29 April 2009

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

community.affairs.sen@aph.gov.au

Dear Sir,

ADAVB SUBMISSION TO THE INQUIRY INTO THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR DOCTORS DENTISTS AND OTHER HEALTH WORKERS

Introduction

The Australian Dental Association Victorian Branch (ADAVB) welcomes the opportunity to comment on aspects of the design of the Federal Government's National Registration and Accreditation Scheme (NRAS) for doctors, dentists and other health workers.

The Victorian Branch of the ADA is part of the federation of ADA organisations, and while normally submissions to Commonwealth entities would be handled solely by the federal body (ADA Inc.), on this occasion the terms of reference of your Inquiry suggest that we should provide a State perspective.

As the NRAS legislation which clarifies the detailed approach to be taken to a wide range of matters (Bill B) is yet to be released, we are constrained to respond to earlier consultation papers which proposed certain approaches that may or may not end up in legislation.

Extensive submissions have been made by ourselves and others in response to these proposals, and copies of those we have made are enclosed for completeness. (NB. Not all of the calls for submission resulted in lodgement of a response by the ADAVB, as most were more appropriately addressed by the ADA Inc.).

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Key Concerns

We take this opportunity to summarise key points of support and opposition to elements of the new scheme as we have come to understand it.

Before doing so however, it is of concern that the very title of the committee's inquiry is indicative of the way that politicians view these reforms. It implies that '*Medical services are a problem and so reform measures are proposed, but while we are at it let's throw in the other health professions as well*'. Such views can damage non-medical areas that have been functioning well under the current arrangements.

According to the Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions:

"*5.3 The objectives of the national scheme, to be set out in the legislation, are to:*

(a) provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;

(b) facilitate workforce mobility across Australia and reduce red tape for practitioners;

(c) facilitate the provision of high quality education and training and rigorous and responsive assessment of overseas-trained practitioners;

(d) have regard to the public interest in promoting access to health services; and

(e) have regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery."

Source: IGA re NRAS, 26 March 2008, accessed at http://www.nhwt.gov.au/natreg.asp on 25 April 2009

The first four objectives are supported, while the last raises a number of issues, which are explored below.

While the ADAVB welcomes the establishment of a single national register of dental practitioners, and a national dental board responsible for regulating all dental service providers consistently across the nation, our chief concern with the scheme is evidence that the changes are being used to advance perceived ideologically driven workforce reform agendas. These reforms could potentially damage the quality of dental service delivery by reducing the standards of course accreditation and recognition of overseas qualified practitioners, and extending the duties of allied dental personnel to the point where they can no longer be distinguished from dentists.

The ADAVB also supports the ADA Inc.'s arguments about the development of the new Scheme:

- In the development of the scheme and any reform implemented, considerations relating to the safety and quality of health care delivery must be the focus. Political adjustment of standards because of temporary workforce shortages or maldistribution of the workforce must never be a consideration.
- The outlined scheme is overly bureaucratic and must be re-designed so it is more efficient and responsible. The new Scheme must be economical for health professionals and their patients.
- The development of Standards and associated scopes of practice must be left to the health board for each profession, so that these key controls are informed by detailed knowledge of the field being regulated.

(a) the impact of the scheme on state and territory health services;

The creation of a national registration system which improves the mobility of registered persons across all jurisdictions will not directly affect State and Territory health services.

If the new scheme is used to expand the duties of ancillary providers in a manner that offers the community a lower standard of care than they have come to expect, this will lead to a significant loss of confidence in our health system. Achieving this outcome in response to objective (e) in the IGA would be inconsistent with the commitment to use the scheme to promote public health and safety as defined in objective (a).

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

ADAVB welcomes measures being introduced to improve patient care and safety such as:

- Mandatory reporting of professionals who are placing the public at risk. Other practitioners or employers (like hospitals) must report conduct which puts patients at harm, including practising under the influence of drugs or alcohol, or sexual misconduct.
- Mandatory criminal history and identity checks for all health professionals registering for the first time in Australia. All other registrants will be required to make an annual declaration on criminal history matters when they renew their registration.

