The Draft Report

The Independent Reviewer, Professor Michael Woods, has been appointed by the Australian Health Minister’s Advisory Council to undertake an Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.
Key Review dates – final submissions

Interested parties are invited to provide a written submission to this Draft Report utilising the template attached to the “Guidelines for preparing a submission” available on the webpage (details below).

Due date: COB Friday 29 September 2017.
Due to the project timelines, extensions cannot be provided.
Submissions can be made by email to: admin@asreview.org.au

Contact
For further information please contact: admin@asreview.org.au

Or visit the webpage at:
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<tr>
<td>ACSQHC</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
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<td>ADC</td>
<td>Australian Dental Council</td>
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<td>Australian Health Ministers’ Advisory Council</td>
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<td>AHWMC</td>
<td>Australian Health Workforce Ministerial Council</td>
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<td>Australian Health Practitioner Regulation Agency</td>
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<td>Australian Industry and Skills Committee</td>
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<td>Australian National Audit Office</td>
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<td>APhysioC</td>
<td>Australian Physiotherapy Council</td>
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<td>Australian Prudential Regulation Authority</td>
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<td>Australian Qualifications Framework</td>
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<td>Australian Securities and Investments Commission</td>
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<td>Australian Universities Quality Agency</td>
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<td>AVETMISS</td>
<td>Australian Vocational Education and Training Management Information Statistical Standard</td>
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<td>BAS</td>
<td>Business Activity Statement</td>
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<td>Centre for the Advancement of Interprofessional Education</td>
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<td>CCEA</td>
<td>Council on Chiropractic Education Australasia</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>Consumer Price Index</td>
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<td>Council of Presidents of Medical Colleges</td>
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<td>Costing Working Group</td>
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<td>DET</td>
<td>Commonwealth Department of Education of Training</td>
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<td>Abbreviation</td>
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<tr>
<td>FARMC</td>
<td>AHPRA Finance, Audit and Risk Management Committee</td>
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<td>Freedom of Information</td>
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<td>Health Professions Accreditation Collaborative Forum</td>
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<td>IPE</td>
<td>Interprofessional education</td>
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<td>ISQua</td>
<td>International Society for Quality in Healthcare</td>
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<td>JAS-ANZ</td>
<td>Joint Accreditation System of Australia and New Zealand</td>
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<td>NASRHP</td>
<td>National Alliance of Self Regulating Health Professionals</td>
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<td>NGO</td>
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<td>National Health Practitioner Ombudsman and Privacy Commissioner</td>
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<td>NRAS</td>
<td>National Registration and Accreditation Scheme</td>
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<td>NSQHS</td>
<td>National Safety and Quality Health Service Standards</td>
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<td>OCANZ</td>
<td>Optometry Council of Australia and New Zealand</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OTC</td>
<td>Occupational Therapy Council (Australia and New Zealand)</td>
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<td>PMC</td>
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<td>Professional Standards Authority</td>
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<td>RACS</td>
<td>Royal Australasian College of Surgeons</td>
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<td>RAF</td>
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<td>RTO</td>
<td>Registered Training Organisation</td>
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<td>TPB</td>
<td>Tax Practitioners Board</td>
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<td>TEQSA</td>
<td>Tertiary Education Quality and Standards Agency</td>
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<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>USDET</td>
<td>United States Department of Education and Training</td>
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<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
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<tr>
<td>VETASSESS</td>
<td>Vocational Education and Training Assessment Services</td>
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<tr>
<td>WFME</td>
<td>World Federation for Medical Education</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WPAME</td>
<td>Western Pacific Association for Medical Education</td>
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Executive summary

This Draft Report is the penultimate product of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (the Review). The Draft Report has been developed through research, analysis of submissions to the Review and input provided at public forums and in individual consultations with key stakeholders.

Responses to the issues and draft recommendations contained in the Draft Report are being sought before a Final Report is prepared for submission to the Australian Health Ministers Advisory Council and the COAG Health Council for consideration.

The Review in context

As identified in the 2014 NRAS Review, the creation of the National Regulation and Accreditation Scheme (NRAS/the National Scheme) is a unique and substantial achievement that consolidated 75 Acts of Parliament and 97 separate health profession boards into one National Law and 14 National Boards for the registered professions, supported by a single administrative arm, the Australian Health Practitioner Regulation Agency (AHPRA). Nonetheless, Australia still has a profession-based complex and polymorphic governance arrangement with multiple overlapping regulators, including 14 accreditation authorities and many other entities having accreditation functions.

The accreditation of health programs of study and the registration of individual health practitioners are separate but intrinsically related functions that operate together within the National Scheme. Whilst registration gives individual practitioners the legal right to practice, the accreditation function provides the threshold assessment and evaluation of education and training courses to ensure that a graduate has the knowledge, clinical skills and professional attributes necessary to practise the profession.

There are six National Law objectives which guide the Scheme and therefore the accreditation functions. They include: protecting the public through the registration of health practitioners who are suitably trained and qualified to practise in a competent and ethical manner; facilitating the provision of high quality education and training of health practitioners; facilitating access to services in accordance with the public interest; enabling the continuous development of a flexible, responsive and sustainable health workforce and enabling innovation in the education of, and service delivery by, health practitioners. As an aside, the Reviewer considers that terms such as ‘innovation in education’ (National Law s3(f)), as with ‘reform’, should not imply endorsement of change for change’s sake, but should be read as change which results in higher quality education and training of health practitioners (National Law s3(c)).

In assessing how the accreditation system can best contribute to achieving all of the objectives in a balanced manner, the Review’s central consideration is that it operates collectively and collaborate with the National Boards and AHPRA to address the evolving health and social needs of the community. These needs arise from the rising burden of chronic diseases, the persistence of disadvantage, the poorer health outcomes for those in rural and remote Australia and for Aboriginal and Torres Strait Islander people, the growing numbers of the frail aged and the opportunities provided by technological and pedagogical advances. These needs are all creating challenges for determining the composition and structure of the future health workforce, including its education and training, models of care, scopes of practice and distribution to areas of need. Innovation in health workforce education is a necessary element of a strategy which integrates workforce reform into overall national health priorities.
A further contextual point for this Review is that, since the establishment of the National Scheme in 2010, other significant national reforms in the regulation of education and health provide new opportunities to remove duplication and more efficiently deliver functions based on expertise and consistency across both sectors. The developing national framework of safety and quality in healthcare similarly provides an opportunity to align the regulation of health workforce education and its accreditation to a whole of health system approach.

In light of the context in which this Review has been undertaken, a threefold approach has been adopted:

- To propose improvements to the efficiency and effectiveness of the current system.
- To ensure the relevance and responsiveness of health education and address the broader question of how education and training, and its accreditation, can help create the workforce that Australia needs, both now and in the future.
- To propose governance arrangements that would deliver the proposed reforms.

**Improving efficiency and effectiveness**

Growth in the cost of health care, including the workforce which delivers that care, is the greatest source of fiscal pressure on governments. In addition, the growing demand for aged care and disability care services are also placing increasing pressure on the costs and availability of a skilled and accessible health and care workforce. In this context, a guiding principle for the education and utilisation of scarce health workforce resources was stated succinctly by the Australian Health Ministers’ Advisory Council (AHMAC) a decade ago to the [Health Workforce Productivity Commission Inquiry](https://www.hpc.gov.au/): “... wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care.” (p14)

To this end, the Review has undertaken a financial assessment of the accreditation system, including the fees charges by accreditation authorities as well as the expenditure they incur in the exercise of their functions. It has also undertaken a consideration of the fees and costs of other like systems.

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

- There are elements within comparator international regulatory systems which can inform improvements in Australia and they need to be addressed in a continuous cycle of improvement and review.
- Assessment of the cost effectiveness of the National Scheme can only be achieved once there is a consistent and transparent funding and accounting framework.

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

To increase the efficiency of the accreditation system, a set of sound and fit-for-purpose processes are required which can reduce complexity and unnecessary duplication, increase clarity and transparency and reduce costs. Each step of an accreditation process has direct resource implications for both education providers and accreditation authorities (and indirect cost implications for students, practitioners and consumers). Greater commonality in accreditation standards, terminology, assessment processes and reporting requirements across the professions, as recommended by this Review, should improve the efficiency and effectiveness of the accreditation of education programs and providers.
There are also opportunities to streamline processes that currently overlap with regulators who operate outside the National Scheme. While the education sector regulatory authorities, the Tertiary Quality Standards Agency (TEQSA) and the Australian Skills Quality Authority (ASQA), have different overarching purposes and foci for accreditation, their underlying domains and processes are largely the same and intersect with the National Scheme regulators at the point of health education. Clarification and separation of roles and responsibilities should further reduce duplication, costs and administrative burdens.

Relevance and responsiveness

The Review has explored the constraints created by the existing accreditation regulatory system, together with opportunities to deliver relevant and responsive health education programs which align with the National Law objectives. The Review has identified a number of key enablers:

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

The Review has explored the issue of what ‘work ready’ means. Some professions only grant new graduates limited registration whilst undertaking supervised practice and, in some cases, require graduates to pass a separate examination(s) before being granted full registration. Clarification is required on the differences between the normal induction, orientation and mentoring provided by employers to assist new graduates and requirements set by National Boards that restrict the attainment of general registration on first entry into the workforce. Accordingly, the Review is proposing the need for clearer demonstration of the need for supervised practice requirements and national examinations.

The importance of consumers

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

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

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

Reforming governance as an enabler of change

This Review has identified a broad range of opportunities to improve the efficiency and effectiveness of accreditation functions and facilitate greater relevance and responsiveness of health education, but these are not new discoveries. Problems and workable solutions can be found in previous reviews, in the deliberations of
the Health Professions Accreditation Collaborative Forum (HPACF) and in submissions to this Review. And yet, while there is a great deal of common agreement on what needs to be done, equally there has been little progress in pursuing reform. The Review considers that this is fundamentally a failure of governance.

The current arrangements are unable to provide an actively regulated and managed accreditation system that delivers on the objectives set out in the National Law. The governance issues explored by the Review include:

- The interdependence/independence of accreditation and registration functions. Any model of governance needs to ensure that regulation is proportionate and the National Boards have trust that accredited programs of study and education providers are graduating students who have the knowledge, clinical skills and professional attributes necessary to practise the profession.
- The independence of the accreditation decisions from the stakeholders being regulated.
- The involvement of consumers to ensure that the public interest remains paramount.
- Whether current arrangements are progressing reform in a sufficiently timely and fulsome manner and, if not, whether there needs to be an entity that is responsible and accountable for driving reform.
- The need for a robust and formalised approach by which government policy directions are developed and communicated to all parties operating within the National Scheme.

The current governance of the accreditation system is complicated by the number of entities involved. In addition to the 14 accreditation authorities, the Review has identified more than 20 other entities undertaking elements of National Law accreditation functions. The majority are private organisations and their oversight is either through commercial agreement, letters of assignment or, in some cases, there appears no direct relationship with the statutory regulators at all. Activities performed by accreditation authorities are part of the regulatory framework, and the governance and accountability arrangements should ensure that all decisions and activities are expert, objective, consistent, transparent and in the public interest.

The accreditation governance model must be able to respond to the imperative that the health workforce is operating in a broader context where the regulated professions come together as health care teams and work collaboratively with the unregistered health professions and social services in responding to the evolving health and care needs of the community.

The Review has developed three options, all drawn from submissions and its own analysis. These options are evaluated in detail in the Draft Report and submissions are invited on all three.

**Option 1 - Enhance an existing forum or liaison committee**

The first option explores streamlining the time-consuming and resource-intensive nature of the current governance arrangements through enhancing the role of an existing forum or liaison committee. A cross-professional advisory body could provide advice on common approaches to accreditation standards and processes, and develop reference and guidance documents to promote principles of consistency, efficiency and transparency. Some submissions to the Discussion Paper suggested that the HPACF or the AHPRA Accreditation Liaison Group (ALG) could assume this more formal role through membership that has been expanded with additional experts in consumer perspectives, the provision of education and from jurisdictions.

**Option 2 - Enhance the Agency Management Committee**

An option advanced by the Review in the Discussion Paper that could provide the desired integrative and determinative approach to accreditation was to expand the remit of the AHPRA Agency Management Committee (AManC). It could be given the role of developing rigorous cross-profession directions for the development of accreditation standards, and for these directions to be embedded within the AHPRA/council agreements.

Very few submissions directly addressed this option, rather they either indicated support for another option or proposed a new one. Of those that did address the expanded AManC option, support was limited. The AManC, in its supplementary submission, proposed a different role to that set out in the Discussion Paper and this has
formed the basis for the configuration of the second option. The AManC proposed it could become responsible for “….developing strong and clear cross-professional requirements for good regulatory practice through new procedures for the development of capability and competency standards and enhancing the existing procedures for development of accreditation standards whilst respecting the profession specific standard setting function of National Boards.” (p2). Responsibilities and operations, as proposed by the AManC in its submission, could include:

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

Option 3 – Establish integrated accreditation governance

The third option is the Review’s preferred governance model. It clarifies the separate but interrelated regulation of accreditation and registration and establishes a single national cross profession accreditation framework for health workforce education and training within the National Scheme. The option establishes a Health Education Accreditation Board, with a secretariat drawn from AHPRA, which would sit alongside the National Registration Boards and have the following responsibilities.

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

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

Accreditation Committees would be able to be appointed within external entities, provided that decisions made by a Committee under the National Law are autonomous from the hosting entity. The external entities (such as the current accreditation councils) must establish their Accreditation Committee operations in a manner that would enable the functions to be covered in the same manner as other National Scheme entities defined in the Health Practitioner Regulation National Law Regulation 2010. This should not relate to the general governance and operations of the external entity beyond normal contractual requirements. External entities should be permitted to have other commercial arrangements. A Committee could be responsible for accreditation functions of more than one registered health profession where the relevant Committees agree to merge.
The Review considers that profession specific competency standards should be developed by **National (Registration) Boards** and recognised under the National Law in accordance with the legislative provisions established for development of registration standards and their approval by Ministerial Council. The Review has noted that many standards are currently developed outside of the regulatory purview of the National Scheme and yet, via the accreditation standards, they have very significant influence on the education foundation of the workforce and ultimately on health service models. This reform should strengthen the National Registration Boards’ trust in the accreditation standards and in the integrity of the accreditation system more generally.

A diagrammatic outline of the proposed entity structures is as follows:

The Review is also aware that the concurrent NRAS Governance Review may be considering proposals for other changes that impact the role of the AManC. It is possible such changes could encompass it taking responsibility for some of the Ministerial Council’s roles. Given this, the Review is also asking respondents whether they wish to comment on the potential for the AManC to undertake the functions proposed for the Accreditation Board.

### The inclusion of non-registered professions

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

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

The National Scheme would not be responsible for the costs of, and fees charged by, participating unregistered professions in relation to their activities and the Accreditation Board could charge fees to recover its own costs.
Assessment of overseas trained practitioners

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

- AHPRA should lead the development of a whole of National Scheme approach to the assessment of overseas trained practitioners for skilled migration and professional registration and a more consistent approach towards the assessment of overseas trained practitioners and competent authorities.
- The Accreditation Board should lead the development of a more consistent approach to the assessment of overseas trained practitioners and competent authorities and pursue opportunities to pool administrative resources.
- The Accreditation Board, in collaboration with National Registration Boards, Accreditation Committees and specialist colleges, should develop a consistent and transparent approach for setting assessments of qualification comparability and additional supervised practice requirements for overseas trained practitioners, with the latter being aligned with Australian trained practitioner requirements.
- Specialist colleges, in relation to the assessment of overseas trained practitioners, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010.
- The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners.
- Specialist medical colleges should ensure that the two pathways to specialist registration (passing the requirements for the approved qualification or being awarded a fellowship) are documented, available and published on college websites and the information is made available to all prospective candidates.

Other governance matters, including grievances and appeals

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

- Accreditation Committees in relation to programs of study and education providers of those programs.
- Postgraduate medical councils and specialist colleges (medical, dental and podiatric) in relation to the accreditation of training posts/sites.
- Any designated entity exercising an accreditation function regarding an assessment of the qualifications of an overseas practitioner.

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

Setting national reform priorities

A key issue identified by the Review is the paucity of guidance to the governance bodies in the National Scheme on health workforce and system priorities. Whilst the Review’s Terms of Reference focus on the accreditation system, there is little to be gained in setting a strategic direction for accreditation entities if that direction does not encompass broader workforce priorities nor be shared by the National Registration Boards, AHPRA, education providers, professional associations, employers and consumers.
Consistent and regular policy guidance should be provided by governments and then acted upon by the National Scheme as a whole. This needs to be integrated into overall national reform processes and directions, given that workforce responsiveness is a critical enabler. The Review is proposing the COAG Health Council oversight a policy review process to identify health workforce directions and reforms that:

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

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

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

Finally, the Review is proposing the Australian Health Ministers’ Advisory Council should work with AHPRA and other entities within the National Scheme to develop a set of clear, consistent and holistic performance indicators that respond to the Statement of Expectations.

### Consolidated list of recommendations

Note: Recommendations in Chapter 7 propose governance arrangements for undertaking many of the actions recommended in Chapters 3, 4, 5 and 6. In particular, it is recommended that a cross-profession Health Education Accreditation Board be established, to which profession-specific Accreditation Committees report.

#### Funding the Accreditation System

1. **Funding principles should be developed to guide accreditation authorities in their setting of fees and charges.** The funding principles should provide guidance on:
   - Development of a cost recovery policy and methodology for all accreditation functions.
   - Common adoption of consistent accrual accounting and business principles.

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

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

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

#### Improving efficiency

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

The relevance and responsiveness of education

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

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

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

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

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

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

Accreditation governance – an assessment

12. All accreditation standards should require education providers to demonstrate the involvement of consumers (health service users, students and employers) in the design of education and training programs, including the development of education curricula, as well as demonstrate that the curricula promotes patient-centred health care.
13. AHPRA should expand the Terms of Reference for the AHPRA Community Reference Group to include accreditation functions and enable accreditation authorities to refer issues to the Group for advice.

Accreditation governance – options for reform

14. Governments should separate responsibility for the regulation of the accreditation functions under the National Law from that of the regulation of individual practitioners, with the governing entities of the two functions operating collaboratively with the Agency Management Committee and AHPRA, to achieve all objectives of the National Scheme.

15. Governments should establish in the National Law a Health Education Accreditation Board (the Accreditation Board) with the following responsibilities:

- Assignment of Accreditation Committees.
- Approval of accreditation standards developed by Accreditation Committees in accordance with the Accreditation Board policies and guidelines.
- Determination of accreditation policies, guidelines and reporting requirements (as described in Recommendations 3, 4, 5, 8 and 12).
- Development and review of policies and guidelines on the criteria and processes for assessment of international practitioners, offshore programs of study and competent authorities.
- Development of funding principles (as described in Recommendation 1) for submission to the Australian Health Workforce Ministerial Council for approval.
- Approval of fees and charges proposed by Accreditation Committees following Cost Recovery Implementation Statement processes.
- Development and management of relationships with TEQSA, ASQA and ACSQHC, including agreement on the delineation of responsibilities between the respective accreditation systems and how they interact within the following parameters:
  - Institutional academic accreditation to be undertaken by TEQSA approved structures for higher education providers or ASQA approved structures for Registered Training Organisations.
  - Professional accreditation to be undertaken by Accreditation Committees.
- Exploration of the potential to include a module within ACSQHC accreditation regimes which encompasses the health service elements of the clinical education/experience domain in professional accreditation.

16. The Accreditation Board should be required to report to the Australian Health Workforce Ministerial Council in the same manner as National Registration Boards and AHPRA, and similarly receive directions as appropriate.

17. The Australian Health Workforce Ministerial Council should appoint members to the Accreditation Board who have the expertise to carry out its health and education functions in the public interest. There should be an appropriate mix of experts in health education, health service provision and health service use. Members are not to represent any particular organisation.

18. AHPRA should support the Accreditation Board with a dedicated Secretariat with policy capability and should work with the Accreditation Board to develop and operate a consolidated fund to:

- Support the development of policy on cross-professional accreditation matters such as common standards and processes.
- Provide a mechanism for the distribution of some proportion of registrant fees as a contribution to accreditation costs to the Accreditation Board and Accreditation Committees.
19. Accreditation Committees, in accordance with the policies and guidelines set by the Accreditation Board, should have the following functions:

- Development of accreditation standards for approval by the Accreditation Board.
- Assessment of programs of study and education providers and approval and monitoring of programs of study and providers which meet approved accreditation standards.
- Assessment of authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study and approve those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia.
- Assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession.

20. In assigning Accreditation Committees to undertake the accreditation functions, the Accreditation Board should ensure that they are configured so as to:

- Place the public interest foremost and provide complete transparency in decision making.
- Provide professional input to decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders.
- Have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

21. Accreditation Committees should be able to be appointed within an external entity. In that circumstance the Accreditation Board should, with the support of AHPRA, oversee the management of a multiyear contract with the external entity for the delivery of accreditation functions, within the following parameters:

- External entities should be permitted to have other commercial arrangements provided their contracted accreditation functions are managed independently and transparently, including the management of any conflicts of interest.
- An external entity must ensure that its Accreditation Committee has full autonomy to make accreditation assessment decisions and establish its operations in a manner that would enable its functions to be covered in the same manner as other National Scheme entities defined in the Health Practitioner Regulation National Law Regulation 2010.
- The application of relevant provisions of the Health Practitioner Regulation National Law Regulation 2010 should apply to the Accreditation Committee only and not more generally to the external entity which is its host.

22. The Accreditation Board should invite current accreditation councils to establish Accreditation Committees for the initial five-year period. The three existing accreditation committees should be made committees of the Accreditation Board, with administrative support continuing to be provided through AHPRA.

23. Following the initial five-year period, the Accreditation Board should seek expressions of interest and assign Accreditation Committee functions for periods of five years.

24. The National Law should enable the Accreditation Committees and/or any external entities that host them to act as merged entities where mutually agreed. Opportunities for streamlining and amalgamation should be considered as part of a drive for continued efficiency.
25. National Registration Boards should develop competency standards formally under the National Law, in accordance with the legislative provisions established for the development of registration standards. Competency standards should be developed cooperatively utilising:

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

26. Governments should amend the National Law to allow unregistered health and social care professions to apply to access the skills and expertise of the Accreditation Board, and operate their accreditation activities under its umbrella, subject to the following conditions:

- Unregistered professions participating in the accreditation provisions of the National Law would be considered separate to the registered professions.
- Accreditation activities undertaken by unregistered professions would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established COAG Health Council processes and in accordance with the COAG agreed criteria.
- The National Scheme would not be responsible for the costs of, and fees charged by, participating unregistered professions in relation to their activities and the Accreditation Board may charge fees to recover its own costs.

Other governance matters

27. AHPRA, in partnership with National Registration Boards and the Accreditation Board, should lead discussions with the Department of Education and Training and the Department of Immigration and Border Protection to develop a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration.

28. The Accreditation Board should work with Accreditation Committees and specialist medical colleges to develop a more consistent approach towards the assessment of overseas trained practitioners and competent authorities. Opportunities to pool resources for administration requirements should also be pursued.

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

30. Specialist colleges, in relation to the assessment of overseas trained practitioners, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

31. The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners. This includes working in partnership with the Medical Board of Australia on the development of agree performance indicators and reporting metrics that are appropriate, comparable and aligned with other relevant National Scheme reporting regimes, in terms of time periods and the ability to trace assessment pathways from application to registration.
32. Specialist colleges should ensure that the two pathways to specialist registration, namely:
   • being assessed by a specialist college and passing the requirements for the approved qualification;
   or
   • being awarded a fellowship of a specialist college;
are documented, available and published on specialist college websites and the necessary information is
made available to all prospective candidates.

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

34. Governments should appoint the National Health Practitioner Ombudsman and Privacy Commissioner to
review any decisions made under the National Law by the following entities (as specified under the
Health Practitioner Regulation National Law Regulation 2010):
   • Accreditation Committees in relation to programs of study and education providers of those
     programs.
   • Postgraduate medical councils and specialist colleges in relation to the accreditation of training
     posts/sites.
   • Any designated entity undertaking an assessment of the qualifications of an overseas trained
     practitioner (including specialist colleges).

35. The National Health Practitioner Ombudsman and Privacy Commissioner should review the grievances
and appeals processes of entities as defined in Recommendation 34, with the view to making
recommendations for improvement by each entity where it is considered those processes are deficient.

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

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

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

This Chapter sets out the background to the establishment of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions. It expands on the Terms of Reference for this Review and provides information on its conduct to this point and remaining opportunities for stakeholder engagement.

Origin of the National Registration and Accreditation Scheme

The National Registration and Accreditation Scheme (NRAS/the National Scheme) came into operation on 1 July 2010 (18 October 2010 in Western Australia) with national registration commencing for 10 regulated health professions. The National Scheme was implemented through enactment of the Health Practitioner Regulation National Law in each state and territory. On 1 July 2012, a further four professions joined, and on 13 June 2017, a legislative amendment was introduced into the Queensland Parliament to include Paramedics as the fifteenth regulated profession.

The National Scheme was established following publication in 2005 of the Productivity Commission report Australia’s Health Workforce. The report highlighted the fragmented arrangements for the registration of practitioners and the accreditation of qualifying programs for entry to the professions. The report recommended a restructuring of the governance arrangements and rationalisation of the multi-jurisdictional bodies, not only to lift standards and provide efficiencies, but also to provide the levers and incentives to drive workforce reform and innovation.

In relation to accreditation, the Productivity Commission recommended a national cross-profession approach, facilitated through the establishment of a single statutory national accreditation entity for all health workforce education and training. The Productivity Commission’s view was that this would preserve the best features of existing arrangements while enabling improved workforce flexibility, increased consistency of course accreditation, reduced compliance costs, and greater inter/multi-disciplinary opportunities.

When the National Scheme was enacted, however, a single national multi-profession accreditation agency was not established. Instead, on transition in 2010, Health Ministers assigned accreditation functions to the existing national councils that were already undertaking these functions on behalf of state and territory registration boards. Following this initial assignment, under the National Law, each of the 14 National Boards has the power to decide whether their accreditation functions are to be exercised by an external accreditation entity or an internal committee established by the National Board.

Objectives and guiding principles of the National Scheme

The National Law s3 identifies six objectives and three guiding principles for the National Scheme as a whole:

(2) The objectives of the national registration and accreditation scheme are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and
(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

(3) The guiding principles of the national registration and accreditation scheme are as follows—

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

As specified in s4 of the National Law, “an entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in section 3.” Accordingly, entities exercising accreditation functions are to have regard to the six National Scheme objectives.

Background to the Review

In 2014, the Australian Health Workforce Ministerial Council (AHWMC) commissioned an independent review of NRAS (NRAS Review) which made several recommendations that were specific to accreditation (Appendix 1).

In responding to the Final Report of the NRAS Review, Health Ministers accepted in principle its recommendations relating to accreditation functions but reported that they were concerned about the high cost, lack of scrutiny, duplication and prescriptive approach to accreditation functions highlighted in the report. The August 2015 COAG Health Council communiqué stated:

“While the recommendations will go some way to improve Australia’s accreditation arrangements, Health Ministers believe that more substantive reform of accreditation functions is required to address the issues.” (p2)

Health Ministers subsequently asked the Australian Health Ministers’ Advisory Council (AHMAC) to commission a comprehensive review of accreditation functions. On 10 October 2016, AHMAC released a communiqué announcing the appointment of Professor Michael Woods as Independent Reviewer.

Related initiatives

Concurrent work undertaken by governments that is of relevance to accreditation functions under the National Scheme, and being pursued through other avenues, includes:

- The NRAS Governance Review which is exploring improvements to governance, reporting and reform arrangements within the National Scheme. Whilst it has determined that governance of accreditation functions is out-of-scope, there is potential for overlap due to interrelationships between accreditation functions, registration functions and the National Scheme more generally.

- Implementation of the previous Review of Medical Intern Training which examined the current medical internship model and potential reforms to support medical graduate transition into practice and further training.

- Work commissioned by the Commonwealth Department of Education and Training on the extent and scope of professional course accreditation practices. This was undertaken to inform the Higher Education Standards Panel of the impact of professional accreditation on Australian higher education.
and opportunities that may exist to reduce the regulatory burden on higher education providers. The PhillipsKPA Professional Accreditation – Mapping the territory final report will be released in the last quarter of 2017.

The Review has been cognisant of these initiatives and has factored their work into its deliberations and the development of its recommendations.

Scope of the Review

The Review has structured its work across three broad themes in line with its Terms of Reference (Appendix 2).

1. The Review has assessed the costs of the accreditation functions and identified opportunities for streamlining current arrangements and removing unnecessary burdens and complexities. It has considered approaches to reduce duplication of activities and data collections and improve the sharing of resources between accreditation authorities. The Review drew lessons from its examination of international accreditation processes.

2. The Review has examined the extent to which accreditation standards and processes could facilitate flexibility and responsiveness in the development and delivery of educational programs. The Review has identified several constraints in the current accreditation system that inhibit beneficial educational innovation in curriculum design, clinical training arrangements, the use of simulation and interprofessional learning. It has also assessed the current arrangements for supervised practice and national examinations to determine whether these additional requirements are necessary to ensure the safety and quality of subsequent patient care and other net benefits, or whether they unnecessarily protect custom and practice or entrench institutional silos.

3. The Review has assessed current governance arrangements for accreditation including their interaction with entities within the National Scheme, AHWMC, the Australian Health Practitioner Regulation Agency [AHPRA], the Agency Management Committee [AManC] and National Boards) and with other stakeholders (consumers, educational institutions, jurisdictions, employers, specialist colleges, postgraduate medical councils and other education regulators). The Review has explored alternative governance arrangements that may promote reforms such as consistency and collaboration across the professions.

The Terms of Reference for this Review focus on the accreditation system within the National Scheme. However, to make a meaningful contribution to improving the accreditation system, the Draft Report has also taken into account the broader context within which accreditation takes place. This context includes its relationship with, and the functions of, other health care system organisations and the overriding objectives of government involvement in the education, training, regulation and funding of the health workforce. The Review acknowledges that the health workforce operates within the overall health care system and has considered the issue of setting overall reform directions for Australia’s health workforce and for the National Scheme’s entities and functions.

Limitations to the scope of the review

The scope of the Review has been limited in the following areas:

- The Review has focused on arrangements for currently regulated professions under the National Scheme. However, it has also been cognisant of the impact on other health professions, noting that the National Scheme is dynamic and other professions may progressively be included, and also recognising the need for greater collaboration across all health and care professions.

- The Review has not explored in detail specific accreditation decisions. It has, where relevant, referred to examples where they represent either best or poor practice in fulfilling the National Scheme’s objectives.
• Noting the concurrent NRAS Governance Review, the Review has focused on matters relating to the governance of accreditation functions. In that context, however, it has also considered matters relating to functions and powers of AManC and National Boards regarding:
  o Where registration standards may impact on education delivery mechanisms and inputs (Chapter 5).
  o Decisions, processes and governance relating to the assignment of accreditation functions and monitoring and reporting on the delivery of those functions (Chapter 7).
  o Approaches to articulating health workforce reform priorities for action by National Scheme entities (Chapter 8).
• Given other work underway, as outlined above, and the time and resources available to the Reviewer, the Review has considered decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of accreditation arrangements and assessment of overseas practitioners but has not considered in detail:
  o Specialist and intern accreditation operations and performance.
  o Operational performance in relation to assessing overseas practitioners for either general or specialist registration.

In particular, it is noted that AHMAC is taking steps to implement other recommendations from the initial NRAS Review including those relevant to the assessment of international medical graduates (recommendations 24 and 25). The Medical Board of Australia has advised that it has commissioned an external review of specialist colleges. Further information is available in Chapter 8.

**Review process**

The Review is underpinned by research and analysis of current evidence and data. The Review has considered previous reports related to the National Scheme and health workforce regulation matters, including stakeholder submissions to this Review and the NRAS Review. It has undertaken further research and analysis into best practice for accreditation systems and health workforce education and development, both nationally and internationally.

The Review has been informed by stakeholder feedback through both targeted and broad-based consultation approaches. This included the development of a communication strategy, a two-stage open consultation process, and direct engagement with a range of interested parties including representatives from:

- AManC and AHPRA
- National Boards
- Accreditation councils and committees
- Health education providers
- Health consumers
- Government departments from all jurisdictions
- Agencies including the Tertiary Education Quality and Standards Agency (TEQSA), the Australian Skills Quality Authority (ASQA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).
- Health service providers
- Health professional associations.

The first stage of the public consultation process commenced with the release of the Discussion Paper on 27 February 2017. The Discussion Paper expanded on issues relating to the efficiency, relevance and the responsiveness of the existing accreditation system and sought stakeholder views on necessary reforms to enable the National Scheme to produce a flexible, responsive and sustainable health workforce. In doing so, the Review requested feedback on whether existing accreditation arrangements provided for an actively managed and regulated accreditation system which responds to National Scheme objectives in a comprehensive and timely manner.
Consultation forums were held in the capital city of each Australian state and territory during March 2017 to provide stakeholders with the opportunity to discuss the topics and questions raised in the Discussion Paper. An additional forum for national organisations was held in Melbourne. A separate workshop was also co-hosted with the Consumers Health Forum of Australia to seek consumer perspectives on accreditation processes and outcomes. Approximately 500 individuals attended the consultation forums representing over 200 organisations. The Review has received over 110 written submissions to the questions posed in the Discussion Paper. Public submissions are available on the COAG Health Council website.

The Review has also considered additional information requested from AHPRA, National Boards and accreditation authorities on current processes in the preparation of the Draft Report. Information that was provided by stakeholders as part of these processes is referred to within the Draft Report as ‘information provided directly to the Review’. The Review also met with officials from TEQSA, ASQA, ACSQHC and the Commonwealth Department of Education and Training to discuss opportunities for a more streamlined and consistent approach to accreditation which could be better aligned with health service and education regulation more broadly. These discussions have informed the design of reforms noted in this Draft Report.

The release of this Draft Report on 4 September 2017 commences the second stage of public consultation for the Review. This consultation process closes on 29 September 2017. Stakeholder feedback is being requested on the draft options and recommendations contained within the Draft Report and will inform the preparation of the Final Report for submission to AHMAC on 31 October 2017.

**Report structure**

This Draft Report has been structured into eight Chapters. Chapters 1 and 2 are an introduction to this Review and the broader accreditation system. Chapters 3 to 8 focus on the key issues relating to funding, efficiency, effectiveness and governance as per the Terms of Reference approved by Health Ministers. Each of these Chapters seeks to define the issues, analyse the evidence and propose solutions for further discussion and debate. A brief outline of each Chapter is provided below:

- **Chapter 1: The Review** provides a background to the establishment of the Accreditation Systems Review and its links with the previous NRAS Review (2014) and the Productivity Commission report on Australia’s Future Workforce (2005). This Chapter expands on the scope of the Review and provides information on the consultation process.

- **Chapter 2: The health professions accreditation system** is a summary of the accreditation functions established within the National Scheme. It includes relevant background information on the broader regulation of the education system and the work undertaken by other education regulators including TEQSA and ASQA.

- **Chapter 3: Funding the accreditation system** details the current funding arrangements including the income received by accreditation authorities as well as the expenditure incurred in the exercise of accreditation functions. It examines opportunities to improve accountability and transparency, and reduce cost through the development of funding principles.

- **Chapter 4: Improving efficiency** explores the development of accreditation standards and the execution of assessment processes. This Chapter evaluates options to improve the efficiency of accreditation processes and proposes a range of reforms to distinguish the role of National Scheme accreditation *viz-a-viz* the regulation functions undertaken by TEQSA and ASQA.

- **Chapter 5: Relevance and responsiveness of education** explores the constraints and opportunities of the existing accreditation system to improve the relevance and responsiveness of health education. It examines the value of outcome-based accreditation standards, the role of professional competency standards, approaches to interprofessional education and practice, the relevance and quality of clinical placements, and the role of supervised practice and national examinations in the context of delivering a workforce with the knowledge, skills and professional attributes to deliver safe and high-quality health services.
• **Chapter 6: Accreditation governance – an assessment** undertakes further analysis of the need for reform, starting with the origins of current accreditation arrangements, performance to date against the National Scheme’s objectives and the role of consumers in reform options. It investigates the relationship between regulation and accreditation and expands on the respective roles of AHPRA and the National Boards including their interaction with the accreditation system.

• **Chapter 7: Accreditation governance – options for reform** examines different models of accreditation governance that could achieve a more directed and timely adoption of reforms proposed in this Draft Report. It investigates three options for governance reform:
  - Enhance an existing forum or liaison committee
  - Enhance the AManC
  - Establish integrated accreditation governance.

• **Chapter 8: Other governance matters** considers the role of specialist colleges, current processes for the assessment of overseas trained health practitioners and the role of governments in setting health workforce reform directions for the accreditation function and for the National Scheme collectively.
2 The health professions accreditation system

This Chapter sets out the role of accreditation within the National Scheme. It describes the responsibilities of profession specific accreditation within the overall context of education and health regulation. It identifies synergies between accreditation functions undertaken as part of the National Scheme and those that are conducted as part of broader education and health service regulation to better understand how the overall accreditation system is influenced by the respective entities.

What is accreditation?

There are two broad categories of accreditation, being the profession-based accreditation of programs of study and the academic accreditation of institutions which provide that education. The Universities Australia and Professions Australia Joint Statement of Principles for Professional Accreditation (p2) defines these as:

- **Professional accreditation:** of university courses of study is intended to ensure that a course of study meets essential criteria in the training and education of its students in the relevant professional discipline, and that graduates from that discipline achieve the professional competencies and learning outcomes necessary for entry into the relevant level of professional practice.

- **Academic accreditation:** refers to the evaluation of a course of study (either by TEQSA or by a self-accrediting provider such as a University) against course requirements specified in the Higher Education Standards Framework.

Academic accreditation structures

The Australian Qualifications Framework (AQF) is the national policy for regulated qualifications in the Australian education and training system. It underpins the national system of qualifications in Australia encompassing higher education, Vocational Education and Training (VET) and schools. The AQF provides an integrated approach to qualifications and qualification pathways, and specifies the learning outcomes for each AQF level and qualification type, the requirements for issuing AQF qualifications, qualification linkages and student pathways, and the alignment of the AQF with international qualifications frameworks. In doing so, the AQF specifies how it applies to the accreditation and development of qualifications and aims to complement national regulatory and quality assurance arrangements for education and training.

**Higher Education**

Accreditation of higher education providers and programs of study is managed by the Commonwealth Government through TEQSA under the [TEQSA Act 2011](https://www.teqsa.gov.au/), in accordance with the [Higher Education Standards Framework (Threshold Standards) 2015](https://www.teqsa.gov.au/). The Threshold Standards outline “the minimum acceptable requirements for provision of higher education in or from Australia by higher education providers registered under the TEQSA Act 2011.” They apply to multiple classifications of higher education provider and regulate provider registration, provider categories, course accreditation and qualifications. The Threshold Standards have 7 elements:

- Student participation and attainment
- Learning environment
• Teaching
• Research and research training
• Institutional quality assurance
• Governance and accountability
• Representation, information and information management.

The TEQSA Act 2011 provides that higher education providers that are registered in certain categories and meet specific criteria, may be classified as a ‘Self-Accrediting Authority’ which authorises the provider to self-accredit one or more of the courses of study it offers. Higher education providers classified by TEQSA in the ‘Australian university’ category have self-accrediting authority status. A majority of approved programs of study within the National Scheme are delivered by Australian universities.

Higher education providers that are not self-accrediting authorities are assessed by TEQSA against the Threshold Standards. For professions under the National Scheme, some Chinese medicine and nursing programs of study are delivered by higher education institutions which are not self-accrediting authorities.

To meet the Threshold Standards, all higher education providers (self-accrediting and non-self-accrediting) must have academic governance processes and structures to assure the quality of programs of study. Self-accrediting universities must ensure a course meets the Threshold Standards and an entity that does not have self-accrediting authority must have the course accredited under the TEQSA Act 2011.

Vocational Education and Training

ASQA is the national regulator for the VET system (as defined in s155 of the National Vocational Education and Training Regulator Act 2011). Its role is to ensure that courses and training providers meet nationally approved quality standards. There are also state based regulators in Victoria and Western Australia. All VET providers must achieve the Standards for Registered Training Organisations (RTOs) 2015. These standards form part of the VET Quality Framework which also includes the:

• Australian Qualifications Framework
• Fit and Proper Person Requirements (the requirements are now part of the Standards)
• Financial Viability Risk Assessment Requirements 2011
• Data Provision Requirements 2012.

Nationally recognised VET qualifications are included within Training Packages which are developed through a process of national consultation. National Training Packages include units of competency and qualifications to meet the training needs of an industry or group or industries. They are developed and validated by Skills Service Organisations in consultation with industry stakeholders, and are then endorsed by the Australian Government and state and territory governments for use nationally. A RTO can deliver units of competency and qualifications in training packages if they are within their scope of registration.

Where a program of study is included within a Training Package, ASQA does not specifically accredit the program of study but continues to monitor the performance of the RTO. This is undertaken through annual reporting requirements including data collected through the full Australian Vocational Education and Training Management Information Statistical Standard (AVETMISS).

All but one VET health professional course leading to registration under the National Scheme are included in a National Training Package. The relevant Industry Reference Committee has identified this for inclusion in its future work program.

ASQA can also delegate high-performing RTOs with the ability to manage their own scope of registration. In this case, RTOs must have and demonstrate formal quality assurance systems to manage VET regulatory functions and operations and comply with the VET Quality Framework throughout the Delegations Agreement. This may include organisational policies and procedures, guidelines and other documentation that outlines how the RTO monitoring ensures the quality of its education and training.
Accreditation under the National Scheme

Under the National Scheme, accreditation is a critical antecedent to registration. As defined in Part 6, Division 1, s42 of the National Law, there are five accreditation functions.

(a) developing accreditation standards for approval by a National Board; or
(b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or
(c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia; or
(d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession; or
(e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d).

Whilst accreditation authorities undertake the accreditation functions, National Boards retain final approval of standards and programs of study. Under s51, National Boards may also impose conditions or cancel approval of programs of study based on advice from accreditation authorities. In addition, under the National Law, assessment of overseas trained practitioners and competent authorities is both a registration and accreditation function and can be undertaken by either a National Board or an accreditation authority. The interrelationship between accreditation and registration functions is explored in Chapter 6.

Governance within the National Scheme

The National Law (s43) specifies that each National Board must decide whether its accreditation function will be undertaken by an external entity (accreditation council) or a committee established by the relevant National Board. One of the primary differences between the two approaches is the operating model. A council is generally an independent not-for-profit registered company, whilst a committee is established by a National Board with Secretariat support provided by AHPRA. Eleven of the National Boards have assigned the accreditation functions to an external entity, whilst the National Boards for Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine and Medical Radiation Practice have established committees.

Accreditation authorities are appointed to exercise accreditation functions through a contractual agreement with AHPRA. Whilst accreditation authorities, once appointed, are able to operate independently internally, they do not make decisions under the National Law. Accreditation authorities report to their National Board at least twice a year. In addition, s11(4) provides that the Australian Health Workforce Ministerial Council may give direction to a National Board if, in its opinion, a proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners. The Ministerial Council, however, may not provide directions in relation to individual programs of study.

Quality Framework for the Accreditation Function

Where external entities (councils) have been contracted to deliver accreditation functions by AHPRA and National Boards, they are required to undertake these functions in accordance with the Quality Framework for the Accreditation Function (Quality Framework). The Quality Framework was developed in 2013 as the principal reference document for National Boards and AHPRA to assess the conduct of accreditation functions by accreditation authorities.
The Quality Framework states that its underpinning principles are:

- The COAG principles for best practice regulation.
- The objectives and guiding principles of the scheme in the legislation.
- The independence of accreditation decision-making within the National Law parameters.

It covers eight domains:

- **Governance**: the authority effectively governs itself and demonstrates competence and professionalism in the performance of its accreditation role.
- **Independence**: the authority carries out its accreditation operations independently.
- **Operational management**: the authority effectively manages its resources.
- **Accreditation standards**: the authority develops accreditation standards for the assessment of programs of study and education providers.
- **Processes for accreditation of programs of study and education providers**: the authority applies the approved accreditation standards and has rigorous, fair and consistent processes for accrediting programs of study and their education providers.
- **Assessing authorities in other countries**: the authority has defined its standards and procedures to assess examining and/or accrediting authorities in other countries.
- **Assessing overseas qualified practitioners**: the authority has processes to assess and/or oversee the assessment of the knowledge, clinical skills and professional attributes of overseas qualified practitioners who are seeking registration in the profession under the National Law, and whose qualifications are not approved qualifications under the National Law for the profession.
- **Stakeholder collaboration**: the authority works to build stakeholder support and collaborates with other national, international and/or professional accreditation authorities.

**Interested parties in accreditation**

Consistent with the eighth Domain above, accreditation authorities are required to be cognisant of the role of stakeholders with an interest in the accreditation process. These include:

- **Governments**: who set the overarching strategic direction of the health care system, determine health regulation and contribute significantly to services and funding. In doing so, governments play a key role in setting the purpose and direction of accreditation standards.
- **Education regulators**: the quality assurance agencies for the higher education (TEQSA) and VET systems (ASQA or state-based authorities in Victoria and Western Australia) are responsible for regulating, monitoring and evaluating the performance of education providers. Education providers must meet the accreditation requirements of education regulators before they can seek accreditation under the National Scheme.
- **Health service regulators**: ACSQHC is the government agency responsible for developing the National Safety and Quality Health Service (NSQHS) Standards and oversees the accreditation of health service settings against these standards. The NSQHS standards and accreditation process intersects with National Scheme processes such as the accreditation of intern positions and specialist training posts/sites and the provision of quality clinical placements. In addition, the NSQHS standards outline key health care practices that underpin the curricula of all health professions across the career continuum.
- **Education providers**: develop and deliver health programs of study designed to meet accreditation standards and attract students to their institution. Education providers consult and engage with a range of stakeholders including consumers and health professions to ensure that their programs of study continue to respond to the needs of the health sector and the health care needs of the community.
- **Employers**: have a strong interest in the outcomes of education health programs. Employers require health graduates to have the knowledge, skills and professional attributes to deliver safe and high-quality health services. Many employers also provide clinical placements and/or vocational training to enable students/trainees to obtain practical experience and consolidate their academic learning.

- **Professional associations** represent, and advocate for, their profession. Professional associations can collaborate to inform and influence the development and implementation of accreditation standards and competency standards, including through identifying opportunities for innovation and reform in professional practice which influences the education and training of that profession.

- **Consumers**: as end-users of the health system, have a direct interest in influencing education and training to ensure the workforce remains responsive to the evolving needs of the community. Consumers provide a useful lens for assessing whether accredited programs are culturally appropriate and responsive to population and demographic changes, and broader health and social care issues.

These stakeholders currently have varying roles in the conduct of accreditation functions and in influencing the operation of the accreditation system. Their roles are explored throughout the Report.
3 Funding the accreditation system

This Chapter explores and assesses the current system for funding accreditation: the income received by accreditation authorities as well as the expenditure incurred in the exercise of accreditation functions. In doing so, it examines opportunities to improve transparency and accountability, minimise duplication and reduce costs through greater efficiency and effectiveness.

The Productivity Commission Report on Government Services (2017) defines efficiency and cost effectiveness as “...how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness).” Cost-effectiveness is further defined as “...how well inputs are converted into outcomes for individual clients or the community.”

The National Law requires, under s208, that AHPRA maintains an Agency Fund which has separate accounts for each National Board. The National Law further states that AHPRA and the National Boards must each “ensure that its operations are carried out efficiently, effectively and economically”, and that “as far as possible, reasonable value is obtained for moneys expended from the Fund” (s212(1)(a), s212(2)(a), s212(1)(c)). The 14 accreditation authorities are each aligned to their respective National Board for the purposes of funding.

When the National Scheme was being established in 2008, First Ministers agreed “It is intended that in the longer term the scheme will be self-funding” (Clause 12.3). The guiding principles specified in the National Law do not explicitly require self-funding, but they do state that the National Scheme is to operate in a “transparent, accountable, efficient and fair way” (s3(3a)) and that “fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme” (s3(3b)).

Beyond those provisions, the National Law does not prescribe how fees and charges should be set, or on how the income (including any surpluses and deficits incurred) earned by the National Scheme is to be allocated amongst the National Boards, accreditation authorities and AHPRA.

The current approach is that registration fees for each profession are credited to the respective National Board account. AHPRA negotiates a Health Professions Agreement with each National Board which includes AHPRA drawing from those accounts sufficient funding for the overall administration of the National Scheme and agreed funding which AHPRA pays to accreditation authorities. Whilst Health Ministers receive advice from AHPRA on the registration fees charged by respective National Boards, this advice does not include any information on the underlying costs of regulation (such as the quantum and proportion of registration fees allocated to accreditation authorities). Similarly, accreditation councils, as independent entities, are not required to disclose their processes for setting accreditation fees and levies on education institutions.

Each accreditation authority is expected to generate income (from its National Board and from fees largely charged to education providers) to sustain its accreditation and assessment processes. There is no direct cross-subsidisation of professions between the 14 National Boards or between the 11 accreditation councils and three committees, nor is there central pooling of funds for cross-professional projects. However, given that AHPRA receives 78% of the total income received by National Boards to meet its expenses (representing $135,909,484 in 2015-16), there is significant funding of common or shared overheads in the National Scheme.
2014 NRAS Review findings and costing analysis

The Terms of Reference for the 2014 NRAS Review included a requirement to assess the cost effectiveness of the existing systems, including the delivery of accreditation functions. The NRAS Review contracted the Professional Standards Authority (PSA), an independent body accountable to the United Kingdom (UK) Parliament, working in collaboration with the Centre for Health Service Economics and Organisation, to undertake the assessment. It was carried out between July - October 2014 and was based largely on the financial year figures for 2013/14.

The NRAS Review findings and recommendations concluded that the Australian system was relatively expensive and that there was evidence of rising costs and the fees charged to providers. Key findings included:

“The National Scheme has an annual operating cost of $214,117,803. This amount includes the expenditure of the National Boards and AHPRA, the Accreditation Authorities, and the notifications arrangements in New South Wales.

The average unit cost for the operation of the National Boards is $346 per registrant: when analysed by profession this varies between $162 and $1,792. The unit cost per registrant in the UK (estimated at $301.50) is slightly lower than in Australia.

The Australian approach is different from UK arrangements, where the quality assurance of higher education courses is undertaken by the regulator funded from the registration fee and there is no direct charge to the education provider. The total expenditure on accreditation represents 19.4% of total NRAS expenditure and 6% of UK expenditure.

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. This is because a large share of the cost of accreditation is borne by the higher education sector. The cost difference in accreditation between Australia and the UK on a per registrant basis is valued at $30.2 million.” (p53)

The NRAS Review report also noted the variability amongst accreditation authorities, including different fee structures, fee-setting methods and extensive duplication of processes (especially in relation to the accreditation of education providers). The PSA suggested that having 11 separate councils was likely to “be an inherently more expensive arrangement for the delivery of this function.” In addition, there was a concern that due to the accreditation authorities having a monopoly on the accreditation process, the continued lack of scrutiny could diminish any incentive to improve efficiency and cost effectiveness. Notwithstanding these findings, the PSA was clear to note that firm conclusions could not be drawn and:

“...a much more detailed analysis of the differences of performance, process and approach within and between them would be required.” (p48)

The NRAS Review recommended a series of measures including further investigation into the UK accreditation system to address the cost of accreditation and enable greater consistency and transparency in accreditation processes across the 14 registered professions (Appendix 1).

Some of the costing analysis and interpretations contained within the NRAS Review Report were challenged by the National Boards and accreditation councils. They considered the data was incomplete and that some costs were a result of the newness of the National Scheme and included establishment costs. The Accreditation Liaison Group (ALG) questioned the interpretation of the cost data and advised that accreditation fees charged to education providers increased initially with the introduction of the National Scheme due to multiple factors, including higher expectations from a national system and a broader role for accreditation authorities.

In preparation for this current Review, the ALG in April 2016 established a Costing Working Group (CWG) to progress work on determining the cost of accreditation in the National Scheme. The Cost of Accreditation in the National Registration and Accreditation Scheme (‘the Costing Paper’) provides a comparative analysis of the income and expenditure incurred by accreditation authorities in the exercise of their functions.
This Review acknowledges the significant work undertaken in compiling data from across 14 different accreditation authorities and commends the CWG and the ALG for the comprehensive information and analysis contained in the Costing Paper. This Review would have been restricted in its ability to review the cost and funding elements related to accreditation without this work. The information on the functions (and income and expenditure) of each accreditation authority as contained in the Costing Paper provides a useful template for future annual publication of income and expenditure across the entities within the National Scheme.

The financial data in the Costing Paper cannot be directly compared to the PSA work: the latter costing figures were based largely on data from the establishment of the National Scheme and the 2013/14 financial year whilst the ALG Costing Paper uses data from 2013/14 to 2015/16.

**How does the National Scheme compare internationally?**

The ALG also undertook a comparison of the accreditation arrangements in Australia and in the USA, Canada, New Zealand, UK and Ireland. These countries were chosen due to similarities in the health services provided, and comparable standards of education for their health professions. The ALG concluded that there were key differences between Australian and international systems such as:

- Legislative frameworks and objectives, noting that only the Australian legislation had an explicit focus on workforce development, innovation and reform.
- The Australian accreditation functions include the assessment of overseas trained health practitioners and overseas authorities. Other countries refer to these as registration functions.

This Review has considered the work of the ALG and undertaken further investigation into some of those systems identified by the ALG and considers that its work is comprehensive.

**Box 3.1 International approaches to accreditation**

The *Comparison of International Accreditation Systems for Registered Health Professions Report* (‘the International Comparisons Report’) prepared by the ALG provides a comprehensive overview of the respective health accreditation systems in place across comparator nations. The ALG notes that New Zealand, UK, Ireland are most similar to Australia in that they have a co-regulatory system. This system is expressed as a system which has “a strong partnership between industry and government; with the industry developing its own code of conduct or accreditation/ratings schemes with legislative backing from government.” (p2)

Canada and USA were assessed as different regulatory systems. USA was classified as a ‘quasi regulated’ system where Government influenced business to comply and assisted with the development of codes of conduct, accreditation and/or rating schemes, but it did not play a role in enforcement. The Canadian system was classified as having aspects of both quasi regulatory and co-regulatory systems.

