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

Submission to the Discussion Paper

Cover Sheet

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About the Health Professions Accreditation Collaborative Forum

The Health Professions Accreditation Collaborative Forum ('the Forum') is a self-funded coalition of the accreditation entities of the regulated professions. Each of these entities is appointed under the Health Practitioner Regulation National Law Act 2009 ('the National Law') as the accreditation authority for the relevant profession-specific national board and is part of the National Registration and Accreditation Scheme ('NRAS', or 'the Scheme').

The Forum comprises:

- Australian Dental Council (ADC)
- Australian Medical Council (AMC)
- Australian Nursing and Midwifery Accreditation Council (ANMAC)
- Australian Pharmacy Council (APC)
- Australian Physiotherapy Council Ltd (APhysioC)
- Australian Psychology Accreditation Council (APAC)
- Australasian Osteopathic Accreditation Council (AOAC)
- Australian and New Zealand Podiatry Accreditation Council (ANZPAC)
- Council on Chiropractic Education Australasia (CCEA)
- Occupational Therapy Council (Australia and New Zealand) Ltd (OTC)
- Optometry Council of Australia and New Zealand (OCANZ)

From March 2017, the following accreditation authorities also joined the Forum:

- Aboriginal and Torres Strait Islander Health Practice Accreditation Committee (ATSIHPAC)
- Chinese Medicine Accreditation Committee (CMEA)
- Medical Radiation Practice Accreditation Committee (MRPAC)

In welcoming these three committees, the Forum agreed to change its name from the Health Professions Accreditation Councils Forum to the Health Professions Accreditation Collaborative Forum.

A submission made by the Forum constitutes the shared response of the Forum members. Each member Council may make a separate submission. The views expressed do not override any views expressed by a member Council in its own separate submission. Member Accreditation Councils

have agreed to the content of this submission and the principles outlined, however it is not possible to represent the views of each Council on each and every matter raised in the questions posed, and a Council may address specific matters in its own submission in more depth.

As the three Committees in the Forum, the Aboriginal and Torres Strait Islander Health Practice Accreditation Committee, the Chinese Medicine Accreditation Committee, and the Medical Radiation Practice Accreditation Committee are relatively new to the Forum, they will not be submitting their views to the Review in this document, but rather in conjunction with their respective national boards.

Accreditation, the NRAS Scheme and the role of the Forum

In July 2010 the National Registration and Accreditation Scheme became operational through the *Health Practitioner Regulation National Law Act*. The Scheme is multi-professional, regulating over 650,000 health practitioners across 14 professions. In addition to the regulation of health practitioners, the Scheme also encompasses accreditation functions. These functions include setting standards for accreditation and assessing programs of study against those standards, and, for some professions, undertaking assessments of overseas-qualified health practitioners. At June 2016, 746 programs of study were accredited in the Scheme.

The aims of NRAS include protection of public safety by ensuring that only suitably trained and qualified practitioners are registered. Accreditation supports this public safety objective through its quality assurance mechanisms for programs of study leading to registration, ensuring that graduates completing approved programs of study have the knowledge, skills and professional attributes to practise the relevant profession in Australia. It also supports this objective through assessment of overseas trained practitioners who are seeking registration in one of the regulated health professions in Australia.

The objectives of NRAS also include enabling the continuous development of a flexible, responsive and sustainable Australian health workforce. The role of accreditation in meeting this objective is twofold: to support innovation as a critical driver in education, allowing both programs of study, and the health workforce it produces, to evolve, and to facilitate evaluation of changes and innovation of the multiple components of health education, such as curricula, teaching methods, clinical placements, and assessment, taking into account community needs and current health practice.

The Health Professions Accreditation Collaborative Forum, the coalition of the accreditation entities of the regulated professions, has a unique role in enhancing collaboration in accreditation. The Forum promotes principles of best practice in accreditation; facilitates shared learning and exchanges of methods and insights regarding delivery of health education programs; and where appropriate, promotes harmonisation in the interests of efficiency and transparency.

The Forum believes that accreditation works best at the intersection of education and training and health professional practice, with each accreditation authority having close and ongoing engagement with the education providers and with the relevant profession. The accreditation authorities, by virtue of these relationships, are able to ensure that accreditation standards reflect contemporary educational practice and future professional practice. The Forum believes this

engagement is also an important factor in the acceptance of accreditation as a performance improvement opportunity and not simply an exercise in regulatory compliance.

Independent Review of Accreditation Systems

As is the cases for many areas of regulation, accreditation is being influenced by widespread changes, such as the growth of data availability, improvements in technology, and evolving perceptions regarding what constitutes best practice in regulation. In this regard the Forum welcomes the opportunity afforded by the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions ('the Review') to examine the way that accreditation within NRAS professions fulfils its tasks, and appreciates the opportunity to contribute this submission to the Review.

According to the Organisation of Economic Cooperation and Development (OECD), "Australia performs well in terms of overall population health status…[and] achieves good outcomes relatively efficiently"[1]. These outcomes are not just the product of economic development. They are also influenced by the work of thousands of health professionals covered by the National Registration and Accreditation Scheme. The Forum looks forward to working with the Review to ensure that the health care professionals who enter the health workforce tomorrow continue to support the health care system's ability to deliver good outcomes, and that these health professionals are well prepared to meet the changing health needs of Australia's population in the future.

Improving efficiency

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

The Review Discussion Paper[2] mentions the main documents which guide development of NRAS accreditation standards, including the Australian Health Practitioner Regulation Agency (AHPRA) Procedures for Development of Accreditation Standards, The Council of Australian Governments (COAG) principles for best practice regulation, the Quality Framework, and the Forum's own High Level Accreditation Principles. In line with these, accreditation standards tend to have a number of characteristics, including health care relevance, outcomes focus, stakeholder buy-in, and international comparability.

Standard development principles also include efficiency criteria. However there has arguably been a stronger focus on effectiveness than efficiency in the past and the Forum is interested in taking up the opportunity suggested by the Review to improve efficiency in this area (although it should be noted that the overall costs associated with this activity are not great - A$1.3M in 2015/16 across all NRAS professions[3]). In order for efficiency initiatives to be effective, standards development will need to be considered as an end-to-end process, including origination, consultation and proposal by accreditation authorities and approval by national boards assisted by AHPRA.

With regard to the application of standards, the Forum believes that NRAS accreditation activities are cost effective. Analysis completed by the Forum on the basis of costs data compiled by the

Accreditation Liaison Group[2] shows that NRAS accreditation costs are mainly driven by the expected factors of high fixed costs and the amount of work that must be done (see Attachment 1). International benchmarking completed by individual accreditation authorities also supports the conclusion that accreditation has a reasonable cost structure[4].

Nevertheless the Forum is committed to continuous improvement and further efficiency gains where possible. In particular, there appears to be a potential for information technology to streamline processes and formats. A number of Forum members have also taken steps towards implementing systems that will improve operational efficiencies. For example:

- Both the Australian Medical Council and Australian Nursing and Midwifery Accreditation Council are implementing systems that will migrate accreditation processes to the web and in doing so create both internal and external efficiencies, i.e. will assist education providers in reducing the burden of accreditation
- Similarly the Australian Pharmacy Council is enhancing its customer relationship management software and web portal developed for assessment and examination candidates in order to assist education providers
- The Occupational Therapy Council Ltd has introduced a streamlined process for submission of forms and annual monitoring reports. All self-reporting and other documentation by education providers for cyclic review processes are accepted electronically
- The Optometry Council of Australia and New Zealand has commenced a joint project with the Council on Chiropractic Education Australasia and the Occupational Therapy Council Ltd to develop a common risk-based framework for use within the accreditation processes of the three councils which may include streamlining of various processes and formats
- The Australian Psychology Accreditation Council is reviewing all processes with the intention of moving to risk-based decision-making and intends to align their processes with those of the other councils
- The Australian Physiotherapy Council has moved from a three day site visit to a two day site visit, reducing costs and likewise aligning with protocols of some of the other councils.