The Government has charged different groups with doing very similar work at the same time. This overlap and duplication comes at a high cost to Government at a time when expenditure restraint is being sought. It also

creates a heavy burden of policy review and response, distracting practitioners from getting on with the job of delivering health services.

Parallel developments affecting patient care and safety include:

- Projects being conducted by the Australian Commission on Safety and Quality in Health Care (ACSQHC) e.g.
  - Minimum safety standards
  - Practice accreditation
  - Patients at risk
  - Open disclosure
  - Clinical handover
  - Infection Control
  - Medication safety
  - Patient identification
  - Charter of Healthcare Rights
- The National Health and Hospitals Reform Commission
- Projects being coordinated by the National Health Workforce Taskforce, including the National Registration and Accreditation Scheme

These parallel developments also create a climate of change overload, which research into change management confirms is likely to lead to resistance rather than the desired outcomes.

The ADAVB supports recommendations from the ADA Inc. calling for

i. The Agency Management Committee to be dispensed with.
ii. The role of policy determination including the setting of professional standards, to rest solely with the National Health Profession Boards.
iii. The National Board for each profession to be made responsible for budget development and expenditure; with administrative support from the central National Agency.

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

The National Registration and Accreditation Scheme is hosted on a website badged the "National Health Workforce Taskforce" (NHWT). In addition to the information provided about the scheme, other pages provide insight into public sector workforce flexibility and restructure proposals, which are motivated by the needs of less than 20% of the service delivery system, and fail to take account of private sector and office based practice perspectives. The following extract from the NHWT website illustrates the commitment to create expanded roles for less qualified healthcare workers, and to achieve this as part of the NRAS reform process.

"Reforming the Workforce

- *System, funding and payment mechanisms to support new models of care and new and expanded roles.*
- *Redesigning roles and creating evidence based alternative scopes of practice.*
- *Developing strategies for aligned incentives surrounding productivity and performance of health professionals and multi-disciplinary teams.*

The agency will work with and across all jurisdictions to develop and articulate a national strategy for workforce reform and progress the demonstration, piloting, evaluation and implementation of new workforce models and reforms to assess their contribution to improving the efficiency and effectiveness of service delivery, within a framework of safety and quality of care.

The agency will identify, from innovation both locally in Australia and overseas, those areas of major job evolution/substitution and redesign that have potential national significance and demonstrate net benefit to the community. Funding will also be provided to support jurisdictions in implementing new models tested and evaluated. The agency will link into the National Registration and Accreditation Scheme to ensure sufficient regulatory protection for workforce redesign pilots and to support changes to scopes of practice." *(emphasis added)*

Source: http://www.nhwt.gov.au/coag.asp - accessed on 25 April 2009

Arguments that the entire health care system needs to shift to a 'models of care' approach when in fact that only really applies in large institutions like hospitals and nursing homes, chiefly in relation to medical services, is holding the rest of the health service providers to ransom. While we recognise that there are issues with the provision of some health services and that the system is stressed, we do not accept that the reforms proposed will be appropriate or effective solutions.

It is alleged that "*The exploration of new approaches to health workforce planning is being driven by demographic shifts and broad health system changes, including, a predominance of illness associated with an ageing population, increasing consumer demand for services and increasing costs*" (Australian Health Workforce Advisory Committee, Australian Medical Workforce Advisory Committee and Australian Health Workforce Officials' Committee (2005), A Models of Care Approach to Workforce Planning - Information Paper, Health Workforce Information Paper 1, Sydney, page 4, accessed at http://www.nhwt.gov.au on 1 April 2009).

This rationale is not explained further so that the reader can understand why these changes necessitate redesign of professional roles such as those performed by dentists or pharmacists. It is essentially an unsubstantiated assertion. It also appears to be driven essentially by a view that doctors could do more if they were able to delegate more duties to nurses. Even if this were true, it has little to do with establishing a need to change other health occupations.

