attributes and competencies for each of the general dental professions recognised under the National Law. NRAS was conceptualised by the government as a profession specific, title based approach (as opposed to a scope of practice regulatory model such as the Health Practitioners Competence Assurance Act 2003 in New Zealand) to the regulation of specific health practitioners, including regard for innovation in education and meeting the future workforce need. These latter objectives are unlike most health practitioner regulatory frameworks in place in the OECD countries.8

With the introduction of NRAS came an increased focus on monitoring under the National Law without defining what monitoring would entail.9 The Health Professions Accreditation Councils Forum (HPACF) approved Guiding Principles for Accreditation in 2016 which included a commitment to consistent and proportionate approaches to provider accreditation and monitoring roles.10 The ADC published its monitoring framework in 2015 which was developed in consultation with education providers to ensure the framework was proportionate and accepted.11

The DBA also recognises a number of programs for extended scope or endorsement on the register of practitioners.

A number of extended scope programs have been designed to allow dental practitioners to extend their education, training and competence in certain areas and within the division in which they are registered. The ADC currently is involved with the accreditation of these programs, however the DBA is phasing out the approval of these programs in a transition phase which concludes at the end of 2018.

The DBA has also recently released approved competencies for endorsement of dentists for Conscious Sedation which the registration standard now references and has requested the ADC review and accredit existing courses leading to endorsement.

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9 National Law, op. cit., Part 6 Accreditation, [s50] Accreditation authority to monitor programs of study
10 Health Professions Accreditation Councils’ Forum, High Level Principles June 2016, available via http://www.healthprofessionscouncils.org.au/files/2cadbe6ec554a48836e6d0d60e54834d33349d6f_original.pdf, accessed 20 April 2017
Accreditation standards for dental practitioner programs

The Australian Dental Council / Dental Council New Zealand accreditation standards includes the following attributes outlined in Table 1 below.

Table 1: ADC / DC(NZ) Accreditation Standards for dental practitioner programs

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<th>Standard Statement</th>
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<td>1. Public Safety</td>
<td>1. Public safety is assured.</td>
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<tr>
<td>3. Program of study</td>
<td>3. Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies.</td>
</tr>
<tr>
<td>4. The student experience</td>
<td>4. Students are provided with equitable and timely access to information and support.</td>
</tr>
<tr>
<td>5. Assessment</td>
<td>5. Assessment is fair, valid and reliable.</td>
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Each Standard Statement is supported by a set of Criteria. The Criteria are indicators that set out what is expected of an ADC accredited program to meet each Standard Statement.

The Criteria are indicators and NOT sub-Standards. When the ADC reviews a program for accreditation, the ADC considers if the Criteria are met, but takes an on-balance view of whether overall the education provider has shown that a Standard Statement has been met.
This accreditation standard forms the basis for the ADC accreditation framework as shown in Figure 1 below.

![Figure 1: ADC Accreditation Framework](image)

This is now the same ‘framework’ being used by the Australian Physiotherapy Council, Australasian Optometry Council, Australasian Council on Chiropractic Education, Australian Psychology Council, and is currently under review for adoption by the Occupational Therapy Council; therefore a shared framework for accreditation standards will be adopted by almost 50% of the regulated health professions within the next 12 months.

**International learning**

International research is showing us that shared frameworks for measurement ensure learning and innovation. The International Consortium for Health Outcomes Measurement (ICHOM)\(^\text{12}\) is a leading advocate in developing a model which harnesses the input of health practitioners and consumers by recognising value-based health care (VBHC) and its transformation of funding and policy in health care. It addresses, head on, the unsustainable cost of current models of care which are being felt globally and uses agreed, shared and adopted frameworks and learnings to assure improvement in patient outcomes.

\(^\text{12}\) [http://www.ichom.org/](http://www.ichom.org/)
ICHOM examines patient reported outcomes utilising a values equation which equals the health outcomes that matter to patients divided by the costs of delivering those outcomes. Outcomes are also defined by the ‘condition’ rather than the specialities or procedures which automatically assures a patient centred care model must be adopted.

ICHOM defines what is called a ‘standard set’ which outlines the outcomes that matter most to patients by integrating the voices of the consumers with the leading experts in specific global diseases. It then defines a standardised way to capture patient reported outcome measures (PROMS) as well as clinical data, which is then shared globally. What makes this an attractive approach is its applicability to the way in which accreditation cross professionally could work.

Take for example the ICHOM Standard Set for Dementia as shown in Figure 2 below:

![ICHOM Standard Set for Dementia](http://www.ichom.org/medical-conditions/dementia/) accessed 20 April 2017
And compare it to the ICHOM Standard Set for Depression and Anxiety\(^\text{14}\) shown in Figure 3 below:

Figure 3: ICHOM Standard Set for Depression and Anxiety

The two frameworks deal with two different conditions, but the concepts and approach apply the same principles, include suggested measurement tools for tracking outcomes, and ultimately lead to better care and innovation in models of care through shared learning. They are developed through a close collaboration between consumers and practitioners to ensure a patient centred framework is achieved.

ICHOM states that, “By 2017, we aim to have published Standard Sets covering more than 50 percent of the global disease burden”. One of the conditions in progress or ‘ramping up’ is oral health and the ADC is grateful to the Dental Health Services Victoria for their leadership in contributing to the development of this Standard Set and for commencing an innovation in clinical models of dentistry conversation.

Shared accreditation frameworks – opportunities and limitations

Accreditation authorities could apply these same principles through a shared framework for accreditation standards, with agreed measurement definitions or references which ‘matter to the objectives of the NRAS’.

Imagine a framework developed for capture of outcomes measuring accreditation contribution to improving Aboriginal and Torres Strait Islander Health Outcomes or another framework looking at the effectiveness of accreditation in measuring inter-professional education as it relates to a set of rural and remote health issues? Importantly, this model is outcomes-focussed on target issues whether they be related to specific populations, disease entities or other key health problems facing Australia.

For this approach to work, we need to have the flexibility to recognise legitimate and justified differences between health professions; and accept them. However, we also need an approach which enforces a need to look up from our own professions, beyond the current definitions of scope of practice and traditions and ask questions. In dentistry this could be a simple question such as are the current structured professional relationships between a dental hygienist or dental therapist and a dentist, optimal for the Australian community or could other health team relationships be considered? Or the questions could be bigger. What is the role of dental accreditation in advocating for all professions which have a practitioner/care relationship with the Australian public, including professions such as teachers, aged care and child care workers, in providing guidance around embedding core or fundamental knowledge of good oral health within their respective accreditation standards and programs? What can we enable a practitioner outside of dentistry do that is traditionally the job of the dental practitioner and vice versa (for example a rural GP, nurse practitioner or dentist) for the good of patient outcomes?

Importantly, any changes which may influence accreditation activities such as changes in scope of practice, models of care or workforce, will require underpinning by robust research. Australia’s most recent approach to exploring such innovative transformations was through the now abolished Health Workforce Australia (HWA). Consideration needs to be given to resourcing innovation across the health professions and this could be managed through a core representative group and funded for example by a portion of registrant fees.

