AUSTRALIAN DENTAL ASSOCIATION INC
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6 August 2010

Committee Secretary
Senate Education, Employment and Workplace Relations Committee
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Committee Secretary,

Re: Inquiry into Industry Skills Councils

The Australian Dental Association (ADA) writes to you today with reference to the Senate Inquiry into Industry Skills Councils (ISC).

About the Australian Dental Association Inc.

The ADA is the peak national professional body representing about 12,000 members 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 objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and
- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health care.

Introduction

The ADA's participation in discussion of vocational training systems has been primarily through working with the Community Services and Health Industry Skills Council. As such, in responding to the Inquiry the ADA will be focusing on the role played by ICSs in the development of training systems in the area of health and in particular, oral health.

The ADA notes that the Community Services and Health Industry Skills Council (CS&HISC) has provided workforce reform in the community services and health industries. In doing so it has attempted to provide integrated industry intelligence and advice to Skills Australia, government and enterprises on workforce development and skills needs. Whilst the ADA is supportive of this role, it has always been keen to advise the Council that in fulfilling this function, attention must always be given to ensuring that in seeking this reform the key elements of safety and quality in healthcare delivery are not compromised. Safety and quality of care delivery must remain paramount, notwithstanding short-term demands for additional trained personnel in any particular area. Demand for short or long-term change of skill sets to meet shortages in the workforce must never result in compromises in the safety and quality of healthcare that is delivered.

The special case from dentistry and the inherent risks involved has been recognised in the National Registration and Accreditation Scheme where dentistry is one of only two areas of health where restriction of practice as well as title protection has been applied.

Dentistry is very different to other areas of health and 'medical' models often do not carry over to it. Also of note is that up to 90% of dentistry is practised in the private sector and in small, community-based office practices.

Terms of reference of the Inquiry

a) *the role and effectiveness of Industry Skills Councils (ISCs) in the operation of the national training system particularly as it relates to states and territories and rural and regional Australia;*

As briefly canvassed above, pressures for reform will from time to time be created by virtue of staff shortages that may have been created. All too often in health, budgetary constraints imposed by State and Territory government budgets cause staff shortages due to inability to recruit suitable staff. Similarly, a lack of supply in rural and remote regions of Australia can also result in calls for reform to meet these shortages.

It can be all too simplistic to seek to address these shortages by attempting to modify the skill set of some existing sector in the workforce or to create a new workforce member to meet the demand created. As stated, the ADA recognises the need for this and recognises that in appropriate cases this can be a viable solution. What does concern the ADA is that in the process there is the risk that safety and quality will be compromised to the detriment of the community.

Others advising the ISCs in the process cannot be familiar with all sectors and with all due respect, can be swayed by pressures from sources that may, in some cases, have a vested interest in a reform agenda being adopted. In consulting, ISCs will naturally seek input from the public health sector. Whilst suitable, the risk is that the advice that could be provided could be coloured by the need for solutions to resource shortages that exist within that sector. Care must therefore be exercised to ensure that a balanced perspective is created in the reform process undertaken.

In conducting any review and creating modifications in the health sector, the ADA suggests that on all occasions significant input and guidance be sought from appropriate personnel within that sector. Peak professional and other representational bodies must be consulted. In the case of reform in the dental health sector the ADA would suggest that as it is the leading representative body for dentists and as dentists are the dental team leader and the major employer in the sector, consultation with the ADA is essential.

By doing this, the ISC will be able to be assured that safety and quality in the reform process is maintained.

b) *accountability mechanisms in relation to Commonwealth funding for the general operation and specific projects and programs of each ISC;*

For general operation and specific projects and programs of each ISC, appropriately educated and trained people should be employed to write relevant competencies, standards and pathways. Currently, in the case of the dental workforce, technical writers with limited dental knowledge are writing these documents and sending them to various bodies for comment. For the reasons set out in (a) above the documents can then on occasions be inappropriate. Such persons may not possess the requisite skills or have some vested interest in seeking to support a reform agenda. In dentistry, this can mean that after a prolonged process of work, dentists, or some other highly skilled group often have

to rewrite and edit the reforms sought to be implemented. This is not only inefficient but could be dangerous in not ensuring maintenance of safety and quality.

Perhaps the management and consultation processes of the ISCs could be more economic and streamlined with consideration being given to greater consultation with such groups early in the process of development. This could then be later supplemented by introduction of a teleconference review process rather than the expensive face to face forums that seem to be currently offered. It is all too often the outspoken individual (with the greatest vested interest in reform) that seems to command all the attention in these large forums. As such, the views of the key stakeholders can be completely overshadowed in such a large group situation.

c) *corporate governance arrangements of ISCs;*

The ADA would argue that corporate governance arrangements need to be reviewed. A case in point is the selection of the chairman of the industry reference groups which has not followed normal protocols. It would appear that chairman are appointed internally and not by external stakeholders.

