



## **Health Sciences Australia** **The Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences**

### **Response to the Review of the National Registration and Accreditation Scheme**

#### **1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?**

Yes. Looking forward, accountability is an important aspect for strengthening the National Registration and Accreditation Scheme. At the same time it is equally important to not over-govern the system or simply lead to increased costs. Finding the balance here is essential. AHWAC would appear to present a workable proposition for improving accountability and providing a mechanism for providing independent advice to the Health Workforce Ministerial Council.

#### **2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross professional issues are addressed?**

Following on from above – yes.

#### **3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving \$11m per annum**

Yes.

The Review is a good reminder that we need to question the current processes within the Scheme and determine if they are what is required into the future. There will be arguments that each profession having its own Board values that profession. The reality is the registration boards are not for the professions but for consumer safety. The critical issue will be is that arrangements are in place to regulate the profession to ensure public safety. The discussion questions in the NRAS Review document primarily relate to management of conduct, complaints and associated management. The document is light on detail but with the correct policies and procedures this should be possible. While the document does not outline in any detail the nature of complaints that have occurred, it is presumed that many are generic and do not necessary require specific professional discipline knowledge. Some Registration Boards are perceived to exert unnecessary influence beyond what is required for the profession including their approach to professional development. A single board may provide consistent and sensible approaches towards the maintenance of safe professional practice nationally.

The estimated cost savings for Options 1 and 2 are predicated on the professions that are currently included in the Scheme. Elsewhere in the Consultation Paper the question is raised about other professions joining the scheme. If this were to happen, the inclusion of additional professions will no doubt impact on these estimates. Nonetheless, given the regulatory workload data, **Option 1** would appear to be a reasonable proposition – at least from an efficiency point of view. Perhaps the bigger question is the extent to which the integrity of the individual professions can be maintained, and their individual interests can be actively progressed.

#### **4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving \$7.4m pa.**

No, a single health professional board is preferable.

From a University perspective the role of a single Board would be welcomed as an opportunity for a more consistent approach in the Scheme, particularly in regards to accreditation. Some Boards are already effectively outsourcing this task to independent bodies. It would be better for the public to know that the minimum standards for a competent health professional were scrutinised by a board who understood best the risks of an unprepared workforce and who can do this across the nine professions with some consistency. With the current mixed models of accreditation where there are Councils who do accreditation on behalf of Registration Boards and sub committees of Registration Boards who do accreditation, it would be good to move to one Board and one model of accreditation. The standards against which accreditation takes place can have some common and some unique elements but overall the judgement of the safety and quality of the program producing graduates should be determined by a committee with a clear link to the HPAB. Currently the link between Accreditation Councils and Registration Boards is not very clear and Councils seem to act independently with no appeal process back to the Registration Board. Also important to consider are the international accreditation standards that could be discipline specific (ie: World Federation of Occupational Therapy accreditation standards).

On cost alone there is a compelling case to collapse the Boards into one. From a university perspective (individual and collective) having one Board may streamline accreditation processes, and make any required discussions and negotiations easier across the professions. Apart from that, the critical outcome for Universities would be ensuring that accreditation processes do not become any more arduous, imposing and costly, whilst still ensuring that graduates being produced meet the minimum standards of their professions for safe and high quality practice.

#### **5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

That would be one option. Another would be to re-consider the current costs of accreditation with a view to lowering these costs. Accreditation costs are mostly borne by educational institutions and have increased substantially in some professions since the introduction of the National Accreditation and Registration scheme. Currently, it appears that only 5% of the NRAS budget supports accreditation processes. Registration is an individual registrant cost, accreditation is an institutional cost charged

to education providers. It is not only the fee that is charged but there is also substantial cost in the resources required to produce accreditation documentation. Reducing accreditation costs and burden are a key priority for the Australian Council of Pro Vice Chancellors and Deans of Health Sciences.

**For detailed (confidential) information on accreditation costs and processes experienced by our members, please see attached the ACPDHS Accreditation Summary for our relevant NRAS professions (Occupational Therapy, Pharmacy, Physiotherapy, Podiatry and Radiation Technology).**

**6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**

Yes –it is important that risk to the public is the threshold by which professions are regulated.

**7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**

**8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**

Yes to q's 7 and 8.

Despite the intent of the National Scheme to include health professions on the basis of risk to the community, it is currently difficult to see why some professions are included or not included in the NRAS. Clear criteria to determine if a profession meets the risk threshold for inclusion in the NRAS should be determined. There is a lack of transparency about the process for inclusion and it would be helpful for the public and professions to understand the inclusion and exclusion criteria.

**9. What changes are required to improve the existing complaints and notifications system under the National Scheme?**

Adopt Option 1 – as per pg.13 of the review consultation paper.

**10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

The Queensland Health Ombudsman approach provides a highly visible point of entry for notifications re the performance or conduct of a health practitioner and Health Complaints Entity complaints. This is a key advantage for consumers.

**11. Should there be a single entry point for complaints and notifications in each State and Territory?**

Yes.

**12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?**

Yes.