The International Comparisons Report highlighted unique elements of the Australian health practitioner regulatory system including:

- its focus on ensuring a flexible, responsive and sustainable Australian health workforce as a key objective;
- the inclusion of the assessment of overseas trained health practitioners and overseas competent authorities as an accreditation function; and
- establishment of a single national legislation which has been adopted across all states and territories in a federal system of government.

The research undertaken by the ALG provides a detailed analysis of international accreditation systems. The Review concurs with the ALG that the significant differences in the legislative, governance and historical contexts in which health practitioner regulation has evolved makes cross-country comparisons difficult.
Box 3.1 International approaches to accreditation

Australia, Canada and the USA all have federal systems of government. Australia has developed a national approach (leading to the establishment of the National Scheme), whereas USA and Canada have retained separate state/provincial approaches to regulation. As a result, there are variances in how health professions are regulated at the sub-national level in these two countries. Canada and the USA have also developed a system of national examinations for registered professions (except for psychology and podiatry). The Review infers that the use of national examinations in these two countries is to allow for assessments of graduates against a consistent national benchmark, given the lack of a single national approach to accreditation.

Whilst New Zealand has a single national legislation governing the regulation of its health practitioners (the Health Practitioners Competence Assurance Act 2003), it has a ‘scope of practice’ approach to practitioner regulation whilst the National Scheme is based on a ‘protection of title’ model. A key difference with the ‘scope of practice’ approach is that it enables regulatory authorities to apply restrictions on the scope of practice of individual practitioners. In Australia, restrictions on individual scopes of practice are primarily undertaken through employer credentialing and privileging processes. The varied use of ‘scope of practice’ (NZ and Canada) vs ‘protection of title’ (Australia, Ireland, UK and USA) suggests that this is influenced by local health systems and the broader regulatory context.

The United States Department of Education and Training (USDET) has a role in accrediting the accrediting authorities whereby each accredited authority has to meet consistent standards set by the USDET. The UK also has a national oversight process for health regulation which is provided by the Professional Standards Authority (PSA).

The lack of a consistent funding and accounting framework across the National Scheme (and in any of the comparators) makes a comparison of cost effectiveness across the different professions within the National Scheme, and with other sectors (outside of health) and with other jurisdictions, problematic. The Australian Medical Council (AMC) in its submission provided its own internal analysis of the cost of medical accreditation in the UK and Australia. The AMC noted:

“The AMC’s best estimate of UK medical accreditation costs comes from GMC expenditure on quality assurance of programs. Using these numbers, UK medical accreditation costs are around A$42 per registrant. The corresponding number in Australia is around A$26. We have checked with the GMC to ensure that, in the main, this is an ‘apples with apples’ comparison.” (p7)

The Australian Dental Council (ADC) in its submission noted:

“Comparative analysis of fees across Councils doesn’t really reflect the real cost and relative quality of the wide diversity of accreditation and examination activities currently undertaken by each accreditation authority. This data is needed to appropriately define key principles for fee setting and levies. In the absence of this data, the ADC believes funding should continue to be set in accordance with the guiding principles of the Scheme through negotiation between the accreditation authority and the respective National Board; transparent, accountable, efficient and linked to effectiveness.” (p24)

The Australian Dental Association in its submission further noted in relation to the Costing Paper:

“While the additional information provided by the Australian Dental Council provides further guidance on its cost effectiveness, a more meaningful analysis can only be done if information on the number of accreditation activities performed and number of overseas qualified health practitioners assessed is made available for all the relevant accreditation authorities across all the health practitioner types within the Scheme.” (p5)

The Review agrees that a comparison across jurisdictions is difficult due to the differing nature of health practitioner registration schemes and accreditation arrangements, governance, intersections with education portfolios and different funding methodologies. An assessment of cost effectiveness can only be achieved upon the implementation of a funding and accounting framework based on sound principles of cost recovery which can be applied across all accreditation functions. This is explored further below.
This Review concludes that, despite the differences between Australian and comparator international regulatory systems, there are elements within each which can inform improvements in Australia. Where the Review has identified additional elements from international accreditation and regulatory systems which are considered beneficial for the Australian system, these are explored further in the respective Chapters.

Sources of accreditation authority income and expenditure

Accreditation authorities receive income from various sources, including National Boards allocating a portion of the registration fees they receive and the charges made to education providers for accreditation services. Nine of the fourteen accreditation authorities (Chiropractic, Dental, Medical, Occupational Therapy, Optometry, Osteopathy, Pharmacy, Physiotherapy and Podiatry) also source additional income from the assessment of overseas trained health practitioners and/or offshore competent authorities. Accreditation authorities can also generate income from other sources (outside the National Scheme) such as skilled migration assessments.

Income from registrant fees

AHPRA and National Board funding is primarily made up of registrant fees, with a lesser amount from other sources (e.g. investments). The AHPRA Annual Report notes that in 2015/16, $161,038,000 was received from registrant fees which made up on 94% of AHPRA’s total income. According to the ALG Costing paper (p21) total AHPRA income and expenses and total funding contributions to accreditation authorities as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total income</td>
<td>$167,859,000</td>
<td>$170,463,000</td>
<td>$170,929,000</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>$151,887,000</td>
<td>$168,602,000</td>
<td>$169,077,000</td>
</tr>
<tr>
<td>Funding to accreditations</td>
<td>$7,438,000</td>
<td>$11,659,000</td>
<td>$9,754,000</td>
</tr>
<tr>
<td>% of total income</td>
<td>4.4%</td>
<td>6.8%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Funding received from National Boards is a significant source of income for accreditation authorities and has risen from 65% in 2013-2014 to 73% in 2015-2016 as a percentage of their income from National Boards and education providers over the same three-year period. The Review undertook further analysis of the income data from various financial reports to understand the total income from registrant fees for the purposes of accreditation. This analysis included assessment of: income received from National Boards by accreditation authorities as noted in the Costing Paper; National Board accreditation expenditure as reported in the 2015/16 AHPRA Annual report and financial data from the respective Health Profession Agreements.

Schedule 5.2 of the Health Profession Agreements between AHPRA and National Boards includes functions provided by AHPRA (included in AHPRA total Indirect Expenses) to National Boards to support their oversight of delivery of accreditation functions, accreditation committees (where applicable) and accreditation standards.
<table>
<thead>
<tr>
<th>Health Profession</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>2,992,900</td>
<td>3,446,000*</td>
<td>4,349,700</td>
<td>47,341,400</td>
</tr>
<tr>
<td>Medical Radiation practice</td>
<td>307,000</td>
<td>306,000</td>
<td>200,106</td>
<td>2,930,184</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>3,378,903</td>
<td>2,619,000</td>
<td>2,619,000</td>
<td>50,435,800</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>6,600</td>
<td>-</td>
<td>-</td>
<td>2,331,900</td>
</tr>
<tr>
<td>Optometry</td>
<td>297,000</td>
<td>297,000</td>
<td>297,000</td>
<td>789,000</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>198,507</td>
<td>219,000</td>
<td>217,732</td>
<td>281,200</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>530,000</td>
<td>530,000</td>
<td>530,000</td>
<td>7,329,700</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>365,251</td>
<td>365,000</td>
<td>254,300</td>
<td>3,120,100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>174,623</td>
<td>162,000</td>
<td>153,200</td>
<td>802,300</td>
</tr>
<tr>
<td>Psychology</td>
<td>740,000</td>
<td>754,000</td>
<td>753,600</td>
<td>10,419,200</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>8,639,854</td>
<td>8,698,000</td>
<td>9,374,638</td>
<td>125,780,784</td>
</tr>
</tbody>
</table>

* The AHPRA 2015/16 Annual report also notes additional funding of $942,763 for the purposes of prevocational accreditation.

The budget notes in all Health Profession Agreements indicate that “Accreditation expenses include the costs of funding provided to (accreditation entity) for accreditation functions and related projects (Note 4).* The reference to related projects raises the possibility that some of this funding may go to AHPRA or another entity. The Review sought clarification of this from AHPRA who was unable to quantify this but advised:

“The note regarding the accreditation line budgets in the HPA refers to the budget for direct costs for accreditation activities relating to each National Board. This will predominantly be the funding for each accreditation authority, including committees of National Boards and external accreditation authorities. It may include other funding provisions for direct accreditation costs incurred by each Board.”

Funding for AHPRA for the administration of the National Scheme is also noted as an ‘Indirect Expense’ within the Health Profession Agreements. Whilst the accompanying budget notes indicate that the Indirect Expense item includes support provided by AHPRA for accreditation activities, the budget does not specify the percentage of the AHPRA Indirect Expense that is used for this activity. As a result, the total of all Indirect Expenses has been listed, noting that the majority relates to the registration and notification functions of AHPRA on behalf of National Boards.

Information provided directly to the Review by AHPRA indicates that, in undertaking the administration of the National Scheme across the 14 professions, it has taken on an increased role in administering all functions (including accreditation). AHPRA advises:

“Over time the initial resources applied to deliver the core regulatory functions have developed to provide greater capacity for accreditation policy advice along with accreditation operations for those 3 professions with internal committees utilising the services provided directly by AHPRA. As the accreditation policy functions have developed over time they are vested in a range of roles that intersect with accreditation functions including advice to National Boards and also the negotiation and management of accreditation service agreements with external authorities. Within a multi-professional regulatory model the direct cost of services provided to accreditation committees is isolated and directly attributed to the relevant professions, the resources for accreditation policy and advice are more dispersed and form part of the allocated cost pool. This much broader cost pool is attributed to across the National Boards in line with our allocated costing model.”
As illustrated above, the income received by accreditation authorities from their National Boards is different in most cases from the reported expenditure on accreditation incurred by National Boards, which in most cases is again different to the original agreed budget in the Health Professions Agreements. Even when the funding provided to AHPRA for administering the National Scheme (which also includes accreditation activity) is removed, then with the exception of pharmacy, there are variations across all professions when reporting expenditure by National Boards for accreditation functions.

The Review is advised that the AHPRA Indirect Expenses distribution is based on a cost allocation methodology developed by Moore Stephens in 2013 (explored later in this Chapter). However, it is understood that this methodology did not factor in AHPRA accreditation functions. An analysis of 2015/16 Health Profession Agreements suggests that the amounts paid as indirect expenses for AHPRA functions vary from 33% to 91% of a National Board’s total income. This Review acknowledges the need to consolidate revenue to support common functions and understands the importance of this and overall resource flexibility. The intent of this Review in highlighting AHPRA Indirect Expenses is only to illustrate the difficulty in determining the full cost of accreditation within the National Scheme, given that it is more than what is reported as direct income to Councils/Committees or expenditure by National Boards in the Annual Reports and the ALG Costing paper.

Accreditation authority budget processes

The process for determining the funding amount required by Councils and Committees from National Boards is via an annual request based on the work plan of respective accreditation authorities. Information provided by AHPRA directly to the Review indicates that the details are set out in formal agreements:

“Where a National Board has decided that the accreditation functions for the profession it regulates will be undertaken by an external accreditation entity, there is a head agreement between that entity and AHPRA. The terms of the agreement are generally consistent across the professions and reflect the accreditation functions in the National Law. The profession specific elements are set out in a Schedule. The agreement provides for an annual update of Items 1 and 4 of the Schedule, which contain the profession specific workplan and funding detail.”

There are four steps to the AHPRA annual budget process for accreditation authorities:

- Identify funding requirements, accreditation activities, projects and workplan (October – February)
- Consider accreditation funding request and workplan and include proposed funding in Board budget (February - March)
- Prepare draft letter and profession-specific schedule to the agreement (March – May)
- Finalisation of the profession specific schedule.

AHPRA advises that the National Board and AHPRA consider and provide feedback on the accreditation authority’s funding request, accreditation functions and workplan for the upcoming financial year. This occurs through separate meetings or the accreditation authority attending a board or committee meeting to discuss the request. Following the finalisation of contractual agreements, accreditation authorities are required to provide regular reports to AHPRA and National Boards.
The Review undertook an analysis of fees and charges levied across the respective accreditation authorities:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Accred. new program</th>
<th>Re-accred.</th>
<th>Major program change</th>
<th>Annual Fee</th>
<th>Extra site visit</th>
<th>OTP assess</th>
<th>OTP Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander health practice</td>
<td>3,000</td>
<td>-</td>
<td>-</td>
<td>3,000</td>
<td>3,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,000</td>
<td>250</td>
</tr>
<tr>
<td>Chinese medicine</td>
<td>12,000</td>
<td>-</td>
<td>-</td>
<td>4,000</td>
<td>6,000</td>
<td>1,158</td>
<td>-</td>
</tr>
<tr>
<td>Dental</td>
<td>44,000</td>
<td>-</td>
<td>-</td>
<td>19,800</td>
<td>-</td>
<td>7,110</td>
<td>610</td>
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<tr>
<td>Medical</td>
<td>10,000</td>
<td>7,500</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6,790</td>
<td>215</td>
</tr>
<tr>
<td>Medical radiation practice</td>
<td>20,000</td>
<td>-</td>
<td>-</td>
<td>4,000</td>
<td>-</td>
<td>345</td>
<td>-</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>38,100</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5,150</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>6,300</td>
<td>-</td>
<td>-</td>
<td>8,300</td>
<td>6,300</td>
<td>1,200</td>
<td>600</td>
</tr>
<tr>
<td>Optometry</td>
<td>60,000</td>
<td>-</td>
<td>-</td>
<td>8,000</td>
<td>-</td>
<td>7,030</td>
<td>660</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>15,000</td>
<td>10,000</td>
<td>5,000</td>
<td>2,000</td>
<td>-</td>
<td>5,250</td>
<td>1,000</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>30,900</td>
<td>-</td>
<td>7,210</td>
<td>18,450</td>
<td>-</td>
<td>1,190</td>
<td>450</td>
</tr>
<tr>
<td>Podiatry</td>
<td>30,000</td>
<td>30,000</td>
<td>10,000</td>
<td>5,000</td>
<td>670</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Psychology</td>
<td>5,841</td>
<td>6,076</td>
<td>-</td>
<td>5,841</td>
<td>-</td>
<td>700</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
Where a fee is not listed, the Review was unable to find any public information on its existence or rate.
The Australian Dental Council has different annual charges for oral health therapy ($12,100), dental hygiene ($8,250), specialist ($5,500) and prosthetist ($6,600) programs for new oral health therapy ($33,000), dental hygiene ($16,500), specialist ($16,500) programs.

Medical radiation practice fees are based on one program per site. Additional programs at the same site attract higher fees.
The Australian Medical Council requires a deposit of $20,000 from education providers. The OTP assessment charge for doctors above includes establishment of a portfolio, multiple choice questionnaire and clinical exam charges.

The Australian Nursing and Midwifery Accreditation Council charges are for programs over 12 months in length. Charges apply for programs of less than 6 months ($10,600), between 6-12 months ($23,700) and for dual degree programs ($53,600). The Nursing and Midwifery Board charges $300 for OTP assessment for the purposes of registration.

The Osteopathy and Psychology Accreditation Councils also charge application fees for programs of study and providers.
The Australian Pharmacy Council charges different fees for overseas campuses; The OTP assessment fee does not include cost of examination ($3700). The Optometry Council of Australia and New Zealand also charges an application fee of $1,650 to OTPs.
As illustrated, each accreditation authority has a different charging regime and charges different fees for accreditation functions and for the assessment of overseas trained health practitioners. With the exception of the Australasian Osteopathic Accreditation Council (AOAC), accreditation authorities that charge an annual fee do not charge additional fees for reviewing previously accredited programs of study. Whilst most accreditation councils include one site visit within their accreditation fees, the Medical, Psychology and Occupational Therapy Councils charge separately for site visits. The fees and charges do not reflect the full cost of education and training as it does not include charges for national examinations, supervised practice or the accreditation of prevocational and specialist training programs.

The fees charged for accreditation processes to education providers and the quantum of the contribution of registrant fees from National Boards appear to be largely determined by the total estimated costs for each accreditation authority to undertake their program of work as opposed to a robust methodology that starts with an annual estimate of the cost of an efficient and effective accreditation process which can be applied across entities in the National Scheme. This is explored later in this Chapter.

**Internal costs of accreditation to education providers**

The ALG reports that accreditation authorities collected fees of $4.1 million (2013/14) and $3.6 million (2015/16) from education providers – predominantly faculties and schools in Universities. Education providers in turn receive their revenue from established Commonwealth funding clusters, student contribution bands and fees charged to international students.

There is variance in how education providers are charged for the accreditation of their programs. As noted earlier, seven accreditation authorities charge annual fees, thus providing a recurrent funding stream for accreditation councils as well as enabling the providers to spread the cost of accreditation over the cycle. AOAC also charges fees for the reaccreditation of existing courses. The Optometry Council of Australia and New Zealand (OCANZ) in its submission undertook a comparative analysis of 2015/16 costing data with the Australian and New Zealand Podiatry Accreditation Council (ANZPAC) and noted:

“We have different models for accreditation charging:

- a) OCANZ charges providers annually, at $12,300 per annum for accreditation over an eight-year cycle;
- b) ANZPAC charges fees per process - $30,000 for an initial accreditation for a five-year cycle, with a $5-10,000 fee for each follow-up during the cycle;
- c) The annual fees from education providers are $68,000 for OCANZ from 7 providers and $67,000 for ANZPAC from 11 providers.” (p7)

Whilst education providers are charged fees for processes undertaken by accreditation authorities, they also incur additional cost as part of the preparatory work. As noted by Universities Australia in its submission:

“There are administrative cost pressures on both universities and accrediting bodies and administration is seen to be a large part of the cost...... The costs of external accreditation exceed the fees paid to the external accreditation body. Staff are employed within universities to support the preparation of the documentation and to support academic staff in developing the curricula.” (p5)

Universities Australia provided an example of a University which employed three full-time staff to provide administrative and curriculum support for both internal and external accreditation processes and further advised that

“…. course accreditation costs the same irrespective of the number of students who take up the course.....there are double accreditation costs for double degrees even where this seems inappropriate...sometimes two separate course accreditation fees are charged for two courses in the same discipline (for example an undergraduate and postgraduate entry level course) even when accreditation of both courses has occurred during the same site visit.” (p6)
Data provided by universities to the Review indicate that internal costs for accreditation of a single course can range from $70,000 to in excess of $200,000 per course per annum. This includes staff time preparing documentation and organising assessment site visits. The University of Queensland noted:

"The current model of highly centralized accreditation systems is expensive. The focus is on monitoring compliance with a complex and arbitrary set of rules and the burden of reporting against those rules is costly. Example: the fee for the accreditation visit by APAC to a Go8 School of Psychology in 2016 was over $100,000. The indirect costs for staff involved in preparing the application and responding to requests for additional information was over $70,000. (p2)

The reasons for the high costs often seem to relate to the separate (but often duplicative) requirements set by accreditation councils. Chapter 4 examines in detail the efficiency of accreditation processes.

Income derived from other sources

The ALG has identified ‘Other Sources’ in its Costing Paper as:

"...income derived from sources other than National Boards and education providers, such as the assessment of overseas-qualified practitioner fees." (p23)

The Pharmacy and Optometry Councils have provided additional information to explain that income from ‘other sources’ includes revenue generated through examinations, intern accreditation and accreditation of organisations providing Continuing Professional Development (CPD) programs (in the case of pharmacy) or as a result of transition from discontinued courses to new courses (optometry).

Based on an analysis of income and expenditure in the Costing Paper, it is noted that from 2013/14 to 2015/16, with the exception of OCANZ (which incurred losses of $359,256 over the three-year period), the remaining eight accreditation authorities that undertook assessment of overseas trained health practitioners made a profit. Surpluses generated by accreditation councils over the three-year period:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$8,669,312</td>
</tr>
<tr>
<td>Dental</td>
<td>$4,577,897</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>$1,292,745</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$739,694</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$208,400</td>
</tr>
<tr>
<td>Podiatry</td>
<td>$188,515</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>$61,019</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$46,422</td>
</tr>
</tbody>
</table>

Whilst funding from National Boards and onshore education providers is a more stable source of income, income from the assessment of overseas trained health practitioners can vary and is dependent in part on whether the profession remains a priority occupation for the purposes of skilled migration and the overall number of applicants. The Commonwealth Department of Health noted:

"It is in the interest of all stakeholders to ensure organisations are not vulnerable should there be a significant change in demand for certain functions, including in the assessment of overseas professionals." (p4)

The Australian Dental Association similarly cautioned against this approach in its submission:

"Policy decisions beyond the control of the accrediting body could significantly impact this income stream. If onshore programmes become partially dependant on these income streams, their ability to continue to function effectively could be threatened if government policy decisions lead to reduced income." (p7)

NSW Health also argued against cross-subsidisation and over-charging overseas qualified practitioners:

"The fees that are set for assessment of overseas qualified practitioners should be determined by the cost of undertaking these assessments by the education providers and not used to cross subsidise accreditation functions for on-shore programs. ... Charging a fee that is more than the cost of assessment may be perceived as unethical, particularly as there is no guarantee of employment after assessment of the qualifications. Fees should not be set to discourage applicants from applying for assessment of their qualifications but to cover the costs of the assessment process." (p3)
The Health Professions Accreditation Collaborative Forum (HPACF) noted in its submission that:

“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.” (p10)

**Expenditure on accreditation functions**

The Costing Paper prepared by the ALG has identified income and expenditure for all accreditation authorities across accreditation activities. The Costing Paper indicates that over the period 2013/14 to 2015/16, fees charged to domestic education providers not only contributed to the cost of assessing domestic programs of study, but also supported the provision of advice to National Boards (Chinese Medicine and Medical Radiation Practice) and the development of accreditation standards.

National Boards contributed to the full range of accreditation activities except for the Occupational Therapy Board which did not provide funding to its accreditation authority in 2015/16. The Occupational Therapy Council (Australia and New Zealand [OTC]) in its submission stated:

“The OTC made the decision the education providers should pay the full cost of program accreditation, including general administration and operating costs of the OTC. The same principle was adopted in relation to the assessment of overseas-trained practitioners. The OTC does not receive any funding from the National Board for either type of accreditation and has found the removal of an annual request for funding in these areas has contributed to a simpler and more effective relationship with the National Board that is more focused on the real issues concerning accreditation.” (p7)

The Costing Paper provides a detailed presentation and explanation by the accreditation authorities of the current activities, income and expenditure.

### Total income and expenditure

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total income</td>
<td>$40,656,418</td>
<td>$42,307,716</td>
<td>$40,353,706</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>$37,757,262</td>
<td>$36,592,250</td>
<td>$35,366,351</td>
</tr>
<tr>
<td>Total annual surplus/(deficit)</td>
<td>$2,799,157</td>
<td>$5,715,467</td>
<td>$4,987,355</td>
</tr>
</tbody>
</table>

### Accreditation activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation standards developed</td>
<td>85</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Accreditation standards reviewed</td>
<td>7</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>New programs of study accredited</td>
<td>77</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Programs re-accredited</td>
<td>95</td>
<td>140</td>
<td>97</td>
</tr>
<tr>
<td>Programs monitored</td>
<td>414</td>
<td>472</td>
<td>610</td>
</tr>
<tr>
<td>Site visits undertaken</td>
<td>104</td>
<td>169</td>
<td>91</td>
</tr>
<tr>
<td>Overseas authorities assessed</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Overseas qualified health practitioners assessed</td>
<td>13,444</td>
<td>10202</td>
<td>8765</td>
</tr>
</tbody>
</table>
The income and expenditure analysis undertaken by the ALG does not include those functions that have been delegated to specialist medical colleges or prevocational medical councils for the accreditation of medical intern or medical specialist training positions. As noted by the Royal Australasian College of Obstetricians and Gynaecologists in its submission:

“Funding is not provided by the Medical Board to the Specialist Medical Colleges for assessing and accrediting training posts. This is a cost borne by members of RANZCOG.” (p4)

AHMAC commissioned the ‘Accreditation of Hospital Training Posts Project’ in 2012 to reduce the cost and duplication in specialist college accreditation processes. This project was led by NSW Health and identified opportunities to streamline specialist college accreditation processes and reduce assessment costs. Further information on this project is provided in Chapter 8.

AHPRA, advised the Review that funding from the Medical Board to postgraduate medical councils for the period 1 July 2014 – 31 December 2014 was based on individual funding arrangements established by the prior State and Territory Boards. It advised that from 1 January 2015, a new funding model was introduced that applied to all intern training accreditation authorities, however, no further detail was provided on the methodology for this new funding model, so the Review has simply applied it as a rate per intern as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total interns</td>
<td>$986,797.94</td>
<td>$925,369.50</td>
<td>$942,763.80</td>
</tr>
<tr>
<td>Rate per intern</td>
<td>$250</td>
<td>$255</td>
<td>$249</td>
</tr>
</tbody>
</table>

The financial standing of accreditation authorities

The ALG data for 2015/16 indicates that five accreditation councils made an operating loss in the 2015/16 financial year (Nursing and Midwifery, Occupational Therapy, Optometry, Pharmacy and Psychology) and six accreditation councils made profits ranging from $14,000 to $4.86M (Chiropractic, Dental, Medical, Osteopathy, Podiatry and Physiotherapy).

The three Committees had exact alignment of income and expenditure (a consequence of their accounting treatment as being a part of the overall budgets of the respective National Boards). Information provided by AHPRA to the Review confirms that the National Boards cover the difference between income received from education providers for the assessment of programs of study and the expenses incurred, thus resulting in a zero balance at the end of the financial year.

As noted earlier, there is currently no common methodology or framework for accreditation councils on the relative sharing of costs between registrant fees, charges to education providers and fees charged to overseas trained health practitioners or overseas competent authorities. The ALG Costing paper concludes that:

“A large majority of Accreditation Authorities reported net results that showed a break even, or in many cases, a deficit result [with the exception of the Australian Medical Council and Australian Dental Council].” (p22)

Due to the disparity in financial data from the various sources and the lack of accrual information on the use of unexpended funds or the level of outstanding liabilities or on how cash losses were managed in any given year, the Review is reluctant to conclude whether operating expenses for National Scheme accreditation functions exceed or fall short of income received, but does note the high dependency of Councils on National Boards directing part of registration fees to them.

The Costing Paper indicates that the management of accreditation seems to be often based on cross subsidisation within the functions of a Council, whereby surpluses made from one activity fund other activities. The Costing Paper indicates that the Council on Chiropractic Education Australia utilised income from ‘other sources’ for the development of accreditation standards and assessment of programs of study and education
providers. The ANZPAC used funding from ‘other sources’ for its accreditation of programs of study and education providers. In some cases, the deficits are being offset by income received from functions undertaken outside the National Scheme. The Australian Nursing and Midwifery Accreditation Council (ANMAC) 2015/16 annual report (p57) indicates that the deficits incurred from accreditation functions was offset by activities such as the skilled migration assessment services provided by the Council.

These figures indicate varying levels of surpluses and deficits across respective activities. Caution should be exercised, however, in reaching any particular conclusion on this, as many councils advised that they do not normally record expenditure in the manner presented in the Costing Paper.

The processes for 12 monthly budgets negotiated between accreditation councils and National Boards appear to be treated as stand-alone negotiations and do not contain information on the outcome of previous budgets, costing methodology. The budgets are silent on how previous surpluses and deficits should be treated. Each accreditation authority is largely left to its own devices to deal with its surpluses and deficits.

An analysis of publicly available annual and director’s reports show that all councils have accrued equity. Whilst accruing and investing income received for performing National Scheme functions over a number of years can be considered appropriate to smooth annual variability in income and expenditure, there does not appear to be a consistent approach on necessary equity levels or the use of such equity as part of annual funding agreements. Given this equity has been largely accrued in the performance of the functions under the National Law, it is considered this should be systematically addressed in a consistent manner.

How are fees and charges determined?

National Boards provide funding to AHPRA for administration functions based on a cost allocation methodology. It was reviewed by Moore Stephens in 2013 which included a three-month timesheet data capture exercise across sections of the AHPRA workforce by profession. It did not include, however, any accreditation functions. At the time, Moore Stephens indicated that:

“We presented AHPRA with an alternate methodology to the one in use since inception, at the time, however we also indicated that due to the infancy of the National Scheme, there were weaknesses in the quality and quantity of AHPRA’s costing data that limited the effectiveness of the adoption of a best practice methodology until such data were accumulated and tested over time. The impact of the addition of 4 new professions from 1 July 2012 also added to the complexity of establishing an appropriate cost model.” (p2)

Moore Stephens further recommended that:

“…. management continue to accumulate data that were reliable and meaningful, enabling AHPRA to implement a cost allocation methodology that would withstand both internal and external scrutiny.” (p2)

Allocation of funding by National Boards to accreditation authorities is based on a combination of previous years’ contributions and the work program of the given year. Information provided by AHPRA directly to the Review indicates that National Boards have different approaches to determining the proportion of registrant fees that is allocated towards accreditation functions. Some National Boards allocate an amount per registrant, whilst others base funding on historical contribution levels. Moreover, as noted earlier, the Occupational Therapy Board does not provide any funding to its accreditation authority.

In terms of the global National Scheme budget process AHPRA has advised that:

“AHPRA and the National Boards follow a hybrid model for budgeting their income and expenses along with the resultant equity position every year. The budgeting process is based on reviewing their historical spend and expected spend by each line and category for the budgeting period. The costs are then allocated to the various lines in their budget Income and Expense statement. This is agreed on an annual basis between Boards and AHPRA within the multi-year Health Profession Agreement Framework in line with five year forward projections being considered to support fee setting and expenditure strategies.”
Whilst overall accreditation costs must therefore be built into any consideration of changes to registrant fees, the Review has not been provided with information as to how that exactly occurs or its relationship to the annual budget submissions made by accreditation councils. In addition, the joint National Boards/AHPRA submission advised that Consumer Price Index (CPI) provides guidance in setting of annual registration fees:

“We have an agreed policy that any requirement to increase the cost of registration fees above the forecast CPI band in a year requires advice to Ministers in the form of a business case. There is currently a similar position taken by AHPRA to our service agreements with Councils for accreditation fees in that proposed increases above the CPI band require agreement from the Board and AHPRA.” (p6)

While the Review notes that a CPI heuristic is widely used in budgeting processes, it has three major limitations in that it assumes:

- The original base level of accreditation fees was set on robust cost recovery principles and they represented the cost of services which were efficiently and effectively delivered.
- Cost components (wages, other operating costs, capital charges) all move in line with CPI.
- There have been no efficiencies achieved in delivering the accreditation functions.

The Australian Psychology Accreditation Council (APAC) was one to point out some of these deficiencies:

“We note that AHPRA’s response to the Snowball Review’s concern about pricing was to add a new term to our most recent Annual Funding Agreement, that fees charged to providers could not increase by more than CPI. Setting aside the implications of the Agreement making requirements relating to Councils’ commercial arrangements with third parties, this edict unfairly disadvantaged those Councils, like APAC, whose fees have historically been quite low. The fees we currently charge providers do not cover the direct costs of site visits and administrative costs, and we are currently using reserves to cover the considerable cost of developing new standards.” (p15)

In terms of the methodology used by accreditation authorities to calculate fees and charges, the ALG noted in its Costing paper that:

“Other than the objectives and guiding principles of the National Law, there are not as yet more specific agreed funding principles for accreditation. National Boards have commenced working on funding principles and will consult on these in the next few months.” (p38)

The HPACF also noted the intention to develop funding principles in its submission:

“Because accreditation lies at the boundary of regulation and service, accreditation authorities do not attempt to fully recover accreditation costs from education providers….A degree of pricing flexibility is desirable, given the different configurations and scales of accredited professions. …..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.” (p9)

In addition, AHPRA has advised that it has recently commissioned Deloitte Access Economics to undertake an update of the Moore Stephens’s cost allocation methodology. The Review has not been provided with the Terms of Reference for this work, however, AHPRA has advised the following:

“The outcomes of the Activity-Based Costing project are not expected to change the budgeting methodology. The work is being undertaken to understand the current costs incurred by AHPRA to perform all the regulatory functions including accreditation. The analysis of AHPRA’s cost base will be done based on the various activities performed by function and profession and also at a jurisdiction level and then nationally.”

As part of the public consultation process, the Review sought stakeholder views on the key principles for setting fees and charges for accreditation functions, including how the respective shares of income provided from registrants and education providers should be determined. The Review received limited responses, but where stakeholders expressed a view, they noted the lack of consistent funding principles.
Universities Australia in its submission called for more transparent principles in setting out what the accreditation costs cover:

“Many universities recognise that accreditation staff work solidly when undertaking the accreditation process however more transparency in what costs cover would be welcomed. While UA members also recognise that accreditation councils need to run as businesses, they are not-for-profit and prices should reflect this.” (p5)

Curtin University advised:

“Key principles related to funding that should apply across the NRAS scheme are transparency and consistency in how accreditation costs are derived. Curtin supports the articulation of a consistent, clear, publicly stated philosophy or set of principles that relate to funding of activities of accreditation authorities. Remuneration of Accreditors should be standardised across all professions.” (p3)

This was supported by the Faculty of Nursing, Medicine and Health Science, Flinders University which stated:

“Key principles for consideration include consistency and equity across health professional programs, and accreditation services should be not-for-profit and cost neutral. The Faculty supports a transparent, fair, and reasonable approach to fee setting for this service. Given their role as a public good, all accreditation services, be they for education programs or overseas qualifications, should be not-for-profit and cost neutral.” (p2)

TAFE NSW suggested that fees and charges should reflect the “level of risk of the provider based on evidence of compliance with standards.” (p2) It further noted that, as funding received for training by the Government was designed to support the delivery of education programs, it did not fully cover the costs associated with accreditation and monitoring, and as a result these costs can be transferred to students as increased fees.

Whilst the National Law has set high level guiding principles with regards to efficiency, transparency and accountability, these have not translated into specific business rules or frameworks to guide National Boards or accreditation authorities in the setting of fees and levies or into consistent reporting templates across the various National Scheme publications. The Review concludes from the submissions made by AHPRA, National Boards and accreditation authorities that, beyond using the cost allocation methodology (for the allocation of National Board funds to AHPRA for the administration of the National Scheme) and CPI as a constraint to fee increases, the National Scheme does not yet have a published set of funding principles to guide the setting of fees and levies for accreditation functions.

Who should fund accreditation?

The Review is not confident it can determine the full cost of all accreditation activities due to the variances in the recording and reporting of income and expenditure across accreditation authorities and National Boards and unknown AHPRA expenditure highlighted earlier. Key risks are:

- The costing data provided by the ALG indicates than in 2015/16, approximately 66% of total accreditation authority income was from ‘other sources’ such as overseas trained practitioners (noting, however, this is skewed by substantial income received in this category for the AMC, ADC, Australian Pharmacy Council (APC) and Australian Physiotherapy Council (APhysioC) relative to their core accreditation income). As highlighted earlier, reliance on that income source increases the vulnerability of accreditation authorities in the event of a change in national skilled migration policy.

- Accreditation councils that charge an annual fee are able to spread the cost of accreditation over the cycle (as well as providing a recurrent funding stream). However, other authorities are vulnerable to volatility of periodic accreditation cycles which may result in significant activity and income in one financial year and none in the following.
On the principle of the user (beneficiary) pays, accreditation system beneficiaries are:

- **Education providers** delivering the programs of study, by attracting income from students wanting to achieve registration as a health practitioner and from the Commonwealth for supported student places.

- **Students** by being able to undertake accredited programs of study which can lead to employment. Students, in most circumstances, then become **registered practitioners** obtaining benefit through the protection of the reputation (and monopoly in some circumstances) of the profession.

- **Health consumers** by receiving health services from well-educated and trained health practitioners and taxpayers from the public good derived from a healthy and well-educated community.

The HPACF supported a user pays approach:

“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.” (p9)

The Review has explored how costs could be allocated across the beneficiaries of the system. Consumers already fund over 30% of healthcare costs through out-of-pocket expenses and private health premiums. Taxpayers directly fund 68% of healthcare costs and contribute significantly to education costs. Similarly, students also contribute through their fees to education providers.

The accreditation system provides a quality assurance process which enables education providers to charge fees for programs of study and for registrants to be maintain the standing of their profession and reflect this in the fees they charge consumers. Education providers and registrants derive a significant direct benefit from the accreditation process, in that it impacts on their ability to generate their own income. Given this, the Review concludes that the accreditation system should continue to be funded through fees and levies charged to education providers and registrants.

The Review acknowledges that a University’s ability to generate income from the delivery of programs of study is dependent on the number of students enrolled in the program. Respective programs of study also fall with different **Commonwealth funding clusters and student contribution bands**, contributing to differences in income for education providers based on the programs of study they deliver. The ability for a university to boost its income from education programs is also influenced by its capacity to attract international students. This is highly dependent on the opportunity for those students to be subsequently registered and either pursue employment opportunities in Australia or have those qualifications recognised in other jurisdictions.

Current funding allocations by National Boards and the fees charged by accreditation authorities are based on a combination of historical funding allocations, budget bids and CPI increases. There is no agreed allocation methodology or formula to guide what proportion of accreditation costs should be met by the education provider and what proportion by the registrant (through registration fees).

The Review considers that current costs of accreditation should reduce as a result of the recommendations in this Report. Given this, an allocation methodology can then be developed and to guide setting fees and charges, and National Boards in the allocation of registrant fees for the purposes of accreditation. This allocation methodology should seek to identify the funding pool for accreditation - this includes taking into account funding provided by National Boards, fees paid by education providers, surpluses generated in the exercise of accreditation and assessment functions and deficits incurred (including the use of investment or equity income by accreditation authorities to offset such deficits).

**A new approach to funding accreditation**

Section 210 of the National Law guides when and for which purposes payments can be made from the Agency (AHPRA) Fund. Section 210(3) states that payments “may be made from a National Board’s account kept within the Agency Fund only if the payment is in accordance with the Board’s budget or otherwise approved by the Board.” As noted earlier, AHPRA is required to maintain separate profession (National Board) accounts within
the National Scheme and, as stated in s210(3), individual National Boards must approve the quantum of their registrant fees that are to be used for accreditation or other operations.

The current funding process is administratively cumbersome. Whilst the National Scheme has been established as a single scheme, administered by a single national agency, the financial rules and processes have not been consolidated and remain based on separate annual negotiations with 14 National Boards. Some improvement can be expected with multiyear Health Profession Agreements, commencing from 2017 providing greater financial certainty and streamlined administrative processes. It should be possible to extend this approach to accreditation functions, given that they follow periodic assessment cycles which are planned in advance. This provides a stable work program where deviation would be primarily a result of a policy change or new projects, which would need to be negotiated with National Boards.

The ALG in its Costing Paper argues for a stable funding model for accreditation authorities:

"Proper governance of Accreditation Authorities requires that funding sources and expenditure be managed so as to provide appropriate reserves for future infrastructure and development, and security against funding shortfalls due to one-off and/or unforeseen circumstances. It is also necessary for the Accreditation Authorities to cost the quality improvement of their processes as a margin on fees." (p22)

The periodic nature of accreditation standard development and review and assessment of programs of study necessarily results in variations to annual income and expenditure. One means of stabilising budgets, as already introduced by some accreditation authorities, is to establish an annual fee framework. This approach not only provides a stable source of income to an accreditation authority but also enables education providers to amortise expenses over the life of the accreditation cycle.

There will be variance across accreditation authorities in fees charged to education providers and income sourced from National Boards. However, these differences should be transparent and be based on factors such as the complexity of the education program or accreditation process, length of the course and additional infrastructure requirements.

A uniqueness of the National Scheme is that it is bound by eight sets of state and territory legislation. Whist an adoption of laws mechanism following the enactment of the National Law by the Parliament of Queensland was used by the majority of states and territories; each respective version of the National Law reigns supreme in each jurisdiction. However, beyond the National Law, other state or territory legislation does not apply (or has been specifically disapplied) to the National Scheme. As a result, the National Scheme is not subject to any business rules that may apply to other government entities within that state/territory.

This is evident in the lack of agreed principles for the accreditation functions covering matters such as whether fees are to be set on a cost recovery basis; whether a profit margin should be considered; what is considered a reasonable profit (or surplus) margin; how deficits are dealt with; assessments of the efficiency and effectiveness of administrative processes and so on. Whilst the AManC has established a Finance, Audit and Risk Management Committee (FARMC), its Terms of Reference focus on financial strategy, risk management and audit for AHPRA and National Boards only. Moreover, the FARMC Investment Policy and its Internal Audit Terms of Reference do not contain information on cost recovery principles when setting fees and charges.

The Commonwealth, states and territories have guidance documents to direct statutory authorities/government entities in setting fees and charges. This guidance largely aligns fees and levies in accordance with cost recovery principles whilst enabling ‘over recovery’ (surpluses) to cover overheads or to manage financial variability in income/expenditure.

The Commonwealth’s charging framework

The Review has considered instruments and policies available to Commonwealth, state and territory entities to set fees and charges. It is of the view that the most relevant policy framework that applies to this national role is the Australian Government Charging Framework (‘the Framework’).
The Framework states that "the cost recovery policy promotes consistent, transparent and accountable charging for government activities and supports the proper use of public resources." (p5) It is designed to enable a common and consistent approach to planning, implementing and reviewing government charging. The key principles of this Framework (p9) are:

**Transparency** – making available key information about the activity, such as the authority to charge, charging rates, and where relevant, the basis of the charges.

**Efficiency** – delivering activities at least cost, while achieving the policy objectives and meeting the legislative requirements.

**Performance** – which relates to effectiveness, risk mitigation, sustainability and responsiveness. Engagement with stakeholders is a key element of managing and achieving performance. Entities must regularly review and evaluate charges in consultation with stakeholders to assess their impact and whether they are contributing to government outcomes.

**Equity** – where specific demand for an activity is created by identifiable individuals or groups, who should then be charged for it, unless the government has decided to fund that activity on grounds of broader public interest. Equity is also achieved through the government’s social safety net, to ensure that vulnerable citizens are not further disadvantaged through the imposition of a charge.

**Simplicity** – whereby charges should be straightforward, practical, easy to understand and easy to collect.

**Policy consistency** – charges must be consistent with government priorities and policies, including entity purpose and outcomes. Government agreement may be required for the introduction of new charges and/or changes to charges.

The Framework includes additional guidance through the Australian Government Cost Recovery Guidelines to assist entities in setting fees and charges to enable cost recovery. The Guidelines are based on cost recovery principles which include a requirement for efficiency and effectiveness which is defined as:

"Efficiency and effectiveness in government involve making the proper use of available resources (people, money and other supplies) to achieve government policy outcomes. Government activities should meet quantity, quality and other targets, be undertaken at minimum cost, and be conducted in accordance with applicable policy and legislative requirements." (p10)

The cost recovery process includes the development of a Cost Recovery Implementation Statement (CRIS). The CRIS is comparable to Regulatory Impact Statement (RIS) requirements, and is designed to ensure best practice in the setting of fees and charges by entities which have a monopoly function assigned through legislation. The development of the CRIS is guided by the Framework and the Cost Recovery Guidelines which include guidance on processes to be followed such as developing a policy case, policy proposals, stakeholder consultation, and further guidance on the timing, governance, staffing and procurement aspects of budgeting. Education regulators are required to comply with the Australian Government Cost Recovery Guidelines when setting fees and charges. CRIS’s for the Tertiary Education Quality Standards Agency and the Australian Skills Quality Authority are publicly available on their websites.

**Funding Principles**

Accreditation authorities have been granted monopoly functions covered under statute by National Boards. This Review considers that accreditation authorities should thus be required to align business and accounting practices for the performance of those functions to what is expected from government entities across Australia. Whilst most accreditation authorities are established as private companies, the performance of their accreditation functions should be subject to the level of transparency and accountability expected from any other public entity. The Queensland Government Performance Management Framework describes this as the:

"public defensibility test where activities and decisions are open to reasonable scrutiny and can withstand a public defensibility test in the context of fairness, equity and value for money." (p4)
Funding principles would need to be developed, which should include the fair and transparent assignment of accreditation costs across registrants and education providers. Accreditation authorities should be required to prepare a CRIS which sets out the reasons for the level of the fees charged to education providers for programs of study. Assessment of overseas trained health practitioners and competent authorities should also be funded through a cost recovery approach and include a CRIS. Where National Boards request authorities to undertake additional projects, these should also be fully funded.

The joint National Boards/AHPRA submission stated:

“A starting point would be to consider the application of established funding principles from other sectors, modified as relevant to the National Scheme and accreditation context. This may provide more guidance about how the respective share of income provided from registrants and education providers should be determined.” (p6)

The Review supports the views of National Boards/AHPRA, and notes that:

- The national accreditation fee structures of TEQSA (as a point of comparison) are under review.
- Acceptance and implementation of some of the recommendations in this Review should result in a reduction in overall costs by reducing the high levels of duplication.
- Critical to the development of funding principles will be increased transparency in the setting of fees, charges and the reporting of financial information.

The Review concludes that the development of funding principles is critical to ensuring the cost effectiveness of the accreditation system. It is important to establish in these principles that the funding of accreditation functions is not restricted to the conduct of assessments and monitoring of programs of study and overseas trained practitioners. Accreditation authorities have a critical role in the quality assurance of the National Scheme through the development of accreditation policy and standards. In addition, there is now and will continue to be the need to develop and advance broader cross professional policy and actions in the design and accreditation of programs of study that will contribute to the evolving health care systems.

These funding principles should include a cost recovery methodology for all accreditation functions that:

- Establishes the full cost of accreditation functions (including the development of standards, policy advice, joint cross professional accreditation activities, accreditation and assessment functions).
- Provides guidance on prudent limits on over recovery (surpluses) and under recovery (deficits) including the use of equity and other investment income.
- Establishes an annual fee structure to cover the cost of ongoing monitoring and reporting and seek to amortise expenses over the life of the accreditation cycle.
- Includes a cost allocation methodology to guide the allocation of costs to education providers and registrants (through National Boards).

The principles should also establish consistent (accrual) accounting methodology and business principles to enable comparison across professions. This methodology should also establish a consistent approach across all accreditation authorities to the reporting of surpluses and deficits in financial reports and budget bids. Development of a CRIS when setting (or reviewing) fees, levies and charges for all accreditation activities, subject to oversight and approval by the authority should also be mandatory. The funding principles should be subject to wide stakeholder consultation, be approved by the Ministerial Council and form the basis of funding agreements.

Accountability and transparency

As noted earlier, a distinct feature of the National Law is that it is established as eight pieces of state and territory legislation. Whilst the National Law has applied relevant Commonwealth legislation (such as the Commonwealth Ombudsman Act 1976, Commonwealth Privacy Act 1988 and Commonwealth Freedom of Information Act 1982) to the National Scheme, it has established reporting requirements (including financial reporting) within the National Law itself (Schedule 3, Part 3). As highlighted earlier, entities operating within
the National Law are only required to comply with reporting requirements as stated in the National Law. This distinguishes the National Scheme entities from most other statutory entities, in that they are not subject to financial scrutiny by respective state, territory or Commonwealth Departments of Treasury and Finance.

Financial reporting

There are inconsistencies in the reporting of financial information which further reinforce the lack of transparency within the National Scheme. The lack of a common funding and accounting framework may explain some of the anomalies in the reporting of financial information.

There are differences in the amounts noted as income from National Boards in the ALG paper, annual reports and health profession agreements for medicine, optometry, osteopathy, physiotherapy, podiatry and psychology. Whilst some of these differences could be explained as budgeted amounts as opposed to actual expenditure, the reasons for other variances are not clear. The APhysioC noted that numbers quoted in the ALG paper were different to their audited financial statements as income from interest and skills assessment, capitalised project costs and provisions for doubtful debts were not included in the ALG costing (p75). OCANZ has advised that deficits incurred in 2014/15 and 2015/16 were ‘planned deficits’ (p66). The ALG Costing paper also notes the variance in the financial figures presented in the paper and annual reports and attributes these to “accounting methodology, amortised funding, variances in the definition of accreditation and other reasons which are determined by the accreditation authority but not revealed.” (p20)

Variations in financial figures were also noted when reporting deficits. For example, ANMAC indicates a loss of $653,755 for 2015/16 in the ALG paper (p59) and shows a loss of $252,479 in its Annual Report (p57). The Review further notes that annual reports are not always publicly available for some accreditation councils. The AHPRA Annual Report documents National Board expenditure for accreditation functions for all professions including Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine and Medical Radiation Practice. However, the AHPRA Annual Report does not provide detail on how National Board allocated funds to the three accreditation committees is utilised.

There is also no consolidated reporting across all National Scheme entities for the delivery of National Law accreditation functions. This inhibits public scrutiny of operations under the National Law as a whole. At present, to access information on accreditation functions, stakeholders are required to access the website of each separate accreditation authority. Accreditation authority reports to National Boards are not publicly available and there is no cross comparison of accreditation activity across the National Scheme. The Costing Paper produced by the ALG, however, is a welcome first step.

The AHPRA Annual Report could be better structured to present a comprehensive report on the entire National Scheme. It should also contain detailed information on the accreditation functions undertaken within the National Scheme. This should include a breakdown of registrant fees spent on accreditation functions as well as the income and expenditure of accreditation authorities in the exercise of accreditation functions. The template developed by the ALG for the Costing Paper serves as a useful guide on how this information could be presented to enable comparison across professions.

Performance monitoring

The guiding principles of the National Scheme emphasise transparency, accountability, efficiency and effectiveness for all entities operating within it. The AHWMC has the power to issue policy directives in relation to functions under the National Law. However, to date, no directions have been issued on issues such as governance, performance and accountability. Public scrutiny of the performance and administrative functions of the National Scheme, which includes accreditation functions, has primarily occurred in the form of this Review, the 2014 NRAS Review (both initiated by the COAG Health Council) and inquiries instigated by respective state and Commonwealth parliaments into aspects of the National Scheme. Whilst these reviews may have been a necessary feature due to the infancy of the National Scheme, they are not best practice for the purposes of enabling continuous improvements of performance and cost effectiveness.
The inability to access comprehensive financial information on income and expenditure by respective accreditation authorities via annual reports or Board papers contributes to the lack of transparency within the accreditation system. Whilst the National Law (Schedule 3, Part 8(4)) provides for an independent audit of the AHPRA and National Board financial statements by a public-sector auditor, this does not extend to assurance about administration and accountability. This contrasts with the expectations of public auditors nationally, for example the Australian National Audit Office (ANAO) audits the financial statements of Commonwealth Government entities and also undertakes “performance audit activity assessing efficiency and administrative effectiveness across all sectors of government.”

Similarly the Victorian Government Auditor General (which is currently the public sector auditor for AHPRA) is also empowered as part of its audit responsibilities to “examine the management of resources within the public sector including conducting financial and performance audit.” The Victorian Auditor General defines a performance audit as an “evaluation of whether an organisation or government program is performing effectively, economically and efficiently, and in compliance with all relevant legislation. Performance audits extend beyond the examination of the financial affairs and transactions to encompass wider management issues of significance to the community.”

In terms of internal audits, AHPRA has advised:

“The internal audit conducted by AHPRA provides independent and objective assurance to the Finance, Audit and Risk Management Committee (FARMC) and other levels of management, that AHPRA’s control environment is operating in an economical, efficient and effective manner; is compliant with relevant legislation and regulations; and that significant risks are being managed through sound control measures.

In meeting these objectives, internal audit assists AHPRA to accomplish its objectives by bringing a disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes across the organisation.”

Whilst broader audit powers are accorded to public auditors for public entities within their legislative scope, the construction of the National Law does not provide this capacity. Similarly, accreditation authorities as private companies are not subject to independent scrutiny beyond their audited financial statements. External performance auditing across the National Scheme is beyond the scope of this Review, however, it is a matter worthwhile of further consideration in the broader exploration of governance issues.

**Draft Recommendations**

1. Funding principles should be developed to guide accreditation authorities in their setting of fees and charges. The funding principles should provide guidance on:
   - Development of a cost recovery policy and methodology for all accreditation functions.
   - Common adoption of consistent accrual accounting and business principles.
   The funding principles should be submitted to the Australian Health Workforce Ministerial Council for approval.

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

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

This Chapter explores the efficiency of current accreditation processes, including development of the accreditation standards and execution of the assessment process, evaluates options to streamline those processes and minimise duplication, and recommends a number of reforms.

The National Law requires that the National Scheme operates “...in a transparent, accountable, efficient, effective and fair way.” As stated in s4, this guiding principle applies to entities that have functions under the National Law including National Boards, the AHPRA and accreditation authorities.

As noted in Chapter 3, an efficient accreditation system is determined by how well it translates inputs into beneficial outputs. It is not just about reducing expenditure but also providing high-quality, fit-for-purpose processes which avoid unnecessary complexity, repetition and duplication and increase transparency and accountability. Overall system effectiveness is assessed on its ability to produce outputs which meet intended outcomes. For the accreditation system this means the high-quality education and training of health practitioners, that is future focussed and responsive to the evolving health and care needs of the community.

Efficiency of the current accreditation system

A transparent, accountable, efficient, effective and fair approach to accreditation, as required by the National Law, ensures multiple benefits for the system, including:

- A reduced regulatory burden with a focus on continuous improvement in both operations and overall system performance.
- Best use of expertise and appropriate allocation of accountability and responsibility.
- Greater alignment of administrative processes across professions and with other regulators and less duplication and repetition.
- Creation of economies of scale through sharing of knowledge, data, information and resources.

However, feedback and analysis of accreditation authority processes reveals multiple inefficiencies through duplication of standards, resources and templates, inconsistent terminology and requirements, and multiple parties collecting similar (or even the same) information without accountable oversight or integration. For education providers which teach multiple disciplines, including both registered and non-registered professions, the numerous regulatory entities and varying requirements create a significant unnecessary workload as demonstrated in case studies (Box 4.1). In some situations, education providers are employing staff to specifically manage health professional accreditation, in addition to their responsibilities under the TEQSA Act 2011, which absorbs significant time, costs and management attention.

