Australian Council of Deans of Health Sciences submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals.

Introduction

The Australian Council of Deans of Health Sciences (ACDHS) welcomes the opportunity to provide input into Accreditation Systems Review. ACDHS is the peak representative body of the Australian universities that provide pre-professional education in the allied health sciences. The Council adopts a whole of health system perspective and considers the development of an innovative and sustainable health workforce will best position Australia to address present and emerging health care demands – both domestically and internationally.

ACDHS member universities include:

Central Queensland University
Charles Sturt University
Curtin University
Deakin University
Flinders University
Griffith University
James Cook University
La Trobe University
Monash University
Queensland University of Technology
University of Canberra
University of Newcastle
University of Queensland
University of South Australia
University of Sydney
Western Sydney University

In addition to providing comment within this submission, many Council members will provide submissions from their respective universities. Individual member responses may provide more specific examples of the impact of accreditation processes on individual school, faculty and whole of university activity. While it is noted that many of our members teach a broader range of health programs, the following professions fall within the remit of our Council:

Clinical exercise physiology/sport and exercise science
Medical laboratory science
Nutrition and dietetics
Occupational therapy
Optometry
Orthoptics
Pharmacy
Physiotherapy
Podiatry
Prosthetics and orthotics
Medical radiation science
Speech pathology

ACDHS members considered both strategic and operational perspectives in developing responses to this review. Strategically, producing the health workforce of the future is a key focus for ACDHS members. This review provides a welcome opportunity to focus on developing a flexible responsive health workforce to meet the evolving health care needs both domestically and internationally. Operationally, the Review provides an opportunity to address issues of efficiency and responsiveness. As our members offer multiple health programs, ACDHS supports initiatives that improve consistency across programs and decreasing duplication between accreditation processes.

Demand for health professionals is projected to continue to be amongst the highest of any employment sector for the foreseeable future. High, persistent demand for health professionals is driven by a range of factors which have been documented extensively[1]. Factors include population growth and structural ageing, changes in the burden of disease, and in the needs, expectations and preferences of the community, persistent workforce shortages in rural and remote Australia and in certain care settings (such as aged care). An innovative and adaptive health workforce is fundamentally important for the Australian health system to meet a range of long term challenges, including how well we are able to deal with and contain the growing burden of chronic disease; timely access to services wherever people live; the ageing population; and the cost of new health technologies. The 2005 Productivity Commission recognized that "*it is critical to increase the efficiency and effectiveness of the available health workforce*" [p. xiv][2].

Allied Health Professionals are educated to competently undertake a greater range of tasks and responsibilities than are often used[3]: often more effectively and in a more integrated manner than traditional care models. Recent innovations in models of service delivery demonstrate improvements in timely access to services when the skills and expertise of the allied health workforce are optimised[4]. However, a number of barriers[5], including accreditation systems, restrict and delay changes to scope of practice to maximise the skills of the health workforce, including Allied Health Professionals.

Australia's international standing in terms of the quality of both education and health sectors, means it is ideally placed to develop complementary strategies that enable innovation in meeting domestic health care needs while also further developing our impressive educational export achievements into regional and global markets. Population growth, rapid economic development and changing patterns of disease globally, particularly in the Asia and Pacific region, suggest there are major potential opportunities to grow our on-shore and off-shore educational export markets. Growth in Australia's educational exports has placed it among the top 3-4 export earners nationally (at around $17B per annum in 2016), and the primary services based export. However, despite this growth, and the rapid increase in domestic health student numbers, the number of international university students studying as health professions has remained largely unchanged over the past decade. The rapid growth in demand for health services in regional nations suggests there may be constraints on Australia as a supplier of health education services-particularly onshore.

The increasing prospects for the globalisation of health and the health workforce is reflected in the inclusion of service provision within the trade agreements Australia has negotiated recently (eg TTP and ASEAN). Australia's comparative strength in health research and translation also strengthens our potential to build on the creativity and innovative capacity of our workforce (including the highly skilled workforce we may be able to attract to Australia or collaborate with).

Regulated and Self-Regulated professions

Accreditation of allied health programs includes both the regulated and self-regulating professions.
The Accreditation component of the National Registration and Accreditation Scheme (NRAS) ensures that Universities provide high quality education and training through critical appraisal of staffing, research

[1] See for example, The Intergenerational Report (2015) and its predecessor reports http://www.treasury.gov.au/~/media/Treasury/Publications%20and%20Media/Publications/2015/2015%20Intergenerational%20Report/Downloads/PDF/2015_IGR.ashx (among others).

[2] Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra http://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf

[3] p4 Queensland Government, May 2014.Department of Health Ministerial Taskforce on health practitioner expanded scope of practice: final report https://www.health.qld.gov.au/ahwac/docs/min-taskforce/ministerial-taskforce-report.pdf

[4] Ibid p3

[5] Ibid p9

outputs, resourcing and curriculum. NRAS has responsibility for the regulated health professions, however, there are also a number of self-regulating health professions that develop accreditation standards for their respective professions.

Self-regulating health professions include, but are not limited to, dietetics, speech pathology, exercise science/exercise physiology, social work and audiology. The accrediting councils of the registered professions, meet as the Health Professions Accreditation Councils Forum (HPACF) to consider cross profession issues. As currently structured, HPACF does not have mechanisms to include the self-regulating professions. A separate organisation (National Alliance of Self Regulating Health Professions) has been formed for the self-regulating health professions.

There would be advantage in broadening the scope of the accreditation structure and processes within NRAS to include the self-regulating professions rather than having a parallel structure with potentially differing requirements. This suggestion is not to presuppose that these professions would require registration, but rather the inclusion of the self-regulating professions could reduce the variability in accreditation requirements across all health professions.

Parallel structure example: National Alliance of Self Regulating Health Professions

An alliance of self-regulating professions was formed to address accreditation matters. The National Alliance of Self Regulating Health Professions (NASRHP)[6] was formed in 2007 and consists of professional associations including:

- Audiology Australia
- Australian Association of Social Workers
- Australian Diabetes Educators Association
- Australian & New Zealand College of Perfusionists
- Australasian Sonographers Association
- Dietitians Association of Australia
- Exercise & Sports Science Australia
- Speech Pathology Australia
- The Australian Orthotic Prosthetic Association

The AHPA website notes that NASRHP's core objective is to provide a forum for allied health professions that are not nationally registered to:

- seek clarity regarding regulation for their respective professions;
- benchmark their self-regulatory environment;
- advocate on behalf of the public for an improved health regulatory environment; and
- address the challenges and consequences for the professions and health agencies of the current fragmentation in health practitioner regulation

It is understood that NASRHP developed a proposal to the Australian governments advocating for an improved health regulatory environment for professions falling outside national registration[7] and most recently, have sought expressions of interest from external (both consumer and non-consumer) representatives to be appointed to the NASRHP Board of Directors[8]. The EOI provided the following information:

> *The National Alliance of Self Regulating Health Professions (NASRHP) is the national peak body representing self-regulating health professions in Australia. NASRHP works to represent the interests of the self-regulating health professions.*
> *Australian peak bodies of self-regulating allied health professions wishing to join NASRHP must meet benchmark standards for regulation and accreditation of practitioners within that profession. NASRHP standards have been closely modelled on AHPRA standards.*

ASReview questions are addressed following a number of recommendations offered by the Australian Council of Deans of Health Sciences for consideration.

[6] http://www.ahpa.com.au/AlliedHealthRepresentation/AlliedHealthRepresentationonOrganisations.aspx
[7] Harnessing Self-Regulation to support safety and quality in health care delivery
[8] https://probonoaustralia.com.au/jobs/2017/04/nasrhp-board-director/

Recommendations for consideration

1. Broaden stakeholder representation on NRAS committees and forums

The consultation process conducted to inform this Review once again highlights the value of forums in which a broad range of key stakeholders can contribute to discussions and the ongoing development, implementation and review of the National Registration and Accreditation Scheme.