**13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?**

We believe there is currently sufficient transparency for the public.

**14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?**

Depending on the dispute, different dispute resolution approaches are required. Flexibility is essential, however with clear guidelines that support which approach is taken based on the risk to the public of the transgression/complaint.

**15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?**

Depends on the severity of the finding. There should be a grading for removal from zero time (warning) to lifetime – with a clear description (possibly a matrix) of the type of adverse finding against the penalty.

**16. Are the legislative provisions on advertising working effectively or do they require change?**

No comment.

**17. How should the National Scheme respond to differences in States and Territories in protected practices?**

Ideally we should be working towards cohesive practice across the States and Territories – although this may take time.

**18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?**

A client/patient will not differentiate NRAS versus non-NRAS profession and will expect the same level of protection from all health professionals. A common Code of Conduct would assist the self-regulated professions to have a common framework against which to set their standards of professional conduct.

**19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?**

Yes. In light of the data regarding mandatory notifications and the advantage of having consistency across the jurisdictions, **Option 2** has merit.

**20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?**

Registration is working well as a national scheme. It is providing some consistency across the states but could do more to get consistency of risk assessment across professions. Accreditation on the other hand can still be managed as a cottage industry with individual professions dictating standards, assessment of standards and limiting workforce innovation. If any change can add value it would be to move toward a more national and consistent accreditation scheme. This would allow more flexibility into the system and allow for more inter-professional standards common to all professions.

In regards to attracting international health professional academics, registration remains a substantial barrier. Some exceptional teaching staff, keen to contribute to our programs, are unable to be registered and hence cannot teach. It would be useful to have a separate category to register academics (as there is for vacation and research student registration).

**22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?**

Accreditation is still driven by individual disciplines - not one body - and the scheme has maintained this.

Accreditation process and the NRAS has ensured that Universities indeed 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 require accreditation and national registration.

However, the role of the accreditation body in determining the curriculum can be unclear and the scheme has not facilitated ownership of the curriculum by the tertiary institutes. Accreditation requirements can be highly inflexible, at a time when the tertiary sector requires maximum flexibility to accommodate the digital learner and within limited resources.

We believe that the Boards can be somewhat removed from innovations in education and service delivery. The Boards can at times appear removed from the development of a flexibly responsive and sustainable health workforce, although they should have input into this. It is imperative that the Accrediting Authorities accommodate multidisciplinary education and training environments and coordinate accreditation processes with some consideration of future models of care and changing health needs. A consideration of access to health services and the development of a flexible and sustainable health workforce should be the concern of the National Boards and Accrediting Authorities. If they are not engaged in this process, they will be going in the opposite direction with respect to the training and accreditation required for the delivery of health care in Australia.

These questions highlight two important and growing areas of concern: 1) the lack of recognition for **simulated learning** using high fidelity and related technologies and, consequently the refusal to count these experiences as clinical placement hours, and similarly 2) the lack of recognition for **interprofessional learning** experiences (and interprofessional supervision) 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.

A related point is that the current National Board structure itself does not necessarily facilitate a cross-professional approach to changing health/health professional education that is reflected through co-ordination in the accreditation processes of individual Boards. Our experience is that accreditation focusses solely on the needs of particular disciplines without apparent reference to emerging needs of the workforce as a whole. The suggested reconstitution of AHWAC as an independent, evidence-based mechanism for the provision of advice should be considered as a means of improving outcomes in this area. Some links with the Commonwealth Health Department would be a good starting point.

Communication between Accrediting bodies and the Universities could be improved. For example in Podiatry, Universities/courses knowing timelines for report submission and reducing the large volume of documentation required at the start of each cycle. In physiotherapy, the APC have introduced an annual reporting cycle which has streamlined processes and gives a definite date for submission which does not change annually.

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**21. Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?**

Yes, if they can have access to this information to make informed decisions.

**23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?**

A very close relationship is required. There are many changes afoot in the graduate entry point for different professions, many externally determined by national educational policies and frameworks, which impact on health professional education and training. These need to be well understood by the Accrediting bodies in order to allow health professional training to be acknowledged at the nationally defined levels of training. One example here is the investment that has been put into simulation learning as a means of building clinical skills and knowledge. Most accreditation standards do not allow simulation to replace clinical training hours. This is a cost as the investment in simulation is not contributing to a reduction in clinical training hours, even if comparable learning outcomes have been achieved.

**24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?**

Variable, depending on the supervisors.

**25. Should the appointment of Chairperson of a National Board be on the basis of merit?**

Definitely.

**26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?**

Currently the link between Accreditation Councils and Registration Boards is not very clear and Councils seem to act independently with no appeal process back to the Registration Board. Processes need to be in place to ensure the Boards and accrediting authorities communicate effectively and efficiently.

**27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?**

With respect to Governance and Accountability of Accreditation Authorities (p41-42), there appears to be insufficient oversight for decisions made by accrediting authorities. The standardisation of decision making between accreditation teams is a reoccurring problem and decisions around necessary requirements differs from one university accreditation to another institutions accreditation.

