



AUSTRALIAN DENTAL
ASSOCIATION INC.

**Australian Dental Association Inc. response to
National Registration And Accreditation Scheme
For The Health Professions**

CONSULTATION PAPER

Other matters for inclusion of Bill B

23 December 2008

**Authorised by
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SUBMISSION IN RESPONSE TO CONSULTATION PAPER

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About the Australian Dental Association Inc (ADA)

The ADA is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers. The primary objective of the ADA is to encourage the improvement of the health of the public and to promote the art and science of dentistry. There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

Introduction.

The ADA thanks the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee for the opportunity to respond to this Consultation Paper.

This submission will deal with the Paper in the order in which it was presented. It will only respond specifically to issues of interest to the ADA by dealing with each of those Proposals. Should a Proposal from the Paper not be responded to, then the ADA has no comment or input to make in respect of that proposal and is generally supportive of it.

Consultation Paper:

3. Delegation powers of national boards.

Proposal 3.5.1:

This proposal is supported as are the restrictions for delegation proposed.

The ADA has on a number of occasions expressed concern as to the costs to be associated with the processes created under the National Registration and Accreditation Scheme, particularly as it has been envisaged that the costs of the scheme are to be primarily met from registration and other fees generated. As any increase in registration fees incurred will only result in costs of health care being correspondingly increased - care must be exercised.

Currently some jurisdictions in Australia have complaints' processes that may deal with professionals that fall outside the scope of professional review schemes and as such those processes are funded separately by government and not the

professions.¹ Where possible, if these processes are to be utilised for professional review, they should remain funded by government as exists now. While the ADA supports the implementation of proper review processes, it does not accept that the costs of such administrative bodies, currently funded by government, become funded under the new scheme and thus met by professionals.

The creation of “statutory” Committees will entail retention of members for those committees, who will in turn be entitled to receipt of appropriate remuneration for their services. Elements of the voluntary participation that now exists in various jurisdictions will be removed with resultant cost increases.

Further, delegation “to staff or other persons” is cause for concern. This provides a very wide and unfettered power of delegation. The ADA would insist that some guidance be provided to the national board as to how and to whom the delegation power is to be provided. Specific guidance would be needed to outline to the board the ‘way and the how’ matters are to be delegated. How delegation occurs must depend on the matters to be considered under the delegation power. There must be clear guidelines established that require the matching of the seriousness of the matter being considered under the delegation power to the skill level and expertise of the delegated panel.

The ADA’s support for this proposal would therefore be conditional on the imposition of caveats for delegation that require:

- A costs benefit analysis be undertaken when delegation of authority is given to a Committee to perform a function, to ensure that the delegation is being efficiently and economically viable.
- A costs benefit analysis be undertaken of any proposed re-structure of existing government funded administrative review bodies which might entail them being brought under the umbrella of the national registration scheme. Unless a very strong case was found to exist for change, the ADA would suggest the administrative costs of such bodies remain with government.
- Specification of appropriate delegation powers and guidance as to the mode of delegation and appointment of delegates.

Proposal 3.5.3:

Whilst supportive of this proposal in general terms, the ADA repeats its often made comments as to the degree or proportion of community representation on various Committees proposed. Again it states that while it recognises the important role of community members in these areas, it suggests that where membership of numerically small committees (3-5 members) is being considered, care be taken that proportionally, community representation does not in fact outweigh and sacrifice professional participation and expertise on committees that will primarily be determining “professional” issues. E.g. ability to practise.

It should be remembered that existing legislation requires all panel members to place the interests of the public “before the interests of the particular health practitioners or any body or organisation that represents health practitioners.” This statutory obligation makes clear the priorities to be considered by members of committees and should restrict the necessity for significant proportions of lay persons to be on committees. In dentistry, dentists have long history of taking

¹ For example the Health Care Complaints Commission in NSW.

this protection of the public seriously. In fact recent evidence suggests that the introduction of independent tribunals has lead to lesser sanctions for dentists.

Proposal 3.6.1:

This proposal is also generally accepted.

