



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

Submission to the Discussion Paper

Cover Sheet

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Dear Prof Woods,

Thank you for the opportunity to provide feedback on the discussion paper released on 27 February 2017, on the independent review of accreditation systems within the National Registration and Accreditation Scheme (NRAS) for health professions.

The discussion paper provides a good overview of the Australian environment related to health workforce policy setting, tertiary and vocational educational quality assurances, and the health profession accreditation functions shared between the national boards within the Australian Health Practitioner Regulation Agency (AHPRA) and the accreditation councils, where appointed.

[Overview of the Dental Council - New Zealand](#)

The Dental Council - New Zealand ('the Council') is a responsible authority established by the Health Practitioners Competence Assurance Act 2003 (HPCA Act). Our primary purpose is to protect the health and safety of the public by ensuring that oral health practitioners are competent and fit to practise. The oral health practitioners regulated by the Council are dentists, dental specialists, dental therapists, dental hygienists, clinical dental technicians, dental technicians, and orthodontic auxiliaries. We regulate approximately 5,200 oral health practitioners—with about 4,440 currently holding annual practising certificates.

Section 118 of the HPCA Act defines our role and functions. The Council's regulatory functions can broadly be described as registration, and ongoing assurance of competence and fitness of practise, of oral health practitioners; managing competence, conduct and health related concerns; and, setting standards. These standards include:

- defining scopes of practices and the associated prescribed qualifications that enable registration in the relevant scope of practice
- describing entry level competencies for each of the professions
- setting accreditation standards, and accrediting and monitoring of programmes to ensure our prescribed qualifications meet and maintain the educational quality to produce graduates that are competent and safe to practise in New Zealand
- the Council's standards framework incorporating ethical principles, professional standards, and practice standards to be met by registered oral health practitioners. The standards framework describes Council's expectation of appropriate professional behaviour and threshold standards that must be met in specific areas of practice—such as infection prevention and control, management of medical emergencies etc.

Trans-Tasman arrangements

The discussion paper covers the Australian context in detail, with some references to other international jurisdictions—in particular, the United Kingdom. The discussion paper fails to recognise the existing relationship between Australia and New Zealand. It is recognised that the focus of the review was on accreditation under NRAS, but current agreements with New Zealand regulators are intrinsically linked to the accreditation scene in Australia. Any change(s) to accreditation under the NRAS scheme will have an (potentially significant) impact on existing arrangements between health regulators and accreditation authorities across the two jurisdictions.

Eight of the fourteen health profession accreditation authorities listed in Appendix 3 of the discussion document have accreditation agreements in place with New Zealand. These relationships rest within the context of the Trans-Tasman Mutual Recognition Arrangement (TTMRA).

The professions with joint accreditation initiatives include dental, medicine, podiatry, pharmacy, physiotherapy, chiropractic, occupational therapy, and optometry. The arrangements differ in nature, with some having a truly joined process (for example, dental) while others delegate the accreditation activities to their Australian counterpart, and decisions are made by the New Zealand regulator based on a recommendation from the Australian accreditation council (for example medicine, pharmacy and physiotherapy).

The New Zealand Ministry of Business, Innovation and Employment describes the TTMRA as a non-treaty arrangement between New Zealand and Australia's commonwealth, state and territory governments.

It is a cornerstone of a single economic market, and a powerful driver of regulatory co-ordination and integration.

Two of the objectives described include:

- *Greater co-operation between regulatory authorities.*
- *Greater discipline on regulators contemplating the introduction of new standards, regulations and occupation registration requirements.*

The arrangement is supported by overarching legislation, which means all laws are subject to it unless specifically excluded or exempt.¹

For dentistry in New Zealand, the TTMRA takes legal precedent over the HPCA Act.

For health professions, the Trans-Tasman Mutual Recognition Act 1997 recognises Australian and New Zealand registration standards as equal. This allows registered oral health practitioners the freedom to work in either country. This means that if you are registered to practise in Australia, you can register and practise in the same profession in New Zealand (NZ), and vice versa.²

To facilitate similar entry standards to the dental professions across both jurisdictions, the Council, the Australian Dental Council (ADC), and the Dental Board of Australia (DBA) since its establishment in 2010, have worked closely together. In particular, on the areas of accreditation and the dentist registration examination³ for overseas applicants who do not hold prescribed (NZ)/approved

¹ Accessed on <http://www.mbie.govt.nz/info-services/business/trade-tariffs/trade-environment/economic-relationship-with-australia/trans-tasman-mutual-recognition-arrangement> as at 34 April 2017.