<table>
<thead>
<tr>
<th>Box 4.1 Case studies – System inefficiencies</th>
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<tr>
<td><strong>Australian Council of Deans of Health Sciences (p5-6)</strong></td>
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<tr>
<td>“In the Faculty of Health and Medicine at University A, there are 12 accredited health professions, with a further four health professions at the university, but outside the Faculty.</td>
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<td>Each health discipline and the School in which it is located takes the bulk of the responsibility for the accreditation of their degree. This means there is little sharing of information when addressing the accreditation standards. Where information is shared, each accreditation body requires that the same information be presented in a different format, so the opportunity to share information in a meaningful and straightforward manner is lost. Some of the information required is discipline specific but much of the</td>
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Box 4.1 Case studies – System inefficiencies

Information required is institution-specific, therefore greater consistency and commonality in the development and application of the standards would allow a more institution-wide approach to completing the required documentation. This will save money and time. It will also encourage the sharing of information and information-collection tools between accreditation bodies which should result in the development of a sensible template for entering information rather than the variety of templates used currently by accrediting bodies, some of which are poorly designed and almost impossible to complete.”

Edith Cowan University (p5)

“To provide some context, in one year from March 2016 to March 2017, ECU submitted accreditation documentation (new or renewal applications and/or annual reports) to 12 different health and health-related accreditation authorities in Australia. Each of these submissions required similar information, with supporting evidence, on operational matters including university governance; academic policies and processes; quality assurance regimes; financial probity; staffing resources and professional development; student support facilities and resources; occupational safety and health, risk and insurance policies and processes; adequate physical infrastructure and teaching spaces; and IT facilities and support. Additionally, many of these operational matters are reflected in the Higher Education Threshold Standards which universities are required to comply with to retain their self-accrediting status.”

The Higher Education Standards Panel (HESP), an advisory body established under the TEQSA Act 2011, is separately examining issues of accreditation efficiency and opportunities to reduce the regulatory burden for higher education providers. To inform this work, the Commonwealth Department of Education and Training commissioned PhillipsKPA to examine the scope of professional course accreditation practices. Whilst its scope was broader than health professional accreditation, one of the key issues highlighted was that:

“...the aggregate effect of coping with idiosyncratic and excessive or unreasonable demands for information and compliance from some accrediting agencies is significant, expensive and problematic.

Specific problems that were commonly cited by providers include the regulatory and financial burden, the wide variation in format and type of information required, inappropriate intervention in institutional autonomy, lack of transparency and due process and poorly prepared accreditation panels.” (p7)

Better alignment across the health professions has the potential to streamline operations, generate efficiencies and create opportunities for greater collaboration and system responsiveness. Whilst recognising the importance of retaining profession-specific attributes, there are opportunities for reducing unnecessary duplication across the accreditation process, through standards development, assessment procedures, panel preparedness, education provider reporting and ongoing monitoring.

Accreditation standards

An accreditation standard, as defined in the National Law (s5), is:

“a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.”

Accreditation standards are generally reviewed every three to five years and can take up to 24 months to complete, and include detailed consultation, alignment with COAG processes and National Board approval. Currently all health professional accreditation standards are at different points within their review cycles and, as such, it is likely that there is more than one review of accreditation standards occurring at any one time.

To provide direction for the process of standards development, AHPRA has created guidance resources for accreditation authorities including the Procedures for the development of accreditation standards which describes the requirements for consistency across procedural elements and best-practice processes. The Procedures reiterate s46(2) of the National Law noting that “in developing an accreditation standard for a
health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.” In addition, the Procedures note that development must take into account the COAG Principles for Best Practice Regulation and consideration of international standards and statements.

Neither the National Law nor the AHPRA documentation provides guidance regarding the structure of an accreditation standard. As such, each of the 14 accreditation authorities independently coordinate, develop and configure their own standards. Whilst increased uniformity has occurred since the establishment of the National Scheme, many of the existing standards vary in structure, content and terminology.

A high-level mapping exercise was completed by the Review to identify the similarities and differences across health and education standards. It included examination of the health profession accreditation standards, education provider standards and the National Safety and Quality Health Service (NSQHS) Standards (primarily in the context of health program curriculum development). Analysis of the high-level domains and their underpinning criteria/elements was undertaken from two different perspectives:

- Comparison across health professions and education standards to identify themes of commonality and consistency. The mapping table is available in Appendix 5.
- Comparison between the Australian Dental Council accreditation standards (as an example) and the higher education Threshold Standards to identify areas of overlap and duplication. Some examples are listed below and also provided in Appendix 6.

Examination of all of the professional entry standards for the registered health professions, identified common themes into which their domains and elements could be categorised. The seven common themes are outlined below, and comprise two broad categories: academic (institutional) and professional. A similar two-category approach has been adopted by Professions Australia and Universities Australia in their Joint Statement of Principles for Professional Accreditation.

**Academic (institutional)**

- **Corporate Governance**: Requirements for an education provider to operate as a viable, responsible and financially sustainable entity, with policies and procedures relating to corporate governance, monitoring, accountability and information management.
- **Academic governance and quality assurance**: Requirements for policies and procedures to ensure academic integrity, research quality and robust educational philosophies that inform high-quality course development, design, monitoring, quality improvement and risk management for a program of study.
- **Student experience**: Appropriate policies and procedures that relate to the student experience whilst at the educational institution. Includes consideration of diversity and equity, wellbeing and safety, fitness-to-practice, student grievances and complaints and feedback processes. Requirements for clear program information for students including clear references to admissions information, credit and recognition of prior learning, orientation and progression and information for prospective/current students.
- **Student assessment**: Methods of assessment are comprehensive, fair, valid and reliable. There is a robust relationship between learning outcomes and assessment strategies.

**Professional**

- **Program design and curriculum development**: Program design ensures learning outcomes align with the professional competency standards. Includes requirements for interaction with students, the health sector and society, and to ensure external entities are engaged to inform program design and content.
- **Learning resources**: Requirements for appropriate learning resources including physical facilities and infrastructure and qualified staffing to deliver the program of study.
- **Clinical experience**: Requirements at the work experience location, including quality and safety polices and processes, informed patient consent procedures and suitable work-based/clinical learning facilities. Also specifies requirements to achieve the learning outcomes and to develop student competence to practise, appropriate duration/quantity of placements and a supportive learning environment.
From this analysis, there are a number of key observations:

- Domains from all standards can be allocated to these two categories and seven themes, thus confirming that accreditation for each profession is examining elements that are common.
- Any one domain from individual health profession accreditation standards can be quite broad and contain a mixture of academic and professional accreditation. This resulted in the same domain being mapped to more than one theme which indicates the need for greater specificity and clarification.
- Terminology for the same concept varies widely across health professions (i.e. program of study, program attributes, the curriculum, course content, curriculum content and sequencing, etc.).
- Corporate governance, Academic governance and quality assurance, and Student experience themes typically reference institutional-requirements which are not directly linked to learning outcomes.
- The Program design and curriculum development, Learning Resources and Clinical experience themes contain references to profession-specific learning outcomes, competencies and requirements. Differences were most evident in relation to program/curriculum content and education practices, with varying references to the use of simulation, supervision requirements, hours of clinical placements and inter-professional practice.
- Student assessment themes have profession-specific aspects such as references that “appropriately qualified staff assess students.” However, these components are commonly related to the assessment of professional and technical competence which could be classified into the clinical experience category.

Although the HPACF and AHPRA have both previously mapped the accreditation standards for inter-professional comparison, these are not publicly available. It is understood that the AHPRA exercise was to explore common focus areas, inform the development of a template for accreditation committee standards and create a general reference and resource for other work. From the consultations and submissions, it is also evident that more than one profession has completed a mapping exercise to compare their accreditation standards to other professions or authorities.

Opportunities for creating common standards

The lack of commonality and consistency across accreditation standards is contributing to the resource-intensive nature of assessment and reporting processes, thus resulting in significant administrative burden for education providers. It may also be undermining broader system-level opportunities to consider integrated patient centred care education models which link health, community and social services.

Many of the submissions, particularly from education providers, agreed with the benefits of increased consistency across accreditation standards, whilst others highlighted potential risks. A sample of benefits and risks identified in submissions is listed below.

**Benefits**

- Consistency and enhanced certainty of what is required of institutions and accreditation panels (Division of Tropical Health and Medicine, James Cook University, p16)
- Consistent language creating clearer expectations for education providers (Occupational Therapy Council, p9)
- Increased efficiency where similar sets of information would only need to be provided once to a single agency (e.g. AHPRA) (Division of Tropical Health and Medicine, James Cook University, p16)

**Risks**

- There are a number of standards that would not be appropriate to all disciplines (Division of Tropical Health and Medicine, James Cook University, p16)
- There is the risk that discipline-specific requirements may be overlooked (Division of Tropical Health and Medicine, James Cook University, p16)
- Lack of profession specific input (Australia and New Zealand Podiatry Accreditation Council, p3)
- Loss of detail required to ensure safety and competency to practise in a specific profession (Occupational Therapy Council, p9)
**Benefits**

- Shared data and learnings for the education provider (Australian Dental Council, p 20)
- Wider adoption and sharing of best practice across accreditation authorities (Edith Cowan University, p11)
- Common priorities may become more evident and high areas needing shared action (Occupational Therapy Council, p9)
- Certain expectations of newly graduated health professionals could be consistently addressed through the alignment of education programmes, such as the need for interprofessional collaboration, and cultural responsiveness (Australian Dental Association, p8)
- Easier to undertake joint accreditation visits and/or reporting (Australian Dental Council, p20)
- Inform risk-based accreditation by sharing data across accreditation authorities (Australian Dental Council, p20)
- Reduced cost and time required to research standards. (Optometry Council Australia and New Zealand, p10)
- Eliminated the need to separately benchmark the requirements of other Australian accreditation councils (Optometry Council Australia and New Zealand, p10)

In 2014, the Australian Dental Council (ADC), in partnership with the Dental Council - New Zealand, developed an accreditation standard template that included five agreed domains for all dental practitioner groups, together with core evidence requirements. The ADC reports that this was to encourage providers to more actively engage with the process (as opposed to ‘tick and flick’) and to reduce the volume of administration.

The template is now being used (with some modifications) by the Optometry Council of Australia and New Zealand (OCANZ), the Australian Physiotherapy Council (APhysioC) and the Council on Chiropractic Education Australasia (CCEA). According to its website, the Australian Psychology Accreditation Council (APAC) is currently seeking approval of its updated standards (also using the template) from its National Board. Other accreditation authorities, including the Occupational Therapy Council (Australia and New Zealand [OTC]) submission (p4) and the three accreditation committees (AHPRA submission, p3), are also considering options to commence with this format when next reviewing and updating their standards.

This wave of unity presupposes that authorities recognise that there are common elements in accreditation standards and potential efficiencies and greater transparency by having consistency of domains where they do not conflict with profession-specific requirements. A number of submissions from accreditation councils identified opportunities for a more collaborative approach to standards development and implementation.

**Risks**

- Standardisation allows for a common process, however, runs the risk of losing relevance through standards being too broad. This could be alleviated by having a broad set of aspirational standards and industry-relevant pathways for attainment (Division of Tropical Health and Medicine, James Cook University, p16)
- May stifle innovation in the programs but also in progressing contemporary accreditation systems (value the healthy competition between authorities to continually improve) (Australian Dental Council, p20)
- The main risk could be the adoption of the lowest rather than the highest standards and a standardised approach to teaching activities that does not allow for innovation or a differentiated approach (University of Newcastle, p4)
- Evidence guides outlining profession specific requirements will become quasi-standards (Occupational Therapy Council, p9)
Box 4.3 Accreditation council views regarding common accreditation standards

**Occupational Therapy Council (Australia and New Zealand)**

...professional input and ownership of standards is important, and for this reason, we consider there is value in developing a combination of common and profession-specific standards. (p4)

**Australian Dental Council**

The ADC believes that consistency and commonality in the approval and application of standards is where the greatest net benefit can be achieved. (p18)

**Australia and New Zealand Podiatry Accreditation Council**

ANZPAC generally agrees that there are opportunities for improving consistency in the development of accreditation standards. ANZPAC further agrees that there is scope to improve the consistency of the structure, content and terminology. (p3)

**Australian Osteopathy Accreditation Council**

Commonality across professions will improve the sharing of best practice across health professions and increase inter-professional coordination, liaison and development. In addition, commonality in a set of core standards across the health professions will ensure education providers maintain a similar level of quality across health programs. (p3)

**Australian Pharmacy Council**

We support having a common structure and terminology of language within standards, and will implement this for the next round of standards development. (p15)

**Australian Nursing and Midwifery Accreditation Council**

There are a number of benefits that could be achieved with greater consistency and commonality in the development and application of accreditation standards. ... In addition to the core elements, specific professional based standards would be required to reflect the specialised requirements that nurses and midwives must meet. This two-tiered system would need an overarching governance body to determine and monitor those standards that are consistent and common without losing the profession-specific requirements. (p1)

**Australian Medical Council**

A potential benefit of greater consistency and commonality is the promotion of evidenced based accreditation practices but only when Australian developments are also informed by international best practice. While there is significant commonality between standards used internationally for accreditation of medical programs, there is less commonality across the standards used internationally for health profession program accreditation. (p7)

The potential for, and benefits of, shared standards has been demonstrated by the UK Health and Care Professions Council (HCPC) which utilises both common and profession-specific documentation for accreditation. The HCPC has developed ‘Standards of Education and Training (SETs)’ to assess education and training programs for 16 separate professions. A learner that completes a SET compliant program is eligible to apply to the HCPC for registration. Each profession also has its own specific ‘Standards of proficiency’ which outline the knowledge and skills a practitioner must meet, throughout their career, to be registered.

The Australia and New Zealand Podiatry Accreditation Council (ANZPAC), as observers on a HCPC monitoring visit, submitted that assessment against a set of uniformly presented standards appeared to be “a tick box exercise, rather than an assessment designed to improve quality and assess strengths and weaknesses” and “there did not appear to be any capacity to raise issues related to the continuous improvement of the program, including most importantly program viability, as these issues were not “anchored” to a particular standard.” (p3) These observations highlight the importance of a robust, thorough and consistent assessment methodology and the need to ensure accreditation is strongly underpinned by a quality assurance philosophy.
Another view on the operations of HCPC was provided by the Australian Physiotherapy Association (APA), who stated that “since common accreditation standards across a range of professions were introduced by the Health and Care Professions Council (HCPC) in the UK, the proportion of complaints to the number of registered health professions has risen each year.” (p6) The Review has investigated this suggested correlation and considered the data provided in the HCPC Fitness to practice annual report 2016. It shows that 0.62% of all registered practitioners had an allegation made against them in 2015-16 which has grown from 0.42% in 2011-12. Further analysis reveals this growth occurred through the inclusion of social workers in 2013 who now make up approximately 26% of the total registrants, however, comprised 55% of the 2127 total complaints in 2015-16. Importantly, the HCPC advises in that report that the number of cases closed without the need for formal investigation grew by 59% compared to 2014–15 to 1,661. Further information on the inclusion of social workers on to the register is provided in Chapter 7. The Review is satisfied there is no link between the adoption of common standards and the number of complaints against health professionals, as suggested by the APA.

Given all 14 accreditation authorities are utilising resources to develop, maintain and assess against profession-specific standards, which have been identified as highly consistent and common, the question is why has there been such a delay by some to taking up an opportunity for rationalisation? The Review concludes that this may be an example of where the HPACF has neither the resources, authority, nor significant influence with individual accreditation authorities or National Boards, to drive practical operationalisation across professions.

Apart from any reluctance by accreditation authorities to progress reforms, the requirement for separate and independent approval of the standards by each of the National Boards has the potential to limit any efficiencies that may be gained through a collective approach to their development. As noted by ANZPAC:

“Even when collaboration has occurred at the accreditation authority level, this could be undone at the National Board level when Boards approve an accreditation standard. There is also no mechanism in the current legislative or regulatory framework to accommodate cross-profession consultations and common topics such as prescribing of scheduled medicines.” (p4)

The Review’s conclusion is that the current governance arrangements do not ensure that generally agreed reform of the standards is undertaken. Possible options to resolve this challenge are explored in Chapter 7.

Overlap and duplication with the education sector

Whilst the health accreditation and education sector regulatory authorities have different overarching purposes and foci for accreditation, the underlying domains and processes are largely the same. Given this commonality, there are many opportunities for streamlining processes and delegating roles and responsibilities that may reduce duplication, costs and administrative burden.

Education sector standards

As noted in Chapter 2, TEQSA and the ASQA are responsible for overseeing the accreditation of the education sector. They have particular expertise in institutional risk assessment and quality assurance, with a focus on protecting the student and maintaining the quality and reputation of the education sectors.

Higher Education

The TEQSA Act 2011 states that:

“TEQSA registers providers and accredits courses of study. TEQSA regulates higher education using principles relating to regulatory necessity, risk and proportionality, and using a standards-based quality framework.”
TEQSA requires providers to comply with the Higher Education Standards Framework (Threshold Standards) 2015 to be registered with TEQSA and to deliver higher education programs of study. A period of registration cannot be longer than seven years, after which the institution can be re-registered following an assessment against the Threshold Standards.

The TEQSA Act 2011 provides that higher education providers that are registered in certain categories, and that meet specific criteria, may be classified as a ‘Self-Accrediting Authority’. This authorises the provider to self-accredit one or more of the courses of study it offers, and determine, within the confines of the Australian Quality Framework, the level of the qualification for a program of study and the length of course. Higher education providers registered in the ‘Australian University’ category have self-accrediting authority. In self-accrediting institutions, academic boards and coursework committees (or equivalent) are responsible for reviewing and accrediting courses every five to seven years, with an annual course performance monitoring process. For providers without self-accrediting authority, TEQSA will complete the course accreditation assessment process against the Threshold Standards. A course can be accredited for a maximum seven years.

Vocational Education and Training

All VET providers must achieve the Standards for Registered Training Organisations (RTOs) 2015. These standards form part of the VET Quality Framework which also includes the:

- Australian Qualifications Framework
- Fit and Proper Person Requirements
- Financial Viability Risk Assessment Requirements 2011
- Data Provision Requirements 2012.

VET qualifications that are nationally recognised are included within National Training Packages which are developed through a process of national consultation. Training Packages include units of competency and qualifications to meet the training needs of an industry or group or industries. A RTO can deliver units of competency and qualifications in training packages if they are within their scope of registration.

To deliver nationally recognised training, RTOs must maintain registration. ASQA may grant registration for a period of up to seven years and RTOs can only deliver the programs of study on their scope of registration. ASQA can also delegate high-performing RTOs with the ability to manage their own scope of registration.

Where a program of study is included within a Training Package, ASQA does not accredit the program of study but continues to monitor the performance of the RTO. RTOs are also required to make an annual declaration on compliance with the standards and submit data requirements detailed in the VET Quality Framework.

As specified in Standard 5 of the Threshold Standards and Standard 2 of the Standards for RTOs, education providers must have robust institutional quality assurance mechanisms to oversight programs of study. It is noted that, compared to the health profession accreditation system, the education sectors have a legislated process for quality assurance which includes standards that apply broadly across institutions irrespective of the classification, type or disciplines of programs delivered. For example, as noted on the ASQA website:

“RTOs take a multitude of forms, including very large TAFE institutes and other public providers; enterprise RTOs that are part of larger organisations and only train staff of those organisations; community-based providers; commercial colleges; and many more. These organisations are diverse in size, structure, governance and the scope and volume of services provided. By describing outcomes rather than inputs, the Standards encourage flexibility and innovation while assuring the quality of training.”

The Review’s mapping process encompassed the relevant Threshold Standards and Standards for RTOs. As outlined in Appendix 5, the findings show areas of similarity and overlap with health professional accreditation standards. Some examples of commonality are set out below with further examples in Appendix 6:
Health professional standard

Domain: Academic Governance and Quality Assurance

Standard Statement: Academic Governance and quality assurance processes are effective.

Criteria 2.1 The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement.

Criteria 2.2. Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program.

Criteria 2.3. There is relevant external input to the design and management of the program, including from representatives of the dental professions.

Criteria 2.4. Mechanisms exist for responding within the curriculum to contemporary developments in health professional education.

Threshold Standards

Standard 6: Governance and Accountability

6.3 Academic Governance

1. Processes and structures are established and responsibilities are assigned that collectively:
   a. achieve effective academic oversight of the quality of teaching, learning, research and research training
   b. set and monitor institutional benchmarks for academic quality and outcomes
   c. establish and maintain academic leadership at an institutional level, consistent with the types and levels of higher education offered, and
   d. provide competent advice to the corporate governing body and management on academic matters, including advice on academic outcomes, policies and practices.

2. Academic oversight assures the quality of teaching, learning, research and research training effectively, including by:
   a. developing, monitoring and reviewing academic policies and their effectiveness
   b. confirming that delegations of academic authority are implemented
   c. critically scrutinising, approving and, if authority to self-accredit is held, accrediting or advising on approving and accrediting, courses of study and their associated qualifications
   d. maintaining oversight of academic and research integrity, including monitoring of potential risks
   e. monitoring and initiating action to improve performance against institutional benchmarks for academic quality and outcomes
   f. critically evaluating the quality and effectiveness of educational innovations or proposals for innovations
   g. evaluating the effectiveness of institutional monitoring, review and improvement of academic activities, and
   h. monitoring and reporting to the corporate governing body on the quality of teaching, learning, research and research training.

3. Students have opportunities to participate in academic governance.

The analysis identifies significant overlap in accreditation standards which ultimately results in the same domain/element being assessed multiple times within an education provider institution by different health accreditation entities, and again by the institutional self-accrediting/quality assurance processes, and by TEQSA or ASQA as the education provider regulator.

Clarification of roles and responsibilities

The literature recognises that good governance of a process requires clarity of roles to ensure that efforts deliver success, and responsibilities are performed in an efficient manner. A lack of clarity can be detrimental and result in duplication of effort or critical tasks not being completed (Uhrig Report, p25).
A number of health professional accreditation standards currently acknowledge the role of TEQSA and ASQA (as relevant) in their accreditation standards. For example, the Medical Radiation Practice Accreditation Standards specifically state that they:

“align with the threshold standards from the Higher education standards framework (Threshold Standards) 2011 (threshold HES). The Accreditation Committee recognises the role of the Higher Education Standards Panel and the Tertiary Education Quality and Standards Agency (TEQSA) in regulation and quality assurance of higher education in Australia and rather than duplicating that role, the accreditation standards will be used to assess education providers and programs in the context of assuring quality outcomes of medical radiation practice programs of study.” (p2)

However, despite this acknowledgement, based upon the Medical radiation practice accreditation guidance material, the accreditation committee still appears to request and assess some evidence that has already been considered by a TEQSA approved self-accrediting university (for example, financial viability and sustainability).

A number of health education accreditation authorities now have MOUs with TEQSA (details available on its website and in Chapter 7) to facilitate sharing of information. The MOU template, at a high-level, outlines the basis for the parties “to share information on matters of mutual interest.” However, it does not consider overlap or duplication in accreditation processes. Most importantly, the MOUs only cover information sharing between TEQSA and the health accreditation authority, and do not consider the self-accrediting/quality assurance process undertaken by the academic boards within individual institutions.

As noted earlier, self-accrediting universities must have stringent internal quality assurance processes to ensure their programs of study meet the Threshold Standards. Academic boards apply pedagogical knowledge and proficiency to a peer-review process ensuring that evidence-based and current educational philosophy and assessment techniques are utilised. Their academic expertise, and engagement with the relevant sector and community, contribute to the program currency and the production of a contemporary graduate.

Comparable to the higher education requirements, RTOs with delegated authority must have a formal quality assurance system in place to manage regulatory functions and operations and comply with the VET Quality Framework throughout the Delegations Agreement period. This includes developing, implementing, monitoring and evaluating quality training and assessment strategies and practices that meet the requirements of training packages and VET accredited courses.

The academic course review and accreditation processes undertaken by self-accrediting authorities appear similar to that undertaken by health profession accreditation authorities, including consideration of quality improvement processes, curriculum development, assessment regimes, resourcing requirements, student demands and other associated risks/benefits. The academic process is underpinned by evidence (including annual course reports) and input from external and internal parties (including students). It is required to scrutinise the available evidence before the program of study is accredited. Whilst there are many commonalities between education institutional and health professional accreditation processes, it is understood that they largely operate in isolation, although the Review has identified pockets of collaboration with some health professions.

The issue of duplication and regulatory burden associated with accreditation assessments has been recognised by Professions Australia and Universities Australia, as demonstrated in their Joint Statement of Principles for Professional Accreditation (2016) which distinguishes professional accreditation of university courses from the academic accreditation of the institution. The principles have been designed to be widely applicable with the aim of creating national consistency and ensuring processes are transparent, accountable, efficient, effective and fair. They outline respective roles and responsibilities for an evidence based collaborative approach. Specifically, the Statement highlights that professional accreditation should:

“be cognisant of and distinguish between the respective requirements of TEQSA – responsible for monitoring adherence to the Higher Education Standards Framework – and professional accreditation bodies – responsible for professional accreditation – and should not lead to duplication of effort or process.” (p4)
A range of health professions, together with others such as accounting, engineering and computing, have endorsed these principles. A number of submissions identified both opportunities and potential limitations of incorporating the findings from education provider accreditation processes.

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**Box 4.4 Incorporation of the decisions of TEQSA/ASQA assessments and accreditations**

<table>
<thead>
<tr>
<th>Faculty of Health and Behavioural Sciences, University of Queensland</th>
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<tr>
<td>Yes, TEQSA’s role in institutional quality assurance, governance and accountability should be acknowledged and the need for evidence of compliance with TEQSA standards be removed from accreditation requirements. Maintaining the need to re-address evidence already provided to another legislated body is redundant and costly in terms of resources for both the accreditation body and the higher education institution. (p1)</td>
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<tr>
<th>Faculty of Medicine Nursing and Health Sciences, Flinders University</th>
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<td>The recognition of TEQSA decisions should be prima facie evidence for accreditation. This would mean that any criteria already satisfied for TEQSA and the Higher Education Standards Framework should not need to be replicated for accrediting authorities. This would significantly reduce the burden for universities of multiple overlapping regulatory regimes. (p1)</td>
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<tr>
<th>Faculty of Pharmacy, University of Sydney</th>
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<td>For some disciplines, it might be appropriate that accrediting bodies rely more on TEQSA for evidence, thus reducing duplication. For others, particularly those with clinical, experiential or practical aspects, information gathered by TEQSA may not be fully sufficient (or appropriate) to ensure maintenance of professional standards for the discipline. (p1)</td>
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<tr>
<th>Medical Deans Australia and New Zealand</th>
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<td>Medical Deans acknowledges the accreditation burden for education providers is high and would support opportunities for evidence from TEQSA reports to be accepted in response to some more generic standards, for example some of the standards in learning and teaching, assessment, students support and the non-clinical learning environment. However, the TEQSA reports will not address many central aspects of primary program accreditation relevant to the health professions such as Aboriginal and Torres Strait Islander or rural quota admission pathways or cross-organisational clinical staff and clinical teaching facilities in public and private and community and hospital settings. (p3)</td>
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<tr>
<th>Australian Council of Deans of Health Sciences</th>
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<tr>
<td>Incorporation of TEQSA/ASQA assessment and relevant decisions has potential to simplify reporting. It would also reflect TEQSA/ASQA areas of knowledge and specialization that program accreditation panels may not possess. Incorporation of the TEQSA/ASQA findings could enable the program assessment teams to concentrate on areas of professional capabilities. There would be a reduction in duplication and less resources wasted by not including the work done by these regulators. (p7)</td>
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The HPACF has the potential to play a role in the accreditation environment. Its submission noted that it:

“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.” (p3)

The HPACF references the Professions Australia/University Australia Joint Statement in its own principles document - [High Level Accreditation Principles](#) (2016). This document seeks to facilitate a common and collective approach to the accreditation process through twelve key principles which promote working collaboratively, benchmarking against international standards and encouraging improvement and innovation. However, compliance is voluntary and is based on each council’s self-assessment. The HPACF document states:

“We recognise the importance of a complementary approach to accreditation processes including professional, academic and where appropriate health service accreditation to harmonise where possible and avoid duplication of effort. We support initiatives which lead to complementary approaches and better understanding of other accreditation processes.” (p3)
The Joint Statement provides clear guidance on the roles and responsibilities of the respective regulatory authorities by distinguishing between academic and professional standards. Whilst directed at the higher education sector, the Review considers greater adherence to these best practice principles could encourage national consistency, reduce regulatory burden and ensure the appropriate allocation and use of expertise for both the health and education sectors. By entrusting each accreditation entity to fully utilise its expertise, and by requiring appropriate governance and accountability, there would be greater efficiencies and opportunities for an integrated assessment model.

Whilst implementation approaches are discussed further in Chapter 7, it is evident that there are opportunities for the health profession accreditation authorities to work more closely with the institutional academic course accreditation processes in self-accrediting authorities and RTOs to better align and integrate processes (including assessment of programs of study, facilities and other learning resources). This may include standardised data collections for annual reporting requirements and aligning timeframes for, and jointly undertaking or reciprocally participating in, cyclical course accreditation processes.

There may also be further advantages in supporting non-regulated health professions to adopt the procedures utilised by the National Scheme rather than operating parallel processes and differing requirements. Engagement and collaboration with peak bodies such as the National Alliance of Self-Regulating Health Professions (NASRHP) to align processes would reduce variability and contribute to greater consistency and efficiency for the health and social care education system more broadly.

Accreditation assessment

An accreditation authority’s particular expertise is in assessing programs of study, given their knowledge and understanding of profession-specific requirements and needs of the health care system. They are also well placed to respond to identified workforce priorities and service delivery models, and thereby ensure alignment of course program curriculum with professional competencies and the objectives of the National Law.

As recognised internationally, there are various parties and processes involved in an accreditation assessment. The World Health Organisation (WHO) identifies in its Policy brief on accreditation of institutions for health professional education that:

“... the most common approach to accreditation has three components: self-evaluation based on published standards; a peer review that should include a site visit; and a report stating the outcome of the accreditation (full accreditation, conditional accreditation or no accreditation).” (piii)

Accreditation within the National Scheme meets these requirements and includes ongoing and regular monitoring of the education provider by the accreditation authority.

Whilst this approach is largely consistent across health professional accreditation in Australia, the use of cyclical and risk-based accreditation differs between authorities. There are also elements of variance regarding roles and responsibilities, cost, data collection and templates, mode of submission, terminology, timeframes, assessment panels (composition and training), performance monitoring and reporting. In addition, this diversity is evident in re-accreditation and monitoring requirements. For education providers that deliver multiple health professional courses, this creates a significant administrative burden in managing the various reporting deliverables and timeframes. Added to this are the accreditation requirements associated with education regulators and internal academic approval processes and timeframes.

The cycle of assessing programs and providers

Most accreditation councils have adopted the practice of undertaking a cyclical review of an education provider’s health programs, in addition to annual performance monitoring. The timeframe for review occurs predominantly every five-years, with the ADC and OCANZ reviewing at seven and eight-years respectively. The Australian Medical Council (AMC) has the longest potential accreditation period of up to ten years without
undertaking a full re-accreditation process (six-years as standard, with a four-year extension). The length of time before re-accreditation occurs, and whether it occurs as a standard process, appears dependent upon the accrediting authority’s approach to risk-based assessment.

Whilst a cyclical assessment approach provides regularity and certainty to parties, it can limit the responsiveness of program innovation between re-accreditation processes and does not offer an incentive to providers to achieve exceptional performance and build an open and transparent reporting process with the assessors in exchange for extended accreditation.

Risk management approaches

A risk management approach concentrates resources and effort towards areas of greatest risk, whilst considering the most efficient and effective mechanisms to achieve and monitor performance and respond to priorities as they arise. This requires processes to be appropriate and proportionate to the level of risk, and responsive to the likelihood and consequence of potential issues. It also directs resources to where they are most needed, and reduces the burden of assessment and regulation for well-performing organisations.

A risk based approach does not automatically remove the need for annual reporting (in fact, this is an important source of evidence for the risk analysis) or periodic comprehensive review. It does, however, aim to create a depth and breadth of information, utilising data from a variety of sources, to create indicators and risk profiles for performance and quality monitoring.

The approach to risk management is variable within the accreditation authorities while both TEQSA and ASQA, as detailed below, utilise a standards and risk-based approach as part of their quality assurance activities to monitor the performance of institutions.

National Scheme accreditation authorities

Whilst there are a range of approaches adopted across accreditation authorities, the Australian Pharmacy Council (APC), Australian Nursing and Midwifery Accreditation Council (ANMAC) and the three accreditation committees indicate they are currently using a risk-based approach to their activities.

- APC has adopted a risk-based cyclical approach, where the length of the cycle is dependent upon a number of risk factors identified in their Risk Decision-Making Framework. Risk is determined by evidence of compliance with accreditation standards. It is noted that the maximum accreditation period is six years for organisations that are categorised as low-risk.

- ANMAC has recently transitioned to a risk-based approach. Based upon ISO 31000:2009 Risk management – Principles and Guidelines, the process identifies three components to its approach:
  - Risk Assessment: categorising each program with a risk rating (low, medium or high) based on risk determinants and measurable indicators (ANMAC notes that they have collected data over a period of time to facilitate this determination).
  - Accreditation: this refers to the standards-based accreditation process (scheduled every five years). The process will be tailored based on the risk rating.
  - Monitoring: education providers are required to submit an annual ‘program monitoring report’ that will contribute to the risk assessment. The level of detail will be largely determined by the risk rating.

Indicator categories used in ANMAC’s risk assessment include Regulatory history, standing and governance (40%), Human resources (30%), Physical resources (20%) and Student experience and outcomes (10%) (ANMAC Accreditation Services Risk Framework, p12).

The three accreditation committees currently use a risk management methodology for monitoring and review. As noted in the Frequently Asked Questions section on each of the committees’ web pages:

“The Accreditation Committee does not accredit programs for a set period. Instead, a program only continues to be accredited if the Accreditation Committee continues to be satisfied that the program and provider continue to meet the accreditation standards.”
It is noted that they are “working to identify effective risk indicators and different monitoring methods that can be aligned to the risk profile of standards, professions and specific providers/programs.” (Joint National Boards/AHPRA submission, p4)

Submissions to the Review identify that the ADC is considering adopting a risk-based approach, and OCANZ, in partnership with the OTC and CCEA, is currently undertaking a project to develop a common risk-based framework. Whilst the National Law requires accreditation authorities to monitor programs of study it does not specify regular cyclical reviews and the rationale for the different approaches to cyclical assessment across accreditation authorities appears to be historical. Whilst it seems there are efforts to further streamline assessment processes and focus on risk management approaches to re-accreditation and monitoring, no explicit timeframes or requirements have been established that apply to all accreditation authorities.

**TEQSA’s Risk Assessment Framework (2016)**

TEQSA’s Risk Assessment Framework (RAF) aligns with its principles of reflecting risk, proportionality and necessity, as specified in the TEQSA Act 2011. The Framework notes that TEQSA risk assessments are not designed to evaluate compliance with the Threshold Standards, but to readily identify potential risks through a consistent, structured and systemic approach with a set of risk indicators across areas of institutional practice and outcomes that are central to all providers.

The RAF identifies the key steps of a risk assessment process and provides detailed guidance on the standardised format and set of risk indicators that are applicable to all education providers. TEQSA undertakes a systematic approach to developing the risk thresholds based upon a variety of elements including previous performance and other related monitoring.

TEQSA has designed its approach and processes to facilitate nuanced judgements on the scope and depth of monitoring and assessment activities and, based on assessment, the nature of regulatory action that may be taken, if any. Higher education providers are required to report annually to TEQSA and the Commonwealth Department of Education and Training. These entities work closely to share data and to minimise the reporting burden for education providers.

**ASQA’s Regulatory Risk Framework (2016)**

The National Vocational Education and Training Act 2011 requires ASQA to use a risk-based approach to reduce regulatory burden for high-performing and compliant entities, and to ensure greater attention is placed on high-risk providers. ASQA states that it uses data and intelligence to inform judgements about interventions that promote sector compliance, improve confidence and ensure the quality and reputation of the VET sector.

ASQA uses its Regulatory Risk Framework (RRF) which “identifies and evaluates risks to the quality of vocational education and training in Australia at the macro (whole of sector - system) and micro (provider) level.” (p2)

System risks, identified through environmental scanning, and provider risks, highlighted through reporting, are evaluated against likelihood and impact measures to determine the response required. ASQA also undertakes annual reviews to monitor performance of providers and the effectiveness of its regulatory responses.

A risk based approach can facilitate a more effective use of scarce resources and allows a focus of effort on providers of highest risk, as opposed to concentrating the same effort equally across all entities. However, informed judgements rely on comprehensive and accurate data. As noted by the AMC:

“Effective accreditation processes rely on collection of accurate data and information to bring objectivity and rigour to processes. A key trend in accreditation in Australia and internationally is the strengthening of collection and analysis of data on which accreditation related-decisions are based. This entails reviewing of accreditation data collections as accreditation standards are reviewed, negotiating access to relevant data held in other systems (such as the Tertiary Education Quality and Standards Agency), and advocating for or commissioning new data collections (such as the proposal for a National Training Survey for all postgraduate/vocational medical training).” (p4)
Notifications data collated by AHPRA could also be incorporated into a broader data analysis as part of a risk-based approach. The joint National Boards/AHPRA submission notes:

“Monitoring outcomes and notifications data could be used to identify specific risks requiring more specific engagement with the provider and other key stakeholders. For example, clusters of notifications that relate to specific programs of study or providers could inform specific monitoring or themes in notifications that identify aspects of practice could be highlighted to education providers. In addition, there may be a need for a more comprehensive assessment of all programs after new or revised accreditation standards are introduced, particularly if the changes relate to higher risk areas.” (p4)

Both risk-based and cyclical approaches provide a quality assurance mechanism for programs of study and providers of those programs. It is noted that a number of submissions appreciate the value of both.

<table>
<thead>
<tr>
<th>Box 4.5 Comparisons between cyclical and risk-based accreditation approaches</th>
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<tbody>
<tr>
<td><strong>Australian Psychology Accreditation Council</strong></td>
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<tr>
<td>As is appropriate, we take considerable care with new providers and new programs: paradoxically, while we wish to encourage innovation, (our proposed new standards, awaiting approval, are designed to allow providers greater freedom to innovate) an unusually innovative program would inevitably come under greater scrutiny, as is consistent with a risk-based approach. (p16)</td>
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<tr>
<td><strong>Australian Pharmacy Council</strong></td>
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<td>Our view is that continuous monitoring without an accreditation cycle could indeed result in a greater burden for education providers, due to an apparently continuous requirement for change reporting; this could be an unintended consequence. (p16)</td>
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<tr>
<td><strong>CQUniversity</strong></td>
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<td>A risk-based approach that involved continuous monitoring through annual report analysis and feedback and analysis of relevant institutional data would be a more effective use of resources than a full, periodic review of every program regardless of its risk profile. Robust monitoring can identify education providers, programs or areas of risk. (p3)</td>
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<tr>
<td><strong>University of Sydney</strong></td>
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<tr>
<td>We recognise that regular cycles of accreditation do support industry engagement and reputation of professional programs and their graduates, however on balance these benefits are outweighed by the significant benefits of open-ended and risk managed accreditation cycles that assist with efficiencies for all parties. (p3)</td>
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<tr>
<td><strong>Australian Council of Deans of Health Sciences</strong></td>
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<tr>
<td>Adoption of risk based approaches requires incisive understanding and description of what constitutes or flags a risk within the accreditation system and how much system penetration is required to identify false positives. Unless both are clearly described, there is a significant risk of delayed identification of problems that may be occurring in a higher education provider’s program. (p10)</td>
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<tr>
<td><strong>Department of Health and Human Services Victoria</strong></td>
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<td>Such a shift relies on much better data about the operation of the accreditation system than is currently available, and far stronger monitoring of the performance of education providers. Sometimes a shift to a risk-based approach has been used as a justification for reducing resources, leaving providers to self-regulate without sufficient oversight. Public confidence in the quality of graduates relies on a robust accreditation system. The current fragmented accreditation system does not provide the capability to generate with sufficient timeliness the data needed to inform policy decisions of this nature. Without governance reform, the potential for evidence informed design and delivery of the accreditation functions (for example, with respect to the length of accreditation cycles) is unlikely to be realised. (p2)</td>
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</table>
Box 4.5 Comparisons between cyclical and risk-based accreditation approaches

**Australian Physiotherapy Association**

We do not support a model of accreditation that excludes cyclical assessment processes. Accreditation councils are set up to have the training and experience to recognise risk within a physiotherapy program, whereas university program staff are experts in their areas of physiotherapy, education and learning. A combination of cyclical and risk-based accreditation is already working within the physiotherapy accreditation system and this approach should be strengthened and harmonised across the professions. (p3)

Considering opportunities for streamlining accreditation processes, transitioning to a risk-based approach is likely to create efficiencies and reduce the regulatory burden associated with accreditation assessment. As demonstrated by the APC approach, determining the need for a comprehensive review based upon a robust risk assessment could tailor its form and frequency, rather than simply base it on a historical process.

Assurance of high-quality education and training of health practitioners is of paramount importance. Having comprehensive data with high relevance, integrity and timeliness to inform decision-making is a critical factor in determining the most appropriate accreditation processes.

**Assessment and monitoring**

All accreditation authorities have produced guidelines and resources to assist education providers to achieve and maintain accreditation of their education programs. These documents commonly outline the accreditation process, assessment teams, fees, types of accreditation outcomes, timeframes, monitoring and reporting requirements and complaints mechanisms. In addition, they can outline the expectations of the professional curriculum and the types of evidence required as mapped to their accreditation standards.

Analysis of the guidance resources and documentary evidence that is collected, shows that items are largely similar across the health professions. In some circumstances, however, the guidance information is not aligned with the standards (i.e. they may have been published at a different date) which may cause confusion. The Review considers common assessment procedures and a uniform evidence framework would resolve this.

**Reporting changes to a program of study**

Any changes to a health program, its delivery mechanisms or its learning outcomes, that represent a significant departure from the accredited course structure, are also required to be reported to the relevant accreditation authority for review and approval. In many cases, notification is required at least 12 months before the intended introduction of the change. The definition of a significant change is often decided by the individual authority and may include changes to:

- governance arrangements of the institution
- resources that impact upon capacity to deliver the program
- subjects, including their addition or removal, that affect content or method of delivery of the program
- enrolment numbers and cohort size
- new streams or learning/educational outcomes
- education philosophy
- student assessment
- overall funding
- conditions imposed by TEQSA or ASQA
- program title, structure or length
- delivery location including adding a new site or withdrawing from an existing site.
These items cover a wide gamut of topics, some of which are already included in annual reporting. It is understood that the information is used to determine what type of action will be taken and whether it requires a re-assessment of the accreditation status and/or a site visit for closer evaluation. Given these decisions are made by the individual accreditation authority, from an education provider’s point of view it is likely that inconsistencies in approach occur across disciplines.

Whilst monitoring and assessing changes are important to maintaining delivery of high-quality programs that meet standards and objectives, they may create a further and longer lag before courses are revised and new graduates seek registration as health practitioners. It is noted that some accreditation authorities require at least 18-24 months’ notice before the introduction of a major change. Education provider feedback at the forums noted that the timeframes and amount of work involved in the process is often a reason not to update the program between cycles of accreditation.

**Annual performance monitoring**

Section 50(1) of the National Law requires that:

“The accreditation authority that accredited an approved program of study must monitor the program and the education provider that provides the program to ensure the authority continues to be satisfied the program and provider meet an approved accreditation standard for the health profession.”

Currently, each accreditation authority manages this reporting requirement slightly differently with a range of data requests, templates and reporting items. This can result in an education provider pulling together similar but separate information, on different templates, and submitting it multiple times for review by different accreditation authorities. Requested items may include:

- statistical information about students: enrolment, progress profiles/reports
- staffing profiles and changes to qualifications and teaching responsibilities
- curriculum changes including to educational goals and objectives
- changes to resources and facilities (particularly if related to clinical placements)
- revising teaching philosophies or methods
- changing methods for student assessment
- financial status

Universities Australia, in recognising this issue, suggests that:

“Some efficiency could be brought to bear by ensuring that terminology for common questions is standardised across disciplines and/or grouping common questions into a core set across the health professions that only need to be assessed once within an institution or used for different courses as relevant.” (p3)

A review of the monitoring reporting requirements reveals that some accreditation authorities provide guidance on their websites, with others referring to a template that is disseminated directly to education providers. The wide variety in style and terminology of questions, data requested, templates and submission mechanisms (i.e. online vs paper-based) reinforces the conclusion that there is a high impost placed upon education providers to keep up with the inconsistent and duplicative nature of health professional accreditation. Australia Catholic University provided a detailed example of the onerous and questionable practices required for some assessments:

“For example, some accreditation agencies require universities to provide multiple copies of the same appendices for double degrees in both hard and soft format. This requirement consumes considerable faculty staff time and cost in printing, compiling, binding and mailing the thousands of pages of the same volumes of appendices. This is an example of duplication and inefficiency imposed by agencies that are involved in the accreditation of only one component of a double degree.” (p4)
Some accreditation authorities advise they are moving to online systems for data reporting which has the potential to reduce the administrative requirements and cumbersome nature of paper-based systems. As noted by Western Sydney University, “the introduction of online reporting capabilities would be of benefit in terms of improving efficiency.” (p1) Whilst integration and collaboration with other authorities towards development of a single portal would be beneficial, wider use of electronic reporting opens the possibility of a more holistic and unified approach to accreditation reporting.

Analysing reporting data is an important aspect of the accreditation process, particularly for risk management and quality assurance. Currently accreditation authorities undertake this in isolation, assessing the individual profession-specific aspect of the program of study or education provider. It is understood that there is often no communication across accreditation authorities to share information that may improve identification of risks or issues across a faculty, school or institution. As noted at a National Academies of Sciences, Engineering and Medicine workshop Exploring the role of Accreditation in Enhancing Quality and Innovation in Health Professional Education, “Innovation in accreditation ... requires capturing data once and using it many times.” (p91) Whilst agreement on common reporting terminology and data items would greatly improve efficiency and reduce duplication, there are also greater opportunities to share data for a more comprehensive risk-assessment and analysis of the health education and training system.

It is evident that requirements and resources associated with assessment, monitoring and reporting vary across accreditation authorities, particularly in term of format, terminology, content and timeframes. Collaboration has the potential to create greater understanding, accountability and transparency between agencies and stakeholders. Greater harmonisation of evidence, documentation and requirements could be a useful first step to streamline assessment processes and reduce duplication of effort for all. In addition, it provides future opportunities for increased sharing and integration of resources and information which would ultimately lead to a more comprehensive data set and improved risk assessments of the health education and training system.

Training and readiness of assessment teams

The Quality Framework for the Accreditation Function developed by AHPRA and the HPACF provides guidance on the processes for accreditation of programs of study and education providers. The Framework requires that:

“...an accreditation authority has policies on the selection, appointment, training and performance review of assessment team members. Its policies provide for the use of competent persons who are qualified by their skills, knowledge and experience to assess professional programs of study and their providers against the accreditation standards.” (p5)

Assessment teams (also known as Site Evaluation Teams or Panels) commonly consist of practitioners (with academic and/or clinical experience), educationalists and, in some cases, students. In assembling a team, consideration can be given to ensuring a balance of educational knowledge, experience, geographic location, clinical disciplines, employer setting and employee status. Members of a team are normally required to identify conflicts of interest, declare standing notices of interest and sign confidentiality agreements.

Some professions have a list or register of approved assessors that may be appointed to undertake an accreditation assessment whilst others simply indicate the likely composition of the team/panel. For example:

- **ANMAC Register of Accreditation Assessors**: The Assessor Handbook notes that ANMAC selects and approves assessors based on current knowledge, skills, expertise and experience, and their standing in the nursing and midwifery professions. Nurses and midwives must hold current registration in Australia.

- **Aboriginal and Torres Strait Islander Health Practice Accreditation Committee**: the list of approved accreditation assessors: comprises persons who:
  - Are a registered Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker
  - Have current experience in delivery of the Aboriginal and Torres Strait Islander primary health care practice and experience in clinical education/workplace training
  - Have sound knowledge of education and experience in teaching and learning.
• **OCANZ**: the *Process and Procedures manual* indicates that the composition of the assessment team usually comprises:
  
  o Three senior academics from optometry schools other than the school undergoing assessment, one normally from overseas; Heads of the Australian and New Zealand schools are not usually appointed.
  
  o Three distinguished and experienced practising optometrists, at least one residing in the state (or country if there are no states) of the school undergoing accreditation.

A majority of councils predominantly include representatives from their profession on the assessment panel, however, some also include ‘educationalists’. The inclusion of other professions (to promote interprofessional education) or representatives from a range of sectors (employers, students, government) or with particular expertise may increase transparency and expand the value of accreditation assessments. It would also promote the value and inclusion of diverse perspectives. This idea has the potential to contribute to greater cross-professional interaction and may ultimately result in the accreditation of health schools within education providers, rather than individual profession-specific programs of study. As noted by Edith Cowan University:

> “As a general principle, broadening the representation on accreditation panels would reflect and promote a better understanding of the links between teaching, learning, research and clinical practice, and how they influence the further development and improvement of teaching standards and graduate outcomes.”

(*p7*)

To establish this protocol, guidance is required around best-practice for the development and structure of assessment teams to ensure appropriate and diverse skills-based representation. Recognising that cost potentially increases with the size of a panel, any such direction would need to balance the need for skills diversity with sufficient professional expertise. The inclusion of consumers on assessment panels received mixed opinions from the various submissions. Further analysis of consumer involvement is explored in Chapter 6.

To provide greater transparency and accountability for accreditation assessments, the Review considers a common register of experts should be developed which could be accessed and utilised by all health profession accreditation authorities. Accreditation authorities could be responsible for nominating and managing the proficiency and appropriateness of experts in their profession. This would allow other authorities to access a breadth of expertise and share best-practice findings and evidence.

Accreditation authorities should also support further research to explore best-practice options for the ‘ideal’ skills and expertise required for panel composition. A key objective should be to achieve true interprofessional collaboration and removal of accreditation assessment silos.

**Other models of assessment panel formation**

As noted earlier, in the UK the HCPC utilises common accreditation procedures for 16 health and social care professions. As part of this process, it has established ‘Partners’ who undertake a number of roles including Continuing Professional Development (CPD) assessors, legal assessors, panel chairs, panel members, registration assessors and visitors. In particular, visitors include registered members of professions and members of the public and, as described on its website, they:

> “…assess HCPC accredited education and training programmer to decide whether they meet our standards. Visitors visit education providers and report back to the Education and Training Committee when it makes decisions about programme approvals. They also give expert advice and contribute to decision making as directed by the Council or relevant committee.”

Each assessment panel includes a member from the specific profession and a lay member wherever possible. The aim is to provide expertise for decision-making and to ensure that there is professional and lay (public) input. It is also noted that, as part of a continuous improvement process, the performance of each ‘Partner’ is assessed every 2 years through self-evaluation and peer observation.
TEQSA uses a ‘Register of Experts’ who are expected to have and maintain significant knowledge and experience in one or more identified areas of expertise. TEQSA is currently reviewing its ‘Experts System’ with a view to guaranteeing functionality and currency of the register. It is noted that TEQSA does not have a prescribed training regime for its experts, with this also being evaluated as part of its review.

Under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, ACSQHC does not complete accreditation processes itself but approves accrediting agencies. Further information on ACSQHC is provided in Chapter 7.

**Assessment teams in practice**

Assessment teams undertake a range of tasks once appointed, including:

- Reviewing the self-evaluation report completed by the education provider.
- Undertaking site visits (often over multiple days) to confirm information provided in the self-evaluation report and to collect additional information regarding facilities, teaching staff, corporate and student records, and program/curriculum details.
- Developing an assessment report and proposing recommendations and reasons for accreditation status.

Education providers report that there are vast differences in the capability and competence of assessment teams. This impacts on the amount and detail of information that they are required to provide.

The PhillipsKPA report similarly notes:

> “The single issue raised most commonly by providers is the inconsistency between the published position of the professional body as a corporate entity and the position of the various members of the profession (including academics) who actually perform the accreditation tasks.” (p63)

A number of submissions also raised examples of their experience with assessment.

**Box 4.7 Examples of interactions with accreditation assessment teams**

<table>
<thead>
<tr>
<th>CQUUniversity</th>
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<tbody>
<tr>
<td><em>From CQUUniversity’s experience there is great variation between accrediting authorities in terms of the application of standards frameworks in a fair and consistent manner. In some cases judgments are made by accrediting authorities to impose conditions on matters outside the scope of the accreditation standards. Some accrediting authorities also do not make it clear where a requirement needs to be imposed to ensure public safety as per National Law objectives and where a recommendation is being proposed for improvement of a program. Accrediting authorities should clearly differentiate where an action should be taken to ensure with compliance with an accreditation standard and where an action is desirable to improve a program though not essential to ensure public safety. In this way the intent of the scheme to ensure public safety can be maintained along with the Quality Frameworks of facilitating quality improvement. (p2)</em></td>
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<tr>
<th>NSW TAFE</th>
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<tr>
<td><em>All assessment teams should have a professional staff member in their teams from their accreditation council who contribute to ensuring a common standard of assessment across accreditations. (p1)</em></td>
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</table>

<table>
<thead>
<tr>
<th>Heads of Department and Schools of Psychology Association (HODSPA)</th>
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<tr>
<td><em>Consistency and professionalism – a number of respondents noted that the panels went beyond the written standards and engaged in conversations that were outside of their remit. These included:</em></td>
</tr>
<tr>
<td>• Standards are unclear, leading to anxiety about whether an AOU is meeting them</td>
</tr>
<tr>
<td>• Arguing about the AQF level of a program that TEQSA had approved at that level. This was also the case for two self-accrediting institutions.</td>
</tr>
<tr>
<td>• Requesting additional documentation that was not used.</td>
</tr>
<tr>
<td>• Asking for a position that is not set out in the standards.*</td>
</tr>
</tbody>
</table>
Examples of interactions with accreditation assessment teams

- Not all Heads are convinced that the standards are applied consistently. They are dubious about some programs at other institutions.
- Stating that something meets the standards in one context, but saying that it does not in another.
- Ignoring the processes of natural justice when dealing with student comments.
- Incorrect material on the web-site. (p12)

The preparation and training of assessment teams varies across professions with some providing face-to-face or online training, and others relying upon written handbooks. For example, as noted in by the AMC:

“The AMC’s training of teams includes written resources, buddyng a new and an experienced assessor, and annual accreditation workshops, led by the Chair of the relevant accreditation committee and AMC accreditation staff. The AMC invites to the workshop: assessment team chairs and deputy chairs, new members of assessment teams, academic heads of education providers undergoing accreditation, medical students/trainees from providers undergoing accreditation. The workshop is an opportunity to learn about the experience of accreditation, consider the role of the different groups engaged in accreditation and learn the processes and techniques for site visit interviews and team evaluation of a medical program against the accreditation standards. This workshop is not only about training, but also about transparent engagement of the providers in the preparation for accreditation assessments.” (p11)

The APC has also established a comprehensive training and selection process for Site Evaluation Teams (SETs) including online training modules. A summary of the modules from the APC submission (p17) lists:

- **SET Module One** provides an overview of the APC accreditation framework which ensures the quality, consistency and rigor of standards and audit processes.
- **SET Module Two** focuses on how to prepare for a SET audit and undertake an initial assessment of an application, ready for the site visit.
- **SET Module Three** outlines methods and tips to conduct an on-site audit which focuses on evidence-gathering against the APC guidelines and standards.
- **SET Module Four** (optional) provides techniques and tools to enable a member to contribute to the development of an evidence-based report against the APC guidelines and standards.

