MAPPING OF PROFESSIONAL ACCREDITATION IN THE CONTEXT OF HIGHER EDUCATION REGULATORY AND STANDARDS FRAMEWORKS

The Australian Council of Deans of Health Sciences welcomes the opportunity to provide input into the Department of Education and Training (DET) commissioned mapping of professional accreditation in the context higher education regulatory and standards frameworks.

The Australian Council of Deans of Health Sciences is the peak representative body of the Australian universities that provide pre-professional education in the allied health sciences. Professional accreditation is a requirement for the majority of allied health professions to enable graduates to practice. The professions of allied health therefore form the primary focus of this submission. Accreditation of allied health programs includes both the registrable and self-regulating professions. 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

In addition to providing comment within this submission, many Council members have provided submissions from their respective universities. Individual member responses may provide more specific examples of the impact of the multiple accreditation processes on individual school, faculty and whole of university activity and processes (including professional accreditation, TEQSA and ESOS).

ACDHS member universities include:

Charles Sturt University
Curtin University
Deakin University
Flinders University
Griffith University
James Cook University
LaTrobe University
Monash University
Queensland University of Technology
University of Canberra
University of Newcastle
University of Queensland
University of South Australia
University of Sydney
University of Tasmania
University of Western Sydney

1. What is the practical impact of professional accreditation on institutions?

Registered and Self-Regulating Health Professions

The National Registration and Accreditation Scheme (NRAS) ensures that Universities provide high quality education and training through critical appraisal of staffing, research outputs, resourcing and curriculum. NRAS has responsibility for the registrable 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, meeting as the Health Professions Accreditation Councils Forum (HPACF) are progressing work to harmonise standards across professions. There is no such structure or process for the self-regulating professions.

There are a number of issues within the accreditation processes common to both registered and self-regulating health professions that could be reviewed. For example cost, transparency and levels of evidence required (detailed below).

Accreditation Costs

Health professional program accreditation costs to Universities are substantial, and do not always reflect the 'service' delivered. There appears to be limited transparency in how fees are determined across the health professions. To date, each professional accrediting body has a different fee schedule and process to determine fees. The variability in fee structures limits a simple comparison of accreditation costs across professions due to variation in amount and timing of payment for the initial accreditation fees, site visits, annual fees and fees for multiple programs and campuses.

The increases in accreditation fees and related costs required to prepare the accreditation documentation and site visits are a frequent point of discussion within Council. For example:

- One member notes an increase of almost 300% in the 5 years from 2010-2015 with costs for health degree accreditation in 2015 totalling $275,000
- Another member estimates the costs associated with preparing for program accreditation and site visits is around $100,000 to $200,000, meaning five-yearly costs are in excess of $1.5 million (accreditation is generally a five-yearly process) or $300,000+ a year

Other examples provided to our Council include annual fees ranging from $10,000- $45,000 per annum, with additional payments for site visits ranging from $10,000-$25,000.

The fee structures for some professions require payments for each campus the course is delivered on (regardless of identical offerings), which members often find hard to justify. Physiotherapy and Occupational Therapy accreditation for example, both have variable (although different) fees depending on number of campuses the course is offered.

- Physiotherapy: '*Programs offered across multiple campuses receive a 30% discount to the Annual Fee for each additional campus. Where an education provider offers multiple programs a 30% discount will be applied to the Annual Fee for each additional program*.
- Occupational Therapy: '*50 per cent discount will be applied to each additional program-75 per cent discount will be applied to fully embedded programs'*

Medical Radiation Science also structures variable payments depending on the number of sites. For example, the fees listed until June 2016 were as follows:

- $20,000 one site
  $25,000 2 programs at one site at the same time
  $30,000 3 Programs at one site at the same time
  Fees for other combinations on request.

These fees are significant for annual costs to the delivery of health programs, particularly so where high numbers of programs are delivered. It has been suggested that as AHPRA only allocates 5% of income towards accreditation purposes, there is greater necessity to seek fees from providers.