² Medical practitioners are exempt from TTMRA

³ The Council (NZ) has changed its provider for dentist examinations in 2016 to the National Dental Examining Board of Canada (NDEB)

(Australia) qualifications. The three parties jointly reviewed the accreditation standards in 2015. As dental regulators, the Council and DBA jointly established entry level competencies for 13 dental specialties in 2015/16. Accredited programmes need to provide evidence as part of accreditation reviews that these competencies are incorporated and assessed within the programme.

The Council and the ADC have a joint accreditation committee responsible for the accreditation and ongoing monitoring of Australian and New Zealand dental programmes. This covers programmes in dentistry, dental specialties, dental hygiene, oral health therapy, clinical dental technology/dental prosthetics (in Australia). The committee administers the accreditation function against the joint accreditation standards and processes.

The Council relies on the educational and quality assurance expertise of the accreditation committee to direct accreditation policy, conduct the programme reviews, perform ongoing monitoring of programmes, and to make recommendations to the Council on whether the programme meets/continues to meet the accreditation standards. The Council has not delegated decision making authority to the accreditation committee. The Council makes all accreditation decisions on both policy directions and individual New Zealand programmes.

These joint initiatives contribute towards achieving consistent standards across both jurisdictions, which facilitate ease of workforce movement and regulatory resource sharing.

The international scene

Another aspect only touched on briefly in the discussion paper is the “competent authority model” (p.69) and cost line item on p.30. The related activities fall under accreditation and registration of overseas registrants.

The Council uses the competent authority model. It validates the accreditation authority in the respective jurisdiction to ensure the competencies/scopes of practice, accreditation standards and processes can be deemed equivalent to New Zealand. Once validation has occurred the Council recognises qualifications accredited by the particular accrediting body. This significantly streamlines the registration process for applicants holding those qualifications, as it closely mirrors that of New Zealand graduates. Registration can occur within a week rather than the more involved, longer and more expensive registration pathways of individual assessment or registration examination. This is of particular importance with an ever-increasing global healthcare workforce and increasing movements, and some areas of recognised skills shortages in the healthcare workforce—particularly in rural areas.

New Zealand have validated Canada (via the Commission on Dental Accreditation of Canada), Ireland (Dental Council), the General Dental Council, and has started a validation process with the Commission on Dental Accreditation of the United States. The ADC has accepted Canada as equivalent, and was approved by DBA for registration as a dentist.

Other professions have also adopted the competent authority model.

There is potential for streamlining of these international recognition processes, and for consistency in application of the model in making registration decisions. Cost savings could be achieved by joint initiatives related to recognition of jurisdictions of shared interest—as this activity does not come cheap. It also has the benefit of increased efficiency for both the regulator and the registration applicant during the registration process. The Council will support initiatives that further strengthen competent authority recognition.

There are also initiatives by some healthcare professions (for example, dental)⁴ to establish international accreditation standards, and some professions have already established international core competencies and educational quality assurance frameworks (for example, pharmacy).⁵

This emphasises that accreditation schemes do not function in isolation, and that there is an increasing trend for international alignment and cooperation to remove unnecessary barriers for workforce movement, whilst ensuring that patient safety is protected by establishing appropriate benchmark entry level standards.

Discussion paper issues

The Council will respond to those issues raised in the discussion document it considers most relevant to its regulatory functions.

It is worth noting that regulatory authorities in New Zealand have no workforce planning mandate. This rests with the Ministry of Health—in particular, Health Workforce New Zealand.

Common approach to accreditation standards, processes and competencies

1. *What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?*
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?*
11. *What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlaid with profession-specific requirements?*

The Council agrees that there are some common competencies across all health professions, and a substantial overlap in accreditation standards and processes across the different health professions.

The Council would support development of common competencies and accreditation standards across professions, subject to discipline-specific competencies and, accreditation standards being retained to support profession differences.

Greater alignment between accreditation processes would provide greater clarity and administrative streamlining to course providers. This in turn could result in resource benefits for the providers, and hopefully downstream benefits to students, either through lower fees or increased service delivery.

Greater alignment of accreditation standards and processes also has the potential benefits of sharing resources, cost savings achieved through economies of scale, and fostering ongoing quality improvements. In particular, for those smaller professions where accreditation resources are spread across a small number of registrants.

Ensuring that profession-specific differences are not lost would be one of the greatest risks associated with the proposal for joint standards and processes. However, having a balance of educationalists and practising professionals involved in the development and/or review of standards, and in the accreditation review process of programmes, would mitigate this risk.