ACDHS supports the intent of Recommendation 18 in the 2014 NRAS Review and would welcome the establishment of a forum within NRAS that involves representatives from the education sector, national boards, accreditation authorities, employers, consumers and jurisdictions.

2. Broaden focus to include all NRAS objectives

The National Registration and Accreditation Scheme is not yet 10 years old and may be considered a developing or maturing system. It is perhaps not surprising that the initial focus has been on the key functions of registration and accreditation. This review provides an opportunity to reflect on the operation and efficiency of these components to date and then to progressively focus on broader NRAS objectives namely:

e: *to facilitate access to services provided by health practitioners in accordance with the public interest*; and

f: *to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners*

3. Include the self-regulating health professions within the scope of NRAS accreditation functions

The development of parallel accreditation systems runs contrary to the intent of many areas noted within the review of accreditation systems. Mechanisms to address accreditation of health profession programs within one system would be welcome.

4. Facilitate health workforce mobility internationally

There is a global awareness of the critical role of health systems and health workforce in underpinning capacity of economies to achieve the goal of Universal Health Coverage (UHC). Strong and effective health systems require a sufficient capacity of well-trained health workers able to meet changing patterns of disease and health care demand.[9]

Developing responsive registration and accreditation systems that enable freer movement of health professionals will underpin Australia's role in the development and supply of the health workforce.

5. Develop systems for innovations and emerging health care needs to be reflected standards

Develop policy leadership and structures in the area of workforce development and innovation. This may include, for example, establishing a broader stakeholder standing committee within NRAS to proactively identify emerging workforce and service trends that may require reflection in standards.

[9] Proposal to Establish an APEC Tropical Health Workforce Development Hub – Concept Note

Improving efficiency

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

Greater consistency and commonality between standards has potential benefit- but will require adoption of the best model to inform such consistency– not the worst. Improving consistency across accreditation process may include, for example, the level and type of information required, common terminology and frameworks.

In considering this question, it, is important to clearly differentiate program accreditation standards from profession specific competency/threshold frameworks. The latter describe the expected competencies of specific health discipline/profession; the former describe the accreditation standards of the higher education program provider. Question 1 relates to the development and application of the program accreditation standards and as such, does not challenge or limit the inclusion of discipline specific references or requirements.

Increased consistency and commonality has potential to decrease the administrative burden on universities and would benefit education providers, particularly providers with multiple programs for regulated professions (the majority). It would enable providers to concentrate resources in key areas to achieve the standards. At a national level it would be easier to track changes – good and bad – with a common set of standards.

The risks include the adoption of the lowest rather than highest standards, or adopting a cookie cutter approach that may stifle differentiation.

ACDHS members are broadly supportive of:

- the standardisation of many aspects of program accreditation processes across the professions
    - Common elements of the review process for each profession could be streamlined into a replicable format across the professions.
        - For example: University structure, course quality provisions, policy frameworks, student support services areas (e.g. library resources, on-line resources), and mechanisms to manage educational quality assurance.
    - Standardisation of format would be more efficient and a welcome improvement
    - Consistency of definitions for key terms amongst accrediting bodies and higher education institutions.

Examples:

Variation despite work to harmonize program accreditation standards

The number of domains and areas assessed by program accreditation agencies varies between professions. The number of 'domains' range from 5-9 with the subsets/sub areas/criteria ranging from 19 -57 A number of professions are working to harmonize the accreditation standards across professions.

Even the recent adoption of a seemingly common approach by the councils for dentistry, physiotherapy and optometry reveal differences below the domain levels. For example, the number of criteria varies from 41 in physiotherapy; 36 for dental and 34 for Optometry.

University A: Lack of consistency

In the Faculty of Health and Medicine at University A, there are **12** accredited health professions, with a **further four** health professions at the university, but outside the Faculty.

Each health discipline and the School in which it is located takes the bulk of the responsibility for the accreditation of their degree. This means there ***is little sharing of information*** when addressing the accreditation standards. Where information is shared, each accreditation body ***requires that the same information be presented in a different format,*** so the opportunity to share information in a meaningful and straightforward manner is lost. Some of the information required is discipline specific but much of the information required is institution-specific, therefore greater consistency and commonality in the development and application of the standards would allow a more institution-wide approach to completing the required documentation. This will save money and time. It will also encourage the sharing of information and information-collection tools between accreditation bodies which should result in the development of a sensible template for entering information rather than the variety of templates used currently by accrediting bodies, some of which are poorly designed and almost impossible to complete,

University B: Highlighting number of programs

The Division runs 100 academic programs at undergraduate and post-graduate levels across three main teaching sites and several smaller sites. The Division's accreditation activity in numbers is as follows:

- 11 Academic Groups within Division offer accredited programs
- 25 accredited courses (including Bachelors, Masters, Graduate Certificate, Honours and Doctorate programs)
- 19 of those 25 courses have mandatory accreditation (regulated professions)
- 6 of the 25 courses have voluntary accreditation (but graduate students cannot gain professional association membership without completing an accredited program)
- 12 different professional accrediting bodies are responsible for accreditation of Division programs

Univerity B: annual accreditation cost

Program Accreditation Cost Snapshot 2015/2016

Program	Fee	Period
B Medicine	120,000.00	Program Fee - every 5 years (Estimate 2007 cost was $95k)
B Midwifery	38,100.00	Program Fee - every 3 years
B Nursing	43,250.00	Program Fee - every 3 years
B Nutrition & Dietetics	19,300.00	Annual Fee
B Oral Health/Oral Health Therapy	18,500.00	Annual Fee
B Occupational Therapy	7,900.00	Annual Fee
B Occupational Therapy	6,000.00	Site Visit - every 4 years
B Pharmacy/M Pharmacy	31,000.00	Annual Fee
B Medical Radiation Therapy	6,000.00	Annual - $2,000 per specialisation
B Physiotherapy	15,800.00	Annual Fee
	305,850.00	

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?

A qualified 'Yes'

Incorporation of TEQSA/ASQA assessment and relevant decisions has potential to simplify reporting. It would also reflect TEQSA/ASQA areas of knowledge and specialization that program accreditation panels may not possess. Incorporation of the TEQSA/ASQA findings could enable the program assessment teams to concentrate on areas of professional capabilities. There would be a reduction in duplication and less resources wasted by not including the work done by these regulators.

There are a number of risks or challenges that would need to be addressed including:

- the applicability of TEQSA/AQSA decisions at a program level
- understanding the impact of the varying accreditation and reporting cycles

Future work is required to clearly articulate the level of additional detail or granularity of information that specific professional program accreditation would require beyond that provided to TEQSA.

A two-step professional accreditation has been suggested where

- Step 1 would assess standards common across programs and professions
  - typically those at the institution level, for example TEQSA standards
    - 1 Student Participation and attainment,
    - 2 Learning environment and
    - 3.3 Learning resources and educational support

- Step 2 would address profession specific standards. Examples include:
  - Domain 3 of harmonised standards of physiotherapy optometry and dentistry
    - program design, delivery and resourcing enable student to achieve the required professional attributes and competencies
  - Domain 5 Assessment
    - 5.2 scope of assessment covers all learning outcomes relevant to attributes and competencies
    - 5.6 all learning outcomes are mapped to the required attributes and competencies and assessed

Standards relating to staffing provide an example of variation and overlaps between TEQSA and professional standards, with the latter at times framing the requirements as inputs rather than outcomes.

