Ahpra Board
Accreditation Committee

Response template for draft principles for the use of outcome-based approaches to accreditation – Public consultation

October 2025

This response template is the preferred way to submit your feedback to the public consultation on the draft **principles for the use of outcome-based approaches to accreditation.**

Please provide any feedback, including your responses to the questions in the text boxes on the following pages. The boxes will expand to accommodate your response. You do not need to respond to a question if you have no comment.

Making a submission

Please complete this response template and email to AC_consultation@ahpra.gov.au using the subject line 'Feedback: Public consultation on principles for the use of outcome-based approaches to accreditation'.

Consultation closes on 24 December 2025

Publication of submissions

We publish submissions at our discretion. We generally publish submissions on our website to encourage discussion and inform the community and stakeholders. Please advise us if you do not want your submission published.

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Published submissions will include the names of the individuals and/or the organisations that made the submission unless confidentiality is expressly requested.

Initial questions
To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.
Question A Are you completing this submission on behalf of an organisation or as an individual?
Your answer:

☒ Organisation

Name of organisation: **ACDHS (Australian Council of Deans of Health Sciences**

Contact email: secretariat@acdhs.edu.au

☐ Myself

Name: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No **– do not** publish my submission

Your responses to the consultation questions

Principles for the use of outcome-based approaches to accreditation

Question 1: Does any content need to be added or amended in the draft principles for the use of outcome-based approaches to accreditation?

1. We applaud the Ahpra Board Accreditation Committee and the accreditation bodies for seeking to implement **principles for the use of outcome-based approaches to accreditation**. We believe an approach to accreditation that is truly outcome-based is the best approach to ensuring that effective, efficient, and fair accreditation processes have been put in place.

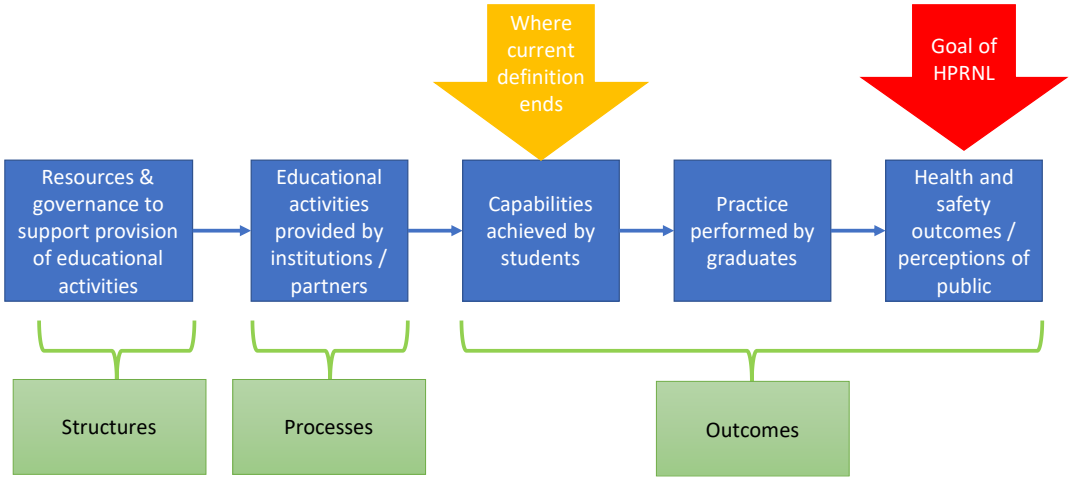
2. The committee's glossary defines outcome-based approaches to accreditation as: "An accreditation approach that focuses on graduating students with the professional capabilities required for safe practice as registered health practitioners in Australia and encourages flexible and innovative approaches to education in response to changes in community need, healthcare models and innovations." (p.8). Additional text on page 9 and in Table 1 (p.10) is also relevant to this point.

   We would critique this definition's focus on "graduating students with the professional capabilities required for safe practice" as falling short of the Guiding Principles of the Health Practitioner Regulation National Law Act 2009 (Qld).

The national law states:
3A Guiding principles

(1) The main guiding principle of the national registration and accreditation scheme is that the following are paramount—
(a)protection of the public.
(b)public confidence in the safety of services provided by registered health practitioners and students.
Health Practitioner Regulation National Law (Qld) Schedule Part 1, section 3A.

Why the current definition falls short of this guiding principle (Goal of HPRNL in figure below) is illustrated.