In response to a related NHWT initiative, the Victorian Department of Human Services recently published a discussion paper on Health Workforce Competency Principles, which refers to the above quotation about a 'models of care' approach to workforce planning. The Executive Summary in that paper admits that:
"The paper does not seek to provide definitive answers to the 'why', 'what' and 'how' of a 'models of care' approach to workforce planning. It is anticipated that answers to these questions will evolve over time as planners and stakeholders further consider or work with this planning approach and reflect and learn from their experiences." (ibid)

Thus this is a policy that is to be imposed on the Australian community and all health professions without any good reason being offered. This is why we believe that ideology is driving the reform agenda rather than an objective rationale. In its present form, it is 'a solution looking for a problem'.

The proposal to establish a Core Competency Framework for the Health Workforce is a key workforce reform initiative, which we see as closely linked to the national registration and accreditation scheme. An NHWT Information Sheet on this subject dated May 2008 states:

> *"Identifying a core competency framework could provide a mechanism by which skill and knowledge can be recognised outside of the traditional silos of discrete professions. A core competency framework is a tool to describe specific skills and knowledge a person has and could assist in facilitating staffing across profession and/or service stream that could result in encouragement of workforce flexibility and role redesign. It is not clear if evidence exists that such a framework will impact on reducing key shortages across the health workforce."*

In other words, what the NHWT is proposing is the creation of a universal healthcare worker with only a core set of competencies and no specialised skill to be able to deal with more complex matters within a field of professional service. Furthermore this proposal is not based on any evidence that it will actually solve the problem of health workforce shortages (which we suggest are distribution problems rather than overall shortages).

The so-called "professional silos" are normally referred to by the professions as specialised 'bodies of knowledge'. Researchers, academics and professionals have spent centuries building up insights, skills, understandings and a knowledge base in each of these fields. Rather than being silos, they are the pillars and foundations on which our high quality healthcare system is built, yet the reformers propose to dismantle them.

According to an Access Economics Report (20 January 2009, prepared for the Australian Association of Pathology Practices) on Health expenditure and outcomes:

> *"To assess Australia's overall performance in terms of outcomes relative to health system costs, OECD countries were ranked 1 to 30 for each data series – expenditure relative to GDP and per capita, public share, life expectancy, PYLL and health status. Two 'summary measures' were then calculated to assess:*
> - *the 'total' score, a metric measuring the 'bang for buck' from total health spending; and*
> - *the 'public' score, a metric measuring the 'bang for buck' from public health spending.*
>
> ***Using these metrics, Australia has the best performance from its public health expenditure of any OECD country, and the fourth highest performance from its total health expenditure (behind Japan, Spain and New Zealand).*** *"* (pp, 3-4) emphasis added

On the one hand we have the community, media and the courts demanding that greater specialisation and skill training is evident in our health service delivery so that we avoid adverse and sentinel events. Then we have Government agencies and Ministerial Councils seriously suggesting that the rich and highly articulated bodies of knowledge in each of the health professional fields are troublesome 'silos' that need to be done away with in the interests of 'flexibility'.

How can the same Health Ministers who advocate the establishment of more and more stringent safety and quality measures – such as those being proposed concurrently by the ACSQHC, entertain proposals to 'dumb down' the training of health service providers, resulting in Australians depending on generic healthcare workers, whose ignorance of the detailed bodies of knowledge in specialised areas may mean that 'they don't know what they don't know'?

The mention of professional silos suggests that these policy initiatives have been influenced by the writing of Prof Stephen Duckett, who in the mid 2000s when he was an academic at LaTrobe University, advocated less emphasis on identifiable professions. Prof Duckett is currently a member of the Government's National Health and Hospitals Reform Commission. The following quote indicates his focus on ideology.