As stated in the Review, there is a poor appeal process for degrees that cannot gain accreditation. Universities are frequently “held to ransom” over accreditation requirements which may not be consistently applied. Many of the accreditation requirements/competencies are the same for different professions, so there could be considerable standardisation across accreditation bodies.

The accreditation bodies also frequently do not have sufficient expertise with respect to educational delivery and the role of, for example, simulation in training health professionals and as a substitute for certain placement requirements. Accreditation of health professional qualifications should be overseen by a multidisciplinary team that includes members of health professions as well as education experts who are aware of new methods of training and qualifying health professionals. Specialist members looking at health workforce needs and models of health care delivery should also be included in the overseeing committee.

There needs to be an overarching committee that looks at all accreditation requirements together and distinguishes between those that are generic and those that are specialist (a process which had commenced with HWA). Perhaps we need a national accrediting authority, with the right to appeal to an independent authority.

Transparency of fees associated with accreditation process is lacking. How fees are determined appears unclear with no justification of why fee schedules are at the set level. Section 3 of the NRAS outlines a required transparency of the accreditation process. Each accrediting body has different fee schedules and processes to determine fees for an individual University. Universities of Australia provide the workforce of Australia that can be registered, yet have substantial fees on top of the workload associated with completing the accreditation process. For example, some physiotherapy programs have annual fees in excess of \$42,000 and should a site visit be required, this is an additional \$25,000. This is a significant annual fee of over \$65,000 in the year for a resource limited tertiary

sector. In addition, occupational therapy and physiotherapy programs are required to pay a fee per program (ie fee per campus program is delivered on), despite the fact that each program has comparable curriculum. The only difference is the campus on which the curriculum is delivered. The fee in physiotherapy is a 30% reduction, however still remains at \$9625 per course. This cost is not justified when review of the curriculum has already occurred through accreditation of the (identical) program on another campus.

Key areas for improvement with accreditation processes across the NRAS professions include:

- There should be different requirements for the accreditation process for courses which are well established and are seeking accreditation/re-accreditation (and those faculties with a history of course offerings) ie 'light touch' in contrast to those courses being delivered for the first time in an institution.
- Ongoing need for accreditation bodies to understand future workforce needs – we need to train the health professionals of the future, rather than just the current and past workforce.
- Standardisation of documentation required across courses and professions, for example information related to University processes and governance, budgetary information, staffing levels, academic levels etc would promote efficiencies in the process for everyone.
- Streamlined processes for submission of required reports would substantially increase transparency and decrease workload burden. For example, paper based submissions required by some bodies which has a significant administrative burden. Where electronic submission has been introduced in 2014 for physiotherapy, the burden has decreased significantly.
- There is the potential for common elements of each discipline (eg. University structure, course quality provisions etc) to be submitted to one overarching body response rather than each discipline to prevent duplication of submission of the same information for each course within one institution. A central repository where all accreditation review panel members from each accrediting body could access and review one set of documentation.
- Some prescriptive accreditation requirements stifle innovation in course development and design, and can be a limitation on cost-effective practice developments. Ie. recognition of inter-professional supervision and placements.
- Some accreditation bodies have - and are currently seeking to extend - their influence to matters that are arguably beyond the scope of the accreditation program into matters that are more properly the purview of universities eg. staffing levels, budgets, administrative processes, governance.
- Some bodies are seeking information outside their scope and remit. They are requiring detailed financial information from courses and faculties; some require details of 'commercial in confidence' partnership arrangements between education providers and healthcare sites where students are placed. The volume of data and information requested is in some cases is out of control and is neither necessary nor efficient.
- Some bodies continue to focus on the minutiae of inputs, not outputs. What matters is whether graduates are competent and safe; the pedagogical pathways to achieving this are and should be allowed to be variable. The over-prescription of numbers of hours, types of placements etc will constrain quality as well as innovation, and limit the ability of universities to place students. Some boards are demanding compliance with educational activities that

are not evidence-based and not good education practice.eg you must include tutorial/practicals on this topic or a lecture on this topic.

- Variability in sophistication across the accreditation boards. Some have a very clear sense of the information they want and make it transparent as to what that should be and in what formats. Others have vague ideas, leave it up to the universities to decide what and how to present and then reject the documentation as ‘not what they wanted’.
- Not all boards have understood that the privacy legislation means universities cannot provide information on placement sequences for individual students. We can only provide de-identified information.
- Uniform yearly reporting requirements across professions and courses would also promote efficiency. The demands in this space appear to be growing and becoming more onerous.
- Training should be provided for accreditation members so they appreciate that university courses are not only governed by the accreditation bodies but robust and reliable university academic processes.
- Clarity is required around how interviewees for site visits should be selected.
- Some focus on “value for money” for universities. If accreditation is a “tick the box” exercise then accreditation is not value for money. If it promotes thoughtful reflection and constructive, critical feedback from peers on curricula then you are more likely to get genuine engagement in the process from universities.

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## **28. The Review seeks comment on the proposed amendments to the National Law.**

The proposed amendments appear reasonable.