Example: Overlap between TEQSA and professional standards

TEQSA standard ***3.2 Staffing*** p13/27	1. The staffing complement for each course of study is sufficient to meet the educational, academic support and administrative needs of student cohorts undertaking the course. 2. The academic staffing profile for each course of study provides the level and extent of academic oversight and teaching capacity needed to lead students in intellectual inquiry suited to the nature and level of expected learning outcomes. 3. Staff with responsibilities for academic oversight and those with teaching and supervisory roles in courses or units of study are equipped for their roles, including having: **a.** knowledge of contemporary developments in the discipline or field, which is informed by continuing scholarship or research or advances in practice **b**. skills in contemporary teaching, learning and assessment principles relevant to the discipline, their role, modes of delivery and the needs of particular student cohorts, and **c**. a qualification in a relevant discipline **at least one level higher** than is awarded for the course of study, or equivalent relevant academic or professional or practice-based experience and expertise, except for staff supervising doctoral degrees having a doctoral degree or equivalent research experience.
Medical Radiation Practice Board Standards **Standard 4.4 Teaching and learning**	The education provider ensures the teaching and learning support for its medical radiation practice program is of high quality and consistent with the requirements for course accreditation specified in the threshold HES, including by: 4.4.1 Appointing academic and research leadership staff at an associate professor level or higher to provide guidance to the medical radiation practice program and its staff 4.4.2 ensuring that staff who teach students in the medical radiation practice program have a sound understanding of current scholarship and/or professional practice in the division of medical radiation practice that they teach, and 4.4.3 Employing mechanisms to ensure that the quality of the clinical supervision is attained and maintained in the medical radiation practice program
Optometry OCANZ Jan 2017 p10	3.6 Teaching staff are suitably qualified and experienced to deliver the units that they teach. ***May be requested at site visit*:** Sample staff position descriptions
OTC Occupational Therapy Accreditation Standards Nov 2013 2.3	2.3 Provide the name, title, qualifications and contact details of person/s developing, updating or modifying the program. ***Evidence required:*** Provide the name, title, qualifications and contact details of person/s developing, updating or modifying the program.

	Provide evidence that the academic staff members responsible for new curriculum have demonstrated capacity to develop innovative and contemporary occupational therapy education programs.
APC Pharmacy Standards 2014 p11 2.3 Human Resources **Standard 11**	The School of Pharmacy has an academic staff complement that ensures an appropriate level of expertise in the pharmaceutical sciences, pharmacotherapeutics and pharmacy practice ***Guidance*** … It is appropriate and desirable for the staffing profile to include academic staff with relevant doctoral degrees and post-doctoral research experience to foster and build the School's research capabilities and to promote research-led teaching
ANZPAC Podiatry May 2015 p16 **D1 Staff**	D1.1 - There is sufficient academic, clinical, technical and administrative support staff to deliver and service the program of study, including clinical practice requirements D1.2 - Teaching staff are suitably qualified to deliver the subjects they teach, to at least one qualification standard higher than the program of study being taught or with equivalent professional experience D1.3 - All staff undergo continuing professional developmer to support the effective conduct of their role within the program of study
Physio APC Dec 2016 p5 Domain 3: Program of Study	3.7 Teaching staff are suitably qualified and experienced to deliver the units that they teach *New Evidence/guidance is not yet available,* however the APC Accreditation Guide 2016 V1.0 p43 listed the following REQUIREMENT 4 - RESOURCES AND INFRASTRUCTURE The university must provide evidence that it has the necessary and appropriate level of staffing and other resources and facilities to provide an entry level physiotherapy program. *Element 4.1: Academic and Research Leadership* **Criterion:** The university must provide evidence that it has the necessary and appropriate level of academic and research leadership to provide an entry level physiotherapy program in an environment that fosters research and scholarship. Universities that are in the planning stages must provide evidence that they are in a position to appoint academic and research leaders and that a full professorial appointment in physiotherapy will be advertised within the first year of offering the program. **Indicators:** The Program Specific Accreditation Panel will evaluate the evidence to report whether: • The staffing profile includes at least one full-time Level D or E appointment in Physiotherapy and at least two other appointments at Levels C or D who have a physiotherapy qualification • The university is committed to appointing, at level E, a physiotherapy program leader who is a physiotherapist and who has completed a PhD or equivalent • The academic staff appointed at Level D and E have well developed track records in research leadership at national and international level. *Examples of evidence include:* • *Profiles of academic staff* • *Curriculum vitae of academic staff appointed at levels D and E* • *Schedule of intended appointments.*

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

Adopting more open-ended and risk-managed accreditation cycles may assist, yet would require development of clear risk flags and common understanding, processes and interpretation. If developed and working optimally, a risk based system would be an efficient use of accreditation and higher education resources. Resources could be then directed where needed most.

Currently, a number of accreditation authorities require both regular reporting and full accreditation visits. There would be enormous benefit in either awarding longer-term or open-ended accreditation with annual reporting regarding outstanding issues and changes to outcomes required, together with a requirement to report on an ad-hoc basis to the accreditation authority of any changes in curriculum delivery or outcomes in degrees. Current accreditation cycles for many professions are considered too short. Often there is

insufficient time to introduce change or innovation, as discussed at a previous accreditation visit, and evaluate it, before the next accreditation visit is underway.

Adoption of risk based approaches requires incisive understanding and description of what constitutes or flags a risk within the accreditation system and how much system penetration is required to identify false positives. Unless both are clearly described, there is a significant risk of delayed identification of problems that may occurring in a higher education provider's program.

Specific areas that require monitoring are

- transition between versions of standards
- detail that may be contained in accompanying guidance documents rather than the standards
- rationale and costs for annual reporting
- level of detail required by some accreditation authorities
    - eg tracking and reporting all clinical education placements of each student
- appropriate panel education
- report back by exception

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?

Panel training

ACDHS strongly recommends the development of consistent and comprehensive training for members of accreditation assessment teams including but not limited to:

- Training for assessors on the scope nature of the assessment
- Some training on different modes and delivery of teaching and learning.
- An understanding of input versus outputs and outcomes
- Appreciation of innovation and understanding that innovation does have risks but may be acceptable as long as risks can be mitigated
- Education from a peak health consumer organisation representatives
- Establish a process of auditing a sample of assessments

Panel composition

A range of suggestions have been provided by ACDHS members including:

- Establishing a trained pool of appropriate people to be appointed to accreditation teams
    - ACHS provides a useful reference (see example below)
    - Develop a register of accreditors (similar to ACHS and TEQSA)
- Accreditation team members could be drawn from discipline-specific and non-discipline- specific staff from universities, practising clinicians from acute and community-based sectors, teaching and learning experts and consumers.
    - practitioners with educational background and experience
    - The team should be multi-disciplinary with respect to heath disciplines represented.
- Each accreditation team should be chaired by an experienced health academic who understands the university environment.
- Consider a reduction in the size of accreditation panels.

- Alternatively, a larger team of well qualified and trained individuals could be managed if the accreditation cycles were more spaced out
  - e.g. full accreditation only occurring on a 10 year basis for those universities and degrees that received a "clean bill of health" in the previous accreditation cycle

Panel remuneration

- Remuneration should be standardized across all professions and linked to remuneration of other assessors/surveyors e.g. TEQSA and/or ACHS
- Consider the possibility of accrediting authorities employing permanent accreditation teams.
  - External expertise can then be brought in as required, similar to the model used by TEQSA.
    - *'TEQSA uses external experts to source advice on specific, identified elements of the Agency's regulatory assessments and reviews. TEQSA recognises that, in performing its regulatory functions, it benefits from having access to a register of external experts. TEQSA staff use input from external experts to inform their analysis and recommendations to the Commission. Individual external experts provide advice as individuals on specific, identified elements of TEQSA's regulatory reviews.'*[10]

Example: Accreditation Surveyors: Australian Council on Healthcare Standards (ACHS)[11]

An Australian Council on Healthcare Standards (ACHS) accreditation surveyor is a health care professional trained by ACHS, to assess the performance of health care organisations against the standards of our accreditation framework (EQuIP) and the National Safety and Quality Health Service (NSQHS) Standards.