An outcome-based accreditation process that seeks to protect the public should be examining primarily, whether the public is safe. We do not dispute evidence that there are links between capabilities achieved by students with both the practice performed by graduates and the health and safety outcomes of patients. For example, poor communication scores in licensure examinations are predictive of a greater frequency of patient complaints to regulatory authorities. However, the strength of this relationship / effect size are modest at best (a 2 standard deviation drop in communication examination score was associated with 1.17 more retained complaints per 100 physicians per year - *Tamblyn R et al. Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. JAMA 2007;298(9):993-1001*), indicating that assessed capabilities achieved by students should not be seen as a substitute for measurement of health and safety outcomes of the public.

We argue that text describing definitions relating to outcome-based approaches to accreditation (p.8, 10) be changed to reflect both the inclusion of health and safety outcomes and perceptions of the public to bring this into alignment with the guiding principles of the Health Practitioner Regulation National Law Act 2009 (Qld).

3. The positioning of outcome-based approaches to accreditation as “complementing other approaches to accreditation” (p.8) places outcome-based accreditation, at best, in co-equal positioning, and at worst as a distant secondary approach. We argue that outcome-based accreditation considerations should be given primacy in deliberations about course accreditation and the processes that support this. Considering the figure above, what value is a program that is classified as providing appropriate learning outcomes and educational activities, if it does not achieve the health outcomes safely for the public?

We argue for rephrasing such that outcome-based approaches can be "supplemented by other approaches" along with other text to indicate the primacy of outcome-based approaches.

4. Figure 3: A fit-for-purpose outcome-based approach to accreditation. This figure contains a factor "promote equity of graduate outcomes across all student groups" which could be applied in ways contrary to the intents of introducing outcome-based accreditation processes. Equity is a term that is often used where people assume a common meaning/understanding is shared by others but rarely is this the case. *Lane H, et al. Equity in healthcare resource allocation decision making: a systematic review. Social science & medicine. 2017; 175:11-27. Lane H, et al. How do allied health professionals define and apply equity when making resource allocation decisions? International Journal of Health Services. 2018 Apr;48(2):349-64.* Further, a "graduate outcome" could be described as capability achieved by a student, for example, the ability to use a particular device in a specialised care setting. If 90% of courses in Australia provide training in use of this device, does this mean that under the principle of "promoting equity of graduate outcomes across all student groups" that a new course would be required to also demonstrate capability to use this device regardless of whether this device is still used by the profession in contemporary care?

   We argue for rephrasing of this factor to remove reference to the term equity and to refocus the graduate outcomes as effective and safe care for the public. E.g. "Promote consistency of graduate outcomes in promoting effective and safe care of the public across all student groups."

5. The criticism of outcomes-based approaches provided (p.10) "… outcome-based approach may not be appropriate as a standalone approach. Indicators of outcomes may not be well established, or difficult to measure" is, in our view an inaccurate framing of the problem and implies a negative moral element to this approach. The present limitations cited may be addressed in future (for example, with collaborative research, indicators currently missing presently may be developed, and constructs presently difficult to measure may become easier to measure), meaning that it is not a matter of appropriateness, but a matter of whether a solution is presently available.

   We argue for rephrasing of text (p.10) to read that "There are some circumstances where an outcomes-based approach may currently be limited as a standalone approach."

6. The framing of work by Bandiera et al (p.10) is, in our view, a misrepresentation and a selective use of test from this reference in the defence of process measures to promote their retention and comparative standing to outcome-based approaches. Specifically, the statement "The use of process measures, often seen as critical to high-quality education and accreditation" is particularly egregious.

   The cited research by Bandiera et al presents the deliberations of a working group that addressed educational process and outcomes in relation to the accreditation of medical residency programs. The results section of this paper contains an entire section titled "The respective roles of outcome and process measures." In this section it is highlighted that most study participants noted that programs need to be attentive to processes and educational methods and attributes of the environment where there is evidence that they have an impact of performance in practice. However, they also reported that:

   "Some participants advocated a focus on educational outcomes, noting that reducing the emphasis on adherence to process requirements would reduce the burden that the accreditation process places on educational programs and would also allow them greater freedom to innovate."

   "…some process elements that serve as surrogates for outcomes could be replaced by more direct measures of program success. Similarly, antiquated, and problematic indicators such as case counts and time on task can be retired in lieu of objective competency assessments."