The Forum itself is enhancing its back end databases and document library to streamline sharing and review of standards, and will continue to facilitate the sharing of benchmarks and best practices for efficient operations.

2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

The emphasis of Tertiary Education Quality Standards Agency (TEQSA) on institutions (at least for self-accrediting higher education providers such as universities), rather than programs of study, leads to a natural division of labour with NRAS accreditation. Most NRAS accreditation authorities have alignment with TEQSA, and some have signed MOUs. However the Forum is keen to avoid any duplication with TEQSA and Australian Skills Quality Authority (ASQA) in any standards areas that might overlap, and members have no objection to incorporating the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews (as some accreditation authorities already do).

It should be remembered that TEQSA's main aim is upholding standards for students, whereas the main aim of professional accreditation is upholding standards in the public interest. They are complementary but the emphasis is on different stakeholders.

3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

Both cyclical and risk-based approaches have their place in accreditation. Most accreditation authorities and processes use both elements, for example Tertiary Education Quality Standards Agency (TEQSA)[5] and most of the large UK regulators. Within NRAS, most authorities also combine the two. Cyclical approaches guarantee that there is a formal review of a program and provider. The experience of the long established accreditation authorities is that the rate of change in programs, people, and the education and health system environment mean that over a period of accreditation there is likely to be significant evolution of the program. For professions where this change is usual, cyclical review is of value.

NRAS accreditation also places emphasis on the assessment of risk. For example, accreditation authorities consider the risk of an education program or its program of study not meeting the accreditation standards when they make decisions such as the scope of an accreditation assessment, the need for visits, or the period of accreditation granted. The setting of accreditation conditions, which is required under the National Law when accreditation standards are not fully met, is a response to risk. The NRAS accreditation monitoring requirements also provide an important opportunity for accreditation agencies to keep abreast of changes in programs and assess risk.

To the extent that the two leading risk criteria, probability of occurrence and extent of damage, are relatively well known, then the relative advantage of risk-based assessment rises[6]. Within NRAS, availability of risk information varies with the number of programs accredited. Where the number of programs is low, the sample size for assessing the risk parameters is low, so a cyclical approach may be more appropriate. On the other hand, it is not hard to see why the Australian Nursing and Midwifery Accreditation Council, with 229 programs of study, might consider it has a sufficient sample size to identify risk factors and implement a risk-based approach. In other professions there has been a steady increase in the number of education programs over the past ten years. For example, the Occupational Therapy Council (OTC), which started with one program per state, now has 25 providers offering 39 accredited programs. This increase leads to a different scenario in the development of risk-based data, and is shaping the current work of the OTC.

The Australian Pharmacy Council (APC) has implemented a risk-based cyclical approach which is a hybrid approach of determining the length of the cycle dependant on a number of risk factors. The APC defines an accreditation risk as: 'any potential or actual event, decision, action or inaction that could affect a program or provider's compliance with the Standards.' The period of accreditation awarded to a program is determined by taking account of a range of the risk factors, including the number of conditions or monitoring requirements. The maximum period of accreditation of six years is available to programs that are determined to have a low risk, with moderate and high risk programs required to demonstrate progress and improvements for certain standards to reduce their risk rating and increase their period of accreditation.

It remains to be seen whether the risk parameters developed by these accreditation authorities have broader application within NRAS, and there is discussion between the accreditation councils on the development of appropriate of risk indicators, reporting formats and so on. The Forum sees this area as an improvement opportunity to reduce both accreditation authority work and the work requirement of education providers.

It is also worth noting that international standards for accreditation authorities are becoming a factor in the debate about cyclical and open-ended accreditation. For example, in the case of medicine, the criteria for international recognition of accreditation agencies indicate that the medical school accreditation agency must conduct a site visit or visits to a medical school prior to making an accreditation decision and that the accrediting agency must require medical schools to be re-evaluated periodically after a positive accreditation decision.

The literature on moves to implement risk-based regulation indicates that access to appropriate data and resources are essential. The cost of the change includes development and management of appropriate data sets, organisational change management restructuring and refocusing, making resources follow risks and, as in all accreditation processes, ensuring that the redesigned processes are clear and transparent to the education providers.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and interprofessional collaboration?

The Forum is interested in the Review's suggestions regarding pooling of assessment team candidates and cooperating in the areas of attraction, training and retention of those candidates. For example, common assessor training program modules may be useful, as assessment teams need to be formally trained against external standards, including knowledge of Higher Education Standards Framework and Tertiary Education Quality Standards Agency requirements for accreditation in higher education providers. There have been instances of peer review on site visits, and this could be expanded, as it is an excellent learning experience for staff or assessors to shadow another council's assessment team.

There is already joint use of team members across some professions. There may be an opportunity to collaborate further in recruitment of team members who have skills and expertise required for a variety of teams, such as health consumer members and health facility managers. A survey of team remuneration by the Forum showed that we are moving towards parity in remuneration practices across NRAS professions, so this is unlikely to pose a barrier to pooling and cross-fertilization in teams. A number of accreditation councils also already use shared materials as the basis for training their assessment teams, and some accreditation authorities such as the Australian Pharmacy Council have made their training materials available online for any profession to view and use.

With regard to team composition, there may also be potential to learn more about the effect on team performance of variables such as inclusion of professional staff, management and governance specialists, consumers and so on. Forum members all take slightly different approaches to this issue,

but the Forum is interested in improving team effectiveness through well-designed initiatives informed by a growing body of research on this topic.

Accreditation teams are one element of an accreditation authority reaching an accreditation decision. There are other mechanisms to moderate the findings of individual team members in addition to good selection, training and role description. These include:

- Moderation of the views of individuals through the team. Accreditation authorities provide guidance to their staff (if staff accompany the team) and to team members in general on how to retain a focus on standards, should any one member, for example, seek to extend the scope of the accreditation assessment
- For most accreditation agencies the accreditation teams do not make the accreditation decision. They provide a report of their findings, and the education provider has an opportunity to comment on that report. Usually staff and an accreditation committee review the reports for sense, consistency and balance.

5. Should the assessment teams include a broader range of stakeholders, such as consumers?

Assessment team members are chosen for their knowledge, skills and expertise relevant to the assessment of programs of study, rather than for their membership of specific stakeholder groups. Consumer representation has become an increasing part of this skills mix, but the benefits of this representation needs to be balanced with other factors such as costs of assessment teams.

Hogg and Williamson[7] have listed some of the motivations for lay representation in health service committees. These include safeguarding the public interest by bringing in the views of people who have neither professional self-interest nor commercial links to the health-care industry; contributing a user perspective or 'patient voice'; and bringing additional skills to the committee, for example, legal, financial or media.

The Forum considers that the contribution of consumers and patient representatives is important in meeting these objectives. All accreditation authorities have health consumer and community input to their accreditation processes. Some accreditation authorities have included health consumers on committees or advisory groups, others on accreditation teams. The Australian Medical Council, for example, includes a health consumer or community member on its teams completing reaccreditation assessments of specialist medical programs. The key is finding the point at which consumer representation can bring the greatest benefit, and there is more work to be done to better understand which of the objectives listed above can be best met by different groups of consumers and where consumer input is most effective. The authors of the above-mentioned study developed a typology of lay representation in health service committees, in terms of the interests that they tend to support[7]. The Forum would like to extend this type of analysis to improve the contribution profile of diverse stakeholders on assessment teams. By pooling team candidates, individual accreditation authorities may also be able to reach out to a wider set of interests to incorporate into accreditation processes.