-The total surveyor workforce consists of around 400 experienced, senior health care practitioners (Directors, Executives and Medical Doctors) with recent and broad experience in health care.
-Surveyors must have a strong working knowledge of health care accreditation frameworks and quality improvement.
-The majority of surveyors are employed full-time within the health care sector and receive support from their employer to survey for ACHS.
-We have a number of coordinators with the aim of increasing inter-rater reliability (the consistency of decisions regarding assessment against accreditation standards).
-The surveyors are trained and skilled in surveying techniques and are able to gather the relevant information to verify the health care organisation's achievement in the standards being assessed.
-The selection process of our surveyor workforce ensures that surveyors have at least five years of senior managerial experience in a health setting, and an excellent understanding of accepted industry standards and best practice.
-The surveyors may also play a consultative role and provide education for an organisation to understand how to progress on their quality journey while ensuring they meet the standards to the required level.
-The ACHS is also fortunate to be able to utilise the expertise of consumer surveyors who participate as crucial members of the survey teams.

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

ACDHS members are supportive of the inclusion of cross discipline representatives.

- Initially the cross disciplines assessors may be drawn from cognate disciplines, and with experience and system maturity, the assessors may be drawn from a broader range of disciplines.
- Training was once again emphasised as a critical success factor

Assessment teams should be considered on the basis of skills they bring to the assessment and ensuring the team covers the skills and perspectives required. As such consumers, as well as cross profession representatives, may be considered.

[10] http://www.teqsa.gov.au/regulatory-approach/experts
[11] http://www.achs.org.au/achs-surveyors/what-is-a-surveyor/

Discussion with the Consumers Health Forum of Australia confirmed their view of the importance of consumer contribution and involvement in the accreditation of health professional programs. This may occur at several levels including

- The development of health profession specific standards
- The development of program accreditation standards
- The training of assessment panels
- As members of program assessment teams

Consumer representatives for the above can be drawn from the national and state registers held by organisations such as the Consumers Health Forum of Australia or state based peak consumer organisation such as Health Consumers NSW or Health Consumers Alliance of South Australia.

There is however, a balance to be achieved between the size and composition of panels. It may be that consumer input continues or is included in the development of health profession specific standards, program accreditation standards and, relevant to this section, the training of assessment panels.

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

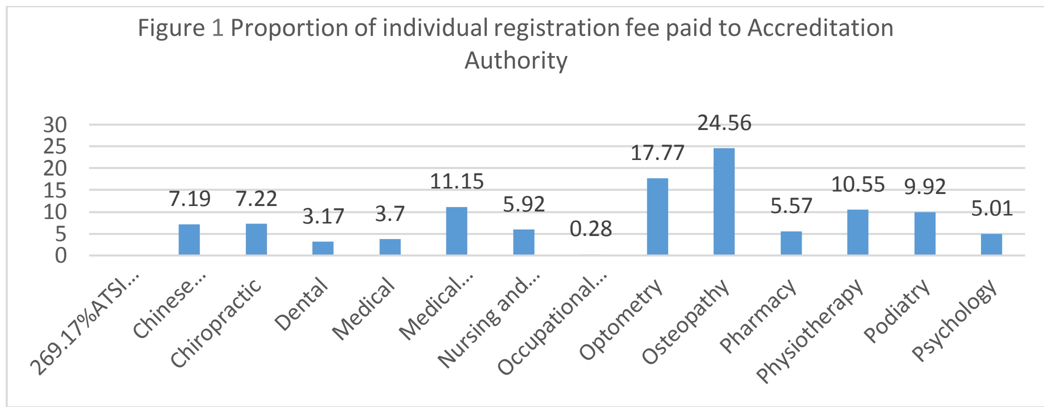
The funding model adopted would need to contain the recent cost escalation of program accreditation and be informed by principles such as:

- Consistency
- Transparency
- Monitoring
- Established mechanisms to set and review accreditation fees
    - The ALG costing paper may be informative in the first instance.[12]

Example: *2016 registrant input to accreditation*

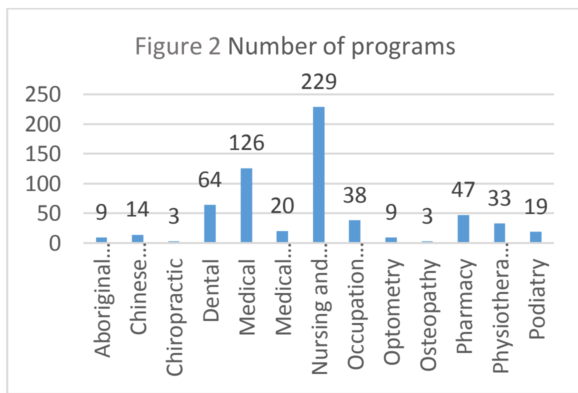
In 2016 the registrants through the Boards contributed an average of 5.7 %[13] ($9,872,160[14]) with the proportion of individual registration fee paid to the Accreditation Authority ranging from 0.28% to 269.17 % (see figure 1)

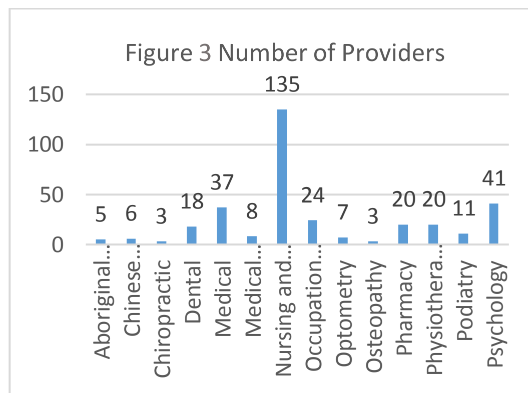
[12] Cost of Accreditation in the National Registration and Accreditation Scheme November 2016 https://amc-cmsprod.s3.amazonaws.com/files/188b4dbc62d9e6c131688912aa404f5b1ab37728_original.pdf
[13] Ibid p 21/94
[14] Ibid p25/94



Note: Due to the high proportion, the Aboriginal and Torres Strait Islander Practice % is not graphed but is noted prior to the profession).

The number of programs range from 3 to 229 (Figure 2) and number of providers range from 3 to 135 (figure 3)





Figures 1, 2 and 3 are adapted from data within Table 15 of the ALG Cost of Accreditation paper (p33/94)

The proportion of registrant contribution can be quite variable between professions- and at times within professions. See the information provided in the ALG costing study of the proportionate funding contributions for Occupational Therapy and Physiotherapy for example (Table 1)

Table1	2013-14		2014-15		2015-16	
Data from ALG Tables 13-15	OT	PT	OT	PT	OT	PT
Proportion of individual registration fee paid to Accreditation Authority	4.85%	5.35%	6.99%	8.33%	0.28%	10.55 %
Total funding from education provider	$5315	$361,559	$18,682	$378,750	$142,850	$634,595
No of providers	23	19	23	19	24	20
No of programs	34	31	36	30	38	33
Mean cost per provider p.a.	$223	$19,029	$812	$19,934	$5,952	$31,730
Mean cost per program p.a.	$151	$11,663	**$519**	**$12625**	$3,759	$19230

Source: Cost of Accreditation in the National Registration and Accreditation Scheme
Paper prepared by the Costing Working Group (CWG) on behalf of the Accreditation Liaison Group (ALG) November 2016

ALG Cost of Accreditation

As noted above, the ALG Cost of Accreditation paper infographic (see Appendix A) and related tables indicate that in 2015-16 the accreditation authorities reported that they

- Received $9,872,160 from national boards
- Expended $10,871,470 on accreditation of programs of study

The difference in the amount received from the board and the expenditure on the accreditation of programs is not large. The addition of expenses for the development and review of accreditation standards ($1,244,717) and assessment of overseas authorities ($288,488) totals $12,404,675. No doubt the funding flows are far more complex and a simplified summary is perhaps not reflective of overhead costs or the cross subsidisation between key areas.

