Australian Dental Council

SUBMISSION

BY THE AUSTRALIAN DENTAL COUNCIL

TO THE SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO
THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR DOCTORS AND OTHER HEALTH WORKERS

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Scope of submission

1. This submission restricts its comments to the key aspects of the proposed National Registration and Accreditation Scheme (NRAS) which affect the work the Australian Dental Council (ADC) currently undertakes in its role as the accreditation body for the dental profession.[1]

2. This submission therefore relates broadly to the following term of reference:

   (c) the effect of the scheme on standards of training and qualification of relevant health professionals;…

   In addressing this term of reference the submission relates importantly and necessarily to the inquiry's second tem of reference:

   (b) the impact of the scheme on patient care and safety.

3. The submission articulates some key matters the ADC believes must be embodied in any accreditation scheme. The ADC is concerned that there is insufficient acknowledgment in the proposals for the NRAS to date that the focus of accreditation is on quality systems and outcomes, and the inputs, processes, content and outputs related to fundamental aspects of the teaching and learning environment, the operating environment and the education and training program for clinical professional education and training. In its role as the national accreditation body for the dental professions the ADC is undertaking a process that ensures that a university or training body has in place the academic and clinical educators, the education and training facilities, and the processes and resources required to demonstrate quality in graduate outcomes, and teaching and learning outcomes that lead to quality oral health services and outcomes for the Australian community.

A. Accreditation standards must be set independently of government and other stakeholders

> *The accreditation system must operate within a legal framework...The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical [or dental] schools and the profession...The legal framework must* ***authorize the accrediting body to set standards****...(emphasis added)* [2]

4. The accreditation body must be responsible for setting accreditation standards to ensure the integrity and independence of the accreditation process. The international standing and acceptance of Australia's professional standards relies on this independence of accreditation processes from government, the bureaucracy and other stakeholders.

5. There is a significant lack of clarity around the respective powers of the Ministerial Council, national boards and accreditation bodies as they have been described to date in the NRAS proposals.

6. The ADC is greatly concerned that the Ministerial Council will have the final sign-off on accreditation standards. Setting accreditation standards is an absolutely central function for an accreditation body which develops them through extensive stakeholder consultation. Standards are based on the maintenance and improvement of education and training in order to ensure continuing quality healthcare and protection of the public.

7. There are demonstrable incentives for the interests of the National Board and Ministerial Council to be significantly influenced by workforce pressures and funding

[1] See page 6 of this submission for information about the composition and role of the ADC
[2] The *World Health Organisation/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education, 2005* (the WHO-WFME guidelines) (section 2)

issues. If these factors become part of the setting of standards for training of health professionals, there is clear potential for education and training standards, and hence, ultimately, public safety to be compromised.

B. Accreditation must embody the principles of quality assurance and quality improvement and the framework adopted needs to support this

8. The aims of accreditation include both quality assurance and quality improvement. To achieve this dual purpose it should be explicitly recognised that accreditation is a collegial process based on self- and peer-assessment. Thus the processes of accreditation should provide both public accountability for the quality of training and should also encourage further improvement in the quality of training. There is inadequate recognition in the NRAS proposals of the ongoing nature of the accreditation process via regular monitoring of progress and developments.

9. This dual function of accreditation is explicitly recognised in the dual standards for quality assurance and quality improvement set out in Professions Australia's *Standards for Professional Accreditation Processes* (June 2008) and by WHO/WFME guidelines for medical education and training. These documents have been endorsed by the ADC and are acknowledged as best practice in the NRAS consultation documents.

10. The accreditation process should involve a rigorous assessment of a course or program that is undertaken as a collegiate process and one that is ongoing throughout the period for which the program is accredited. An important feature of the accreditation process is its ability to facilitate and encourage quality improvement.

11. It is important that the framework that is established does not limit the quality improvement aspect of accreditation; adversely affect the collegiate nature of the process; or inhibit the ability of the accrediting body to engage with the institution to address problems that might arise.

C. Accreditation must be undertaken by experts under flexible arrangements

12. Selection of panels who undertake the accreditation of programs should be the responsibility of the accreditation body. The NRAS proposal has been overly prescriptive in defining the composition of an accreditation panel. This must remain very flexible and be able to be tailored for the circumstances, incorporating the following principles:
    - expertise is essential on a Panel, as is an appropriate balance of knowledge and experience and some exclusionary criteria (to avoid potential conflict of interest, eg not from the same institution; not from the same State);
    - expertise on the Panel needs to be appropriate for the task;
    - appointments to Panels should be by invitation, not by open application process (although there could be an open process of application for inclusion on a list of those eligible and qualified for appointment to Panels) to ensure the Panel contains suitably qualified members who are both relevant and appropriate for the program that is being reviewed, and who will have the respect of all parties for the authority of the panel.

13. Each program to be accredited can require unique skills and experience from a panel; the lack of such input can jeopardise the integrity and success of the process.

14. The assurance of transparency, independence and accountability by way of wide representation from within and outside the profession in relation to accreditation will come in the several layers within the accreditation body through which accreditation recommendations of the assessment panels are made.

D. The distinct functions of program accreditation and assessment of international dental graduates need to be clearly demarcated

15. The assessment of individual education and training courses and institutions against pre-defined accreditation standards ('program accreditation') is a separate and distinct function from the assessment for registration eligibility in Australia of individual overseas trained practitioners who are qualified in courses which are not recognised in Australia ('assessment' or 'examination').

16. It is the norm for Australian health professions that these two different and distinct functions are undertaken by the same existing health profession council (such as the Australian Dental Council, for dentistry). However, these two functions are managed differently and separately, their processes are entirely distinct, and decisions occur through separate committees and governance pathways.