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

The Review Discussion Paper lists the various beneficiaries of the accreditation system, including education providers, students, registered practitioners and health consumers. Governments are also a beneficiary of the accreditation system. The public – via government – receives the greatest benefit but pays nothing directly, given the accreditation authorities are allocated a portion of registrants' fees. The Forum considers that all users should contribute to the Scheme, that is, registrants, education providers, and, recognising the public benefit of safe and competent health practitioners, public funding.

The Forum believes the user pays principle has some application in the setting of fees and levies for funding accreditation. Where it can be implemented, the principle promotes efficiency in resource allocation and equitable outcomes. However the principle is weakened when user and beneficiary are not completely aligned, as is often the case.

The education provider is both a user and beneficiary of accreditation. However user-beneficiary alignment is weakened because accreditation is not discretionary, but a form of regulation. On the other hand, as the author of a recent analysis[8] of accreditation in Australia has noted, most education providers agree that if conducted in an appropriate and transparent manner, accreditation is a beneficial process well worth the effort expended. This perspective casts accreditation more as a service and less as enforcement. Consistent with the National Law objectives, Forum members aim to provide a service that stresses the quality improvement aspects of accreditation, and the Forum believes accreditation is most effective as a collegiate endeavour that captures performance upside.

Because accreditation lies at the boundary of regulation and service, accreditation authorities do not attempt to fully recover accreditation costs from education providers. However charging some quantum of costs provides an incentive to both education provider and accreditation authority to maximise the value flowing from the process.

A degree of pricing flexibility is desirable, given the different configurations and scales of accredited professions. For example some accreditation authorities are reviewing programs for different degrees across national and international campuses, with significant implications for costs. Recently discussions have begun between AHPRA, the national boards and the Forum on the funding principles for accreditation functions across the professions. The Forum is keen to progress this work.

7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

These are both accreditation functions under the National Law.

There are synergies and overlaps between these two accreditation arms. For some accreditation authorities the standards and competency statements that apply to education programs also apply

to the assessment of internationally qualified practitioners. The same educational and assessment experts may provide input into the accreditation and assessment functions.

Cross-subsidisation is a persistent feature in many public and semi-public settings. For example, fee paying students in some courses in Australian universities cross-subsidise other educational and research activities. Accreditation cannot operate effectively unless it is fully funded, so changes in this area would require agreement and understanding on the part of registrants or education providers who are the other main sources of accreditation income.

Relevance and responsiveness

Input and outcome based accreditation standards

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

The continuing emphasis on outcome-based standards stems partly from recognition that prescriptive input standards concerning curriculum or training locations inhibit innovation (see Christensen (2007)[9] for a definition of terms – in this paper 'input' equates to 'process'). However this emphasis masks the fact that both input and outcome-based standards are necessary for assessment of a provider and accreditation of a program. The following observation by Christensen describes the problem:

"In the curriculum there should be a direct and operational link between intended outcome and the specifications of learning situations, including definition of content, the instructional process and assessment… Assessment of process alone as well as assessment of outcome alone provides the medical school with limited information to be used in decision-making. A comprehensive approach is necessary for quality improvement."[9]

The same can be said for professions other than medicine, and it is worth reiterating why this is the case. Intuitively a purely input-based accreditation is not reliable as the assessor cannot be confident that the inputs will result in a program of study that will deliver the desired graduate capabilities. But a purely output-based process is not able to answer why graduate performance varies across cohorts, and will give no hint of where to look for improvement in health profession education. Only by combining both can the accreditation process be as effective as it should be.

With regard to the type of input standard that is best suited to the task, there continues to be something of a spectrum of opinion within the Forum. Consider the example of clinical experience mentioned in the Discussion Paper. Some accreditation authorities will address this issue by having a discussion about the type and duration of clinical placement, and attempt to draw out a conclusion about optimal exposure. Others will set minimum reference points, by stipulating a minimum number of hours for a given placement. They require different responses from the education provider: the first requires the provider to demonstrate that its own decisions about types and duration of clinical placements are sound. The second requires the provider to demonstrate that they achieve the specified hours. These differences are not necessarily indicative of an underlying problem. NRAS professions have different cultures, and what seems prescriptive in one may seem

normal in another. The Forum is more concerned that standards can fulfil both of their key roles as a vehicle for assurance, and as a basis of a conversation for improving educational quality.

9. Are changes required to current assessment processes to meet outcome-based standards?

See answer to Question 8.

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

Competency standards/ graduate outcome statements are an important basis by which most professions in Australia define the attributes of the competent practitioner, and a competency framework including attributes and performance factors forms a core set of output-based standards for NRAS professions. Competency standards were introduced to trades and professions in Australia in the early 1990s, to enable maximum use of skills in the community, provide an equitable method of testing overseas trained professionals and provide a framework for mutual recognition processes between states. At the time, the Government stated that competency standards for a particular profession belonged to the profession and would be modified only by that profession as required[10].

Since then, the professional competency frameworks have evolved to be mainly used as a basis for registration standards, in accreditation, and as a framework for assessment of overseas trained professionals. For example, specialised competencies for optometry were developed in 2000 when the prospect of legislation made it clear that there needed to be a mechanism in place to specify the skills and knowledge required for an optometrist to be able to prescribe medications[11]. In the first instance these new competencies were applied to registration standards, and optometrists who wished to administer a range of prescribed medicines were required to undergoing additional training to gain therapeutic licensing. Therapeutic competencies were then introduced into entry level curricula and the entry-level accreditation standards, so that all entry-level optometrists were trained in the use of scheduled medicines.

The optometry example shows that there are distinctive factors applying to competency frameworks when their role in accreditation is considered. First, there tends to be greater profession specificity. To the extent that the frameworks are used for registration standards, the National Board and other professional associations that may have ownership will need to be consulted extensively, or may even drive the process when standards are revised. Second, the health professional expert workload tends to be higher. The process of developing and reviewing standards is usually undertaken with input from professionals and academics. It is estimated that revisions were circulated to over 80 optometrists and Board members in the course of the revision of competency standards in 2000[11]. Qualitative methodologies, such as focus groups, Delphi methods, stakeholder consultation and consumer feedback have been used. Some professions, such as nursing, have incorporated direct observation of practice to inform competence standards[12].

Where accreditation authorities are driving the development of competency frameworks, broad consultation takes place in line with procedures for development of accreditation standards. That said, the Forum considers that some efficiencies may flow from a shared understanding of what constitutes good practice in the particular case of competency standard development. For example,

the AHPRA statement on development of accreditation standards could be revised to be appropriate for best practice in the development of competency frameworks. Consideration could also be given to common competency elements such as occurs in New Zealand health regulation with respect to topics such as cultural competence and ethics. Evidence from NRAS and other health professions suggest competency frameworks need to be reviewed periodically to meet workforce needs and to coordinate with developments in the education sector.

11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

It is part of the Forum's mission to promote beneficial alignments in terms of standards. The Forum sees benefits of consistency and commonality in accreditation standards, particularly in the development of a common language and concepts in health education and accreditation. However the apparent simplicity of the proposal for 'common health profession elements/domains, overlayed with profession-specific requirements' might be belied by the realities of trying to achieve commonality. Undoubtedly, the profession-specific competencies would have to be developed in consultation with the profession, and adopted by the accreditation authority. The following outlines some of what the Forum sees as the risks and benefits of such a process.