However, if the assumptions of costs included above are reasonable and primarily related to NRAS objectives 'a' and 'c', the funding gap to address what may be considered program accreditation costs is $2,532,515

- The $3,662,784 charged to education providers more than covers this shortfall with little indication of where the remaining funds ($1,130,209) were allocated.
- There is an amount of $905,053 itemised against 'm*aking recommendations to the National Board'*, but it is not clear if this pertains to assessment of programs of study or assessment of overseas qualified practitioners

As such, further work may be required to assist in determining the proportion funding that should be provided via the Boards to the Accrediting authorities from individual registration fees.

Related to question 7, greater clarity is required to determine the degree of cross subsidisation from assessment of overseas qualified practitioners and assessment of offshore competent authorities that currently occurs.

A transparent cost of actual on-shore accreditation costs would be welcome.

7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

Ideally no.

Transparency would be enhanced if costs for accreditation of on-shore programs were identified without cross subsidisation.

This may be qualified by the work noted on Q6 to further clarify costs of on shore program accreditation (*without any cross subsidisation*)

Relevance and responsiveness

Input and outcome based accreditation standards

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

The adoption of outcome based standards and assessment processes has general agreement: yet some standards may require assessment of inputs. For example, where an input measure may better assure safety or where there is no clear outcome measure and inputs are used as a proxy measure.

However, there is a view held by some ACDHS members that expressing standards as outcomes should be sufficient to also explore how the outcomes are achieved: that it would be possible to introduce granularity in the outcomes required that enables process to be explored. Achieving the intent of the NRAS objectives can usefully inform whether, and if, an outcome measure is sufficient or if there is a requirement to specify inputs.

The importance of considering the guidance documents that are developed to accompany program accreditation standards was also noted. Inputs are often specified at this level rather than the standard as such.

Considerable discussion occurred around the specifications by some standards in the area of staffing. For example does a program need specify the number and level of appointments (eg 1 level E or D , 2 level C) or could statements requiring intellectual leadership suffice.

While not within the scope of NRAS, the Speech Pathology accreditation standards were offered as a good example.

> **Example:** SPA 3.2 Flexibility
>
> Speech Pathology Australia's accreditation framework is sufficiently flexible to allow for the development of diverse and distinctive degree programs.
>
> Speech Pathology Australia does not seek to prescribe the input of speech pathology degree programs by way of hours of study of any specified subjects. The Association recognises that the universities involved are responsible for the educational process and accepts that varying program structures, pedagogy and assessment strategies may be used to develop students' skills and to assess students' competency against the Competency Based Occupational Standards 2011. Speech Pathology Australia will however consider the evidence of competency of the graduates, by reviewing course and subject outlines, and the assessments carried out in the university degree programs.
>
> **10. How the Accrediting Panel Reviews the Evidence Presented by the University**
>
> **10.1 Principles**
>
> - Speech Pathology Australia is committed to implementing primarily an outcomes focussed accreditation, in which the Accrediting Panel obtains a thorough and detailed understanding of the educational program to be accredited. There will be a major focus on in-depth investigation of the adequacy of the assessments of competency that are carried out in the program.

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

Yes

If learning outcomes in health degrees are also expressed in outcome-based terms, the assessment of learning outcomes should also assess outcome-based standards. There should be a requirement that education providers demonstrate how their assessment is outcomes-based. In some cases this may require changes in assessment processes, and in other cases it may not. Many current assessment processes already assess outcomes-based learning goals and standards.

Other related work includes training of assessors in this area and the development of proxies for measurement where required.

Health program development and timeliness of assessment

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?

There is value in developing consistency in the following:

- The ownership and authorship of the professional competency standard
  - Which currently varies, and includes the National Boards, the accreditation councils and professional associations
  - Consistency in ownership would aid a better understanding of the interaction of standards, as well as the assessment and interpretation of standards
- How the professional competency frameworks respond to changing health care priorities or adopt to new roles, including
  - how future priorities or changes are flagged to the owner/author of the standard
  - mechanisms for cross profession discussion and/or response to identified priorities or changes
- A common stakeholder list, that in addition to those currently consulted, could include consumers and other stakeholders identified as relevant.

It could be of use to make reference to the Threshold Learning Outcomes for Health, Medicine and Veterinary Science[15] in the framing of the standards.

> **Example**: Threshold Learning Outcomes for Health, Medicine and Veterinary Science
>
> The TLOs developed for Health, Medicine and Veterinary Science are shown below. While there has been an attempt to ensure minimal overlap across the TLOs and, as far as possible, each is listed independently, even at the threshold level of achievement it is expected that graduates would demonstrate a broad and coherent assimilation of the identified TLOs across the various knowledge, skills and attitudinal domains.
> **Health, Medicine and Veterinary Science Threshold Learning Outcomes**
> Upon completion of their program of study, healthcare graduates at professional entry-level* will be able to: (*as defined by each individual discipline)
> 1 Demonstrate professional behaviours
> 2 Assess individual and/or population health status and, where necessary, formulate, implement and monitor management plans in consultation with patients/clients/carers/animal owners/communities
> 3 Promote and optimise the health and welfare of individuals and/or populations
> 4 Retrieve, critically evaluate, and apply evidence in the performance of health-related activities
> 5 Deliver safe and effective collaborative healthcare
> 6 Reflect on current skills, knowledge and attitudes, and plan ongoing personal and professional development

[15] HEALTH, MEDICINE AND VETERINARY SCIENCE Learning and Teaching Academic Standards Statement June 201 1P10 http://disciplinestandards.pbworks.com/w/file/fetch/52723773/altc_standards_HMVS_210611.pdf

11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

In part, this is addressed in responses to question 1.

Also noted in question 1, it is important to clearly differentiate program accreditation standards from profession specific competency/threshold frameworks. The latter describe the expected competencies of specific health discipline/profession; the former describe the accreditation standards of the higher education program provider.

The benefits to the higher education provider include consistency between the many programs delivered by each organisation and efficiencies in responding to accreditation requirements.

Clearly articulated and prioritised profession specific-requirements would be critical.

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?

ACDHS members considered this question in two parts.

1. Members suggest the following to improve the timeliness and responsiveness

- Clearer and consistent definitions of what is considered a minor or major change and differentiating the triggers for a significant review or documentation
- Preferably, reporting would be by exception or where major changes are proposed
- Review how accreditation authorities approach well established programs compared to newly developing programs
- This may occur in the adoption of a risk based approach to program accreditation
  - Members noted the ANC high, medium and low risk stratification

2. In terms of delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce, the following points were made:

- Focus on the 'bread & butter' of the profession
- Free up the practice curricula
- Enable clinical experience overseas to equip graduates to work in the internationally
  - The acceptance within standards while not prohibited, is variable, with most dependent on approval

Interprofessional education, learning and practice

13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

The requirement for inter-professional education is expressed in some program standards, albeit with the various authorities placing different emphasis on IPE/IPP.

Describing the component parts of IPE/IPP (eg patient centred care, interprofessional communication or role clarification) in outcome-based statements for graduates remains a useful approach.

IPE is described in both program accreditation standards and profession specific standards.

Example: *IPE in program accreditation standards*

- Harmonised standards adopted by the accrediting councils for dentistry, optometry and physiotherapy
  - Domain 3 Program of Study, Criteria 3.5/3.6
    - 'Principles *of inter-professional learning and practice are embedded in the curriculum'*
- Medical Radiation Practice Board Accreditation standard
  - 4.1.5 *designing an integrated, structured clinical education and placement program that provides each student with*:
    - a) experiences (including patient contact, simulated learning and opportunities for inter-professional learning) across the scope of practice program's expected of entry level medical radiation practice practitioners

Examples of IPE in profession specific accreditation standards

- Physiotherapy Practice Thresholds in Australia and Aotearoa New Zealand 1 May 2015
  - competence to practise as a physiotherapist autonomously as well as a member of an interprofessional team in relevant clinical situations (p11/37)
  - and in the key competencies of the Collaborative Practitioner role
    - 5.1 engage in an inclusive, collaborative, consultative, culturally responsive and client-centred model of practice
    - 5.2 engage in safe, effective and collaborative interprofessional practice
- Graduate Outcome Statements Australian Medical Council's Graduate Outcomes[16] Domain 4 Professionalism and Leadership: the medical graduate as a professional and leader
  - 4.8 Describe and respect the roles and expertise of other health care professionals, and demonstrate ability to learn and work effectively as a member of an inter-professional team or other professional group.