   The quote used in the consultation paper "The use of process measures, often seen as critical to high-quality education and accreditation" is framed as a statement of principle, with the modal "As found by Bandiera et al." being used. However, when this statement appears in Bandiera, it is a

concession based on the present-day limitations associated with measuring more relevant outcomes. The full quote from Bandiera et al. is in the Recommendations section of this paper, and reads:

"There was a consensus that the assessment of competency, both in training and in practice, provides useful data for the quality assessment of postgraduate medical education. At the same time, participants appreciated the inherent challenges in measuring outcomes and using this information to generate timely, actionable feedback to foster improvement. They also agreed that process measures remain critical to high-quality education and accreditation."

The critical contextual phrase to our interpretation of this statement which is different to that in the consultation paper is "…that process measures remain critical…." The statement is not that they are always critical as implied in the consultation paper, but that they remain critical because of the present-day limitations of fully applying an outcome-based approach.

We do not argue for the abandonment of all process measures, however, we argue for the framing of their use and value in the consultation paper to be revised to a position that is consistent with evidence presented in Bandiera et al. that process measures i) stifle freedom to innovate, ii) create burden in accreditation processes, and iii) should be replaced by measures of outcomes where more direct measures can feasibly be used.

7. Table 1 should have separate columns for three subcategories of outcomes: i) outcomes related to the capabilities achieved by graduating students, ii) outcomes related to practices of graduates (e.g. proportion of graduates working in rural / remote areas to promote access to care by disadvantaged populations), and iii) health and safety outcomes / perceptions of the public (e.g. upheld health complaints against graduates).

8. Table 1 (p.10) lists advantages and disadvantages and continues the framing that Input and Process measures have considerable advantages related to feasibility over Outcome measures and perpetuates myths and misconceptions that it is not feasible to use outcome-based approaches. For example, Ahpra manages a national dataset related to complaints. This dataset could be used with little expense as a measure of safety of graduates. The outcomes listed in Table 1 inputs are very distant and have highly questionable relationships to the outcomes that form the Guiding Principles of the Health Practitioner Regulation National Law Act 2009 (Qld). What point is there of spending time collecting and reporting on easy to collect measures if they have tenuous connection to the outcomes we are trying to impact?

   We argue that rows related to advantages and disadvantages in Table 1 be removed.

9. Figure 4: Elements that contribute to achieving an outcome-based approach to accreditation.
   As per our criticism in response 2, this figure represents a conceptualisation of outcome-based accreditation that falls short of the guiding principles of the Health Practitioner Regulation National Law Act 2009 (Qld) and should be revised to reflect outcomes beyond the capabilities, knowledge and skills of graduating students, to include outcomes related to the practices of graduates and health and safety outcomes / perceptions of the public.

10. Principle 1: Safe Practice.
    "Protecting the public by ensuring students graduate with the knowledge, skills and professional attributes required for safe practice is the principal outcome of accreditation and is informed by wide-ranging stakeholder input." (p.12)

    We argue to revise wording to be more inclusive and allow prioritisation of outcomes related to direct measures of public safety and the perception of public safety consistent with the Guiding Principles of the Health Practitioner Regulation National Law Act 2009 (Qld). Wording suggestion is "Protecting the public by examining outcomes related to safety of the public and perception of safety informed by wide-ranging stakeholder input."

11. “1.1 Culturally safe practice and the elimination of racism must be central to all accreditation standards and processes.” (p.12)

    We argue a clear definition of culturally safe practice should be provided here.

12. “1.2 Enabling diverse input and adopting co-design principles in the development of accreditation standards and processes will allow accreditation authorities to develop accreditation standards that are person-centred and have a focus on public safety.” (p.12)

    The role of evidence in guiding current accreditation processes and future reforms needs to be made central. We argue that effective codesign processes include discussion of relevant evidence and assists stakeholders to engage with this evidence. This is consistent with the approach of “evidence-informed, experience-based co-design” (*Morley et al. Evidence-informed, experience-based co-design: a novel framework integrating research evidence and lived experience in priority-setting and co-design of health services. BMJ Open 2024;14: e084620)*. In this paper it is argued that “While health services need to meet the needs of its users, it is imperative that they also deliver evidence-based care.” We argue the same principle applies to accreditation. We must directly incorporate the evidence into our co-design activities with stakeholders.

    We suggest wording “1.2 Enabling diverse input to engage with relevant evidence to underpin codesigned accreditation standards and processes to allow accreditation authorities to develop accreditation standards that are evidence-based, person-centred and have a focus on public safety.”