If the vision remains narrow or there is an unwillingness to engage in these discussions regarding the future health needs and health workforce needs, interprofessional education or other initiatives will fail before they begin simply because they have no purpose. To what end are we encouraging the principles of interprofessional education? The future of the dental workforce will shift significantly over the next 20 years and, just as is happening in areas of medicine, there will be a need for a broader skilled workforce. In the world of oral health care, this could suggest an increased reliance on dentists providing specific surgical care alongside medical practitioners and other allied health care practitioners and a greater focus on Oral Health Therapy education for the broader community. This is already being recognised through the recent removal of approval of extended scope programs and delineating between entry to practice competence and Continuing Professional Development (CPD). Removing extended scope leaves a gap which consumers will expect is managed through the primary qualification rather than relying on a practitioner working only within their scope.

Consumers can rightly expect a clear and transparent understanding of what a practitioner or a ‘health care team’ can be expected to provide. They can also expect in the future that models of care will be patient led (as opposed to patient centred which we are currently working towards),
supported by technology and information in real time, with a focus on the patient wellness at the centre of the care model as we are seeing with the ICHOM Standard Sets.

So how does the dental education model ensure it remains in step with the future health workforce need? The ADC currently collects data sets relating to its accreditation standards. These data sets were defined in consultation with education providers to ensure their relevance and availability for reporting. The ADC is now sharing this framework with the other accreditation authorities that are moving to the ADC accreditation standard framework as a basis for greater sharing of measurement against particular domains and standards; and in the future the potential to measure more accurately the direct impact of accreditation of programs on the health of the Australian population. This will also lead to greater sharing of metrics for the same provider, and in turn lead to a more risk based and proportionate approach to accreditation. This could be facilitated by a single entry portal by providers responding to the agreed metrics across a number of the cross professional areas but also allow for the more technical or profession specific areas to be captured as well. The current governance and funding arrangements are not designed to enable this and a lot is dependent on the work plans of individual accreditation authorities, individuals in leadership positions and funding available.

Professor Sir Michael Marmot writes, “The Merseyside Fire and Rescue Service made a lasting impression. …. Their compelling story was of going outside their core professional practice of fighting fires to preventing them, which entailed engaging with the local community. They then became involved in looking at quality of housing, and at smoking, which are fire risks, to more general issues that benefit the community, including activities for youngsters and older people. If the fire fighters can do it, why not the doctors?”

It’s no longer a question of why can’t we do this, it’s a question of why aren’t we all already doing this?

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15 IHE, op. cit., Foreword, page 3
INTRODUCTION TO THE AUSTRALIAN DENTAL COUNCIL

Accreditation Functions

The Australian Dental Council (ADC) is the appointed accrediting authority for the dental professions in Australia under the Health Practitioner Regulation National Law Act 2009\textsuperscript{16} (National Law).

The National Law defines accreditation functions as:

(a) developing accreditation standards for approval by a National Board; or
(b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or
(c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia; or
(d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession; or
(e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d).

Of the above defined accreditation functions, the ADC currently undertakes activities relating to (a), (b), (d) and (e) which specifically include:

1. Accreditation of all dental practitioner programs (including dentistry, oral health therapy, dental hygiene, dental therapy, dental prosthetics and dental specialist programs);
2. Assessment of knowledge, clinical skills and professional attributes of overseas trained dental practitioners seeking registration practise in Australia;
3. Accreditation of extended scope programs of study; and
4. Providing advice to the Dental Board of Australia (DBA) regarding the above functions.

In addition to these functions, the ADC also undertakes related activities including:

1. Designated Skills Assessing Authority for Australia’s skilled migration program for Dentists and Dental Specialists (ANZCO 252312, 252311);
2. Development and/or review of standards (such as the review of the professional competencies for the dental professions in 2015);
3. Other projects as requested (such as the development of a specialist assessment model in 2017 on behalf of the DBA).

\textsuperscript{16} National Law, op. cit.
The ADC also currently has in place, Memoranda of Understanding with the following organisations:

- Commission on Dental Accreditation Canada (CDAC) – enabling Australian graduates from accredited programs to be eligible to sit the Canadian National Examinations and for Canadian graduates to be eligible for registration in Australia;
- Tertiary Education Quality Standards Agency (TEQSA) – enabling shared reporting and collaboration; and
- Dental Council New Zealand (DC(NZ)) – a Joint Accreditation Committee using the same accreditation standard.

The ADC does not currently undertake the following accreditation or related functions:

- Assessment of knowledge, clinical skills and professional attributes of overseas qualified dental specialists;
- Assessment of overseas authorities (as defined in (c)); and
- Skills Assessments of overseas qualified dental hygienists, dental therapists and/or oral health therapists seeking to migrate to Australia\(^\text{17}\).

\(^{17}\) VETASSESS and Trades Recognition Australia are the respective, approved Skills Assessing Authorities for these professions.
1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

The ADC supports the existing mechanisms already in place which assure consistency in the development of accreditation standards by accrediting authorities, while maintaining some flexibility for requisite variation of approaches between professions based on scale, work load or risk profile.

Some unnecessary variability can however be observed in the processes associated with the:

- approval of accreditation standards by National Boards; and
- application of accreditation standards by accrediting authorities.

The ADC believes that consistency and commonality in the approval and application of standards is where the greatest net benefit can be achieved.

Commonality in the development of accreditation standards

All accrediting authorities must adhere to the AHPRA Procedures for the development of accreditation standards publication\(^{18}\) which describes a common and consistent approach to the development of accreditation standards. It also ensures that any proposed, or reviewed accreditation standard adheres to, or takes into account the following:

- Objectives of the Scheme;
- Consultation requirements as described in the National Law;
- International standards comparisons; and
- COAG Principles for Best Practice Regulation.

The National Law also allows for Ministerial Council direction to a National Board in relation to new or proposed accreditation standards where there may be impact on recruitment or supply of health practitioners and/or quality and safety of health care.

It is not unusual for the review/development of an accreditation standard to take 12 – 18 months from commencement to approval by a National Board, depending on the feedback during the consultation stages of the review and development of the standard. This is in addition to several revisions usually required by the respective National Board in consideration of approval of a standard. While accountability for assuring the process for wide ranging consultation and the objectives of the Scheme have been considered through the process, the length of time it takes to approve an accreditation standard is contrary to a responsive accreditation system.

Some greater flexibility to undertake an abridged or fast tracked process to responsively embed government health policy which affects one or more regulated health professions should be made available.

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The Health Professions Accreditation Councils Forum is currently undertaking a review of minimum standards promoting an understanding of quality use of medicines in all accredited health practitioner programs in Australia, regardless of whether you are already permitted to ‘prescribe’ or not. On achieving an agreed wording for embedding in all accreditation standards, the current procedures will mean that each accrediting authority is required to undertake each consultation step; and in many cases seek feedback from similar if not the same sets of stakeholder in addition to the respective professional bodies. While these limitations are recognised and the Forum is considering a collective approach to these joint stakeholders, the inflexibility of en masse update where there is clear mandates (and accreditation is the appropriate place for embedding such initiatives) of standards is a limitation.

Consistency across accreditation standards has also been a particular focus of a number of the accreditation authorities over the past 2 years.

The cycle of review of accreditation standards is usually five (5) years, or as agreed with the respective National Board. The ADC reviewed its’ accreditation standard in 2014 which took effect as of 1 January 2016. Subsequently, the ADC Accreditation Standards for Dental Practitioner Programs have now been used by the Optometry Council of Australia and New Zealand, the Australian Physiotherapy Council, the Council on Chiropractic Education Australasia and the Australian Psychology Accreditation Council, as a basis for review of their respective accreditation standards with the Occupational Therapy Council Australia and New Zealand commencing consultation on its accreditation standard in the coming months based on the ADC standard.