In general, the closer to the outcome, the more specific the accreditation standard becomes. Competency outcomes for individual professions are the most specific type of standard, designating the skill sets and capabilities of graduates. Because there are also specific educational emphases in different professions, this specificity does extend back to some extent to standards related to inputs and processes (see answer to Question 8). However at some point standards develop more commonality, and hence the Review's suggestions may be a useful way to achieve some efficiencies.

These benefits would need to be weighed against the costs of change, and these costs appear in several forms. First, there are transition costs, including the work entailed in changing standards which would involve substantial consultation across the professions and their stakeholder bodies, work by the accreditation authorities to develop new accreditation guides and templates, and team and committee training. The work for education providers in reporting against new standards is not insubstantial. Second, there are potential hidden costs from creating one-size-fits-all standards. These may not be as responsive to changes in education and the health care environment, given the higher costs of consultation and reduced probability of consensus for standards revision. They may also lack the degree of ownership of discipline-specific standards, with the consequences that accreditation becomes more compliance-focused and less capable of generating initiatives for improvement[13].

In summary, the Forum considers more work on harmonisation and commonality will be required to establish, with a higher degree of confidence, the nature of the trade-offs involved and the implications for further action. Greater commonality in standards would presumably involve a different, broader kind of development process. This implies supporting mechanisms, and a collaborative body such as the Forum would be of benefit for coordinating tasks, as well as in developing the fact base for quantifying the benefits of standardisation.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

Timeliness and responsiveness can be influenced both by the development and the application of standards. There is no doubt that working within the Scheme can create additional steps in the process of development of standards, such as consulting the Office of Best Practice Regulation, and the interaction between the accreditation authority developing the standards and the national board, as well as, in recent instances, the review of standards by AHPRA staff. These changes have tended to mean that accreditation authorities are less likely to make minor changes to standards – evolutionary changes – and are more inclined to make a range of changes at one point in time.

In some instances, expansion to scopes of practice within professions can require accreditation to act expediently on standards development to meet the needs of the workforce. This can include both changes to student graduate outcomes and additional requirements for the registered workforce through continuing professional development. The recent inclusion of administration of vaccines in the scope of practice of pharmacists to was managed by the Australian Pharmacy Council with the development of accreditation standards in a timely manner for courses for registered pharmacists and intern pharmacists. These standards are also being implemented into pharmacy degree programs.

With regard to the application of standards, both outcome and process based standards have a role to play in ensuring responsiveness of programs of study to changes in workforce, health care, education, and technology. Most accreditation authorities now produce outcomes-based accreditation standards that can accommodate changes in priorities and in the operating environment immediately. The level of generality in outcome-based standards is also designed to avoid stifling innovation in teaching methods and curricula, and allow moderate changes to take place without reference to accreditation authorities.

On the other hand, all education providers have their own relationships with the health system in which their students will undertake clinical training and which they will eventually work. They will adapt their programs based on their understanding of the needs of the health system in order to ensure their graduates are employable in the system. Accreditation authorities set process standards (e.g. standards that require a formalised relationship with the relevant elements of the health care system or that require the provider seek stakeholder feedback on the graduates of the program) to ensure that education providers are continuously improving their programs in this way.

Definitions of what constitutes a major structural change are also set in such a way as to identify those changes which accreditation authority experience indicates will have a profound effect on the accredited program, and to limit the conditions which would trigger accreditation review to those changes. Advance notice of major changes is required for two reasons: it enables the accreditation authority to give feedback on the plans and the likelihood that they will align with the accreditation standards. Secondly, if a proposed change will have a significant impact on the program, and requires review, the work needs to be scheduled between the education provider and the accreditation entity. Accreditation resources are booked up to a year in advance. The Forum considers that lead times for education providers contemplating major structural changes are similar

to those for the accreditation agency. In other words, the lead times for both accreditation agency and education provider should run concurrently.

There are similarities and differences in how accreditation authorities approach major changes to programs. The Forum agrees that a shared definition of what constitutes a major structural change to a program would be of value, and is reviewing this in 2017. The structure of programs and the context in which they are delivered is not the same across disciplines, however, and some differences are likely to remain.

Interprofessional education, learning and practice

13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

Studies show that interprofessional education (IPE) is now quite widely reflected in health education accreditation standards in Australia[14]. The NRAS professions have accreditation standards which either explicitly set out interprofessional competencies or stipulate skills which are core to effective interdisciplinary practice, such as the concepts of the ability to establish and maintain professional relationships; the ability to communicate effectively in a range of contexts and with a variety of people; the competencies associated with teamwork and collaboration; the ability to manage and lead teams; and a broad category of professionalism which is associated with behaving in an appropriate manner[14]. There has been work by accreditation councils on this topic, including jointly agreed definitions of inter-professional education and inter-disciplinary practice from the Forum position paper in November 2015 as well as the Forum's work on incorporating IPE into accreditation standards and competency frameworks.

Some of the barriers to implementing and sustaining interprofessional education in programs of study across health education barriers include: incompatible alignment of teaching blocks; student absence on clinical placements at different times; staff and student focus on professional identity; and differing professional requirements for IPE competencies[15]. Despite these obstacles, through accreditation assessments the Forum is seeing increased emphasis given to IPE – with good practices commended – for organisations to see that it is valued in accreditation. Incorporation of IPE standards has enhanced adoption and reporting of many initiatives being undertaken by education providers. For example, within occupational therapy, the boundaries of IPE are not just within traditional health areas. Some universities have extended opportunities for student learning to address broader impacts on health, for example, collaborative learning with architecture students around universal design to promote accessibility in communities.

The Forum members support innovation in the education and training of health professionals and recognise that education and training must evolve in response to changing models of care, community need and educational developments. As interprofessional education itself also continues to develop and evolve, the Forum members have agreed to adopt the Forum IPE statement and the IPE competencies as reference material and recognise that education providers will continue to review and develop IPE in their own learning outcomes, curriculum content, learning and teaching approaches and assessment methods. Significant educational expertise in IPE exists in Australia. The Forum is keen to see this resource supported and to assist with the review and development of accreditation standards for IPE.

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

These are not incompatible. Given the different roles of health practitioners in the 14 health professions regulated in the Scheme, healthcare priorities are best reflected through setting standards which are outcome focussed. As an example, the Australian Medical Council requires that education providers set objectives for their programs of study that take account of community needs and medical and health practice, and that they ensure that the clinical learning environment offers students sufficient patient contact, is appropriate to achieve the outcomes of the medical program, and can prepare students for clinical practice. Other accreditation authorities also require that mechanisms exist within the curriculum to respond to contemporary developments in health profession education and practice. Occupational therapy standards address relevant practice contexts such as indigenous health priorities, and new and emerging areas of practice. These efforts have resulted in partnerships between education providers and health providers, as well as non-government organisations who are responding to Government initiatives, such as the National Disability Insurance Scheme.

What constitutes traditional clinical teaching varies from profession to profession. As the roles of some professions expand, accreditation authorities are monitoring that changes in clinical teaching occur in line with these changes. For example:

- In Optometry increasing numbers of students are placed with practitioners in the community, with several hundred optometry students requiring placement with practitioners nationally every year[16]
- Clinical training in a rural setting is a component of all medical schools' clinical training programs, facilitated by the Rural Clinical Schools initiative[17]
- The Australian Pharmacy Council standards now require pharmacy students to complete experiential placements in a range of different settings along the continuum of care, to prepare students as generalists within both primary and secondary care
- Australian Osteopathic Accreditation Council standards require that clinical education is located within facilities which enable innovative educational approaches through supervision and assessment strategies and/or by engaging students in multi-disciplinary healthcare settings
- Physiotherapy Practice Thresholds require clinical practice across acute, rehabilitation and community practice in a range of environments and settings, across the lifespan
- Given the growth of the primary care workforce in nursing, education providers are increasingly looking to non-traditional, community settings to secure placement opportunities[18].