17. There is limited acknowledgment in the NRAS proposals that these two functions, and the separate assessment processes that they involve, are different and distinct. They are inappropriately linked and the failure to make this distinction gives rise to inappropriate proposals.

E. Accreditation bodies must be allowed to get on with their job

18. The bodies undertaking the accreditation and assessment process must be accountable for the use of funds and the transparency of processes and decision making. Micro-management of and onerous reporting requirements on the accreditation bodies would militate against their effective functioning. There is clear risk in the NRAS proposals for this to occur, and this risk should be removed.

19. The NRAS proposal sees the agency's and board's involvement in specifying what the accrediting body should do and the services it should provide, as well as its budget, and the potential capacity of the national agency/national board to direct the accreditation body in this regard. There needs to be significant provision for flexibility of the organisation and responsiveness to particular circumstances that arise. Excessive prescription in contractual arrangements would inhibit optimal delivery of accreditation functions.

20. As set out in section A above, independence in decision-making is critical to ensure the integrity of the health professions' accreditation processes. This independence is inherent in the corporate nature and governance structure of the ADC. Any changes that might be required by the NRAS in the membership provisions of the ADC or in the composition of its Board are the responsibility and prerogative of the corporate entity that is the ADC. Matters concerning the legal framework for the accreditation and examination functions which are to be undertaken by the ADC are appropriately the concern of the Ministerial Council (as set out in the WHO-WFME guidelines). The implementation of these functions should be addressed in the proposed contractual relationship with accreditation bodies, which can negotiate provision for community input as well as input from education providers and the relevant professions. These are not matters into which the Ministerial Council should intrude.

F. Funding for accreditation functions should be based on the capitation model

21. Due to the nature of the tasks involved, the frequent emergence of unforeseen new issues and the collegial model of continual improvement, the expenditure related to accreditation is inconsistent and unpredictable on an annual basis. There therefore needs to be recognition in the funding arrangements between the national agency/national board and the external accreditation body of the requirement for infrastructure funding ('core funding') as well as funding for direct service provision for program accreditation and examining activities.

22. Funding from the NRAS to accreditation bodies should continue to be based on the current capitation model (or another future-secure funding base) to ensure the accreditation body is able to cover both infrastructure and operating costs associated with the accreditation role.

23. The ADC supports continuation of the cross-subsidy for program accreditation from practitioner registration fees provided this cross-subsidy applies *within* professions and *not between* professions and that the fees for a profession are set at levels that support the regulatory activities for that profession only.

G. Concluding comments

24. The ADC supports the objective of greater national uniformity in the regulatory framework for the health professions, and the existence of national, independent, profession-specific accreditation processes to secure the ongoing supply of well-trained health professionals to deliver high quality patient care and treatment for the Australian community.

25. In this submission the ADC has outlined a number of concerns about proposed features and operational arrangements for the NRAS that, in our view, would be detrimental to the attainment and sustainability of the standards of health professional education and training, and so ultimately of the quality of health care delivery. The ADC would support recommendations by the Senate Community Affairs Committee for action by Governments to address the concerns of the ADC (and the other health professions national accreditation bodies) to ensure that in the implementation of the NRAS the standards and benefits of the current arrangements are preserved and the high standing internationally of Australia's accreditation processes for the health professions is protected

BACKGROUND INFORMATION

About the ADC

The Australian Dental Council (ADC) was formed in 1993. The ADC incorporated in 1996 and is a registered company limited by guarantee.

Membership of the ADC comprises the following bodies associated with the standards of education and training and regulation of professional practice for dentists, dental specialists, dental therapists and oral health therapists, and dental hygienists in Australia:

(a) the Dental Boards of the States and Territories of Australia
(b) the Australasian Council of Dental Schools
(c) the Australian Dental Association Inc
(d) the Royal Australasian College of Dental Surgeons
(e) the Australian Dental and Oral Health Therapists Association
(f) the Dental Hygienists Association of Australia

In addition, the Dental Council of New Zealand and the Council of Regulatory Authorities for Dental Technicians and Dental Prosthetists Australia and New Zealand Inc (CORA) have Observer status on the ADC Board.

The ADC is governed by a Board of Directors comprising nominees of the above member bodies, together with the officebearers and Chairs of standing committees.

The **principal functions** of the ADC are:

(a) to advise and make recommendations to Australian State and Territory Dental Boards in relation to:
    - *accreditation* of education courses leading to a registrable dental or oral health qualification, conducted by Australian dental schools and other recognised institutions
    - *assessment* of the suitability for practice in Australia of persons with overseas dental qualifications, and
    - uniform criteria for recognition of qualifications for registration and standards of practice
(b) to provide advice on matters concerning the occupational regulation of dentists, including general and specialist registration, and of professions allied to dentistry
(c) to undertake certification of other education courses that do not lead to a registrable dental or oral health qualification, conducted by Australian dental schools and other appropriate institutions.

Accreditation Functions

The ADC first accredited the dental programs of Australian Universities in 1995. In recent years the ADC has joined with the Dental Council of New Zealand to form a joint Accreditation Committee whose role is to advise the ADC and DCNZ on accreditation matters, including criteria for the accreditation of education programs leading to registration as a dentist, dental specialist, dental hygienist, dental therapist or oral health therapist. Whilst the ADC and DCNZ have adopted a joint Australasian accreditation process the two Councils retain jurisdictional authority for the accreditation of educational programs in their respective countries.

The ADC has been advised that the Australian governments have assigned to the ADC the accreditation functions for the Dental Board of Australia under the national registration and accreditation scheme (NRAS). In terms of the intergovernmental agreement for this scheme, this assignment of accreditation functions is a transitional measure for a period of three years from 01 July 2010.