Transparency of Processes and Scope of Reviews

The processes associated with accreditation (timelines, documentation required, instructions) for many health professions are often unclear and difficult to interpret. While there are exceptions, the experience of our members includes a lack of clarity around accreditation processes and at times, conflicting and confusing information regarding the information required and the timelines involved.

There is also considerable variation in the transparency of accreditation process between professions. The basic processes, such as timelines for accreditation reporting and documentation requirements are often not specified and are highly variable between professions. For example,

- In recent experience of members, podiatry had not provided clear timelines for submissions for the very large volumes of documentation required.
- In contrast, the Australian Physiotherapy Council (APC) and the Occupational Therapy Council (OTC) have introduced an annual reporting cycle with all programs now required to submit annual documentation in June each year.

Similarly there is variation in the requirements and consistency of site visits, including frequency and panel experience. The composition and experience of the teams conducting the site visits has been a point of discussion by members of our Council. For example:

- It has been suggested that some panel members do not appear to have contemporary educational experience, and that
- A perception of members is that visiting panel members variably interpret the accrediting guidelines of their profession.

However, some accreditation bodies, such as the APC, are providing clearer expectations and offering training for panel members.

The level of documentation and evidence universities are required to provide are also highly variable. Members consider some requests for information border on "commercial in confidence". For example

- Details required have at times included: current balance sheets, student names and projected clinical placements over an entire cohort, projected income, and expenditure statements over a three year period.
- One profession requires the provider to submit every clinical placement undertaken by every student across the 4-year program. They do note that student names however can be stripped off these documents to uphold privacy.
- Levels of evidence required around professional development of staff members also vary between disciplines.

There are some areas where the content of requirements is similar, but the format required differs between disciplines. Some standardisation of format around such areas (e.g. library resources, on-line resources) would be more efficient and a welcome improvement.

For some accreditation bodies there appears to be an undefined process of accountability. It can be unclear at times how stakeholders are engaged and how decisions following consultation are made. At times, accreditation processes can become adversarial which undermines the process and aims of the scheme.

A transparent and accountable process with clear governance is necessary across the professions within the NRAS system and the self-regulating professions. It is noted that the Health Professions Accreditation Councils Forum (HPACF) is working on reducing variations across the registrable professions. This is a welcome step, however HPACF does not include the self-regulating professions. Consideration of broadening the remit to include the self-regulating professions would also be welcomed.

The practical impact of professional accreditation on each university thus requires the allocation of considerable human and financial resources for each of the health programs offered within their university. The impact is exacerbated when multiple programs are due for reaccreditation within the same year and when site visits are scheduled without consultation, for example in peak teaching times.

TEQSA and ESOS accreditation requirements further compound the human resource and financial burden. Professional accreditation is usually managed at faculty or school level, whereas TEQSA and ESOS accreditation are usually managed at a university rather than program level. The documents of professional accreditation contribute in part to the evidence base for TEQSA accreditation, however the specific requirements of each accrediting or regulatory body require tailored responses *additional* to those developed for the professional accreditation.

2. Are there advantages and/or disadvantages to professional accreditation processes as they are currently managed? What are they?

Universities have often been advocates for change in "future proofing" practice, knowing from global trends and research where there is need for change in workforce and practice. Working together through accreditation provides an excellent opportunity for rigorous quality control, a chance to reflect and review programs and for Universities to showcase areas of excellence and innovation. Accreditation processes provide focus for staff, students and institutions to attend to areas requiring change and facilitates external guidance around the future of academic programs. Accreditation processes that are exemplary demonstrate transparency, inclusivity and comprehensiveness.

The accreditation process is not viewed lightly by tertiary providers and their staff, who seek to provide all that they can – often "warts and all" – to get the most out of a highly valuable and often expensive and time-consuming accreditation process.

Accreditation for the registrable professions sits underneath the Health Practitioners Regulation National Law Act. There are aspects of the accreditation processes within NRAS which could improve. For example transparency of process, accreditation costs, consistency between accrediting standards professions and enabling innovation in curricula and clinical education.

However, many health professions are self-regulating and the accreditation of programs for these professions does not fall under this Act. There would be advantage in broadening the scope of the accreditation structure and processes within NRAS to include the self-regulating professions. 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.