> *"The health workforce is now characterised by a large number of separate professions, each with a different course of preparation, a different emphasis in practice and, to some extent, a different ideological foundation in terms of the way in which the profession interacts with other professions and with patients or consumers. The workforce has changed dramatically over the last 20 years with increasing specialisation both within professions (for example, additional specialisations in medicine and nursing) and also by the creation of new professions. To some extent, this specialisation has led to increased quality of care as individual professionals have been able to develop in-depth knowledge and skills across a narrower range of areas.' However, by the late 1990s there was recognition that this increasing specialisation may have a downside in increased coordination costs, leading to inefficiency and problems of continuity of care."*

(Duckett, S. Australian Health Review May 2005 Vol 29 No 2, p.202)

While conceding that specialisation has improved quality of care, Prof Duckett asserts that coordination costs and continuity of care problems outweigh these benefits. We argue that specialisation is necessary to allow practitioners to learn, apply and keep up to date in health disciplines that are constantly evolving. At the same time however, the well-informed consumer/patient expects health providers to be able to offer them all possible treatment alternatives.

In the same paper, Prof Duckett offers the following radical view about the kind of future health service he wants Australians to have:

> *"ICT facilitated access to state of the art care paths and protocols changes the nature of the required educational preparation for health professionals. Currently, professional education is based on a "just in case" model of attempting to acquaint students with skills and knowledge to prepare them for a wider range of conditions than might possibly be faced in practice. In the future, service delivery (and provider knowledge) could be on a "just in time" basis where care protocols can guide the professional through the diagnosis and treatment process."*

(Duckett, S. Australian Health Review May 2005 Vol 29 No 2, p.203)

The ADAVB associates the NHWT initiative, including the National Registration and Accreditation Scheme, with this agenda to remove the emphasis on developing high-level critical thinking skills that will allow practitioners to make effective judgements based on the complex range of factors that may present uniquely with each and every patient. The alternative is a behaviourist model (a la BF Skinner) in which healthcare workers would do a basic Vocational Education and Training course before commencing practice, and then 'Google the answer' or refer to a protocol when they run into something they don't know.

The irresponsibility and irrationality of such proposals is of grave concern.

The widespread use of Problem-Based Learning (PBL) by higher education health training facilities reflects a recognition that **knowledge is 'context bound'**, and that meaning is attached to information by virtue of experience and reflection. This means that simplistic notions of healthcare workers undertaking general training and then seeking the specific answer to a problem when a situation demands it can only lead to lower quality care.

In the case of health professional services, both the training to become a professional and the practice of the profession require subtle appreciation of context. Such an appreciation is **emergent** rather than fixed, and is not amenable to the central issuance of a care protocol which is 'carved in stone'.

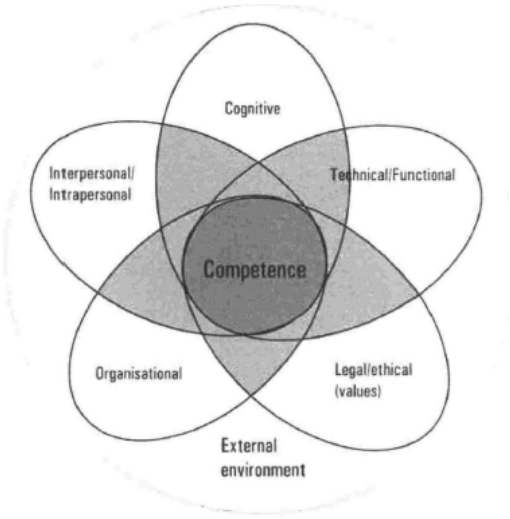
Current health professional education programs seek to develop the highest levels of expert competence in dentists, doctors and other health professionals as demanded and expected by the community. This table describes the stages in becoming a professional, and indicates the now generally accepted levels of competency from novice to expert.

Source: Chambers, D. W. JADA, Vol. 135, February 2004, p 177

STAGES IN BECOMING A PROFESSIONAL: CHARACTERISTICS, OPTIMAL LEARNING CONDITIONS AND BEST ASSESSMENT APPROACHES.