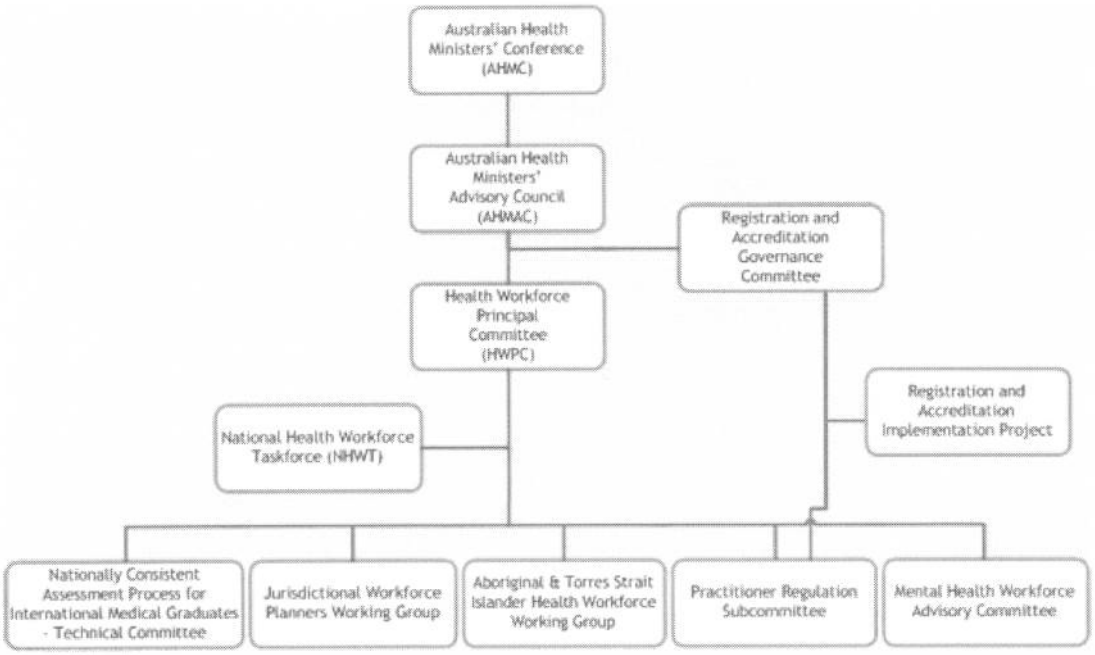
This is concerning as it means the agenda of the reference group can be potentially uninformed, skewed and biased. There is also apprehension towards the fact that information is not being recorded accurately (or recorded at all) and meeting procedures are not being adhered to. Chairs need to be selected independently to ensure no bias and to prevent certain agendas from being pushed.

As the peak professional body for dental care, the ADA is of the opinion that it should be able to have some say in the direction of dental personnel training and the articulation pathways should be developed through relevant reference group meetings.

There is also some concern at the timeframes given to participate in ISC deliberations and to respond to ISC submissions are inadequate. There has often been a lack of flexibility in these timeframes. The demands upon participants' time will mean that often private, as distinct from public sector personnel and others may prevent participation. Time spent by private individuals in consultation is often at the personal expense of that participant. ISCs need to be mindful that private businesses cannot drop everything at the last minute to attend meetings as this can be detrimental to those involved.

In the health sector there has been significant reform particularly – in health workforce issues. The Australian Health Practitioner Regulation Agency has now created national boards for the major health professions. With this has come considerable change. The Health Workforce Authority has also been created.

The organisational support for reform is complex. See table below.



The CS&HISC must recognise this structure and ensure that its actions are consistent with the activities of these groups. Failure to do this will create inconsistencies and result in gaps in training that will compromise those key factors – safety and quality.

d) *Commonwealth Government processes to prioritise funding allocations across all ISCs;*

The ADA reiterates that ISCs need to listen to the relevant stakeholders.

e) *ISC network arrangements and cooperative mechanisms implemented between relevant boards;*

Again, more stakeholder consultation needs to be conducted. The ADA has consistently been required to remind the ISC of relevant legislative requirements during recent revisions of competencies.

f) *the accrual of accumulated surpluses from public funding over the life of each ISC's operation and its use and purpose;*

This information has not been disclosed to the ADA at any stage, therefore it has no comment.

g) *the effectiveness of each ISC in implementing specific training initiatives, for example the Skills for Sustainability initiative under the National Green Skills Agreement;*

The ADA would advocate that the effectiveness of each ISC in implementing specific training initiatives has been reasonably well communicated in the VET sector. It is concerning, however, that stakeholders only find out about such programs after they have been implemented. Such information was not communicated to the ADA. Activities would be improved if wider awareness of review was provided.

h) *any related matters;*

The ADA would like to draw particular attention to the fact that most dental assisting traineeships occur in the private sector. The ISCs should be aware of this. The training occurs predominantly onsite in private dental practices under

the relevant terms and agreements. Often the dentist pays the course fees for the trainee. It is apparent that the ADA, as the peak stakeholder body with its members employing many of the allied dental personnel, must be included in discussions with the ISCs considering such dental competencies.

Yours sincerely

Dr Neil Hewson
Federal President