Education providers are not able to achieve these changes without agreement and support of healthcare facilities and community practitioners. Where there have been significant improvements in exposure to non-urban and non-acute clinical settings, this has been supported through other government policy initiatives and, crucially, funding. Accreditation can be an enabler of these

changes, by setting appropriate accreditation standards that emphasise clinical teaching in a wide variety of settings and models of care.

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

Contemporary education practices are being incorporated in curricula and clinical experience. The examples of case-based discussion, problem-based learning, early clinical exposure, peer to peer teaching, and online learning resources are examples of fundamental changes in the way teaching and learning is being delivered. The Forum supports innovation in education, without which a wide range of quality improvements would not occur.

All health care training accredited by Forum members includes some opportunities to practice skills, techniques and patient/ client interactions before using them in real clinical situations. These opportunities will vary depending on the role of the profession in health care. The accreditation standards for all the health professions support this.

Simulation based education is an example of innovation facilitated by changes in technology. As the technologies underpinning simulation-based education mature, there is widespread growth in the use of simulation as an efficient way to develop some communication, clinical and interprofessional skills without requiring patient involvement[19].

At times simulation will be an essential educational adjunct, for example, simulated patient/client encounters, or intubation simulation. At other times simulation will have a less clear advantage over actual clinical encounters or other teaching methods. An example of an important deployment decision is the level of simulation fidelity, which should be appropriate to the type of task and training stage. A novice can achieve similar or higher skills transfer with a simple simulator, for example, a clinical vignette, than with a complex training aid such as a simulated environment[20]. At more advanced levels of training, the level of fidelity should support higher levels of speed and practice of a task. A simulator is best utilized if used in alignment with educational goals that underpin its use within a program.

The Forum sees its role as promoting discussions regarding the best mix of approaches to meet an educational goal, and ensuring that education providers are able to review and evaluate their educational practices to ensure that the appropriate teaching and learning approach is chosen. Key topics in these discussions revolve around appropriate uses of simulation, as well as deployment issues such as curricular integration, distribution of simulation training over time, outcome measurement, and strategies that promote the transfer of learning from simulation to clinical practice. Some Forum members have also become involved in simulation research. For example, Occupational Therapy Council Ltd is currently participating in a randomised controlled trial investigating the use of simulation. The Forum considers that this is an important and evolving area where developments in education warrant research and application of evidence-based principles, within the professional practice context.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

In NRAS professional education students progress through various levels of supervised practice towards registration. In general, clinical exposure is greater towards the end of the training, allowing education providers to place more emphasis on development and assessment of work readiness before graduates enter the profession. For some professions, supervised practice sits within and not separate to the program of study. For others the final year of supervised practice sits as an intern year. There is a tendency for these practices to align with professions internationally.

The need for a formal period of supervised practice would appear to increase with capacity to harm, the need for integration of complex skills, and the requirement for competence in institutional and team-based environments. These factors do not apply uniformly across the professions, so the Forum considers this is a decision best left with the respective National Boards.

17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

A lot of progress has been made in the understanding of work readiness since Miller proposed the Pyramid of Clinical Competence in 1990[21]. For example, a statement of learning outcomes for a Critical Care course at the Australian College of Nursing include: applying specialist knowledge; evaluating qualitative and quantitative health research; analysing the nurse's role as an integral member of the critical care team; leadership, mentoring and educational skills; justification and prioritisation of clinical decisions; and so on[22]. Many of the skills required are meta-skills that require evaluation of evidence, and soft skills in the areas of professionalism, teamwork and communication and their application in patient care.

In recognition of the considerable personal investment involved in health care education, some part of the task of ensuring that students can acquire the skills necessary for functioning effectively in the workforce may be undertaken at screening for student admission, with evaluation of personal and professional skills. Further assessment is necessary as the student progresses towards the workforce. For example, within Osteopathy, a profession in which most graduates transition immediately to independent practice, evaluation through a series of formative and summative assessments in the final years are designed to evaluate if graduates are work ready.

Despite progress on this issue, some work remains to be done achieving a shared understanding of work readiness between the education providers, accreditation authorities and health service providers (as the assessment of these skills takes part mainly in clinical placements and supervised practice).

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

Internationally there is variation regarding national assessment and accreditation – some countries have both, some only have one. An examination at the point of applying for registration uniformly tests knowledge however acquired, e.g. through an accredited program, work experience, etc. so it can be an outcome measure of accreditation. It is not, however, a substitute for accreditation. Accreditation is the quality assurance of the provider and the program to ensure in a more direct

way that students have the best opportunity of achieving the graduate competencies (not just knowledge) and assuring public safety during the study period and on entry to the workforce.

It is not clear that the benefits of introducing complementary accreditation and national assessment for all professions would outweigh the costs (which would run to thousands of dollars per student, not including requirements for student study time, travel expense and so on). As discussed under Question 17, work readiness is a function of a broad range of experiences and capabilities, only some of which are tested in traditional examination formats. The Forum considers that the focus of development should be assessing performance in clinical and team-based settings, not necessarily adding more traditional exam assessment at considerable expense, unless profession-specific risks warrant such a step. (Pharmacy is such a profession, and such an assessment is carried out in all similar jurisdictions internationally.)

Perhaps because restricting assessment to outcomes exclusively limits understanding of the root causes of performance gaps (see answer to Question 8), in other cases of which the Forum is aware, countries which have national exams for health professions also have accreditation processes. However other models exist for enhancing consistency among education providers' assessment practices. For example, the Medical Deans Australia and New Zealand benchmarking project allows for collaboration in assessment. The Optometry Council of Australia and New Zealand accreditation standards require that each provider arrange for external experts to assess students' competence in final year, without specifying how that will take place. This arrangement is consistent with outcomes standards that do not specify how learning outcomes are to be achieved.

Producing the future health workforce

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

Approval of accreditation standards is a function of the National Boards of health professions, whereas accreditation standards development and enforcement is performed by non-government corporate entities in the case of 11 of the 14 NRAS professions. As studies such as Shapiro (2003)[22] make clear, where operational components of regulatory functions are outsourced, resources must be retained within government to perform the standard setting function, as well as to negotiate contracts and monitor the performance of external entities performing standards enforcement. In the case of national boards, accreditation roles and skills must also be represented in the board skills mix, in addition to core expertise in registration functions, and this is usually the case. However accreditation is a small part of the work of the national boards, and the Forum sees that these roles and skills can be awkward additions to the board's other duties. This requirement is complicated by the fact that the national board appointment process is reliant on jurisdictional appointments, not skills-based appointments.

There is also an onus on accreditation authorities to provide support at this stage of standards development, and most accreditation authorities provide additional guidance to boards on factors

such as the criteria applied to changes in standards; the evidence suggesting the need for change; and the process adhered to in producing the changes.