Advantages:

Some advantages listed by members include that accreditation:

- Provides external evidence that programs meet national standards, and
    - Allows for identification of areas for continual quality improvement
    - Ensures appropriate quality is in place for students and the professions for which they are being trained;
- Provides confidence in the profession. The accreditation process
    - Provides an opportunity to reflect on course content and structure aligned to professional expectations, and
    - Enables withholding professional accreditation for institutions not sufficiently prepared to deliver a program to the accepted standards.

- The accreditation process and associated professional requirements can provide a point of leverage in respect of ensuring adequate resourcing of programs.
    - Recommendations from professional accreditation can support internal budget processes for resource allocation (for example, applications for additional funding for curriculum development and/or staffing rather than for accreditation process itself).
    - Accreditation standards enable Universities to enforce requirements and expectations of students.
- Where in use, templates makes it easy to know what information to provide and in what format.

Disadvantages

Many accreditation standards continue to emphasise and assess course inputs rather than outcomes and required competencies. While the expressed aim of accreditation requirements is to produce safe practitioner, a number of the standards are considered to be rigidly prescriptive. This may limit the opportunities of students to pursue more innovative learning experiences in emerging areas of practice, either at the university or when undertaking clinical placement.

Preparing our future health workforce for their role in an evolving health system requires flexibility and responsiveness. There are issues with clinical placements including:

- a continuing focus on traditional clinical placement providers
- challenges to placing students in smaller private providers and organisations
- strict accreditation requirements and funding barriers
- capacity to provide placements in rural and remote locations

Other disadvantages noted by members can be grouped as follows*:*

Responsiveness

Accreditation processes tend not to encourage rapid change, which may make it difficult for universities to respond in the current operating environment. For example:

> There have been challenges to the sector responsiveness to emerging service models, such as NDIS, where there has been a shift service delivery from state or not-for-profit organisations to smaller private providers or for-profit organisations. The latter are not funded to take students and may have limited capacity to provide profession specific student supervision, a common requirement of accreditation standards.

However for some allied health professions, undertaking fieldwork placements with industry partners other than traditional services is not common for students because of accreditation

barriers. There are exceptions of course, with many students in Occupational Therapy undertaking fieldwork placements with industry partners other than traditional clinical services.

Cost

As noted above in Question 1, the cost of accreditation is high, both in terms of fees levied by the professional accrediting bodies and costs related to producing the accreditation report and managing site visits.

Quality

With the focus often on process rather than outcomes; some unrealistic targets may be set (e.g. student/staff ratios) that do not account for

- innovative learning and teaching approaches, or
- Quality Indicators for Learning and Teaching (QILT) and other measures of student success and satisfaction

Some members have expressed a concern that professional accreditation should not be driving university quality assurance processes or pedagogical developments.

Scope

Accreditation bodies may at times, make recommendations around issues which might be considered outside their scope (for example, staffing requirements, either number and/or level, or budget) rather than focussing on graduate outcomes and competencies.

Timeframes

The timeframes can be problematic; for example the requirement to submit an application 12 months before starting to take enrolments.

Extended processing time perhaps reflects the result of limited resources of many accrediting bodies and the growing number of institutions that require accreditation.

Timeframes in which to respond to new accreditation processes and professional standards can be very short. The lead time can stifle innovation and progress.

Where accreditations require a print submission, this needs more time to produce, at higher cost, and longer production times (compared with online submission).

Consistency of accrediting panel members

Given the diverse background of panel members, some accreditation panels have at times been considered to display some subjective bias.

Panel members may tend to emphasise particular areas (perhaps reflective of their own interests, rather than what is happening in the industry/market).

3. Are there trends emerging in professional accreditation that you are aware of and are the bodies you are associated with adopting them? What new approaches are emerging?

As noted in the previous section, the continued focus of many standards on inputs can place limits on the responsiveness of universities to prepare graduates for contemporary and future professional practice. When combined with the often prescriptive, high content professional curriculum requirements, the opportunity for universities to add new content that reflects emerging practice is constrained. However, where new or revised standards are being developed, requirements are generally less prescriptive and focus more pointedly on what is achieved rather than how it is achieved.