The ADC has been keenly watching the evolution of its accreditation standard as adopted by other accrediting authorities. Feedback provided to the ADC has been positive in its applicability cross professionally and has therefore enabled a consistent approach to the spirit and structure of the standard being maintained, with the addition of specific wording where there are justified technical differences between professions occur.

However, it has been reported that the range and number of conversations between National Boards and their respective accrediting authorities has now led to potentially very significant changes to the accreditation standard which, if adopted, would alter or would have altered the overall approach to accreditation being consistent.

The ADC is aware that such suggested changes from National Boards to accreditation authorities included:

- Changing the design principles by making every criteria a part of each standard (some accrediting authorities were able to oppose this with justification and stayed consistent with ADC arrangement; others have had to agree to this change);
- Changing the wording (and in the process the meaning of) a particular Standard Statement - Standard 3, from the program ‘enabling’ to the program ‘ensuring’; and
- Changing the wording of some criteria within statements (several issues have been raised by accreditation authorities regarding approval of their Standard).

Only the optometry and physiotherapy accreditation standards have been approved and published at the time of this submission. A mapping document of the approved/proposed standards has been prepared by the ADC for the Accreditation Systems Review Team which is submitted confidentially in Attachment A which highlights material and immaterial differences in the standards in the ADC’s opinion. This is submitted in confidence as some standards are still in the approval process.
Commonality in the application of standards

A cost benefit analysis of consistency in the application of standards is provided below:

Benefits:

- easier to understand for the provider (ease of response, could resubmit evidence across professional accreditation/s);
- easier to undertake joint accreditation visits and/or reporting;
- easier to recognise other accreditation authority decisions;
- easier to embed cross professional standards;
- shared data and learning across same standards across the same provider for different professions; and
- informing risk based accreditation by sharing across accreditation authorities.

Costs:

- potentially focussed on lowest common denominator;
- so generic in approach any detail ends up in an evidence/provider guide;
- there is an argument for variation/difference in application of standards given profession and provider risk profiles (the ADC accredits across the suite of providers including TAFE, University and specialist college);
- may stifle innovation in the programs but also in progressing contemporary accreditation systems (value the healthy competition between authorities to continually improve); and
- loss of specific profession input to, or confidence in, the accreditation process (perceived or real).

The ADC recommends that the Accreditation Systems Review team does not consider a list of benefits and costs as equally weighted; the loss of the professions support or confidence for the system overall would be a higher risk than any benefit achieved in a system which lacks professional identity but has a common approach.

The ADC and AMC are already working together in a collaborative way to jointly re-accredit the Fellowship of the Royal Australasian College of Dental Surgeons Oral and Maxillofacial Surgery in 2017 (following on from a previous joint accreditation in 2012). The ADC and AMC have different accreditation standards for this program however this has not been a limitation to a collaborative approach. The Site Evaluation Team (SET) have already commenced joint training and the schedule associated with the site visit has been structured to best utilise the experience and skills of all SET members and to cross train and learn from each other.

The ADC has also provided the Optometry Council of Australia and New Zealand, the Australian Physiotherapy Council, the Council on Chiropractic Education Australasia and the Australian Psychology Accreditation Council with its templates and learnings over the past 2 years in the transition to and implementation of the new standard.

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This collaboration is quadripartite and includes the Dental Council of New Zealand and the Medical Council of New Zealand.
Collaboration with other regulators & stakeholders

The ADC was the first accreditation body to enter into a Memorandum of Understanding (MoU) with the TEQSA\(^\text{20}\) which outlined an agreement of good intention to work together in providing information across the organisations. This initial MoU is due to expire in late 2017 and discussions have commenced regarding the routine sharing of data and information between TEQSA and the ADC to inform risk based decisions. The ADC is working with providers and TEQSA to better understand the data being collected at a provider level which will complement the data being collected at a program level. The focus and remit of the ADC and TEQSA are different. TEQSA does not look at competence of graduates from a public safety or future health workforce perspective. The roles are complementary. The ADC is an associate member of Professions Australia and contributes to discussions regarding professional accreditation, including outside the regulated health professions and professional accreditation more broadly.

The ADC has a very strong relationship with the Dental Council New Zealand (DC(NZ)) as the dental regulator in New Zealand. The importance of collaboration with New Zealand is extremely important given the Trans-Tasman Mutual Recognition legislation; which includes dentistry. Any changes to accreditation systems in Australia may have unintended consequences should the changes limit ability to be cooperative between the two countries at a profession level.

Evidence of a common approach across professions

The ADC is in a unique position as the dental professions encompass the professions of dentist, dental hygienist and dental therapist, oral health therapist, dental prosthetist and dental specialist (in 13 different specialist areas). As a consequence, the ADC must work collaboratively across all the dental professions and has modelled how cross profession standards and competencies can be achieved.

The ADC accreditation standard applies to all dental profession programs at all levels. When reviewing the accreditation standards in 2014, there were four (4) separate standards (dentist, dental hygienists/dental therapist, dental prosthetist and dental specialist) of which each had around 20 – 22 standards. These were collapsed and are now embedded into five domains with corresponding standard statements. The net benefit was a consistent standard across all programs and a significant shift to outputs focus in alignment with the professional competencies.

The ADC also reviewed the professional competencies of the dental professions (with the exception of dental specialists) in 2015. There were five (5) separate competencies for each part of the dental profession (dentist, dental hygienist, dental therapist, oral health therapist, dental prosthetists) and each had approximately 100 statements of competence (which could largely be described as a task list).

The new, revised versions of the professional competencies have now been reduced to three, with 6 domains each, of which the first 4 are common across all professions. The number of statements were also reduced from 100 to approximately 50 with a more outcomes focus. Specificity regarding the technical components of the profession are in the final two domains.

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?

Yes. The ADC already incorporates the decisions of TEQSA and ASQA in its evaluation of a dental program and mapped the accreditation standard to the Higher Education Standards (HES). The ADC works with providers across the spectrum and as such will interact with providers holding self-accrediting authority and those who do not. As stated in response to question 1, the focus of TEQSA and/or ASQA is very different to that of a health accreditation authority. What is required is a maturity of understanding between regulatory bodies, education providers and accreditation authorities. In addition, the ADC encourages providers to submit documents to the ADC prepared for other purposes (e.g. a TEQSA review) rather than require preparation of new documentation.

TAFE Queensland Bachelor of Dental Prosthetics, is an AQF Level 7 program being delivered in a TAFE and is therefore not self-accrediting. In this instance, TEQSA was compelled to review this provider at a program level. The ADC and TEQSA combined processes to use common experts to enable the program to be accredited by both organisations simultaneously. This was a first attempt at working together and there are several opportunities being pursued in the coming year to work collaboratively with providers, regulators and accrediting authorities including University of Sydney (TEQSA, internal university review and ADC) and reaccreditation of the Royal Australasian College of Dental Surgeons Oral and Maxillofacial Surgery program (ADC, AMC, DC(NZ) and MC(NZ)).

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

The ADC advocates for risk managed and based decision making but not at the detriment of the ability of an accreditation authority to accurately assess a program and be satisfied of the competence of graduates. Internationally, dental program accreditation and regulation is summarised in Table 2 below.

