Australian Council of Deans of Health Sciences

Submission to the Draft Report

Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

16 October 2017

Review of Accreditation Systems within the National Registration and Accreditation Scheme

Draft Report - Submission Template

Funding the accreditation system

The Review has examined opportunities to improve transparency and accountability, minimise duplication and reduce costs through greater efficiency and effectiveness. In doing so, it has undertaken a financial assessment of the accreditation system, including the fees charges by accreditation authorities as well as the expenditure they incur in the exercise of their functions. It has also undertaken a consideration of the fees and costs of other like systems.

There are many complexities involved in comparing the cost of accreditation across jurisdictions (both in Australia and overseas) due to the differing nature of health practitioner registration schemes and accreditation arrangements, intersections with other parts of public systems and different funding methodologies. Despite these differences, the Review has concluded that:

There are elements within comparator international regulatory systems which can inform improvements in Australia and they need to be addressed in a continuous cycle of improvement and review.

Assessment of the cost effectiveness of the National Scheme can only be achieved once there is a consistent and transparent funding and accounting framework.

The Review is recommending the adoption of consistent accrual accounting and business standards and the development of a single set of funding principles to guide the setting of fees and charges for accreditation and the application of a transparent cost recovery policy and methodology. The Commonwealth's model of public Cost Recovery Implementation Statements should also be employed when levies and charges for accreditation activities are to be set.

Specific draft recommendations are 1, 2 and 3 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 3 of the Draft Report and any or all of the specific recommendations.

ACDHS members support <u>recommendations 1, 2, and 3</u>.

1. Funding principles should be developed to guide accreditation authorities in their setting of fees and charges. The funding principles should provide guidance on:

- *Development of a cost recovery policy and methodology for all accreditation functions.*
- *Common adoption of consistent accrual accounting and business principles.*

The funding principles should be submitted to the Australian Health Workforce Ministerial Council for approval.

***2**. A Cost Recovery Implementation Statement should be a mandated requirement when accreditation authorities set (or review) fees, levies and charges.*

***3.** Consistent and comparable accreditation activity information and financial data should be developed for inclusion in National Scheme reporting.*

Within these recommendations, members of the Australian Council of Deans of Health Sciences (ACDHS) **recommend** the development of specific mechanisms to enable universities to reduce the financial and administrative costs of health program accreditation.

Improving efficiency

The accreditation system requires sound and fit-for-purpose processes which are designed to reduce complexity and unnecessary duplication, increase clarity and transparency and reduce cost within the system. Each step of an accreditation process has direct resource implications for both education providers and accreditation authorities (and indirect cost implications for students, practitioners and consumers). Greater commonality in accreditation standards, terminology, assessment processes and reporting requirements across the professions, as recommended by this Review, should create opportunities for greater efficiency and effectiveness in the accreditation of education programs and providers.

There are also opportunities to streamline processes that currently overlap with regulators who operate outside the National Scheme. While the education sector regulatory authorities, the Tertiary Quality Standards Agency (TEQSA) and the Australian Skills Quality Authority (ASQA), have different overarching purposes and foci for accreditation, their underlying domains and processes are largely the same and intersect with National Scheme regulators at the point of health education. Clarification and separation of roles and responsibilities should further reduce duplication, costs and administrative burdens.

Specific draft recommendations are 4 and 5 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 4 of the Draft Report and any or all of the specific recommendations.

ACDHS members generally support <u>recommendations 4 and 5</u>.

> ***4.*** *Cross profession policies and guidelines should be developed to improve the efficiency of the accreditation process including:*
> - *Standardised terminology and definitions across the accreditation process.*
> - *An accreditation standards template based on common domains.*
> - *Consistent assessment processes, procedures and timeframes.*
> - *A common reporting framework that sets out uniform requirements for education providers and includes consistent risk indicators and standardised data collection.*
>
> ***5.*** *Cross profession policies and guidelines should be developed to improve the quality and performance of assessment panels, including through consideration of:*
> - *A common register of experts with comprehensive and consistent training.*
> - *A regular review process for panel quality assurance and performance.*
> - *A common approach to the remuneration of assessment panel members.*

Additional to recommendation 5, ACDHS **recommend**s that policies also specify that assessment panels are to have profession specific representation and input.

Members also note that consistency, together with links to outcomes of agreed standards and competencies, would be a large improvement over current situation where variability of assessment is large across the professions.

However, if efficiency and quality of the accreditation processes are to be achieved, the duplication, costs and administrative burdens on education providers created by the dual requirements of program accreditation and TEQSA will need to be addressed.