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

The separation between accreditation authority and national board recognises the different focus, processes and structures involved in accreditation of education providers and registration of professional individuals. This separation allows appropriate specialisation of both organisations, and adaptation to the specific legal and regulatory tasks with which they are charged. However this specialisation does not imply that the two bodies can function independently. There are critical linkages between education and training, registration and professional conduct, and ongoing professional development, and so the work of both sides must be well coordinated. This coordination is currently embedded in two facets of the governance structure: approval by national boards of accreditation standards and/or approval of programs of study and providers; and accreditation authority accountability to national boards. These arrangements are generally sufficient to ensure that the necessary coordination takes place, and they provide a good basis for ensuring that education and training can meet workforce needs, and hence the evolving needs of health consumers.

Under the current governance arrangement, there may be room for improvement in the execution of the coordination between an accreditation authority and a national board. For example, revision of the AHPRA accreditation standards procedures document could strengthen the consideration given to evolving health policy needs. There may also be a need for national boards, with a focus set on registration matters by the National Law, to adopt a more consistent and transparent approach to accreditation standards approval. Furthermore, the assessment of the performance of accreditation needs to take the role of both accreditation authorities and national boards into account, to ensure that various principles of regulation take into account the end-to-end standard setting process from inception through approval to implementation.

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?

Our answer to Question 5 addresses the question of community representation in key accreditation decisions, including on the accreditation agency's governing board or accreditation committees. The Australian Institute of Company Directors' (AICD) 2013 guidance regarding board composition (and governance in general) for not-for-profit organisations is a sound source of additional principles and guidance on this issue[23]. Some of the skills areas the AICD nominates include strategic, accounting, legal and risk management, which are more specialised skills. Others include managing people, fundraising, and experience in similar organisations. It cannot easily be gauged whether community representation is adequate in every instance, however there is a strong trend in for community representatives to add to their skills and contribute a user perspective or 'patient voice' in accreditation decisions.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

The Forum Councils which are not Board committees are structured as not-for-profit companies, and their Board directors understand the legal and ethical environment in which they are operating. This understanding is underpinned by conflict of interest policies in each of the agencies in recognition of their statutory and legislative requirements to do so. Contracts for service also contain confidentiality and conflict of interest clauses. The Forum considers that these governance measures are sufficient to manage conflict of interest issues.

23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

Accreditation agencies that are structured as not-for-profit companies are 'for purpose' organisations. Their objects as a company relate to one or a set of related purposes such as improving standards of health profession education. They are governed by Australian company law, as well as the *Australian Charities and Not-For-Profits Act 2012* and associated acts and regulations. Objects of the company are codified in the constitution and company directors have a duty to ensure that the company continues to meet its objects and to ensure that there are systems to check performance against those objects. The Forum considers that this legal framework is sufficient for management of activities that might be construed as commercial (which includes executing accreditation activities under contract), although naturally the Forum is willing to consider proposals that the Review may have in this area. It is expected that there would be synergy between the functions in a 'for purpose' company so that knowledge, skills and technologies developed would benefit all areas of the organisation including the delivery of high quality accreditation functions. Some accreditation authorities have separated their accreditation activities from commercial obligations by way of delegation frameworks - the directors approve the policies under which the accreditation committee functions, and appoint the members of these committees based on the relevant skills needed for the appropriate decision-making.

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

The Forum considers that further discussion between AHPRA and accreditation authorities is necessary to target specific actions or priority areas. This discussion is necessary to ensure what is being asked of accreditation authorities is clear, resourced and that there are mechanisms in the Scheme to facilitate achievement of actions that are beyond the scope of work of the accreditation authorities. For example, the wording quoted in the Review Discussion Paper was added unilaterally to the letter sent to each accreditation authority with their funding agreement in 2016. From 2013 until then, there was a slightly different wording to the clause. The meaning and expectations, and the capacity to seek funding support to achieve specific outcomes have been unclear.

The Forum considers that current legal and governance framework is still evolving, and work done between the accreditation authorities and AHPRA in 2016 to clarify timelines and negotiation of agreements will assist in this regard. There is scope for more explicit performance indicators (see under Question 27) and for a more substantial dialogue regarding the performance of accreditation against those indicators.

What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- **Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;**
- **Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.**

The current NRAS governance structure treats accreditation separately to the bulk of the work of the system which relates to regulation of health practitioners. In the early days of the Scheme this allowed each accreditation authority to work closely with their national board to integrate accreditation processes into the Scheme in a way that preserved operational independence while maintaining accountability. Additional mechanisms, such as the Accreditation Liaison group, were established by consensus to facilitate communication and to address common problems. From these early successes, the Forum learned that strengthening cross-profession accountability is possible, but that it needs to be approached sensibly.

Bearing these factors in mind, one potential solution to the challenge of carrying out the accreditation functions provided in the National Law while progressing cross-profession issues is a coordination group building on the existing Accreditation Liaison Group, giving that group enhanced remit and expanded membership. It would need representation from all three major types of organisation within accreditation roles in NRAS: national boards; accreditation authorities; and AHPRA, as well as community representatives, education providers and possibly also policy advisors. Such a group would be able to reflect the requirements for intra- and inter-professional coordination by nature of its representation. It would have accountability for progressing cross-profession issues in accreditation standards, and would be accountable to the AHPRA Agency Management Committee, and thus to ministers through a transparent process. Some of the key points to ensuring the success of such a group would be:

- That such a group should be a committee and report directly to the Agency Management Committee (which may need revised terms of reference and membership)
- That it be a committee not a board;
- That the committee be responsible for monitoring the performance of accreditation authorities, AHPRA and national boards in delivering on their accreditation functions under the national law
- That the committee have capacity to identify priorities for cross profession work, and to provide resources for agreed work

- That such a committee be sufficiently resourced to undertake policy work, but otherwise be as lean and efficient as possible;
- That the committee should be fully funded within NRAS;
- That the committee membership be restricted to a number consistent with agile decision-making but enable appropriate representation from the professions (small, medium, large defined by registration numbers, for example) in the Scheme and an independent chair;
- That is should have a formal and clear channel of communication with ministers;
- That is should be both accountable, and able to enforce accountability, in areas of responsibility.

The Forum considers this is the type of solution that stands the best chance of addressing policy, cross-professional coordination, and accountability gaps while preserving the best aspects of the current system. However it is worth considering other possible models for the purposes of comparison and perspective.

For example, the Review suggests that AHPRA's Agency Management Committee might be a logical vehicle for managing cross-profession issues. This committee's job is to manage AHPRA, and it has the sorts of business, administrative, legal and health sector skills to perform that role. However it does not necessarily make sense to ask such a group to take on the additional task of coordinating cross-profession activities in accreditation and ensuring responsiveness to community health needs. A committee charged with that task needs to be fit for purpose, and include the appropriate skills to fulfil that purpose. AHPRA is a key part of the NRAS structure and should be represented. However accreditation authorities and national boards should also be represented to contribute cross-profession perspectives and accreditation expertise. Education providers and community representatives also need to be on the committee if objectives of relevance to health education and responsiveness to community need are to be met.

The Review Discussion Paper puts forward the UK model of the Health and Care Professions Council (HCPC). This accreditation body encompasses a number of health professions. It has driven standardisation by amalgamating the accreditation bodies themselves rather than attempting to coordinate the work of separate organisations. However, from what the Forum has been able to gather about the way the HCPC works, it has done so at the cost of watering down the peer review and quality improvement aspects of accreditation considerably[13]. It is worth pointing out that UK social workers are due to leave the HCPC by 2020 and set up their own accreditation/regulation body, with UK Education Secretary Nicky Morgan citing "a relentless focus on raising the quality of social work"[24] as part of the reason. A letter from the UK Departments of Health and Education to the HCPC outlining the circumstances surrounding the decision by the social workers refers to the need for a "different model of regulation, one that is specific to this unique and challenging profession"[25].