STAGE OF COMPETENCY	LEARNING ISSUES	EDUCATIONAL METHODS	EVALUATION METHODS
Novice	Isolated facts, performance	Lecturing, laboratories, faculty control	Tests
Beginner	Some synthesis, integration, few choices	Seminars, laboratories, supervised work	Simulations
Competent	Independence, choice, self-control	Realistic work settings	Authentic evaluation (portfolios)
Proficient	Identity, professional norms, context	Socialization, specialized training	Practice characteristics
Expert	Internalized, patient-centered focus	Outcomes-based practice	Self-assessment, internalized standards

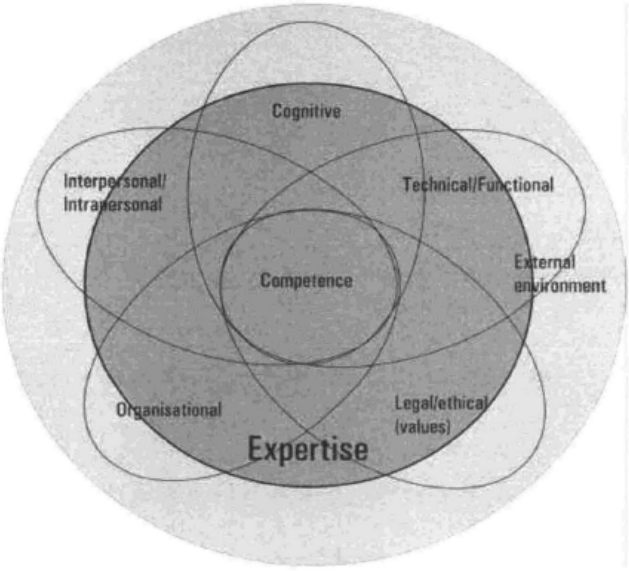
In his seminal work "The Reflective Practitioner", Schon (1983) sought to define the nature of professional practice. He challenged the belief that professionals solve problems by simply applying specialist or scientific knowledge. Instead, he offered a new epistemology of professional practice of 'knowing-in-action' - a form of acquired tacit knowledge - and 'reflection' - the ability to learn through and within practice. Schon argued that reflection (both reflection in action and reflection about action) is vital to the process professionals go through in reframing and resolving day-to-day problems that are not answered by the simple application of scientific or technical principles.



Dr Amanda Torr (PhD) in her 2005 thesis 'Professional Competence - Complexity, Concepts and Characteristics: A Case Study of New Zealand Pharmacy', offers a more refined and integrated model which we suggest would be useful as an alternative to the simplistic models being advocated by the NHWT. She states:

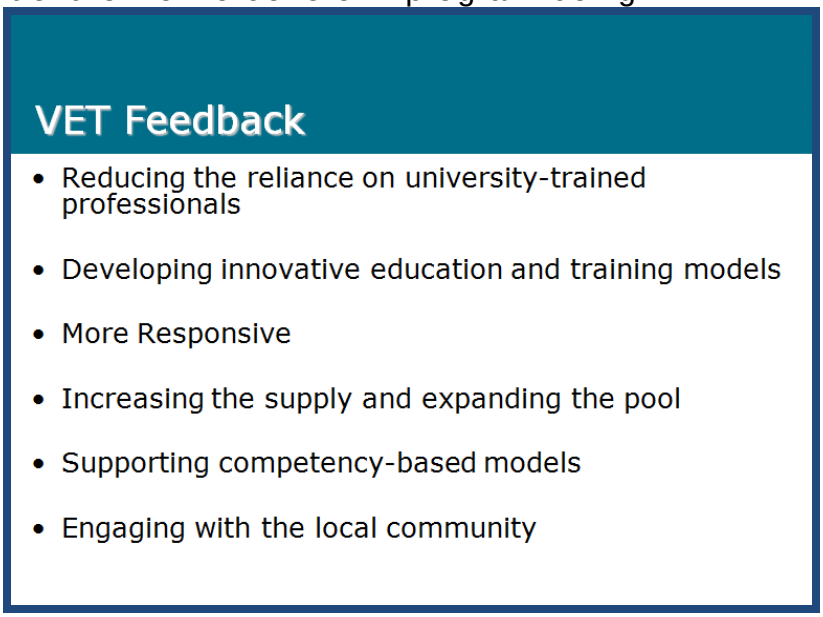
"*The core construct of this model is that professional competence and expertise are accounted for by the ability of the practitioner to integrate the knowledge skills and attributes associated with these five "domains of competence": professional knowledge and cognitive skills, intra and interpersonal skills, technical skills, legal and ethical behaviour, and organisational skills.*" (p.151)