Table 2: Comparison of International Dental program accreditation and regulation

<table>
<thead>
<tr>
<th>International jurisdiction</th>
<th>Open ended or periodic</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Dental Council (ADC) – Australia</td>
<td>Periodic</td>
<td>Periodic accreditation of between 5 – 7 years with an accreditation visit usually at 5 years.</td>
</tr>
<tr>
<td>Dental Council New Zealand (DC(NZ)) – New Zealand</td>
<td>Periodic</td>
<td>The same as for Australia. There is only one dental school in New Zealand which delivers 19 of the 24 accredited programs.</td>
</tr>
<tr>
<td>General Dental Council (GDC) - UK</td>
<td>Open - ended</td>
<td>Open ended accreditation with a site visit at 5 years; at that visit representatives from the GDC observe final exams and observe the examination board deliberations which can/does add 4 days to the visit.</td>
</tr>
<tr>
<td>Commission on Dental Accreditation Canada (CDAC) - Canada</td>
<td>Periodic</td>
<td>5 day accreditation visit, still largely inputs focussed, National examination required</td>
</tr>
<tr>
<td>Commission on Dental Accreditation (CODA) – USA</td>
<td>Periodic</td>
<td>A largely inputs focussed system, National Examination required.</td>
</tr>
</tbody>
</table>
The ADC introduced its new accreditation standard commencing 1 January 2016. Since then, the Council has collected annual report/monitoring data relevant to this standard (effectively the ADC will have 3 years data as at 30 September 2017) and this is the foundation upon which the ADC will introduce risk based accreditation in late 2017. The ADC has been deliberate in its approach to working with education providers to develop the reporting templates which assure alignment with their own systems, avoiding unnecessary duplication at the provider end, but which satisfies the ADC requirements. It is intended that there will be de-identified, aggregated data available to the providers, as well as the DBA to assist in workforce planning, at the end of 2017.

Any risk based approach should avoid a ‘lead table’ style process where innovation may be stifled or discourage a program from discussing and collaborating with an accreditation authority about potential changes within a program. This includes any sliding scale fees.

Benefits to open-ended accreditation are likely to result in resources being directed in the right areas but also require the right tools to be in place to ensure you have the information to make risk based decisions. The ADC contends that we already make decisions on a risk basis but moving towards greater transparency of this decision making process for providers.

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?

The ADC believes that a common foundation is needed; which would come from a common approach to accreditation frameworks. This may include common nomenclature (ie. Site Evaluation Team (SET) or Assessment Panel or similar) in addition to common fee structures for remuneration for SET’s as well as greater consistency in fees for providers.

The ADC would be open to collaborating on a shared training model for assessors.

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

The ADC has previously defined its consumer as overseas qualified dental practitioners seeking assessment of competence and education providers as the consumer of our accreditation processes. This has recently broadened to include greater engagement with consumers of dental services.

The ADC includes, through committee charters and constitution the following consumer representation on key decision making bodies:

- Accreditation Committee – student representative, 2 community members (non-dental practitioners);
- Assessment Committee – 2 past candidates of the ADC overseas qualified dental practitioner assessment, 2 community representatives; and
- ADC Board – 2 community representative directors.
All consultations for reviews of standards have involved direct request for input by consumer groups including the Consumer Health Forum.21

The ADC Board is a skills based board in accordance with the skills and attributes needed for the strategic direction of the ADC.

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?

The ADC believes the focus should be on understanding costs at an activity level rather than a comparison of the income and fees charged by the fourteen accreditation authorities. Comparative analysis of fees across Councils doesn’t really reflect the real cost and relative quality of the wide diversity of accreditation and examination activities currently undertaken by each accreditation authority. This data is needed to appropriately define key principles for fee setting and levies. In the absence of this data, the ADC believes funding should continue to be set in accordance with the guiding principles of the Scheme through negotiation between the accreditation authority and the respective National Board; transparent, accountable, efficient and linked to effectiveness.

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?

On face value this seems to be logical and fair to candidates and programs; however they are not mutually exclusive processes. Both functions lead to eligibility for registration and draw from the competency documentation in dentistry. There is some cross function work being undertaken and the outcomes of the processes are also the same; to meet or not meet a standard for eligibility for registration. If this principle were to be enforced, the ADC would be required to apply for additional funding from the DBA, to increase fees to providers, or to significantly decrease activity relating to accreditation of dental programs.

The ADC has recently undertaken an in depth analysis of the cost of delivering the practical examination component of its assessment framework which can be shared with the Review team on request. Dental profession examinations require use of dental seats with specific services including plumbing, suction, radiographs and enormous amounts of instrumentation. Comparatively, the cost of the ADC overseas qualified dentist assessment process is comparable, or cheaper, when benchmarked internationally.

21 The Consumer Health Forum was invited to participate in the consultation processes of the revised professional competencies and revised accreditation standards in 2014 and 2015 respectively. No responses were received by the ADC to these consultations.
Table 3: Assessment of Overseas Qualified Dentists Examination Fees in AUD*

<table>
<thead>
<tr>
<th>Country</th>
<th>Initial</th>
<th>Written</th>
<th>Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUS</td>
<td>$610</td>
<td>$2,000</td>
<td>$4,500</td>
</tr>
<tr>
<td>CAN</td>
<td>$931</td>
<td>$2,256</td>
<td>$5,885</td>
</tr>
<tr>
<td>USA</td>
<td>$1,117.59</td>
<td></td>
<td>Clinical examination equivalent conducted by a number of agencies as a licensure exam</td>
</tr>
<tr>
<td>UK</td>
<td>$1,395</td>
<td></td>
<td>$5,072</td>
</tr>
<tr>
<td>IRELAND</td>
<td></td>
<td>$2,194</td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td></td>
<td>Same as Canada (utilises the NDEB equivalency process)</td>
<td></td>
</tr>
</tbody>
</table>

*exchange rates as at 1 May 2017

RELEVANCE AND RESPONSIVENESS
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?

Standards should remain outcome-based where possible. This provides flexibility to providers in order to achieve innovation in programs. Where there is an initiative/directive which requires more specificity, some reporting standards/templates or a specific outcome standard might be articulated. With the right flexibility in amending accreditation standards, these changes could also be time limited. Accreditation should be an enabler and not a barrier.

The ADC currently collects data annually on the number of clinical hours students are exposed to throughout the program. This is not specified in our standard but is a metric we have defined that will provide data to inform our risk based decision making.

Thematic monitoring is also a mechanism in the National Law for application by all accreditation authorities regarding a specific cross scheme imperative.

The ADC commenced discussion with its members in November 2016 regarding the role of the dental accreditation authority in contributing to Closing the Gap. This included great support from education providers in sharing initiatives, limitations and lessons learned in order to work towards a shared and strategic partnership between accreditation and accredited programs in contributing to Aboriginal and Torres Strait Islander health outcomes. The ADC has since had further discussions with the Australasian Council of Dental Schools (ACODS) and is currently preparing thematic monitoring questions for 2017 which all programs will respond. This is an example where some specific inputs questions are warranted to measure the validity of the accreditation role in working towards the Scheme objectives; particularly workforce outcomes and innovation.
9. Are changes required to current assessment processes to meet outcome-based standards?

The ADC would advocate that its current accreditation processes are appropriately structured to assess dental programs against the approved accreditation standard which is outcome-based. However there is still some variability between authorities.