The Review also raises the example of the Australian Commission on Safety and Quality in Health Care (ACSQH) within the Australian Health Service Safety and Quality Accreditation Scheme. The Forum considers that ACSQH is doing important work in health care accreditation. The ACSQH contracts external parties to complete hospital accreditations against standards developed by the ACSQH. Many of the ACSQH approved accrediting agencies have a number of business lines for different industries, with an emphasis on activities such as ISO certification. The ISO system is a

common form of quality control in hospitals, pharmaceutical manufacturing, and emergency services. However this type of certification is closer to audit than it is to evaluation, and would not be appropriate for health education accreditation. It would not seem to be compatible with a peer review approach, the strengths of which include attracting talent from the peak of the professions, gaining acceptance from education providers for collaboration on performance improvement, and managing professional diversity while upholding high education standards. (This is quite apart from the fact that the ACSQH has around 90 full time equivalent staff, not including the resources of the external contractors performing the accreditation reviews.)

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

There is not a clear mechanism for dealing with these issues now. The Forum progresses issues through workshops, working groups and stakeholder consultations. However, currently accreditation standards must be approved by the national board for the profession. A mechanism such as the one proposed in answer to Question 25 would provide a mechanism for cross profession coordination, and could eventually provide a basis for recognition and accreditation of cross-professional competencies within the Scheme.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

The Forum agrees that accountability of such a large national scheme is important. Accountability should relate to the accreditation-related roles of accreditation entities, national boards and AHPRA under the National Law. Improved accountability, coupled with enhanced communication is strongly supported.

There also needs to be some performance measurement of how these three elements work together. In 2014, in response to the Review of the NRAS Scheme, the Forum noted that the separate but related functions can work effectively, and do so in professions where good processes have been established. Work has been done by the accreditation authorities, the national boards and AHPRA to develop good practice guidelines when issues arise. This is contributing to better delineation of roles, with clear expectations about good practice, but there is no measurement/evaluation of whether these practices are being applied.

Accreditation entities report regularly to their national board on their work (at least every six months on their accreditation work overall as well as when accreditation decisions are made). The reports address the domains of the Quality Framework for Accreditation. They include data (programs accredited, overseas trained practitioners assessed, complaints received and outcomes of complaints), as well as exception reporting on changes in policies and processes. Currently, feedback on these reports varies from national board to national board. In 2016, the Forum members, national boards and AHPRA discussed the possibility of reviewing the information provided in these reports to provide a more standardised set of performance data.

These reports could form the basis for development of KPIs for accreditation authorities. Other indicators for the accreditation-related work of the national boards and AHPRA would also need to be developed.

Development of KPIs related to achievement of National Law objectives, particularly health workforce reform and education innovation objectives, will need further consideration. The Forum is willing to contribute to this development. Other accreditation and regulation schemes do not seem to include these objectives explicitly. As there appears to be a lack of models to follow these KPIs would need to be developed from first principles.

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

Accreditation should coordinate with health education policy. Because ministers are generally concerned with macro aspects of health policy, not the details of its implementation, this coordination need not relate to specifics of accreditation standards, but rather to policy issues that impact standards, such as IPE, indigenous health care, clinical placements and so on. The Forum has some suggestions about how such coordination could be structured - see answer to Question 25 and 30.

Experience in consulting health jurisdictions when accreditation entities are proposing changes to accreditation standards shows that responses from individual jurisdictions may be quite different. While this is not surprising, given Australia's state-based delivery of health services and the different geographic, population and disease profiles, accreditation authorities would welcome discussion about a mechanism that allowed them to navigate these different priorities and responses.

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

The direction under s11(3)(d) actually includes another clause that requires that the Ministerial Council first given consideration to the potential impact of the Council's direction on the quality and safety of health care before it issues a direction on the basis of substantial and negative impact on the recruitment or supply of health practitioner. This clause was the subject of significant discussion when the Scheme was being developed and canvassed in consultation papers during 2008. The addition of the clause at (b) was considered essential so that health workforce recruitment and supply considerations did not override safety and quality.

The clause (with both parts) is considered sufficient, given that the AHPRA Procedures for development of Accreditation Standards, which developed with the input of the accreditation authorities, provide other mechanisms for governments to comment on proposed new standards, and to ensure that standards development takes account of the National Law's objectives and guiding principles. These procedures require that accreditation authorities consult fully on any significant change to standards, or on new standards. The education sector, relevant profession, and governments should be consulted as a minimum.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- **As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?**
- **Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?**

Responsiveness to policy and workforce needs is an important theme in the Review Discussion Paper. However articulating just what exactly the future health workforce needs, and how policy can assist in delivering it, is no trivial task. The demise of Health Workforce Australia has left some gaps in this area, and these are gaps that NRAS, as well as education providers, health services and governments will need to work together to fill. Resources will need to be devoted to building the research and fact base upon which informed policy debate can be based.

In this regard it makes sense that there should be a body which can deal with cross-profession issues and has the skills to identify the policies relevant to accreditation and then work with accreditation authorities on standards in a 'right touch' regulatory manner. As suggested in the answer to Question 25, one way to address such a requirement would be to create a committee with the resources and authority to coordinate policy for accreditation.

The Forum itself can and does play constructive role in considering health policy issues as they relate to accreditation. Because the Forum works in conjunction with accreditation authorities and other stakeholders it can contribute to policy outcomes that benefit from top down and bottom up perspectives i.e. an articulation of what desirable tempered by an appreciation of what is achievable. The Forum also plays a valuable role improving/ streamlining the processes of policy implementation.

There are other potential ways to strengthen policy debate within NRAS. For example, an annual forum/conference on health workforce priorities would allow the entities which have responsibility for accreditation in the Scheme to work each other and with education providers to consider major challenges.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

There are standards and mechanisms to provide scrutiny of these operations and the performance of these functions. The Australian Medical Council (AMC) revised the Standards for Assessment and Accreditation of Specialist Medical Programs in 2015, implementing the new standards in 2016. The standards concerning college accreditation of posts and training programs have been strengthened. The AMC deliberately brought standards into alignment with the Australian Health Ministers'

Advisory Council Health Workforce Principal Committee, Accreditation of Specialist Medical Training Sites Project Final Report, 2013.

Intern training accreditation authorities – generally called postgraduate medical councils – undertake a variety of roles for their state health departments, one of which is accreditation of medical intern training posts and programs. They generally work under a contract or service agreement with their state or territory health department as well as an agreement for service with AHPRA on behalf on the Medical Board of Australia. The accreditation of intern posts and programs is covered by national standards, developed by the AMC on behalf of the Medical Board of Australia The AMC assesses this work through an accreditation process, but it is not accreditation of a program of study under the national law. The domains the AMC uses for assessment build on the domains of the Quality Framework for Accreditation. AMC accreditation of intern training accreditation authorities only began in 2013. A similar arrangement is in place for pharmacy intern training programs, where Australian Pharmacy Council (APC) accredits the program provider against standards developed by APC on behalf of the Pharmacy Board of Australia. APC accreditation of intern training programs has been in operation since 2010.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

Practices vary across NRAS professions and are too complex to be answered here. Each accreditation authority will address this separately in their own submissions.

33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

Accreditation authorities should have regulatory influence both with regard to international and domestic health profession graduates in order to exercise coordination with regard to the skills sets of both groups as they enter the Australian workforce. They are able to fulfil this role because they utilise networks of professionals with educational and practice expertise with relevance to both areas. In fact, development and maintenance of expert networks is a core capability for accreditation authorities, and so in general an economy of scope applies to between accreditation and the assessment of overseas trained practitioners, creating a synergy in this area. Separation of these functions is therefore likely to result in a less efficient economic outcome.