The challenge often expressed by ACDHS members, is not developing IPP competencies in pre-entry students, but rather the challenge for students to translate IPE/IPP knowledge and competencies into practice following graduation. Anecdotal feedback from new and early career professionals similarly reflect their perception of limited capacity to transcend the more traditional and often siloed workplace cultures.

Inter-professional practice is prioritised in policy and programs and should be a reflected in degrees. To assist in translating theoretical learning into practice it could be valuable to describe what IPP might look like in different services and settings. It is likely that there will be a continuum of applications in practice ranging from:

- a cohesive team based in a ward setting collaboratively making decisions with the patient
- to more multidisciplinary service settings that are able to apply some IPP components (eg interprofessional conflict resolution and role clarification)
- to primary care practitioners developing networks with colleagues to better deliver coordinated care and developing opportunities for the patient participation in decision making

However, IPE and IPP also have to be achievable within current education frameworks. Perhaps "exposure" and "immersion" to IPE should be encouraged in all curricula with "integration" desirable. The distinction is drawn in the University of Newcastle example below.

[16] Standards for Assessment and Accreditation of Primary Medical Programs by the AMC 2012 http://www.amc.org.au/files/d0ffcecda9608cf49c66c93a79a4ad549638bea0_original.pdf

> In 2013, a framework for the development of an interprofessional curriculum in health-related degrees was developed through a series of workshops and forums attended by staff from sixteen health professional degrees at the University of Newcastle. The framework identifies three levels of interprofessional education (IPE); Level 1 or Exposure, Level 2 or Immersion and Level 3 or Integration (Figure 1).

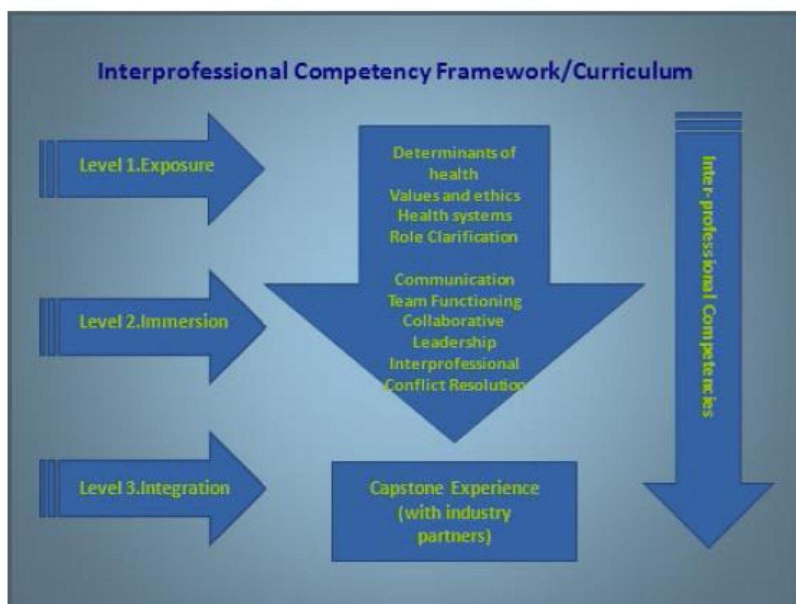


Figure 1

> Level 1 learning focuses on students gaining an understanding of the determinants of health, values and ethics, health systems and role clarification. Level 2 learning has a focus on communication and functioning as a team, collaborative leadership and interprofessional conflict resolution. The final level of learning, Integration, is characterised by a capstone experience which ideally should be student-managed and be conducted in partnership with health service providers. The IPE curriculum should be an identified "domain" or "stream" of learning through each degree.

University of Newcastle

Noting the above in terms of achievability, it is expected that a more detailed discussion of IPE/IPP will be provided to the ASReview by the SIF project team (Securing and Interprofessional Future).

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?

Achieving a balance between outcome-based standards and perceived need to specify inputs in key areas underpin a number of questions posed in this review. Other areas where deliberation is required on the balance of outcomes to inputs include for questions 8, 13 and 15.

Inherent in question 14 is that healthcare priorities are not well embedded within curricula and clinical experience.

Options for improvement may include:

- Establishing an advisory committee within NRAS to proactively flag current or emerging health care priorities that should be reflected into outcome based statements of graduate knowledge, skill and attributes
- Establishing a set of guiding principles related to the NRAS objectives, for example

- Where specifying an input will better ensure public safety

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

By requiring consistent recognition in all accreditation standards approving the use of quality simulation-based education in areas supported by evidence. Such education should contribute to the clinical skills development of students and, for example be counted to input standards for clinical placement hours.

Simulation-based training is already incorporated into curricula, particularly when preparing students for clinical placement. However, despite the recent recognition and qualified approval for the use of simulated based education by a number of accreditation authorities, there remain some that do not allow it to substitute for clinical placement hours-even when certain types of simulation may represent a good substitute for placement requirements with respect to specific activities.

In some placement settings it is difficult for students to demonstrate certain skills because there are insufficient patients to work with or the opportunity does not arise in a specific placement location at a specific time. There could be great advantage to demonstrating the skills in a simulation setting where all students have time to learn the skill and then demonstrate it in a more controlled environment. It is possible that many of the early year placements in degrees could be substituted with simulation-based education and training, thereby relieving placement sites of early year students and making more time for longer and more complex placements in the later years of degrees. The placement sites are also gaining more experienced students to assist with their work which would improve the relationship between placements sites and education providers.

The delivery of work-ready graduates

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?

There are certain circumstances where a period of supervised practice should be required as a pre-condition of general registration, for example:

- some overseas health practitioners seeking registration in Australia
- health practitioners returning to the workforce
- notifications from regulation authorities

More broadly, a requirement for a period of supervised practice for recent graduates of all health professions would be good in an ideal world, but difficult to enforce in the current labour market where there are often not enough new graduate positions to go around. Therefore, it is difficult to mandate supervised practice prior to general registration.

An intern system similar to that implemented for medical graduates would have to be put in place for all health professions. This would mean controlling the number of graduates in each profession and creating an expensive postgraduate training framework. Pharmacy currently requires that recent graduates complete a graduate training year and undertake a national exam before full registration is awarded. If a Pharmacy graduate cannot find a graduate position, which can be difficult in the current job market, their degree may be wasted.

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

Graduates should, at a minimum, be able to perform satisfactorily at the lowest level graduate position available in that profession. A work-ready graduate should also demonstrate the capacity to learn from employers and possess the skills to be a life-long learner.

The expectation for a new graduate to have specific service system and organisational knowledge and capabilities may not be fulfilled as this knowledge typically requires development by the employer. The expectation that a graduate who has met the requirements of an accredited program will also have organisational and systems knowledge pertaining to each service and sector *may underpin* employer perceptions of employability or otherwise and/or work readiness. An example of how one sector has addressed the development of early career allied health professionals to work as generalist in rural areas is provided below.