When transitioning towards an outcomes based standard, there are some changes required to approaches which would have leant themselves more to an inputs focussed standard which the ADC has now embedded.

Specifically, the training of SET members includes specific direction to be less focussed on inputs and to be flexible in accepting all forms of evidence when demonstrating their compliance with a standard.

SET members are provided with two stages of training. The first stage, provided three months in advance of an accreditation site visit, provides an overview of the ADC approach and the accreditation standard in order to provide context for reviewing an accreditation submission. The second stage, conducted nearer the site visit, focusses on the accreditation process, the collection and triangulation of evidence and the preparation of the SET report. Across these two stages, SET members are:

- Guided to focus on gathering evidence of whether an accreditation standard is met – focussing on the outcome, rather than the input;
- Reminded that there are no specified requirements for various metrics such as clinical hours experienced by students or staff to student ratios – again that the focus should be on whether outcomes (e.g. program learning outcomes) have been achieved;
- Reminded not to ‘benchmark’ a program against their own experience – and recognise that there will be multiple ways to demonstrate that a standard is met; and
- Reminded to ensure that any conclusions are supported by clear evidence gained during the review of the program.

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?

A pragmatic approach to the development of professional competency frameworks should be taken. In the case of the dental professions, the ADC achievement of combining several competency documents into a smaller number with largely consistent core domains may have potentially not been achieved if this role was devolved to the individual professional associations. However, the inclusion, feedback and sense of ownership by the professions in the process of reviewing these frameworks was and continues to be crucial to their ongoing usefulness. Consumers are included in all consultations undertaken by the ADC and are directly invited to provide feedback.

11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

Answered above in response to questions 1 and 10.
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?

Early involvement by the accreditation authority in discussions regarding the future workforce need is important. A major or incremental change of focus in any education delivery model will conservatively require approximately five to six years lead time (from curriculum/accreditation changes, first enrolments for curricula, to graduation). Often, the accreditation authority is the last to be advised of directives.

There is a notable absence of a cohesive, national, future focussed, health workforce plan which articulates the overall need of Australians with respect to their future health needs.

For the dental professions, HWA published significant research and statistics including the 2014 publication *Australia’s Future Health Workforce – Oral Health*\(^\text{22}\). This paper provides the results of oral health workforce planning projections to 2025 conducted by HWA in 2014, but its greatest limitation of useful application is freely stated within its opening pages where it states, “...the demand component of the workforce planning projections are based on current utilisation patterns, and any potential unmet need is not accounted for.” So while this paper concludes that generally there is no real over/under supply issue with the oral health workforce (with some exceptions), it is based solely on current dental service provision models which are unsustainable for the time horizon this data is concerned with.

In 2015, the Australian Government published the *Healthy Mouths Health Lives: National Oral Health Plan 2015 – 2024*\(^\text{23}\), which was preceded by national plans for the periods 2004 – 2013 and 2014 – 2023. There is evidence of participation of the Australian Dental Council in the early papers, however not in the subsequent and more recent papers\(^\text{24}\) despite several areas which identify accreditation as essential or a lever for potentially influencing the oral health workforce.\(^\text{25}\) This paper also recommended the appointment of an Australian Chief Dental Officer, supported by a committee, to promote inter-sectorial collaboration nationally (and therefore drive service delivery models which would in turn influence education). Accountability for the success of the National Oral Health Plan is also unclear.

\(^{22}\) *Australia’s Future Health Workforce - Oral Health*, page 2, accessed 25 April 2017


\(^{24}\) Although there are representatives identified as key informants/participants who do have formal appointments on the ADC governing board or its Committees, those individuals were not there in their ADC capacity.

\(^{25}\) *Healthy Mouths Health Lives: National Oral Health Plan 2015 – 2024*, op. cit. pages 37 and 43, accessed 25 April 2017. ADC has a role in working with other professions to determine a base level of oral health education in dental and other health and non-health professions which may have the potential to impact on the oral health of Australians.
13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in the accreditation standards that would reflect the priority accorded to them?

The ADC accreditation standards for dental practitioner programs already include several references within the standard statements which compels providers to demonstrate the following:

<table>
<thead>
<tr>
<th>Standard Statement</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies.</td>
<td>3.3 The quality and quantity of clinical education is sufficient to produce a graduate competent to practice across a range of settings.</td>
</tr>
<tr>
<td></td>
<td>3.4 Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes.</td>
</tr>
<tr>
<td></td>
<td>3.6 Principles of inter-professional learning and practice are embedded in the curriculum.</td>
</tr>
<tr>
<td></td>
<td>3.8 Learning environments support the achievement of the required learning outcomes</td>
</tr>
</tbody>
</table>

Clinical experience and student placements

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

The ADC recommends clear articulation of health care priorities in order for programs and accreditation systems to be responsive to these priorities, rather than looking to curricula to be more specific. In addition, clinical experiences in dentistry are in some cases limited by the arrangements and contracts in place with the state and territory based dental health services. Access to patients for clinical experience is provided in accordance with the outcomes-based accreditation standards and the exposure and mix of patients needed to achieve the competencies of a newly graduated oral health practitioner. Healthcare priorities expressed in terms of outcomes would complement the outcomes focus of accreditation standards.

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

The ADC considers this a matter for educators and as an accrediting authority we must ensure only that we are not a barrier to the incorporation of contemporaneous or innovative education methodologies. All entry to practice level dental programs will definitely include a strong element of simulation.

26 Note that criteria are not sub-standards that are individually assessed
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?

The ADC believes the current arrangements in specific professions, are most likely historical and are a matter for those professions to comment on from an evidentiary perspective.

However, should a period of supervised practice be imposed in dentistry in particular, the ADC believes this would have a significant impact on the workforce as well as the resources within the public dental health services around the country. The current dental profession education model relies on dental students providing dental care as the operator to patients in a ‘supervised’ environment and in accordance with their education level. This occurs once the students have demonstrated relevant competencies in a simulation learning environment. It would be prohibitive to identify suitable supervised practice opportunities for all newly graduated dentists\(^{27}\) and would rely on the identification of supervised practice opportunities potentially also being undertaken in private practice. This would also have limitations especially with respect to funding. Education providers would likely advocate for a period of practical experience/training outside the qualification to enable greater focus on education and research foundational knowledge, which in turn may lead to innovative education and clinical practices.

17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

The ADC can break this question into three specific areas to clearly delineate the differences between work readiness, registration requirements and employment requirements:

**Work Readiness**
The ADC looks to the professional competencies as the expectation of what a newly qualified dental practitioner is expected to be able to do to be safe to practise.

**Registration standards**
Registration standards assure a practitioners’ fitness to practise and includes evidence of Professional Indemnity Insurance (PII), criminal history, meeting Continuing Professional Development (CPD) requirements and adherence to the Code of Conduct.

**Employment matters**
Employers of newly qualified dental practitioners should have the expectation that they will be working at threshold level. The responsibility of an employer is to induct employees into their workplace in order to assure the employees are only undertaking roles and tasks which the employer is satisfied the employee is competent to undertake. This is no different to a day one graduate of an engineering, legal or accounting qualification. This is also sometimes considered ‘credentialing’ in public health services and would take into account the level of experience of the new graduate in accordance with descriptors relating to pay levels. These are expected skills/competence for their employment but not necessarily an expected professional competency on graduation.