⁴ Through the International Dental Society for Dental Regulators - <http://isdronline.org/>

⁵ Competencies: https://www.fip.org/files/fip/PharmacyEducation/GbCF_v1.pdf and Educational quality assurance framework https://www.fip.org/files/fip/PharmacyEducation/Quality_Assurance/QA_Framework_2nd_Edition_online_version.pdf

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?*

Since the 2015 review of the dental accreditation standards, evidence associated with external assessment processes conducted on the programme—such as, by TEQSA/ASQA in Australia⁶ and CUAP/NZQA in New Zealand⁷—can be used to show how the accreditation standards are met.

An alternative model has been adopted by the Nursing Council in New Zealand, where the Nursing Council accredits programmes jointly with NZQA and CUAP. The Nursing Council conducts the ongoing monitoring.⁸

The Council would support greater alignment and potential closer collaboration between the various agencies to streamline the accreditation/quality assurance processes, and avoid unnecessary duplication. However, the Council considers profession involvement essential in the quality assurance of educational programmes to ensure that it reflects contemporary practice, and is fit for purpose to deliver competent and safe practitioners.

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

9. *Are changes required to current assessment processes to meet outcome-based standards?*

In 2015, the Council confirmed its regulatory approach as right-touch and risk proportionate. To reflect this in its operations, the Council has started reviewing its regulatory frameworks.

Over recent years the joint dental accreditation committee has adopted a risk-framework for the ongoing monitoring of programmes, but a risk-based approach for accreditation of new programmes and cyclical reviews has not yet been adopted. The same cycle and process applies for all programmes. The Council would support initiatives that would further strengthen a risk-proportional approach to accreditation, within its statutory responsibility to accredit and monitor programmes to ensure appropriate quality of education to deliver competent oral health practitioners.

The new dental accreditation standards that came into effect on 1 January 2016, was designed as outcome-focused standards, underpinned by competencies described for each profession. This was to avoid limiting flexibility and innovation on how programmes could be delivered. There was a greater focus on the curriculum mapping against the relevant competencies, and the introduction of appropriate assessments to ensure all the competencies had been attained. This change has been welcomed by the education providers, and no concern to date has been received on the new approach.

If Australia was to consider an open-ended accreditation, i.e. initial accreditation and re-accreditation only occurs in the case of a major change or serious risk identified to the programme's ability to continue to meet the accreditation standards, then the ongoing monitoring would need significant strengthening. The regulators must be satisfied that the programme is delivering appropriately trained practitioners for contemporary practice. A valid question could be raised whether quality assurance by both health regulators and the educational sector quality assurance systems (such as NZQA, TEQSA) is not overly burdensome on the educational institutions; or whether joint processes could not achieve an appropriate balance between educational and discipline specific review.

⁶ TEQSA=Tertiary Educational Quality and Standards Agency; AQF=Australian Skills Quality Authority

⁷ CUAP=Committee on University Academic Programmes (CUAP); NZQA=New Zealand Qualifications Authority.

⁸ <http://www.nursingcouncil.org.nz/Education/Approving-and-monitoring-programmes>

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?*

The dental accreditation process has to date been fairly responsive to major changes of programmes. Documentation might state longer timeframes to allow for existing workplans of normal cyclical reviews, but in reality these major change reviews have usually been completed in much shorter timeframes.

However, this might be an area where risk-proportional regulation can play a greater role to dictate the extent and nature of the review required to assure the continuation in meeting accreditation standards. In particular, as all major programme changes also undergo normal university approvals, that would assure some educational aspects. Greater reliance on these external quality assurance processes can be placed in considering the nature of a major change review.

Some common descriptions and consistent approaches on what major programme changes entail could also be helpful to providers.

Within the paradigm of risk-proportional regulation, any serious risk to a programme could be immediately escalated and investigated. The necessary safeguards can be put in place to protect the safety of the public whilst allowing the education provider an opportunity to get the programme up to the required standard, if possible.

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?*

If greater alignment in accreditation standards and processes can be achieved, then a number of the resources listed in the discussion document can be shared. This could include accreditation documentation; the assessors' pool—in particular, community members and senior academics; training of assessors, etc.

The two dental councils (NZ and Australia) are currently undertaking a joint accreditation process with the two medical councils (NZ and Australia), for a programme approved as a registerable qualification by both the dental and medical regulators across both jurisdictions. This is achievable due to the large overlap in accreditation standards on a principle level and similar accreditation processes. The primary purpose of this is to make the process easier for the provider to undergo a single accreditation review with a single submission and site visits, and hopefully similar outcomes at the end of the process that would streamline future monitoring and reporting.

Interprofessional collaboration can work, with willing participants.

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

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

The Council's mandate is to protect the safety of the public, and it considers the public/patient voice important in its key statutory functions, including accreditation. The Council strongly supports greater involvement of community representation at all levels of the accreditation process. All New Zealand site evaluation teams have a lay member present, and the Council has a third lay member representation. These members bring a valuable and unique perspective to the table.

