Health Sciences Australia

Australian Council of Pro Vice -Chancellors and Deans of Health Sciences

NRAS as a Governing Body

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. This aim has been improved with the introduction of the Scheme, particularly for professions that did not previously require accreditation and national registration.

The NRAS has delivered a range of positive outcomes:

- The AHPRA web site has been upgraded over time and it is now user friendly, with documents easily retrieved and submitted.
- The national database for registered health professionals available for viewing is useful.
- Registration checks and restrictions on practice can be viewed by prospective and current employers. Those registering for the first time have access to home state and territories, which expedites registration processes.
- The capacity for final year students to partially complete registration documentation in the weeks leading up to course completion is useful, reducing registration delays following submission of their university transcript.
- Scrutiny of overseas trained health professionals leading up to AHPRA registration is thorough and maintains Australian standards of practice which supports the safety of health care consumers.
- Annual registration fee is appropriate, electronic notification procedures timely and the ability to make payment online is convenient.
- Benefits in respect to mobility are evident; reduces the burden for employers as national registration brings with it the capacity to recruit immediately into vacancies.

Registration across the professions has seen a successful national approach to registration of health professionals, with improved efficiencies, clarity and transparency of process. Accreditation, on the other hand, has more work to be done in achieving a truly national scheme. Accreditation in particular is still very much driven by individual disciplines as opposed to a cohesive body. In reality, accrediting groups grew out of professional associations and the shift from a professional tribal mentality to a professional group acting on behalf of the NRAS is still beginning to be realised. Greater work could still be done to refocus on the, ‘continuous development of a flexible, responsive and sustainable Australian health workforce’.

Accreditation

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 focus our 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 accreditation process.

Accreditation sits underneath the Health Practitioners Regulation National Law Act. As part of this law, accreditation authorities have eight quality assurance domains: governance, independence, operational management, accreditation standards, processes for accreditation of programs of study and education providers, assessing authorities in other countries, assessing overseas qualified practitioners and stakeholder collaboration. There are aspects of the NRAS which could improve in these areas and these are detailed below.

Accreditation Processes

Transparency of Processes and Scope of Reviews

The processes associated with accreditation (timelines, documentation required, instructions) are often unclear and difficult to interpret. Experience of our members is at best a lack of clarity around accreditation processes. At worst, there is conflicting and confusing information around what information is required and the timelines involved.

There is tremendous variation in the transparency of accreditation process between professions. Very basic processes, such as timelines for accreditation reporting and documentation requirements are often not specified and are highly variable between professions. For example, podiatry does not given clear timelines for submissions for the very large volumes of documentation required. In contrast, the APC has introduced an annual reporting cycle which has streamlined processes, including defined dates which do not change annually.

The level of documentation and evidence Universities are required to provide are also highly variable. Some requests for information border on "commercial in confidence". Examples of detail required include: current balance sheets, student's names and projected clinical placements over an entire cohort, projected income, and expenditure statements over a three year period. Levels of evidence required around professional development of staff members also vary between disciplines. Professional development is a requirement of professional registration and so appears unnecessary to document at the University level. There are examples from our members of accreditation bodies dictating staffing numbers and appointment levels in a discipline, mandating naming conventions for subjects and imposing requirements on institutional services outside of the discipline in review. These functions appear outside the scope of an accrediting panel's authority (and often, their expertise).

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 within the NRAS system is necessary across the professions.

Considerations:

- Greater transparency of accreditation processes, requirements and timelines within and between professions
- A move towards electronic submission of accreditation documents to reduce the burden of hard copy documentation
- Standardisation of some aspects of accreditation processes across the professions. Common elements of the review process for each profession (ie: University structure, course quality provisions) could be streamlined into a replicable format across the professions.
- Processes to provide feedback to accreditation boards to be refined, with greater transparency in processes including published responses to stakeholder feedback and collaborations.

Accreditation Costs

Accreditation costs to Universities are substantial, and do not always reflect the "service" delivered. There appears to be no transparency in how fees are determined across the scheme. Each accrediting body has a different fee schedule and process to determine fees for each individual university. There are examples of dramatic and unnecessary increases in accreditation fees since the scheme was introduced. One University course has experienced an almost tenfold increase in fees since the introduction of the scheme. Some professions require fee payments for each campus the course is delivered on (regardless of identical offerings), which cannot be justified.

As an example, physiotherapy accreditation has variable fees depending on number of campuses the course is offered. Examples provided to our Council range from $10,000- $45,000 per annum, with addition payments for site visits ranging from $10,000-$25,000. These fees are significant for a resource limited tertiary sector.

Considerations:

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

Innovations in Education and Health and Accreditation

Educational Practices

Accreditation teams often 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.

Considerations:

- Accreditation panel composition to include practitioners with educational background and experience

Clinical Settings, Supervision and Placement Hours

Many professions have very prescriptive requirements regarding clinical placement hours and settings. Whilst these are intended to ensure competency across areas of practice, how these relate to competency to practice are often unclear. A greater focus on the graduate outcomes and not the detail of the curriculum could be taken here. Hours of placement do not necessarily equate to quality of graduate. Overly prescriptive specification of contexts for practice can lead to reduced opportunities for students to take advantage of novel or non-traditional areas of practice as they are often considered "additional" placement hours, completed in addition to the required hours and settings.