\(^{27}\) Number of graduating dentists was 580 in 2015 and 630 in 2016.
National Examinations

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

There are likely a number of reasons specific professions have introduced or maintained a national assessment prior to registration. This is particularly prevalent in North American jurisdictions including our colleagues within dentistry.

The ADC believes the limitations of a national assessment for dental programs would be numerous including:

- National Assessments are a point in time, summative assessment, whereas the integrated assessments throughout a program by the education providers are a more accurate assessment of overall competence rather than just competence on that particular day or for that exam;
- Limited ability to assess all competencies especially in dentistry;
- Undermines the expertise and quality of the program and its integrated assessments which have already been accredited;
- Programs will teach to the exam rather than teaching to the expected competencies;
- Potentially unfair to students; there are time limitations on attempts in several international jurisdictions which ultimately can result in a student being awarded a dental degree without being registrable; and
- In comparing our processes to international dental regulation, those jurisdictions that have National Examinations have not reduced the burden on their providers as a result; and
- In some international jurisdictions, there have been unintended consequences of the introduction of a national examination including the use of one section of an examination as a barrier to progression within a program. In those cases it is expected that the student will pay the fee to sit the examination, however the program is in fact using it as a summative assessment which must be passed in order to progress in a program.

There is continued international discussion regarding the fairness and transparency of national examinations and attempt limitations including recently at the Association of Test Publishers Conference held in Scottsdale, AZ meeting of the ATP Health Special Interest Group (SIG)28. The ADC CEO has committed to a working committee of this SIG to develop principles regarding assessments in health, be it for internationally qualified practitioners or domestic graduates.

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PRODUCING THE FUTURE HEALTH WORKFORCE

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?

Broadly speaking, the National Board appointments are jurisdictional and practitioner representative dominant. This is in contrast to the accreditation authority governing boards which are mostly skills based. There is a need for checks and balances to ensure policy decisions, of which an accreditation standard is, are meeting the future needs of Australia and the National Boards undertake this role given their collective profession/consumer knowledge. If an accreditation authority is providing advice to the National Board on the appropriateness of a new or revised accreditation standard in a way which addresses the objectives and guiding principles of the Scheme, which includes consideration of workforce needs, then there should be no limitation to the National Board current composition in approving the proposed standard.

However, this can quickly become problematic if there is inadequate communication between the National Board and accreditation authority regarding the future workforce need.

The ADC would advocate for greater transparency by Ministers in the appointment of National Board members.

The Health and Care Professions Council (HCPC) in the UK have a governing Council which includes 12 members; of which 6 are registrants and 6 are lay members. This is a regulatory model which emphasises the importance of the consumer voice in key decisions at the regulation/policy direction level.

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?

There are no current governance issues which prohibit or limit the alignment of education and training with evolving needs of health consumers however the ADC supports appropriate checks and balances. There are specific guidelines regarding the requirements for development of standards (registration and accreditation) which include specific references to the Office of Best Practice Regulation (OBPR), Health Workforce Principle Committee (HWPC) and wide ranging stakeholder/consumer input. As a further measure the introduction of a ‘major change’ mechanism to enable a more responsive accreditation system where there is a governmental or cross professional major initiative, would allow an en masse update to standards without necessarily requiring 12 months of consultation.

There are some examples of where a National Board has not approved or deferred a decision on a program of study for approval for registration following a positive accreditation decision by an accreditation authority. This is sometimes a duplication and consequently, inefficient. Any deferral or delay in decisions regarding approval for registration ultimate impact on students, education providers and workforce. Some National Boards maintain their own Accreditation Committee of the
Governance of accreditation authorities

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

The ADC currently involves community representation in the following key decision making bodies:

- ADC Governing Board – 2 independent/community representative directors
- Accreditation Committee – 1 student, 2 independent members
- Assessment Committee – 1 x past candidate, 2 community members

In addition, consumer input on all standards consultations is actively sought.

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 ADC believes it has the required flexibility which allows the engagement of the appropriate professional expertise without creating perceived or real conflicts of interest.

The nature of professional accreditation requires a level of knowledge/experience of the profession in order to appropriately discharge our role.

Some of the mechanisms and policies in place to mitigate conflict of interest include:

- Declaration of conflict of interest registers;
- Education providers right to raise a conflict of interest with a potential SET member/s;
- For a review of a specialist program, the Chair of the SET is considered ‘neutral’ from a different part of the register to the program being assessed;
- All SET members are based in a different state to the education provider;
- Always administrative support to ensure consistency in application and adherence to policies and processes; SET team makes a recommendation to either the Accreditation Committee or Board;
- Appeals and complaints mechanisms are in place; and
- Accreditation authorities report to the National Board regarding management of Conflict of interest.

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?

Accreditation authorities are appointed by its respective National Board in accordance with the National Law. In making their decision to appoint an accrediting authority, the National Boards consult widely in order to ensure there is wide support for the entity undertaking this role. In undertaking their due diligence in appointing an entity as the accreditation authority they must ensure the entity will be able to meet the independence criteria. This is satisfied in submissions to
the National Boards through the appointment process and in the reporting to National Boards by accreditation authorities against the Quality Framework\textsuperscript{29} for accreditation.

The Directors on the Governing Board of the ADC are subject to the fiduciary responsibilities for Directors under the Corporations Act 2011. Therefore they are required to work within the confines of the objectives of the company and within the statutory responsibilities defined under the National Law. The ADC is also a registered charity for the purposes of the Charities Act 2012 (ACNC). The decisions made by the ADC require a balance between knowledge of the dental professions but also of contemporary accreditation and business practices. In 2013 the ADC understood this need and moved to amend its constitution to enable appointment of a skills based governing board rather than a nominee/representative governing board as the previous constitution had defined.

Role of Accreditation Authorities

\textbf{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 standard clause in the AHPRA funding agreements with accreditation councils is insufficient in ensuring delivering of the accreditation functions in alignment with the objectives of the Scheme due to their input focus.

The Health Workforce Australia (Abolition) Bill was formally passed in both houses in September 2014. The Bills Digest\textsuperscript{30} reminds us of the purpose and achievements of HWA during its short life and points to the potential gaps we are experiencing now in resourcing innovation and promotion of cross profession health practitioner education. Simply writing into the AHPRA funding agreements with accreditation authorities that Councils’ should seek out opportunities in cross-professional collaboration and innovation, inter-professional learning, and facilitation and support for alternative learning environments, without any additional funding to accreditation authorities or education providers and clear articulation of the outcome expected (ie. the ‘problem’ these directives are trying to solve at the National level) is not enough to really make a difference.

The Health Professions Accreditation Councils Forum has progressed a number of initiatives over the past six (6) years and this ‘good will’ should not be discounted. Forum members have worked to lead and/or contribute to the development of the following:

\begin{itemize}
  \item Shared definition of inter-professional education;
  \item Shared accreditation principles;
  \item Contribution to the development of the Quality Framework for the Accreditation Function;
  \item Contribution to the development of guidance notes for the Management of Complaints relating to accreditation functions under the National Law;
  \item Development of an innovations and good practice database mapped to the Quality Framework as a shared learning resource cross-professionally;
\end{itemize}


• Contribution to the development of an international accreditation systems comparisons paper; and
• Contribution to the development of the Cost of Accreditation in the National Registration and Accreditation Scheme paper.