A number of the accrediting councils of the registrable health professions are progressing work towards harmonising their accreditation standards (through the Health Professions Accreditation Councils Forum). Common domains have been proposed in recent standards or draft standards with the majority of the criteria being similar (the exception being discipline specific qualifiers). Public safety for instance, is prominently listed as the first domain in each of the standards listed below Examples include:

- Accreditation Standards for dental practitioner programs 2016
- Accreditation Standard for entry-level Optometry Programs 2015
- Psychology (2016 Draft standard)
- Physiotherapy (Fourth Draft Standards)

These standards have increasingly adopted an outcomes-based approach in assessing standards rather than the previous inputs based approach. The development of accompanying Evidence Guides then documents the evidence required to demonstrate achievement of the standards.

A number of accrediting councils have previously used the Higher Education Standards Framework (HESF) to frame their accreditation standards however, this is less obvious in recent iterations of standards.

> For example, the Third Draft Accreditation Standard for entry-level Physiotherapy in Australia was prepared utilizing a framework aligned with the Standards for Higher Education in the Higher Education Standards Framework (Threshold Standards) 2015, as far as practicable, and with other professions' standards.
>
> Following the release of the COAG response to the Independent review of the National Registration and Accreditation Scheme suggesting cross professional work toward alignment of accreditation protocols, the Fourth iteration of the draft Accreditation Standard for entry-level Physiotherapy in Australia adopted a format, structure and style similar to other accreditation bodies and is less obviously aligned to the HESF. For example, these recent standards place *Public Safety* rather than *Student Participation and Attainment* as the first domain.

4. Does accreditation make innovation in course design more difficult, or does it encourage innovation?

Innovations in Education and Health and Accreditation

The role of accreditation bodies in supporting innovation, and the approach that some accreditation bodies currently take, can stifle innovation in the way that health students are educated.

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 related disciplines, which potentially limits innovation 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. Concern has also been expressed about making changes to a currently accredited program that may jeopardise their accreditation status.

The cost and timing of the accreditation cycle can inadvertently reduce innovation in curricula as it is difficult to innovate, implement and adjust the curriculum in response to either student or partner feedback. If innovation is not impacted, then responsiveness probably is. Not all changes require additional accreditation material, of course, but the constraints can be quite tight.

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.

Educational Practices

Accreditation teams at times do not appear to have contemporary educational experience. Educational practices have evolved rapidly over the past decade in response to significant advances in technology for teaching. Higher education facilities in many circumstances are moving away from highly didactic face to face delivery to more flexible and dynamic online and interactive teaching models. Many accreditation bodies appear reluctant to support innovations in teaching methods for health professional courses, particularly around online and blended teaching approaches. The acceptance of simulated learning environments for clinical education is variably accepted across the standards of the health professions.

High content courses

Allied health courses are high content degrees in order to meet the requirements of external accreditation bodies, so often there is less opportunity to introduce additional content which may have a greater focus on future needs. Member comments included:

> *'…too many accreditation requirements and needing to map to a professional standards framework restrict flexibility in program design, and can lead to overcrowded curriculum with little scope to introduce different topics/electives that might broaden a student's university education (and subsequently their future prospects)'*

> *'…many health degrees offer no elective options because mandated curriculum content takes up the entire duration of the degree, and there is not even the space in the curriculum to offer students additional content that the University believes would be beneficial to their professional preparation (e.g., content related to developing and managing their own business).'*

The prescribed nature of degrees also make it difficult to combine them in 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 .

Prescriptive clinical placement requirements

Accreditation bodies frequently demand that students undertake very prescriptive practical experiences and are reluctant to recognize alternative experiences which may broaden the scope of health professional degrees and produce a graduate more aligned with future requirements in health care, and possibly more focused on innovation within future health care.

Clinical placement for students is often considered the area in which accreditation requirements are most stifling and constraining. Highly prescriptive requirements about the experience of clinical supervisors, types of settings and quality of facilities in some specific disciplines limit the ability to offer students 'accredited' professional experience placements, particularly in rural, remote and international settings.