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

Given the wide diversity settings, treatment modalities, specific skills and levels of risk reflected in the groupings of health professions captured by the NRAS scheme, consistency of assessment process is unlikely to be achievable let alone desirable. Assessment must be fit for purpose, depending on the profession, and on the skills, knowledge and attributes that should be assessed.

More important than consistency across all professions is that processes adopted for assessment by individual professions are relevant to the needs of that profession and delivered in a fair and transparent manner. This does not require all assessment processes to adopt the same format.

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

The supervised practice requirement in some professions has been implemented in recognition of the fact that the available screening processes do not cover all aspects of performance critical to safe practice. In these cases, supervised practice provides not only a means of comprehensive assessment, but also a way to facilitate integration. For example, for pharmacy, the assessment pathways for most overseas trained pharmacists require completion of a full year internship or shortened supervised practice dependant on the stream of entry. As many overseas trained pharmacists come from countries whose practice is substantially different to Australia, including from countries without regulated medicine supply systems, this is an effective mechanism for their integration in the Australian pharmacy workforce.

The choice of assessment pathway will also depend on the resources available to support the assessment. In the case of medicine, the workplace-based assessment (WBA) pathway has been shown to be effective in measuring performance, and not merely competence alone. It also enables the upskilling of international medical graduates (IMGs) over time and is the most effective mechanism for integration of the IMG into the Australian medical workforce. However, limited opportunities for WBA placement mean that this pathway will only be available to a limited number of IMGs each year.

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

The Quality Framework for Accreditation has requirements about managing complaints about our work, and accreditation authorities have to report to AHPRA and National Boards regarding the complaints. All accreditation authorities have processes that allow for feedback on accreditation assessments and escalation of unresolved issues.

Regarding the issue of a channel outside the accreditation authorities for unresolved complaints and grievances, the Forum could potentially offer a channel external to any one provider, depending of course on the scope of the complaint.

The Forum is unclear about the extent of a "perceived need" for an external grievance handling body. Those accreditation authorities which have dealt with major complaints by education providers indicate that they have set up independent processes to address the complaint.

37. If an external grievance appeal process is to be considered:

- **Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?**

- **Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?**

One of the strengths of the NRAS is the independence of accreditation entities (with reporting and accountability requirements). That means that they are able to make decisions free of undue influence of stakeholders such as the professions, national boards, and education providers. If there is to be a complaints mechanism external to the accreditation entities then it either has to be an entity akin to the National Health Practitioner Ombudsman (NHPO), or a separate system (which is just another cost).

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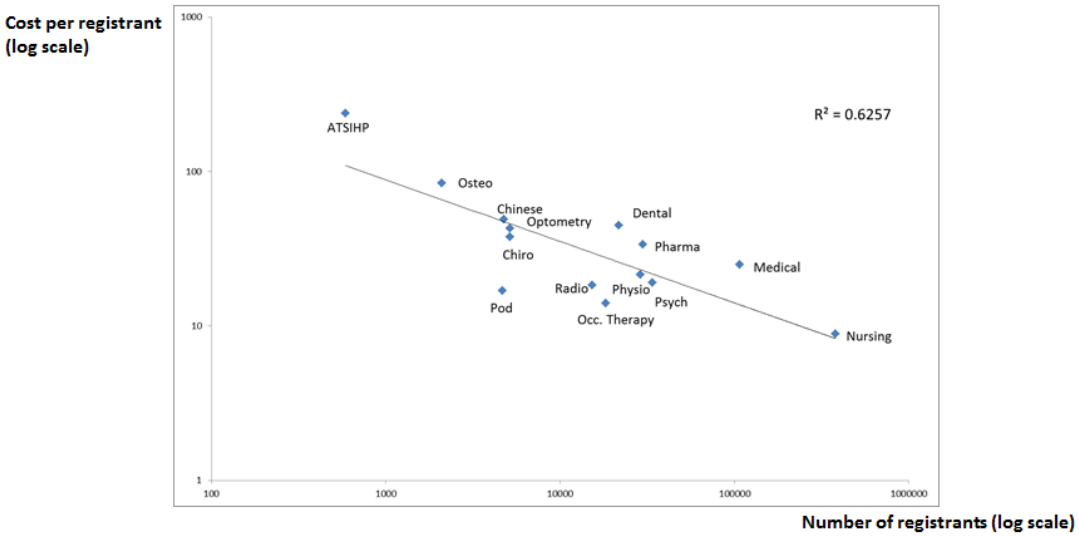
The work done by the ALG Costing Working Group provides a basis for assessing whether NRAS accreditation costs in Australia are too high

- The current Independent Review of Accreditation Systems quoted a statement from the previous NRAS review (2014) that "As a proportion of total spending, the accreditation function in Australia is markedly more expensive than the quality assurance of higher education in the UK. It costs almost three times per registrant when the full cost of accreditation is recognised."*
- In April 2016, a Costing Working Group (CWG) was established by the Accreditation Liaison Group to provide a transparent accounting of accreditation costs within the NRAS scheme and to allow benchmarking
- The CWG completed its work in November 2016 and the results were published in March 2017**

* Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions Discussion Paper, p. 19
** http://www.ahpra.gov.au/Publications/Accreditation-publications.aspx

Using the ALG data, it can be shown that costs of accreditation of programs of study are driven partly by scale

NUMBER OF REGISTRANTS VS COST PER REGISTRANT, NRAS PROFESSIONS 2015-16*



* Source: ALG 'Costs of Accreditation': including Accreditation of Programs of Study costs only

And partly by the number of programs of study that require accreditation

COST REGRESSION MODEL, NRAS PROFESSIONS DATA, 2015-16*

SUMMARY OUTPUT

Regression Statistics	
Multiple R	88%
R Square	77%
Adjusted R Square	75%
Standard Error	0.182878
Observations	36

ANOVA

	df	*SS*	*MS*	*F*	*gnificance F*
Regression	2	3.653336	1.826668	54.6183	3.39E-11
Residual	33	1.10366	0.033444		
Total	35	4.756996			

	Coefficients	*tandard Err*	*t Stat*	*P-value*	*Lower 95%*	*Upper 95%*	*ower 95.0%*	*pper 95.0%*
Intercept	3.882875	0.248532	15.62324	8.27E-17	3.377233	4.388517	3.377233	4.388517
Number of registered practitioners	-0.67948	0.082333	-8.25282	1.57E-09	-0.84699	-0.51197	-0.84699	-0.51197
Number of programs	0.333636	0.092927	3.5903	0.001058	0.144575	0.522698	0.144575	0.522698

Two factors drive 75% of the variability in costs per registrant (log-log regression)

* Source: ALG 'Costs of Accreditation'.
Note: Dependent variable is Accreditation of Programs of Study costs/ Number of registered practitioners in FY 2013/14, 2014/15, and 2015/16. Independent variables are 1. Number of registered practitioners (in the same years), and 2. Total number of accredited programs (in the same years). ATSIHP FY 2013/14, Chinese Medicine FY 2013/14, Radiotherapy FY 2013/14, and Podiatry FY 2013-16 removed as outliers

In summary, accreditation costs are driven by the expected factors of high fixed costs and the amount of work to be done

- The Independent Review of Accreditation Systems implies that NRAS accreditation costs in Australia are too high
- The data supplied by the Costing Working Group suggests otherwise
- Accreditation costs are shown, in a simple regression model, to be driven mainly by two factors: scale and number of programs accredited
- In other words, the costs of accreditation are driven by the expected factors of high fixed costs and the amount of work that needs to be done