There is reluctance by many accreditation bodies to accept inter-professional supervision of students on clinical placements. Many health services are moving away from professional silos towards integrated and generalist models of practice which should be reflected in the professional training of students. However, there appears to be a continued reluctance of accrediting bodies to allow supervision of students by health professionals from alternative disciplines. This makes inter-professional clinical placements almost impossible to implement and has a negative impact on clinical placement innovation, particularly in regards to areas of workforce need and training students to work in multidisciplinary healthcare settings. Further, the requirement to have a supervisor from the students chosen profession available at all times throughout the placement can prevent smaller or under resourced healthcare services (including rural and regional services that do not have the same access to health professional staff as their larger urban counterparts) from delivering student education, particularly if health professionals are only appointed on a part time basis. The approach taken by some accreditation bodies to restrict placements to better-resourced health services only serves to reinforce the critical maldistribution of health workforce in Australia, with students prevented from undertaking valuable

learning opportunities in smaller or under-resourced facilities and, as a result, graduating with less awareness of the future career opportunities that exist in such facilities.

Simulated learning experiences are an aspect of clinical learning that has been controversial with some accreditation bodies. Simulation cannot always replace clinical placement requirements, however in some situations (particularly rare or high risk circumstances), simulation can allow students to develop clinical competency in a safe environment. The latest Occupational Therapy Accreditation Standards 2013 (http://www.occupationaltherapyboard.gov.au/Accreditation.aspx) are one on the first examples of a considered and sensible approach to simulation for learning. The Standards state that evidence of clinical placements should, "Provide detail of the range of practice education/fieldwork opportunities available for students (practice education/fieldwork is the time where students implement an occupational therapy process, or an aspect of this process, with or for a real living person and may include up to 20 per cent of well-designed simulation experience)". Such standards could be considered across the accredited professions.

The requirements for detailed data on clinical placement offerings can be overly burdensome. Some professions require extensive detail around individual students and individual placements, which are sometimes impossible to provide. The availability of the ClinConnect program for example has supported data collection; however systems like this are not universally available and there are examples of this information not being accepted by accrediting bodies.

Clinical placements should ensure the health workforce is competent to meet the required health needs of the community. Overly restrictive clinical placement requirements set by accreditation bodies sometimes appear to be in the interest of the status of the professional group rather than the community need. Ideally accreditation bodies should be leaders in innovation within their professions, in order to assist in the education of a health workforce that is best skilled to meet the future health needs of the community.

Considerations:

- 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.

Registration

Registration Processes

There are significant concerns from our members regarding the manual processes imposed by AHPRA on Universities in order to meet reporting requirements for the Health Practitioners Law Act 2009. The following processes are particularly burdensome:

- Providing manual, paper based templates for graduating students
- Identifying students enrolled at census date across professions through manually adding full details of students training.
- Reporting on changes to student enrolments after census date. This seems unnecessary given that enrolment and graduation reports are provided each semester.

Considerations:

- Review the number of reporting requirements, formats and timing for registration processes
- Move to electronic reporting

International Students and Health Professional Registration

In regards to international students in health professional programs, there are reports of graduates being required to re-take the IELTS test after graduation (after original passing of IELTS tests and passing the course). This is an unnecessary burden.

Regarding the renewal regulations for Limited registration, as set out by Section 72 of the National Law, an employer would only be confident to offer a three year contract of employment to employees applying for or with this category of registration. While it is now clear that health professionals employed under this category of registration are able to apply for a further three year term it is unclear on what grounds this will or will not be approved.

With relocation, the first year of employment (or longer) is a ‘settling in’ and probation period for most employment settings. Most employees start their contract with a temporary visa. If at the end of the first year of the contract the employee has satisfactorily completed probation and wishes to apply for a permanent visa, they are required to provide evidence of a contract of employment for at least two years. The amount of time to prepare paperwork and submit visa applications means that the length of the contract, based on the three year term of registration, will not support the visa application. This has resulted in hesitancy on the part of the employer to provide an extension of the contract due to the three year term of Limited registration.

Considerations:

- Review processes of IELTS testing for international graduates across the scheme.
- Consider the implications of a move to a Limited registration of five years to allow employers to confidently provide a contract of employment to support employee probation and permanent visa applications.

Professions Included in the NRAS

We recognise that the objectives and guiding principles of the NRAS are set out in Section 3 of the National Law, but would be keen to see the objective of "protection of public safety" clarified to include safety in terms of recognition of qualified professionals. At present there are several professions with stringent self-regulation requirements (including but not limited to dietetics, speech pathology and exercise physiology) which have been deemed "safe" in terms of adverse medical events, and therefore not included. We would like to see these disciplines considered for inclusion in the scheme as the public is better protected when all recognised professions are regulated.

We request that the definition of “public safety” be broadened to recognise that this includes more than physical safety. Clinical exercise physiology, speech pathology and dietetics can lead to major physical harm, but the reliance on self-regulation can lead to mental and financial harm for the following reasons.

a) There is no legal requirement to employ a qualified, accredited professional in the role if the accreditation is voluntary self-regulation. This means that employers must be well versed in the differences between qualified and non-qualified persons (for example persons referring to themselves as “nutritionists” may be qualified accredited dieticians, or may be persons with no formal qualifications at all.) There are many examples of hospitals and residential aged care facilities inadvertently employing non-qualified persons in professional positions, putting themselves and their patients at significant risk.

b) The lack of registration and protection of professional titles can allow a system where unqualified persons offer therapeutic services to the general public. Public safety in terms of “buyer beware” is jeopardised by this. There have been some very high profile examples recently of persons without appropriate qualifications styling themselves sports scientists and exercise physiologists placing athletes and the public at considerable risk by offering inappropriate therapeutic regimens.

Considerations:

- Review of professions included in the scheme