It is evident that, whilst some professions have consistent and well-designed approaches to training, a contributing factor to the large variability in accreditation assessments is likely to be inconsistency or inadequacy of the preparation of assessment teams. The Phillips KPA report also highlights that smaller professional bodies may not have the available resources to invest in development and training.

The Review considers that a standardised approach to the training and preparation of assessment teams would potentially address the unpredictability in assessment processes across professions and education providers. Training should provide opportunities for engagement and networking, as utilised by the AMC, and include development in skills such as communication, adult teaching techniques, future health care models, innovative approaches to health education and training (including international and national best-practice models), auditing/sampling techniques, and a clear direction on the scope of assessment. Where appropriate, existing best-practice approaches and training should be utilised, such as on a fee for service basis, rather than the development of new resources.

A quality assurance process for monitoring the relatability of assessment teams and experts should also be considered. Options could include a regular self-assessment/peer review of assessors and standardised reporting templates with greater clarity and consistency in terminology. As noted previously, some of the accreditation authorities are considering and progressing the use of an electronic reporting tool to collect and collate information which could also create opportunities for data integration across professions.
Remuneration of panel members

Accreditation authorities have policies which guide remuneration, travel arrangements and honorariums paid to assessors. Payment to assessment teams varies with some authorities aligning payment with the Remuneration Tribunal (an independent statutory body that handles the remuneration of certain Commonwealth officers) and others establishing their own rates. Some authorities have in place a lump sum arrangement whilst others base payment on the number of days worked. Assessors are also paid honorariums whilst undertaking onsite assessments which cover meals, accommodation and travel expenses. Accreditation councils factor in the cost of remuneration, honorariums and travel expenses in the fees charged to education providers and overseas trained practitioners and in their funding requests to National Boards.

In addition to the respective policies of the accreditation councils, AHPRA also has in place remuneration and travel policies which apply to its staff, National Boards and the three accreditation committees. AHPRA fees for Committee members are based on the Queensland Government Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities and have been approved by the Australian Health Workforce Ministerial Council.

The Review examined the fees paid to panel members by accreditation councils against the AHPRA Schedule of Fees. Daily fees paid by the Chiropractic, Dental, Nursing and Midwifery, Osteopathy and Pharmacy accreditation councils to assessment panel members were within the benchmark or lower than the sitting fees paid by AHPRA. The AMC aligned its payments with the Commonwealth Remuneration Tribunal. The Review was unable to assess the fees paid by ANZPAC and OTC as these were lump sum payments and not based on the number of days worked. The Review did not receive remuneration information from APhysioC and APAC.

It is administratively inefficient for each accreditation authority to develop (and annually update) its detailed polices on remuneration and travel. It also makes any comparison or benchmarking of accreditation costs very difficult. To enable greater consistency and reduce administrative cost, this Review proposes a common approach to the remuneration of assessment panel members, their travel and payment of honorariums. Whilst the Review does not consider it appropriate to make recommendations on how these should be set, there is an obvious attraction to a consistent approach in this regard across all National Scheme entities.

This Review has specifically not considered the payments paid to members who sit on accreditation council governance boards. It is considered these are entirely matters for the accreditation councils who are independent, not for profit registered companies.

Draft recommendations

4. Cross profession policies and guidelines should be developed to improve the efficiency of the accreditation process including:
   - Standardised terminology and definitions across the accreditation process.
   - An accreditation standards template based on common domains.
   - Consistent assessment processes, procedures and timeframes.
   - A common reporting framework that sets out uniform requirements for education providers and includes consistent risk indicators and standardised data collection.

5. Cross profession policies and guidelines should be developed to improve the quality and performance of assessment panels, including through consideration of:
   - A common register of experts with comprehensive and consistent training.
   - A regular review process for panel quality assurance and performance.
   - A common approach to the remuneration of assessment panel members.
5 Relevance and responsiveness of education

This Chapter explores the opportunities provided in, and constraints created by, the existing accreditation regulatory system in delivering relevant and responsive health education programs that align with the National Scheme objectives and address health workforce priorities. In particular, it examines the value of outcome-based accreditation standards, the role of professional competency standards, approaches to interprofessional education and practice, the relevance and quality of clinical placements, definitions of work readiness and the role of national examinations.

An effective accreditation process advances the health education system by guiding the continual quality improvement of programs of study to achieve best-practice and to respond to health service reform priorities. As noted by the Australian Physiotherapy Council:

“The effectiveness of the accreditation system is predicated on balancing regulation (which has a focus on public safety) with the capacity for innovation and thereby the responsiveness to rapidly emerging drivers.” (p2)

The Productivity Commission in its Staff Research Note On efficiency and effectiveness: some definitions (2013) defines effectiveness as “the extent to which stated objectives are met – the policy achieves what it intended to achieve.” (p6) In essence, effectiveness is an assessment of whether the system’s outputs achieve the intended outcomes. Four of the six objectives set out in the National Law relate directly to the effectiveness of health professional education and training, with two of them also addressing the broader issue of innovation in service delivery (i.e. service access and workforce reform). The relevant objectives include requirements to:

- Provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
- Facilitate the provision of high-quality education and training of health practitioners.
- Facilitate access to services provided by health practitioners in accordance with the public interest.
- Enable the continuous development of a flexible, responsive and sustainable health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

Accreditation authorities and their processes can contribute to the achievement of these objectives by driving beneficial innovation in health professional education and responding promptly to workforce reform priorities through the development, implementation and assessment of accreditation standards. Education providers are guided by both accreditation and professional competency standards in designing a contemporary curriculum and program of study. An inflexible approach to the content of, and assessment against, accreditation standards and competency standards can limit the responsiveness of education providers.

Consumers, as end users of the system, expect that practitioners will respond to changing health care needs, that competency standards maintain their currency, and that education programs will keep up with these changes. Consumers expect that the system produces competent and skilled graduates who are ready to work in new and evolving healthcare environments. As noted in one consumer’s submission:

“Accreditation processes should contribute to creating the workforce the community needs and prefers, now and into the future. This includes: ...Anticipating and responding to new and emerging consumer- and community-centred service models that focus on what matters to consumers: achieving safety, wellness and quality of life.” (Consumer 2, p4)
At the Consumer Health Forum workshop in March 2017, held as part of the Review’s consultation process, one participant reflected that a health professional’s primary purpose is to ‘help people live well lives’. Consumers currently observe a scheme of 14 professions, each with their own National Board and accreditation authority. They are cognisant of siloed approaches which are counterintuitive to team-based care arrangements which aim to place a patient at the centre-of-care to achieve a ‘well life’. They do not see the differences between, or need for, 14 different sets of accreditation requirements. There was support at the workshop for a more unified and effective accreditation system which encouraged respect, inter-collegiality and collaboration across health professions, and greater commonality of fundamental skills training whilst retaining technical/craft-specific skills. A more unified consumer engagement process to capture the patient voice was also supported.

**Input and outcome-based accreditation standards**

The accreditation standards and assessment processes, while contributing to educational quality assurance, should not unnecessarily constrain educational innovation in the development of a flexible and responsive health workforce. The Review has assessed the respective benefits and limitations of outcome-based standards compared to those which specify educational inputs and processes.

The HPACF has adopted and/or produced a number of documents which provide guidance to accreditation authorities in the delivery of best practice. For example, the [High-level Accreditation Principles](#) recommends:

- A right-touch approach based upon a proper evaluation of risk, is proportionate and outcome focussed.
- Development of accreditation standards that give priority to outcomes and results, and encourage improvement and innovation in education programs.

Historically, higher education has focused on subject and time-based learning with predominantly summative assessment methodology. This placed an emphasis on knowledge rather than on the attainment of competency. An outcome or competency-based approach focuses on monitoring the desired performance characteristics of graduates and establishes observable and measurable metrics that demonstrate successful achievement of the identified competencies ([Gruppen, 2012](#)). As noted by Garfolo (2016):

> “Competency based education moved education from an academic focus (what graduates need to know from an academician’s point of view) to a workplace focus (what graduates need to know and do in a variety of complex workplace situations).” (p97)

Most accreditation authorities are either considering, currently developing, or have already implemented accreditation standards with a focus on outcomes. An outcome-based approach, with an emphasis on competence, provides flexibility to respond to changes in community health care needs, technology and innovations in health practices. It puts the onus on education providers to demonstrate that the program of study and associated training (however delivered) will produce high-quality graduates with the knowledge, skills and professional attributes necessary to practise the profession.

Some examples of outcome-based accreditation standards and statements on competencies include:

- **Medicine**: [Procedures for Assessment and Accreditation of Medical Schools](#) (2017) specifically notes assessments focus on the achievement of objectives, maintenance of educational standards, public safety requirements, and expected outputs and outcomes rather than on detailed specification of curriculum content or educational method.

- **Optometry**: [Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs; Part 2 – Standards](#) (2017) recognise practice in standards development across Australia and internationally, where there is a strong shift away from ‘inputs’ towards patient and learner centred ‘outcomes’.

- **Dental**: [Professional competencies of the newly qualified Dentist](#) (2016) outline the attributes and competencies required by a new graduate. They note that, although it does not prescribe the curriculum of a training program, providers need to demonstrate that learning outcomes address the competencies and that there is a clear relationship between learning outcomes and the student assessment used.
Support has been expressed by some stakeholders for the retention of a limited number of input-based standards on the basis that they can provide clear guidance to education providers and direct the necessary minimum achievement of specific tasks. Some accreditation authorities include input-based standards to align with international benchmarking. Examples of standards that include input-based requirements are:

- **Nursing**: Registered Nurse Accreditation Standards (2012) are predominantly outcome focussed. They state that the standards do not prescribe the content of the curricula, the inclusion of core subjects or the educational approaches required to deliver the study program. However, the criterion in Standard 3 specifies that the program provider must demonstrate a minimum of 800 hours of workplace experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health-care settings.

- **Occupational Therapy**: Accreditation Standards for Entry-level Occupational Therapy Education Programs December (2013) states in Standard 4.2 that fieldwork/practice education experiences are of sufficient duration to allow integration of theory to practise. The standard references the World Federation of Occupational Therapists’ requirements as being a minimum of 1000 hours, including at least one fieldwork placement of up to eight weeks duration.

- **Podiatry**: Accreditation Standards for Podiatry Programs for Australia and New Zealand (2015) state that the indicative clinical practice amount per student is a minimum of 1000 hours.

The Occupational Therapy Council (Australia and New Zealand [OTC]) advises that its requirement for 1000 hours of fieldwork is to ensure “that occupational therapy education programs in Australia are not required to undergo a separate accreditation assessment via the professional association to meet international requirements for employment of graduates.” (p8) The Review has undertaken an initial investigation and has identified that this is not a consistent requirement across many jurisdictions and that the World Federation of Occupational Therapists’ is a private organisation made up of professional associations from a number of countries. Whilst alignment of standards to international requirements can provide mobility for practitioners, and participation in international forums may contribute to continuous improvement, it may not be a sufficient reason to maintain an input-based accreditation standard.

The inclusion of some input-based standards can also be in response to views within a profession itself. The Australian Nursing and Midwifery Accreditation Council notes that the stipulated minimum of 800 hours of clinical experience was instigated when the norm was an excess of 1000 hours. However:

> “the profession was trying to balance the criticism that nursing graduates were not workplace ready with the increasing demand for clinical placements and the increasing number of placements at university for nursing students and the lack of evidence to support an appropriate workplace experience. “ (p4)

Many of the input requirements identified in accreditation standards relate to hours of workplace experience. This raises questions regarding the type and amount of skill development expected from these placements and the consideration of alternative options where appropriate (such as simulation-based learning environments).

Interaction with patients is essential for the development of key professional skills such as communication and empathy (Leonard, 2004). However, attaching prescribed hours to clinical placements presumes that the competence required will be achieved at completion. Whilst it is intuitive that more hours of practice or the more times a task is completed will lead to more highly developed skills (as implied by the Minimum Operative Experience by some specialist medical colleges), it is suggested that validated measurement and a holistic assessment of competence should align with the attainment of learning outcomes. As noted in the Australian Catholic University submission:

> “While students value exposure to the workplace during their courses, there is little evidence to support a fixed number of hours of supervised practice for any health discipline. The crucial element is the overall outcome of the learning experience that occurs within a course of study rather than the input measure that is the proxy for this outcome.” (p5)
Many submissions by stakeholders proposed balancing input and outcome-based standards.

<table>
<thead>
<tr>
<th>Box 5.1 Stakeholder views regarding input and outcome-based accreditation standards</th>
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<tbody>
<tr>
<td><strong>Australian Medical Council</strong></td>
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<tr>
<td>The AMC supports outcome based standards; these are better correlated with medical practitioner skill sets and, ultimately, health outcomes. It is also important to consider inputs when undertaking accreditation, as this facilitates analysis and discussion of the causes of variation in outcomes. What is not warranted or necessary, in the AMC’s experience are standards that prescribe particular governance structures, processes, a particular curriculum model, or specific hours or subjects. (p14)</td>
</tr>
<tr>
<td><strong>Australian Psychology Accreditation Council</strong></td>
</tr>
<tr>
<td>Our focus in our proposed new standards has moved from an inputs-based approach to primarily an outcomes-based approach, albeit supported by a number of key inputs which have been retained at the request of stakeholders. We expect that this change will allow for more flexibility in the ways providers may choose to structure programs, and allow for innovative and effective approaches to learning and teaching. (p16-17)</td>
</tr>
<tr>
<td><strong>Australian Rural Health Education Network</strong></td>
</tr>
<tr>
<td>The outcomes based accreditation framework should focus education providers on determining and demonstrating how they meet accreditation and curriculum specifications, including the depth, complexity and volume of learning, rather than simply ticking boxes associated with inputs and outputs. (p4)</td>
</tr>
<tr>
<td><strong>Division of Tropical Health and Medicine, James Cook University</strong></td>
</tr>
<tr>
<td>Overall, there needs to be a balanced mix of input, process and outcome-based standards. We also recommend that all accrediting teams consider performance measures such as QILT and other higher education innovations in the Australian scene in their assessments. We also emphasise a need for the criteria for the outcome-based standards to be clearly defined. (p16)</td>
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<tr>
<td><strong>Australian Catholic University</strong></td>
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<tr>
<td>There may be circumstances where input and process standards are required but, in most cases, input standards are unjustified. For instance, the hours some disciplines prescribe for clinical learning are not justified by research and are quite arbitrary, and do not allow simulation to be a recognised adjunct to clinical supervision. (p5)</td>
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<tr>
<td><strong>Curtin University</strong></td>
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<tr>
<td>Standards driven by evidence and practice. Currently there is no transparency on the fundamental drivers that create the standards. For example, is there any evidence that a staff ratio of 1:15 is necessary for effective small group work, or that a minimum of 600 hours vs 1000 hours of supervised clinical practice is necessary to graduate a competent practitioner? (p1)</td>
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<td><strong>Faculty of Pharmacy, University of Sydney</strong></td>
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<td>We are of the view that input and process standards should be included, where warranted. Educationally speaking, this issue and #9 below, speak to a broader and important point about assessment, outcomes and standards. All three should be closely aligned, particularly as some risks to the sustainability and quality of the programs are input-related, for example, governance, finances, staffing profile in terms of qualification and expertise, quality and numbers of the student cohort. (p3)</td>
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<td><strong>Director from a University Department of Rural Health, Australian Rural Health Education Network</strong></td>
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<td>An inputs/outputs approach can be a real problem in rural and remote placements. We may have a student on placement working with patients with very complex needs but because scheduled patients don’t show due to the vagaries of travel or whatever, they can’t tick off the nominal number of required consultations. This approach gives no weight to the fact that the patients they have seen have multiple issues and complex needs providing a much richer and challenging learning experience that has in fact ticked off all the learning requirements. (p4)</td>
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Assessment against outcome-based standards can be more complex than measurement against defined inputs. In this context, Holmboe (2010) suggests that competency based education requires a multi-pronged approach with a greater focus on formative assessment to ensure a student receives frequent and high-quality feedback that assists in their ongoing development of competencies. This does not underestimate the value of summative assessment and the need for clinical skills assessment.

Whilst not in line with current educational approaches, it is possible that input and process-based indicators can, in certain circumstances, contribute to demonstrating that an accreditation standard domain or element has been achieved. The Review proposes that input and process-based indicators must be justified by strong evidence and supported by a peer-review governance process to ensure relevance and consistency.

National Boards are responsible for approving accreditation standards and assessments of providers and their programs of study, as well as developing or approving registration standards, codes and guidelines for the health profession. Whilst registration standards are outside the purview of this Review, it is noted that they can outline requirements for interns and specialist training which are commonly input focused. These standards often specify number of hours, number of training sessions and define work experience locations and types without stating the evidence which links the requirements to higher quality outcomes.

**Draft Recommendations**

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

**Simulation based education and training**

Simulation based education and training (SBET) is gaining acceptance as an evidence-based education modality which can develop skills, confidence and problem-solving abilities in a safe, controlled and monitored environment (Solymos, 2015). SBET has been shown to improve knowledge, skills, attitudes, teamwork and communication, systems and processes, and the identification and mitigation of threats to safety (Gaba, 2004; Stone, 2016; Smith, 2015). Simulated Learning Environments (SLEs) are recognised as particularly useful to introduce students to critical care situations (Solymos, 2015) and team-based, interprofessional scenarios (Davis, 2016). Simulation scenarios can be used to assess performance and competence and, with well-trained educators and appropriate coordination and support, may expand clinical learning opportunities and alleviate pressures on health services to provide clinical placements. Nonetheless, interactions with ‘real-world’ clients and situations are essential for the development of empathy and communication skills (Leonard, 2004).

The current accreditation standards vary in their acceptance of simulation as a standard component of the health curricula. Some examples include:

- **Podiatry:** [Accreditation Standards for Podiatry Programs for Australia and New Zealand](2015) note that possible examples of evidence could include ‘models of clinical education utilised, including details on use of emerging innovations for developing clinical competencies such as simulation’.

- **Occupational Therapy:** [Accreditation Standards for Entry-level Occupational Therapy Education Programs December](2013) notes that an education provider may include up to 20% of well-designed simulation experiences in the range of practice/ education/fieldwork opportunities available to students.

- **Pharmacy:** [Accreditation Standards for Pharmacy Programs in Australia and New Zealand](2014), when referring to Experiential Placements, note that ‘simulated experiences may support the development of clinical skills and competences required by Pharmacists to supplement and complement, but not replace, the placement experience’.
A number of submissions identified the value of simulated experiences being made available.

Box 5.2 Use of simulation-based education and training in health programs of study

**Australian Private Hospitals Association and Catholic Health Australia**

*Simulation-based learning is essential, and should be included as a tool in curricula and clinical experience provision to students. It is especially valuable to provide multidisciplinary training opportunities. Having said that, it is important to stress simulation should be one of the tools, and should not be the only way students receive clinical experience. It is not acceptable to rely on simulated learning as a substitution for adequate clinical placement.* (p6)

**Australian Dental Council**

*The ADC considers this a matter for educators and as an accrediting authority we must ensure only that we are not a barrier to the incorporation of contemporaneous or innovative education methodologies. All entry to practice level dental programs will definitely include a strong element of simulation.* (p28)

**Australian Pharmacy Council**

*Schools of Pharmacy use simulations as a key part of pharmacist education, and we recognise the importance of this. Our standards rightly state that simulation can support the placement experience, but not fully replace this. In particular, simulation has a role in first experiences in pharmacy.* (p26)

**Edith Cowan University**

*The special value of simulation-based learning is that the environment and what happens within, can be manipulated in line with the learning objectives, unlike in real life. ECU believes that the NRAS is the most appropriate instrument for furthering the uptake of SLEs in Australian health professional education. There needs to be explicit recognition of the benefit of these learning experiences within accreditation processes across disciplines so that higher education providers feel confident in embedding them within programs* (p18)

**Department of Health and Human Services Tasmania**

*Simulation is a good example of a wide training variation across the professions. Successful use of simulation education could be translated to great effect in terms of driving innovation in education methodologies to support the delivery of health services into the future.* (p3)

Health Workforce Australia (HWA) made significant investments in facilitating the use of SBET. The focus of its Simulated Learning Environments Program was to “look at innovative and affordable ways to deliver clinical training.” This included building the evidence for simulation, enabling the adoption of simulation and expanding simulation capacity to increase physical SLE resources and numbers of trained staff.

The HWA initiative was able to evidence the value of SLEs but, with the abolition of that agency the program ceased before recognition and standardisation was achieved broadly across professional programs of study. In addition, despite the scope and funding of the HWA program, the Review is not aware of any enduring overarching national approach or guidelines for the use of simulation in education and training.

Simulation represents just one innovative education and training modality, amongst ever-evolving new and advancing technologies in pedagogical instruction and delivery of modern health care. To maintain currency, accreditation standards should promote and encourage education providers to incorporate innovations and technologies, including SBET, in the delivery of programs of study. An outcomes-based approach should put the focus on the assessment and achievement of health professional competence.

**Draft Recommendation**

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

Professional competency underpins the registration system, and professional entry education is expected to deliver the knowledge, skills and attributes necessary to practise the profession. As noted by Universities Australia, quality assurance through health education accreditation:

“... enables continuous quality improvement, brings professional knowledge to university teaching practices, assists in the consistent delivery of competent and appropriately skilled health professionals and provides a pathway for developing the future health workforce in line with emerging trends.” (p1)

Each health profession accreditation standard refers to professional competency standards (also known as professional capabilities, professional attributes, standards/thresholds for practice). These documents describe the desired characteristics and threshold competencies of graduates and entry-level practitioners. As depicted in the Chiropractic Accreditation and Competency Standards (2017, p4), accreditation standards and competency standards are inextricably linked (see diagram below).

As competency standards specify the skills required of individual practitioners, they are also fundamental to the registration function. As noted in the joint National Boards/AHPRA submission:

“professional capabilities have a critical regulatory purpose because they establish threshold capabilities for initial (and continuing) registration. Because the focus is on registrant capability, they should reflect contemporary practice and provide an important mechanism to respond to changing consumer and health service needs and priorities.” (p7)

Development of the standards

There is variability across professions regarding the authorship and ownership of the competency standards. This currently includes the National Boards, accreditation councils and the professional associations. They are not developed formally within the purview of the National Law, even though they are referred to in the accreditation standards, underpin curricula developed by education providers and are used by accreditation authorities in their assessment processes. There is a trend, however, for them to be increasingly formalised.

The joint National Boards/AHPRA submission notes that “since the National Scheme, the direction is increasingly for National Boards to fund development and ‘own’ the capabilities.” (p7) This may also reflect the move of some competency standards towards a CanMEDS approach (discussed further below) which applies to practitioners across the career continuum and demonstrates their potential relevance to other aspects of practitioner regulation such as Continuing Professional Development.
Whilst the involvement of educators, practitioners and regulatory bodies in the development and review process is identified in many of the competency standards, few mention the involvement of consumers and others (e.g. employers or target population groups such as Aboriginal and Torres Strait Islander advocates) who could provide critical perspectives of community need and broader workforce reform. As noted by the Australian Healthcare and Hospitals Association (AHHA) and the AMC:

“Such frameworks should be developed in collaboration with employers and education providers (so there is agreement in expectations for ‘work readiness’ and the delineation between registration requirements and employer training are clear), and with consultation with the public and Governments (so that public expectations are met, safety can be assured and health workforce reform can be achieved). If there are multiple steps towards becoming registered, the framework should identify the expectations of students at each step, reflecting a clear continuation towards being competent.” (AHHA, p6)

“the AMC considers that health consumers, employers, jurisdictions, education providers and other health professions as well as the medical profession have capacity to contribute to the development of these competency frameworks.” (AMC, p15)

Given the strong relationship between professional competency standards and how a professional operates in practice, it is important that there is broad consultation on them. The principle of the ‘wide-ranging consultation requirements’ as outlined in the National Law (s46(2)) for accreditation standards should equally apply to the development of competency standards.

Content and structure

Rather than specifying the detail of any curriculum, the competency standards provide guidance to education providers on the required learning outcomes for a program of study. During an accreditation assessment, evidence demonstrating that the curricula is mapped against the domains, elements and performance criteria of competency standards is examined to assure competence will be achieved by graduates.

Whilst technical skills and knowledge define a particular profession, there are common characteristics across all health practitioners that contribute to healthcare practices. A number of projects and frameworks have sought to define these underpinning common competencies, as demonstrated by two initiatives outlined below:

**Threshold Learning Outcomes for Health, Medicine and Veterinary Science**

In 2011, as part of a broader higher education reform agenda, the Australian Learning and Teaching Council developed the **Threshold Learning Outcomes (TLOs) for Health, Medicine and Veterinary Science** to align with the Australian Government’s standards based quality assurance framework. The TLOs were developed to provide an overarching statement of healthcare professional-entry level outcomes and to define common domains of competence that graduates are expected to demonstrate. The TLO domains are:

- Demonstrate professional behaviours
- Assess individual and/or population health status and, where necessary, formulate, implement and monitor management plans in consultation with patients/carers/animal owners/communities
- Promote and optimise the health and welfare of individuals and/or populations
- Retrieve, critically evaluate, and apply evidence in the performance of health-related activities
- Deliver safe and effective collaborative healthcare
- Reflect on current skills, knowledge and attitudes, and plan ongoing personal and professional development.

During development, the TLOs were mapped against existing professional competency standards to identify alignment and logical fit. Further to this, in 2014, the **Harmonisation project** aimed to:

“…work with higher education institutions and healthcare professional accreditation agencies to identify and match the goals and expectations of education, professional and government institutions.”
The project sought to create common assessment principles that through achievement of the TLOs would simultaneously demonstrate compliance with accreditation, registration and higher education quality assurance requirements, thus potentially minimising the burden and cost of accreditation processes in practice. The project outcomes included engagement between disciplines, with the production of a framework of principles for incorporating professional accreditation and Australian Qualifications Framework standards into assessment mapping in health disciplines. Whilst the TLOs are mentioned in some accreditation reference material, there does not appear to be an approach to further their adoption or to standardisation.

**Common Health Capability Resource**

HWA also developed a national Common Health Capability Resource: shared activities and behaviours in the Australian health workforce which identifies five ‘overarching domains of activity common to the Australian health workforce’ (p9) as depicted in the following diagram.

HWA described the resource as a tool to inform workforce innovation and reform initiatives and to support development of common behavioural attributes in the workforce. Whilst it extends beyond the learning outcomes expected of a professional-entry program of study, the similarities with the TLOs are evident. Competency standards for at least ten registered and five non-registered professions were used in its development. However, it is not mentioned in current competency standards, and its current use is unknown.

Consistent with the findings of the TLOs and HWA common capability initiative, an analysis of current health professional competency standards by the Review highlights a range of common qualities, abilities, skills and required knowledge expected from high-quality health practitioners. These attributes include communication, professionalism and ethical behaviours, patient assessment and care, leadership, collaboration, cultural competence, critical thinking and evaluation, population health and comprehensive care. Despite this, each framework uses different structures, terminology and domains (or fields or elements) that define a competent health practitioner. For example:

- **Physiotherapy:** Physiotherapy practice thresholds in Australia and Aotearoa New Zealand (2015) state they describe the “competence required for initial and continuing registration.” They outline the varying roles played by a physiotherapy practitioner (including practitioner, professional and ethical practitioner, communicator, reflective practitioner and self-directed learner, collaborative practitioner, educator and manager/leaders) and describe the key competencies associated with each role.

- **Osteopathy:** Capabilities for Osteopathic Practice (2009) describes six domains across clinical analysis, person oriented care and communication, osteopathic care and scope of practice, primary healthcare responsibilities, interprofessional relationships and behaviour and professional and business activities.
- **Medicine:** The Graduate Outcome Statements within the [Standards for Assessment and Accreditation of Primary Medical Programs](#) (2012) defines four domains that define a competent medical graduate which are Science and Scholarship: the medical graduate as scientist and scholar, Clinical Practice: the medical graduate as practitioner, Health and Society: the medical graduate as a health advocate and Professionalism and Leadership: the medical graduate as a professional and leader.

At least two of the professions (medicine and physiotherapy) use a format that categorises the domains of competence into roles of the practitioner. This is similar to the CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada which extends the relevance of the framework beyond professional-entry to the skills demonstrated across the career continuum.

Given the underlying common qualities, abilities, skills and required knowledge in competency standards, there is an opportunity to consider a more common approach to terminology, structure and content. Submissions provided a range of differing views, particularly regarding maintaining a profession’s value and individuality.

### Box 5.3 Greater commonality across competency standards

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<th>Council of Ambulance Authorities</th>
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<td>A set of common competencies could be developed similar to those used by the UK HCPC and used to complement profession specific competencies, as well as providing a higher level of consistency across registered professions. The intra-disciplinary opportunity arising from the common competencies arrangement would be valuable especially in rural and remote settings where training opportunities can be infrequent. (p5)</td>
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<th>Australian Physiotherapy Council</th>
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<tr>
<td>...the Thresholds in Australia and Aotearoa New Zealand (2015) describe the competence required for initial and ongoing registration and describe the varying roles played by a physiotherapy practitioner. The Council notes that these roles share similar themes or domains with other available health professional frameworks, largely based on the CanMEDS framework and agrees that there would be value in working toward shared professional competency frameworks. Shared frameworks may have the additional benefit in providing a platform for reinforcing and embedding interprofessional learning. A useful starting point may be to agree on consistent and shared terminology with the other health professions. (p8)</td>
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<th>Joint National Boards/AHPRA</th>
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<td>There is also potential to achieve increased commonality across accreditation standards and potentially professional capabilities, on areas relevant to all professions to complement profession-specific content. Joint work by some Accreditation Authorities on interprofessional education and the Health Professions Accreditation Collaborative Forum work on prescribing are examples which could be built on to progress work on other important areas such as Aboriginal and Torres Strait Islander health and cultural competence. (p7-8)</td>
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<th>Australian Physiotherapy Association</th>
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<td>We believe a common approach to the development of professional competency frameworks would reduce the standards of safety and quality within the physiotherapy profession, and would endanger the public. We support a consistent approach to the accreditation of common elements of health programs; however common requirements should not be extended to professional competency frameworks. ...So while it may be tempting to look for a common approach to the formulation of profession specific competency frameworks, we believe that this would stifle the development of contemporary professional frameworks and limit the schemes ability to take a global approach to professional competency frameworks. (p10)</td>
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<th>Australian Medical Council</th>
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<td>The AMC competency framework is a set of graduate outcome statements, based on four domains which describe the roles of the medical practitioner. The AMC chose this structure because it is commonly used in most medical schools. There is no intrinsic benefit in aligning graduate outcomes for medicine with another profession. They are separate professions with separate roles. There is, however, benefit in aligning medical school and intern outcomes which the AMC has done. (p15)</td>
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As suggested in a number of submissions, there are common overarching domains and learning outcomes that could apply across professions, while at the same time the underpinning performance criteria and indicators need to be interpreted in the context of the profession in practice and reflective of the specific technical capabilities. As such, professional input is paramount.

**Competency standards and responsiveness to health priorities**

System-wide safety and quality standards are regularly updated to reflect evolving community needs. These generally outline a national policy direction and provide guidance to the health system on the processes and procedures required to deliver safe, high-quality and culturally respectful services. They should also be reflected within an education provider’s program of study to ensure health graduates have the most current knowledge, skills and attributes required to practise the profession.

These standards often contain elements that can be translated directly into practitioner competencies and could either be referenced within competency standards or as content and context within a health curriculum.

**National Safety and Quality Health Services Standards**

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is the government agency responsible for driving a sustainable, safe and high-quality health system. ACSQHC develops the National Safety and Quality Health Service (NSQHS) Standards and oversees the accreditation of health service settings through the approval of accrediting agencies to assess health service organisations against these standards. Whilst the NSQHS Standards are directed at organisational clinical governance, health practitioners employed in these health services are responsible for providing care in accordance with the NSQHS Standards.

The NSQHS Standards (second edition) were approved by Ministers in June 2017. They comprise eight standards including clinical governance, partnering with consumers, preventing and controlling healthcare-associated infection, medication safety, comprehensive care, communicating for safety, blood management and recognising and responding to acute deterioration. Many are central to the clinical practice of health practitioners and should thus be reflected as professional competence or incorporated into a program of study.

The ACSQHC has recently surveyed education providers to determine what they currently teach about the NSQHS Standards and alignment with the programs of study for a number of health professions. Whilst analysis is ongoing, it is understood that this varies considerably. The outcomes of this project will inform the development of supporting materials for implementation of the NSQHS Standards, and could also guide references in professional competency standards.

**Aboriginal and Torres Strait Islander health – cultural safety and capability**

Given the priority to address generally poorer health outcomes for Aboriginal and Torres Strait Islander people, it is important to ensure all health practitioners are equipped with cultural capability. As noted by CATSINaM “...cultural safety and respectful practice are as important to quality care as clinical safety.” (p5)

In 2011, Health Workforce Australia released Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker project which sought to strengthen the Aboriginal and Torres Strait Islander health workforce. It also identified the need for non-indigenous health professionals to be clinically and culturally capable and recommended embedding cultural competency curricula in all health professional training. In response, the Aboriginal and Torres Strait Islander Health Curriculum Framework was developed to provide a benchmark for cultural capability standards and an interprofessional approach for consistent learning outcomes. This document provides resources and guidelines, including for accreditation authorities, regarding how to incorporate cultural capability within programs of study. As noted by Edith Cowan University:

“This has seen some excellent developments in the implementation of Aboriginal and Torres Strait Islander health curricula across some professional organisations and accreditation authorities, though more can be done by other accreditation authorities, particularly those sitting under the NRAS, to adopt this Curriculum Framework.” (p13)
In 2016, the National Aboriginal and Torres Strait Islander Health Standing Committee developed the Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health for AHMAC. The Framework commits all governments to include ‘cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services’. The vision of this framework is to provide better and more culturally aware health care.

In addition, the National Boards, AHPRA and accreditation authorities have established an Aboriginal and Torres Strait Islander Health Strategy Group to develop an ‘Aboriginal and Torres Strait Islander Health Strategy for the National Registration and Accreditation Scheme’. The vision of this strategy is to achieve:

“Patient safety for Aboriginal and Torres Strait Islander peoples in Australia’s health system is the norm, as defined by Aboriginal and Torres Strait Islander peoples.”

Whilst work is ongoing, the 16 June 2017 Communique affirms the importance of cultural safety and Aboriginal and Torres Strait Islander health training for all practitioners under the National Scheme.

Many accreditation standards already specify the need for cultural competence to be integrated into programs of study. Applying equally to all health professions, the Australian Indigenous Doctor’s Association noted:

“Formalising an expectation of cultural safety in standards for accreditation would ensure that trainees and fellows, both Indigenous and non-Indigenous, and medical college staff are culturally safe and provide optimal education and employment environments for Aboriginal and Torres Strait Islander people.” (p3)

Safety and quality and cultural safety and awareness are key competencies for all practitioners and should be included within competency standards. Standardised and mandated references would ensure implementation through appropriate health practitioner education and training. Identifying a particular topic for inclusion within an accreditation standard or competency standard is often not enough, however, to ensure active implementation within a program of study – as has been demonstrated with Interprofessional education. The Australian College of Rural and Remote Medicine reflected that:

“It should be noted that the NRAS is not the only mechanism by which healthcare priorities can or should be incorporated into professional education. Valuable initiatives also arise out of direct dialogue between the government (jurisdictional and federal) and colleges/professional organisations as appropriate to specific health priority issues.” (p6)

Guidance and clear direction is required to facilitate a pathway to implementation within programs of study, clinical placements and in the workplace. A governance approach to the promotion of cross-professional and cross-sector engagement, and to assist in achieving these objectives, is explored in Chapter 7.

Interprofessional education, learning and practice

Team-based health care is essential to the delivery of safe, high-quality patient-centred health services. Interprofessional practice is also an important contributor to the sustainability of the workforce in the face of financial and human resourcing constraints. The accreditation system strongly influences the education and training delivered in health professional programs of study, as noted in the ‘Securing an Interprofessional Future’ submission to the Review:

“Accreditation not only acts as a cultural marker of inclusion, legitimacy and status but, importantly, in terms of available incentives, requires action that meets externally prescribed criteria.” (p8)

Almost all accreditation standards include a reference to interprofessional learning, albeit in different terms and with varying degrees of attention through the assessment processes. The Centre for the Advancement of Interprofessional Education (CAIPE), in its Interprofessional Education Guidelines 2017, defines interprofessional education (IPE) as “occasions when two or more professions learn with, from and about each other to improve collaboration and quality of care.”
The literature recognises interprofessional practice as an important contributor to positive health outcomes through improved communication, efficiency, cost effectiveness and the patient-centeredness of the health care team (McNair, 2005). In like manner, the World Health Organisation’s (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010) notes that IPE is a “…necessary step in preparing a “collaborative practice-ready” health workforce that is better prepared to respond to local health needs.” (p7) The framework further adds to the definition of IPE the objective to improve health outcomes.

As noted in the WHO’s 2010 Framework, IPE must be purposeful, requiring supportive management practices, a resolve to change the culture and attitudes of professional bodies and workers, and a willingness to update, and renew existing curricula. It must extend beyond the classroom where different professions learn common subjects, to opportunities for shared communication, understanding roles and functions of other health professions and opportunities for collaborative and innovative team-based practice models with patients at the centre of care. Educators and supervisors must be trained and supported to deliver and assess well-constructed learning outcomes (Stein, 2016) – irrespective of profession or discipline.

The HPACF outlines in its guiding principles the need for interprofessional learning. It also issued a position statement from its Interprofessional Learning Workshop 2015 which endorsed a shared definition and commitment to adopt a common statement for accreditation processes. Whilst a number of the accreditation standards reference interprofessional learning, progress in meeting this aim is variable. For example:

- **Podiatry:** The Accreditation Standards for Podiatry Programs for Australia and New Zealand (2015) specify that graduates understand the importance of interprofessional practice and are able to contribute to teams of health care practitioners in a cooperative, collaborative and integrative manner.

- **Nursing:** Registered Nurse Accreditation Standards (2012) require that workplace experience opportunities are to be provided for intraprofessional and interprofessional learning and development of knowledge, skills and behaviours for collaborative practice.

- **Physiotherapy:** Accreditation Standard for Physiotherapy Practitioner Programs (2016) specifies principles of interprofessional learning and practice are embedded in curriculum.

The literature highlights that IPE opportunities can be difficult to execute in health programs due to issues such as entrenched professional and organisational cultures, limited financial resources, conflicting curricula, and supervision of clinical placements (Lawlis, 2014). This is also reflected in the WHO’s Interprofessional Collaborative Practice in Primary Health Care: Nursing and Midwifery Perspectives. Six Case Studies (2013).

Since 2009, the Commonwealth Government has supported work to consider opportunities to promote and develop IPE (as outlined in the Curriculum Renewal in Interprofessional Education in Health: Establishing Leadership and Capacity. This has included the identification of eight Interprofessional learning competency standards as part of the Harmonisation extension project). Current work includes a project entitled ‘Securing an interprofessional future for Australian health professional education and practice’. The intended outcome is a whole of system approach to Australian IPE “to ensure that every student who graduates from an Australian university with a health profession qualification at entry level has achieved the core capabilities required for successful interprofessional and collaborative practice and continuing interprofessional learning.” (p3)

IPE has been on the national agenda for almost a decade, including project funding support from Commonwealth and State entities. Like many other countries, Australia has numerous positive examples of IPE and collaborative practice. It is noted, however, that there are few examples of countries that have managed to incorporate IPE into their accreditation process, although Canada and the United Kingdom (UK) are working towards this objective (SIF project, p6).

The sustainability of initiatives and projects is often precarious as they tend to be local, organisation based and/or dependent upon change champions. Despite these pockets of proactive and positive initiatives, it is apparent that IPE is still not consistently or adequately represented in education curricula or course delivery. Incentives and drivers are required to systematically operationalise this concept into practice, such as through the development of common and clear practical and overarching guidelines for IPE accreditation. A number of submissions identified the role for the accreditation system creating a collective and shared approach.
Stakeholder views regarding the role of the accreditation system in IPE

**Australian Dental Council**
If the vision remains narrow or there is an unwillingness to engage in these discussions regarding the future health needs and health workforce needs, interprofessional education or other initiatives will fail before they begin simply because they have no purpose. (p14)

**Securing an interprofessional future for Australian health professional education and practice project**
While it may well be that additional powers and incentives are required by the Australian accreditation system, there is both a need for and an opportunity to prescribe greater consistency and commonality in the way in which IPE standards are defined and IPE accreditation conducted. (p9)

**Australian Psychology Accreditation Council**
A criterion in the standards, common to all professions, requiring interprofessional education to be part of all programs of study, would be acceptable to APAC. (p19)

**Australian Osteopathy Accreditation Council**
Further development of interprofessional education (IPE) across the professions would require a shared standard with a clear definition for the term IPE together with criteria to ensure consistency. The standard needs to be sufficiently broad to enable innovative approaches by education providers to meet the standard while taking account of the structural constraints education providers face in delivering interprofessional learning. (p9)

**Medical Deans Australia and New Zealand**
It is important the focus remains on the intended outcome which is the delivery of effective team based health care, not the delivery of an interprofessional educational activity. Not all interprofessional educational activities result in better team-based care; some detract from it.

There are some common curricular domains (e.g. professionalism, leadership, communication, research skills) across many health professional degree courses and a common approach in these areas may be achievable. However, interprofessional learning opportunities need to be real and not contrived and can be extremely resource intensive to deliver. (p5-6)

**University of Newcastle**
...good inter-professional practice is not commonly seen in the workplace so translating education to practice is difficult and the priority of IPE in curricula and for students is diminished. (p5)

**Joint National Boards/AHPRA**
The National Scheme can make an important contribution to embedding interprofessional education and practice in the health system but cannot achieve this alone. Including IPL in entry to practice education is only one part of what is needed to effectively promote and build interdisciplinary practice. (p9)

**University of Sydney**
The University supports evidence-based reform of accreditation processes that aim to more closely align those processes to education and research strategies of relevance across the range of health professions, such as in interprofessional education and in translational science. We see two primary benefits.

The first is that graduates’ mastery of common health profession elements and domains provides an enriched understanding of the broader systems within which graduates operate, as well as a strong foundation for interprofessional communication and innovation.

The second is that interprofessional health care is known to enhance patient care outcomes. Interprofessional learning as an important component of clinical training supports multi-professional input for more complex assessment and diagnostic presentations, training and clinical practice needs. If the intent of accreditation processes were more aligned to evaluate contemporary health professional education strategies, those accreditation processes could directly contribute to the achieving of strong educational objectives. (p7)
The Review considers there is sufficient robust evidence, and cross-sector support to warrant the inclusion of a common approach to IPE within accreditation standards to deliver the learning outcomes of patient-centred, comprehensive care. Interprofessional practice needs equal recognition in professional competency standards. It is evident from the slow progress to date, however, that a cross-professional governance system is required to drive this agenda. It would include guidance on the evidence required of education providers to demonstrate their achievement of this element, and could include adoption of findings across professions (to eliminate need for multiple ‘silied’ assessments) and evaluation of IPE across a health school or faculty.

The Review also considers that quality interprofessional practice, as an outcome of IPE, should be reflected within professional competency standards and potentially in Continuing Professional Development requirements to place a greater emphasis on the use and uptake of team-based care.

There is a need for a clear feedback loop between workforce priorities, programs of study and accreditation assessment. It is noted that the SIF project is seeking to establish an IPE council to “enable and support the formulation, design and uptake of common IPE standards and a common approach to accreditation, and develop resources to support implementation in higher education and in practice settings.” (p12) As noted in Chapter 7, accreditation governance reform could support the delivery of this project.

**Clinical experience and student placements**

Student placements are an essential element of the health professional curriculum. They provide students with an opportunity to turn knowledge learned in the classroom into practice and introduce students to a range of workplace settings and experiences.

The HPACF, in its Essential Elements of Education and Training in the Registered Health Professions (2015), identifies the importance of health programs providing a range of clinical education opportunities including “use of an appropriate variety of clinical settings, patients and clinical problems for training purposes.”

As healthcare evolves towards more patient-centred, integrated care services, there is a need to ensure that clinical placement opportunities adequately reflect future community need (Stein, 2016). Flexible and creative placements in primary care, as well as in ‘expanded’ and non-traditional settings, such as in rural and regional areas, and with specific demographic groups such as disadvantaged communities, are necessary to ensure students are adequately prepared to be able to deliver safe, high-quality services in a range of environments.

Education providers have a responsibility to proactively facilitate healthcare reform and the accreditation system should assist in promoting and facilitating ongoing leadership and innovation. As noted by Frenk (2010):

> “the challenges for academic systems is to provide a more balanced environment for the education of professionals through engagement with local communities, to proactively address population-based prevention, anticipate future health threats and to lead in the overall design and management of the health system.” (p1940)

The Australian Catholic University submission provided statistics about the clinical placement environment:

> “In 2012 (the latest year for which national data is available), for example, about three-quarters of the almost 35 million health training hours in Australia were provided by public health services. The national figures also show that the proportion of training provided by the private sector declined by 7% between 2011 and 2012. As a University of Sydney study observed, ‘the shift to primary and community based care and to private provision has not been matched by a proportionate or significant increase in clinical placements in those settings’. (p11)

Barriers to the delivery of clinical placements outside traditional acute care settings commonly include the issues of additional cost and time, shortage of resources, development of new partnerships, lack of tradition, difficulties with coordination and negative attitudes and perceptions. In addition, the fees charged by some health services for hosting placements, as well as the costs of travel and accommodation, can impact upon the diversity of settings and experiences available to students.
All health professional accreditation standards note that the clinical placement experience should be structured to align with the required practitioner competencies. Some standards also reflect the need to undertake clinical practice in a diverse range of settings, for example:

- **Nursing**: Standard 8 of the *Registered Nurse Accreditation Standards* (2012) states that each student should be provided with a variety of workplace experiences reflecting the major health priorities and broad landscape of nursing practice.

- **Medicine**: Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council (2012) notes that clinical placements should be structured to enable students to demonstrate graduate outcomes across a range of clinical disciplines including medicine, women’s health, child health, surgery, mental health and primary care.

- **Occupational Therapy**: Section 4 Practice Education/Fieldwork of the *Accreditation Standards for Entry-Level Occupational Therapy Education Programs* (2013) notes that fieldwork experiences will also encompass different delivery systems such as hospital and community, public and private, health and educational, urban and rural, and local and international.

Whilst a majority of clinical placements continue to occur in hospitals, there appears to be a concerted effort to expand options beyond these traditional settings. This reflects a key objective of the National Law “to facilitate access to services provided by health practitioners in accordance with the public interest.” The Commonwealth Government’s Health Care Home initiative has also prompted a re-think by education providers and regulators about training required to adequately prepare health practitioners for team-based, primary care models. Health care accessibility (and clinical placements) in rural, regional and remote areas, and for disadvantaged communities, also remain significant issues for workforce planners. A number of submissions identified both opportunities and barriers to achieving this objective.

**Box 5.5 Clinical placements impact upon future health service needs**

**Faculty of Pharmacy, University of Sydney**

*If flexibility and responsiveness are the desired qualities of an education program, then the focus should be on creating practitioners who are able to change with the evolving context – which includes evolving health care priorities. This suggests skills development priority as part of the education experience. (p4)*

**Department of Health Northern Territory**

*Healthcare priorities will vary across jurisdictions. NT education providers understand local requirements/environments such as the challenges of working in remote locations. Interstate education providers also need to understand the NT context as many students in the NT are from interstate, particularly in nursing, and many do placements in the NT especially for allied health, where courses are not taught in the NT. Student exchanges may help develop the experience and skills of students for remote practice. (p7)*

**Division of Tropical Health and Medicine, James Cook University**

*Accreditation requirements often restrict DTHM’s capacity to administer clinical placements in strategic locations, including in areas relevant to students’ future practice where there is high health workforce need. Highly prescriptive requirements about the experience of clinical supervisors, types of settings and quality of facilities in some specific disciplines limit the University’s ability to offer students ‘accredited’ professional experience placements, particularly in rural, remote and international settings. The barriers relate to limited provision for inter-professional supervision, including strict ‘who, what, where’ guidelines. (p12)*

**Monash Health**

*...the following suggestions could assist;*

*Teaching students a greater understanding of the healthcare context, political influences, government objectives etc. will aid in a great understanding and preparedness for the workplace*
Box 5.5 Clinical placements impact upon future health service needs

*Teaching students how to respond to and adapt to an ever changing healthcare environment – this includes a greater understanding of how clinicians and teams can proactively manage the increasing burden of chronic disease*

*An expectation that clinical placements include an opportunity for students to practice within teams*

*An avenue for health care services to feed practice trends, issues and changes back to the educators. Both the ‘what’ and ‘how’ of service delivery. This would ensure students and graduates are prepared for the potentially confronting issues faced by health practitioners. (p4)*

One issue that limits broader opportunities is the professional-specific, input-based supervision restrictions outlined in some accreditation standards. For example:

- **Nursing:** [Registered Nurse Accreditation Standards](#) (2012) In the Management of Workforce Experience domain specifies that “Assessment of nursing competence within the context of the workplace experience is undertaken by an appropriately qualified registered nurse.” The need for a registered nurse to complete student assessment is also noted in domains Student Assessment and Resources.

- **Psychology:** [Proposed Accreditation Standards for Psychology Programs – Consultation Paper](#) (2016). Whilst not yet finalised, the proposed accreditation standard requires “Suitably qualified psychologists, approved as supervisors by the psychology Board of Australia, supervise psychology students during professional client contact and provide the hours of supervision as per PsyBA requirements.”

- **Occupational Therapy:** [Accreditation Standards for Entry-Level Occupational Therapy Education Programs](#) (2013). Standard 4.4 under Practice Education/Field work specifies that “all supervisors of practice education/fieldwork are occupational therapy practitioners with at least one year’s experience, or an experience occupational therapy educator.”

As noted in the Australian Rural Health Education Network submission:

> “a critical factor in the ability to offer programs that respond to healthcare priorities is the use of flexible interprofessional supervision arrangements that take account of the nature of clinical practice being provided, the training level of the student, and access to remote supervision through video-conferencing for a proportion of the training time.” (p5)

Some professions already enable supervision to be provided by health practitioners outside the profession. This is reflected in the [Chiropractic Accreditation and Competency Standards](#) (to take effect 1 January 2018) which states under the criteria for Standard 1 Public Safety “1.6. Students are supervised by registered, suitably qualified and experienced chiropractors and/or health practitioners during clinical experience placements.”

Given the link between work experience opportunities and potential employment, the accreditation system could provide greater leadership and support education providers to seek out clinical placements that expose students to future workforce models, and develop clear guidance on how education providers should demonstrate those linkages. The development of standardised competency assessment modules may expand supervisory roles and clinical placement opportunities. This would allow students to be supervised by a profession other than their own, particularly where learning outcomes relate to common competencies.

**Accreditation of quality clinical placements**

Ensuring the quality and appropriateness of clinical placements is important for the patient and student safety, and for the achievement of placement outcomes. All accreditation standards include references to clinical education, however, again, content and terminology vary across health professions, including:

- The provision of a range of different practice education opportunities
- Duration and timing within a program of study
- Supervision requirements and staff training or educational experience
• Achievement of learning outcomes
• Incorporation of simulation-based education and training
• Administration requirements between education provider and placement facility
• Appropriate safeguards for patients and students.

It is understood that an accreditation assessment of clinical placements within a program of study would expect to observe policies and procedures, appropriate insurance arrangements, identification of learning outcomes and assessment modalities, and supervisory skills of staff. In some instances, however, education providers have advised that they have also been expected to provide levels of detail which have tenuous links to quality assurance and could restrict innovation. As stated by the University of Sydney:

“As an example, currently in physiotherapy we need to report on every individual student’s clinical placements (de-identified data) and they check off each student against old criteria. There is very little scope for including new types of placements to meet changing health needs. This is incredibly time-consuming for the University, does not provide placements that best contribute to fostering graduates through high quality higher education to best meet Australia’s future health needs.” (p3)

As noted earlier, the accreditation of health service organisations against the NSQHS Standards, by extension, has the ability to evaluate most of the environments in which professional-entry students undertake clinical placements, and interns and specialist trainees complete supervised practice. Whilst the current NSQHS Standards do not examine from an education perspective, an option that could be explored is for ACSQHC accredited agencies to extend their assessments to include certain clinical educational environments.

Accreditation authorities, including specialist colleges in their assessment of training posts, could adopt the findings of these agencies as part of the overall accreditation process. A standardised system of quality monitoring of clinical environments, across disciplines and placement settings, would create consistency in quality assurance, streamline accreditation assessment, and improve the timeliness and ease of reporting. This opportunity is explored further in Chapter 7.