13. “1.3 Accreditation authorities should undertake wide-ranging consultation in the development and review of accreditation standards and processes, including but not limited to:”

    This list does not specifically include representatives of Tertiary Education Providers (e.g. Deans, Heads of Schools, Heads of Departments) or their peak bodies. Education providers and their representative peak bodies (e.g. ACDHS, CDNM, MDANZ) are key stakeholders in the accreditation process. Re-structuring of accreditation processes to successfully adopt outcomes focused and evidence-based accreditation should involve meaningful engagement with all stakeholders, these bodies in particular.

14. Principle 2: Section 2.3 (p.13) describes the approach to assessment of internationally qualified health practitioners being “informed by a risk-based approach”. Clarity should be provided here as to what this means. Does the use of the phrase “informed by” mean that only a risk-based approach is being used at the exclusion of an outcomes-based approach?

15. Principle 3: Interprofessional collaboration on accreditation should be used to build a culture of partnership in health profession accreditation to encourage innovative initiatives to benefit person-centred care.” (p.14). We argue the focus of a principle related to interprofessional collaboration should be to address Guiding Principles of the Health Practitioner Regulation National Law Act 2009 (Qld) to be consistent with all other motivations for use of outcomes-based accreditation. We agree that person-centred care is likely to promote these outcomes but note that person-centred care does not guarantee these outcomes or that inter-professional collaboration guarantees either these outcomes or that person-centred care is being provided.

16. “3.1 Staff from across accreditation authorities should be consulted in the development and review of accreditation standards, policies and guidelines.” (p.14) This activity should not involve consultation only with staff across accreditation authorities, but the expanded list of stakeholders described in principle 1.3 (including tertiary education providers and their peak body representatives) so that consultation processes are consistent. Not including these stakeholders devalues the contribution they make to the shared effort of creating a safe and effective health workforce.

17. “Principle 4: The use and effectiveness of outcome-based approaches to accreditation is supported by data and evidence.” (p.16)

    The sub-points 4.1-4.4 in this principle focus on use of data to evaluate the effectiveness of outcomes base approaches. A broader range of data sources should be considered, and the evaluation codesigned with relevant stakeholders including peak bodies representing tertiary education providers (e.g. CDNM, ACDHS, MDANZ). Rather than specifying the data sources and research designs in this document, a statement relating to working toward a codesigned evaluation plan would be preferred.

18. “4.5 Outcomes of data analysis should lead to the implementation of new or amended processes to foster continuous improvement of outcome-based approaches.” (p.16). We argue for a much more expansive involvement in use of evidence and data analysis in setting what outcomes are focused upon in accreditation. We argue that a review process of current and future accreditation requirements and processes be undertaken with particular regard to removing input-based elements that can either be replaced by outcomes-based approaches, or where there is insufficient evidence to indicate that the problem itself exists or that strategies that can be implemented by education providers actually can have an impact. For example, calls were made by one keynote speaker at the 2025 National Registration and Accreditation Scheme annual accreditation meeting held in Melbourne for accreditation schemes to consider what could be done through accreditation to boost workforce retention. Other examples include the emerging issues listed under principle 6.4 (p.20). Such a request to add to the burden of accreditation should pass through a review process where a team with multiple stakeholder representation including tertiary education provider peak bodies could evaluate the evidence that such a problem exists, and that there are strategies that can be realistically implemented by education providers that can address this problem. The same process could be used by those seeking to remove accreditation requirements. All of this should proceed through an agreed framework for assessing the quality of evidence and strength of recommendations arising (such as the GRADE framework – *Prasad M. Introduction to the GRADE tool for rating certainty in evidence and recommendations. Clinical Epidemiology and Global Health 2024; 25:101484*).

19. “Principle 6: Sharing Information” (p.20)

    Consideration should be given to use of dashboards to report on routinely collected, real-time outcomes data (e.g. complaints data) that could be used to signal to both accreditation authorities and education providers where issues may be arising.

Question 2: Are the case studies helpful in illustrating the principles? Are there additional case studies that it would be beneficial to include?

Case study 2 – could use of abbreviations be avoided in case studies to improve their readability?

A case study that demonstrates improved safety outcomes for the public or perceptions of this should be included for principle 1.

Case study 3 is relevant.

Case study 4 did not appear to be particularly relevant to the main issues dealt with in Principle 2.

Question 3: Are there any implementation issues the Accreditation Committee should be aware of?