Examples of prescriptive requirements include completion of a prescribed number of hours and/or specific clinical areas. *(Note: Regulation governance is indicated in brackets after each example as either NRAS or self-regulating.)*

> **Occupational Therapy** (NRAS): *…a minimum of 1000 hours is normally required, including at least one fieldwork placement of up to eight weeks' duratio*n.
> **Podiatry** (Self-regulating): *…indicative clinical practice amount per student is a minimum of 1000 Hours*
> **Dietetics** (Self-regulating): specify minimum number of clinical education hours …*totalling a minimum of 20 weeks (or 100 days*).
> **Exercise Physiology** (Self-regulating): …*demonstrate evidence of a minimum of 500 hours of practicum hours as outlined in Section 1 [of the ESSA 2016 AEP Practicum Guide]*

- *At least 140 hours of apparently healthy practicum*
- *At least 360 hours of clinical practicum including:*
  a) At least 140 hours of cardiopulmonary/metabolic practicum
  b) At least 140 hours of musculoskeletal/neurological/neuromuscular practicum
  c) Up to 80 hours of other clinical health delivery activities IF individuals have not completed a total of 360 hours of practicum in category a) and b) above.

A number of newer or draft standards are increasingly less prescriptive including:

> **Physiotherapy** (NRAS) : … *sufficient to achieve the competencies expected of a physiotherapist detailed in the Physiotherapy practice thresholds… and work autonomously and within teams across the lifespan, settings and sectors*
>
> **Medical Radiation Science** (NRAS): … *ensuring the volume, range and level of clinical education and placements is adequate for effective delivery of the medical radiation practice program's learning outcomes*.

There is a relative absence of active measures and support for innovative cross-discipline or other reform within the professions governed by AHPRA. This is despite a specific objective of the National Registration and Accreditation Scheme (NRAS) to '*… enable innovation in the education of, and service delivery by, health practitioners*'. There is variable inclusion for adoption of interprofessional education or simulated based learning, with many professional standards (under NRAS or self-regulating) silent on these areas (Table 1). The impacts include:

- *limited or no provision for students to be supervised by a clinician from a different profession to their own in some disciplines,*
- *failure to take into account that modern healthcare is patient-focused and more often delivered by inter-professional teams in settings other than hospitals (e.g. Health in the Home and primary healthcare focus).*
- *Constraints on clinical placements in multi-disciplinary team contexts because there is not a full time clinical supervisor in the student's discipline*

Table 1: A brief summary of changes re simulation and interprofessional placements from 2014 -2016

2014	2016 update
A lack of recognition for simulated learning using high fidelity and related technologies and, consequently the refusal to count these experiences as clinical placement hours	A number of standards now include simulated learning, including Dietetics, Occupational Therapy, Pharmacy and Physiotherapy
A lack of recognition for interprofessional (IP) learning experiences as valid clinical placement hours for individual disciplines despite strong national and international endorsement of the importance of inter-professional education within health professional curricula.	Many standards are silent on IP placements. Physiotherapy specifically notes that Clinical Education may include interprofessional placements
A lack of recognition for interprofessional supervision	Specified profession specific supervision remains the case for MRP, OT and Dietetics for example. Physiotherapy, while not specifying that the supervisor is a physiotherapist, has a qualification about assessment … *'Suitably qualified and experienced physiotherapists undertake the assessment of physiotherapy specific competence*."

The standards should evolve to allow innovation in clinical education for example, to address such questions as:

- Where can new practical training (e.g., work placement) capacity be found in non-traditional sites and new formats?
    - For example, where can we safely allow cross-disciplinary and inter-professional supervision models, and encourage access to new and different training sites, rather than continuing to overload existing placement providers?; and
- How can we better-use the practical training requirements available to help to address workforce maldistribution, getting students to learn where we hope they will work once they graduate?
    - For example, developing clinical training opportunities in rural and regional areas, in schools, and in sectors of the workforce where there is growing need and emerging workforce shortages such as aged and disability care.

5. How do international professional recognition requirements impact on course design in your discipline(s)? Do these requirements mesh easily with internal academic quality assurance, the HESF and the TEQSA process? What, if any, are the problems?