**Draft Recommendation**

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

**The delivery of work ready graduates**

The desired outcome from an accredited health education program is a graduate who has the required knowledge, skills and professional attributes necessary to practise the profession and who has an appropriate foundation for lifelong learning.

Despite the move to competency-based education, there is a lack of definition of what ‘work ready’ means. In any business or service new graduates are not expected to immediately demonstrate the capabilities and knowledge of experienced practitioners. Most employers acknowledge this and provide induction, orientation, mentoring and further education to assist new graduates to develop skills and to acclimatise to a workplace. The literature, supported by feedback from the consultations, notes that the areas that employers identify as ‘work-ready gaps’ of graduates seem to primarily relate to functioning as a health professional within a system, rather than lacking specific clinical and technical skills. A study by Merga (2016) identified these gaps as including caseload and time management, clinical administration, employability, conflict management, stress management and reality shock.
Supervised practice requirements

Whilst for the majority of registered health professions the completion of an approved program of study meets the education and training requirements for general registration, s52 of the National Law provides for a National Board to establish a registration standard requiring a period of ‘supervised practice’, which has been defined as internships by those National Boards. It also permits a National Board to require completion of an examination as a prerequisite for general registration.

The Australian Health Ministerial Workforce Council has approved supervised practice requirements as registration standards under the National Law (s52(b)) for the professions of medicine, pharmacy and psychology. The respective National Boards have established a category of provisional registration to differentiate graduates who are undertaking supervised practice (internship) programs from registered practitioners and students. Medicine and pharmacy require a 12-month internship following graduation and psychology provides for a triple pathway through either completion of a higher (six-year) degree or lesser length degrees (four or five years) with a one or two-year internship.

All internship programs require, in the first instance, mandated time spent under supervised practice. There is no capacity for individuals in the programs to demonstrate competency ahead of serving that requirement, even though all graduates have undertaken extensive clinical education as part of their professional-entry qualification. It is expected that the level of clinical competence of a health professional will further change and develop with experience and professional development once in employment.

The National Law is clear regarding the differences between registration and accreditation standards and states ‘A registration standard may not be about a matter for which an accreditation standard may provide’ (s38(3)). These Provisional Registration standards indicate, however, that the boundaries are blurred. The Pharmacy Board of Australia (PBA) requires graduates to complete a program of study approved by the Board, (the undergraduate degree), then undertake a year of supervised practice (internship). The design of the internship program comprises an accredited intern training program, supervised practice requirements (1,824 hours), and national oral and written examinations which are undertaken during the period of supervised practice (at the 30% and 75% completion points). The pharmacy supervised practice program appears to have originated from work on the development of a Professional Practice Profile for Initial Registration as a Pharmacist adopted by the PBA in 2011, although internships were well in place before that. This document maps the competencies expected from a pharmacist upon completion of an accredited program of study and an internship.

The Australian Pharmacy Council (APC) has responsibility for accrediting Intern Training Program providers and the National Board issues guidance to preceptors who take on the role of supervisors for graduate pharmacists. The Review notes that the approval of preceptors by the National Board is linked to the application for supervised practice by the pharmacy intern (p8) as opposed to a separate appointment and oversight process.

The joint National Boards/AHPRA submission gives the following reasons these requirements in pharmacy:

“Internship is additional to the clinical training student placements that are undertaken as part of all accredited and approved pharmacy programs. The internship is a comprehensive workplace training experience across an entire year, providing firsthand experience in dealing with a broad range of health conditions including seasonal health complaints. The current outcomes approach to accreditation of pharmacy programs enables pharmacy schools to achieve outcomes in various ways rather than requiring all programs to adopt the same approach, this includes approaches to student training experience in the workplace. There aren’t the same incentives to provide student placements in the workplace that exist in other professions and removing the internship requirement would require significant modification to the current flexible approach to how pharmacy schools ensure students achieve graduate competencies. The availability of training placements in pharmacy practices is under strain. There would be significant impacts on the education sector if universities were required to ensure accredited programs include the training in the workplace that is currently provided through largely privately funded employment of interns in private practice.” (p10)
The rationale for supervised practice in pharmacy therefore includes addressing the variability in the quality of clinical placements during the undergraduate program and sharing the cost of training with private providers.

The Medical Board of Australia (MBA) registration standards also require graduates to undertake specified periods in accredited training sites. In recognition of the education and training requirements of medical internship, the MBA in 2014 formally delegated the oversight and accreditation of medical internship accreditation by Postgraduate Medical Councils (PMCs) to the AMC against National Standards. PMCs accredit posts, oversight the education programs and approve the intern’s successful completion of the program. Historically, PMCs have done this with varying levels of oversight from the former state/territory Medical Boards and the state/territory health departments. As noted in Chapter 3, the MBA also has a direct funding relationship with each state/territory PMC for the intern accreditation function.

PMC accreditation of intern training posts is based on the National Intern Training Framework and the Prevocational Medical Accreditation Framework. This guidance is further supplemented by work undertaken by Medical Deans in identifying the expected competencies of medical graduates and the Australian Curriculum Framework for Junior Doctors. The Curriculum Framework identifies the core competencies and capabilities expected from interns and prevocational trainees.

The Psychology Board of Australia (PsyBA) registration model requires some graduates to be provisionally registered and to complete designated hours of supervised psychological practice which includes specified hours of direct client contact, as well as specific hours of direct supervision and professional development. Its intern programs are for graduates who undertake a four-year approved program of study (requiring two-years of supervised practice – minimum 3000 hours) or a five-year approved program of study (requiring 12 months of supervised practice- minimum 1500 hours). Unlike the MBA and the PBA, the PsyBA has not delegated any aspect of its internship program to its accreditation authority - the Australian Psychology Accreditation Council (APAC). The reasons for this appear historical as, prior to the establishment of the APAC in 2005, accreditation functions were undertaken by the Australian Psychological Society which had been the accrediting body for university psychology education and training programs in Australia. The PsyBA currently retains a greater role than its accreditation authority in the conduct of education and training functions for the purposes of supervised practice and national examinations.

The registration standards governing medicine, pharmacy and psychology internship all mandate experiential learning, supported by curriculum and/or training plans. For example, whilst the medical registration standards for internship are based on ‘time served practicing under supervision’ without references to curricula or learning outcomes, the Medical Intern Training Framework approved by the Medical Board includes domains, standards for intern training and assessment criteria. The Guide for Intern Training and supporting documents all set explicit requirements which reflect a vocational/workplace based training program.

Similarly, pharmacy accreditation standards state that “the goal of pharmacy (undergraduate) education is to prepare graduates for the intern training program.” (p5) Graduates are required to successfully complete an accredited Intern Training Program, and undertake supervised practice which is also linked to a training plan. The Intern pharmacist and preceptor guide issued by the Pharmacy Board states:

“After orientation into the workplace, each intern should organise a time to develop a training plan with the preceptor which addresses contemporary pharmacy practice and indicates the competencies to be addressed each month. A training plan is a map of the list of topics to be covered by the preceptor (or other pharmacist, as arranged by the preceptor) with the intern throughout the year. This should be planned and run in conjunction with the ITP to avoid overlaps and maximise learning outcomes. The plan should be kept onsite and used to track progress of topics covered and referred to regularly. There is flexibility in the order in which topics can be covered, as long as topics are marked off as they are completed. Topics may also be covered from day-to-day experiences (such as primary health care requests from patients, dispensing and counselling new medications); however, this should be supplemented with further research and discussion if this is to be incorporated as part of the training plan.” (p10)
A review of sample intern training plans on the Pharmacy Board website indicates that training plans can include items such as ‘Familiarise with cash register policies and credit facilities available to customers’ (for community pharmacy interns) and ‘Familiarise with the pharmacy’s procedures in case of armed hold-up or burglary’ (for hospital pharmacy interns). It is debatable whether these are education and training outcomes for registration purposes or merely part of expected employer responsibilities for employees. The Review notes that the Pharmacy Guild also provides professional development opportunities to pharmacy interns designed to ‘equip interns with practical skills and clinical knowledge to succeed in the industry’.

The psychology internship programs also include explicit requirements for each internship pathway (one or two-years of supervised practice). The Guidelines for the 4+2 Internship Program and the Guidelines for the 5+1 Internship program contain specific requirements in relation to the expected competencies, supervision and assessment processes for periods of supervised practice.

The need for a business case

Provisional registration is a restriction on practice which places significant burdens on students and supervisors, and impacts on service providers providing such training posts and on overall workforce supply pipelines. National Boards should be required to identify gaps in existing accredited programs of study which prevent a National Board from being satisfied that the graduate is eligible for general registration. Upon identifying these gaps, the first step should be to work with accreditation authorities to address any perceived deficiencies in the education and training programs. If provisional registration is deemed as a necessary additional category for practitioner registration (in addition to student and general registration), then National Boards should be required to prepare a business case and complete a Regulatory Impact Statement (RIS).

The Review sought feedback from stakeholders on this issue, as well as on the broader question of work readiness. The prevailing view amongst the submissions was that work readiness was multi-faceted and included the knowledge, skills and professional attributes developed during education as well as those that are developed through experience. There were mixed views as to whether this should be regulated or whether this was the normal development of any professional entering the workforce.

Box 5.6 Stakeholder perspectives on supervised practice and work readiness

**Australian Private Hospitals Association and Catholic Health Australia**

*It is recognised across the board that employers are responsible for some level of induction as well as continuing professional development for the newly registered professionals they employ..... Registration requirements must define a minimum expected set of outcomes and competencies a graduate in any profession will have at the outset.* (p7)

**Australian Dental Council**

*Employers of newly qualified dental practitioners should have the expectation that they will be working at threshold level. The responsibility of an employer is to induct employees into their workplace in order to assure the employees are only undertaking roles and tasks which the employer is satisfied the employee is competent to undertake. This is no different to a day one graduate of an engineering, legal or accounting qualification. This is also sometimes considered ‘credentialing’ in public health services and would take into account the level of experience of the new graduate in accordance with descriptors relating to pay levels. These are expected skills/competence for their employment but not necessarily an expected professional competency on graduation.* (p29)

**Australian Pharmacy Council**

*An Australian study into the perceptions of pharmacy students and preceptor pharmacists between 2011 and 2014 indicated that there were many similarities between pharmacists’ and students’ perceptions, both emphasising transferable skills. Knowledge was seen as secondary to experience, practice skills, and personal attributes, and more recently (in 2014) pharmacy employers’ focus shifted towards graduates’ management skills, ability to grow business, and implement novel pharmacy services...*
Stakeholder perspectives on supervised practice and work readiness

The intern year for pharmacy is positioned to allow development and assessment of a graduate within a safety net of supervised practice. Both the safety of the graduate and the safety of the public must be taken into account within this framework. (p28)

Australian Medical Council

Work readiness should be defined through consultation between the stakeholders – National Boards, accreditation authorities, education providers, health services and other employers and the community. It should take account of data such as graduate outcome surveys, and readiness to practice surveys. In 2017, the AMC hopes to begin work with the Medical Board of Australia on reviewing interns’ perception of their readiness for practice that will help inform this discussion. (p20)

Edith Cowan University

In principle, ECU supports a period of supervised practice in certain health professions, although it should be understood that supervised practice often occurs prior to graduation as part of mandatory clinical practicum requirements. Whether a student undertakes supervised practice in a clinical environment prior to graduation or immediately post-graduation may vary from profession to profession; it should remain at the discretion of National Boards to determine post-graduation periods of supervised practice prior to full registration being granted. Work readiness might be defined by the competencies deemed to be essential in order to work independently, with typical cases, within the specific profession. In turn, those competencies should be developed according to what the industry requirement is, through balancing feedback from health employers about their expectations of new graduates, along with consideration of new and emerging roles, changes in health priorities, and academic developments reflected in course learning outcomes. There needs to be a clear distinction between the skills and competencies expected of a recent graduate compared to the more advanced skills required of an employee with more workplace experience. Requirements to work within a specific site, such as a specific hospital or type of health provider, are the responsibility of the employer, as are on-the-job training and induction programs. (p18)

Australian Psychology Accreditation Council

Work readiness needs to be defined to enable a sensible approach to supervised practice. Formal education can only take graduates to ‘the starting gate’, that is, graduates are ready to start work in their profession/occupation/field, a concept which we believe is different from that of being ‘work ready’. Once a graduate starts work, the responsibility for building competence lies with the individual and employer. (p20)

SA Health

Commencing work as a novice practitioner following graduation from a relevant educational program is a very significant transition in the life of all professionals, and it is not surprising that structured programs have emerged in a number of professions to support this transition. However, mandated programs limit flexibility, may tend to imply that skills at the level of a new practitioner are not required prior to entry, may create significant demands on health services providing programs, and may also cloud the fact that managing transitions will be an ongoing process throughout professional life. In relation to nursing and midwifery, while completion of a formal transition to professional practice program is not a requirement of general registration, a de facto intern year has arisen, creating expectations that graduates will have access to such a program prior to obtaining ongoing employment. In relation to medicine, SA Health does not believe there is good evidence for the medical intern program as currently constituted. SA Health supports moving eligibility to apply for general registration to graduation and moving away from current accreditation standards for the intern year. This need not preclude a requirement for supervised practice during a transition to independent practice. It would however significantly increase flexibility of clinical learning opportunities in the initial postgraduate years. SA Health supports work being undertaken nationally to move towards a new model. (p3)
An approach to training that addresses gaps in work readiness, and provides mentoring and support for students in the early phases of employment could better prepare graduates to operate safely, effectively and with confidence. This training could be delivered as:

- workplace based training programs (also known as vocational training) with learning outcomes and competencies to be achieved within a period of time; or
- opportunities to practice under supervision where the graduates improve their skills by practicing the knowledge, skills and professional attributes gained during the undergraduate years.

For each of the professions with internship programs, there are clear expectations of curricula, assessment processes and competency requirements which are similar to those expected from accredited programs of study. This blurs the boundaries between what would be considered a period of supervised practice specifically for the purpose of consolidating prior learning and a workplace based vocational training program designed to enable graduates to acquire additional competencies with learning outcomes and assessment processes.

**Supervised practice versus formal education programs**

Whilst the stated rationale for supervised practice is for graduates to consolidate their education and training in a supervised environment, the focus of all three National Boards with provisional registration standards indicates an expectation of specific education and training deliverables to be met to before general registration can be approved. In some cases, a formal curriculum also needs to be in place which can also place such programs within the scope of accreditation functions under the National Law.

Expertise in overseeing education and training is intended to rest with the accreditation authority with the expectation of good practice, effectiveness and efficiency in the design and approval of education and training programs. The Heads of Department and Schools of Psychology Association (HODSPA) summarises the dichotomy that results from a National Board taking on an education and training and accreditation function:

“We understand that the 4+2 pathway presents the PsyBA with a problem. Because they have to approve the +2 internships, they have moved beyond their role as a registration board into ‘training’….. Thus, we believe that re-working the status quo to ensure that each of the parties, HODSPA, APAC, and the PsyBA understands its role in the system, namely ‘training’, ‘accreditation’, and ‘registration’ is the best outcome of the current review.” (p10)

The role of a National Board is to set standards for registration. In setting these standards, National Boards can establish additional requirements for pre-registrants to demonstrate their ability to practice in accordance with the objectives of the National Law. However, the ability of National Boards to establish registration requirements based on education and training criteria requires greater justification and scrutiny. When a National Board decides to establish additional requirements for general registration that are additional to domestic qualification attainment, that decision should meet the following requirements:

- Articulation of the competencies required at profession entry level that can be differentiated from normal and expected progressive work experience and ongoing lifelong learning expectation.
- Provision of evidence that the approved program of study does not meet the approved accreditation standards as defined in the National Law as standards “...used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.”
- Provision of evidence that the approved program of study, with amendment, is unable to deliver the necessary education and training that overcomes any knowledge, skills and professional deficits.
- Documentation of whether the requirement is for supervised practice or for vocational education and training and specify what the expected learning outcomes are and how they will be assessed.
- Specification that the work based learning requirement warrants a category other than general registration, along with the limitations of that registration.
Existing intern training programs should be assessed against the above criteria and, where internship programs are established as vocational training programs with established learning outcomes, curricula, supervision and assessment requirements, they should be formally recognised as programs of study and subject to monitoring and oversight by the accreditation authority. The Review notes that this already occurs with medicine, although the MBA has retained direct links with PMCs. The governance of PMCs is explored in Chapter 7.

**National examinations**

Domestic pharmacy graduates are required to pass additional national examinations, as are all graduates of the four and five-year psychology degree courses. National examinations are a cost to the student, with pharmacy graduates paying $1,018 (this includes oral and written components) and psychology graduates paying $450. The Review notes that National Boards can generate significant income through the national examination process. The AHPRA Annual Report indicates that the PBA achieved a surplus of $447,000 in 2015/16 from the conduct of examinations (p95-97). Similar data was not available for the PsyBA.

Pharmacy interns sit written exams following 30% completion of internship (conducted by the APC) and oral exams at completion of 75% of internship (conducted by the National Board). The written exam is a multiple-choice questionnaire of 125 questions completed over three hours, whilst the oral exam requires interns to demonstrate their knowledge through role play or discussion. The Pharmacy Oral Examination (Practice) Candidate Guide provides information on the competencies being assessed as part of the oral examination.

Psychology graduates who have completed the five-year training program can sit the exam at commencement of their supervised practice year whilst those who have undertaken the four-year degree program can sit the exam upon completion of 1,540 hours of supervised practice. The exams are based on an examination curriculum which is “designed to test applied knowledge appropriate for the fifth and, in particular, the sixth year of psychology training.” (p1) The exam comprises of 150 multiple choice questions which are based on the four domains of the examination curriculum (ethics, assessment, intervention, and communication).

The timing of the psychology examinations suggests that it is aimed at assessing competency of a graduate at the completion of five years of education and training as opposed to an assessment at the completion of internship prior to general registration. Given that the pharmacy and psychology examinations are set during the period of supervised practice, the intent would appear to be further assessment of the knowledge and skills obtained during the program of study instead of being targeted towards assessing the efficacy of the supervised practice/internship. Such examinations are summative assessments and follow on from accredited programs of study which already include a mix of formative and summative assessments. The PsyBA in its submission provided the following rationale for the examinations:

> “National examinations are used in other jurisdictions .... for example, the Examination for Professional Practice in Psychology examination in the USA and Canada has been operating successfully since the 1960s and harmonises a common standard for entry to the profession despite different pathways and educational contexts and arrangements across the 64 jurisdictions of North America.“ (p4)

It is worth noting, however, that there no single national approach to accreditation and regulation in either the United States of America (USA) or Canada. In Australia on the other hand, there are national approaches to practitioner regulation and the accreditation of programs of study and education providers. There is also an argument that a national approach to competency assessment of graduates has the potential to increase consistency of outcomes, create system-wide data to benchmark across education providers and their health programs, and deliver reliable, standardised information on graduate performance and quality.

Australia’s health profession accreditation standards outline the need for evidence-based assessment mechanisms, undertaken by appropriately trained assessors. Standard 26 of Pharmacy accreditation standard already requires robust assessment processes: “The School of Pharmacy uses a range of assessment methods that are appropriate to the outcomes of the program.” It expands this further as “…assessment processes will be directed to assessing knowledge, skills and professional attributes in the pharmacy practice context (e.g. OSCEs).” (p15) Similarly the psychology accreditation standards also include specific requirements for
assessments for each pathway. Standard 2.6.10 (p39), Standard 3.1.11 (p42), Standard 4.1.16 (p45), Standard 5.1.13 (p53), Standard 5.3.29 (p60) all detail requirements for assessment based on the training pathway.

While some submissions to the Review supported national examinations, generally they were questioned, given accreditation includes the assessment methodology in programs of study. Some also questioned the relevance of a national examination (for graduates of approved and accredited programs of study) during a supervised practice period which is not linked to competencies expected at the end of that supervision.

**Box 5.7 Stakeholder feedback on the value of national examinations**

**CQUniversity**

A system of national examinations could allow for the streamlining of accreditation processes. In a model of a single accreditation agency applying a common set of accreditation standards and processes, a national examination could facilitate the move away from cyclical accreditation reviews.... if after that the accreditation system moved to a system of risk-based monitoring a national examination could be used as a key mechanism for monitoring programs against nationally agreed benchmarks. A national examination could therefore be used to facilitate the streamlining of accreditation processes in a move toward a risk-based approach, although it would not be a necessary pre-condition of such a move. (p7)

**Psychology Board of Australia**

Examinations have a different purpose to accreditation. Accreditation is more "formative" in that it outlines evidence for institutional quality assurance of the curriculum and overall student experience, whilst an exam is "summative" in that it tests actual individual performance. One should lead to the other, therefore there is a need for both accreditation and examinations along the pathway to ensuring work readiness. They serve different functions but both are requisite. (p4)

**NSW Health**

A national assessment may address the issue of variability however it may not address the issue of work readiness if the assessments were not valid. The easiest way to administer national assessment is via multiple choice examination, however that process may not be appropriate for assessing non-technical skills such as teamwork and communication skills. Further clarification of medical graduate outcomes with a more robust accreditation process would better address issues concerning work readiness. (p7)

**Faculty of Medicine, The University of Queensland**

A robust accreditation process should negate the need for further national assessment to gain general registration. It is likely that a national assessment process would be in addition and not instead of existing accreditation processes. We would recommend that further research is needed in Australia to determine whether a national assessment would add value to our current accreditation system and that this study should draw upon the experience and evidence from other countries. (p4)

**Optometrists and Dispensing Opticians Board New Zealand**

The Board is not persuaded that national examinations should be introduced as a useful way to determine the educational quality of programmes of study. The Board believes that valid and reliable assessment methods are best evaluated within the overall context of assessment in the specific programmes of study. This is in line with the risk level of the particular profession, rather than in line with an abstract uniform standard. The cost of such examinations is also bound to fall on the student, which for the profession of optometry, could deter students from entering the workforce. (p3)

The National Boards and AHPRA in their joint submission to acknowledged that a robust accreditation process should negate the need for further assessments:

“We do not consider a national assessment process allows for a more streamlined accreditation process. It would introduce an unnecessary regulatory requirement because the accreditation arrangements under the National Law are designed to ensure graduates of accredited programs have achieved the Board’s expectations of graduate competence.” (p11)
That submission, however, then conversely justifies the pharmacy examinations as “the regulatory purpose of the examination is to ensure competence to practice and work readiness.” (p11) Other submissions allude to a lack of confidence in the quality of the pharmacy graduate. The Pharmaceutical Society of Australia stated:

“Pharmacy graduates currently have varying levels of work readiness and this is supported by the number of interns that are taking longer to complete their internship year and the pass rates of the Pharmacy Board written and oral exam. The current pass rates of Pharmacy Board of Australia exams by interns suggest that undergraduate programs do not contain sufficient experiential learning to satisfy this requirement alone.” (p8-9)

The Pharmacy Guild highlights that “removing the national examination system would place a greater burden on preceptors and training organisations who would be required to assess the interns more rigorously.” (p4)

Similarly, the PsyBA advises the rationale for its examinations:

“In psychology, two ministerial council approved pathways to registration rely upon unaccredited workplace internships. The content and form of these vary widely, making a national examination a way of assuring competence despite widely different education experiences during intern training, or from those trained overseas.” (p4)

Adding another hurdle to entry to practice is not an effective approach to dealing with concerns regarding the quality of (accredited) undergraduate training or the lack of oversight of intern training. Examinations are useful in assessing the knowledge, skills and attributes of overseas trained practitioners in that they enable a consistent approach to assessing learning outcomes from varying education and training programs. National examinations can also be useful if they assess competencies gained during periods of supervised practice or post-graduation vocational placements. Where, however, such examinations are seen as a response to deficiencies in undergraduate and/or internship programs, those should be addressed in the first instance.

**Draft Recommendations**

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

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

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

This Chapter undertakes an assessment of the governance arrangements for the accreditation functions conducted within the National Scheme. It starts by exploring the origins of the current arrangements, then assesses the performance of the accreditation system to date against the National Scheme’s objectives and finally considers the importance of consumers in any reform options.

Previous Chapters have examined opportunities to improve the cost effectiveness of accreditation functions and facilitate greater relevance and responsiveness of, and institutional capability to deliver, health education. Some of the reforms proposed, however, are not new, nor are the problems they are seeking to address. What this Review has brought to the debate, in particular, is a focus on whether, without reform of the underlying governance of accreditation, those reform proposals can be progressed in a timely manner. Additionally, the Review has questioned whether the incentives embedded in the accreditation system (and within the National Scheme as a whole) are sufficiently aligned for the various entities to collectively and collaboratively achieve all the National Law objectives.

Origins of the current governance arrangements

The Productivity Commission (2005) proposed that accreditation should have regulatory separation:

“...it would be good regulatory practice to separate the setting and verification of standards at the education and training institutional level from the application and maintenance of standards in relation to individual practitioners. Further, the Commission believes it is possible to establish two separate boards — accreditation and registration — on an ‘impartial and independent’ basis.”

The March 2008 COAG Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions referred to its 2006 decision to establish registration and accreditation as two distinct activities. In responding to the Productivity Commission’s 2006 Report, the Agreement noted:

2.2 The report recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training; to deal with workforce shortages/pressures faced by the Australian health workforce and to increase their flexibility, responsiveness, sustainability, mobility and reduce red tape.

2.3 At its meeting of 14 July 2006, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions.

2.4 COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.

2.5 COAG has subsequently agreed to establish a single national scheme, with a single national agency encompassing both the registration and accreditation functions.

It brought these two processes together through the one national agency, AHPRA, and granting of authority to National Boards. AHPRA’s role is to set frameworks and requirements for the procedural development of registration, accreditation and practice standards by National Boards and to ensure that good regulatory practice is followed in accordance with the legislative objectives and any policy directions of Health Ministers. AHPRA, however, has no role in any decisions made by National Boards, as they are independent entities.
As a transitional measure, the Intergovernmental Agreement provided that the Ministerial Council would assign accreditation functions to existing accreditation bodies, with the requirement that they meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies and that:

1.36  Within three years, in consultation with the relevant accreditation body and the profession, the relevant board will review this assignation and the future arrangements and make a recommendation to the Ministerial Council on the best future arrangements for its profession.

1.37  Ongoing decisions about whether external bodies should continue to perform accreditation functions will be taken by the Ministerial Council following consultation with the boards.

Whilst requiring the review of assignment of accreditation functions within three years, the finally agreed National Law that came into effect, however, critically shifted responsibility for the determination of how accreditation functions would be delivered on an ongoing basis to each National Board (s43) rather than to the Ministerial Council.

National Boards undertook a review of their arrangements in 2012 and all endorsed the continuation of their external entities under the National Law to exercise accreditation functions – albeit in some cases for periods of only one or three years (all of which were subsequently extended).

Achieving the National Scheme objectives

In the 2008 Agreement, COAG specified both the objectives and the guiding principles for the National Scheme, as a whole, as now reflected in the National Law (s3) and set out in Chapter 1.

Noting that all of these objectives and guiding principles apply, directly or indirectly, to accreditation functions within the National Scheme, the Review has examined how they have been applied by all entities. The Review considers that all objectives should be addressed in a balanced manner and responded to both in terms of the policy framework adopted for the National Scheme as a whole and in terms of individual decisions taken by entities within it.

The initial AHPRA Corporate Plan 2011-2014 stated that its vision was to achieve “A competent and flexible health workforce that meets the current and future needs of the Australian community.” It is acknowledged, however, that in the initial set up period none of the strategic priorities identified for the three years sought to address that vision – the focus instead was on establishing the National Scheme and its systems. Whilst AHPRA does not have a current corporate plan, its National Registration and Accreditation Scheme Strategy 2015-20 broadly provides the same vision and includes the following statement in its strategic outcomes “Improved access to healthcare through our contribution to a more sustainable health workforce.” Further, AHPRA and the National Boards developed a set of principles in 2014 with the stated intent being to shape the thinking about their regulatory decision-making. Although not referenced in the National Law, one of the principles is that “While we balance all the objectives of the National Registration and Accreditation Scheme, our primary consideration is to protect the public.”

The Review considers that this is a retrograde step, with safety and quality potentially being offered as reasons to resist beneficial innovation and the development of a flexible, responsive and sustainable workforce. The range of potential reforms identified by the Review, and set out in this Report, recognise the critical importance of the education of the health workforce in being able to respond to and shape future directions in health service delivery and access to services.

The Review’s conclusions drawn from earlier Chapters are that there has been little progress in pursuing reform under the current arrangements. Reliance should not be placed on periodic reviews such as this one to identify what is generally known and agreed, but not yet implemented.
Managing accreditation

To assist in the Review’s examination of the management of accreditation, it has reviewed all of the publicly available AHPRA business plans (2012/13 to 2015/16), its 2011-2014 Corporate Plan and, to the extent that they have been made available to the Review, budget proposals and agreements between National Boards and accreditation entities and performance reports since the National Scheme’s establishment.

The relationship between each National Board, AHPRA and accreditation council is managed through a standard funding agreement with AHPRA, supported by a profession-specific schedule outlining deliverables and reporting requirements. Accreditation authorities are required to report on some indicators twice yearly, while a more comprehensive report is provided annually. There is a standard clause in each 2015/16 agreement with a council as follows:

“The Council and the Board note continuing interest in demonstrable changes in line with the following goals as part of the broader context for the Accreditation Functions within the National Registration and Accreditation Scheme (the Scheme):

- opportunities to increase cross-profession collaboration and innovation, including to address the guiding principle of the National Law that the Scheme is to operate in a transparent, accountable, efficient, effective and fair way. For example, joint projects with other accreditation entities or through the Health Professions Accreditation Councils’ Forum;
- opportunities for the Council to facilitate and support inter-professional learning in its work; and
- opportunities for the Council to encourage use of alternative learning environments, including simulation, where appropriate.

The Council will advise the Board about current activity to address the issues outlined as part of its first routine report in the 2015/2016 financial year. The Board and Council will subsequently share information about health workforce reform issues when relevant to the [xxx] profession.”

Such a clause, whilst acknowledging key reform needs, is relatively passive and stops short of setting any specific targets for individual councils. This is echoed in the content of budget proposals, approvals and performance plans. There is great variability in content and structure of the information provided to the Review by the National Boards and accreditation councils (including in some circumstances where only single year examples were provided). Notwithstanding, the Review has not identified any instances of funding being sought or approved for cross profession or other innovation initiatives. The HPACF has similarly advised that it has not received funding to undertake any of its activities or to progress broader reform priorities.

In the case of the three accreditation committees, the operational aspects of independence seem largely absent, with AHPRA advising the following:

“The (AHPRA) Accreditation Unit, in consultation with each Committee, develops the proposed budget and workplan.

Each Board that exercises the accreditation functions through a committee pays an allocation to AHPRA to provide support for delivery of accreditation functions under the Health Professions Agreement.

Income from fees paid by education providers is treated as Board income and all expenses are treated as Board expenses. This means any variation against budget is attributed to the Board. In this way, only the amount of registrant fees required to break even is required for the relevant Accreditation Committee’s activities.”

As discussed below, and in broad accordance with the Quality Framework for the Accreditation Function, accreditation operations are largely carried out with a degree of autonomy, although not in terms of final approvals.
Reviewing the relationship between accreditation and registration

The accreditation of health programs of study and the registration of individual health practitioners are separate but inextricably related functions that contribute to the overall objectives of the National Scheme. Accreditation of professional entry health education is a fundamental antecedent to registration. Assessing how these functions operate and interrelate is thus critical to any assessment of National Scheme governance and recommendations for any improvement.

Whilst registration gives individual practitioners the legal right to practice, the accreditation functions provide the threshold assessment and evaluation of education and training courses and providers to assess whether graduates have the knowledge, skills and professional attributes necessary to practice the profession in Australia. A threshold question for this Review has been whether the accountability for accreditation should be at the accreditation function level or, as at present, at the registration level where accreditation authority activities could be considered more as administrative actions delivered by contracted service providers. Under the National Law, the National Boards are currently the final decision makers on the accreditation standards and programs of study, as well as on whether a practitioner will be registered:

- While each council/committee develops accreditation standards, they must submit them to the National Board for approval (which the National Board may approve, refuse to approve or ask for a review) (s47).
- A National Board may also approve (with conditions if it so chooses) or refuse to approve a program of study provided by an education provider that has been accredited by the council/committee as providing a qualification (comprising knowledge, clinical skills and professional attributes) for the purposes of registration in a health profession (s49).

It is essential that each National Board has a high level of trust in the accreditation process. Accordingly, the Review’s consideration of reform of the governance of the accreditation functions has placed great emphasis on ensuring that this trust is not eroded.

In both perception and operation, there appear to be different views on the degree of independence of the accreditation entities from National Boards. The Ministerial Council Communiqué of 8 May 2009 stated:

“The Ministerial Council agreed today that the accreditation function will be independent of governments. Accreditation standards will be developed by the independent accrediting body or the accreditation committee of the board where an external body has not been assigned the function. The accrediting body or committee will recommend to the board, in a transparent manner, the courses and training programs it has accredited and that it considers to have met the requirements for registration. The final decision on whether the accreditation standards, courses and training programs are approved for the purposes of registration is the responsibility of the national board. The accrediting body will have the ability to make its recommendations publicly available in the circumstance that agreement between the accrediting body and the national board cannot be achieved.”

A view has been put forward that this means the decision to accredit the program and the decision to approve it for registration purposes are separate. This is not the case under current arrangements. Firstly, given the primary purpose of completing the qualification is to be able to practice, the program of study must have the approval of the relevant National Board to have that effect. Secondly, the Higher Education Standards Framework at Standard 3.15 requires

“Where professional accreditation of a course of study is required for graduates to be eligible to practise, the course of study is accredited and continues to be accredited by the relevant professional body.”

This accreditation standard is designed to encompass both statutorily regulated and self-regulating professions. While the term ‘relevant professional body’ is not further defined under the Threshold Standards, both TEQSA and self-accrediting universities advise that, in the case of professions under the National Scheme, if a course has not received approval by a National Board for the purposes of registration it also cannot be accredited as a higher education qualification under the Australian Qualifications Framework.
The role and expertise of National Boards

In considering best practice governance models for regulatory schemes it is important to understand the scope, nature and type of the various domains being regulated. In the case of the National Scheme, there are two distinct domains of regulatory scope for National Boards:

- The regulation of individual health practitioners
- The regulation of accreditation standards, programs of study and the providers of those programs (including the performance of their governance and operational activities).

The National Law does not specify particular fields of expertise required by Board members to deliver these functions other than the ratio of practitioner members to other members and a mandated representation quantum from jurisdictions based on both jurisdictional size and representation from a rural or regional area.

This geographic and representational approach is different to most other regulatory arrangements. A more usual model is one where members are appointed on the basis of their expertise in areas relevant to the functions of the entity. The current National Scheme arrangements provide for 14 separate schemes with AHPRA providing the common secretariat and each National Board having responsibility for all matters relating to their profession, as opposed to an approach that provides a greater degree of separation between accreditation and regulation, but which relies on skills appropriate to each function on a cross profession basis.

National Boards, by virtue of their role and expertise in registration, can be expected to be appropriately risk averse in carrying out that function. They may not necessarily have the expertise in innovations in pedagogy, and in the educational foundation needed for a health workforce which can respond to evolving health needs. Given this, the current relationship of accreditation authorities has the potential to constrain compliance with achievement of objective 3(f) of the National Law which requires, in part, enablement of innovation in the education of health practitioners. The relationship could also constrain the achievement of objective 3(c) which requires facilitating the provision of high-quality education and training of health practitioners and 3(e) which requires facilitating access to services provided by health practitioners in accordance with the public interest.

Submissions to the Review on the relationship between National Boards and accreditation authorities were limited, with many respondents citing a lack of knowledge on the specifics of current governance structures. Responses that did comment were mixed, with the substantial majority considering that National Boards did not have the requisite skill mix to undertake their accreditation approval functions and supporting greater independence in accreditation decision making. Proposed solutions to the issue, however, were varied.

Box 6.1 Stakeholder views on National Boards and accreditation

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<th>Joint National Boards/AHPRA</th>
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*National Boards are, as part of their functions, responsible for regulating the professions, including determining notifications about professional performance. National Boards are keenly aware of the objectives of the National Scheme, including the objectives relating to public protection, access to services and enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and educational innovation.*

*While the National Law is silent on the attributes of board members, National Boards have established succession planning principles and regularly identify the mix of skills and knowledge they need to undertake their functions. Most National Boards have practitioner or community members who are currently working in the education sector.*

*National Boards have the appropriate skills, knowledge and incentives to approve accreditation standards and accredited programs within the framework established by the National Law including consideration of the workforce needs of a rapidly evolving health system. National Boards have regard for the objectives and guiding principles of the National Law and the regulatory principles for the Scheme when they perform these functions.*
Box 6.1 Stakeholder views on National Boards and accreditation

If there is a perceived need for greater assurance that National Boards have the requisite knowledge and skills, it would be possible to formalise current approaches by articulating the knowledge, skills and incentives needed to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system and the ways to achieve this with a greater or lesser level of formality for example, through collective agreement, Ministerial Council direction etc. (p11)

Health Professions Accreditation Collaborative Forum

.. 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 is complicated by the fact that the national board appointment process is reliant on jurisdictional appointments, not skills-based appointments. (p18)

Australian Council of Deans of Health Sciences

The current constitution of profession specific boards, while having a depth and breadth of knowledge and skills, may lack the incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system. The many responses to this question will perhaps align with the perspective from which they are provided; ranging from maintaining the status quo to innovative responses to changing health care needs. Fundamental health workforce reform may not be a common or priority focus. (p22)

Council of Deans of Nursing and Midwifery Australian and New Zealand

The Nursing and Midwifery Board of Australia is constituted from representation from the States and Territories. Board appointments are made by Ministers, who should be cognizant of the requirements. AHPRA has a separate accreditation policy area that provides advice on matters related to accreditation. The accreditation area in AHPRA appears to be becoming utilised more by the Boards, which appears to support the notion that the National Boards are not constituted for purpose. (p5)

Council of Ambulance Authorities

.... some Boards have been guilty of making biased judgements which have impacted on the growth of their particular workforce and limiting broader inter-professional practise and learning. (p7)

Australian Psychology Accreditation Council

.... the national Registration Board is not constituted to enable informed approval of accreditation standards. The Board members have been chosen for their expertise in disciplinary and registration functions. Approval of accreditation determinations and accreditation standards, even were they to be governed by better guidelines as described above, are awkward additions to the Board’s other duties. (p23)

NSW Health

A board’s knowledge and skills can be highly dependent on its individual members, rather than the categories of membership set out in the National Law, which relate largely to jurisdictional practitioner representation. For this reason, there is always a danger that an individual board does not have appropriate knowledge and skills in any given domain. (p7)

School of Psychology, University of Queensland

There is insufficient independence of accreditation bodies and their governing boards. This compromises the efficiency of accreditation, with flow-on negative outcomes for the tertiary education providers and for the profession. In 2014 the Australian Psychology Accreditation Council (APAC) initiated an overhaul of the psychology accreditation standards. The new standards were completed and subject to stakeholder review in mid-2014. Following that consultation process, the standards were revised but the final draft has been repeatedly held up as a result of independent input from the Psychology Board of Australia, which appears to have the “last word” on what should be included in the new standards, over and above the public consultation and revision. The back-and-forth between APAC and the Board has resulted in a complete stalling of the new standards, such that institutions are now informed that they will not be available until 2018. (p1)
Whilst there is broad agreement from many of the accreditation councils that current arrangements for accreditation are sub-optimal in terms of facilitating a number of the National Scheme’s objectives, the joint National Boards/AHPRA submission reinforced the intrinsic link between accreditation and registration:

“The regulatory system established by the NRAS creates an intrinsic link between Board approval of accreditation standards, accreditation decisions and National Boards’ decisions on eligibility of practitioners for registration. That is, in order to effectively regulate practitioners within the flexible framework of the National Law, a National Board relies on assessment against accreditation standards that it has approved or examinations and assessments that it has approved. Reforms that decouple this link create inherent risks to the integrity of the NRAS regulatory system. Many National Boards and Accreditation Authorities have long-standing and effective mechanisms that reflect this link and are critical in achieving the objective of the National Law to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.” (p12)

Any change in governance arrangements for accreditation needs to recognise and adequately respond to maintaining the integrity of the National Scheme as a whole. However, whilst significant steps have been made to achieve national uniformity in the registration of practitioners in each health profession, and whilst AHPRA has made progress on certain aspects of cross profession commonality, the National Scheme is not yet operating effectively as a single collaborative scheme which appoints persons with the necessary expertise to perform particular regulatory functions.

Regulatory relationships in other regimes

On the question of appointment of expertise to regulate specific functions, the Review has examined other approaches where governments have determined there is a need to regulate professions that deliver services requiring public protection. Although the regulation of trades where entry qualifications are fundamental to public protection varies by jurisdiction (e.g. the various categories of electrician, plumbing and gas fitting occupations), there is a universal approach whereby the regulating entities do not seek to separately determine qualification accreditation standards or assess individual courses. In all circumstances, they leave the responsibility to the ASQA, as the national VET regulator, established under the National Vocational Education and Training Regulator Act 2011, to regulate both RTOs and the courses they deliver.

In the case of tertiary qualified professions, the Commonwealth Tax Practitioners Board (TPB) regulates tax agents, BAS agents and financial advisers Australia wide and has adopted the same approach. In its information sheet TPB i 07 2011 Approval Process For Course Providers it states:

6. The TPB is of the view that where a course is provided by a university, RTO or other registered higher education institution (for example, a non self-accrediting higher education institution), there are:
   - sufficient quality assurance safeguards in place to ensure that the course is provided according to appropriate professional and educational standards
   - the course provider has sufficient internal mechanisms to be sustainable.

7. The TPB recognises that universities are subject to regulatory activities and quality assurance mechanisms undertaken by the Tertiary Education Quality and Standards Agency (TEQSA). TEQSA has been established as an independent body with powers to regulate university and non-university higher education providers, monitor quality and set standards.

8. Similarly, the TPB recognises that RTOs are subject to regulatory activities and quality assurance mechanisms undertaken by the Australian Skills Quality Authority (ASQA), the national regulator for the vocational education and training (VET) sector.
This is not to say the trades regulators and the TPB in the schemes referred to above do not (and should not) have a role in setting qualification requirements for entry into a profession. They do play a critical role in setting those requirements, but they also understand, accept and work with other responsible entities both within and outside their individual regulatory environments to manage threshold qualification matters which are intrinsic to practitioners being registered.

A significant example of best practice role separation, balance and cooperation in regulation where there are multiple and sometimes competing objectives is Australia’s model for the regulation of the financial system, named the “Twin Peaks” model, which is being emulated world-wide. The model is characterised by two equal and independent peaks: the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA). Crucial to the model’s success is the notion that both regulators are equal in power and importance.

The Australian Government specifically addresses the effective operation of this multi entity regulatory model in the Federal Treasurer’s Statements of Expectations issued to ASIC and APRA with the identical provision:

“The Government expects that ASIC will maintain robust, effective and collaborative working partnerships with other Commonwealth and State and Territory agencies, as well as APRA’s counterpart regulators in overseas jurisdictions, to ensure the proper functioning of Australia’s regulatory framework. APRA should avoid the duplication of the supervisory activities of other regulators, and should consider whether outcomes could be achieved by using existing regulation administered by another regulator, in order to ensure an integrated regulatory framework and minimise compliance costs.”

These regulators then provide a complementary Statement of Intent in response, outlining how they will meet those expectations.

**Governance features to align with National Scheme objectives**

Accreditation sits within a model of regulation of the various health professions which has become a complex and polymorphic governance system. The National Law, as with any legislation enacted to regulate activities, apportions various responsibilities to different entities within the National Scheme. Section 4 states in the legislative preliminaries:

“How functions to be exercised

An entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in Section 3.”

The key factor in designing and operating a health profession regulatory model with so many component parts and objectives is that accountability and quality in decision making is inextricably linked to ensuring that the expertise aligns with the functional responsibilities. The Review considers the most important test of any governance arrangements is whether it promotes quality, continuous improvement and innovation. Given the pace of change in the health system and health care, status quo bias is inevitably self-defeating.

**Independence of regulatory administration**

If a structural separation between practitioner registration and health education accreditation is to be considered, then the regulatory governance needs to be examined and designed appropriately. Regulation is a mechanism through which government can aim to safeguard the welfare of the community and protect the broader public interest. Attachment B of the Intergovernmental Agreement signed by COAG in 2008 set criteria for the inclusion of professions into the National Scheme only where it could be demonstrated that the occupation’s practice presents a serious risk to public health and safety which could be minimised by regulation.
However, regulators can fail to protect the public interest if their activities are unduly influenced, whether by the regulated industry, government or outside interest groups. Most systems internationally and in Australia adopt best practice by separating the policy advice and direction function from the body which administers the regulation.

In 2012, the Council of the Organisation for Economic Co-operation and Development (OECD) adopted the Recommendation of the Council on Regulatory Policy and Governance. According to these recommendations:

“Independent regulatory agencies should be considered in situations where:

- there is a need for the regulator to be seen as independent, to maintain public confidence in the objectivity and impartiality of decisions; or
- both government and non-government entities are regulated under the same framework and competitive neutrality is therefore required; or
- the decisions of the regulator can have a significant impact on particular interests and there is a need to protect its impartiality.” (p16)

Regulatory independence, though, is not an end in itself but rather a means toward ensuring effective and efficient service delivery by those subject to regulation. Independence should not come at the price of accountability.

Regulation, by its very nature, requires a source of regulatory authority. The most appropriate locus of this authority was vigorously debated in setting up the National Scheme in 2010. This reflected a tension between efforts of some professions to maintain a level of self-governance and governments’ attempts to develop a more independent, actively managed and responsive externally regulated system. This was in response to concerns that, where professions operate as self-regulatory institutions, they can benefit from a triple monopoly – economic, political and administrative.

This system shift and resolution of the accompanying tensions has been a common development across most health systems globally. This was observed by the WHO European Observatory on Health Systems and Policies in its analysis of ongoing practitioner regulation reform across the European Union that arose from calls for closer public scrutiny of professional activities. The Observatory noted:

“...the emergence of new externalized forms of control and the development of new reporting lines - upwards to governmental or independent regulatory agencies and downwards to consumers and citizens.....Other social actors, not only governments but also managers, parliaments and the general public, have assumed increased responsibility for overseeing professional activity and defining the framework of self-regulation.” (p210)

The focus on the independence of accreditation in the current legislation and regulations has been to an extent on independence from government. Effective independence however, should also be conceived with respect to representatives of the sectors targeted by regulation, and thus include a wide range of public and private stakeholders.

Independence from governments

Any consideration of independence must acknowledge that a regulator’s ‘independence’ from government can never be absolute, rather is a matter of degree and nature and that it should be clearly articulated – usually through statute. The Australian National Audit Office (ANAO) depicted the continuum of statutory governance arrangements as follows:
The health system is a network of governance mechanisms that enable the policy, legislation, coordination, regulation and funding aspects of delivering quality services to operate in a collective set of interdependencies. These matters are complex, as is the planning and delivery of services, given that it is shared between several levels of governments and multiple agencies of those governments as well as private businesses and the not-for-profit sector. In this environment governments face large and intractable challenges, with many dimensions, multiple stakeholders, and far-reaching impacts.

Australian governments have adopted a stewardship role in their focus on providing the policy settings and regulatory regimes to oversight and ensure that service delivery and public expenditure are in the public interest. The World Health Report 2000 - Health Systems: Improving Performance identified stewardship as one of the four key functions for governments in health system management and policy making, the other three being providing services, generating the human and physical resources that make service delivery possible, and raising and pooling the resources used to pay for health care.

"The government is particularly called on to play the role of a steward, because it spends revenues that people are required to pay through taxes and social insurance, and because it makes many of the rules ......and part of the state’s task as the overall steward or trustee of the system is to see that private organisations and actors also act carefully and responsibly. A large part of stewardship consists of regulation, whether undertaken by the government or by private bodies which regulate their members, often under general rules determined by government.” (p45)

The National Law has generally adopted this stewardship concept in that governments have retained some roles in the regulation of health practitioners, but have largely established a regulatory regime that is not under direct governmental control. In the context of accreditation of education and recognition of qualifications for registered professions, the Ministerial Council has only a limited role in the approval of accreditation standards. Whilst some aspects of the National Scheme can be largely regarded as co regulatory, the accreditation model equates more to a quasi-regulatory approach on the ANAO continuum.

Whilst the assessment of education programs and providers against accreditation standards clearly requires objectivity and independence, the initial setting (and review) of the standards can effectively set policy directions for health education, such as emphasis on interprofessional approaches that better align to expected service demand and workforce innovation. Whether governments’ role in setting and monitoring these public interest policy directions is adequately provided for in the National Scheme is discussed later in this Chapter.
Independence from other stakeholders

As noted in Chapter 2, there are two accreditation governance structures set out as options in the National Law: either committees of National Boards or external entities (councils). In the context of this Review, the activities performed by accreditation authorities are part of the regulatory framework, and there must be an expectation that, at least at the system level, the governance and accountability arrangements of those entities should ensure that all decisions and activities are objective, impartial, consistent, expert and transparent.

Accreditation committees, being creations of the National Boards, have different governance issues compared to councils. As outlined earlier, the appointment of the members of the committees, in particular, is the direct prerogative of the National Boards and this can influence the decisions of the members on those committees. Where councils have been assigned the accreditation function, the overarching principles for their operation were agreed with AHPRA and the National Boards and published as an agreed Quality Framework (see Chapter 2). The Review is examining whether these governance arrangements, both real and in perception, are adequate in terms of:

- Providing independence in the delivery of standards and assessments, with a view to fostering accountability, transparency, trust and a focus on the public interest.
- Performance against National Scheme objectives and guiding principles.
- Whether there are checks and balances in the exercise of administrative discretion comparable to that in regulatory scrutiny.

The Quality Framework requires that the external accreditation authority carries out its accreditation operations independently, that decision-making processes are independent and there is no evidence that any area of the community, including government, higher education institutions, business, industry and professional associations, has undue influence.

The Quality Framework also establishes a number of governance attributes, including:

- The accreditation authority is a legally constituted body, is registered as a business entity and can demonstrate business stability.
- The accreditation authority’s governance and management structures give priority to its accreditation function relative to other activities (or relative to its importance).
- There is a transparent process for selection of the governing body.
- The accreditation authority’s governance arrangements comply with the National Law and other applicable legislative requirements.

Of importance to note is that these governance attribute requirements are largely concerned with the overall management of each accreditation entity, whereas the Review is focussed on the independence of the subset of accreditation decisions made under the National Scheme.

A small number of accreditation councils have advised they support the principles which are articulated in the World Health Organisation/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education (2005):

“The accreditation system must operate within a legal framework. The system must be pursuant to either a governmental law or decree; the statutory instrument will most probably be rules and regulations approved by government. The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession.”

According to information available from its website, the World Federation for Medical Education (WFME) is a voluntary international federation in which accrediting bodies of/and medical schools can participate via regional associations. Australia participates via the Western Pacific Association for Medical Education (WPAME). It states it has NGO status with the World Health Organization (WHO), in direct relationship with
WHO Geneva Headquarters and its six Regional Offices. Whilst the Australian Medical Council is not a formal member of either the WFME or the WPAME, the WFME website states the AMC is seeking WFME recognition as an organisation that has “the authority to accredit education programmes or schools that award a medical qualifying degree.” Any difficulties the AMC might experience in seeking recognition under current National Scheme arrangements may be addressed through this Review’s recommendations.

Whilst the Review strongly endorses the above WFME statement, it does not support all of the elements of the guidelines, for example, specifications that the governing council should be made up of predetermined numbers of persons nominated by medical schools, professional associations, and others, i.e. essentially those who are being regulated or could benefit from decisions made by the council. This and some other statements in the guidelines are not commensurate with national and international approaches to best regulatory practice, including that individuals with expertise appropriate to the function should be on the governing councils rather than persons who are nominated by, or representative of, particular organisations.

Whilst participation in international forums that may contribute to continuous improvement is supported, the Review is making this observation not in relation to this specific example but rather as a caution that circumstances do not arise where participation in international affiliations or forums are advanced as reasons to adopt approaches that may not be in the best interest of achieving the National Scheme objectives.

**Separating organisational governance from accreditation**

Given the legal construction of councils, a further consideration for the Review is the need to achieve a balance between director’s duties in managing a legally constituted company that has shareholders/members and performing public interest functions under the National Scheme.

Depending on the structures as to how accreditation activities are commissioned, the makeup of each council’s governing board can be a key factor in considering its institutional independence and underlying ability to deliver on the National Scheme objectives and the reform directions in the health system more generally. While noting the Quality Framework requires that there is a transparent process for selecting the governing body, it is silent on how the membership of the organisation is constructed.

This Review’s analysis of annual reports, web sites and council constitutions suggests the following:

- Membership is generally limited to specific categories such as industrial organisations, professional associations, education providers and other representative or umbrella councils, including in some circumstances National Boards themselves. For example:
  - The Australian Nursing and Midwifery Council’s constitution states “There shall be a maximum of five (5) Members of the Company, those being the Australian College of Midwives, Australian College of Nursing, Australian Nursing and Midwifery Federation, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and Council of Deans of Nursing and Midwifery (Australia and New Zealand).”
  - The Optometry Council of Australia and New Zealand similarly comprises the Accredited Schools acting collectively, the Optometrists Association Australia, the Optometry Board of Australia, the New Zealand Association of Optometrists and the Optometrists and Dispensing Opticians Board of New Zealand.

- With the exception of non-practitioner individuals on governing boards, almost exclusively individuals are nominees of the participating member organisations. It is, however, also difficult from the available public information to identify all board members’ affiliations and backgrounds.

- Representatives from education providers and from nominating member organisations are almost always also members of the relevant profession.

- In relation to non-practitioner members, some constitutions specify the processes of how governing board appointments should be made but others are silent. Non-practitioner members appear to be primarily people with expertise in corporate governance, with a much smaller subset appearing to be community members specifically selected to represent the interests of healthcare consumers.
The final decisions for each individual accreditation activity are either clearly stated to be the province of the governing board or the decision-making process is unclear. The degree of autonomy varies by profession. In psychology, for example, the National Board is named as a member of the Australian Psychology Accreditation Council.