In addition the Forum is currently progressing two significant projects in 2017:

• Forum funded project to develop shared educational standards for safe prescribing (currently in a pre-consultation phase); and
• A project investigating how accreditation can contribute to the health outcomes of Aboriginal and Torres Strait Islander peoples (currently in the planning phase).

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 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.

There is a need for enablement in this area however the governance model is the most important mechanism. For consideration should be:

• Independence of the body in making policy decisions in the interests of the future health needs of Australians;
• The skills, attributes, background and knowledge needed on that body to ensure the right information is available to it in making policy decisions;
• The balance of power needed to ensure the body can make enforceable decisions, but has the support of all professions;
• The funding and support available to the body; and

The need for a clearly articulated plan for the future health workforce to which this body references in its decision making.

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

Answered in 25.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across the NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?
The current reporting mechanism is the Quality Framework Report which should be constantly updated/reviewed for its relevance/fitness for purpose. Accreditation authorities should report against the framework and the National Boards should monitor performance of their appointed accreditation authority against that Framework. Where the appointed accreditation authority is not assigned responsibility for an accreditation function under the National Law, the National Board should report against those domains. The ADC is not aware of any aggregated analysis of performance of accreditation across the Scheme against the framework but would welcome the opportunities such reporting would provide in terms of shared learning of good and best practice across the Scheme.

Setting health workforce reform priorities

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

The ADC believes if the right entities with the appropriate skills and knowledge are making decisions then this should not require Ministerial Council intervention.

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers the 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?

Any further empowerment of the Ministerial Council would potentially be contrary to the principle that accreditation should be independent and free from influence from the profession, government and/or other interested parties. The articulation of the future health workforce and overall accountability of the performance of the Scheme in outputting the articulated future health workforce should be their role.

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?

The ADC believes that there is not one way or approach to achieve this. A multi-layered, frequent, transparent, and inclusive (of all health professions, not just the regulated health profession) approach to understanding a National workforce reform agenda is needed. Understanding the expected output is necessary for the entities within and complementary to the Scheme and in the wider Australian health system.
Specific governance matters - the roles of specialist colleges and post-graduate medical councils

31. Does 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 ADC can only comment on the engagement of specialist colleges with respect to specialist dental programs. The arrangements for dental specialist accreditation is very different to medical accreditation, and is delivered both through universities and specialist colleges, usually as a Doctor of Clinical Dentistry (DClinDent) qualification. The ADC accreditation standard is the same across all dental programs encompassing entry to practice programs to specialist programs. This means that the ADC is less concerned with the type of education provider delivering the program and more focussed on the graduate outcomes. This allows an open market for delivery of specialist education in dentistry and enables innovation in the way a program is delivered.

In December 2016 the ADC conducted a review of the Royal College of Pathologists of Australasia (RCPA) Fellowship of the Faculty of Oral and Maxillofacial Pathology (Fellowship in Forensic Odontology) program. This new program was the first offered in Australia designed to enable graduates to apply for registration with the Dental Board of Australia as a Forensic Odontologist.

The program is not required to comply with Tertiary Education Quality and Standards Agency’s (TEQSA’s) Higher Education Standards as it does not lead to an award within the Australian Qualifications Framework (AQF). Instead, it is a five year program based on a situated learning model of course delivery. Trainees in the program are located at training sites accredited by the RCPA and supervised by Fellows of the RCPA. As such, the program does not follow the traditional university-based format of specialist dental program; the focus is very much on trainees achieving program outcomes through a variety of pathways.

The facilities used by trainees are accredited by the RCPA as training sites appropriate for the training of Forensic Odontologists and the supervisors identified by the College support trainees in the development of the skills and knowledge needed for specialist practice. The trainee handbook provides trainees with the expected program outcomes, examples of activities that may be undertaken to achieve these outcomes and details of the assessments to be completed to be awarded fellowship. The experience of every trainee in progressing through the program may be very different in terms of didactic learning and clinical practice.

Despite the non-traditional delivery format the College was able to clearly map evidence against the ADC Accreditation Standard in its submission and the ADC Site Evaluation Team were able to clearly determine how each standard statement had been addressed. In early 2017 the program was awarded accreditation by the ADC for a period of five years.

The ADC does not approach the accreditation of a specialist program differently to a general dental program, except for the composition of the Site Evaluation Team (SET) which would normally include three members; a ‘neutral’ chair from a different part of the register, at least one academic and one clinician from the relevant part of the register to bring specialty-specific knowledge to the review.
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?

For dentistry the processes are already aligned; with one application process and fee charged.

VETASSESS is the current appointed authority approved for assessing skilled migration for dental therapists and hygienists. These processes are largely duplicated when these candidates subsequently apply to the ADC for assessment of competence.

Trades Recognition Australia is the appointed authority approved for assessment of dental prosthetists. This process would also largely be duplicated for candidates when the ADC makes available its competence assessment pathway in April/May 2017 for overseas qualified dental prosthetists.

The ADC would advocate for the alignment of qualifications assessments to be undertaken by entities undertaking assessments for registration to minimise duplication and cost for the candidates, minimise complexity for the public, and to ensure all assessments are being conducted by practitioners.

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?

The ADC does not delineate between the assessment of overseas qualified dentists and accreditation of Australian dental profession programs; both are accreditation functions under the National Law. Both functions reference back to the professional competencies for the dental professions and contribute to the quality improvement in all ADC processes.

Furthermore, the ADC has committed to the cross functional learning between the assessment of overseas qualified dental practitioners and accreditation of programs functions including:

- Trial Testing of items for the ADC overseas qualified dentist examinations utilising various student groups currently enrolled in accredited programs; and
- A pilot of a monitoring examination in 2016 whereby several accredited dental programs ran an ADC prepared examination comprised of questions from the ADC Item Bank for their final year students to allow them to test, and confidentially benchmark, the progress of those students towards achieving the relevant professional competencies.

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

This should remain flexible to allow for required profession specific variability, however there should be clear principles and evidence based decisions regarding the most appropriate methodology for determining assessment of competence. The ADC is exploring the potential for a shared assessment across a number of professions in communication.
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 ADC has largely responded to this question earlier in question 16. The ADC maintains that flexibility should remain for specific professions to assess overseas qualified practitioners in the most appropriate way for that profession. In dentistry this involves a need to assess a practitioners’ ability to undertake dental surgery safely which is achieved through a written examination (application of clinical knowledge through scenario based MCQ’s) and a practical examination (candidates use a simulated patient through manikin heads and standardised typodonts as well as simulated patients for communication tasks). This is very different to any other health profession and would not be assessable through a desktop assessment, written examination, *viva voce* or OSCE assessment alone. We see no requirement for a period of supervised practice if a candidate is successful in completing the ADC assessment. This assessment has been mapped against the professional competencies for the newly graduated dental practitioner and it is expected that success at the ADC assessment demonstrates a candidate’s competence within the limitations of the assessment tool.

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?

No. The ADC would welcome an external mechanism for consideration of grievances/appeals beyond those mechanisms already defined which are still largely internal/guidelines.

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 ADC does not have an opinion whether an existing entity is appropriate for this role; however any entity must have the appropriate skills and knowledge of the scope of the complaints it is empowered to deliberate on. This may also include fees and charges if the entity is equipped to adjudicate on such matters.
APPENDICES

Appendix 1: Dental professions as defined in the Health Practitioner Regulation National Law

National Boards in conjunction with the Australian Health Practitioner Regulation Agency (AHPRA) maintain Public Registers of health practitioners, including registered specialists. Within the 14 registers, Chinese medicine, dental, medical radiation and nursing professions are further categorised into divisions.