ACDHS members **recommend** specifying strategies and recommendations to address the dual requirements and associated financial and human resource costs of program and TEQSA accreditation processes.

Relevance and responsiveness

The health education system is critical in delivering a health workforce that is responsive to emerging health and social care issues and priorities. Education providers are guided by accreditation standards and competency standards in designing contemporary programs of study. The Review has explored the constraints created by the existing accreditation regulatory system, together with opportunities to deliver relevant and responsive health education programs which align with the National Law objectives. The Review has identified a number of key enablers:

- Adoption of outcome-based approaches for accreditation standards.
- Encouragement of innovative use of technological and pedagogical advances such as simulation-based education and training in the delivery of programs of study and a common, cross-professional approach to the inclusion of interprofessional education as a mandatory requirement in all accreditation standards.
- A requirement that clinical placements to occur in a variety of settings, geographical locations and communities, with a focus on emerging workforce priorities and service reform.
- Adoption of a common approach to the development of domains and learning outcomes for competency standards for professions that ensures relevance to contemporary health care needs.

The Review has also explored the issue of what 'work ready' means. Clarification is required on the differences between the normal induction, support, orientation and mentoring provided by employers to assist new graduates and requirements set by National Boards that restrict the attainment of general registration on first entry into the workforce. Accordingly, the Review is proposing the need for clearer demonstration of the need for supervised practice requirements and national examinations.

Specific draft recommendations are 6 to 11 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 5 of the Draft Report and any or all of the specific recommendations.

ACDHS members provide *qualified* support <u>recommendation 6</u>

> *6. Accreditation authorities should adopt **outcome-based approaches** when developing new, or revising existing, accreditation standards, consistent with achieving innovative high-quality education of health practitioners.*
> *An input or process-based element should only be utilised when there is robust evidence that it is essential to the overarching quality assurance process and is consistent with the achievement of the National Law objectives.*

ACDHS members:

- are generally supportive of a shift to outcome-based approaches and removal of input requirements that are unsupported by evidence,
- stress the need for such approaches to be tied to evidence of what produces a competent entry-level graduate within professional areas, while noting that:
    - the theory-practice divide needs to be better researched if a move to a totally outcome based approach is undertaken, and
    - that a combination of input and outcomes based standards may be the best model,
- Note that whilst the standards might be outcome approached, the indicators of such outcomes could still involve input based measures especially where indicators of outcomes are not well established,
- value the increased flexibility and responsiveness that is enabled through adoption of outcomes based approaches

It is interesting to consider payment for clinical placements within this conversation.
Payment is currently based on 'placement hours' and does not assure placement quality.
So within an 'outcome-based' approach:

- *On what basis would payments be made and might placement quality be more closely tied to payment?*
- *In turn, would such changes improve the quality of work-integrated learning experiences or drive down placement availability?*

Response – You are invited to respond to the general directions proposed in Chapter 5 of the Draft Report and any or all of the specific recommendations.

Concern has been expressed by some members about unintended consequences of a shift to outcome based approaches and note the lack of research in this area to provide either supporting or opposing evidence. The requirement for robust evidence must be equally applied to input, output and outcome based approaches.
An additional note is made about the absence of evidence, specifically, that the relative absence of evidence to support specific inputs (for example, number of hours or areas of practice) should not be considered as refuting the specified input.

Members would highlight a number of tensions that may subsequently emerge with removal of input requirements.
For example:

- *If* the number of *clinical placement hours available and funded is eroded*, there is the potential for future challenges to meeting health industry expectations of work-ready graduates, despite the higher education program meeting accreditation standards.

  There is a risk of escalating tensions between the higher education sector and the health industry in providing, accessing and funding clinical placements. This is not to say that the number of clinical hours should be prescribed-but that some areas may need qualification to provide transparency to remove potential for future doubt.

- *The cheapest option may become the priority driver*.
  - For example, in response to such a priority, some professions or programs may deliver an online program with no practice experience, all based on online content, online simulation and virtual reality.
  - It must then be asked if this will deliver safe and competent practitioners
    - including competence to fit in with organisational contexts, culture and actual face to face clinical activity

Care must be taken to protect the students in a move toward outcome-based accreditation. Students should be seen as stakeholders, particularly where there is potential to erode clinical placement hours. Feedback indicates students tend to want more, rather than less and consistently value placements highest in the overall teaching components in curricula.

Concerns have also been expressed regarding possible consequences of shifts in government or organisational policy on funding for clinical placements and system capacity to meet placement requirements.

