Response Template - Consultation on *Australia's Health Workforce: strengthening the education foundation*

This template is for responses to *Australia's Health Workforce: strengthening the education foundation,* the final report of the Accreditation Systems Review project.

Please return your response to MOH-ASR@health.nsw.gov.au. **Responses are due by 28 March 2019**

Stakeholder details	
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FUNDING AND COST EFFECTIVENESS (RECOMMENDATIONS 1-3)	
1. What are the costs, benefits and risks in relation to the implementation of funding principles and performance indicators as recommended in the final report? Are there other ways to achieve the outcomes the ASR was seeking with less cost and risk?	The ADA supports the implementation of principles and performance indicators as this will improve transparency of the true costs of accreditation however, the recommendations only deal with one side of the equation, cost and not quality. It should be noted, however, that there is already significant harmonisation of these factors as all five dental practitioner programs of study are accredited by the one organisation, the Australian Dental Council. The ADA would support the need for the development of these principles and indicators to be undertaken in conjunction with the accreditation bodies to ensure they are fit for purpose and flexible enough to meet the individual and functional and complexity of the accreditation processes to be undertaken.
IMPROVING EFFICIENCY (RECOMMENDATIONS 4-6)	
2. What implications may the implementation of these recommendations have for bodies outside AHPRA and the National Boards (e.g. education providers, education regulators, health professional accreditation bodies)? In what timeframes would these bodies be able to achieve the outcomes of the recommendations?	These recommendations, while supported in principle, must recognise that the bodies involved in the accreditation of providers and those that accredited courses both provide complementary but unique functions which are not interchangeable. Any attempt to streamline these processes will not address any perceived deficiencies and is likely to result in significant investment and potentially disrupt, what is in many cases, already a smooth-running model. The ADA would not support any moves to replace professional accreditation in favour of oversight for all accreditation functions by TEQSA/ASQA as it does not believe that TEQSA/ASQA assessment is adequate. The ADA is aware that the Health Professions Accreditation Councils' Forum is already acting to address the concerns raised in the Wood's Report.
3. What are the costs, benefits and risks related to the	For the dental professions, there are already significant efficiencies being made through the Health Professions Accreditation Councils' Forum, and

implementation of recommendations 4-6?	there is continued work being undertaken to introduce common terminology and definitions. Whilst the ADA supports further efficiencies, any implementation of 'uniform requirements' must carefully balance any streamlining against the different levels of invasiveness of procedures performed by the different health professions. Lack of careful balance will lead to public safety risks (if under-regulated) or irrelevant bureaucracy (if over-regulated).
RELEVANCE AND RESPONSIVENESS OF EDUCATION (RECOMMENDATIONS 7-14)	
4. What implications may the implementation of these recommendations have for bodies outside of AHPRA and National Boards (e.g. consumer groups, education providers, accreditation bodies)? In what timeframes would these bodies be able to achieve the outcomes in the recommendations?	Accrediting programs whose graduates are eligible for registration under the national scheme requires a detailed understanding of the profession involved, the pedagogy underpinning the preparation of that profession and an understanding of the graduate's role in the workplace. Few consumers would have the level of knowledge required to contribute effectively to this process. The inclusion of students and employers would, however, be useful in the accreditation of training programs. That is not to say that there is not a role for consumers – many accreditation councils have consumer input to the process already as do universities. There is no evidence to support an expanded role for the AHPRA Community reference group in accreditation.
5. What are the costs, benefits and risks related to the implementation of recommendations 7-14?	As above, greater consumer input may not result in improvements to the responsiveness of education providers. The ADA supports the development of competency standards with standard definitions and terminology and agreement on common areas and profession specific areas. As it stands, considerable confusion exists in the scope of practice that mid-level dental providers (therapists and hygienists) can perform after their training, which is less rigorous than that required to become a dentist. There have been suggestions that more liberal guidelines and even independent practice is being recommended for mid-level providers as a panacea solution to access to dental care in Australia. This risks compromising public safety and quality of care. However, too much standardisation in definitions and terminology may result in not enough delineation between programs and professions. We agree the system needs to allow for profession specific variations if it is to be responsive to technological change. Similarly, there should be an option to allow programs to include both input and output based standards to ensure graduates are able to meet the requirements for safe and competent practice required for registration.
ACCREDITATION GOVERNANCE – FOUNDATION PRINCIPLES (RECOMMENDATIONS 15-18)	
6. Do these recommendations reflect the most efficient and appropriate manner of delivering a governance foundation that will allow reform of accreditation functions?	The ADA does not support the recommendations. The ADA cannot see how increasing the governance role of AHPRA will provide independence but rather adds another layer of bureaucracy to the process. The accreditation process must be independent of the registration process and must be overseen by the profession involved to ensure it is contemporary and fit for purpose. The current partnership arrangements are working effectively.

7. What are the costs, benefits and risks related to the implementation of recommendations 15-18?	There may be some benefit for education providers but any savings may not flow on to the scheme. Through the Health Professionals Accreditation Councils' Forum, several protocols have already been standardised. Proposing that AHPRA sponsor consultations ignores the fact that such sponsorship would need to be funded from registrant fees and would most likely, therefore, require an increase in registrant fees which seems counter-intuitive to the purpose of the recommendation.
A GOVERNANCE MODEL FOR MORE EFFICIENT AND EFFECTIVE ACCREDITATION (RECOMMENDATIONS 19-24)	
8. What are the costs, benefits and risks associated with the implementation of recommendations 19-24 and of any proposed governance model?	There may be some role for such a body as recommended within AHPRA in relation to the development of guidelines for example to ensure some consistency, not unlike what happens across Boards now through the AHPRA policy group, however, its role should not replace the current responsibilities of the National Boards.
OTHER GOVERNANCE MATTERS (RECOMMENDATIONS 25-32)	
9. What implications may the implementation of these recommendations have for bodies outside AHPRA and the National Boards (e.g. Commonwealth Government departments, specialist medical colleges and the National Health Practitioner Ombudsman and Privacy Commissioner)?	Colleges and specialist societies are actively involved in accreditation processes, so any changes to these arrangements will potentially impact on their ability to provide expertise to the accreditation process. There could be negative impacts on the number of dentists undertaking specialist training if their role was diminished. Bodies involved in overseas practitioner accreditation play a vital role, but currently, do not consider the health workforce. The ADA supports discussions with the Department of Immigration and Border Protection to consider whether further overseas practitioners are actually required for skilled migration, using contemporary health workforce statistics.
10. What are the costs, benefits and risks related to the implementation of recommendations 25-32?	N/A
COST ISSUES	
11. Separate consultation will be undertaken with AHPRA and the National Boards on costs of implementing recommendations. Are there any other significant costs to other bodies not already canvassed in the preceding questions?	The ADA does not have a view.
PROGRESS ALREADY MADE ON AREAS ADDRESSED BY RECOMMENDATIONS	

12. To what extent do the actions undertaken since the completion of the ASR project address the recommendations of the final report?	Given the length of time that has passed since the review was undertaken, it would be appropriate to liaise with the Health Professions Accreditation Councils' Forum to seek up to date information relating to these matters.
ADDITIONAL QUESTIONS	
13. Are there any other costs, risks or benefits related to the final report recommendations, not addressed in other questions?	Consideration of the impact of changes on registrant's fees must be a paramount consideration in any decisions made by COAG.