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*Note that ACM comments are shaded in grey
Quick Summary:

- Across the professions there are commonalities that could provide the basis for commonality in the development of accreditation standards. These would need to incorporate some discipline specific considerations. The downside to a common approach would be the use of language and the power inherent in some words which is of critical importance to midwives and midwifery.

- Using a risk managed approach to accreditation has the potential to reduce the burden of the process on education providers (less paper work) and the accreditation body (they concentrate their work on the education providers & courses that are of most risk to students learning and the protection of the public).

- An organized approach to ensuring that assessment panels are adequately prepared for their task is preferred. This supports a consistent approach to the review of providers and programs and has the potential to reduce complaints from education providers that some panel members seem to pursue issues that do not fall within the standards.

- The ACM advocates for the inclusion of consumers on accreditation teams which is congruent with the midwifery philosophy. However this requires consumers to be well informed about principles of education, standards of practice and accreditation requirements.

- Careful consideration must be undertaken if moving midwifery away from an input standard to ensure minimal practice requirements are maintained to ensure that students graduate with beginning competence in the full range of midwifery practice. There is high risk of program hours and practical experiences being squeezed by the cost of practice placements. A review of how practice placements are managed and accessed would be ideal with review of access to the private system being part of this. Central to this is the requirement for accreditation processes to acknowledge that placements need to be a continuing process (i.e. potentially outside of
There is a continuing thread of inter-professional education in the document and ACM are supportive of it but are concerned that the concept will be difficult to implement and requires time and support from all parties to make it work. For example, inter-professional education can be promoted in practice settings but it has the potential to ad hoc in implementation/uptake due to the variety of models of care and diversity of practice settings.

There is a range of literature exploring the usefulness of simulation-based education and training in the professions. Most useful in teaching responses to emergencies that occur infrequently. At one stage, HWA asked a group of researchers to explore the possibility of a RCT testing the concept of the impact of simulation on the curricula, clinical experiences and competencies of graduates. The group tasked with exploring it argued that it was not possible to conduct the research and so we have little evidence on how much, when or what effect does replacing practice with simulation have on the competence of graduates and their abilities to be 'work ready'. Of note, Simulated learning should be seen as a beginning point related to principles of practice. For example, abdominal examination. Further, the focus needs to be on real world experiences.

A return to national exams is seen as counterproductive especially if flexibility and the ability to respond to innovations is critical for the education of future workforce. In the current system, a variety of academic assessments are typically promoted for the benefit of student diversity in academic abilities.

Accreditation bodies to be independent of registering authorities is supported. Further, This body requires members of an accreditation team who are suitably qualified (academic qualifications) and importantly, capable of maintaining objectivity for this role.
How we manage the issue of assessing overseas-qualified midwives is critical. Currently these applicants may be rated as suitable for a visa but not then gain registration when they apply to the national board. Consistency across the registering authorities in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners is required.

Further how we manage the issue of practitioners who were previously registered who wish to return to the register is critical. Currently these midwifery applicants are not provided any feasible pathways to re-enter practice despite there being a guidance paper created outlining the steps they need to follow. This is due to a lack of suitable providers.

An external grievance process may be beneficial and if implemented the National Health Practitioner Ombudsman would seem to be the appropriate entity.

What areas does ACM support and why?

- Greater involvement of ACM as professional association may be possible as well as some consumer/woman input. Note that the consumer could be an industry representative.
- Streamlining of accreditation processes avoiding overlap with other organisations such as TEQSA - possible reduction in costs, which could benefit students and practitioners related to university & registration fees being considered against costs of accreditation.
- Review of accreditation approval periods to determine a suitable timeframe.
- Preparation of assessment panels to improve consistency in outcomes and standards of assessment.
- Improve processes for assessment of overseas qualified practitioners.
Australian College of Midwives (ACM) Response paper
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Areas that concern ACM

- Refer responses to questions 3, 5, 8, 9, 10, 11, 13, 14, 15, 16, 16, 17, 19, 20, 21, 25, 31, 32
- Use of the term ‘patient’ as opposed to ‘person’ eg ‘patient-centred care’, should be ‘person-centred care’ and for midwifery ‘woman-centred care’
- Focus in paper on professions addressing ill health/sickness, when midwifery is a wellness model
- No mention of woman’s health or choices and how well women fit into the current health care model/framework
- No mention of culture such as Aboriginal and Torres Strait Islander communities. They should not be factored into ‘disadvantaged’
- AS structure is metro centric and has minimal referral to rural and remote requirements – eg for international placements
- Risk of smaller professions being overpowered by larger bodied professions (nursing and medical)
- Clearer definition of consumers required – and for midwifery to include women as well as students
- Midwifery retaining its own professional identity including demonstration of meeting professional practice standards
- Use of simulation based education – possible replacement of clinical practice time