- Complex, often implicit or historical arrangements between education and health sectors underpin current provision of clinical placements. The tension between increasing enrolments in health programs (*with consequential increasing demand for clinical placements*) and fiscal pressures that constrain both sectors is flagged as a risk to be addressed.
- A number of possible scenarios should be considered and managed, for example,
  - if the health sector significantly limits the volume of clinical placements for some or all health programs, or
  - if the higher education sector can no longer sustain the provision of clinical placements within the funded programs with a possible shift of clinical education to the health sector

Consideration of the ultimate outcome- the health and wellbeing of individuals and communities- should also be considered if/as changes are made to the accreditation of health professional education programs.

Response – You are invited to respond to the general directions proposed in Chapter 5 of the Draft Report and any or all of the specific recommendations.

ACDHS members provide qualified support for <u>recommendation 7</u>

> *7. Accreditation authorities should, within an outcome-based approach to accreditation standards and assessment processes, encourage innovative use of technological and pedagogical advances such as simulation-based education and training in the delivery of programs of study*

ACDHS members note that

- Simulation is a clinical training delivery model that provides opportunity for some substitution of clinical placement, but it is part of a scaffolded approach to practice based learning
- Simulation based education and training approaches are useful, but a question remains whether such approaches necessarily improve/strengthen placement outcomes and/or practitioner skills knowledge, and if so, in what circumstances?
    - While research continues to be undertaken to look at learning outcomes using traditional placements and simulation, some results suggest that while learning outcomes appear to be similar, so are the costs incurred.
    - As with recommendation 6, if sufficient evidence is not readily available – there is a need to develop and support research to address this gap.
- Simulation may reduce demand on clinical sites, but it increases demand on education providers to provide simulation facilities that duplicate clinical facilities.
- Development of quality simulation based education is costly.
- Care should be taken to look at a balanced approach and not dictate one method over another as it may end up making clinical training more expensive overall.

Re <u>recommendation 8</u>, ACDHS members have varied views on the mandating of IPE and would qualify the comment on clinical placement settings

> *8. Accreditation standards based on common domains and consistent assessment approaches should include:*
>
> *• Interprofessional education as a mandatory requirement.*
>
> *• Requirements for clinical placements to occur in a variety of settings, geographical locations and communities with a focus on emerging workforce priorities and service reform.*

Mandating IPE within accreditation standards

ACDHS members are generally supportive of encouraging a common, cross-professional approach to the inclusion of interprofessional education within all accreditation standards, but there is not full agreement on the mandating of IPE within accreditation standards.

The many understandings of what constitutes IPE and IPP and how these are implemented in education and practice settings provides a challenge in assessing such a mandated standard. Clarification of the range of approaches that are 'acceptable' as mandatory IPE will be essential to implement this recommendation; this will also be challenging, given the differing configurations of professions/teams/workers with whom each health profession typically needs to interact.

The 2010 Canadian 'National Interprofessional Competency Framework' recognises some of these challenges by describing dimensions of complexity, context and quality (p11 https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf).

Understanding how a mandated IPE standard would be assessed within program accreditation standards underpins the limited support for this part of recommendation 8.

An alternative may be to rephrase this recommendation such that IPE is considered within a safety and quality framework.

All health professionals should understand principles of safety and quality that link to the Australian Commission of Safety and Quality standards.

Response – You are invited to respond to the general directions proposed in Chapter 5 of the Draft Report and any or all of the specific recommendations.

- If IPE is part of those principles, then it will be easier to assess if graduates are able to understand and apply quality and safety principles, as these become assessable components of both theory and practice courses within programs.
- IPE on its own is difficult to assess in a consistent and reliable way.
- Safety and quality, which embeds principles of working as a team and quality communication, may provide better opportunity for assessment.

ACDHS members **recommend** that the consideration is given for the IPE clause to be tied to a safety and quality agenda, rather than a standalone domain embedded into standards.

Qualifying the requirement for clinical placements to occur in a variety of settings

Members agree that clinical placements need to

- be broadened beyond the traditional hospital based placements
- occur in a variety of settings, geographical locations and communities,
- have a focus on emerging workforce priorities and service reform
- be able to be easily developed to respond to emerging workforce or service priorities

However, as currently written there has been concern expressed about an interpretation of this recommendation to mean all students must have rural placements or placements in other service settings with limited capacity to take large volumes of students.

ACDHS members **recommend** rephrasing this recommendation to minimise potential for mandating placement types where capacity would not meet demand.