The ADA suggests a number of areas need to be considered here and they are:

1. Consideration needs to be given to the status of the practitioner's right to practise pending a review or appeal and to identify who or what authority will determine this.
2. The imposition of a time limit within which a review or appeal can be lodged.
3. In whom or what authority a right of review or appeal will vest. Is it envisaged that a review will be able to be sought by a Board from a decision of a Committee to whom the Board has delegated its role or will the right of review be confined to the practitioner?
4. The third point above, unless addressed, may suggest that an unlimited right of review may be available. A limitation needs to be imposed to avoid the creation of an indeterminate process of review.
5. Any exercise of the ability to suspend a practitioner must be limited to a Board decision. Should the recommendation to suspend be made by any authority then that penalty should not be imposed without the original recommendation to suspend being reviewed by the Board. Such a significant penalty should not be imposed without Board review.

4. Appointments to board (non statutory) committees or (statutory) panels.

Proposal 4.1.1.

Similar concerns to those expressed in respect of Proposal 3.5.1 are raised here and should be addressed. Allowing "silence" on the process through which a board might establish committees seems contrary to the spirit of the scheme as expressed elsewhere. Transparency in the process must exist.

Proposal 4.1.2.

For the reason provided in Proposal 4.1.1, the adoption of Option 1 is preferred by the ADA. Again, this support is qualified to the extent that in creating the make up of the committee, it has to be ensured that those that comprise the committee are qualified and have the expertise to be fully capable of addressing the issues to be considered.

See comments above under *Proposal 3.5.3.*

Proposal 4.1.3.

Adoption of Option 1 and/or Option 3 with elements of option 1, insofar as it provides transparency, is preferred by the ADA.

5. Interaction of national scheme with other legislative schemes.

5.1 Options

In relation to the interface between the national scheme and state and territory schemes, the ADA feels that for the creation of clarity and certainty between jurisdictions, Option 1 is preferred.

The ADA sees Option 2 being acceptable but only if in doing so there is national consistency between the State and Territory laws created.

The creation of a national scheme provides the opportunity to create uniformity and to do otherwise would undermine the basic premise upon which the national scheme was designed.

5.2 Criteria

Proposals 5.2.1- 5.2.8 and 5.2.10.

The options suggested for each Proposal under consideration are acceptable.

Proposal 5.2.9.

Qualified support for Option 2 is provided by the ADA.

As a general principle, all Australian children should be subject to the same protection measures notwithstanding the State or Territory in which they reside. It is anticipated that the National Framework for Protecting Australia's Children will be released in early 2009. COAG noted that all jurisdictions, with the exception of Victoria and the Australian Capital Territory, would exchange information on non-conviction charges for screening of people working with children.

Every opportunity for uniformity and certainty ought to be pursued here but at the same time the interests of children must be the primary determinant of the approach to be taken.

6. Trans –Tasman Mutual Recognition (TTMR) and the national scheme.

This is acceptable. Care must be taken to best protect the quality of care that will be able to be delivered to Australians. The ADA is concerned that with the creation of the new scheme, some segments of health professions may attempt to utilise the process to "up skill" their scope of eligible practice without the appropriate training.

Every effort must be made by the Ministerial Council and the board to ensure that for each "equivalent occupation" there is an assessment completed by the accrediting authority to ensure that the applicant for registration has the requisite skills and experience to practice that "equivalent occupation" in Australia. As between state and territory jurisdictions, there are some minor but relevant differences between scopes of practice that require checks to be performed upon a registrant to ensure that the appropriate knowledge and skills are possessed by the applicant prior to registration. The same will also occur in TTMR matters. There may be a need to have appropriate accredited 'bridging' courses to achieve protection of the public.

Special care will also have to be exercised to ensure that Boards communicate with each other to ensure that in the process of providing registration for an equivalent occupation there is no encroachment by a health professional that crosses the 'boarder' of the jurisdiction of one Board to another. What is suggested is that care would have to be taken that a particular occupation within nursing for example did not in the TTMR process (or in the development of professional standards) cause a nurse to be granted registration as an "equivalent" health professional that would authorise practice of a profession that in Australia would fall within another category of registrant registered under another board's jurisdiction.

Thank you for the opportunity to respond to the Paper.

A handwritten signature in black ink, appearing to read 'N D Hewson', with a long horizontal flourish extending to the right.

Dr. N D Hewson
President
Australian Dental Association Inc.

23 December 2008.