The Council would encourage Australia to do the same.

Clinical experience and student placements

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

Clear strategic policy direction on healthcare priorities and educational needs to implement these should be communicated to both educational institutions, regulators, accreditation authorities, and professional bodies to ensure wider awareness.

Regulators and accreditation councils can facilitate change through the establishment of new professions or changes to scopes of practice, and embedding the principles within profession competencies and accreditation standards, as appropriate.

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

Having accreditation standards and curricula that are not descriptive in approach, and having the necessary educational expertise and profession-specific representation on the accreditation review panels, could all contribute towards driving the quality improvement changes. Outcome-based standards also facilitate educational innovation, and allow the provider with sufficient flexibility to incorporate different learning techniques that best suit the topic and support different learning styles of individual students.

Simulation-based training and outplacements for additional clinical experiences have been well embedded within dental education over recent years. The role of the accreditation body should be to facilitate these practices through standards that promote patient safety, and assurance that these learning methods and experiences within the overall programme allow students to attain the necessary competencies.

The delivery of work-ready graduates and national examinations

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?*

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

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

With the exception of a small number of jurisdictions, such as Canada and the United States of America, other dental regulators do not require a national “licensing” examination before practising. No dental regulator requires a period of practice supervision for dentists/dental specialists following registration.

The entry level standards are already defined in the competencies, and multiple accreditation standards relate to assurance that this is achieved by the programme (through the curriculum, assessments, external quality assurances, etc.).

The Council supports the principle in the discussion paper that—a new graduate has achieved competency, but that confidence and proficiency comes in time and with experience. Mentoring and support during the first few years of practice could assist these graduates during their early careers.

Within a risk-based regulatory environment, the key question is whether the regulatory response is proportionate to the risk posed? Is there sufficient evidence of competence notifications and concern of systemic risk of harm by recent graduates to justify a blanket approach of a national examination and/or supervision of new graduates?

If a risk-based approach to accreditation monitoring is adopted, then particular issues with a specific institution and/or programme could be addressed through the accreditation processes.

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?*
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?*

It is the Council's view that an appropriate balance between educational expertise and profession-specific representation is required to effectively assess programmes. Academic representation ensures appropriate academic rigour of the programme, while the profession representatives focus mostly on whether the programme represents contemporary practice and delivers fit-for-purpose practitioners for the workforce.

Community members normally focus on the overall “health” of the programme, student support and wellbeing, fairness and transparency of processes and documentation, cultural components of the programme, etc.

The Council does not consider it appropriate to comment on the most appropriate vehicle for the national boards to fulfil its accreditation function, except to emphasise that the various roles of parties responsible for accreditation should be clear to educational providers, and not put unnecessary barriers in place to ensure educational quality assurance.

We would like to use this opportunity to raise an area of potential tension within the existing arrangements. This is the possibility of different accreditation decisions being reached by the accreditation authority and the national board on a programme accreditation, relying on the same accreditation standards and underpinned by the same competency standards. This has the potential to create confusion with providers and students of these programmes; and potential difficulty for monitoring of conditions placed on the programme by the board, but not necessarily supported by the accreditation authority.

Assessment of overseas health practitioners

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

Our experience in New Zealand has been that there is significant overlap on a registration policy level on entry level standards, which allows for potential streamlining of registration processes. This could be more easily achieved within the context of a central regulatory authority, namely AHPRA.

On a principle level, the Council believes that once threshold entry standards have been met, registrants should be able to practise independently; as they have been considered competent to practise within their specific area of practice. Particularly registrants from competent authority jurisdictions where the entry level standards have been considered in detail, and determined to be equivalent to Australia. Similarly, a candidate that has passed a registration examination should be able to practise independently. Robust examinations should provide the necessary assurance that an applicant that has passed is competent and safe to practise.

Grievances and appeals

37. *If an external grievance appeal process is to be considered:*

- *Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?*

An independent panel/body for accreditation grievance appeals could be beneficial, particularly once an internal appeal process with the accrediting body has been followed, and the applicant/provider is still dissatisfied. A joint grievance panel by accrediting authorities can fulfil this function, excluding the accreditation authority involved. It is further proposed that the panel should include regulatory representation from the respective national board. Such composition would have the benefit of accreditation and regulatory knowledge. Perhaps such a panel could also include TEQSA or VET representation for accreditation appeals, to further strengthen the independence.

Alternatively, using an independent body, such as the ombudsman could be appropriate for Australian appeals.

Please do not hesitate to contact us if you require additional information or clarification.

Best regards,



Robin Whyman
Chair