It is important that accreditation decisions in relation to standards, policies and individual assessments are protected from the risk of stakeholder capture and that those decisions are made in an objective manner in the public interest. The member organisations have a deep interest in the matters being regulated and can be affected by the decisions that are made.

The National Law does not specify how independence from the sectors targeted by regulation should be addressed in carrying out the accreditation function. Part 6 of the National Law does impose some procedural requirements on the accreditation authority that include:

- Publishing how it will exercise its accreditation function
- In developing accreditation standards, undertaking wide ranging consultation about their content
- Providing written notice to the education provider of a decision to refuse to accredit a program of study
- Conducting internal reviews of a decision to refuse to accredit a program of study, if requested by the education provider
- Monitoring programs and education providers.

Accreditation councils are established, in the first instance, under the Corporations Act 2001. This Act, together with the Australian Securities and Investments Commission Act 2001 and various standards or guidelines issued by ASIC or the Australian Charities and Not-for-Profits Commission may not always be in sync with a council’s obligations in running a scheme for public benefit.

The HPACF submitted a position taken universally by those accreditation councils that have been granted not for profit status:

“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. 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.” (p20)

In considering this issue it is important to note that, in addition to legal requirements around such matters as property, rights, liabilities, etc., many accreditation councils can and do earn income from other sources, and are also able to set fees for their services. Councils and their prescribed members can also be involved in various partnerships and international affiliations.

Whilst it would be expected that robust conflict-of-interest policies could deal with many individual program accreditation decisions, the strategic nature of accreditation policy and standards and their impact on the current and future functioning of the health system, makes consideration of this principle of independence more complex to define but particularly pertinent. In 2014, the OECD produced a set of agreed principles for governance models for regulatory authorities. In relation to the role of stakeholders that have an interest in the decisions made by the authorities. The Governance of Regulators stated:

“To avoid conflicts of interest, where there is a need for formal representation of specific stakeholders in strategic decision making, stakeholder engagement mechanisms such as an advisory or consultative committee should be established, rather than making those stakeholders members of the regulator’s governing body.” (p68)
The Review is agnostic on the appropriate governance structures for the accreditation councils and appreciates the need for the requirements set in the agreed Quality Framework around their constitution and business stability. As private companies, they should also be able to pursue other commercial arrangements provided they are transparent and any conflicts with their National Scheme accreditation functions are managed.

The focus of this Review on the conduct of directors is thus not on how the governing boards of accreditation councils conduct their affairs, but rather on the specific responsibilities for the development and approval of accreditation standards and the assessment of health educational programs and providers, and the qualifications of overseas practitioners, under the National Law.

Input to, and involvement in, the accreditation functions requires a high level of expertise and should be based on a balancing that across a number of individuals rather than being seen to potentially represent the interests of particular organisation. The accreditation function should draw on those with knowledge of the professions, professional registration, provision of education, requirements of employers, and the needs and expectations of consumers, rather than governance more generally (such as finance and law). This becomes even more critical if consideration is to be given to providing more independence in decision making in accreditation.

The Review considers that the management of defined functions under the National Scheme, and decisions made in relation to those functions, need to be by non-representational expertise that operates independently from representational structures, whether they be governing boards or other council arrangements.

The centrality of consumers

Health care consumers are central to ensuring the health care system and its workforce are fit for purpose and responsive to the community’s health care needs. In addition to the system’s effectiveness, consumers have a primary stake in ensuring its efficiency and sustainability. According to the OECD, Australian consumers meet 20% of health care costs directly through out-of-pocket funding with a further 12% being met mainly through private health insurance premiums. A further summary from the OECD states that the remaining 68% is met by all taxpayers, whether or not they are consumers of health care services.

The National Law provides for community involvement in the operations of the National Boards. There are no specific requirements under the National Law, or under the contractual agreements with accreditation authorities, regarding community involvement in carrying out accreditation functions. The National Law does not define the concept of a community member. Similarly, where community members are included in accreditation council governance or assessment panels, the concept of a community member is not defined.

Reference is made to community members within accreditation council constitutions, where the definition ranges from persons with academic, public and private hospital, legal, finance and consumer health backgrounds. As noted in the Victorian Department of Health and Human Services submission:

“There is lack of clarity about the concept of a ‘community member’ within the National Scheme... Some consider community members should be health service consumers with a background in consumer advocacy, and with strong links with consumer representative groups and no alliances or links, past or present, with the regulated health professions. Others see community members simply as persons who are not from the regulated profession and who bring an independence of thought and useful skills and knowledge to their role, such as in governance, the law, finances, or education and training.” (p3)

There is a broad group of stakeholders who are consumers of the health care accreditation system – in effect the beneficiaries of that system. While consumers from this perspective can include registrants and education providers, for the purposes of this Review the consumers are defined more narrowly as:

- **Service Users** who are patients, families/carers who utilise the services provided by a health professional who has received accredited education and training.
- **Students** who are recipients of education and training from accredited education providers.
- **Employers** who recruit graduates of accredited programs to provide healthcare services.
The rationale for separating service users, students and employers from education providers and registrants is that, whilst all derive a direct benefit from an effective accreditation system, the inclusion of the former group in accreditation functions ensures that activities and decisions are open to reasonable scrutiny and can withstand a ‘public defensibility’ test in the context of fairness, equity and value for money.

Why include consumers?

Health systems globally are recognising the value of including the consumer voice in the design and delivery of healthcare services. Consumers are an effective safeguard to ensure that the health system is patient centred, transparent and provides value for money for the Australian taxpayer.

Service users

The definition of what it means for health care services to be ‘patient centred’ is expanding and evolving, from listening and communicating with patients, to actively involving patients as partners in their healthcare. The National Safety and Quality Health Service Standard 2 notes that delivering care which is based on partnerships provides many benefits for the healthcare consumer, provider, organisation and system. It further states that evidence is building about the link between effective partnerships, good consumer experience and high-quality health care, including improved clinical outcomes, decreased re-admission rates, improved delivery of preventive care services, improved adherence to treatment regimens and decreased rates of healthcare acquired infections.

There have been studies locally and internationally which have found a direct correlation between increased consumer centred care and an efficient and effective health system. Consumers, as service users, can add value to the design and implementation of health education reforms. The General Medical Council (in the United Kingdom) in its Guidance to medical schools noted that:

“Patients can contribute unique and invaluable expertise to teaching, feedback and assessment and involving patients in medical education can be beneficial to learners: not only does it facilitate acquisition of skills such as communication, but it can also change professional attitudes positively and develop empathy and clinical reasoning. It provides context to the learning material and motivates learners.” (p6)

Submissions received by this Review highlighted the benefits of including service users (patients, carers and families) in accreditation functions including curriculum development, assessment panels and also in the development of competency standards. The Health Care Consumers Association in its submission noted:

“Consumers often ask questions about issues that are about the culture of healthcare and are less affected by the unspoken norms that often guide health care practice and systems, often in ways which do not best serve patients and families …… but which are seldom questioned inside the organisation or by professionals themselves.” (p4)

Other submissions highlighted the value that service users bring to the accreditation process in relation to diversity and cultural safety. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives noted:

“To ensure cultural safety and respectful practice are embedded in education and training for health professionals, Aboriginal and Torres Strait Islander communities and their representatives must be systematically engaged in curriculum planning and review for education courses and accreditation assessment.” (p10)

Service users are able to identify gaps within the health system which may not be as evident to those providing or regulating healthcare:

“Consumers and Carer’s with a ‘lived experience’ are vital educators of our health professionals. The value that we can add to the overall education of health professionals and undergraduates is priceless.” (Consumer 1, p3)
On the other hand, several submissions from professional organisations considered that consumer involvement needed to be balanced with the cost and relevance of this involvement. The Royal Australasian College of Ophthalmologists stated that:

“Given the level of complexity involved in the accreditation process, consumers should only be added to the accreditation team if they have appropriate training and qualifications.” (p2)

The Australian Nursing and Midwifery Federation noted:

“Consumer members of the ANMAC Board provide invaluable contributions to the accreditation process for entry to practice education programs for nurses and midwives. While consumers can contribute their perspective on care requirements to the higher level accreditation standards development, they do not have the necessary discipline-specific knowledge of requirements for competent and safe practice as a nurse or midwife. We do not therefore support consumer engagement as part of the assessment team for accreditation of nursing and midwifery education programs.” (p9)

Optometry Australia submitted:

“We do not consider that there is a need for consumer representation in the specific activities of the accreditation process, where that consumer is a member of the general public or a representative from a consumer organisation. At the level of accreditation of training, consumer input is difficult to integrate as the needs of the curriculum, facilities and so on are not directed to the consumer, but to the student and ensuring their development as competent health professionals.” (p4)

Students

Students are a second group of system consumers, as direct beneficiaries of accredited education and training programs. The Higher Education Standards Framework (Threshold Standards) 2015 has a requirement for student feedback as part of the overall assessment of Institutional Quality Assurance. Accreditation authorities, as part of their quality assurance and improvement processes, incorporate similar requirements for student input within their standards. This approach is supported by education providers such as the CQUniversity:

“There may be value in having student assessors from senior years as part of assessment teams to bring the perspective of current students to the assessment of a program.” (p4)

Employers

Employers have expectations that the accreditation system will provide graduates who are work ready. Employers can provide useful feedback in terms of ‘people skills’ capability across health courses (such as communication skills, resilience, ability to work in teams) which are an important feature of competency standards and health education curricula more broadly. Whilst some of these learning needs may be delivered through employer programs, employers, including clinical supervisors, can also highlight gaps in pre-vocational education and training. An individual optometry service provider noted:

“…… employers of graduates should be satisfied that the program is sustainable, produces graduates that protect the public and delivers adequate knowledge, skills and attributes to the graduates that meet current and ongoing contemporary standards of the profession.” (Individual practitioner, p2)

Employers can also contribute specialist knowledge on the effectiveness and viability of clinical placement sites being assessed as part of the accreditation process.

How are consumers currently involved?

Consumers currently contribute to the accreditation system through participation in a variety of forums and processes:

- Accreditation authority governance – through representation directly on Boards or on decision-making committees.
• **Assessment processes** – participation as members of assessment panels or by providing consumer feedback.

• **Curriculum development** – through input in the design and content of the curricula as developed by education providers.

• **Development of competency standards** – participation in deliberations on scope of practice and skills requirements and ensuring alignment with modern health practices of delivering patient centred care.

• **Risk management and monitoring** – contributing intelligence to the regulatory system through complaints and notification processes and feedback during accreditation activities.

As noted earlier, there is no legislative requirement for consumer or community representation in the governance or work of accreditation authorities. However, AHPRA has established a [Community Reference Group](#) to advise on matters related to the National Scheme including advising AHPRA on how to better understand, and respond to, community needs. This is seen by some as having limitations. Consumer representatives at the workshop organised by the Consumers Health Forum of Australia for this Review advised that issues brought to the Community Reference Group were determined by AHPRA and there was limited feedback from AHPRA and National Boards on how their feedback was treated.

Whilst National Boards have a role at the approval stage of accrediting programs of study and education providers, the AHPRA Community Reference Group is not engaged in discussions regarding accreditation activities. The joint National Boards/AHPRA submission notes that:

> “Currently there are varying levels of consumer/community involvement in accreditation governance and decision-making, with less involvement in assessment teams..... We have had an increasing focus on consumer involvement and engagement since the Scheme commenced. Exploring opportunities for more consumer involvement in the accreditation functions is consistent with that philosophy and direction.” (p5)

An analysis of individual accreditation authority governance and assessment processes indicates there are varied approaches to the participation of consumers in accreditation activities and decisions. Some accreditation authorities (dental, nursing and midwifery, medical, osteopathy, pharmacy, physiotherapy, podiatry and psychology) include consumer or community representatives on their Boards. However, consumer representatives on governing boards are largely lawyers, academics and sometimes health service executives.

Some authorities include consumer representatives on internal committees which are convened to develop accreditation standards and review the assessment of programs of study (dental and pharmacy). The Optometry Council Australia and New Zealand noted in its submission that it includes employer and student representatives on accreditation committees. The Council on Chiropractic Education Australia advised that it includes consumer representatives (patients, carers or community members) on assessment panels for education programs or providers, whilst the Australian Dental Council in its submission advised:

> “All consultations for reviews of standards have involved a direct request for input by consumer groups including the Consumer Health Forum.” (p24)

Accreditation authorities can also require education providers to demonstrate consumer (service user) involvement in the design and development of programs of study. The Occupational Therapy Council (Australia and New Zealand) advised:

> “Current standards require evidence of consumer input into curriculum and learning activities – consumers in education provider advisory panels as well as in teaching and assessment roles.” (p6)

Education regulators such as TEQSA use external experts to provide advice on regulatory issues and participate in regulatory assessment processes. TEQSA has a [Register of Experts](#) who are expected to have and maintain significant experience in areas which are relevant to TEQSA’s scope of work. It is understood, however, that the Register of Experts is targeted towards persons with education and training expertise and with significant experience in the governance of educational institutions.
As noted earlier, the Higher Education Standards Framework (Threshold Standards) 2015 has a requirement for student feedback as part of overall assessment of institutional quality assurance. The TEQSA assessment processes are also linked with other opportunities that enable student and employer input. For example, all Australian universities and many other higher education providers utilise the Quality Indicators for Learning and Teaching to obtain feedback from students, graduates and employers regarding the program quality.

**How can consumers add value to the accreditation system?**

The Review considers that consumer involvement in accreditation functions is desirable to ensure a continued focus on patient centred care and as an important addition to professional input. However, it is noted that effective participation requires clear identification of where it would provide most value and consumers will require additional support and training if they are to be expected to participate as equal members.

The HCPC commissioned research on the inclusion of consumers in accreditation and registration activities. This research noted the merits of a meaningful level of service user involvement but its suggestions were more focussed on the design and delivery of the programs of study rather than on accreditation processes.

The Review is supportive of the AHPRA Community Reference Group and considers that its Terms of Reference should be expanded to include a consumer perspective on accreditation. For example, consumer representatives from the Community Reference Group who attended consultation forums and the consumer workshop as part of this Review, advised that on multiple occasions documentation from different professions appeared repetitive due to the high level of common elements. In this regard, the Group can provide a useful perspective on the effectiveness of the National Scheme as a whole, including the extent to which the different professions and are operating cohesively to achieve patient centred care.

AHPRA plays an important role in its active support of the community members and provides opportunities for them to engage with each other. This can limit ‘capture’ of the members by the interests of the professions, particularly when trying to understand and evaluate matters relating to a health system where information asymmetry is often a hallmark of the relationship between health professionals and consumers.

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

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

**Draft Recommendations**

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

13. AHPRA should expand the Terms of Reference for the AHPRA Community Reference Group to include accreditation functions and enable accreditation authorities to refer issues to the Group for advice.
7 Accreditation governance - options for reform

Following on from the consideration of the performance of the accreditation system within the National Scheme and an examination of other regulatory regimes, this Chapter proposes and assesses several different models of governance that could drive a more directed and timely adoption of reforms proposed in this Report.

The improvements in accreditation system efficiency and effectiveness proposed in this Draft Report are not new discoveries. The problems and workable solutions can be found in previous reviews, in the deliberations of the HPACF and in submissions to this Review. There is common agreement on what needs to be done, but equally there has been little progress in pursuing reform. This view is shared by many stakeholders themselves, including the National Boards and AHPRA. They acknowledge that reforms are possible but that progress has been sub-optimal and more integrative approaches are necessary.

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<tr>
<th>Box 7.1 Stakeholder views on reform progress</th>
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<tr>
<td><strong>Joint National Boards/AHPRA</strong></td>
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<tr>
<td>We recognise that more can be done in terms of the potential of accreditation to contribute to the Scheme as a whole. In addition, we are committed to adopting more risk and evidence based policy and processes supported by good evaluation and research. (p2)</td>
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<tr>
<td><strong>AHPRA Agency Management Committee (supplementary submission)</strong></td>
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<td>AManC considers that while reasonable progress has been made by National Boards and AHPRA to support flexibility and sustainability of the health workforce, the governance of accreditation systems that transitioned into the National Scheme in 2010 has contributed to slower progress of some initiatives. These transition arrangements do not reflect the maturation of the National Scheme since 2010. (p4)</td>
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<tr>
<td><strong>Department of Health and Human Services Victoria</strong></td>
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<tr>
<td>The future health workforce will be required to work across professions, within integrated services, in new and flexible roles, delivering person-centred care. The current profession-led accreditation system, with 14 accreditation councils or committees, maintains a profession focus which presents challenges in developing the future workforce. (p8)</td>
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<tr>
<td><strong>Department of Health Australian Government</strong></td>
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<td>A more integrated accreditation system would support the education sector to produce a health workforce that is designed to meet the future needs of the Australian community, and will encourage a system that produces a health workforce that is responsive to new and innovative models of care. (p3)</td>
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<tr>
<td><strong>NSW Health</strong></td>
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<td>The current system of single profession specific accreditation authorities is hampering:</td>
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<td>o equality of professionalism in accreditation;</td>
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<td>o cross-disciplinary education.</td>
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<td>The current system perpetuates:</td>
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<td>o duplication of work both by accrediting authorities and education providers;</td>
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<td>o lack of an overall health policy focus in relation to education provision;</td>
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</table>
Box 7.1 Stakeholder views on reform progress

- interests of each profession over wider community interests and the objectives of the NRAS;
- fragmented consideration of workforce requirements. (p1)

**Australian Council of Deans of Health Sciences**

The current constitution of profession specific boards, while having a depth and breadth of knowledge and skills, may lack the incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system.

The many responses to this question will perhaps align with the perspective from which they are provided; ranging from maintaining the status quo to innovative responses to changing health care needs. Fundamental health workforce reform may not be a common or priority focus. Recent OECD policy recommends that governments ‘... develop and maintain a strategic capacity to ensure that regulatory policy remains relevant and effective and can adjust and respond to emerging challenges’. Perhaps not all stakeholders view the responsiveness to emerging challenges in the same manner or equate innovation in service delivery with workforce reform. (p22)

**Australian Medical Council**

However, the discussion paper identifies some challenges that need to be addressed and resourced at a systems-level rather than between an individual accreditation authority and the relevant National Board. There is not a clear mechanism to bring together all parties to set performance expectation or goals for this element of the National Scheme. (p4)

In the Review’s judgement, the greatest constraint to reform of the accreditation system is its model of governance. The current arrangements are unable to provide an actively regulated and managed accreditation system that delivers on the objectives set out in the National Law. The Review has explored governance reform that could better position the health education system to develop a foundation of workforce skills, knowledge and attributes which responds to and shapes future directions in health service delivery.

The first level of reform would involve greater functional separation of the registration of individual health practitioners from the development of accreditation standards and the accreditation of programs of study. However, to only propose the separation of these functions, without further reform, could continue to perpetuate the largely professionally siloed approach to setting standards, undertaking assessments and influencing curriculum development and delivery. Accordingly, the Review has also explored a second level of reform which would lead to a more integrated approach to the accreditation of health profession education.

**Lessons from overseas regulation of health professionals**

The Review has looked to the regulatory systems of other countries for guidance. Of particular relevance is the HCPC in the UK which has been set up as a regulator of chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers and speech and language therapists. The HCPC does not regulate nursing, medicine, pharmacy, dental or several other health professions that are registered professions under the National Scheme, but those do come under the purview of the PSA (see below). The HCPC sets standards for the education and training, professional knowledge, skills, conduct and performance of registrants and approves education programs.

The HCPC [standards of proficiency](#) for registrants include both common and profession-specific elements. It has one set of standards for education and training that apply across all the professions it regulates, covering the level of qualification, program admissions, program management and resources, curriculum, practice placements and assessment. Benefits are in such areas as consistent expectations for interprofessional education and for consumer and carer involvement. The HCPC also provides a single and consistent approach to assessing and accrediting education programs against those standards through its Education and Training Committee, which has been given statutory responsibility for this function.
In terms of the applicability of such an integrated model in Australia, the Australian Medical Council (AMC), Australian Pharmacy Council (APC) and the HPACF all referred to the 2015 decision by the UK Government to move regulation of social workers from the HCPC and to create a separate entity, as evidence that a joined-up accreditation approach is not fit for purpose.

The Review is aware of that decision and, while recognising that Australia does not regulate social workers, it has explored the background and reason behind this move. The Review concludes that the decision was preceded by a long period of calls for reform to the social work system, a number of high profile protection issues arising in residential and other services for children, various reports into the fragmentation of social work education in the UK and the financial collapse of the College of Social Work.

The UK Government’s response has seen the passing of the Children and Social Work Act 2017 and the announcement of the creation of a new body, Social Work England, to oversee and regulate a range of matters relating to social work and the delivery of social care services. The remit of the organisation is planned to be different to all other profession regulatory bodies and broad ranging, as identified in UK Department of Health correspondence, encompassing “the rollout of a new post qualification assessment and accreditation system for children and family social workers as well as delivering national accreditation of statutory functions for social workers in adult social care.” This also means that the UK Government is committing substantial public funds to underpin the new organisation. It would seem apparent that the approach for this profession is a new regulatory model and does not reflect on the HCPC. Similarly, it is not a regulatory model in use in Australia.

More generally, whilst the HCPC does not cover many of the professions under the National Scheme, the umbrella authority to which it reports – the PSA – oversees nine regulators who ‘register’ health and care professionals working in occupations nominated by Parliament. The PSA is responsible for oversiting the HCPC as well as the:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Nursing & Midwifery Council
- Pharmaceutical Society of Northern Ireland
- Nursing and Midwifery Council

The PSA also provides policy advice to government, reports to Parliament on regulators’ performance, undertakes investigations commissioned by and for government, and accredits voluntary registers held by non-statutory regulators of health and care professionals. It has produced a set of best practice standards against which it assesses the performance of the regulators it oversees.

The PSA has been undertaking research focused on the UK health and social care professions regulatory framework. The PSA produced a report, Regulation Rethought - Proposals for Reform in 2016, on difficulties facing educators in supporting innovation in service delivery. Its findings resonate with those of this Review:

“Educators too are affected by multiple regulators with different standards and quality assurance mechanisms. This may inhibit their ability to train practitioners who are centered on patients’ needs, with shared values, and who can work across professional boundaries within health and care. Team roles and functions may change as population needs, technological innovations or service requirements alter. Those striving to re-design service delivery, integrate care, or introduce new working practices may be frustrated and delayed by the difficulties inherent in flexing scopes of practice or creating new roles, because of protected titles and boundary protection by particular professions.” (p1)

It is apparent that the UK and Australia often share experiences in the development of more integrated education and regulatory arrangements. In 2014, the British, Scottish and Northern Ireland Law Commissions jointly released their review report into the Regulation of Health Care Professionals and Regulation of Social Care Professionals (in England only), along with a draft Bill. Of particular relevance to this Review was the proposal put forward by the Scottish Government around the need for system integration:

“The new statute could provide further clarity and consistency by coordinating their activities through one central body with representation from individual regulators as required (i.e. a ‘hub and spoke’ model). This
would provide greater consistency in standards and a more coordinated approach to quality assurance and inspections, and provide opportunities for shared learning and decision-making including, for example, in relation to multi-disciplinary/multi-professional education and training.” (p2)

The Commissions acknowledged the need for flexibility and further consideration of this concept:

“Suggestions made by the Scottish Government for the establishment of a new central body to co-ordinate activity in these areas and a combined code of conduct are interesting. At this point, there are no concrete plans to take these suggestions forward. However, the draft Bill would certainly not preclude the establishment of such a body or the development of joint codes and indeed would facilitate these through partnership arrangements [see Part 10].” (p94)

The final legislation is still under consideration by the UK Parliament.

The report, referenced above, goes on to outline a number of the benefits demonstrated through the establishment of AHPRA in Australia and proposes an extension and enhancement of the model to create a single assurance entity for all health and care occupations as depicted in the following diagram:

Amongst many of the benefits the PSA sees in such a model are:

- A shared ‘theory of regulation’ based on right-touch thinking
- Shared objectives for system and professional regulators and greater clarity of roles
- Transparent benchmarking to set standards
- A reduced scope of regulation so that it focuses on what works
- A proper risk assessed model of whom and what should be regulated put into practice through a continuum of assurance
- Breaking down boundaries between statutory professions and accredited occupations
- Making it easier to create new roles and occupations within a continuum of assurance.
- A drive for efficiency and reduced cost which may lead to functional mergers and deregulation.
The model is similar to that proposed by the Productivity Commission in 2005 and, whilst the overall concept is beyond the Terms of Reference of this Review, it does provide valuable insight into similar issues being explored around the accreditation of education. The 2016 PSA discussion paper, quoted earlier in this Chapter, draws attention to the deleterious impact on educators and their attempts to support reform that results from having a multitude of regulators, including those from different professions. The PSA argues that the training of health professionals who can work across professional boundaries is central in responding to evolving needs, technologies and service requirements with models of integrated care and flexible scopes of practice.

The Productivity Commission 2005 report, in recommending the establishment of a single statutory national accreditation board for health workforce education and training, similarly concluded that:

“Current accreditation arrangements can inappropriately reinforce traditional professional roles and boundaries, and thus impede job innovation. Inconsistent requirements imposed on educational institutions and trainers by different agencies create further inefficiency.

A national cross-profession approach to accreditation would preserve the best features of current arrangements while facilitating:
- More timely and objective consideration and adoption of beneficial cross-profession job evolution and redesign options
- Interdisciplinary and multidisciplinary education and training and articulation between Vocational Education and Training (VET) and higher education and training
- Improvements in the appropriateness and consistency of accreditation in the different professions; – uniform national standards on which to base professional registration
- Reductions in administrative and compliance costs.” (p111)

Relevant other Australian reforms in education and health

Since the establishment of the National Scheme in 2010, other significant national reforms in both education and health have been implemented that provide unique opportunities for improved regulatory administration not previously available to governments, AHPRA and the National Boards. The maturity of national regulatory schemes in higher and vocational education offers opportunities for the removal of unnecessary duplication and more efficient delivery of functions based on expertise and consistency across both health and education. Structured alignment of workforce education and its accreditation with the national developments in safety and quality in healthcare similarly provides the opportunity to progress a whole of health system approach.

Education

In the education sector, the Bradley Review of Higher Education recommended the development of a quality assurance framework based on externally validated standards and rigorous performance measures. It further recommended creation of an independent national agency, with responsibility for all aspects of regulation.

In response to the review, the TEQSA Act 2011 established a single national regulator for higher education, combining the scope of operations of the former Australian Universities Quality Agency (AUQA) and the state and territory government registration and accreditation authorities. This has been strongly underpinned by the Higher Education Standards Framework (Threshold Standards).

TEQSA now registers and evaluates the performance of higher education providers against the Higher Education Standards Framework - which all providers must meet in order to enter and remain within Australia’s higher education system. TEQSA also plays an important role in the global quality assurance and regulation of Australia’s higher education sector.

TEQSA has been progressively looking to improve the relationship with professional bodies with links to the higher education sector that have a mutual interest in maintaining and improving quality in the provision of higher education in Australia.
In February 2011, COAG took significant steps in endorsing the ‘Intergovernmental Agreement for Regulatory Reform of Vocational Education and Training’. The objectives were to streamline regulation, increase consistency across states and territories, and address quality concerns. This included a referral of powers to the Commonwealth from most states (except Victoria and Western Australia) and exercise of the Commonwealth’s constitutional powers in regulation of VET in the territories.

The agreement provided the framework for national VET regulation, including the establishment of ASQA and the National Skills Standards Council. This new regime is underpinned by the National Vocational Education and Training Act 2011, related legislation and a range of standards in the VET Quality Framework.

This was followed by further COAG agreed reforms aimed at ensuring industry is involved in policy development and oversight of performance and at streamlining governance arrangements and committees. This involved the creation of an industry-led body, the Australian Industry and Skills Committee (AISC), supported by specific Industry Reference Committees, to:

- Provide advice to ensure that directions taken by governments are informed by an industry-based perspective focused on the quality and relevance of the national training system
- Provide direction to ensure future and emerging skills needs of industry are met
- Approve industry-defined training qualifications (sector training packages).

The most recent Health Training Package was approved by AISC in July 2015.

Importantly, both the higher education and VET approaches also apply to relevant health and social care professions which are not part of the National Scheme.

Health

Significant reform has been undertaken in relation to the quality and safety of the health system as a whole. The Australian Commission on Safety and Quality in Health Care (ACSQHC) was initially established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in safety and quality in health care. In 2011, the National Health Reform Act 2011 established ACSQHC as an independent statutory authority. ACSQHC is jointly funded by all governments on a cost sharing basis, and ACSQHC’s annual program of work is developed in consultation with the Australian, state and territory Health Ministers.

To drive the implementation of safety and quality systems and improve the quality of health care in Australia, ACSQHC developed the National Safety and Quality Health Service (NSQHS) Standards to be managed through a national accreditation model, the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. In September 2011, Health Ministers endorsed the NSQHS Standards and the AHSSQA Scheme.

From a governance perspective, the AHSSQA Scheme contains some similar elements to the National Scheme approach, with ACSQHC being an umbrella organisation which:

- Develops and maintains the NSQHS standards
- Undertakes ongoing liaison with state and territory health departments on opportunities to improve the Standards and the accreditation system
- Approves expert accrediting agencies which assess health service organisations against the standards
- Monitors and reviews the approved accrediting agencies
- Hears complaints about decisions made by accrediting agencies
- Reports to Health Ministers annually on safety and quality.

A threshold requirement for any expert accrediting agency to be approved is that it must hold current organisational accreditation with an internationally recognised body. ACSQHC quotes as examples the International Society for Quality in Healthcare (ISQua) and the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Third-party accreditation provides an assurance mechanism to clients, funders and other stakeholders that the external evaluation and standards setting organisations and their standards and assessor training programs meet international best practice requirements.
An important component of ACSQHC’s overall role is its focus on continuous improvement around the nature and currency of the standards, assessment mechanisms and overall performance of the scheme. ACSQHC also has a major focus on credentialing – a process used by health service organisations to verify the qualifications and experience of health practitioners to determine their ability to provide safe, high quality health care services within specific health care settings.

Credentialing has the potential to improve safety for patients by ensuring clinicians practice within the bounds of their training and competency, and within the capacity of the service in which they are working. Equally, it can ensure more efficient utilisation of the workforce by permitting those clinicians to practice to the full scope of their training and competency. A National standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals, was developed by the former Australian Council for Safety and Quality in Health Care in 2004.

ACSQHC advises that implementation of the national standard is underway in all jurisdictions and across the private hospital sector, with the structures and processes being used varying between states and different health care settings. Credentialing by health services has largely focused on specialist medical practitioners, but it has the potential for wider application to other health professions.

ACSQHC includes in its success measures in its Strategic Plan 2014 – 2019 whether safety and quality are considered as important aspects of undergraduate and postgraduate curricula for health professionals. To this end, ACSQHC has been in dialogue with education providers regarding the need to address the NSQHS Standards in curriculum for all health professions, both within and outside the National Scheme.

**Options for governance reform**

Evidence and analysis set out earlier in this Report have identified the governance arrangements within the National Scheme, and across other relevant regulatory regimes, as a set of overlapping functions and powers that can result in inefficiency, reduced transparency and a lack of accountability for reforms which would be in the public interest. This is evident from the depiction of the current ‘system’ in the following diagram.
Reform of accreditation governance can help simplify this complex array of entities and functions through: establishing greater separation between the registration of practitioners and the accreditation of health education; creating a more integrated cross-profession accreditation regime within the National Scheme; and removing unnecessary overlaps between the National Scheme and other accreditation regimes.

Governance reform goals

As the basis for determining the most appropriate governance arrangements for the accreditation function, the Review has identified four broad goals which reforms should target.

- Planning for the future workforce must be embedded within overall health system reform priorities. The role of education and its accreditation is to provide a foundation for a workforce that is more flexible, responsive and sustainable and which enables innovative improvement in service delivery.
- Health services and the education of the workforce that delivers those services must be developed to foster collaboration between health interventions and related social and other services in responding to community needs. The delivery of such integrated service responses is aimed at having a greater client focus, improving health and wellbeing, assisting individuals and households with multiple and complex health and social needs and making cost-effective use of technological innovations.
- Joined up service delivery needs to connect many professions both within and outside the remit of the National Scheme. Whilst there are important additional requirements and standards that registered health practitioners are required to meet, the various National Scheme functions should not become a silo in themselves by virtue of only considering the education and practice of the registered health professions.
- The regulation of health professionals does not exist in a vacuum and must better link into related national systems and initiatives both within health and beyond. The functions of the regulators frequently cross organisational and legal boundaries and the same function or a similar function is often undertaken by different organisations.

Regulatory principles

In progressing these goals, the Review has identified the following principles to guide the design of the reforms:

- It is the responsibility of all National Scheme entities to proportionately and transparently balance all National Law objectives according to their functions, and comply with all National Law guiding principles.
- It is a single National Scheme with a number of component regulatory responsibilities and accountabilities for decisions that should be applied to all scheme entities. Multivariable controllers need to be established that can regulate a number of distinct elements. In that regard, the National Scheme has two separate but inter-related areas of regulatory focus:
  - the regulation of individuals (health practitioners); and
  - the regulation of accreditation standards, programs of study, and the providers of those programs.
- Governance arrangements must provide a framework for all decision-making entities in the National Scheme to have trust in the integrity and expertise of all decisions made by each responsible entity.
- Duplication of the supervisory and decision-making functions of regulators should be avoided and where there are more competent regulatory authorities (both within and external to the National Scheme) they should be utilised to ensure an integrated, consistent and efficient regulatory framework.
- As far as is practicable the principles of good regulatory practice of separating the standard setting function from the function of assessing compliance against those standards should be adopted.
- Governance arrangements should operate with the minimum necessary costs and administrative burden. Entities should administer a principles-based regulatory framework in a way that minimises compliance costs, provides stability, and is efficient, effective and transparent.
• Individuals appointed to governance roles are to collectively hold the knowledge, skills and attributes necessary to discharge their responsibilities as independent experts. Professional input to, and involvement in, key elements of the accreditation regime is critical but the sourcing of that input should be based on the expertise of individuals rather than being seen to be potentially representing the interest of particular organisations.

• Accreditation decisions on standards, policies and individual assessments of programs of study must be made in an objective manner in the public interest.

• The accreditation governance arrangements should be structured to:
  o Provide authority to progress the reform proposals in this report in a manner that transcends individual professions whilst ensuring the input of professional expertise where necessary.
  o Provide governments, stakeholders and the community with confidence that the arrangements will deliver continuous improvement of the standards, assessment processes and overall performance of the accreditation system and its component entities, ensuring that regulatory administration remains relevant and effective over time.

• The requirement for regulatory independence should only apply to those accreditation functions of accreditation authorities that are specified under the National Law.

Whilst most stakeholders agree that reforms are possible but that progress has been sub-optimal and more integrative approaches are necessary, views on solutions diverge between making minor enhancements to the status quo and more substantive governance change. The Review has developed three options, all drawn from submissions and its own analysis.

• The first option largely reflects the approach proposed by the HPACF and by the National Boards/AHPRA in their joint submission. This option is to adopt a more rigorous approach to the utilisation of cross profession advisory committees and the creation of additional advisory committees on particular issues.

• The second option is based on the proposal put forward by the AMAnC in its supplementary submission to the Review. This option suggests some change and expansion to the role of AMAnC, but largely maintains the separate approach to regulatory arrangements for the 14 registered professions.

• The third option is a governance model that separates the regulation of accreditation from that of registration and establishes a national cross profession accreditation framework for health workforce education and training within the National Scheme structure. The option establishes a statutory board with a secretariat drawn from AHPRA, to sit alongside the National Registration Boards.

**Option 1 - Enhance an existing forum or liaison committee**

The first option is to streamline the time consuming and resource intensive nature of the current governance arrangements by enhancing the role of an existing forum or liaison committee. A cross-professional advisory body could provide advice on common approaches to accreditation standards and processes, and develop reference and guidance documents to promote principles of consistency, efficiency and transparency.

Submissions to the Discussion Paper suggested that HPACF or the ALG could assume this more formal role with membership expanded to include representatives from National Boards, accreditation authorities, AHPRA, consumers, education providers and possibly jurisdictions.

The joint National Boards/AHPRA submission acknowledged the time consuming and resource intensive nature of the current governance arrangements and asked whether it was possible to streamline them:

“…current governance arrangements involve 29 different entities (including statutory authorities and not for profit companies) within NRAS that make decisions and perform activities related to accreditation. As a result, there is significant reliance on goodwill and consensus approaches, which can be time consuming and resource intensive. The question is whether it is possible to streamline governance arrangements to increase the effectiveness of the accreditation functions, and which model will best do this.” (p13)
submission, however, then focused on enhancing the existing system:

“For example, recognition and accreditation of cross-professional competencies and roles could be dealt with in the existing system, including through the establishment of a cross-profession advisory group or even a multi-profession accreditation body. It would be possible to establish a multiprofession group to advise on common content in accreditation standards, and new or revised accreditation standards, to promote consistency where appropriate while retaining appropriate professional input to profession specific standards. This could help to disseminate good practice and also achieve the separation between standard setting and application raised by the discussion paper.” (p13)

Whilst under the National Law the individual accreditation functions continue to be exercised by profession-specific bodies, the accreditation authorities, with the support of AHPRA, have sought to improve approaches to cross-profession and interprofessional accreditation through the establishment of the HPACF. The HPACF was established in 2007 when COAG was discussing the national registration of health practitioners. The HPACF’s stated purpose (as provided on its website) is for the accreditation authorities to:

- Work together on issues of national importance to the regulated health professions
- Identify areas of common interest and concern in relation to the regulated health professions
- Work toward a position of consensus on identified issues and concerns
- Take joint action in areas of importance to the regulated health professions
- Develop joint position statements which provide recommended policy directions for governments and other relevant stakeholders.

Even though the HPACF is a long-standing body, it was not until March 2017 that the accreditation committees for Aboriginal and Torres Strait Islander health practice, Chinese medicine and medical radiation practice were invited by HPACF to become members, with HPACF renaming itself a “Collaborative” forum. As a system-level collaborative model, HPACF has proven to be a valuable initiative and has achieved a number of improvements to the accreditation system. As noted earlier in the Report, HPACF has issued several position statements on matters relating to accreditation functions and advises that it meets annually with all National Boards and AHPRA to discuss how to build effectiveness in the National Scheme, particularly in relation to accreditation.

In 2012, the ALG was also established as a subcommittee of the Forum of NRAS Chairs and advises on common accreditation issues. It comprises representatives of National Boards, accreditation authorities and AHPRA. AHPRA has advised that:

“...it is an advisory group which has developed a number of reference documents to promote consistency and good practice in accreditation while taking into account the variation across entities. These documents have been approved by National Boards and Accreditation Authorities.”

The ALG is provided with project and administrative support by AHPRA. The ALG was proposed by HPACF as the entity which could be enhanced to provide cross-profession consideration of accreditation issues:

“...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 organisations within accreditation roles in NRAS: National Boards; accreditation authorities; and AHPRA, as well as community representatives, education providers and possibly also policy advisors.” (p21)

Impact assessment

The Review has analysed the performance of accreditation functions in the National Scheme, including the performance of the collaborative committees, and the resultant progress with reforms within the limits of the information made available. As indicated earlier, the Review is unable to find any reference in funding agreements, performance reports, and governance arrangements that signpost a structured focus on resolving long standing issues that are well understood and agreed to in principle both within and across professions.
The issue of prescribing rights by health practitioners is a case in point. In 2012 Health Workforce Australia commenced a project to develop a nationally consistent approach for prescribing by health practitioners, building on a set of prescribing competencies developed by the National Prescribing Service. The project aimed to deliver a consistent platform by which health practitioners other than medical practitioners may undertake prescribing of medicines consistent with their scope of professional practice.

It has taken over four years to reach agreement between stakeholders and the issuing of an AHMAC Guidance Note in December 2016 on how individual National Boards may make application to the Ministerial Council for approval of the terms of a new scheduled medicines endorsement or amendment. The application process itself also remains profession specific and requires a further lengthy process for individual applications.

In an ideal regulatory model, any decisions made within the National Scheme in relation to prescribing should be agnostic to professional boundaries and focus on whether the programs of study provide the necessary competencies to undertake safe prescribing. Decisions as to whether this capability could become practice are separate approval matters which currently remain in the province of jurisdictions.

A second example is the development of closer collaboration with TEQSA. The Review sought advice on efforts by either AHPRA or accreditation councils to integrate or share information on accreditation assessments being undertaken under the TEQSA regulatory system. The Australian Dental Council (ADC) established a MoU with TEQSA for information sharing in November 2014 and the AMC in July 2016. TEQSA has subsequently reported greater interest by accreditation councils in such arrangements with short form information sharing MoUs having now been signed with Speech Pathology Australia (December 2016), Australasian Osteopathic Accreditation Council (February 2017) and the Australian Nursing and Midwifery Accreditation Council (February 2017). TEQSA has also advised, however, that steps have yet to be taken by any of the Councils to implement the MoUs. The ADC, which has the longest standing MoU, stated in its submission:

“...discussions have commenced regarding the routine sharing of data and information between TEQSA and the ADC to inform risk based decisions.” (p21)

Neither the HPACF nor the ALG appear to have a forward work program, although the ADC submission states that the Forum is progressing two projects in 2017:

- Forum funded project to develop shared educational standards for safe prescribing (currently in a pre-consultation phase).
- A project investigating how accreditation can contribute to the health outcomes of Aboriginal and Torres Strait Islander peoples (currently in the planning phase).

In relation to the prescribing reforms, a short 2016 project outline was provided to the Review although no further information has been provided to clarify the status of the project. On the latter project, the Review has been unable to obtain any further information.

In terms of the likely overall impact of this option, the Review does not consider that either the HPACF or the ALG, even in an enhanced form, would deliver an optimal solution for reform. The Review estimates that the additional costs would be negligible, but there are no significant benefits as both bodies have fundamental limitations. They are not determinative bodies and cannot drive the necessary reforms to a timely conclusion. The functions have no mechanism to bring common matters together at decision making points because the accreditation system and the National Scheme as a whole remains subject to individual decisions for the 14 regulated professions, either at an accreditation authority level or National Board level. This lack of a cross-profession locus of authority also puts at risk the collective reform of relationships and assignment of responsibilities with TEQSA and ASQA and also with ACSQHC on matters such as safety and quality in competencies and curriculum.

Whatever final governance models for accreditation functions are determined, however, the Review recognises the important role that the HPACF plays in bringing together accreditation entities to enhance cooperation and progress common issues, and the role of the ALG in providing a forum for accreditation authorities and National Boards to pursue common interests.
Option 2 - Enhance the Agency Management Committee

An option advanced in the Discussion Paper that could provide the desired integrative and determinative approach to accreditation was to expand the remit of the AManC. It could be given the role of objectively developing rigorous cross-profession directions for the development of accreditation standards, and for these directions to be embedded within the AHPRA/council agreements.

The National Law gives the AManC the following functions:

### s30 Functions of Agency Management Committee

1. The functions of the Agency Management Committee are as follows—
   a. subject to any directions of the Ministerial Council, to decide the policies of the National Agency;
   b. to ensure that the National Agency performs its functions in a proper, effective and efficient way;
   c. any other function given to the Committee by or under this Law.

Very few submissions directly addressed this option, rather they either indicated support for another option or proposed a new one. Of those that did address the expanded AManC option, support was limited.

<table>
<thead>
<tr>
<th>Box 7.2 Stakeholder views on an enhanced role for the Agency Management Committee</th>
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<tbody>
<tr>
<td><strong>Medical Deans Australia and New Zealand</strong></td>
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<tr>
<td>Expanding the remit of the AHPRA Agency Management Committee may help improve consistency and encourage interprofessional education, particularly if it were able to influence the behaviour of accrediting bodies for the non-registered professions. (p8)</td>
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<tr>
<td><strong>Australian Physiotherapy Association</strong></td>
</tr>
<tr>
<td>Given the broad responsibilities of the AHPRA Agency Management Committee, membership is unlikely to consist of an adequate skill set for the breadth of health professionals represented by AHPRA. (p14)</td>
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<tr>
<td><strong>Osteopathy Australia</strong></td>
</tr>
<tr>
<td>Osteopathy Australia had grave concerns with this proposal due to the past and ongoing failures of the AHPRA Agency Management Committee to implement efficiencies and transparencies across the NRAS scheme. Interestingly, despite several NRAS reviews their role at the head of AHPRA or their responsibility to be accountable for the past failures have been completely ignored in favour of blaming National Board or Councils. (p5)</td>
</tr>
<tr>
<td><strong>Health Professions Accreditation Collaborative Forum</strong></td>
</tr>
<tr>
<td>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. (p22)</td>
</tr>
<tr>
<td><strong>Department of Health Northern Territory</strong></td>
</tr>
<tr>
<td>AHPRA is a multi-million dollar agency with specific business and operational functions under the National Registration and Accreditation Scheme including support for the functions of National Boards. It could easily be seen as a conflict of interest if the AHPRA Agency Management Committee also had responsibility for accreditation over the boards. (p10)</td>
</tr>
<tr>
<td><strong>Psychology Board of Australia</strong></td>
</tr>
<tr>
<td>The proposal that the Agency Management Committee or another body have a role in decision making is not supported by the Board. (p3)</td>
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</tbody>
</table>
The Review notes that the AManC, in its supplementary submission, proposed a slightly different role to that set out in the Discussion Paper. AManC would become responsible for:

“…..developing strong and clear cross-professional requirements for good regulatory practice through new procedures for the development of capability and competency standards and enhancing the existing procedures for development of accreditation standards whilst respecting the profession specific standard setting function of National Boards.” (p2)

The supplementary submission also included proposals for:

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

**Impact assessment**

The Review has assessed these proposals carefully. The costs involved in expanding AManC’s functions would be minimal, including potentially adding up to two members expert in accreditation on that body. In terms of benefits, however, it is not clear how AManC’s role in assigning accreditation entities, in consultation with National Boards, would provide significant change that could not already be achieved by simply setting more robust performance requirements in current contracts with accreditation councils. The Review notes that the accreditation standards would remain profession-specific and is also not convinced that the governance arrangement would particularly facilitate the amalgamation of accreditation authorities.

In terms of a standing committee, it is unclear to what extent this would be different to enhancing the ALG under the first option, given that individual National Boards would continue to have approval powers.

Lastly, the proposal to deem decisions made by accrediting entities as approvals, but with National Boards retaining the power to subsequently place conditions on the program of study in terms of the graduate’s registration status, seems largely to reflect the status quo as provided under s49(2) and s52 respectively of the National Law. This would simply provide a defacto approval power for the National Boards, as it would be expected there would be immediate pressures from many parties, including students, to amend a program of study or a practitioner’s registration status to avoid any systematic imposition of conditions.

As noted in this Review’s scope, it is possible that the NRAS Governance Review may be considering proposals for other governance changes that impact of the role of the AManC. The AManC’s current role is largely one of managing the functions and polices of AHPRA and overseeing the development of systems and guidelines for the operation of National Scheme entities. Expanding its role more directly into accreditation would mean a substantive shift in focus. The Review is not averse to such an expansion but considers that to do this in isolation of consideration of other broader governance options that may be developed could be premature.

Any further reform through that process could result in yet another adjustment to the configuration and skill mix of the AManC.

In summary, there would be some small cost in establishing this function within AManC and some loss of focus on its current role of managing AHPRA. Further, the Review is proposing a third option that more closely reflects the goals and principles outlined earlier in this Chapter at little additional cost and with greater benefits.
Option 3 - Establish integrated accreditation governance

The Review’s third option is to introduce a national cross profession accreditation framework for health workforce education and training within the National Scheme. This would require the establishment of a statutory Accreditation Board, with secretariat and policy capability drawn from AHPRA, to sit alongside the National Registration Boards. Whilst this option involves a new body of experts, it would be the single point of approval of accreditation standards rather than the 14 individual approval arrangements in the current National Scheme. Additionally, the Accreditation Board would drive common policies and guidelines across education accreditation for the 14 professions, pursue greater interprofessional education and remove unnecessary overlap with TEQSA and ASQA processes. It would also remove the duplicative decision making in the approval of programs of study by National Registration Boards by vesting that authority solely in the Accreditation Committees provided the programs were consistent with the accreditation standards.

The key features of this option are as follows:

- The separation of the functions of regulation of individual practitioners from accreditation of programs of study and related matters. This would clarify that there are two distinct areas of expertise in regulation within the single National Scheme, with each having responsibility to meet the National Law objectives.

- Delineation of responsibilities for institutional academic accreditation and for professional accreditation. As outlined in Chapter 4, these two accreditation domains would be separated and managed appropriately through the Higher Education Standards Framework and National Scheme accreditation responsibilities in accordance with relevant legislation. Operational separation would result in:
  - Institutional academic accreditation to be undertaken by either TEQSA approved structures under academic boards in self-accrediting higher education providers or TEQSA assessments for other higher education providers, or ASQA assessments for RTOs.
  - Professional accreditation to be undertaken by Accreditation Committees.

The combined institutional and professional assessments and approval of the qualification would be accepted for the purposes of registration by National Registration Boards and recognised within the Australian Qualifications Framework.

- A single integrated point where ACSQHC could interface on the safety and quality training requirements for future health professionals. It could also allow an exploration of the potential to develop and include within ACSQHC accreditation regimes a module which encompasses the health service clinical education/experience domain in professional accreditation. It would assess requirements at the clinical location including robust safety and quality policies and processes, informed patient consent procedures and suitable learning facilities. The Review considers this would be worthwhile as part of the process of rationalising accreditation processes, resulting in substantial burden reduction and alignment with broader safety and quality standards.

- A clear best practice operational separation of the role of approval of accreditation standards from the role of enforcing those standards at the program and institutional level through assessment and approval. There would be clarity in ensuring that National Scheme decisions and their underpinning processes are appropriately managed, transparent, accountable and subject to the norms expected in all regulatory systems.

- A reduction in cost and compliance burdens at both a system and education provider level. There would also be improved workforce flexibility, responsiveness through collective adherence to cross-profession accreditation standards, greater interprofessional education and collaborative clinical placements and opportunities for more innovative educational design and delivery.
The proposed entity structures and brief outline of functions under this option would be as follows:

**Health Education Accreditation Board**

A new Health Education Accreditation Board (the Accreditation Board) would have the following functions:

- Assignment of Accreditation Committees (see below), including assignment of multi-professional Accreditation Committees where their predecessor Councils/Committees, or future Committees, agree.
- Approval of accreditation standards developed by Accreditation Committees in accordance with the Accreditation Board policies and guidelines.
- Determination of common cross-profession policies, guidelines and reporting requirements for inclusion in all accreditation standards or for recommendation to National Registration Boards for inclusion in professional competency standards.
- Determination of policies and guidelines on the criteria and processes for course accreditation and for assessment of international practitioners following consultation with stakeholders such as education providers, Accreditation Committees, National Registration Boards, employers, professions, consumers and governments. This would include the development of common standards, fees and charges.
- Development and management of the overall relationships with TEQSA, ASQA and ACSQHC, including agreements with those regulators on the policies and procedures for the clear delineation of responsibilities between the respective accreditation systems and how they interact.
- Determination of what elements of the NSQHS Standards should be incorporated into the Accreditation Standards and what elements should be recommended to National Registration Boards for inclusion in professional competency standards.
- Active participation with AManC and National Boards in the National Scheme’s role in developing a flexible, responsive and sustainable health workforce and in enabling innovation in the education of, and service delivery by, health practitioners.

Membership of the Accreditation Board should provide the expertise to carry out its functions in the public interest. This should be an appropriate mix of educational and health professional experts, service providers and service users. Appointment should be by the Ministerial Council, with overlapping terms of up to five years to ensure continuity of experience. The Accreditation Board should have a dedicated Secretariat, drawn from AHPRA staff.
The Accreditation Board would report to the Ministerial Council in the same manner as National Boards and AHPRA, and similarly receive directions as appropriate.

Accreditation Committees

Accreditation Committees, in accordance with the policies and guidelines set by the Accreditation Board, should have the following functions:

- Development of accreditation standards for approval by the Accreditation Board.
- Assessment of programs of study and education providers and approval and monitoring of programs of study and providers which meet approved accreditation standards.
- Assessment of authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study and approve those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia.
- Assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession.

The Review is cognisant of the substantial contribution that has been made to accreditation by the current accreditation councils and the critical value they provide through expert professional input. Accordingly, the Review considers that the National Scheme should be agnostic to the governance structures of those Councils. The new Accreditation Committees should thus be able to be appointed within an external entity provided that decisions that are made by Accreditation Committees under the legislated requirements of the National Law should be so configured as to:

- Place the public interest foremost and ensure that professional input to decision making is based on the expertise of individuals rather than representing the interests of any particular stakeholders.
- Ensure complete transparency in decision making.

The external entity must ensure that the Accreditation Committee has full autonomy to make accreditation assessment decisions and establish its operations in a manner that would enable its functions to be covered in the same manner as other National Scheme entities defined in the Health Practitioner Regulation National Law Regulation made by AHWMC in June 2010.

None of these requirements should relate to the general governance and operations of any current accreditation council or other potential external accreditation entity, beyond normal contractual requirements. The application of relevant provisions of the Health Practitioner Regulation National Law Regulation 2010 should apply to the Accreditation Committee only and not more generally to the external entity which hosts it.

To remove all potential for future doubt and provide transparency, the management of, and decisions made that are part of, any defined functions under the National Scheme need to be undertaken under arrangements that are clearly separate to the governing boards and members of the external accreditation entity more generally. External entities should be permitted to have other commercial arrangements provided their contracted accreditation functions are managed independently and transparently, including the management of any conflicts of interest.

The three existing accreditation committees should become committees of the Accreditation Board, with administrative support continuing to be provided through AHPRA. Committee members should be selected using the same criteria that apply to accreditation councils in establishing their Accreditation Committee.