ACDHS members have expressed some concern re *future* interpretation and implementation regarding recommendation 9.

> 9. *National Boards that wish to set requirements for general registration additional to domestic qualification attainment should:*
>
> *• Base these requirements on postgraduate competencies required at profession entry level that can be differentiated from normal and expected progressive work experience.*
>
> *• Provide demonstrated evidence that the approved accreditation standard is unable to deliver, even following amendments, the necessary knowledge, skills and professional attributes necessary to practise the profession.*
>
> *• Establish and document whether there is a requirement for supervised practice or vocational training and specify the expected learning outcomes and how they will be assessed.*
>
> *• Specify if the supervised practice or vocational training warrants a category other than general registration and the limitations of that registration.*

ACDHS members would **recommend** a qualification be added to this recommendation to remove all potential for future doubt re the intent of this recommendation, including any potential for a future shift for all clinical education to occur in the health sector post-graduation from a theory/course-work only program.

Further, ACDHS members consider that if a degree is seen as a professional entry degree then it should be that – entry to a profession, and that additional requirements to enter a profession do need to be addressed within the AQF, that is,

- If a profession requires an intern year, graduate program or supervised practice, this should be at postgraduate level, such as a Graduate Certificate, as it extends and advances knowledge within an Australian Qualifications Framework.

If cross profession polices and approaches (chapter 4) are to be adopted, then this area of further training requirements beyond professional entry will need to be addressed.

Response – You are invited to respond to the general directions proposed in Chapter 5 of the Draft Report and any or all of the specific recommendations.

ACDHS members generally support <u>recommendation 10.</u>

> *10. If National Boards set requirements for general registration additional to domestic qualification attainment that requires further vocational or academic education these should be defined as programs of study and accredited by accreditation authorities.*

Members also suggest that the rationale, learning outcomes and assessment for such programs of study need to be clear. Embedding such programs within an accreditation framework would assist with this.

ACDHS members generally support <u>recommendation 11.</u>

> *11. National Boards which require the assessment of intern outcomes in the form of an examination should require those to be summative assessments conducted by the relevant accreditation authority at the conclusion of the period of supervised practice*

Yet ACDHS members have expressed mixed views on this recommendation, including

- Some doubt that an accreditation process should determine how outcomes are assessed.
- Rather, this should be up to the discretion of the qualification granting body who can justify the assessment approach taken.
- As written, the recommendation is quite directive when accreditation should be about outcomes – not how outcomes are achieved or assessed.

Reforming governance - the importance of consumers

The Review considers that there should be greater **consumer involvement** in accreditation functions to ensure a continued focus on patient centred care and to provide an important addition to professional input. However, effective participation requires clear identification of where such involvement would provide most value and consumers will require additional support and training if they are to be expected to participate as equal members. Consumer involvement (whether it be service users, students and/or employers) in governance committees and assessment processes should be considered where it is relevant, rather than as a matter of course across all functions. Nonetheless, it should be considered in the following areas:

- In the development of professional competency standards.
- In the design of education and training programs, including curricula.
- In the assessment of programs of study and education providers as appropriate.

The Review is also supportive of the AHPRA Community Reference Group and considers that its Terms of Reference should be expanded to include a consumer perspective on accreditation.

Specific draft recommendations are 12 and 13 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 6 of the Draft Report and any or all of the specific recommendations.

ACDHS members recognise the importance of consumer input, however would recommend rephrasing of <u>recommendation 12.</u>

> *12. All accreditation standards should require education providers to demonstrate the involvement of consumers (health service users, students and employers) in the design of education and training programs, including the development of education curricula, as well as demonstrate that the curricula promotes patient-centred health care.*

As currently written the recommendation implies mandating consumer involvement.

Members have suggested that while there should be a consumer/patient centred principle in accreditation standards, it could be considered within a safety and quality framework as mentioned above in relation to IPE (recommendation 8). Safety and quality standards clearly specify the involvement of consumers in providing input into safe and high quality services.

ACDHS members are generally supportive of <u>recommendation 13</u>.

> *13. AHPRA should expand the Terms of Reference for the AHPRA Community Reference Group to include accreditation functions and enable accreditation authorities to refer issues to the Group for advice.*

Reforming governance - the overarching model

The Review considers that the greatest constraint to reform of the accreditation system is its model of governance. The current arrangements are unable to provide an actively regulated and managed accreditation system that delivers on all of the objectives set out in the National Law. The Review has developed three options, all drawn from submissions and its own analysis and are evaluated in detail in the Draft Report.

