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Review of the National Registration and Accreditation Scheme for health professions

The Dental Council (the Council) appreciates the opportunity to respond to the consultation document on the Review of the National Registration and Accreditation Scheme for health professions, commissioned by the Australian Health Workforce Ministerial Council.

The Council is a regulatory authority established by the Health Practitioners Competence Assurance Act 2003 (the Act). The primary purpose of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions.

The oral health practitioners the Council regulates are dentists, dental specialists, dental therapists, dental hygienists, clinical dental technicians, dental technicians and orthodontic auxiliaries. The Council’s primary functions are set out in section 118 of the Act.

We are responsible for:

- setting standards for entry to the Register
- registering oral health practitioners
- setting standards of clinical and cultural competence, and ethical conduct to be met by all oral health practitioners
- recertifying all practising oral health practitioners each year
- reviewing and remediating the competence of oral health practitioners, where concerns have been identified
- investigating the conduct or health of oral health practitioners where there are concerns about their performance, and taking appropriate action.

As a part of those functions and responsibilities we:

- set accreditation standards and competencies for each of the dental professions
- monitor and accredit the oral health programmes to ensure the quality of education and training is appropriate
- set scopes of practice within which oral health practitioners may practise
- prescribe qualifications for each scope of practice
- maintain a public register of all registered oral health practitioners, including those who are not currently practising
- issue annual practising certificates to oral health practitioners who have maintained their competence and fitness to practise, to continue practising their professions
- develop and maintain minimum standards through codes of practice that all oral health practitioners must comply with
- require registered oral health practitioners to undertake continuing professional development education
- manage oral health practitioners suffering from health issues affecting their practice
- place conditions on, or restrict an oral health practitioner’s scope of practice, or suspend their practising certificate, if that is appropriate to protect the health and safety of the public.

Responses have been provided to consultation questions where parallels with the New Zealand health practitioner registration and accreditation processes and environment exist.

**Q3 – Should a single Health Professions Advisory Board be established to manage the regulatory functions that oversee nine low regulatory workload professions? (Estimated cost saving $11m per annum).**

**Q4 - Alternatively should the nine National Boards overseeing low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? (Estimated cost savings $7.4m pa).**

A proposal for shared secretariat services for all sixteen New Zealand responsible authorities (RAs) was proposed and consulted on by the Minister of Health in 2011. Significant analysis was undertaken by the Council in conjunction with nine other RAs, and subsequently with all the RAs. Although the proposal for a single shared secretariat service was not accepted by all RAs, further proposals on shared services in IT are still being explored.

On a principle level the Council fully supported the principle of shared secretariat services and the business case showed costs savings could have been achieved for practitioner’s annual recertification fees, with more substantial savings achieved when the regulatory functions (notifications, complaints, registration etc.) were also consolidated. Additionally, the added value of knowledge sharing and opportunities for standardisation of approaches in administering the HPCA Act were identified as key benefits from a shared model. However, if a shared servicing arrangement is implemented the Council strongly supports profession-specific representation and clinical knowledge at the governance structure level to regulate the specific professions.

It is desirable that regulation of health professions should be proportionate to the risk associated by the practice of the health profession.

Without commenting on the financial models presented, an option where savings are achieved while maintaining professions-specific governance would be in line with the Council’s position on shared regulatory services.

**Q5 – Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

Savings generated through shared services could be redirected to achieve regulatory quality improvements, within the appropriate regulatory framework developed based on risk-assessment, or the savings could translate to lower fees for those registrants.
Q6 – Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and associated cost benefit analysis?

The Council fully supports the concept of regulation proportionate to risk, and the decision to include a new profession into the National Scheme should be based on the potential risk of harm to the public rather than potential cost benefits to the Scheme or the profession involved.

Q11 - Should there be a single entry point for complaints and notifications in each State and Territory?

From a New Zealand regulatory perspective, when a practitioner from Australia applies for registration in New Zealand under the Trans-Tasman Mutual Recognition Act, it is fundamental to that process that the Council is informed of any concerns, complaints or proceedings against a practitioner in Australia. Currently there appears to be inconsistency in the information reported to the Council by the various States and Territories. A single access point at AHPRA could facilitate consistent reporting, and ease of access to information. More importantly, consistent approaches in dealing with complaints and similar outcomes will facilitate public confidence and ensure fairness to all practitioners.

Q12 – Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

Council believes that clear and transparent processes and target timeframes for dealing with complaints and notifications should be adopted nationally, communicated to the complainant and promoted to the public to ensure all involved are informed.

Q14 – Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

The Council supports the concept of more flexible powers for the National Boards, underpinned by the principle of an outcome proportional to the potential risk posed to the public.

Under the HPCA Act, the Council has the power to investigate and manage practitioners with competence concerns. The underlying philosophy is one of review, remediation and education. Similarly, with Health concerns the majority of practitioners are managed by voluntary undertakings.

Flexible powers and the ability to find alternative ways in addressing concerns, would enable the Boards to reach quicker resolutions and more pro-active interventions.