The Accreditation Board should conduct regular reviews of the entities contracted to deliver the accreditation service, including the opportunity for other bodies to tender for the function after the first five years of operation of the new arrangements.
National Boards

National Boards would continue to focus on the key elements of the National Scheme covering the regulation of individual practitioners, protecting the public and setting the standards and policies that all registered health practitioners must meet. This would include:

- Registration standards and policy
- Codes and guidelines
- Notifications
- Enforcement

One of the essential design criteria for new accreditation governance arrangements is that National Boards continue to have trust in the integrity of the accreditation institutions and processes, while no longer having powers of approval of accreditation standards, programs of study and education providers. Their ability to have that trust would include assurance that successful candidates of accredited programs of study have the knowledge, skills and professional attributes necessary to practice the profession in Australia.

An essential element of accreditation standards is that the curriculum is founded on the competency standards relevant to the individual professions. As noted earlier, there is variability across professions regarding the authorship and ownership of the competency standards, involving National Boards, accreditation councils and professional associations. As also noted, the standards are generally developed outside of the regulatory purview of the National Scheme and yet (via the accreditation standards) they have very significant influence on the education foundation of the workforce and ultimately their practice.

As discussed in Chapter 5, the competency standards identify many roles, responsibilities and required knowledge that are common across professions, including communication, ethical behaviours, leadership, collaboration, areas of clinical practice and cultural awareness. In addition, a number of system-wide safety and quality standards will have elements that translate directly to practitioner competencies that need to be embedded in those frameworks.

The Review considers the establishment of these competency standards should be integral to the National Scheme. It would be consistent with the National Registration Boards’ focus on individual practitioners for the responsibility for these standards to rest with them in a more formal manner. This would also strengthen the National Registration Boards’ trust in the integrity of the accreditation system.

Given the importance of commonality across various domains, a final single approval point somewhere within the National Registration Board structures and processes would be preferred but are beyond the scope of the Review. Thus, to ensure broad consultation, and that these competency standards adequately provide the foundation for educating the future health workforce, their development and final approval should be in accordance with the legislative provisions established for development of registration standards by National Boards and their approval by Ministerial Council under the National Law.

A cooperative approach should be adopted between National Registration Boards themselves and also with the Accreditation Board to define those commonalities and ensure that competency requirements arising from the ACSQHC continuous improvement approach to improving safety and quality in health care are adopted.

Agency Management Committee

Under this option, no changes are recommended for AManC at this stage. However, its functions and membership should be reassessed if the Ministerial Council considers additional responsibilities should be provided to AManC as part of the broader governance review, such as AManC undertaking the Ministerial Council’s role in accreditation standards as provided for under s11 of the National Law. This could include AManC having the power of approval of competency standards, with a broader general direction power from the Ministerial Council on policies by way of transmitting Statements of Expectations to all National Scheme entities.
The AMAnC could also undertake the functions proposed for the Health Education Accreditation Board. Consideration of such a model, however, by necessity goes to a broader view on the role of the AMAnC as the Review considers it would likely be dysfunctional to amend its role for only the accreditation function within the National Scheme. The Review is also conscious of the limited role that AMAnC proposed for itself as set out in Option 2.

Consideration of the unregistered professions

The opportunity to consider unregistered professions in the overall reform of accreditation of health education under the National Scheme was raised in a number of submissions. Unregistered professions operate outside of the National Scheme’s regulatory regime, though the Review acknowledges that many have some form of self-regulatory governance structures. In particular, this issue was a major theme in the submission from the Australian Council of Deans of Health Sciences:

“There would be advantage in broadening the scope of the accreditation structure and processes within NRAS to include the self-regulating professions rather than having a parallel structure with potentially differing requirements. This suggestion is not to presuppose that these professions would require registration, but rather the inclusion of the self-regulating professions could reduce the variability in accreditation requirements across all health professions.” (p4)

“Whilst establishing a single accreditation standard may be the ideal; unless all of the professions currently within NRAS (and ideally the self-regulating professions) are included, the progression of cross profession development, education and accreditation consistency and efficiency will be sub optimal……. the scope should include all of the regulated professions covered by NRAS and ideally consider including self-regulating health professions under a broader accreditation function.” (p24)

Providing a capacity to encompass the accreditation of education of relevant unregistered professions is consistent with the Review’s assessment that the new governance arrangements should be developed in the broader context that takes account of interactions of all health interventions with social and other services in responding to community needs.

The Review is proposing that the legislative arrangements be designed to allow the limited participation of other unregistered health and social care professions in certain matters. This would need to be carefully specified:

- Unregistered health and social care professions could apply to access the skills and expertise available by, and operate their accreditation activities under the umbrella of, the Accreditation Board.
- Unregistered professions participating in the accreditation model would be considered separate to National Scheme registered professions.
- Accreditation activities undertaken by unregistered professions within this framework would have no implications for the registration of that profession. All applications for registration would continue to be dealt with through established Ministerial Council processes and in accordance with the COAG agreed criteria.
- The National Scheme would not be responsible for costs and fees charged by participating unregistered professions in relation to those activities and the Accreditation Board may need to charge fees to recover its own costs.
- Any legislative provisions relating to Freedom of Information (FOI), privacy, etc. would not apply to unregistered professions seeking to participate. Application of best practice standards would be voluntary.

Such a model would also provide capability within the National Scheme to support requests from ASQA when it is asked to consider the accreditation of VET courses and it requires expert advice on the safety and technical practice elements of competencies being taught.
It is appreciated that the precise design of this approach would need to be carefully considered to ensure there are no unintended consequences. However, the Review considers that introducing this flexibility into the National Scheme could provide a foundation for even further consistency across a range of health and social care professions, enable cooperative participation in the inclusion of common competencies, support the development of education models which would facilitate integrated service responses with a greater client focus, tackling issues associated with social disadvantage, mental health, insecure housing, family violence, drugs and alcohol, chronic health conditions, disability and frailty.

**Impact assessment**

Changes proposed under Option 3 are largely technical in terms of regulatory amendment. In most circumstances, they involve a transfer of existing functional responsibilities to different bodies, all of which (with the exception of the Health Education Accreditation Board) exist in some form. The transfer of responsibilities is intended to provide a more forward looking and efficient and effective regulatory framework.

**Reform benefits**

The reform proposals recognise that health services must be developed and integrated into a broader context that takes account of interactions of health interventions with social and other services in responding to community needs. The education of the registered health professions is fundamental to this continuous development need. Education models and the accreditation of programs of study are the entry point.

From a regulatory perspective, the development and delivery of the accreditation of education of health professionals must also take account of, and better link into, other complementary national systems and initiatives both within health and beyond.

The assessed reform benefits would include:

- Enabling entities within the National Scheme to better understand the proportionate and transparent balancing of all National Law objectives and guiding principles.
- Supporting improvement in the National Scheme’s governance capacity. A more robust and clear system will provide governments, stakeholders and the community with confidence that the arrangements can deliver continuous improvement of the standards, assessment processes and overall performance of the accreditation scheme and its component entities, ensuring that regulatory administration remains relevant and effective over time.
- Ensuring that, where there are more competent regulatory authorities (both within and external to the National Scheme), they are utilised. There would be more efficient and effective integration with the accreditation systems for higher and vocational education programs (TEQSA and ASQA) and with the accreditation of safety and quality in the delivery of health services (ACSQHC) across professions.
- Creating a principles-based regulatory framework that can minimise compliance costs, provide stability, and is efficient, effective and transparent. This would include delivering on the principles of good regulatory practice of separating the standard setting function from the function of assessing compliance against those standards.
- Progressing accreditation reforms in a manner that transcends individual professions whilst ensuring the input of professional expertise where necessary.
- Recognising that, as private companies, accreditation councils can have other commercial arrangements provided their contracted accreditation functions are managed independently and transparently, including the management of any conflicts of interest. The National Scheme would only apply such requirements to those functions specified under the National Law. Whilst this will place requirements on those entities, it is considered the most effective means by which to ensure complete transparency in decision making and ensure that those functions are subject to the same as all other decisions made by entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioners Ombudsman and Privacy Commissioner.
• Removing duplicative approaches across government agencies to the assessment of qualifications and skills of international practitioners seeking to work in Australia.

• Enabling National Registration Boards to continue to focus on the important work they have been prioritising as identified in the AHPRA Annual Reports and AHPRA’s current Business Plan including:
  o Raising awareness of the National Scheme and improving its transparency
  o Improving risk assessment and ensuring thorough investigations
  o Refining the service model including improving the registration renewal process, responses to notifications and the experience of notifiers
  o Applying a ‘risk-based’ regulation philosophy and ensuring thorough investigations of practitioners
  o Prosecuting statutory offences
  o Ensuring practitioners meet advertising requirements.

Cost and burden

Overall, the Review is confident the governance reforms proposed under this option, together with the more timely and fulsome implementation of reforms proposed elsewhere in this Report, will result in significant reductions in costs and burdens which can then be reflected in reductions in fees charged to education providers and in the components of registrant fees supporting accreditation functions. Quantification of this, however, can only occur as the precise elements of the new accreditation model are developed. As outlined in Chapter 3:

• Each accreditation authority currently has a different charging regime and charges different fees for accreditation functions and for the assessment of overseas trained health practitioners. Once the delineation of accreditation requirements with TEQSA and ASQA is established, reductions in fees can be identified commensurate with the reduced assessment workload in accreditation authorities.

• Costs and burdens incurred by education providers would be reduced commensurate with decreases in their accreditation preparatory and compliance work. Education providers also incur accreditation costs through the TEQSA and ASQA processes and the proposed model would result in this work only being required once for a number of common accreditation elements across all regimes.

• The adoption of transparent cost recovery models for functions where accreditation authorities are currently generating surpluses would lead to a more efficient charging regime.

In terms of cost increases, this mainly relates to the operation of the proposed Accreditation Board which would be responsible for a range of activities that transcend individual professional boundaries. These costs are limited to funding members of the Accreditation Board and their meetings, but no additional secretariat or other operational costs.

An initial comparative assessment of the cost of the Accreditation Board has been made by looking at the budgets for the current National Boards as documented in the Health Professions Agreements recently published that cover the period 2016-2020. It is not possible to make a direct comparison as the budgeted expenses listed in the Agreements are designed to cover “the meeting costs of the Board and its committees, which have the delegated authority to make decisions about individual registered pharmacists. Costs include sitting fees, travel and accommodation while attending meetings for the Board and its committees.” For some professions, this also includes state boards. By considering those professions that only have National Boards and supporting committees, a median annual budget is $430,000 per annum, based on monthly meetings and Board numbers ranging from nine to 12. Further work will be undertaken with AHPRA to develop a more accurate cost estimate for the final report.

The funding framework and cost recovery model will need to factor in the establishment of a consolidated funding stream that can support the development of common accreditation standards, joint projects, and other cross professional and oversight functions. It is expected, however, most of those costs can be funded through the transfer of current ‘indirect expenses’ allocated to AHPRA within Health Profession Agreements for the administration for accreditation activities. This is also considered further below.
Given the service and financial viability needs of several accreditation authorities which lack opportunities for scale economies, an operating funding floor may be required. In this respect, however, a drive for efficiency and reduced cost may lead to some authorities exploring functional mergers, as is currently the case for some accreditation councils.

As outlined in Chapter 3, support for accreditation functions within AHPRA is already funded through agreed indirect expenses budgets with each National Registration Board. Even though AHPRA is unable to quantify the amounts, it has advised the Review that:

“The explanation of indirect expenditure in the HPA states: “AHPRA supports the work of the National Boards and committees by employing all staff and providing systems and infrastructure to manage core regulatory (registration, notifications, compliance, accreditation and professional standards) and support services in eight state and territory offices.

AHPRA supports all National Boards (those that have assigned accreditation functions to an external entity and those that have established Committees) by employing all staff and providing systems and infrastructure to manage the aspects of Part 6, Division 3 Accreditation Functions that apply to National Boards/AHPRA such as:

- Decision on accreditation entity (section 43)
- Management of contracts with accreditation entities including the Agreement for the Accreditation Functions and the annual funding and revised schedules to that agreement and reports against the Quality framework under that Agreement (section 44)
- Approval and publication of accreditation standards and relevant written notices (section 47)
- Approval of accredited programs and relevant written notices
- Changes to approval of programs and relevant written notices
- Maintaining the published list of approved programs

AHPRA also engages in a range of other activities such as support for the Accreditation Liaison Group.”

With the transfer of these functions to the Accreditation Board (and Accreditation Committees) the accompanying resources could be transferred to support the new functional allocations without additional costs. Indeed, there would be further savings from this reform as National Boards (and AHPRA staff) will no longer review and evaluate recommendations from accreditation authorities on programs of study. These savings could be deployed to further enhance policy capability to support the Accreditation Board.

Reform risks

The Review has identified two key risks in this reform option:

- Profession specific knowledge and input could be lost.
- The entities within the National Scheme do not approach their respective regulatory responsibilities cooperatively and the National Law objectives are not appropriately balanced.

To ensure that profession-based input is not only preserved but enhanced, the Review has proposed that the existing profession-based accreditation authorities should be able to operate their Accreditation Committees in a more independent manner but with clear public accountability requirements established for their accreditation responsibilities under the National Scheme. The functions of the Accreditation Committees were set out earlier in this Chapter.

Such a model should ensure that professional expertise is accessed and applied within an overarching framework of transparency and review, and within a policy framework that is designed to develop a workforce that can support evolving health care delivery approaches.

In relation to the appropriate exercising and balancing of functions within the National Scheme, as outlined earlier, a major consideration of the Review is to ensure that in this model National Registration Boards and the system as a whole continue to have trust in the integrity of the accreditation institutions and processes.
Whilst it would be expected that regulatory cooperation would be a bottom line requirement, it could be further enhanced through the proposed Statement of Expectations approach outlined in Chapter 8. This could include expectations around regulatory cooperation and the operation of working partnerships with other entities both within and external to the National Scheme. This could be further enhanced by relevant National Scheme entities producing Statements of Intent in response that outline how that would be achieved.

Draft Recommendations

14. Governments should separate responsibility for the regulation of the accreditation functions under the National Law from that of the regulation of individual practitioners, with the governing entities of the two functions operating collaboratively with the Agency Management Committee and AHPRA, to achieve all objectives of the National Scheme.

15. Governments should establish in the National Law a Health Education Accreditation Board (the Accreditation Board) with the following responsibilities:
   - Assignment of Accreditation Committees.
   - Approval of accreditation standards developed by Accreditation Committees in accordance with the Accreditation Board policies and guidelines.
   - Determination of accreditation policies, guidelines and reporting requirements (as described in Recommendations 3, 4, 5, 8 and 12).
   - Development and review of policies and guidelines on the criteria and processes for assessment of international practitioners, offshore programs of study and competent authorities.
   - Development of funding principles (as described in Recommendation 1) for submission to the Australian Health Workforce Ministerial Council for approval.
   - Approval of fees and charges proposed by Accreditation Committees following Cost Recovery Implementation Statement processes.
   - Development and management of relationships with TEQSA, ASQA and ACSQHC, including agreement on the delineation of responsibilities between the respective accreditation systems and how they interact within the following parameters:
     - Institutional academic accreditation to be undertaken by TEQSA approved structures for higher education providers or ASQA approved structures for Registered Training Organisations.
     - Professional accreditation to be undertaken by Accreditation Committees.
   - Exploration of the potential to include a module within ACSQHC accreditation regimes which encompasses the health service elements of the clinical education/experience domain in professional accreditation.

16. The Accreditation Board should be required to report to the Australian Health Workforce Ministerial Council in the same manner as National Registration Boards and AHPRA, and similarly receive directions as appropriate.

17. The Australian Health Workforce Ministerial Council should appoint members to the Accreditation Board who have the expertise to carry out its health and education functions in the public interest. There should be an appropriate mix of experts in health education, health service provision and health service use. Members are not to represent any particular organisation.
Draft Recommendations

18. AHPRA should support the Accreditation Board with a dedicated Secretariat with policy capability and should work with the Accreditation Board to develop and operate a consolidated fund to:
   - Support the development of policy on cross-professional accreditation matters such as common standards and processes.
   - Provide a mechanism for the distribution of some proportion of registrant fees as a contribution to accreditation costs to the Accreditation Board and Accreditation Committees.

19. Accreditation Committees, in accordance with the policies and guidelines set by the Accreditation Board, should have the following functions:
   - Development of accreditation standards for approval by the Accreditation Board.
   - Assessment of programs of study and education providers and approval and monitoring of programs of study and providers which meet approved accreditation standards.
   - Assessment of authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study and approve those which would provide a practitioner with the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia.
   - Assessment of the knowledge, clinical skills and professional attributes of overseas health practitioners whose qualifications are not approved qualifications for the health profession.

20. In assigning Accreditation Committees to undertake the accreditation functions, the Accreditation Board should ensure that they are configured so as to:
   - Place the public interest foremost and provide complete transparency in decision making.
   - Provide professional input to decision making based on the expertise of individuals rather than representing the interests of any particular stakeholders.
   - Have their decisions subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation 2010. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

21. Accreditation Committees should be able to be appointed within an external entity. In that circumstance the Accreditation Board should, with the support of AHPRA, oversight the management of a multiyear contract with the external entity for the delivery of accreditation functions, within the following parameters:
   - External entities should be permitted to have other commercial arrangements provided their contracted accreditation functions are managed independently and transparently, including the management of any conflicts of interest.
   - An external entity must ensure that its Accreditation Committee has full autonomy to make accreditation assessment decisions and establish its operations in a manner that would enable its functions to be covered in the same manner as other National Scheme entities defined in the Health Practitioner Regulation National Law Regulation 2010.
   - The application of relevant provisions of the Health Practitioner Regulation National Law Regulation 2010 should apply to the Accreditation Committee only and not more generally to the external entity which is its host.
Draft Recommendations

22. The Accreditation Board should invite current accreditation councils to establish Accreditation Committees for the initial five-year period. The three existing accreditation committees should be made committees of the Accreditation Board, with administrative support continuing to be provided through AHPRA.

23. Following the initial five-year period, the Accreditation Board should seek expressions of interest and assign Accreditation Committee functions for periods of five years.

24. The National Law should enable the Accreditation Committees and/or any external entities that host them to act as merged entities where mutually agreed. Opportunities for streamlining and amalgamation should be considered as part of a drive for continued efficiency.

25. National Registration Boards should develop competency standards formally under the National Law, in accordance with the legislative provisions established for the development of registration standards. Competency standards should be developed cooperatively utilising:
   - Standardised definitions and terminology.
   - A common template with domains that apply to all health professions and which include profession-specific performance criteria and indicators as needed.
   - Wide-ranging consultation to align with health service models that best serve evolving community health care needs, and incorporate developing requirements such as a greater emphasis on cultural safety and references to the NSQHS Standards.

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

As the Review progressed it became evident that there were a range of matters identified that reflected the somewhat bespoke nature of the final agreed configuration of the National Scheme, largely as a consequence of moving from individual arrangements in eight jurisdictions for 14 different professions, supported in different ways by a wide range of entities.

This required careful assessment as to:

- Whether they were in scope and did they need separate and detailed consideration.
- How they fit into the accreditation functions and the broader governance changes under consideration.

Those matters are covered in this Chapter, along with some specific issues raised in the 2014 NRAS Review.

Assessment of overseas trained health practitioners

For overseas trained health practitioners seeking to practice in Australia, accreditation, registration and skills assessments are part of a process that requires engagement with numerous organisations responsible for immigration, state and territory governments, recruitment agencies National Boards, AHPRA and employers.

Section 2, Part 6, Division 1, s42 of the National Law defines qualifications assessment for registration as accreditation functions as they relate to overseas practitioners as follows:

- Assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia (s42c).
- Overseeing assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession (s42d).

The National Law enables the assessment of overseas trained practitioners to be undertaken by both National Boards (s35e) and accreditation authorities (s42c and s42d). The classification of this as both a registration and accreditation function is unusual and largely reflected legacy arrangements in place in previous state and territory schemes.

Given the time and resources available, the Review has focused on decisions, processes and governance relating to function assignment, monitoring and reporting across the variety of arrangements for assessment, rather than the specific operational performance of the assessment processes.

Skilled migration visas versus registration

To work as a registered health practitioner in Australia, it is necessary to gain registration through the relevant National Board. Overseas trained practitioners may also need to apply for a qualifications assessment for a skilled migration visa issued by the Australian Department of Immigration and Border Protection. Approval of bodies to perform the skills assessment function for migration purposes for the relevant occupations is through gazettal by the Minister for Immigration, under the Migration Act 1958, Migration Regulations. The Regulations require the Minister for Immigration to seek approval when selecting an assessment authority to undertake the skills assessment function. In the case of registered health practitioners under the National Scheme, this approval process is provided by the Commonwealth Minister for Education and Training.
This Review has consulted the Commonwealth Department of Education and Training (DET) regarding the criteria used by the Commonwealth Minister when approving skilled migration assessing authorities under 2.26B of the Migration Regulations 1994. The DET Guidelines for skilled migration assessing authorities (‘the Guidelines’) specify five criterion which form the basis for assigning skilled migration assessment functions:

- **Criterion 1:** The body is financially viable and has administrative structures, policies and processes to operate effectively as an assessing authority;
- **Criterion 2:** The body represents the nominated occupation nationally and has written support from relevant organisations to operate as the assessing authority for the nominated occupation;
- **Criterion 3:** The body has assessment standards that are consistent with standards needed for employment in the nominated occupation in Australia and has appropriate processes for assessing applicants against these standards;
- **Criterion 4:** The body will clearly inform prospective migrants about skills assessments; and
- **Criterion 5:** The body has an appropriate review and/or appeal process for its skills assessments.

Whilst all criteria apply, Criterion 3 is the most relevant as it requires standards used by assessing authorities (for skilled migration) to be consistent with standards for employment in Australia and the Guidelines detail the required evidence. In the case of registered professions, given that registration is required for employment, eligibility for registration would be the expected standard.

The Migration Regulations 1994 - Skilled Occupations, Relevant Assessing Authorities and Countries for General Skilled Migration Visas lists accreditation authorities such as the Australian Nursing and Midwifery Accreditation Council (ANMAC), Council on Chiropractic Education Australasia, Australasian Osteopathic Accreditation Council, Australian Dental Council (ADC), Australian Physiotherapy Council (APhysioC), Australian Pharmacy Council, Australian and New Zealand Podiatry Accreditation Council, Occupational Therapy Council (Australia and New Zealand) and the Optometry Council of Australia and New Zealand.

In certain cases, assessment is undertaken by peak bodies – for example the Australian Society of Medical Imaging and Radiation Therapy has responsibility for assessing medical diagnostic radiographers, medical radiation therapists and nuclear medicine technologists. External entities undertake some assessments such as the Vocational Education and Training Assessment Services (VETASSESS) which has responsibility for assessing dental hygienists, dental therapists and Aboriginal and Torres Strait Islander health workers. VETASSSSS also has responsibility for assessing ambulance officers and intensive care paramedics.

The Chinese Medicine Board of Australia is the assessing authority for acupuncturists and traditional Chinese medicine. The Medical Board of Australia is the assessing authority for medical practitioners. Importantly, registration (instead of education and training) has been set as the appropriate benchmark for general or specialist recognition for skilled migration. As noted by the Australian Medical Council (AMC) in its submission:

“....... evidence of full medical registration is a suitable skills assessment for Points Tested Skilled Migration, so alignment of migration and registration requirements exists in the case of medicine. Prior to registration applicants must undergo assessment conducted by the AMC.” (p29)

The majority of National Boards make it clear that the application processes for skilled migration and registration are separate and success in one does not guarantee success in the other. For medicine, however, registration is a considered suitable for Points Tested Skilled Migration. Whilst not as explicit as medicine, for dentistry and physiotherapy alignment of the qualification assessment requirements and processes for both registration and skilled migration has also been achieved. APhysioC in its submission advised:

“The Council is delegated the authority to assess the qualifications of overseas qualified physiotherapists for the purpose of general registration with the Physiotherapy Board of Australia. It provides this service to over 340 new candidates a year. As the Department of Immigration and Border Protection gazetted “skills assessing authority”, the Council also assesses the relevant skilled employment experience of skilled migrants under the General Skilled Migration framework.” (p10)
Some National Boards (Nursing and Midwifery and Psychology) have made an explicit decision not to assign functions relating to the assessment of overseas trained practitioners for the purposes of registration to the respective accreditation council. The joint National Boards/AHPRA to this Review states:

“There is not an automatic link between the expertise required for accreditation of Australian programs and the expertise required for assessment of overseas qualified practitioners seeking registration... There are a range of reasons why some National Boards have not assigned the function to assess overseas trained practitioners to the bodies responsible for accreditation of Australian programs. These include the locus of expertise, volume of applications, impact on applicants and risk profile of the profession.” (p15)

In relation to the locus of expertise, it is unclear why an accreditation authority might not be considered to have expertise in assessing international programs of study or competent authorities, given that each has been granted the authority to accredit onshore programs.

In relation to the volume of applications, the Cost of Accreditation in the National Registration and Accreditation Scheme indicates that in 2015/16 financial year, accreditation authorities had accredited 746 programs of study across 338 education providers and expended approximately $19,262,143 on the assessment of overseas qualified health practitioners (p3). Accreditation authorities undertook assessment of 32,411 applications from overseas applicants from 2013/14 to 2015/16 (p29). Given this volume of activity, it can be safely assumed that accreditation authorities can and do deal with a high volume of transactions.

The question of impact on applicants appears to be a concern only where National Boards have chosen not to align skilled migration and registration processes, as significant distress can be caused when overseas applicants who have been assessed for skilled migration by an accreditation authority are then denied registration by the National Board. For example, the Review understands this occurred in 2014 when the Nursing and Midwifery Board of Australia implemented a new model for the assessment of qualifications for Internationally Qualified Nurses and Midwives which resulted in overseas trained nurses who had been assessed by the ANMAC for skilled migration purposes being denied registration. The National Board has explained its decision to not align the two assessments on its website:

“ANMAC takes into consideration work experience in assessing an applicant’s qualifications, which is then used to determine suitability for skilled migration. Under the National Law, the NMBA can only take into account an applicant’s qualifications when establishing whether their qualifications are substantially equivalent to an Australian qualification. This is why some applicants may be approved for skilled migration but do not meet the registration requirements of the Nursing and Midwifery Board of Australia.”

It is clear the impact this approach can have on overseas practitioners applying for a skilled migration visa. It is also evident that National Boards may have different interpretations of the National Law which is resulting in diverse approaches. For example, the Psychology Board of Australia in its submission advises that its process "includes an assessment of their training, qualifications, skills, experience and suitability for practice." (p5) However, the Review notes that the Psychology Board’s assessment process for overseas trained psychologists focuses on the education and training and any periods of supervised practice (similar to what is in place for Australian domestic graduates). The Review was not provided any further information on how the Psychology Board assessed the skills and experience of overseas trained psychologists.

It is assumed that the National Boards/AHPRA reference to a profession’s risk profile is based on the associated regulatory workload. The 2014 NRAS Review noted that the professions of medicine, dentistry, nursing and midwifery, pharmacy and psychology had a higher regulatory workload (p20) and its Consultation Paper indicated that a ‘high regulatory workload’ was based on ‘ascertaining the potential risk of harm to the public, and largely calculated this risk on the basis of the number, frequency and significance of the complaints and notifications made against members of the profession’. (p8) AHPRA data on notifications and complaints indicate that of the total complaints or notification, 41.8% were related to clinical care, 11.5% to medication issues and 10.7% related to health impairment (p45). AHPRA further indicates that 53.3% of all notifications were related to medical practitioners, 19.3% to Nurses and 10% to dental practitioners (p49).
The concept of using notification data as a guide to necessary changes and improvements in competency standards and curriculum (which are equally applicable to both Australian and overseas trained practitioners) is supported, however, the Review is not aware of this analysis having been undertaken. The Review believes that its earlier recommendation that profession specific competency standards should be recognised formally under the National Law and be developed by National Boards would establish a foundation for this approach which would then provide Accreditation Committees with the appropriate information upon which to accredit curriculum and qualifications for both Australian and overseas education and training programs.

A number of stakeholders expressed a preference for a one step approach.

**Box 8.1 Stakeholder views on a one step qualification assessment process**

**Department of Health Australian Government**

*The Commonwealth Department of Health supports a one step process for assessing overseas health practitioners for permanent skill visa requirements and for registration. This process could be facilitated either through the accreditation council or the national boards... The assessment of overseas trained health practitioners must include a skills based assessment process and not be reliant on a minimum level of qualification that is assessed equivalent to the Australian qualification framework level.* (p3)

**Australian Pharmacy Council**

*..... there is duplication in the existing arrangement between assessment for skilled migration and assessment for registration functions. We cannot see why these are not aligned for all professions, as there is considerable overlap for some of the requirements. Alignment for all professions to the accreditation authority could reduce regulatory burden and costs.* (p38)

**Council of Ambulance Authorities**

*A National approach to assessment may be advantageous to ‘harmonising’ processes...... A ‘centralised’ national policy approach and support is desirable.* (p10)

**Pharmaceutical Society of Australia**

*The pharmacy accreditation authority, APC, already possess the necessary expertise in assessing local programs to ensure work-ready graduates so it is PSA’s view that they should be assigned the function and responsibility to assess overseas trained practitioners.* (p12)

**Australian Dental Association**

*Assessment of Overseas Qualified Dentists is currently done by the ADC on behalf of the Dental Board of Australia and the ADA supports no change.* (p13)

**Psychology Board of Australia**

*Individuals from overseas apply to the Board to register in Australia, making the registration board an appropriate entity to assess their application including their training, qualifications, skills, experience and suitability for practice, in a "one-stop-shop" assessment for fitness to practice. This streamlines the process and reduces the costs for individuals as there is a single assessment fee. Assessment of qualifications by an accreditation council creates a duplicate and more costly process, as a separate assessment would then need to be conducted by the Board for the purposes of registration, leading to double-handling and increased cost and delays.* (p5)

The purpose of a skilled migration assessment is to test whether the applicant can work in that profession in Australia and, in the case of National Scheme professions, the requirement is, in the first instance, registration under the National Scheme. DET advised that alignment of registration and migration skills assessments should consider the requirements of the guidelines for the assessment to:

- Be able to be met through skills, qualifications and/or experience relevant to the occupation
- Be not less or more than those an Australian would need to meet for employment in the occupation
- Be based on the standards for licensing or registration and/or the Australian Qualifications Framework
Be flexible enough to allow an applicant to meet the standards through a variety of pathways.

Be the minimum required to assess the applicant against the standards.

In the case of exams, be available at appropriate intervals throughout the year and in a range of geographic locations taking into account: costs, feasibility, number of assessments and visa issues.

DET also advised that:

“Skilled migration assessments must be appropriate and not pose unreasonable barriers to migration. In practice this means that skilled migration assessments must be accessible to applicants who are not residing in Australia. Registration under NRAS does not have this remit and subsequently can include requirements such as periods of supervised practice, which require residency in Australia.”

Clearly this needs to be further explored as requirements for supervised practice in Australia do not constrain alignment between registration and skilled migration. This has been demonstrated by the Medical Board of Australia (which does place conditions of supervised practice for general and specialist registration) and the AMC who have already aligned their processes to support a one-step approach.

Officials from DET advised the Review of their willingness to work with National Boards and accreditation authorities to develop a one-step approach to the assessment for the purposes of both skilled migration and registration. National Boards and AHPRA in their joint submission also acknowledged this opportunity:

“We recognise the scope to reduce duplication in this area and support proposals to align the assessment of qualifications for individuals seeking both skilled migration visas and registration in Australia. This alignment can occur in two ways – recognising the individual’s registration status for visa purposes as currently occurs for the medical and Chinese medicine professions or the same body being responsible for both assessments and the outcome being used for both purposes (such as the Australian Dental Council assessment for overseas qualified dentists).” (p15)

The Review notes the two approaches proposed by AHPRA and National Boards and recommends that whilst both approaches have validity, there are several arguments in favour of assessments being undertaken by the accreditation authorities. They have expertise in the assessment of programs of study and education providers and this approach would ensure comparability in qualification assessment with on shore requirements.

As part of the development of a one-step approach, the respective entities will need to review the criteria for assessment of overseas trained practitioners for the purposes of registration and skilled migration to address anomalies, reduce duplication and enable a consistent approach. The Review considers that there will continue to be elements of the assessment process which remain profession specific. It also acknowledges that some element of supervised practice may be necessary for certain professions (such as those that work in solo practitioner settings). However, where elements remain different for the purposes of profession specific requirements, the reasons for these should be transparent.

There are obvious benefits to overseas candidates in providing greater consistency in both application and assessment steps across professions. Benefits could also accrue for the administration of those process, including primary source verification of overseas education qualifications and the organisation of interviews and clinical assessments. The benefits would include consistency in the provision of information to the applicant and reducing costs through pooling of infrastructure (for example, use of digital technology such as a single portal, and international examination sites).

As noted in the joint National Boards/AHPRA and response to this Review, there is an appetite to review current processes and explore opportunities for consistency, transparency and a reduction of duplication. The Review notes that elements of the registration process (such as English language requirements, criminal history checks) have been centralised and is of the view that there is scope to expand this to include an integrated assessment process for overseas trained practitioners for skilled migration and registration. The Review notes that this is yet another example of the disparity between the appetite for reform and the timely execution of that reform. Changes to the governance arrangements proposed in this report will provide the missing link.
Based on the information provided to this Review, it is considered that a one-step approach could be achieved in the short term. It is also noted that other requirements for migration and registration could be better aligned, however, this is beyond the scope of this Review.

Commonality in qualification assessment approaches across professions

The Review has sought to map the assessment processes across the 14 professions and additional specialties within those professions. It is a diverse and often complex landscape:

- Pathways and assessment techniques vary considerably across professions.
- The Nursing and Midwifery and the Psychology accreditation councils and the three accreditation committees do not have a role in the assessment of overseas trained practitioners or competent authorities. For these professions, this role is undertaken by the National Board.
- The chiropractic, dental, medical, nursing and midwifery, osteopathy, pharmacy, physiotherapy and podiatry professions undertake assessments of overseas competent authorities as well as assessment of overseas trained practitioners. There are differing approaches to progressing and applying overseas competent authority pathways between professions.
- Where assessment decisions impose additional requirements (such as supervised practice or examinations), the reasons for these decisions are unclear.
- Appeals and their processes are clear in some circumstances and not in others. Applications for skilled migration assessment are required to include a process for an independent review of the decision whilst registration appeals can only be referred to the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) or be lodged with respective state/territory administrative tribunals.

The Review sought views from stakeholders on whether there should be consistency across the professions in assessment pathways, approaches and subsequent granting of registration status for overseas trained practitioners. The National Boards/AHPRA joint response indicated a willingness to develop common protocols:

“The National Law provides multiple pathways to assess overseas qualified practitioners, which provides regulatory flexibility to respond to the risk profile of the profession, volume of overseas qualified applicants seeking registration and other considerations including workforce needs. There are options both in terms of the pathways to qualify for registration and in terms of the types of registration…..If more consistent approaches are desirable, there is scope to develop common protocols about assessment across all bodies undertaking this function.“ (p15)

The HPACF was less receptive to a more consistent approach. In its submission, it highlighted:

“Given the wide diversity of 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…….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.” (p26)

The Royal Australasian College of Surgeons (RACS) in its submission noted:

“Consistent approaches across the National Boards are to be encouraged where they are relevant and workable, however, there are differences in the way that the specialties are practiced, and consequently there may be valid differences in processes for assessment. Processes should be designed to ensure that the best assessment outcome is achieved for the IMG and the healthcare consumers, even if that means there are differences between National Boards.” (p4)
The Australian and New Zealand College of Anaesthetists (ANZCA) provided feedback on areas where consistency could be achieved and areas where some level of differences may remain. ANZCA suggested:

“… there should be consistency in the major steps in this process (application, interview, clinical practice and external assessment) but not in the intricacies within each of these steps. The assessment of competence of each profession should be different. The current guidelines for the assessment and subsequent granting of registration status for overseas-trained medical practitioners provide enough structure to build excellent processes without compromising patient safety or the quality of trained practitioners.” (p11)

The New Zealand Dental Council also highlighted areas where a consistent approach would be desirable.

“Our experience in New Zealand has been that there is significant overlap on a registration policy level on entry level standards, which allows for potential streamlining of registration processes. This could be more easily achieved within the context of a central regulatory authority.…. On a principle level, the Council believes that once threshold entry standards have been met, registrants should be able to practise independently; as they have been considered competent to practise within their specific area of practice. Particularly registrants from competent authority jurisdictions where the entry level standards have been considered in detail, and determined to be equivalent to Australia. Similarly, a candidate that has passed a registration examination should be able to practise independently. Robust examinations should provide the necessary assurance that an applicant that has passed is competent and safe to practice.” (p10)

As discussed in Chapter 5 in relation to work readiness, whilst domestic pharmacy, medical and psychology graduates (of four/five-year degree programs) are also required to undertake a period of supervised practice (commonly referred to as an ‘internship’) prior to general registration, all other professions achieve registration upon the attainment of a recognised qualification from an accredited education provider or program of study.

Setting requirements for supervised practice

National Boards also have the capacity to set additional conditions whereby registered practitioners can be required to work under supervision to further demonstrate their competency. Conditions can be established for Australian trained practitioners (new graduates and registrants who have been subject to complaints/notifications processes) as well as overseas trained practitioners. The efficacy of supervised practice requirements has been explored in Chapter 5.

In the case of overseas practitioners, it is often unclear whether the setting of supervised practice requirements with restricted registration is due to a need to learn and/or demonstrate competence or for general experience in and familiarization with the Australian health system. As with Australian trained practitioners, employers also have responsibility for orienting overseas trained practitioners with the local processes such as codes of conduct and government funding requirements (for example the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme).

ANMAC questioned whether supervised practice for overseas trained practitioners was a valid requirement for general registration and advised:

“ANMAC questions the need for periods of supervised practice for overseas educated nurses and midwives. Robust standards and assessment processes should be the basis on which registration is gained. Supervised practice is generally a post-registration treatment rather than a pre-registration requirement.” (p14)

The HPACF expanded on the reasons for supervised practice as a requirement for general registration:

“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.” (p27)
Curtin University highlighted potential opportunities to the broader health and education sector from a more consistent approach to the assessment of overseas trained practitioners for the purpose of general registration. It noted:

“Greater consistency in assessment pathways affords opportunities for system efficiency and cross-professional collaboration, while simplifying and demystifying this process for health care practitioners. It may also offer opportunities for higher education providers to develop educational programs to facilitate the transition of internationally qualified practitioners into the workforce.” (p8)

The Review acknowledges that the ability to practice under supervision can be useful for overseas trained practitioners as they transition to working in the Australian health system. However, as highlighted in Chapter 5, when setting requirements for supervised practice, National Boards should provide clear guidance on the competencies to be acquired and differentiate these from progressive work experience and ongoing lifelong learning expectation.

Draft Recommendations

27. AHPRA, in partnership with National Registration Boards and the Accreditation Board, should lead discussions with the Department of Education and Training and the Department of Immigration and Border Protection to develop a one-step approach to the assessment of overseas trained practitioners for the purposes of skilled migration and registration.

28. The Accreditation Board should work with Accreditation Committees and specialist medical colleges to develop a more consistent approach towards the assessment of overseas trained practitioners and competent authorities. Opportunities to pool resources for administration requirements should also be pursued.

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

Specialist colleges and postgraduate medical councils

Specialist colleges

Of interest to this Review is the level of guidance and oversight provided by either accreditation authorities and National Boards in the conduct of the accreditation, education and assessment functions of specialist colleges. Whilst the Review largely focuses its comments on specialist medical colleges to illustrate the conduct of these functions, the issues raised also apply to specialist colleges in dentistry and podiatry.

As part of recognition under the National Law similar requirements were established for the accreditation of programs of study and/or education providers for specialist registration as for other registration categories. This resulted in specialist education and training being placed within the remit of accreditation authorities.

Prior to the introduction of the National Law, the Commonwealth Minister for Health and Ageing had the decision-making power to, firstly, recognise a new medical specialty or sub-specialty and, if necessary, approve an amendment to the Health Insurance Regulations, 1975. The first component of this recognition was for organisations who wished to have specialist medical skills and knowledge acknowledged and accepted as the
standard for a particular area of practice. This form of recognition had no legal status, but had a clear impact on approaches to health care delivery. The second component enabled doctors with specific qualifications to attract a relevant Medicare benefit for services rendered.

In July 2010, accreditation of specialist medical education and training programs became mandatory under the National Law for the purposes of specialist registration and provided for the protection of specialist titles. This was an important privilege accorded under the National Law as specialist titles were not previously protected. The professions of medicine, podiatry and dentistry now have specialist registration categories.

The decision to recognise specialist titles for registration purposes now rests with the Ministerial Council which has issued guidance on the recognition of specialties under the National Law. However, Ministerial Council decisions do not impact on eligibility for Commonwealth benefit programs such as the Medicare Benefits Schedule or the Pharmaceutical Benefits Schedule. Eligibility for these programs takes place under separate Commonwealth Government application and assessment processes.

There are 13 specialist categories within dentistry, one specialist category in podiatry and 23 specialist categories (and 63 fields of specialty practice) in medicine. Each respective National Board has established a registration standard which governs specialist registration. The full list of specialist categories is available on the AHPRA website. The range of approved specialist training programs include:

- **Dentistry**: Three-year Doctorate programs delivered by universities across the range of specialties or five-year Fellowship programs delivered by specialist colleges.
- **Podiatry**: Three-year Doctorate program in podiatric surgery from the University of Western Australia or three-year Fellowship of the Australasian College of Podiatric Surgeons.
- **Medicine**: Fellowship programs ranging from three-six years across various specialties delivered by specialist colleges.

Whilst the dental and podiatry specialist registrations can also be obtained through programs of study delivered through universities, the specialist medical program is delivered entirely by specialist medical colleges. The ADC in its submission summarises the key difference in its approach:

“The arrangements for dental specialist accreditation is very different to medical accreditation, and is delivered both through universities and specialist Colleges, usually as a Doctor of Clinical Dentistry (DClInDent) qualification. The ADC accreditation standard is the same across all dental programs encompassing entry to practice programs to specialist programs. This means that the ADC is less concerned with the type of education provider delivering the program and more focussed on the graduate outcomes. This allows an open market for the delivery of specialist education in dentistry and enables innovation in the way a program is delivered.” (p36)

The accreditation processes for approval of specialist programs of study and education providers is different for specialist colleges and universities. Specialist college programs are not required to comply with the Higher Education Threshold Standards as it does not lead to an award within the Australian Qualifications Framework (AQF). The accreditation processes for specialist colleges have a triple functionality. Accreditation effectively:

- Endorses the specialist college as an approved education provider of specialist training for the purposes of specialist registration. This process enables college specialist training programs (for the purposes of Fellowship) to be recognised as approved qualifications for practice in the specialty.
- Empowers specialist college as an accreditation authority with the mandate to establish specialty specific accreditation standards against which training providers are assessed. This provides specialist colleges with the ability to accredit training sites or individual training posts which influences workforce supply as well as the ability of health services (such as public hospitals) to provide specialist services.
- Authorises specialist colleges to undertake assessments of overseas trained specialists. This enables specialist colleges to establish processes to assess overseas trained specialists including the ability to charge fees and set additional education and supervised practice requirements for overseas trained practitioners seeking specialist registration in Australia.
Unlike dentistry and podiatry (which also have specialist training programs delivered by universities), the Medical Board registration standard for specialist registration has established ‘Fellowship’ of a specialist medical college as the only approved qualification for the purposes of specialist registration. In doing so, the National Board has potentially established eligibility for membership of a private organisation as a pre-requisite for specialist registration. The National Board, in recognition of this action, advises:

“....the Board will accept for specialist registration confirmation that an applicant has been assessed by a specialist college and has passed the requirements for the approved qualifications, regardless of whether they have been awarded a fellowship. It is not necessary for medical practitioners with specialist registration to continue to be members or fellows of the specialist college to remain on the Specialists Register. Fellowship in this context does not refer to the qualification (which cannot be revoked), but to the ongoing affiliation with or membership of the specialist college. However, medical practitioners on the Specialists Register are required to continue to comply with the Board’s registration standard for CPD. In the case of medical practitioners on the Specialists Register, this requires that they meet the standards for CPD set by the relevant AMC accredited specialist college.” (p2)

The Review has been unable to identify any similar clarification in dentistry and podiatry where the recognised qualification may also come from a specialist college. In terms of medicine, the Review has been unable to identify what is provided to trainees regarding the advice that Fellowship itself is not a requirement for specialist registration. Given that specialist colleges can hold a monopoly on the provision of a recognised qualification for the purposes of specialist registration, absolute clarity and transparency on this is critical.

The AMC undertakes a periodic review of the specialist medical colleges in the exercise of its accreditation and education functions. Each specialist college is assessed against the AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs which were approved by the Medical Board and came into effect on 1 January 2016. The accreditation process is guided by the AMC Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs. Periodic reviews are supplemented with annual reporting by each specialist college. Whilst information on the outcomes of accreditation reviews undertaken by the AMC is available on its website, the annual reports from respective specialist colleges are not available.

With regard to the role of the specialist college as a ‘sub’-accreditation authority (with the ability to set accreditation standards and assess training sites), the AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs includes guidance on the expectations from specialist colleges with regard to their interaction with the health sector (including training sites) and the expected outcomes of specialist education training. However, whilst the AMC accredits specialist medical colleges against the same standard, each specialist college has established its own discipline specific accreditation standards against which it assesses its training providers.

Following concerns raised by health services in a number of jurisdictions regarding duplication across specialist medical college assessment processes, in 2012 AHMAC commissioned the Accreditation of Hospital Training Posts Project, led by NSW Health. The final phase was undertaken in partnership with the Council of Presidents of Medical Colleges (CPMC) to finalise agreed domains, standards and criteria for accreditation of training sites. The project highlighted the significant levels of duplication in accreditation processes and recommended a number of changes, including consistent accreditation cycles, coordinated site visits, joint training of assessors and agreement on common evidence requirements. The Accreditation of Specialist Medical Training Sites Project - Final Report includes a National Accreditation Framework for Medical Specialty Training: domains and standards to be used by all colleges. Three common domains and corresponding standards were identified and agreement was reached with the CPMC that all colleges would include these domains in accreditation standards. Beyond these agreed domains, specialist colleges still retained the ability to establish additional domains and standards with evidence requirements which were specific to its specialty/sub speciality.

The Review understands that, whilst timelines for implementation of these recommendations were not set, there is an expectation that, as colleges review their respective accreditation standards, they will incorporate the agreed domains and standards to the assessment of training sites. However, five years after the AHMAC
Project was commissioned, there is no requirement for the CPMC or the AMC to report on the number of specialist colleges who have incorporated these domains within their accreditation standards.

Given the significant work to identify and streamline the common elements of specialist college assessment processes to minimise cost, duplication and improve transparency, the Review considers there should be a more proactive approach to ensure specialist college implementation of the agreed domains and standards as part of its accreditation of specialist colleges.

In addition to the lack of consistent and common approaches to specialist accreditation highlighted by the AHMAC Project, this Review notes that there are additional gaps in the level of oversight and accountability of specialist colleges. Standard 2.2.1 of the AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs requires:

“The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice…..” (p6)

The AMC Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs also notes that “Accreditation is awarded to the education provider for the specific medical program, identified by its award title and recognised specialty and field of specialty practice (in Australia).” (p5) A review of accreditation reports undertaken by the Review confirms that periodic assessments for the purposes of accreditation of specialist colleges as education providers only include assessments of some subspecialty programs of study.

Whilst the assessments are designed to capture the functions of the college and related subspecialty societies, faculties or chapters as education providers, they do not consistently include assessment of the roles in accreditation of training posts. Colleges have their own standards for the accreditation of training sites. The RACP Standards for the Accreditation of Training Settings is high level and comprises five standards including supervision and infrastructure requirements. In addition, the RACP has additional sub-accreditation criteria to guide the accreditation of subspecialty training programs which detail the requirements for accreditation of training sites. RACS also has established criteria, as well as further sub-accreditation criteria which are specific to its subspecialties, however, the sub-criteria are not publicly available. The role of the AMC in monitoring the respective sub-accreditation criteria which governs subspecialty accreditation of training sites is also not clear. The AMC accreditation reports focus on the role of the specialist college more broadly and do not include assessment of the efficacy of any sub-accreditation criteria.

There is a complex sub-accreditation process for subspecialties which include the 63 fields of specialty practice referred to within the specialist registration standard. The Review notes that this issue was recognised by the AMC in its assessment of RACS in 2007:

“There are clear differences across the nine surgical training programs. While these may be appropriately related to intrinsic differences in the practice of surgery in the surgical specialties the Team urges the College to work towards common standards when these are sensible and achievable. Differences should be defensible and the reasons for them clearly explained.” (p2)

This is further complicated as, in some cases, the accreditation of training sites is not undertaken by the specialist college but by a professional association. This issue came to the fore recently when the Sunshine Coast University Hospital failed to meet accreditation criteria for orthopaedic surgery. The accreditation of orthopaedic surgery is undertaken by the Australian Orthopaedic Association (AOA) which is the peak professional organisation for orthopaedic surgery in Australia. RACS has assigned this function to the AOA. Similarly, RACS has also assigned the accreditation of general surgery, neurosurgery, otolaryngology head and neck surgery and urology to professional bodies. These assignments again raises the issue of whether they are subject to the same standards of transparency, cost effectiveness and accountability expected of other accreditation authorities undertaking a monopoly function under the National Law.
The AMC assessment report for RACS is silent on whether its assessment processes include investigation of the accreditation processes of the respective professional associations. The Review is concerned that, when sub-accreditation authorities (specialist medical colleges) further assign functions to other professional associations, the level of accountability to the National Scheme and the National Law is further removed. The Review considers that any organisation which undertakes such functions should be subject to the same standards of efficiency, accountability, public scrutiny and cost effectiveness of other entities as raised in earlier Chapters. This applies to all processes including the establishment of accreditation standards, assessment processes, setting fees and charges, grievances and appeals processes and monitoring and reporting requirements. Accreditation processes should also be reviewed and updated periodically to ensure that they remain fit for purpose and aligned with contemporary health practice. All activities related to the accreditation, education and assessment functions should be documented, publicly available and subject to monitoring and assessment.

**Assessment of overseas trained specialists**

Specialist colleges also undertake assessments of overseas trained specialists. Authority is provided by the Medical Board of Australia to specialist medical colleges to conduct assessments of overseas training specialists through an exchange of letters. In those letters, the Board advises that the National Law indemnifies the College from liability for “anything done or omitted to be done in good faith in the exercise of this function under the National Law” (s236) and any liability is borne by AHPRA and not the College (s236(2)).

In that correspondence, the Medical Board also advises that the AMC “will not have a role” in the assessment of overseas trained practitioners. However, the Medical Board goes on to state that the “College will provide advice to the National Board on the results of the assessment by providing that advice to the AMC.” These reporting and accountability mechanisms are confusing and the role of AMC in monitoring or oversighting this function undertaken by specialist colleges is unclear.

The Medical Board of Australia issued Good practice guidelines for the specialist international Medical graduate assessment process (the Guidelines) to support specialist medical colleges in their role of assessing specialist international medical graduates. These Guidelines came into effect on 2 November 2015. The Guidelines (p4) refer to the National Specialist IMG Committee whose Terms of Reference includes reviewing the operation, monitoring and reporting on the assessment of specialist IMGs. Based on the information available on the Medical Board of Australia website, records of meetings of that Committee, however, have not been published since 2013 and it suggests any necessary information is provided through the Board’s monthly updates. The latest published report on overseas practitioner assessments also states:

“On 1 July 2014 changes were made to the specialist pathway for IMGs. IMGs now apply directly to the relevant specialist medical college for assessment rather than through the Australian Medical Council (AMC). The AMC previously collected a range of data on specialist pathway applications. As the AMC no longer collect pathway data, colleges now report their data directly to the Board.” (p1)

The Review has only been granted access to examples of agreements involving the Board, AMC and specialist medical colleges so it is difficult to fully understand how assessment, accreditation and monitoring in relation to overseas practitioners now operates. AHPRA advised the Review:

“The AMC provides the MBA with a comprehensive report on each specialist college that it reviews and accredits. The report assesses colleges against all of the accreditation domains in the accreditation standards. In addition to the comprehensive report (which can be more than 100 pages), the Chair of the Specialist Education Accreditation Committee attends the meeting of the MBA to provide any additional information and to answer questions The AMC monitors specialist colleges via the accreditation function and provides the MBA with regular monitoring reports of each specialist college.”

The monitoring and reporting process seems not only unclear in terms of roles but also in the data produced. Different items are reported on by specialist medical colleges and the Medical Board and over different time periods, making it difficult to draw any conclusions on the assessment pathway to actual registration as a
medical specialist. Other key areas of interest such as the number, patterns and reasons for application withdrawals are not detailed and no information is provided on the outcome of appeals.

In relation to the question of Fellowship being defined as the necessary qualification, an analysis of the specialist medical college data for 2016 shows 493 candidates were recommended for specialist recognition and 491 were awarded Fellowship. Given the Medical Board does not report on the pathway it is not possible to identify if any candidate applied or was approved for specialist registration based on being assessed and passing the requirements for the approved qualifications, regardless of whether Fellowship had been awarded.

The Review has also been unable to find reference to this alternate specialist registration pathway to Fellowship on college websites so it is unclear whether this information or the pathway itself is being explicitly provided to applicants. Whilst it is not possible to draw any conclusions from this, given the importance of separating the meeting of requirements for the approved qualifications for registration purposes and the decision to seek membership of a private organisation, the Review considers that colleges should explicitly ensure that both pathways are available, this is published on their websites and the necessary information is made available to all prospective candidates.

The 2014 NRAS Review recommended that the Medical Board evaluate and report on the performance of specialist medical colleges in the assessment of overseas trained specialist and establish performance benchmarks for completion of these assessments. The Medical Board in its submission highlighted:

“Following the Snowball review, the Board started collecting performance data annually from all the specialist colleges in relation to their assessment of specialist international medical graduates. The data is published on the Board’s website. In 2016, the Board set specific performance benchmarks in relation to the assessment of specialist international medical graduates. The Board will publish the performance of Colleges against the benchmarks.” (p2)

Noting the proposed evaluation of the performance of specialist colleges, in the Discussion Paper this Review advised it would consider decisions, processes and governance relating to the assignment, monitoring and reporting of functions across the variety of accreditation arrangements and assessment of overseas practitioners but would not consider in detail any international assessments or operations and performance.