Option 1 - Enhance an existing forum or liaison committee

The first option explores streamlining the time-consuming and resource-intensive nature of the current governance arrangements through enhancing the role of an existing forum or liaison committee. A cross-professional advisory body could provide advice on common approaches to accreditation standards and processes, and develop reference and guidance documents to promote principles of consistency, efficiency and transparency. Submissions to the Discussion Paper suggested that the Health Professions Accreditation Collaborative Forum (HPACF) or the AHPRA Accreditation Liaison Group (ALG) could assume this more formalised role with membership expanded with additional representatives from consumers, education providers and jurisdictions.

Option 2 - Enhance the Agency Management Committee

An option advanced in the Discussion Paper that could provide the desired integrative and determinative approach to accreditation was to expand the remit of the AHPRA Agency Management Committee (AManC). Very few submissions directly addressed this option, rather they either indicated support for another option or proposed a new one. Of those that did address the expanded AManC option, support was limited.

However, the AManC, in its supplementary submission, proposed a different role to that set out in the Discussion Paper and this has formed the basis for the configuration of the second option. The AManC proposed it could become responsible for *".....developing strong and clear cross-professional requirements for good regulatory practice through new procedures for the development of capability and competency standards and enhancing the existing procedures for development of accreditation standards whilst respecting the profession specific standard setting function of National Boards." (p2).* Responsibilities and operations, as proposed by the AManC in its submission, could include:

- AManC, in consultation with each National Board, deciding which body will be assigned responsibility for the accreditation functions for each profession.
- AManC would create a standing committee to advise on approaches to approving programs of study, procedures for the review of accreditation arrangements, procedures for accreditation standards development and review, and procedures to support multi-profession approaches, including the development and use of professional capabilities. The committee would comprise representatives from accreditation authorities, National Boards, AHPRA and potentially other key stakeholders such as government and education providers.
- A program of study accredited by an accreditation authority being automatically deemed to be approved without the need for a decision by a National Board. A Board would retain the power to restrict a program's approval for registration, including imposing conditions on a program of study or on graduates' registration.

Option 3 – Establish integrated accreditation governance

The third option is a governance model that separates the regulation of accreditation from that of registration and establishes a single national cross profession accreditation framework for health workforce education and training within the National Scheme. The option establishes a Health Education Accreditation Board with a secretariat drawn from AHPRA, to sit alongside the National Registration Boards with the following responsibilities.

- Assignment of Accreditation Committees.
- Determination of common cross-profession policies, guidelines and reporting requirements, including the fees and charges regime.
- Approval of accreditation standards across the professions that meet its policies and guidelines.
- Development and management of the relationships with TEQSA, ASQA and the Australian Commission on Safety and Quality in Health Care (ACSQHC), including agreements for the delineation of responsibilities between the respective accreditation systems and how they interact.

Accreditation Committees would be established and be responsible for the development of accreditation standards for approval by the Accreditation Board. Accreditation Committees would have independent responsibility for the assessment and approval of on-shore programs of study and education providers, authorities in other countries who conduct examinations for registration, programs of study in other countries and the qualifications of overseas health practitioners.

Accreditation Committees would be able to be appointed within external entities, provided that decisions made by a Committee under the National Law are autonomous from the hosting entity. The external entities (such as the current accreditation councils) must establish their Accreditation Committee operations in a manner that would enable the functions to be covered in the same manner as other National Scheme entities defined in the *Health Practitioner Regulation National Law Regulation 2010.* This should not relate to the general governance and operations of the external entity beyond normal contractual requirements. External entities should be permitted

to have other commercial arrangements. A Committee could be responsible for accreditation functions of more than one registered health profession where the relevant Committees agree to merge.

Profession specific competency standards should be developed by **National (Registration) Boards** and recognised under the National Law in accordance with the legislative provisions established for development of registration standards and their approval by Ministerial Council. These standards are currently developed outside of the regulatory purview of the National Scheme and yet, via the accreditation standards, they have very significant influence on the education foundation of the workforce and ultimately on health service models. This reform should strengthen the National Registration Boards' trust in the accreditation standards and in the integrity of the accreditation system more generally.

Specific draft recommendations are 14 to 25 in the Draft Report.