For the dental profession these divisions include:

- Dentist
- Dental therapist
- Dental hygienist
- Dental prosthetist; and
- Oral health therapist

In addition, the following is the approved list of specialties and specialist titles for dental practitioners:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Specialist Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dento-maxillofacial radiology</td>
<td>Dento-maxillofacial radiologist</td>
</tr>
<tr>
<td></td>
<td>Oral and maxillofacial radiologist</td>
</tr>
<tr>
<td></td>
<td>Dental radiologist</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Endodontist</td>
</tr>
<tr>
<td>Oral and maxillofacial surgery</td>
<td>Oral and maxillofacial surgeon</td>
</tr>
<tr>
<td>Oral medicine</td>
<td>Specialist in oral medicine</td>
</tr>
<tr>
<td></td>
<td>Oral medicine specialist</td>
</tr>
<tr>
<td>Oral pathology</td>
<td>Oral pathologist</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>Oral surgeon</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Orthodontist</td>
</tr>
<tr>
<td>Paediatric dentistry</td>
<td>Specialist in paediatric dentistry</td>
</tr>
<tr>
<td></td>
<td>Paediatric dentist</td>
</tr>
<tr>
<td></td>
<td>Paedodontist</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Periodontist</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>Prosthodontist</td>
</tr>
<tr>
<td>Public health dentistry (Community dentistry)</td>
<td>Specialist in public health dentistry</td>
</tr>
<tr>
<td>Special needs dentistry</td>
<td>Specialist in special needs dentistry</td>
</tr>
<tr>
<td>Forensic odontology</td>
<td>Forensic odontologist</td>
</tr>
<tr>
<td></td>
<td>Forensic dentist</td>
</tr>
</tbody>
</table>
### Appendix 2: Snap shot of dental professions accreditation activity 2013 – 2016

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accreditation standards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of accreditation standards developed in the financial year</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of accreditation standards reviewed in the financial year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accreditation of programs of study and education providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of new programs accredited in the financial year</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Number of programs re-accredited in the financial year</td>
<td>7</td>
<td>19</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Number of programs monitored in the financial year</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Number of site visits undertaken in the financial year</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td><strong>Accredited programs and providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of accredited programs</td>
<td>58</td>
<td>61</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>Total number of providers offering accredited programs</td>
<td>16</td>
<td>18</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td><strong>Assessment of overseas authorities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of overseas authorities assessed in the financial year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Assessment of overseas qualified health practitioners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of overseas qualified health practitioners assessed in the financial year</td>
<td>2,227</td>
<td>3,301</td>
<td>2,340</td>
<td>2,777</td>
</tr>
</tbody>
</table>
### Appendix 3: Number of dental programs accredited by the ADC (March 2017)

<table>
<thead>
<tr>
<th>Dental Profession</th>
<th>No. of Accredited Programs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>11</td>
<td>Including both Doctor of Dental Medicine (DMD) and Bachelor of Dental Science (BDSc) at the University of Western Australia (BDSc is currently in teach out and was an undergraduate program whereas the DMD is a graduate entry level program); and the BDSc and BDSc (Hons) at University of Queensland.</td>
</tr>
<tr>
<td>Dental therapist</td>
<td>0</td>
<td>Dental Therapy training programs have been subsumed by Oral Health Therapy programs.</td>
</tr>
<tr>
<td>Dental hygienist</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Dental prosthetist</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Oral health therapist</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL DENTAL PROFESSION PROGRAMS</strong></td>
<td><strong>28</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist area</th>
<th>No. of Accredited Programs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dento-maxillofacial radiology</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Forensic odontology</td>
<td>1</td>
<td>Delivered through the Royal College of Pathologists of Australasia.</td>
</tr>
<tr>
<td>Oral and maxillofacial surgery</td>
<td>1</td>
<td>Delivered through the Royal Australasian College of Dental Surgeons.</td>
</tr>
<tr>
<td>Oral medicine</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Oral pathology</td>
<td>2</td>
<td>1 x Doctor of Clinical Dentistry; and 1 delivered through the Royal College of Pathologists of Australasia.</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Paediatric dentistry</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Public health dentistry (Community dentistry)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Special needs dentistry</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL DENTAL SPECIALIST PROGRAMS</strong></td>
<td><strong>33</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL NUMBER OF ACCREDITED PROGRAMS</strong></td>
<td><strong>61</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 4: Chronology of Milestones for the ADC

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 March 1993</td>
<td>Inaugural meeting of the Australian Dental Council</td>
</tr>
<tr>
<td>1994</td>
<td>Dental Council of New Zealand begins attendance at ADC meetings</td>
</tr>
<tr>
<td>1994</td>
<td>ADC accepts the Dental Assistants Educational Council of Australia accreditation processes for para-dental personnel</td>
</tr>
<tr>
<td>1995</td>
<td>ADC Governing Board considers report ‘The Assessment and Accreditation of Dental Schools in Australia 1993 – 1995’ prepared by the inaugural Accreditation Committee</td>
</tr>
<tr>
<td>1996</td>
<td>Commencement of accreditation of dental schools – University of Western Australia received accreditation with some qualifications. After a new Dental School was built, full accreditation was achieved.</td>
</tr>
<tr>
<td>1996</td>
<td>Discussions held between representatives of the ADC, NOOSR and Dental Boards; agreement was reached for ADC to assume the assessment responsibilities</td>
</tr>
<tr>
<td>1996</td>
<td>Accreditation of post graduate courses such as Intravenous Sedation commenced</td>
</tr>
<tr>
<td>1998</td>
<td>In principle support from AHMAC for the ADC to be recognised as the national body responsible for the assessment and accreditation of dental schools and courses in Australia</td>
</tr>
<tr>
<td>1999</td>
<td>Accreditation of specialist postgraduate programs commenced</td>
</tr>
<tr>
<td>2003</td>
<td>Accreditation of dental hygienist and dental therapist programs commenced</td>
</tr>
<tr>
<td>2003</td>
<td>ADC assessment of overseas trained dental specialist’s qualifications commenced</td>
</tr>
<tr>
<td>2004</td>
<td>Accreditation Committee becomes a Joint Committee of ADC and Dental Council NZ ((DC)NZ)</td>
</tr>
<tr>
<td>2011</td>
<td>Accreditation of Dental Prosthetist programs commenced</td>
</tr>
<tr>
<td>2011</td>
<td>Development of the professional competencies</td>
</tr>
<tr>
<td>2015 (approved 2016)</td>
<td>ADC Reviews the professional competencies</td>
</tr>
<tr>
<td>2014</td>
<td>ADC reviews the accreditations standard. Approval by the DBA</td>
</tr>
<tr>
<td>2016</td>
<td>New accreditation standard implemented</td>
</tr>
<tr>
<td>2014</td>
<td>ADC moves to simulated practical examination)</td>
</tr>
<tr>
<td>2016</td>
<td>ADC ceases assessing overseas qualified dental specialists</td>
</tr>
<tr>
<td>2018</td>
<td>ADC moves to single site practical examination</td>
</tr>
</tbody>
</table>