"*In the model, expertise is accounted for by the degree of overlap between the domains of competence. In expert performance there is a larger and deeper degree of overlap in the domains than is seen with competent performance. In demonstrating this expertise, an expert performer is able to integrate across all the domains of competence at this higher, more comprehensive level.*" (p. 159)



There is a world of difference between this nuanced approach and Prof Duckett's concept of 'just in time' healthcare training, which borrows from manufacturing industry a reliance on behaviouralist approaches such as use of checklists and protocols. The reform being advocated is to progressively replace health professionals with generic healthcare workers who have done a short general health course to equip them to operate at the Beginner level – where they have few choices and do what they are told. Such an approach constitutes an attack on the 'competent', 'proficient' and 'expert' levels as being elitist, costly and inefficient.

The ADAVB considers these proposals to be dangerous and a most serious threat to public health and safety. Regrettably, we have formed the view that these proposals lie at the heart of the workforce reform program being implemented in conjunction with the national registration and accreditation scheme. This view has been shaped by presentations given recently by Victorian Department of Human Services staff arguing for a greater emphasis on VET trained workers and less reliance on professionals. The adjacent slide is extracted from one such presentation:



The interim report of the National Health and Hospitals Reform Commission (of which Prof Duckett is a member) also supports this reduction in specialised professional education:

> *"Particularly important is the introduction of a competency based framework. Competencies are what a person needs to do and to know to carry out a particular job role or function. A competency framework would allow for a variety of entry points into health care careers, recognise prior learning, and foster more flexible, multidisciplinary training across undergraduate programs." (emphasis added)*

Source: NHHRC 2008, A Healthier Future For All Australians, p.25

An alternative view is provided in a critique of the outcomes of similar reforms in the United Kingdom. In his essay, *Medical Education and the Tyranny of Competency*, medical educator Michael A Brooks describes the emergent, holistic and dynamic nature of a health professional's knowledge and skill, and condemns the emphasis on competency checklists in the education of medical professionals:

> *"The competency framework is not compatible with what is known about the development of expertise. The medical professional does not follow a learned set of rules when diagnosing and treating patients. Rather, the professional decides whether to follow a rule and which one to follow (Tanenbaum 1999). The knowledge derived from medical research relates to statistical aggregates, but such knowledge must be applied using the practiced judgment of the professional in order to be useful. Physicians operate within the cloud of uncertainty that is each individual patient. A physician's personal experience, intuition, ability to reflect, interpret, and perceive are vital to the health of patients, and these qualities are even more vital to future advances and innovation in medical practice. A prescriptive, sclerotic model of education such as is proposed by the partisans of competency would be disastrous. The practice of medicine is not a checklist."*

Source: Perspectives in Biology and Medicine, Vol 52, No 1 (winter 2009):90–102

The ADAVB agrees with concerns expressed by Dr Martin Talbot, the Director of Undergraduate Medical Education at Sheffield Teaching Hospitals, about the 'monocultural classifications' and 'limiting ideologies' of competence based models, in his 2004 article *Monkey see, monkey do: a critique of the competency model in graduate medical education:*