The increasing focus on health workforce mobility will impact future course design. However the current focus is perhaps more toward course design for the Australian context. A number of programs are offered offshore, some of which seek course accreditation by accrediting bodies within Australia. There is then the question of eligibility for professional registration by the relevant professional registration board should the graduate seek to practice in Australia.

Many health accreditation bodies do not allow students to count clinical training placements undertaken at sites outside of Australia or under the supervision of professionals who are not registered under the Australian health registration system.

Further development of education as an export strength for Australia is potentially limited where we do not progress opportunities to mutually recognise qualifications. Similarly, the lack of mutual recognition can limit the opportunity to attract both clinical and academic staff. For example:

- *There is a shortage of high quality clinical academics with strong research records in Australia, and recognition of internationally qualified and registered clinicians is an important strategy to address this work force shortage. It does not appear to attract much attention, and yet it is an excellent strategy to enhance our allied health academic workforce*.

6. What could be done to streamline the various regulatory, quality assurance and professional accreditation processes to reduce the burden on institutions?

Purpose and quality

- TEQSA to continue to work with the professional accreditation bodies to share efficiencies and minimise overlap.
- Consideration of the overall aim of accreditation process
- Ensuring public safety underpins the elements of accreditation
- Accreditation panel composition to include practitioners with educational background and experience, and also 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.
    - Reductions in the size of accreditation panels.

Consultation, feedback and appeals

- Establish advisory committees to accreditation bodies that includes members drawn from educational institutions and industry.
    - Advisory committees could undertake a process of strategic planning in conjunction with key players in the accreditation system within each profession to actively share and debate for example, the merit of new and innovative educational models.
- Establish a review and appeal process through which parties to the accreditation process can raise objections or appeal the findings of a review.
- Develop processes to provide feedback to accreditation boards
- Reconsider how deeply accrediting bodies look into issues that, possibly, go beyond the bounds of assuring quality and completeness of education for that professional group. For example:
    - A recent accreditation process at one university looked deeply into the way the University managed depreciation of assets, which was not considered by the Academic Group to have any bearing on education standards and practices. In that same visit, suggestions were also made about
        - Overall University governance and business practice.

- Non-university facilities used for professional experience placement. It was suggested these outside entities needed to change parts of their operations and build new infrastructure.

Standardisation and consistency

- Progress standardisation of some aspects of 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.
- Some standardisation of format would be more efficient and a welcome improvement
- Greater transparency of accreditation processes, requirements and timelines within and between professions.
- Consistency of definitions for key terms amongst accrediting bodies and higher education institutions.
- A move towards electronic submission of accreditation documents to reduce the burden of hard copy documentation and reconsider the overall volume of documentation required.
- Consideration of broadening the remit to include the self-regulating professions would also be welcomed.

Responsiveness and flexibility

- Greater acceptance of inter-professional and generalist models of practice for placement settings and supervision models.
- Greater flexibility in contexts of practice and non-traditional clinical placements.
- Ensuring that students are competent to practice, with sufficient breadth and depth of knowledge should drive and inform the overall accreditation process.
- Consider a differentiated approach, so that established programs with leaders in pedagogy would not be expected to provide the same level of detail every year as new programs with inexperienced staff, who do not have the same level of experience in teaching or research. Newer entrants could/should be inspected more closely and new programs might undergo short accreditation approvals, stricter scrutiny and stronger surveillance.

Cost and support

A review of accreditation fees, funding and expenditure across the professions would be welcomed.

There have been some suggestions to increase the proportion of the AHPRA budget allocation for the administration of the accreditation

- It is understood that AHPRA directs around 5 per cent of its total budget to accreditation matters, providing little capacity for accreditation bodies and others to promote workforce innovation and reform.
- However, others have suggested this should be preceded by improvements to streamline the overall accreditation processes, identifying common reporting requirements across the various accreditation and regulatory processes.

Thank you once again for the opportunity to provide input into to the mapping of professional accreditation in the context of higher education regulation and standards frameworks.

The Australian Council of Deans of Health Sciences.

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The Paper 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*

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