** Note: As observed in the Draft Report, the NRAS Governance Review may be considering proposals for other changes that impact of the role of the AManC. It is possible that such changes could encompass it taking responsibility for some of the Ministerial Council's roles. Given this, if you wish, your response could also encompass the potential for the AManC undertaking the functions proposed for the Accreditation Board.*

Response – You are invited to respond to the general directions proposed in Chapter 7 of the Draft Report and any or all of the specific recommendations (*refer also to the Note in the above summary).

In regard to governance structures for accreditation (<u>recommendations 14 to 25</u>), ACDHS members note the following principles and would support the option that is best able to provide a governance structure that can deliver on the following:

- An accreditation system that delivers on *all* of the objectives set out in the National Law, that is
    - The National Law s3(2) identifies six objectives for the Scheme as a whole:

      a. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
      b. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
      c. to facilitate the provision of high quality education and training of health practitioners; and
      d. to facilitate the rigorous and responsive assessment of overseas-trained health-trained health practitioners; and
      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.
- Coordinated and consistent development of
    - policies, guidelines and reporting requirements
    - funding principles and
    - fees and charges

  in order to reduce the financial and administrative costs of accreditation to universities where multiple programs currently require duplication of information.

- Agreement on the delineation of responsibilities between the respective accreditation systems (eg TEQSA, ASQA)
    - It is important to make explicit the link between the profession competency/threshold standards, the higher education program accreditation standards and TEQSA standards.
- Consideration of the possible inclusion of a module within ACSQHC accreditation regimes
- Development of an accreditation governance structure that has
    - an appropriate mix of experts in health education, health service provision and health service users
    - a dedicated secretariat with policy capability
    - the public interest foremost and provides complete transparency in decision making
    - professional input to decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders
    - If members are not to represent any particular stakeholders, a set of skill based criteria and transparent recruitment and appointment process for the preferred governing body will require development.

While recognising the challenge of balancing independence of professions and the governing authorities, ACDHS members agree that development of competency standards should be consistent. Falling under the national law would be one mechanism to achieve consistency.

Response – You are invited to respond to the general directions proposed in Chapter 7 of the Draft Report and any or all of the specific recommendations (*refer also to the Note in the above summary).

This would mean the Registration Boards would be responsible for the development rather than current variable ownership of standards. Competency standards then to be developed cooperatively utilising:

- Standardised definitions and terminology.
- A common template with domains that apply to all health professions and which include profession-specific performance criteria and indicators as needed.
- Wide-ranging consultation to align with health service models that best serve evolving community health care needs,
    - That may include incorporation of developing requirements such as a greater emphasis on cultural safety and references to the NSQHS Standards.

Additionally, as noted above, some members would recommend a level of independence of the professions from government structures and direction. The consolidation of accreditation and regulation functions under the umbrella of one national body (AHPRA) is seen by some to weaken the scope for independent professional contribution and reduce external checks/balances in the accreditation/regulation/registration system.

Reforming governance - the inclusion of non-registered professions

The opportunity to consider unregistered professions in the overall reform of accreditation of health education under the National Scheme was raised in a number of submissions. Unregistered professions operate outside of the National Scheme.

Amendment of the National Law is proposed to allow unregistered health and social care professions to apply to access the skills and expertise of the Accreditation Board and operate their accreditation activities under the umbrella of the Accreditation Board, subject to specified conditions and in a manner that would have no implications for the registration of those profession. All applications for registration would continue to be dealt with through established Ministerial Council processes and in accordance with the COAG agreed criteria.

Specific draft recommendation is 26 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 7 of the Draft Report and any or all of the specific recommendations.

To achieve greater consistency between all health professional accreditation processes, ACDHS members support <u>recommendation 26.</u>

> *26. Governments should amend the National Law to allow unregistered health and social care professions to apply to access the skills and expertise of the Accreditation Board, and operate their accreditation activities under its umbrella, subject to the following conditions:*
>
> *• Unregistered professions participating in the accreditation provisions of the National Law would be considered separate to the registered professions.*
>
> *• Accreditation activities undertaken by unregistered professions would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established COAG Health Council processes and in accordance with the COAG agreed criteria.*
>
> *• The National Scheme would not be responsible for the costs of, and fees charged by, participating unregistered professions in relation to their activities and the Accreditation Board may charge fees to recover its own costs.*

In supporting this recommendation, members acknowledge the many challenges involved and would be keen to participate in any future discussions to progress this recommendation.