> *"... competence is not the same as understanding. Understanding brings with it a critical edge and, in this era of evidence-based practice, a critical edge is a priceless tool for the professional. Competence demands a dichotomous resolution; understanding exists on many levels. Competence is a monolayer; understanding is many layered. Competence negates dialogue; understanding embraces it. Competence becomes stuck in an authoritarian certainty (and this begs the question of whose authority), but one's understanding may change tomorrow: that, surely, is the true nature of professional practice. Competence is value-neutral; medical practice is not. The immediate transfer of competence from one context of use to another involves considerable further learning. The leeway for this to occur under competency is very limited. Eraut concurs with many authors in cognitive psychology and process analysis who show that professional learning is an adaptive and heuristic process: skill-specific training only has a short-run effect unless it is backed up by longer lasting support."*

Source: MEDICAL EDUCATION 2004; Blackwell Publishing Ltd 38: 587–592

If these workforce reforms are implemented, then we predict that there will be a massive increase in the number and proportion of treatment failures and adverse events. There can be no other outcome when complex conditions are not understood by the treating practitioner and they are not equipped to refer such cases to more highly specialised practitioners – which the system has ceased to train because of its commitment to 'flexibility', and 'just in time' and 'by the numbers' health care.

Of course healthcare practitioners should be competent, and we support interdisciplinary care, with clear triggers for patient referral across disciplines, but we reject the construction of graduate and specialist health professional education based **solely** upon a competency model.

(d) how the scheme will affect complaints management and disciplinary processes within particular professional streams;

Recently, there have been suggestions that the approach used by the NSW Health Care Complaints Commission (HCCC) will be imposed on all States and Territories.

From a timeliness perspective, we understand that there is a lengthy period between a notification (complaint) and its resolution in the NSW system. This does not help either the complainant or the practitioner, particularly if retraining or education or harsher measures to protect the public are envisioned. By contrast, the timeline for a case being heard by Victorian Civil and Administrative Tribunal at the moment is only a matter of months.

The NSW approach appears to lack expertise of various sorts. The investigation of allegations should be done by persons with a clinical dental background. This happens in Victoria but not necessarily in NSW, especially once the case gets to the HCCC.

The decision to proceed to a tribunal hearing is taken in NSW by the Director of Public Prosecutions. While this may have some appeal to consumer groups because of its independence, the decision is taken on a legal probability of success. In other jurisdictions, where such a decision is taken by the Board, factors such as unprofessional conduct and protection of the public weigh more heavily.

In NSW, the legal team involved on the prosecution have little or no dental expertise. Notwithstanding the extensive experience of the participating lawyers, their lack of dental knowledge often results in failure to pursue more telling directions of inquiry. It appears to be a more legalistic process than VCAT.

The dental persons available to serve on the Tribunal in NSW appear to be eminent (retired) persons, often with specialist backgrounds. Without reflecting any discredit on these people, if a charged practitioner is a General Practitioner involved in 'cutting edge' work; then a pool of Tribunal members which included a practising General Practitioner would offer them more relevant insights.

In one recent case, an expert witness from outside NSW had three teleconferences with the lawyers, and three trips to Sydney including overnight accommodation. Most of the time spent involved teaching the lawyers basic dental concepts. This could have been pared down if the legal team had been experienced in handling dental prosecutions, as is the case with the Dental Practice Board of Victoria's prosecuting lawyer. In our view, there is likely to be a reduction in the standard of public protection if the NSW model is imposed.

On a positive note, the NSW system uses an "expert witness convivium" in which witnesses for both sides get together as part of the Tribunal process and come to agreed positions. We recognise the potential for merit in this process.