Greater use of available, relevant, outcomes data and data that could be made available needs to be a focus. Ahpra has access to health complaints data. This is a key source of data to indicate whether a problem exists in domains that are covered by accreditation. Health services and state departments have access to health outcomes and adverse event data, another potentially useful source of patient safety information. Education providers who also administer student clinics may further capture data on consumer outcomes and satisfaction with care. ACDHS proposes that a joint workshop with other stakeholders to discuss data being held by different stakeholders that can be leveraged to create a data environment that would demonstrate the safety and effectiveness of students / recent graduates.

There are a lot of recommendations here that will require resourcing. There is no specification of where these resources will come from. The risk here is that this will again eventually result in increased financial burden on universities.

Question 4: Are there any potential unintended consequences of the draft principles?

1. A key potential, unintended consequence of the draft principles is that this process will increase the burden on education providers and that there will be addition of or a failure to remove input-based and process measures from accreditation procedures.

   We raise the wording of the Health Practitioner Regulation National Law Act 2009 (Qld) Schedule section 3A Guiding Principles subsection 2a “The scheme is to operate in a transparent, accountable, efficient, effective and fair way;”

   We argue that retention of input-based and process measures where either i) the outcome they seek to address can be measured more directly using an outcome-focused approach, ii) where there is insufficient evidence that a problem it seeks to address actually exists, or iii) where the strategies for education providers to implement have insufficient evidence of impact on the desired end outcome, is inconsistent with the need for the scheme to operate in an “efficient, effective and fair way”.

2. Another potential, unintended consequence of the draft principles is that decisions regarding accreditation may be made that are unjust. We recognise the dynamic nature of health care in Australia, the education environment that creates health workforce, and the evolving evidence base that may be relevant to these decisions. We recommend that procedures be introduced to enable stakeholders to raise or challenge the outcomes of decisions focused on use of evidence. Presently complaints processes relate only to processes (not outcomes/decisions) which can be raised to the Health Practitioner Ombudsman.

3. There is a risk that some education providers may have less capacity to meet any new reporting obligations in the short term. Consideration should be given to gradual phasing in of any new reporting requirements that may require new resources or processes to establish.

4. There is risk that some outcomes may be more indirectly related to the outcome of interest and have more room to be subjectively interpreted than others. For example, in assessing graduate safety to practice, a very direct form of evidence may be the number of safety complaints raised with Ahpra from a cohort of new graduates from a particular university. A less direct form of evidence may be implementation of a set of teaching materials related to patient safety. We consider that the number of safety complaints raised with Ahpra from a cohort of new graduates is a stronger form of direct evidence that has less room for subjective interpretation by an accreditation panel member. We argue that efforts should be made to preference direct forms of evidence in accreditation processes.

Question 5: Do you have any general comments or feedback about the draft proposed principles?
We advocate strongly for the use of a parsimonious approach to accreditation, harmonisation of accreditation processes across disciplines, and the reduction of duplication between disciplines and across accreditation bodies (including TEQSA). We recognise the importance and value of accreditation processes that are outcome focused and evidence based. There is need to focus accreditation on what is important and what is required under the law. We have repeatedly referenced in this response the alignment of our comments with the Guiding Principles of the Health Practitioner Regulation National Law Act 2009 (Qld). There is need to contain the spiralling costs of course accreditation, both in terms of fees and in terms of the time spent by education providers to prepare the required paperwork and respond to accreditation conditions. These costs have grown rapidly in recent years; however, we question whether there was an evidentiary need for this? We question what data can be pointed to of the public safety threats that we were responding to and what were the improvements in public safety and perceptions of safety that have resulted from this growth in accreditation costs and requirements? Education providers are a central stakeholder in creating the health workforce for our community. We are systemically disempowered by current structures under the scheme, are the ones who take all the risk to create new courses and to innovate in meeting Australia's needs, must endure decisions of questionable merit without an avenue of challenge, and are met with long time-lines for approvals, which all compound the risks and costs of these business decisions all for questionable gain to Australian society. The construct of Ahpra to only manage a select sub-set of health professional disciplines (though admittedly beyond the scope of this consultation) further creates difficulties for education providers, and obvious inefficiencies for Australian society to not have these processes all contained within a "one-stop shop" (some of these disciplines have progressed with outcomes-based accreditation, and may be useful allies in rolling out outcome-based accreditation approaches). These general comments point to the need for further structural reform to accreditation in Australia. Incorporation of evidence-informed, outcome-based approaches will help to address some parts of what is needed. However, more substantive reform is needed to solve the broader structural problems for the sector.