Assessment of overseas trained practitioners

For overseas trained health practitioners seeking to practice in Australia, accreditation, registration, and skills assessments are part of a broader process that requires engagement with numerous organisations responsible for immigration, state and territory governments, recruitment agencies National Boards, the Australian Health Practitioner Regulation Agency (AHPRA) and potential employers. The Review has focused on decisions, processes and governance relating to functional assignment, monitoring and reporting across the variety of arrangements for the assessment of overseas practitioners. Proposals are:

AHPRA should lead the development of a whole of National Scheme approach to the assessment of overseas trained practitioners for skilled migration and professional registration and a more consistent approach towards the assessment of overseas trained practitioners and competent authorities.

The Accreditation Board should lead the development of a more consistent approach to the assessment of overseas trained practitioners and competent authorities and pursue opportunities to pool administrative resources.

The Accreditation Board, in collaboration with National Boards, Accreditation Committees and specialist colleges, should develop a consistent and transparent approach for setting assessments of qualification comparability and additional supervised practice requirements for overseas trained practitioners, with the latter being aligned with Australian trained practitioner requirements.

Specialist colleges, in relation to the assessment of overseas trained practitioners, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the *Health Practitioner Regulation National Law Regulation 2010.*

The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners.

Specialist medical colleges should ensure that the two pathways to specialist registration (passing the requirements for the approved qualification or being awarded a fellowship) are documented, available and published on college websites and the information is made available to all prospective candidates

Specific draft recommendations are 27 to 32 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 8 of the Draft Report and any or all of the specific recommendations.

> ***27****. AHPRA, in partnership with National Registration Boards and the Accreditation Board, should lead discussions with the Department of Education and Training and the Department of Immigration and Border Protection to develop a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration.*
> ***28.*** *The Accreditation Board should work with Accreditation Committees and specialist medical colleges to develop a more consistent approach towards the assessment of overseas trained practitioners and competent authorities. Opportunities to pool resources for administration requirements should also be pursued.*
> ***29.*** *The Accreditation Board, in collaboration with National Registration Boards, Accreditation Committees and specialist medical colleges, should establish a consistent and transparent approach for setting assessments of qualification comparability and additional supervised practice requirements for overseas trained practitioners, with the latter being aligned with Australian trained practitioner knowledge, skills and professional attributes requirements.*

Re recommendation 27: ACDHS members are supportive of the development of a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration *if*

- this is consistent with the WHO Global Code of Practice on the International Recruitment of Health Personnel http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf
- the assessment includes other key stakeholders such as health professions, departments and accrediting councils/committees

Re recommendation 28: **ACDHS members are supportive of the development of a more consistent approach** towards the assessment of overseas trained practitioners and competent authorities. This may include identifying opportunities to pool resources for administration requirements. Such an approach should

- recognise professional qualifications and enable the freer movement of health professionals between countries
- be consistent with the WHO Global Code of Practice on the International Recruitment of Health Personnel

Response – You are invited to respond to the general directions proposed in Chapter 8 of the Draft Report and any or all of the specific recommendations.

In addition to developing a more consistent approach to the assessment of overseas authorities, ACDHS members would also recommend a consistent approach to the registration of overseas practitioners who have completed an Australian accredited program of study at an offshore campus of an Australian University.

> *A member university has noted that graduates of an accredited program delivered at an offshore campus of their university were denied automatic registration to practice in Australia.*

ACDHS members defer to other relevant bodies to comment on recommendations 30-32, but note the possibility of an increased numbers of appeals subsequent to recommendation 30.

> *30. Specialist colleges, in relation to the assessment of overseas trained practitioners, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.*
> *31. The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners. This includes working in partnership with the Medical Board of Australia on the development of agree performance indicators and reporting metrics that are appropriate, comparable and aligned with other relevant National Scheme reporting regimes, in terms of time periods and the ability to trace assessment pathways from application to registration.*
> *32. Specialist colleges should ensure that the two pathways to specialist registration, namely:*
> - *being assessed by a specialist college and passing the requirements for the approved qualification; or*
> - *being awarded a fellowship of a specialist college;*
>
> *are documented, available and published on specialist college websites and the necessary information is made available to all prospective candidates.*

Other governance matters, including grievances and appeals

The Review is proposing the appointment of the National Health Practitioner Ombudsman and Privacy Commissioner to review any decisions made by the following entities specified under the *Health Practitioner Regulation National Law Regulation 2010*:

Accreditation Committees in relation to programs of study and education providers of those programs.

Postgraduate medical councils and specialist colleges (medical, dental and podiatric) in relation to the accreditation of training posts/sites.

Any designated entity exercising an accreditation function regarding an assessment of the qualifications of an overseas practitioner.