> **Example:** development of a structured development program for early career AHPs working in rural areas
>
> It is perhaps worth considering the formative work informing the development of the allied health rural generalist (AHRG) program. Recognising that rural and remote health services faced with recruitment challenges often employed new graduates, the AHRG program has developed a 2 level learning program to support new/early career graduates working in rural settings. Level 1 is a structured workplace-based program with supervision and mentoring. Level 2 is a formal academic program (initially a graduate diploma) structured to articulate with the Level 1 program.
>
> This program recognises the broad based entry level skills and competencies of a new graduate and provides a structured workplace-based learning program to build on new graduate competencies that then articulates with a formal academic program and qualification.
>
> In effect, this provides a structured organisational education program for the new/early career graduates in the professions of allied health and may in time be considered a vocational pathway.
>
> The principles of this program could be applied more broadly to assist in addressing the gap between employer expectation of new graduates in a wide range of health settings (acute, rural, private, primary care, disability) and the competencies of graduating health professionals from accredited programs. (see Q 26 for additional detail)

National examinations

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?

The Australian Council of Deans of Health Sciences **strongly oppose** the introduction of a national assessment or examination process.

National assessment as an end-point for registration would drive the way students learn throughout their degrees and the way teaching is conducted. A national assessment or examination would also limit innovation and constrain the ability of universities to develop programs that reflect the needs of their region. Such a reductionist approach would result in an enormous focus on being exam-ready and not on learning.

Pharmacy currently has a national exam one year post-graduation and also has a 5 yearly re-accreditation requirement and regular reporting on accreditation standards throughout the five years. If Pharmacy is taken as

the example, a final national exam before full registration has not resulted in more streamlined accreditation processes.

A robust accreditation process negates the need for further national assessment to gain general registration. Improvements suggested in responses to questions on improving the efficiency and responsiveness of the accreditation systems will inform the development of a sufficiently robust system.

Producing the future health workforce

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?

The current constitution of profession specific boards, while having a depth and breadth of knowledge and skills, may lack the incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system.

The many responses to this question will perhaps align with the perspective from which they are provided; ranging from maintaining the status quo to innovative responses to changing health care needs. Fundamental health workforce reform may not be a common or priority focus. Recent OECD policy recommends that governments '... *develop and maintain a strategic capacity to ensure that regulatory policy remains relevant and effective and can adjust and respond to emerging challenges'*[17]. Perhaps not all stakeholders view the responsiveness to emerging challenges in the same manner or equate innovation in service delivery with workforce reform.

Inherent barriers to innovation within the accreditation system that constrain the responsiveness to changing need are often cited by ACDHS members. Examples include barriers to providing relevant clinical experience in community settings to respond to more community-based services including primary care, disability and aged care. Barriers include specification of mandatory clinical practice areas, prescribed number of clinical practice hours, supervision requirements that preclude cross-profession supervision in some professions.

Allied health courses, for example, are high content degrees designed to meet the requirements of accreditation bodies. ACDHS members have previously commented on the limited opportunity to introduce additional content which may have a greater focus on future needs[18].

- The prescribed nature of degrees can make it difficult to combine into double degree programs which could introduce new knowledge and skills, and possibly prepare graduates for broader scopes of practice and the future needs of the community.
- Innovation frequently comes from interactions at the margins of disciplines – so the structure and demands of health professional degrees often allows little time for intersection with non-health

[17] [17] 1.3 p5 Annex to the Recommendation of the Council on Regulatory Policy and Governance 2012 OECD http://www.oecd.org/gov/regulatory-policy/49990817.pdf

[18] ACDHS submission to the House of Representatives Standing Committee on Education and Employment Inquiry into innovation and creativity: workforce for the new economy

related disciplines, which potentially limits innovation and creativity in graduates of health professional degrees.

- Several accreditation bodies have strict, rigid and prescriptive requirements for both academic and clinical programs. Therefore, the opportunity to offer broad subjects that encourage skills in innovation, research and creativity is being lost. While many universities are attempting to incorporate these skills into other clinically focussed subjects, this would be far more achievable with more flexible criteria and requirements for course accreditation. In addition, the accreditation requirements are not necessarily appropriate for modern healthcare either in terms of the systems that students should or could be working in, or in terms of the changing health profile of the community.
- Responsiveness and innovation in clinical education (and placements): The structure, format and content of clinical placements often work against innovation.
- The capacity to respond to innovations in traditional placement settings can be limited by service requirements, established service models or time pressures.
- This then has negative flow on effects for the development of leadership skills in allied health graduates and their desire to lead change in the future.
- They (Allied Health graduates) are also not exposed to new models of healthcare or new areas of practice (such as physical health in people with mental health disorders, or problems of multi-morbidity).

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?

The degree to which the subsidiary relationship of the accrediting authorities to their respective board constrains the most appropriate education and training of health practitioners is fundamental to this question. Arguably, not possessing ultimate responsibility for the approval of standards or programs of study may be a rate limiting step to driving innovation.

However, vesting approval authority with each separate profession accrediting council may have similar challenges in terms of proactively and promptly responding to workforce reform priorities without the establishment of mechanisms to engage a broad range of stakeholders in discussions on workforce priorities (see response to Q 30). Where independence continues within professions as is the current situation, in many instances this greater independence has resulted in more insularity and more rigid accreditation standards.

Governance of accreditation authorities

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

Not addressed

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

Not addressed

23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

Not addressed

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

The use of the word 'ensure', in effect, requires a negative response to this question.

The standard clause is written without specifying any mandatory activities or reporting, but rather broad descriptive statements. Phrases within the statements do not reflect mandated reporting, for example:

- The Council and the Board *note continuing interest* in demonstrable changes
    - …opportunities to increase cross-profession collaboration and innovation
    - …opportunities for the Council to facilitate and support inter-professional learning
    - …opportunities for the Council to encourage use of alternative learning environments
- … *will advise*
- …*will subsequently share information about health workforce reform issues*

The clause, as written, does not detail the NRAS objectives it seeks to 'ensure' the delivery of and alignment with. If this is the only clause that relates to the broader context for the accreditation functions, for example NRAS objectives 'e' and 'f' - then additional mechanisms may be required.

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

Whilst establishing a single accreditation standard may be the ideal; unless *all* of the professions currently within NRAS (*and ideally the self-regulating professions*) are included, the progression of cross profession development, education and accreditation consistency and efficiency will be sub optimal.

An interim, pragmatic option suggested by some members would be the establishment of three accrediting councils: medicine, nursing and allied health. This is not however a consensus view of all members. The proposed strength of merging the councils for the professions of allied health is the potential to develop the cohesiveness of the professions of allied health to strategically respond to emerging health care and health workforce requirements. If such an option were to progress, it would be opportune to establish mechanisms to include the core self-regulating health professions- many of which are considered part of the collective allied health workforce.

Alternatively, expansion of the remit of the AHPRA Agency Management Committee may be more feasible in the first instance. As NRAS matures, the potential to shift the focus from improving efficiency and effectiveness to that of deciding policy would, as noted in the discussion paper, require clear delineation between the Committee's scope of interest with those of the expert accreditation authorities. As noted above, the scope should include all of the regulated professions covered by NRAS and ideally consider including self-regulating health professions under a broader accreditation function.

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

Within the preferred governance model, mechanisms should be established to assess and accredit developing practice standards, curriculum design and accreditation standards for new or enhanced roles. This may be a subcommittee of HPACF (formalised and resourced) or an expanded Agency Management

Committee- but may well be better addressed by the formation of a specific entity to address cross profession and/or generalist competencies.

Work in the post graduate area would be a logical first step and would enable the alignment of accreditation of programs with current and future health workforce innovations.

Example: The development of the Allied Health Rural Generalist program is one example

ACDHS-Brief_AHRGP_20170110.pdf

Rural generalist allied health professionals practice to the full scope of their profession, and into extended scope including skill sharing with other professions where this is safe and appropriate for the service context. Rural generalism should not be confused with the concept of a "generic (allied) health worker" that does not have an existing role definition, qualification or regulatory instruments in the health sector.

Expected benefits of the Allied Health Rural Generalist Pathway

- Improved attraction and retention of early career and experienced allied health professionals in rural and remote communities.
- Improved "fitness for purpose" of the allied health workforce to meet the needs of rural and remote communities.
- Enhanced effectiveness, efficiency and accessibility of allied health services to support improved health outcomes.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

Not addressed

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

Not addressed

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

Not addressed

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

As questions such as this have been addressed in previous reviews of the health workforce and workforce regulation, it would be valuable to draw upon relevant findings and recommendations.