Q15 – At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

Entries on the public register should reflect any information required to inform potential patients of any risk of harm to them or their care. If the Board is convinced that the risk of harm to patients no longer exist, then that information should be removed from the public register. That information should be retained in the registration systems and reported to other overseas jurisdictions in reporting on the practitioner’s standing, excluding information that is bound by “clean-slate” legislation, where in place.
Q19 – Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

The Council believes that mandatory notification of any condition that impact on the practitioner’s ability to practise is required. The Board can then decide, based on independent expert advice, whether the condition poses a risk of harm to patients, and if it does the associated practice limitations and monitoring required. The decision of whether the condition poses a risk to the public should not be left to the individual practitioner.

Q20 – To what extent are National Boards and Accrediting Authorities meeting statutory objectives and guiding principles of the national law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce and innovation in education and service delivery?

Q22 – To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

Q23 – What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualifications for entry to professions remains available?

Accreditation standards review

The Dental Board of Australia (DBA) has appointed the Australian Dental Council (ADC) as its accreditation authority. The ADC and Dental Council (New Zealand) [DC(NZ)] has established a joint accreditation committee in 2005, that oversees the accreditation of all dental programmes across both jurisdictions.

The DBA and DC(NZ) commission a joint review of the ADC/DC(NZ) Accreditation Standards earlier this year, with the ADC appointed to manage the review.

The primary objectives of the review were to ensure that the standards are fit for purpose and contemporary.

To achieve this, the proposed draft accreditation standards were developed to:

- set at a minimum level at the entry level for registration as a dental practitioner/oral health practitioner in Australia and New Zealand;
- be outcomes focused and evidence based;
- have sufficient flexibility to enable different teaching and learning approaches and their clinical experience arrangements, and of new and emerging educational trends;
- use the ADC/DC(NZ) professional attributes and competencies statements for each discipline as part of the standards criteria that must be met;
- enable rationalisation of processes and evidence requirements to maximise the benefit and minimise the reporting burden on education providers.

These draft accreditation standards are currently still consulted on, but the intent of the review was to ensure that the accreditation standards meet the primary requirement of protecting the safety of the public by ensuring appropriate standards for entering into the profession, but also be future proofed by allowing for emerging trends in education and development within the clinical practice of the various professions.
Specialist qualification framework and competencies

The Council and DBA also initiated a joint project to develop a proposed specialist qualification framework and competencies to enable consistent assessment of applications for specialist registration.

The framework will be used in a range of contexts in Australia and New Zealand including:

- the outcome measure for accredited specialist programs of study;
- assessing qualifications (including those of overseas trained practitioners) for equivalence to an approved specialist registration in Australia and prescribed qualification in New Zealand; and
- evaluating the competence of dental specialists in the context of regulatory processes such as management of a notification.

The proposed framework and competencies will be consulted on in early 2015.

Throughout both projects, considerable consultation was undertaken with both the professions and educational institutions.Whilst it is the regulators responsibility to set the minimum standards and to monitor compliance in meeting those standards, it is important to ensure good working relationships exist with its stakeholders. Open dialogue would facilitate understanding of different objectives and views, early identification of potential areas of concern and associated risks, and a collaborative approach to achieve the shared objective – to deliver fit for purpose and competent graduates to register and practise competently and safely.

Based on the approaches taken during both projects, I am of the view that the accreditation standards of dental programmes and the associated accreditation processes:

- meet the objectives and guiding principles of the National Scheme to facilitate access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery;
- accommodate future health practitioner skills and competencies to address changes in technology, models of care and changing health needs; and
- ensure appropriate standards for entry to the profession to achieve our regulatory objective to protect the health and safety of the public.

Q24 – How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Oral health practitioners with overseas undergraduate qualifications not approved by DBA for the purpose of registration, has the option of completing an examination registration pathway. The Council and ADC share a written examination for dentists, with the clinical component of the examination completed at selective universities in Australia and New Zealand.

Dental specialist applicants with an overseas qualification can be assessed to determine if their qualifications are ‘substantially equivalent’ (section 58(b) of the National Law).

The fundamental principle of all overseas assessments must be that the qualification be assessed against the competencies and attributes of a new graduate for the respective profession.
Q25 – Should the appointment of Chairperson of a National Board be on the basis of merit?

The Council supports the concept of good governance which requires appointment of a member to be based on merit and the necessary governance skillset required.

Q26 – Is there sufficient oversight for decisions made by accrediting authorities? If not what changes are required?

The appointment of an external accreditation authority by a National Board is provided for under the National Law. The DBA has followed this approach with the appointment of the ADC as its accreditation authority.

The accreditation authority makes an accreditation decision. The regulator then approves, or otherwise, the accreditation of the programme to allow graduates from that programme to register within a specific profession. Both decisions share the same threshold – does the programme meet the minimum standards to deliver competent graduates to practise safely once registered?

However, there is a potential, where two different accreditation decisions for the same programme were reached. This creates difficulty in explaining the two different outcomes reached through consideration of the same report, based on the same minimum standards to the provider. This creates confusion for the provider, the programme’s students, and could lead to tension between the parties involved.

It is the Council’s view that the regulator should make the accreditation decision based on the recommendation of the accreditation committee – appointed for their educational expertise.

Please do not hesitate to contact me for any clarification or further information required on any aspect addressed above.

Yours sincerely,

Michael Bain
Chair

Marie Warner
Chief Executive