Given the number and variety of entities, it is proposed that the National Health Practitioner Ombudsman and Privacy Commissioner should progressively review those entities' grievances and appeals processes, with the view to making recommendations for improvement by each entity where it is considered those processes are deficient.

Specific draft recommendations are 33 to 35 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 8 of the Draft Report and any or all of the specific recommendations.

ACDHS members defer to relevant bodies to comment on recommendation 33, but note the possibility of an increased numbers of appeals subsequent to recommendation 33.

> *33. Specialist colleges and postgraduate medical councils, in relation to their accreditation functions, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.*

ACDHS members support recommendations 34 and 35.

> *34. Governments should appoint the National Health Practitioner Ombudsman and Privacy Commissioner to review any decisions made under the National Law by the following entities (as specified under the Health Practitioner Regulation National Law Regulation 2010):*
>
> - *Accreditation Committees in relation to programs of study and education providers of those programs.*
> - *Postgraduate medical councils and specialist colleges in relation to the accreditation of training posts/sites.*
> - *Any designated entity undertaking an assessment of the qualifications of an overseas trained practitioner (including specialist colleges).*
>
> *35. The National Health Practitioner Ombudsman and Privacy Commissioner should review the grievances and appeals processes of entities as defined in Recommendation 34, with the view to making recommendations for improvement by each entity where it is considered those processes are deficient.*

Setting national reform priorities

A key issue identified by the Review is the paucity of guidance to the governance bodies in the National Scheme on health workforce and system priorities. Consistent and regular policy guidance should be provided by governments and then acted upon by the National Scheme as a whole. This needs to be integrated into overall national reform processes and directions, given that workforce responsiveness is a critical enabler. The Review is proposing the COAG Health Council oversight a policy review process to identify health workforce directions and reforms that:

- Aim to align workforce requirements with broader health and social care policies.
- Engage health professions, consumers, private and not-for-profit health service providers, educators and regulators.
- Is approached in a formal manner in a regular cycle to ensure currency and continuous improvement.

The Review is also proposing that the COAG Health Council (as the Australian Health Workforce Ministerial Council) should then periodically deliver a Statement of Expectations to AHPRA, the AManC, National Registration Boards and the Accreditation Board that encompasses:

- National health workforce reform directions, including policies and objectives relevant to entities.
- Expectations about the role and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations and their relationships with governments.
- Expectations of regulator performance, improvement, transparency and accountability.

Finally, the Review is proposing the Australian Health Ministers' Advisory Council should work with AHPRA and other entities within the National Scheme to develop a set of clear, consistent and holistic performance indicators that respond to the Statement of Expectations.
Specific draft recommendations are 36 to 38 in the Draft Report.

Response – You are invited to respond to the general directions proposed in Chapter 8 of the Draft Report and any or all of the specific recommendations.

Re recommendation 36, ACDHS members are *generally supportive* of the need for a policy process to identify national health workforce directions and possible reforms listed in recommendation 36. As a collaborative approach between states and the Commonwealth is required, the COAG Health Council may be the body best positioned to provide oversight for such a process.

> *36. The COAG Health Council should oversight a policy review process to identify national health workforce directions and reform that:*
>
> *• Aims to connect workforce requirements with broader health and social care policies which responds to evolving community needs.*
> *• Engage health professions, consumers, private and not-for-profit health service providers, educators and regulators.*
> *• Is approached in a robust and formalised manner in a regular cycle to ensure currency and continuous improvement.*

Re recommendation 37 ACDHS members are generally supportive of the intent to provide advice on key workforce directions to assist in developing the health workforce to meet emerging health priorities, yet would seek some level of separation of governmental agencies and instruments from the professions.

> *37. The Australian Health Workforce Ministerial Council should periodically deliver a Statement of Expectations to AHPRA, the Agency Management Committee, National Registration Boards and the Accreditation Board that encompasses:*
>
> *• Key health workforce reform directions, including policies and objectives relevant to entities in the National Scheme.*
> *• Expectations about the role and responsibilities of National Scheme entities, the priorities expected to be observed in conducting operations and their relationships with governments.*
> *• Expectations of regulator performance, improvement, transparency and accountability.*

ACDHS members support recommendation 38.

> *38. The Australian Health Ministers' Advisory Council should work with AHPRA and other entities within the National Scheme to develop a set of clear, consistent and holistic performance indicators that respond to the Australian Health Workforce Ministerial Council's Statement of Expectations. Indicators should be both quantitative and qualitative and reported on a regular and formal basis to promote continuous improvement.*