The 2014 Independent Review of the National Registration and Accreditation Scheme for Health Professions recommended the establishment of a standing committee within NRAS.

> Recommendation 18:
>
> *'A standing committee is needed within the National Registration and Accreditation Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:*
>
> > *a. discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals*
> >
> > *b. consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)*
> >
> > *c. share an understanding of workforce distribution and projected workforce need.*
> >
> > *d. ensure that education opportunities exist for students to meet the minimum standard'*

Where required, the objectives listed above (a-d) may be reviewed to reflect the findings of the current review. The committee could inform the development of shared or multi use of data for use across systems to inform workforce data collections and regulatory functions. Consideration of emerging innovations in education such as block chain education and micro credentialing would be valuable.

The 2005 Productivity Commission Research Report- Australia's Health Workforce addressed workforce innovation in Section 4. While noting the many developments since the publication of the report, the discussion on the institutional and regulatory frameworks affecting workforce deployment remains relevant. The linked sequential processes presented in Figure 4.1 of the report (p51) provides an approach that could inform the activity of a standing committee established within NRAS (Figure 4.1 from the 2005 report is provided below).

Should it be established, health workforce mobility is recommended to form an additional focus area for the standing committee. Developing a responsive regulatory system that enables freer movement of health professionals will underpin Australia's role in the development and supply of the health workforce.

The global awareness of the critical role of health systems and health workforce in underpinning capacity of economies to achieve the goal of Universal Health Coverage (UHC). Strong and effective health systems require a sufficient capacity of well-trained health workers able to meet changing patterns of disease and health care demand[19].

Possible considerations include: the impact of the inclusion of services in recent Free Trade Agreements; the type of health professionals required in developing economies; how Australia will be best positioned to educate and regulate health professionals who meet the domestic and international health care needs.

[19] Proposal to Establish an APEC Tropical Health Workforce Development Hub – Concept Note

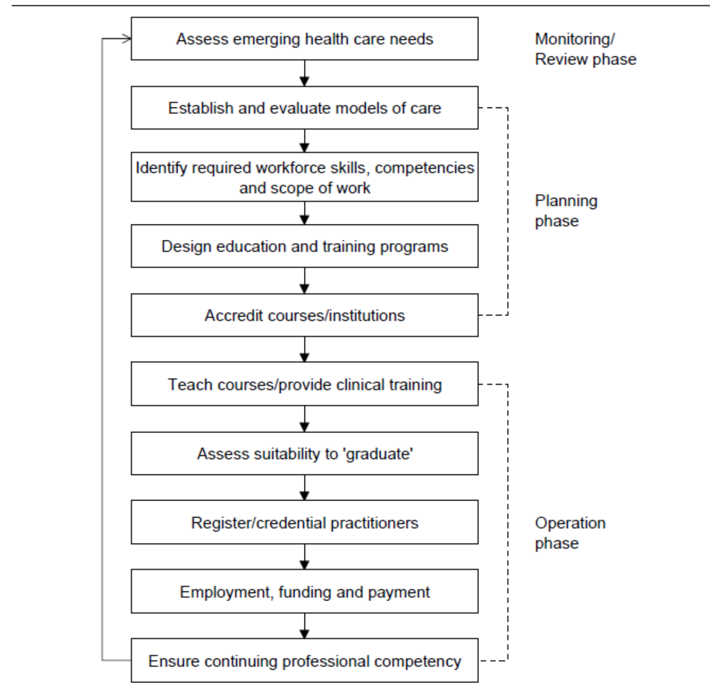


Figure 4.1 **Processes influencing workforce deployment**

Some of the most prominent entities that control or impact on workforce deployment and scopes of practice include: governments; bodies with delegated powers (including registration boards and some accreditation agencies); employers; educators and trainers; professional associations; industrial associations; and health insurers (box 4.1). State and Territory Governments play a particularly important role — so that even where national approaches are warranted, the ability to 'make things happen' often lies with those jurisdictional governments.

Source: Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra[20]

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

Not addressed

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

Not addressed

33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

Not addressed

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

Not addressed

[20] http://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf

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?
Not addressed

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
No

ACDHS members assert there should be a formal appeal process where all matters are dealt with in a transparent manner by an independent arbiter.

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

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

Not as the first line of appeal. The Ombudsman should be a secondary level of dispute or complaint resolution. As such alternative options should be considered.

Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

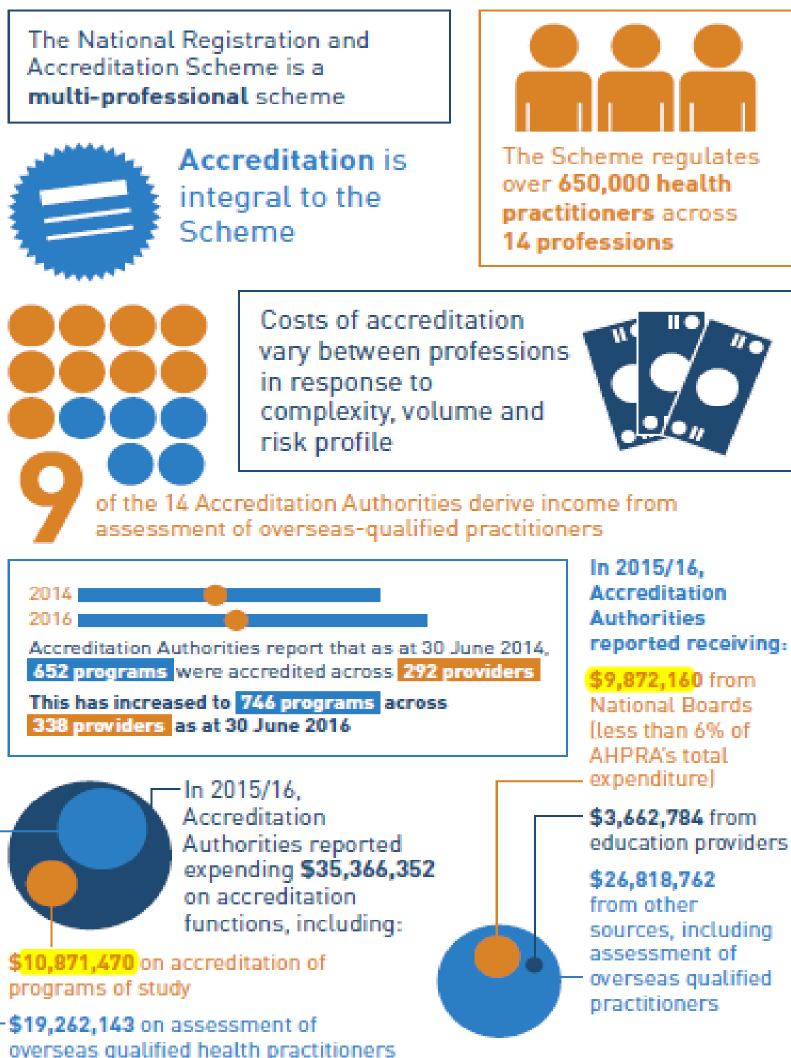
Yes

Related discussions included

- better preparation and education of assessment panel members
- scope for inclusion of the self-regulating professions
- the risk of repeated appeals/challenges to the Ombudsman or other established external review body and the pressure to inappropriately change a decision

Appendix A

Source: *Cost of Accreditation in the National Registration and Accreditation Scheme*
Paper prepared by the Costing Working Group (CWG) on behalf of the Accreditation Liaison Group (ALG)
November 2016



Thank you for the opportunity to provide input into the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals.

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The submission reflects the main themes expressed by members of the Australian Council of Deans of Health Sciences, but not necessarily the full or particular views of all of its Member organisations.