The Medical Board advised that it has commissioned an external review of specialist medical colleges. The Review has been provided its Terms of Reference (Appendix 7). Whilst that work appears able to make recommendations in relation to performance measures set by the Medical Board and its future monitoring of college performance, a concern is that the task is limited to only consider:

“The extent to which each college’s processes and procedures comply with the guidance in the ‘Good practice guidelines for the specialist international medical graduate assessment process’ (the Good Practice guidelines).” (p1)

The Review considers it would be preferable for the reviewers to be able comment on the adequacy of those Guidelines, given they were developed by the Medical Board as the best practice benchmark and encompass matters such as roles, fees and assessment criteria and procedures.

Concerns about specialist medical colleges and their assessments of overseas trained specialists was highlighted in the NRAS Review and has been subject to frequent media coverage and a number of government inquiries. It would seem time to look beyond immediate performance issues and consider a model that provides governments and the public with the confidence that arrangements are robust and transparent and that systems are able to monitor and respond to issues as they arise and ensure continuous improvement.

Specialist colleges derive a direct benefit from the introduction of protected specialist titles and are protected under the National Law for their accreditation and assessment functions. The Review concludes that the accreditation and assessment activities undertaken by specialist colleges within the National Scheme are similar to that being undertaken by the 14 accreditation authorities (and the education providers), thus all recommendations relating to efficiency, transparency and governance applying to accreditation authorities should also apply to specialist medical, dentistry and podiatry colleges.
Postgraduate medical councils

The medical, pharmacy and podiatry professions have introduced a category for provisional registration which requires all graduates of approved programs of study to undertake a period of supervised practice, commonly known as internship. Medicine (and pharmacy to a lesser extent) has established accreditation processes to guide the implementation of supervised practice programs. This is detailed in Chapter 5.

The medical internship program has been designed in a similar manner to specialist training programs whereby the AMC accredits postgraduate medical councils (PMCs) against National Standards, and they in turn accredit intern training sites, as well as establish and provide oversight of appropriate educational activities and programs for prevocational doctors with hospitals and practices. Upon achieving AMC accreditation, a PMC is granted the authority to accredit intern training programs and posts in its state or territory.

PMCs work is based on the National Intern Training Framework and the Prevocational Medical Accreditation Framework. Successful completion of an internship is a necessary prerequisite for general registration. Accreditation of intern posts is mandatory and undertaken in accordance with the Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training standard. As noted in Chapter 3, the MBA funds the PMCs to undertake this process and they also receive funding from state and territory health departments for activities including broader education and training of all prevocational trainees.

The Medical Board and the AMC have established a national accreditation process which enables the development of a consistent approach to medical intern training nationally is a very positive advancement.

Submissions to the Review on PMCs were very limited and, where provided, were largely supportive of existing processes but several suggested greater clarity.

<table>
<thead>
<tr>
<th>Box 8.2 Stakeholder views on the governance of specialist colleges and PMCs</th>
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<tr>
<td><strong>Australian Medical Council</strong></td>
</tr>
<tr>
<td>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 of 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. (p29)</td>
</tr>
<tr>
<td><strong>Australian and New Zealand College of Anaesthetists</strong></td>
</tr>
<tr>
<td>ANZCA suggests there should be clear delineation of responsibility between the National Boards, specialist colleges and postgraduate medical councils and the relationships between these entities should be more collaborative. There are three principal layers in the Australian and New Zealand medical education systems:</td>
</tr>
<tr>
<td>• Undergraduate training towards a primary medical degree (overseen by the universities).</td>
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<tr>
<td>• Pre-vocational medical education (overseen by the pre-vocational medical councils and AHPRA and the MBA).</td>
</tr>
<tr>
<td>• Vocational (specialist) medical training (overseen by the postgraduate medical colleges).</td>
</tr>
<tr>
<td>The AMC has effectively implemented accreditation functions at each of these levels, appropriately tailored to the nature and context of medical training at each level. The AMC governance and committee structure draws representation from each level, and bodies such as Medical Deans Australia and New Zealand, the Council of Presidents of Medical Colleges, and the Confederation of Postgraduate Medical Education Councils provide input on behalf of their members. The AMC and the Medical Board of Australia are well-placed to oversee integration and coordination between these phases of medical training as competency-based medical education evolves and there is increasing recognition of the importance of transitions between these phases. (p11)</td>
</tr>
</tbody>
</table>
Draft Recommendations

30. Specialist colleges, in relation to the assessment of overseas trained practitioners, should have their decisions subject to the same requirements as all other decisions made by the entities specified under the *Health Practitioner Regulation National Law Regulation 2010*. These encompass privacy, FOI and the role of the National Health Practitioner Ombudsman and Privacy Commissioner.

31. The Australian Medical Council should undertake all monitoring and reporting on specialist medical colleges in relation to the assessment of overseas trained practitioners. This includes working in partnership with the Medical Board of Australia on the development of agree performance indicators and reporting metrics that are appropriate, comparable and aligned with other relevant National Scheme reporting regimes, in terms of time periods and the ability to trace assessment pathways from application to registration.

32. Specialist colleges should ensure that the two pathways to specialist registration, namely:
   - being assessed by a specialist college and passing the requirements for the approved qualification; or
   - being awarded a fellowship of a specialist college;
are documented, available and published on specialist college websites and the necessary information is made available to all prospective candidates.

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

The 2014 NRAS Review observed that accreditation councils have varying structures and fee-setting methods and that there was little recourse in the National Scheme for appeal of their decision-making processes. Recommendation 17 of the 2014 Review stated:

“Amend the Health Practitioner Regulation National Law 2009 to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions.”

Subsequent to the 2014 Review, AHPRA and the HPACF released Management of complaints relating to accreditation functions under the National Law – a guidance document in May 2015. This establishes the scope of appeal responsibilities of accreditation authorities as follows:

"Where a complaint is received by an Accreditation Authority, the Accreditation Authority will consider whether the complaint:

- directly relates to an accreditation function under the National Law
- is an issue that should be considered in the accreditation entity’s monitoring processes under Section 50 of the National Law.
- relates to compliance with the Quality Framework.

If the complaint relates to one or more of the above issues, the Accreditation Authority will consider the complaint and respond to the complainant.”

Submissions in relation to the Guidance Document itself were limited, and focussed on the current accreditation councils’ grievance/appeals processes. Generally, stakeholders held the view that systems would benefit from some form of independent review process and the NHPOPC or a body with similar characteristics was considered the most appropriate entity to undertake this function, although some submissions suggested that there should be a capacity for a decision to be overruled and a new one made by an appeals entity.

<table>
<thead>
<tr>
<th>Box 8.3 Stakeholders views on grievances and appeals</th>
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<tr>
<td><strong>Occupational Therapy Council (Australia and New Zealand)</strong></td>
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<tr>
<td>The OTC believes the current system works well. However, if a change in that system were to occur, the OTC believes the external appeal facility should be with a body akin to the National Health Practitioner Ombudsman or be a separate system. However, the cost of such an external body should be carefully considered before implemented. (p20)</td>
</tr>
<tr>
<td><strong>Australian Dental Council</strong></td>
</tr>
<tr>
<td>The ADC does not have an opinion whether an existing entity is appropriate for this role; however, any entity must have the appropriate skills and knowledge of the scope of the complaints it is empowered to deliberate on. This may also include fees and charges if the entity is equipped to adjudicate on such matters. (p38)</td>
</tr>
<tr>
<td><strong>Health Professions Accreditation Collaborative Forum</strong></td>
</tr>
<tr>
<td>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). (p28)</td>
</tr>
<tr>
<td><strong>Australasian Osteopathic Accreditation Council</strong></td>
</tr>
<tr>
<td>AOAC supports the need for robust review of the decisions made by accreditation authorities and utilises an approach to appeals from education providers regarding decisions which emphasises the independence of the appeal process. AOAC has not received any appeals regarding its accreditation process to date. This may be because of the open channels of communication between education providers and AOAC.</td>
</tr>
</tbody>
</table>
Box 8.3 Stakeholders views on grievances and appeals

*If an external entity is considered necessary AOAC supports the National Health Practitioner Ombudsman as an appropriate channel for grievances and appeals. AOAC further supports the scope of complaints to encompass all accreditation functions including fees and charges. (p19)*

**Australian Medical Council**

*In general the AMC agrees that a channel outside the accreditation authorities for unresolved complaints and grievances is a reasonable point, depending on the scope of the complaint.*

*If there is to be a complaints mechanism external to the accreditation entities then it either has to be something like the National Health Practitioner Ombudsman, (NHPO) which is not really independent of the main NRAS players or a separate system which is another cost. The Forum collectively might provide this channel at reasonable cost. (p31)*

**CQUniversity**

*Mechanisms for lodging complaints with NRAS accreditation authorities are currently inadequate. Mechanisms vary across accreditation authorities and an appeal of an accreditation decision to the accreditation authority generally constitutes the only avenue for appeal. ...... There appears to be no mechanisms to appeal the decision of National Boards regarding decisions on the approval of programs since a search on the AHPRA website for National Boards does not provide any options for appeals regarding program approval decision, only information on individual practitioner registration appeals.*

*There is therefore a need for an external appeal mechanism for adverse decisions regarding the accreditation and approval of a program. The NRAS appeal mechanism should operate in a similar manner to appeal mechanisms in place for TEQSA whereby there is an initial internal appeal mechanism. In the event of dissatisfaction with the internal appeal TEQSA providers may appeal to the Administrative Appeals Tribunal (AAT) for reconsideration of the decision. A similar, legally binding external appeal mechanism should be available to education providers under the NRAS scheme where providers believe a decision has been made that is inconsistent with the intent and meaning of the applicable accreditation standard. (p11)*

**Australian Council of Deans of Health Sciences**

*ACDHS members assert there should be a formal appeal process where all matters are dealt with in a transparent manner by an independent arbiter. (p28)*

The NHPOPC considers that there are inadequacies with the current guidelines:

*“While the Guidance Document provides some explanation of the processes applicable to accreditation-relation complaints, it tends to focus on situations where complaints are made to accreditation authorities about accredited programs of study or an education provider. The Guidance Document does not comprehensively address all situations where complaints about accreditation-related matters may arise, particularly in relation to complaints about accreditation authorities themselves (for example, complaints about the process for assessment of overseas trained health practitioners seeking registration in Australia). In this regard, there is a lack of clarity about the management of the full range of accreditation-related complaints.” (p11)*

Another issue raised is the conduct of a review “on the merits”, where a body will look again at a decision and substitute its own decision for the decision originally made. However, the Review considers it would be inappropriate to establish a separate body with the powers to make new decisions, given the need to rely on specialised knowledge and as accreditation authorities all have in place appeals models with that capability. The Review considers it important that all accreditation decisions made under National Law statute should be subject to the same requirements as all other decisions made by the entities specified under the Health Practitioner Regulation National Law Regulation.*
Both the submission from the NHPOPC and in subsequent consultation, that Office indicated its support for expanding its remit in this area with a scope consistent with that expected of an Ombudsman type role that is adopted globally. As per the NHPOPC’s website, this would mean that the Ombudsman would conduct investigations into the administrative actions of accreditation entities and either:

- Determine that the actions were reasonable and take no further action.
- Provide (or recommend that the relevant body provide) a better explanation of the decision or process.
- Expedite delayed action.
- Recommend that an apology be offered.
- Recommend that processes or policies be reviewed or changed.
- Recommend that a decision be re-considered.

This would be consistent with other grievance review arrangements and could be achieved through the Review’s proposal to place the accreditation functions under the Health Practitioner Regulation National Law Regulation meaning the model should apply to any decisions made by:

- Accreditation Committees in relation to programs of study.
- PMCs and specialist colleges in relation to the accreditation of training posts/sites.
- Any designated entity exercising an accreditation function regarding an assessment of the qualifications of an overseas practitioner (including specialist colleges).

If the proposed operational separation of the professional accreditation and institutional academic accreditation components is implemented, this would permit the latter elements to be subject to the TEQSA and ASQA established processes. In relation to fees and charges the Review further considers that a structured system-wide response to how fees are set would be more appropriate.

Given the Review has not had the resources to investigate the appeals processes for every accreditation authority, it would be worthwhile for the NHPOPC to conduct a systematic review of the HPACF’s guidance document and each relevant entity’s appeals processes with the view to making recommendations for improvement by each entity where it is considered those processes are deficient. This would provide comfort to the Ministerial Council and stakeholders more generally that the systems in place are fair and transparent and are commensurate with general expectations of any entity exercising statutory functions.

**Draft Recommendations**

34. Governments should appoint the National Health Practitioner Ombudsman and Privacy Commissioner to review any decisions made under the National Law by the following entities (as specified under the Health Practitioner Regulation National Law Regulation 2010):

- Accreditation Committees in relation to programs of study and education providers of those programs.
- Postgraduate medical councils and specialist colleges in relation to the accreditation of training posts/sites.
- Any designated entity undertaking an assessment of the qualifications of an overseas trained practitioner (including specialist colleges).

35. The National Health Practitioner Ombudsman and Privacy Commissioner should review the grievances and appeals processes of entities as defined in Recommendation 34, with the view to making recommendations for improvement by each entity where it is considered those processes are deficient.
Setting national reform priorities

Government directions

A key issue identified by the Review is the paucity of guidance to the various governance bodies in the National Scheme on health workforce and health system priorities. Whereas this Report’s Terms of Reference focus on the accreditation system within the National Scheme, there is little to be gained in setting out a strategic direction for the accreditation authorities if that direction is not shared by the National Boards, AHPRA and AManC – let alone the education providers, professional associations, employers and consumers.

Several stakeholders involved in accreditation have stated that while it is not their responsibility to set the priorities, they could more effectively respond if there were better arrangements in place to advise them of those priorities. A similar conclusion was reached in the 2014 NRAS Review:

“This Review found that little attention has been directed towards understanding and designing the regulators’ response to health workforce reform in the early stages of the National Scheme. Its importance is being increasingly recognised with the formation of cross-profession forums and the involvement of the Australian Health Ministers’ Advisory Council (AHMAC) as a means of improving mutual understanding about the future agenda in workforce reform. While this recent development is encouraging, the National Scheme needs to have very specific and measurable targets to deliver on the health workforce reform agenda.”

Section 19 of the National Law provides one possible mechanism – the establishment of an Australian Health Workforce Advisory Council (AHWAC):

1) The function of the Advisory Council is to provide independent advice to the Ministerial Council about the following—
   a) any matter relating to the National Registration and Accreditation Scheme that is referred to it by the Ministerial Council;
   b) if asked by the Ministerial Council, any matter relating to the National Registration and Accreditation Scheme on which the Ministerial Council has been unable to reach a decision;
   c) any other matter relating to the National Registration and Accreditation Scheme that it considers appropriate.

Although this body remains on the statute book within the National Law, it is not utilised. The decision on the future of AHWAC was referred to the 2014 NRAS Review for advice. It recommended that a new body be established (to be known as the Professional Standards Advisory Council) to advise the Ministerial Council on key matters of interest in the performance of the National Scheme. The Ministerial Council, in response, accepted that improvements to governance, reporting and reform arrangements are necessary, but determined that this should be achieved through existing structures.

The Ministerial Council is also empowered to provide a range of advice and directions to the National Scheme. Section 11 of the National Law provides:

1) The Ministerial Council may give directions to the National Agency about the policies to be applied by the National Agency in exercising its functions under this Law.

2) The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law.

3) Without limiting subsections (1) and (2), a direction under this section may relate to—
   a) a matter relevant to the policies of the National Agency or a National Board; or
   b) an administrative process of the National Agency or a National Board; or
   c) a procedure of the National Agency or a National Board; or
(d) a particular proposed accreditation standard, or a particular proposed amendment of an accreditation standard, for a health profession.

4) However, the Ministerial Council may give a National Board a direction under subsection (3)(d) only if—
   a) in the Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and
   b) the Council has first given consideration to the potential impact of the Council’s direction on the quality and safety of health care.

5) A direction under this section cannot be about—
   a) a particular person; or
   b) a particular qualification; or
   c) a particular application, notification or proceeding.

6) The National Agency or a National Board must comply with a direction given to it by the Ministerial Council under this section.

The statutory provisions of the National Law provide a general power of direction to the Ministerial Council about the policies to be applied by AHPRA and National Boards in exercising their functions. It is less usual, however, to enable directions to be made on matters such as standards issued by a regulatory body, and for the Ministerial powers to be restricted in the form provided under s11(4).

It is important to understand the particular context where governments sought to create a single health workforce regulatory scheme which resulted in 14 separate independent National Boards being individually responsible for the regulation and accreditation of their respective professions or professional groups. In particular, a number of the functions of the National Scheme had been traditionally run by the professions themselves, with these professions being able to direct, both explicitly and implicitly, crucial areas such as competency standards, scopes of practice and professional boundaries, workforce interdependencies and education and training regimes.

All of these functions can have a significant impact on the delivery of health care, service access, service configuration, payment regimes and the like. Health systems and governments have been faced with responding to disputes between professions over expanding scopes of practice and professional boundary matters in either regulatory schemes or the industrial regime.

Such matters continue to arise. For example, the AMA's submission referred to the National Law Objective (f). In relation to the nursing, pharmacy and optometry professions, the AMA stated:

"Further, the AMA is of the view that health practitioner boards are misusing the objectives in paragraph 3(2)(f) of the National Law ....... Some boards appear to be applying this objective in the broadest sense, acting as champions of their practitioners and not as protectors of the public, by permitting changes to scopes of practice without any robust assessment of: need; the existence of accredited education and training programs that deliver the required competencies; the risks to patients; the impact on training for and care provided by other practitioners; or the costs to the health care system." (p2)

These matters are complex, usually requiring an assessment of claims of threats to safety and quality when professional boundary disputes arise. In the absence of an integrated approach which provides an overarching and fully independent entity that can determine where either commonality or consistency across professions is appropriate and boundary and scopes of practice matters if necessary, Ministerial Council involvement will continue to be the point of resolution. Often the Ministerial Council is required to be involved in matters that are entirely operational and procedural, as advised by NSW Health in relation to the NRAS Governance Review:

“One common area is the role of the Ministerial Council in providing oversight of various regulatory instruments generated under the National Scheme. For the governance review, this includes registration standards, codes and guidelines. The NRAS governance review is considering in what circumstances it is appropriate for these instruments to be approved by the Ministerial Council (as is currently the case for registration standards) or by another delegated body. Views have been put forward that the Ministerial Council..."
Council’s time is being unduly expended on approving instruments (including amendments to instruments) that have no strategic impact in terms of the Scheme’s objectives. Consideration therefore needs to be given to (a) possible delegates in relation to some of these approval powers; (b) bodies responsible for giving advice or guidance to the delegate; and (c) protocols for guiding such delegated approvals.

In relation to accreditation standards, this may be relevant if it is anticipated that entities in addition to Boards have some oversight or approval role in regard to accreditation standards, for example if Ministerial approval of accreditation standards were to be mandated. In that case, it may be that the findings from the governance review could also be applicable to accreditation standards.”  

The Review has sought to address the accreditation issues through the proposed establishment of a Health Education Accreditation Board and a cooperative approach to clarifying regulatory responsibilities with TEQSA and ASQA on specific domains within the accreditation standards. Should this change of governance be endorsed it would be appropriate to remove reference to accreditation standards in the National Law’s Ministerial Council directions provisions.

In relation to the Review’s proposed formal assignment of competency standards to the National Boards, however, the issue of establishing a whole-of-workforce perspective remains. Given the current fragmented governance arrangements, it is considered that the competency standards be treated the same as registration standards, with mandated consultation requirements and Ministerial Council approval. Should, however the NRAS Governance Review recommend a change to those structures it is considered appropriate that competency standards should be included in a consolidated registration regime. The Review also notes the limitation on Ministerial Council intervention in accreditation standards to issues only if they have a substantive and negative impact on the recruitment and supply of health practitioners.

Development of national workforce policy

There is broad support for a process whereby consistent and regular policy guidance can be provided and then acted upon by all entities and processes within, and interdependent with, the National Scheme. Submissions showed an almost universal agreement on the importance of this, whilst acknowledging the complexities.

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<tr>
<th>Box 8.4 Stakeholder views on the need for national policy guidance</th>
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<tr>
<td><strong>Medical Deans Australia and New Zealand</strong></td>
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<tr>
<td>Medical Deans acknowledges the difficulty in identifying the key levers and drivers required for reform in such a complex space that contains a myriad of funders, policy makers, trainers/educators and health care providers. Health Workforce Principal Committee and/or National Medical Training Advisory Network (NMTAN) potentially provide vehicles where important workforce reform issues could be addressed. (p8)</td>
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<tr>
<td><strong>Health Professionals Accreditation Collaborative Forum</strong></td>
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<tr>
<td>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. (p25)</td>
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<tr>
<td><strong>Joint National Boards/AHPRA</strong></td>
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<tr>
<td>We agree that clearer identification of health workforce priorities would help National Scheme bodies deliver on the workforce objectives of the National Law. There is currently no nationally articulated workforce reform agenda, which means that National Boards and Accreditation Authorities endeavour to respond to local agendas. We accept that accreditation is seen as a workforce lever but there is often a lack of clarity about how that lever can be used to facilitate workforce reform in a system that regulates by title rather than practice. More guidance from Ministers would be helpful in this regard.</td>
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</table>
We consider a national workforce reform agenda developed in consultation with key stakeholders would be more effective in delivering a national focus and facilitating appropriate regulatory responses from National Scheme bodies. As an interim step, with appropriate support, NRAS bodies could convene regular discussions with stakeholders about workforce reform priorities, in addition to the usual wide-ranging consultation required in the development of accreditation standards. (p14)

**Department of Health and Human Services Victoria**

DHHS considers there is a need to strengthen the mechanisms through which jurisdictions jointly identify reform priorities concerning the accreditation functions and negotiate and agree performance targets and measures with the agencies of NRAS. The Ministerial Statement of Expectations process that has been implemented in Victoria is a key tool for negotiating priorities for reform and setting performance measures with statutory regulators. Ideally such a process should be occurring on a three-yearly cycle, with annual review. (p11)

**Department of Health Australian Government**

A single Forum to facilitate dialogue and decision making between employers and educators, is necessary, and could be a key focus of AMaCom. AMaCom could work in partnership with jurisdictions, private health sector, and professional bodies, with the aim of providing a more coordinated, flexible and streamlined system for collaboration and joint effort around the capabilities required for the health professionals of the future. (p5)

**Monash Health**

A strong governance model with appropriate representation from all professional groups and service settings would assist in meeting this objective. Monash Health acknowledges the number and complexity of external stakeholders, however if we require the workforce to work in an inter-professional / interdisciplinary manner than the approach at a national level also needs to reflect this. Again the consumer voice in this is critical. (p6)

**Australian Private Hospitals Association and Catholic Health Australia**

The Australian Government has acknowledged the importance of a strong private sector in the provision of health services. It is therefore essential the private sector also has a voice in the broader workforce reform agenda and the delivery of health workforce accreditation.

Current frameworks (e.g. AHMAC and HWPC) are predominantly focused on jurisdictional processes and priorities with limited to no engagement with the private sector, despite the work already being completed there and the additional capacity the sector has to offer. (p8)

**Australian Catholic University**

ACU believes there is a need for a more holistic approach to the future health workforce. The current, highly uncoordinated approach to the training of Australia’s health workforce creates unnecessary costs for universities as well as a broad risk for the community by failing to ensure Australia’s future health workforce needs are met.

The Organisation for Economic Co-operation and Development (OECD) has observed that Australia is experiencing a substantial expansion of its medical workforce that will improve access to health care but is placing stress on current training capacity.

A lack of national vision and coordination is opening up cracks in the quality of the training provided. The escalating costs of clinical placements that are one result of this misalignment impacts universities directly and, ultimately, the health workforce as a whole. (p15)

A strong view advanced by some stakeholders was that AHMAC structures currently have the responsibility and capacity to develop and refine workforce policy and reform priorities and are also uniquely placed to bring
together jurisdictions, regulators and stakeholders in a broad ongoing consultative process which discusses those national reform directions. Under AHMAC governance arrangements, the Health Workforce Principal Committee has operated as a forum for all jurisdictions to reach agreement on key national health workforce issues requiring government collaborative action and provided advice on health workforce issues to Health Ministers, though there were criticisms that it had a procedural rather than policy focus.

In this context, the Productivity Commission’s 2005 Report noted that there were many innovations in health care regulation and delivery, but these were often fragmented, poorly evaluated and were often contested by other stakeholders. The Commission proposed the establishment of a body which would evaluate, publicly report on, recommend and, where appropriate, facilitate health workforce innovation and reform on a national, systematic and timetabled basis. The intent was to create an independent evidence-base that policy makers could draw on, as could all other stakeholders. COAG’s response was to establish Health Workforce Australia (HWA) in 2010. It was provided with a number of statutory responsibilities including:

- Carrying out research and collecting, analysing and publishing data or other information for the purpose of informing the evaluation and development of policies in relation to the health workforce.
- Developing and evaluating strategies for development of the health workforce.

HWA was never intended to be a policy formulation body, but nor did it prove to be an independent source of evidence – it required approval for its publications. Notwithstanding this, a number of its activities demonstrated the value of a national focus on innovation and workforce reform. During the course of the Review, a number of stakeholders spoke favourably of the contribution made by HWA.

However, as part of the ‘Smaller Government Reform Agenda’, the Australian Government abolished HWA in 2014 and transferred its programs and functions to the Commonwealth Department of Health. A view advanced by some stakeholders is that AHMAC arrangements, whilst progressively enhancing engagement in this area, have yet to effectively replace the independent evidence-generating capability provided by HWA.

The Review is aware that AHMAC is considering a reconfiguring of its Principal Committee structures. In this context, the Review observes that such arrangements should:

- Be integrated into overall national reform processes and directions, given that workforce responsiveness is a critical enabler in progressing health reforms. Reforms encompass multiple domains and within each of these there are various levers for policy action that can be used at different levels of the health system. A broad system approach stresses the interconnectedness of strategies in these domains and may prevent problems that are more likely to arise with a reductionist focus on a single factor.
- Effectively engage all stakeholders in a consultation, including regulators, professional groups, public and private service providers and other health workforce employers, education providers and consumers.
- Be approached in a robust and formalised manner in a regular cycle of policy review to ensure currency and continuous improvement.
- Draw on evidence from independent, objective and public evaluations of programs and practices.

The dissemination of the ensuing reform priorities set by governments collectively to regulators and stakeholders similarly should be formalised. As advised in its submission to the Review, Victoria has instituted a statement of expectations framework for statutory regulators. The Australian Government has already in place a similar model for major portfolio agencies.

Whilst the format and configurations vary and noting that those statements are largely formulated from a Treasury point of view, the model could be amended to provide a vehicle whereby the Ministerial Council issues periodic statements to National Scheme entities (which would be public and therefore available to all stakeholders). Such a process, while respecting the regulators exercise of their responsibilities under the National Law, could:

- Ensure a balanced focus on all National Law objectives.
- Articulate key health workforce reform directions.
• Provide greater clarity about policies and objectives relevant to National Scheme entities, including the policies and priorities expected to be observed in conducting their operations.

• Articulate expectations about the role and responsibilities of National Scheme entities, their relationships with Governments, issues of transparency and accountability and operational matters.

• Establish clear expectations of regulator performance and improvement.

• Provide a platform for dialogue between jurisdictions and National Scheme entities which could include agreed deliverables and outcomes and the capability to effectively monitor progress.

**Accountability and performance monitoring**

Irrespective of how the future governance of the accreditation system is constructed, regulators need to be accountable, including about what they are expected to achieve and be linked to broader policy objectives. Consistent and comparable reporting on, and measurement of, quantitative and qualitative performance metrics need to be included. Public reporting improves public confidence in the system by demonstrating how well regulatory objectives are being met, allows the regulator to be assessed and provides an incentive to improve performance.

Whilst a review of AHPRA annual reports reveals comprehensive quantitative reporting on key registration, notification and practitioner performance output indicators, reporting on accreditation metrics is less consistent, both within and across the regulated professions. This may be partly due to the nature of the relationship between National Boards and accreditation authorities and differing views on responsibility for compiling and reporting on such metrics. Some of these metrics can be found in accreditation councils’ annual reports, however, the Review considers it important that key metrics form part of core National Scheme indicators to enable the assessment of activity both within and across professions. The Health Care Consumers’ Association submitted:

“However, until many of the aspects of good performance sought by accreditation are built into normal business, organisations see the process of accreditation as an unnecessary embuggerance—something else they need to ramp up and perform for. Such specialised “performances” are the antithesis of what is really needed and produce expensive shows of accreditation performance rather than health care or education and training performance. The data needed to provide evidence for accreditation should be automatically produced from everyday performance systems with the standards actually forming part of how they do business, rather than how they do accreditation.” (p6)

The Council of Ambulance Authorities provide some very useful proposals on potential performance indicators:

“Consider structural outcome and process indicators which can direct attention to (and health goals can be focused on) the patient. Provide clear pathways for Action.

One approach would be to look at optimal risk-adjustment models which result from a multidisciplinary effort that involves the interaction of clinicians with statisticians, as well as with experts in education, information systems and data production.

Given the complexity of health systems, accreditation could consider composite indicators which combine separate performance indicators into a single index or measure and are often used to rank or compare the performance of different practitioners, organisations or systems, by providing a ‘bigger picture’ and offering a more rounded view of performance.

Composite indicators can offer policy-makers at all levels the freedom to concentrate on areas where improvements are most readily secured, in contrast to piecemeal performance indicators.” (p9)

Whilst the Statement of Expectations model could provide the foundation for setting agreed outcome and output targets, key performance measures should also be incorporated into planning systems and investigated and acted upon when required. Both internal and external performance evaluation is critical as part of good governance practices.
The proposed overarching Accreditation Board could develop robust quantitative and qualitative metrics and require them to be applied consistently across the accreditation functions by the individual accreditation authorities. Such metrics should provide additional focus on the reform objectives of governments. Importantly, The HPACF acknowledged the need for, and a willingness to participate in, the development of indicators that go beyond simple input and output reporting:

“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.” (p24)

The Review considers that a range of datasets could be accessed, both at a health service level and from within AHPRA itself. AHPRA acknowledges the importance of the data it holds and has developed a public access research policy to support this. There are also substantial opportunities to explore the linking of relevant datasets (with appropriate privacy protections in place) to better understand the outcomes of education and training programs (and broader domains within the National Scheme), both in terms of success as well as providing indicators of gaps. The Review considers there would be substantial value in this data being more proactively used by entities within the National Scheme for such purposes, in addition to providing a research resource for external parties.

**Draft Recommendations**

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

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

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

Appendix 1: Recommendations related to accreditation functions from the 2014 NRAS Review

Recommendation 1
The Australian Health Workforce Ministerial Council (the Ministerial Council) to establish the Professional Standards Advisory Council (PSAC) for a period of three years to:

a) facilitate the implementation of accepted recommendations of the Review
b) establish key performance standards, including financial standards to be reported to the Ministerial Council and individual Health Ministers by National Boards, the Agency Committee, Accrediting Authorities and the Australian Health Practitioner Regulation Agency (AHPRA) in delivering the objectives of the Health Practitioner Regulation National Law 2009 (the National Law)
c) inform National Boards, AHPRA and Accreditation Authorities on key health workforce reform priorities and health service access gaps, as identified by Australian Health Minister Advisory Council (AHMAC) standing committee structure and processes, and requiring action by the regulators
d) examine evidence on contested cross-profession issues that arise from time to time within or between professions.
e) undertake reviews or audits at the direction of Ministerial Council where safety issues or concerns are raised.

Recommendation 14
Through the contractual arrangements between the Australian Health Practitioner Regulation Agency and the Accreditation Authorities, no fee increases levied on either National Boards or higher education institutions beyond the Consumer Price Index rate will be allowed without the express approval of the relevant National Board.

Recommendation 15
Through contractual arrangements between the Australian Health Practitioner Regulation Agency and Accreditation Authorities, standardised accreditation protocols and fee structures must be established within 12 months so that common accreditation processes can be adopted between all regulated health professions. These should be focused on education outcomes relevant to the outcomes of the National Registration and Accreditation Scheme not prescriptive education inputs.

Recommendation 16
The standardised accreditation protocols should be the subject of consultation with higher education policy makers and providers to streamline accreditation processes and avoid duplication with existing university accreditation processes. This consultation should be sponsored by the Australian Health Practitioner Regulation Agency.
Recommendation 17
Amend the Health Practitioner Regulation National Law 2009 to provide that the National Health Practitioner Ombudsman has jurisdiction over accreditation functions within the National Registration and Accreditation Scheme.

Recommendation 18
A standing committee is needed within the National Registration and Accreditation Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:

a. discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals
b. consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)
c. share an understanding of workforce distribution and projected workforce need.
d. ensure that education opportunities exist for students to meet the minimum standard of entry

Recommendation 19
The fee structures for the accreditation functions associated with standard setting and assessment of overseas-trained health professionals and the accreditation of university programs of study should be clear and transparent as to which functions are funded by the National Boards from registrant fees and which are being met by the higher education sector. 8 Independent Review of the National Registration and Accreditation Scheme for health professions

Recommendation 20
The UK approach to accreditation should be explored to examine whether the significant cost difference between the UK and Australia results in better education outcomes in Australia. If this is not the case, then the UK approach to accreditation should be considered for application.

Recommendation 24
The performance of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, in the implementation of changes to the International Medical Graduate assessment process arising out of the Lost in the Labyrinth report, form part of the key performance standards to report to the Australian Health Workforce Ministerial Council.

Recommendation 25
The Medical Board of Australia to evaluate and report on the performance of specialist colleges in applying standard assessments of International Medical Graduate applications and apply benchmarks for timeframes for completion of assessments.
Appendix 2: Terms of Reference

The Review of Accreditation Systems will provide advice to AHMAC on the governance, structure, cost, and reporting arrangements to improve the efficiency, transparency and cost effectiveness of the health professions accreditation system, to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Review is to address:

• cost effectiveness of the regime for delivering the accreditation functions
• governance structures including reporting arrangements
• opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes e.g. Tertiary Education Quality Standards Agency (TEQSA) and Australian Skills Quality Authority (ASQA)
• the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
• opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

The advice to AHMAC and Health Ministers will include a report outlining options for reform of accreditation systems and structures. The final report will also include advice on any necessary legislative changes, and policy or administrative actions required to give effect to the preferred option/s and recommendations.
Appendix 3: Health profession accreditation authorities

Aboriginal and Torres Strait Islander Health Practice Accreditation Committee
Australasian Osteopathic Accreditation Council
Australian and New Zealand Podiatry Accreditation Council
Australian Dental Council
Australian Medical Council
Australian Nursing and Midwifery Accreditation Council
Australian Pharmacy Council
Australian Physiotherapy Council
Australian Psychology Accreditation Council
Chinese Medicine Accreditation Committee
Council on Chiropractic Education Australasia
Medical Radiation Practice Accreditation Committee
Occupational Therapy Council (Australia and New Zealand)
Optometry Council of Australia and New Zealand
Appendix 4: *Australia’s Health Workforce – Accreditation recommendations*

**Accreditation (Chapter 6)**

The Australian Health Ministers’ Conference should establish a single national accreditation board for health professional education and training.

The board would assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.

VET should be included as soon as feasible, although there are grounds for excluding it until the new arrangement is implemented and operating successfully in other areas.

Collectively, board membership should provide for the necessary health and education knowledge and experience, while being structured to reflect the public interest generally rather than represent the interests of particular stakeholders.

Initially, at least, the board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities should be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime.

The new national accreditation board should assume statutory responsibility for the range of accreditation functions in relation to overseas trained health professionals currently carried out by existing profession based entities.
### Appendix 5: Mapping of accreditation standards

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**Legenda:**
- **Governance**: Management and leadership structures and processes.
- **Program attributes**: Program characteristics, attributes, and outcomes.
- **Learning resources**: Resources for learning and teaching.
- **Clinical experience**: Clinical training and practice.

**Additional resources:**
- **Monitoring and teaching**: Techniques for monitoring and evaluating learning.
- **Assessment**: Evaluation and assessment processes.
- **Qualification**: Qualification requirements and outcomes.
- **Records**: Documentation and records management.
- **Governance and quality improvement**: Governance structures and processes for improving quality.
- **Academic governance**: Academic governance structures and processes.
- **Learning and teaching**: Learning and teaching strategies.
- **Curriculum development**: Curriculum development and improvement processes.
- **Standards**: Accreditation standards and guidelines.
- **Program**: Program attributes and outcomes.
- **Infrastructure**: Infrastructure needs and requirements.
- **Management and quality assurance**: Management and quality assurance structures and processes.
- **Program of study**: Program of study attributes and outcomes.
- **Professional capabilities**: Professional capabilities and qualities.
- **Registration and accreditation**: Registration and accreditation processes.
- **Student assessment**: Assessment of student outcomes and capabilities.
- **Program attributes**: Program attributes and outcomes.
- **Monitoring and teaching**: Monitoring and teaching techniques.
- **Clinical experience**: Clinical experience and training.
- **Infrastructure**: Infrastructure needs and requirements.
- **Management and quality assurance**: Management and quality assurance structures and processes.
- **Student assessment**: Student assessment and evaluation.
- **Program of study**: Program of study attributes and outcomes.
- **Clinical experience**: Clinical experience and training.
- **Infrastructure**: Infrastructure needs and requirements.
- **Management and quality assurance**: Management and quality assurance structures and processes.
- **Student assessment**: Student assessment and evaluation.
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<td>Program design and curriculum development</td>
<td>Learning resources (including staffing)</td>
<td>Clinical experience</td>
<td>In addition to common themes (if relevant)</td>
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</table>
| **Published: July 2016**                |                      | • Scholarship and research in the curriculum  
• Learning outcomes and curriculum content |                    |                  | • Clinical content |                                        |                   |                                                             |
| **Accreditation standards for pharmacy programs in Australia and New Zealand** |                      | • Governance  
• Strategic and operational planning  
• Leadership and autonomy  
• Financial resources |                    |                  | • Admissions policy  
• Student selection  
• Student support  
• Student representation |                    |                  |                                                             |
| **Date of effect: January 2014**        |                      |                                        |                   |                 | • Curriculum development  
• Educational outcomes |                                        |                   |                                                             |
| **Published: December 2016**            |                      | • Public safety  
• Academic governance and quality assurance  
• Program of study |                    |                  | • Public safety  
• The student experience  
• Assessment |                    |                  | • External relationships  
• Human resources  
• Curriculum development  
• Curriculum management  
• Experiential placements  
• Educational outcomes  
• Student representation  
• Quality management |                    |                  | • Infrastructure  
• Human resources  
• External relationships  
• Experiential placements  
• Educational outcomes |
| **Accreditation standard for physiotherapy practitioner programs** |                      | • Governance  
• Academic governance and quality assurance  
• Program of Study |                    |                  | • Assessment |                                        |                   |                                                             |
| **Published: December 2016**            |                      |                                        |                   |                 | • Public safety  
• Academic governance and quality assurance  
• Program of study  
• The student experience  
• Assessment |                    |                  | • Student representation  
• Learning outcomes  
• Staff  
• Facilities  
• Patient care services |                    |                  |                                                             |
| **Accreditation standards for podiatry programs for Australia and New Zealand** |                      | • Governance and program administration  
• Policies and procedures  
• Financial sustainability |                    |                  | • Assessment of learning outcomes |                                        |                   |                                                             |
| **Published: May 2015**                 |                      | • Governance and program administration  
• Strategic directions and autonomy  
• Academic Leadership  
• Student representation  
• Curriculum philosophy and framework  
• Learning outcomes and curriculum content  
• Learning and teaching  
• Research in the curriculum  
• Quality monitoring mechanisms |                    |                  | • Strategic directions and autonomy  
• Student representation  
• Learning outcomes and curriculum content  
• Clinical education  
• Learning and teaching  
• Quality monitoring mechanisms |                    |                  | • Clinical education  
• Learning and teaching  
• Assessment of learning outcomes  
• Staff  
• Facilities  
• Patient care services |                    |                  |                                                             |
## Proposed accreditation standards for psychology programs

**Consultation:** June 2016

### Other Standards

<table>
<thead>
<tr>
<th>Health profession accreditation standards</th>
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### Higher Education Standards Framework (Threshold Standards) 2015

- Student participation and attainment
- Governance and accountability
- Representation, information and information management
- Teaching
- Research and research training
- Institutional quality assurance
- Governance and accountability
- Student participation and attainment
- Learning environment
- Representation, information and information management
- Student participation and attainment
- Teaching
- Institutional quality assurance
- Learning environment
- Teaching
- Research and research training
- Institutional quality assurance

### Standards for Registered Training Organisations (RTOs) 2015

- Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses
- Standard 2. The RTO issues, maintains and accepts AQF certification documentation in accordance with these Standards and provides access to learner records.
- Standard 3. The RTO has effective governance and administration arrangements in place.
- Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses
- Standard 1. The RTO issues, maintains and accepts AQF certification documentation in accordance with these Standards and provides access to learner records.
- Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses
- Standard 1. The RTOs training and assessment strategies and practices are responsive to industry and learner needs and meet the requirements of training packages and VET accredited courses
- Standard 2. The operations of the RTO are quality assured.
<table>
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<tr>
<th>Health profession accreditation standards</th>
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<th>Student assessment</th>
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<th>Clinical experience</th>
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<tr>
<td></td>
<td>current learners and clients.</td>
<td>acknowledged and dealt with fairly, efficiently.</td>
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<tr>
<td>Draft National Safety and Quality Health Service Standards (version 2)</td>
<td>Consultation: 2016</td>
<td>Anticipated release: 2017</td>
<td>Note: whilst it is recognised that these standards apply to health service organisations, the content and context is relevant to health professional programs of study.</td>
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<td>• Standard 7. The RTO has effective governance and administration arrangements in place.</td>
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<td>• Standard 8. The RTO cooperates with the VET Regulator and is legally compliant at all times.</td>
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### Appendix 6: Examples of commonality and overlap between accreditation standards

<table>
<thead>
<tr>
<th>Health professional standard (Dental Accreditation Standard template used as an example)</th>
<th>Higher Education Standards Framework (Threshold Standards) 2015</th>
</tr>
</thead>
</table>
| **Domain 2: Academic Governance and Quality Assurance**  
**Standard Statement:** Academic governance and quality assurance processes are effective.  
Criteria 2.1 The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement.  
Criteria 2.2 Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program  
Criteria 2.3 There is relevant external input to the design and management of the program, including from representatives of the dental professions.  
Criteria 2.4 Mechanisms exist for responding within the curriculum to contemporary developments in health professional education | **Standard 5: Institutional Quality Assurance**  
5.3 **Monitoring, Review and Improvement**  
1. All accredited courses of study are subject to periodic (at least every seven years) comprehensive reviews that are overseen by peak academic governance processes and include external referencing or other benchmarking activities.  
2. A comprehensive review includes the design and content of each course of study, the expected learning outcomes, the methods for assessment of those outcomes, the extent of students’ achievement of learning outcomes, and also takes account of emerging developments in the field of education, modes of delivery, the changing needs of students and identified risks to the quality of the course of study.  
3. Comprehensive reviews of courses of study are informed and supported by regular interim monitoring, of the quality of teaching and supervision of research students, student progress and the overall delivery of units within each course of study.  
4. Review and improvement activities include regular external referencing of the success of student cohorts against comparable courses of study, including:  
   a. analyses of progression rates, attrition rates, completion times and rates and, where applicable, comparing different locations of delivery, and  
   b. the assessment methods and grading of students’ achievement of learning outcomes for selected units of study within courses of study.  
5. All students have opportunities to provide feedback on their educational experiences and student feedback informs institutional monitoring, review and improvement activities.  
6. All teachers and supervisors have opportunities to review feedback on their teaching and research supervision and are supported in enhancing these activities.  
7. The results of regular interim monitoring, comprehensive reviews, external referencing and student feedback are used to mitigate future risks to the quality of the education provided and to guide and evaluate improvements, including the use of data on student progress and success to inform admission criteria and approaches to course design, teaching, supervision, learning and academic support. |
| **Domain 3: Program of Study**  
**Standard Statement:** Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies  
Criteria 3.1 A coherent educational philosophy informs the program of study design and delivery.  
Criteria 3.2 Program learning outcomes address all the relevant attributes and competencies. | **Standard 3: Teaching**  
3.2 **Staffing**  
1. The staffing complement for each course of study is sufficient to meet the educational, academic support and administrative needs of student cohorts undertaking the course.  
2. The academic staffing profile for each course of study provides the level and extent of academic oversight and teaching capacity needed to lead students in intellectual inquiry suited to the nature and level of expected learning outcomes. |
### Health professional standard (Dental Accreditation Standard template used as an example)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>3.3</td>
<td>The quality and quantity of clinical education is sufficient to produce a graduate competent to practice across a range of settings.</td>
</tr>
<tr>
<td>3.4</td>
<td>Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes.</td>
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<tr>
<td>3.5</td>
<td>Graduates are competence in research literacy for the level and type of the program.</td>
</tr>
<tr>
<td>3.6</td>
<td>Principles of inter-professional learning and practice are embedded in the curriculum.</td>
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<tr>
<td>3.7</td>
<td>Teaching staff are suitably qualified and experienced to deliver the units that they teach.</td>
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<tr>
<td>3.8</td>
<td>Learning environments support the achievement of the required learning outcomes.</td>
</tr>
<tr>
<td>3.9</td>
<td>Facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes.</td>
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<tr>
<td>3.10</td>
<td>Cultural competence is integrated within the program and clearly articulated as required disciplinary learning outcomes: this includes Aboriginal, Torres Strait Islander and Māori cultures.</td>
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<tr>
<td>3.11</td>
<td>The dental program has the resources to sustain the quality of education that is required to facilitate the achievement of the necessary attributes and competencies.</td>
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</table>

### Domain 4: The student experience

**Standard Statement: Students are provided with equitable and timely access to information and support**

- Criteria 4.1 Course information is clear and accessible.
- Criteria 4.2 Admission and progression requirements and processes are fair and transparent.
- Criteria 4.3 Students have access to effective grievance and appeals processes.
- Criteria 4.4 The provider identifies and provides support to meet the academic learning needs of students.
- Criteria 4.5 Students are informed of and have access to personal support services provided by qualified personnel.
- Criteria 4.6 Students are represented within the deliberative and decision making processes for the program.
- Criteria 4.7 Equity and diversity principles are observed and promoted in the student experience.

### Higher Education Standards Framework (Threshold Standards) 2015

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<th>Section</th>
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<tr>
<td>3.1</td>
<td>Admissions policies, requirements and procedures are documented, are applied fairly and consistently, and are designed to ensure that admitted students have the academic preparation and proficiency in English needed to participate in their intended study, and no known limitations that would be expected to impede their progression and completion.</td>
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<td>3.2</td>
<td>The admissions process ensures that, prior to enrolment and before fees are accepted, students are informed of their rights and obligations, including:</td>
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<td>a. all charges associated with their proposed studies as known at the time and advice on the potential for changes in charges during their studies</td>
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<td>b. policies, arrangements and potential eligibility for credit for prior learning, and</td>
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<td>c. policies on changes to or withdrawal from offers, acceptance and enrolment, tuition protection and refunds of charges.</td>
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<td>3.3</td>
<td>Admission and other contractual arrangements with students, or where legally required, with their parent or guardian, are in writing and include any particular conditions of enrolment and participation for undertaking particular courses of study that may not apply to other courses more generally, such as health requirements for students undertaking clinical work, requirements for security checks, particular language requirements and particular requirements of work placements.</td>
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<tr>
<td>Health professional standard (Dental Accreditation Standard template used as an example)</td>
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<td><strong>Domain 5: Assessment</strong>&lt;br&gt;<strong>Standard Statement:</strong> Assessment is fair, valid and reliable</td>
<td><strong>Standard 1: Student Participation and Attainment</strong>&lt;br&gt;<strong>1.4 Learning Outcomes and Assessment</strong></td>
</tr>
<tr>
<td>Criteria 5.1 There is a clear relationship between learning outcomes and assessment strategies.</td>
<td>1. The expected learning outcomes for each course of study are specified, consistent with the level and field of education of the qualification awarded, and informed by national and international comparators.</td>
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</table>
| Criteria 5.2 Scope of assessment covers all learning outcomes relevant to attributes and competencies. | 2. The specified learning outcomes for each course of study encompass discipline-related and generic outcomes, including:  
  a. specific knowledge and skills and their application that characterise the field(s) of education or disciplines involved  
  b. generic skills and their application in the context of the field(s) of education or disciplines involved  
  c. knowledge and skills required for employment and further study related to the course of study, including those required to be eligible to seek registration to practise where applicable, and  
  d. skills in independent and critical thinking suitable for lifelong learning. |
| Criteria 5.3 Multiple assessment tools, modes and sampling are used including direct observation in the clinical setting. | 3. Methods of assessment are consistent with the learning outcomes being assessed, are capable of confirming that all specified learning outcomes are achieved and that grades awarded reflect the level of student attainment. |
| Criteria 5.4 Program management and coordination, including moderation procedures ensure consistent and appropriate assessment and feedback to students. | 4. On completion of a course of study, students have demonstrated the learning outcomes specified for the course of study, whether assessed at unit level, course level, or in combination. |
| Criteria 5.5 Suitably qualified and experienced staff, including external experts for final year, assess students. | 5. On completion of research training, students have demonstrated specific and generic learning outcomes related to research, including:  
  a. a detailed understanding of the specific topic of their research, within a broad understanding of the field of research  
  b. capacity to scope, design and conduct research projects independently  
  c. technical research skills and competence in the application of research methods, and  
  d. skills in analysis, critical evaluation and reporting of research, and in presentation, publication and dissemination of their research. |
| Criteria 5.6 All learning outcomes are mapped to the required attributes and competencies, and assessed. | 6. Assessment of major assessable research outputs for higher degrees by research, such as theses, dissertations, exegeses, creative works or other major works arising from a candidate’s research incorporates assessment by at least two assessors with international standing in the field of research, who are independent of the conduct of the research, competent to undertake the assessment and do not have a conflict of interest, and:  
  a. for doctoral degrees, are external to the higher education provider, and  
  b. for masters degrees by research, at least one of whom is external to the higher education provider. |
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<td>7. The outputs arising from research training contribute to the development of the field of research, practice or creative field and, in the case of doctoral degrees, demonstrate a significant original contribution.</td>
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Appendix 7: Review of specialist medical colleges’ assessment of IMGs

External review of the performance of the specialist medical colleges performance in relation to the assessment of specialist international medical graduates

Deloitte Access Economics has been commissioned by the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Medical Board of Australia (the Medical Board) to review and report on the performance of the specialist medical colleges (the colleges) in relation to the assessment of specialist international medical graduates (IMGs). This review forms part of the Medical Board’s and AHPRA’s response to Recommendation 25 from the Independent Review of the National Registration and Accreditation Scheme for health professionals.

Scope of the review

The scope of the review is to explore the following lines of enquiry:

1) The extent to which each college’s processes and procedures comply with the guidance in the Good practice guidelines for the specialist international medical graduate assessment process (the Good practice guidelines);

2) The extent to which each college complies with specified compliance measures in the Good practice guidelines;

3) Each college’s performance against the Medical Board’s benchmarks for time measures relating to assessments;

4) Whether each college is applying standard assessment of specialist IMGs; and

5) Each college’s assessment process for Australian and New Zealand medical graduates with overseas specialist qualifications.

The review will also consider:

- Whether the benchmarks and compliance measures set by the Medical Board are reasonable and an effective measure of college performance.

- Recommendations for the Medical Board’s future monitoring of college performance.

- With reference to the advantages and disadvantages of the current model, we will recommend methods for optimising the way in which colleges assess specialist IMGs.

Out of scope

The review is limited to current college assessment of specialist IMGs. The following are out of scope of this review and should not be included:

- historical specialist IMG assessment processes pre 1 July 2014

- IMGs who have been accepted into the full accredited college training program
• training pathways for Australian and New Zealand graduates not seeking recognition of overseas specialist qualifications
• college specialist IMG processes that relate to a Medical Council of New Zealand component of the assessment
• college committees (or equivalent) other than those which have a role in specialist IMG assessments
• college governance structures other than where it relates to specialist IMG assessments
• college regulations, policies and procedures not directly related to specialist IMG assessments
• registration of specialist IMGs by the Board
• broader employment issues (other than issues relating to the requirements for supervised practice, workplace based assessments, etc)
• immigration, visa and Medicare issues.

Fees

Fees for the assessment process are being looked at in the context of whether the college process complies with the Good practice guidelines. The review will consider the fees set by the colleges for the assessment of specialist IMGs in relation to the guidance in the Good practice guidelines, which state that the college can set fees, the fees are expected to be reasonable, they can set fees for specific stages of the assessment process and they must publish their fees. Analysis on the reasonableness of the fees will be based on feedback from the colleges, comparing the fees set across the colleges, and feedback from IMGs. Based on our findings, we may make recommendations in relation to the fees as part of our recommendations about optimising the assessment of specialist IMGs.

We will not be undertaking detailed financial analysis of the revenue generated by the colleges from the fees, the costs incurred by the college for the assessments and the net financial impact of the fees on the colleges operating budget. These aspects are outside the scope of what we were engaged to undertake.

National Specialist IMG Committee

The National Specialist IMG Committee is a committee of the Board. The committee’s terms of reference provide for them to make recommendations to the Board in relation to the assessment of Specialist IMGs. The committee does not have any decision making powers. The review will not comment on the terms of reference or performance of the National Specialist IMG Committee. The review may consider the role of the National Specialist IMG Committee in relation to the Medical Board’s future monitoring of college performance in relation to the assessment of specialist IMGs and possible methods for optimising the way in which colleges assess specialist IMGs.
References

Where documents referenced are freely available on the internet, a hyperlink to that document is provided in the body of the Discussion Paper. Where documents are not available, a detailed reference is provided below.


Commissioned by the Australian Health Ministers’ Advisory Council for the