ACM seeks further advice on the following:

- Assurance that individual professions will retain responsibility for specific practice standards
- Resourcing requirements for initiatives will be considered (eg simulation) or involvement of consumers
- In reference to point 18 on page 5 of the Discussion document, what is meant by the statement, “… robust accreditation process to negate the need for further national assessment to gain general registration”. To whom does this apply? Further what is meant by greater independence of accrediting authorities in terms of time and how accreditation processes are conducted?
In reference to community representation, how is this defined? For example, does it include a disciplined based individual external to the tertiary sector? Or does this apply to a ‘lay person’ who is not biased by either disciplined based professional or academic experiences?

In reference to work readiness it needs to be recognised that all graduates, from health courses, commence the professions as a ‘beginning practitioner’. It can be unfair to expect an individual to be completely work ready as a new graduate.

There is a continued need for new graduates to have access to mentors to guide them in this time of professional growth and identity formation in their discipline. There is a great deal of literature available to support this point where new graduates require mentorship from more experienced practitioners. It is therefore unreasonable for any new graduate to be work ready as they are work ready in principle, not in practice experience.
Improving efficiency

- Limited transparency in processes between councils & committees identified as a concern.
- International comparisons very difficult because of significant differences in processes.
- There is currently a massive amount of repetition in the provision of and reference to policies, rules, and other non-program specific evidence currently. There is opportunity for this to be streamlined and accessible resources created to improve efficiency.
  - The university system not only involves external accreditation but also internal accreditation and this internal accreditation system can be onerous when making significant changes to the curriculum, in fact 24 months lead up time is the usual time frame. The overlap between internal and external accreditation needs to be timed and given that education providers experience such a rigorous process with internal accreditation, that is, school teaching and learning committee, faculty teaching and learning committee, university and then Vice Chancellors Advisory Group, perhaps external accreditation could complete a review following the intensive process of internal accreditation. In practice, there is a lengthy process to gain accreditation as an education provider for curriculum prior to the ANMAC process, therefore timing is an issue. The National Law does not set time limitations on accreditation standards, so cyclical approach would be useful.
  - The complexity of accreditation is acknowledged with variations between programs of study within the same profession and duplication of site visits within the same university for similar programs such as nursing and midwifery.
- If planning on implementing changes to assessments then there is a need to understand how annual reporting costs are incorporated into wider accreditation costs. Accreditation thresholds across (and sometimes within disciplines) is seemingly inconsistent.
- Risk v Cyclical. A combination of risk assessment and a cyclical approach may be more appropriate for safeguarding. If moving to Risk then a clear definition needs development. For example, clinical context and personnel change fairly rapidly and a new program is more
'risky' than an established one. Further, when looking at students and assessing risk criteria it is multifactorial such that you must address student experience, length of establishment of program and capacity of program to enable students to achieve profession's practice competencies (which rely on profession's practice standards being 'right') are the key ones.

- In regards to TEQSA it is important to remember that their priority is education outcomes, not professional outcomes. There may be aspects of TEQSA's accreditation processes that can be removed from professional accreditation processes (e.g. campus facility assessment etc.).
  - Suggestion: TEQSA also should coincide their timeline with accreditation of courses or could form the basis for accreditation of providers and programs, providing some consistency and recognition of common elements. This would allow the accreditation authority to focus on the expertise of professional practice, standards, outcomes and minimising risk to the public.

- There needs to be a process whereby education providers are able to respond (are invited by ANMAC) to revise accredited programs to incorporate outcomes of national practice standards reviews and outcomes of national education standards reviews that arise while that/ those program/s are accredited. Cost - and cost-bearing - of this needs would need deciding upon.

Accreditation standards

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

Response: Any reduction in accreditation costs for education providers should benefit students – would need to see evidence of this from fees. There needs to be a more streamlined process. For example, the current process requires a very large amount of documentation that can take a very long time to complete. Further there is repeated information to be supplied.
2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

**Response:** There still appears to be significant overlap with meeting the requirements of TEQSA and professional accreditation with ANMAC.