The proposed complaint system under the NRAS has a number of other potential problems and our concerns and suggestions regarding this key dimension of the new arrangements are:

- Notifiers (complainants) should not be treated as if they are parties to disciplinary proceedings. This system is about regulating professional standards, not providing a consumer court. Notifiers should not have a right of review where a board or its committee determines no case to answer.
- Panels need 50% of their members to be drawn from the same class and division of the register as the practitioner involved. Most allegations require clinical insight to know whether professional standards have not been met.
- We don't believe the three streams proposed (performance, health and conduct) will be easily separated and most cases will involve at least two streams.
- Unsatisfactory professional performance (as grounds for a charge of unsatisfactory professional conduct) must not arise from mere treatment failure, which can be due to causes other than the health practitioner's care and skill.
- To ensure that the system is credible to health professionals, procedural fairness must be evident.
- The link between this reform and the quality and safety agenda is most noteworthy, especially with the emphasis in the Open Disclosure Standard on moving away from a culture of blaming individuals for adverse events.

- Health funds should not be treated as consumer representatives if they seek to notify a matter. They are usually large corporations seeking to exert commercial control over the market.
- Negative licensing similar to that used in NSW should be considered to deal with unregistered practitioners and with registered persons practicing outside their registered field.
- Mandatory reporting should be restricted to treating practitioners, otherwise associations would be unable to assist many members in need.
- Suspension without hearing for more than three months would be unjust.
- Those involved in health management and assessment must be bound to strict confidentiality or suffer significant penalties for breaches of this.
- A single national health assistance program should be instituted for all registered health practitioners, arranged by the national agency.
- Investigators must be registered in the field they are investigating where clinical judgments are required e.g. infection control, records, drugs and poisons.
- No hearings should be conducted without completed investigations.
- Investigators must not make unannounced raids that could affect a practitioner's reputation and livelihood. They should make appointments so that the inspection time does not inconvenience patients.
- Advertising restrictions should be enshrined in the legislation to avoid creating unreasonable expectation of beneficial outcomes.

Part of the ADAVB's system for dealing with dental consumer issues is a Community Relations function staffed by four senior dentists, who are rostered (each on a part-time basis and supported by ADAVB staff) to be available to assist dental consumers with their enquiries or complaints. A conciliation service is offered to seek resolution of disputes between members and their patients.

This service is available to patients and practitioners as an objective, non-biased method for resolving disputes. It is free to complainants, and creates no drain on the taxpayer. The vast majority of complaints are handled without legal intervention resulting in low costs to the Branch. Many issues are resolved over the telephone, i.e. at the first conversation.

Complainants are often referred to the ADAVB by the Dental Practice Board of Victoria and the Health Services Commission (HSC). The Victorian Board does not have the power to handle fee disputes and so these are best addressed by the ADAVB conciliators. The HSC also refers complainants to the ADAVB rather than using their own mediation facility because of the complexity of dental treatment problems and the impartial and professional approach taken to considering both patient and practitioner perspectives.

Information about this service is published on the ADAVB's website (http://www.adavb.net/DentalConsumerHelpline/tabid/609/language/en-AU/Default.aspx)

(e) the appropriate role, if any, in the scheme for state and territory registration boards;

This aspect of the Committee Inquiry suggests that those who drafted the terms of reference were unaware that State Governments have agreed, via the Intergovernmental Agreement, to wind up existing State Registration Boards.

> *"6.5 Each of the States and Territories will use their best endeavours to repeal their existing registration legislation which covers the health professions that are subject to the new national scheme. This will have the effect of abolishing the current State and Territory based registration boards for those health professions."*

Source: IGA re NRAS, 26 March 2008, accessed at http://www.nhwt.gov.au/natreg.asp on 25 April 2009

State Committees are expected to be appointed to deal with various matters on behalf of the national registration boards at the local level, and formal complaints regarding alleged unprofessional conduct and misconduct are to be addressed through State-based tribunals e.g. VCAT (as at present under the Health Professions Registration Act (Victoria) 2005).

(f) alternative models for implementation of the scheme.

Adoption of the various suggestions and recommendations contained above would create a variation on the scheme as presently proposed. While delivering on the first four of the scheme's objectives, it would avoid the threat to the quality of health care services associated with the NHWT's radical workforce redesign reforms.

Yours sincerely,

Garry Pearson
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ENCLOSED: Please find attached copies of various ADAVB submissions relating to aspects of the National Registration and Accreditation Scheme