- For example, in QLD in the university sector, there is a requirement to adhere to the TEQSA for accreditation. Universities are therefore required to meet all of the TEQSA standards using a top down approach by the implementation of policies and procedures.
- ACM is concerned that this may be leading to the development of another layer to report to/meet. There are already internal processes within Universities that are required (also related to TEQSA) as well as one very large commitment to an external accreditation process.

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

**Response:** Current accreditation cycle is 5 years with a requirement for an annual report – consideration could be given to requiring a new accreditation only when something significant such as new professional standards are developed otherwise annual reporting against a set of specific criteria may be sufficient. All higher education providers have built in evaluation systems that capture required elements to demonstrate effective performance of courses. Alternately re-accreditation may not require a new response to all elements if processes have not changed. There should be equity between medicine, nursing and midwifery, which is not currently the case with medicine having the potential for accreditation to be granted for up to 10 years.

Annual reports within this 10 years would be a reasonable approach. If major changes are made to curricula then there needs to be notification and approval obtained from the accrediting authority.

QLD example:
- The internal processes of the tertiary sector include course reviews that are extremely rigorous where course outcomes are to be demonstrated. These are required each **five years** along with the requirement that courses are reviewed by team members annually for performance, including student progress and outcomes. It is also a time for course improvements through units of study.
• The external process currently includes ANMAC through the NMBA, where course accreditation is to be undertaken each five years. In the current format, this is an extremely rigorous process whereby evidence is required such as university processes and outcomes, student feedback on courses and units of study. The ANMAC accreditation process is more than a year-long given the internal course review process, preparation of the application to ANMAC followed up with site visits. The completion of the accreditation application document is extremely long and repetitive but it does ensure a thorough review process. The ANMAC reviewers are disciplined based academics with many having a strong history of both clinical experience as a midwife and as an academic.

• There is a great need for suitably qualified academics who can manage the responsibility of this important role.

• **QUESTION:** if there were to be changes to how reviewers were assigned, how would objectivity and professionalism be managed/continued if no longer relying on the experience of discipline based academics located within Australia who understand the context?

### Key Messages

- Any reduction in accreditation costs should be passed onto students and be apparent (transparency)
- There is a need for equity amongst the professions regarding length of accreditation to be approved
- There is a consistent framework for all nine accreditation standards that have been developed in consultation with the nursing and midwifery professions.
- Having a common framework for all Nursing and Midwifery Accreditation Standards provides a degree of consistency across the professions. However, the continued overlap between TEQSA and ASQA need to be considered and reviewed specifically to address relevance and contemporary content.
- Careful consideration of recruitment and retention of assessors needs to be undertaken to ensure objectivity, professionalism and maintenance of requisite skills to complete assessment requirements
Training and readiness of assessment panels

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

Response: Agree that there could be greater consistency in terms of assessment panels – evidence of significant variation in questions posed by panels, which can be very challenging and unnecessary for education providers. Assessment team members need to demonstrate their scope of teaching and learning activities including understanding of curricula. In other words, understanding of what is meant by unit learning outcomes and the alignment with assessments (academic and practice).

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

Response: Agree in principle with this – would need to clarify who the ‘consumer’ is – students as well as women to be considered for midwifery. Further, the consumer would be required to possess a reasonable understanding of the parameters available in higher education, standards etc. In others words, the consumer needs to be carefully selected to be effective in this role.

Sources of accreditation authority income

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

Response: Not currently clear what the key principles should be, but cost comparison with the UK suggests that Australia needs to find a more cost effective way to function. It would seem more appropriate for education providers to fund a greater proportion of the fee that should be obtained from registrants. Note that funding from the higher education is currently applied and it is very expensive.

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

Response: Yes in principle but could not be a guaranteed source of income.
Key Messages

- There is a need for greater consistency for Assessment panels and process for questions and areas to be addressed.
- Consumer involvement is supported with women and students being considered for midwifery.
- There is a need for fees applied to accreditation functions to be transparent and published on the ANMAC website and that they should be set in keeping with the complexity of the function being undertaken.

Relevance and responsiveness

- This Review raises the question of whether this equates to a ‘work-ready’ graduate, however all professions need to be very careful about what becomes expected of entry level practitioners.
  - Further work ready’ may be better described as ‘work capable’.
- In regards to assessment, Internship of a period of time enables assessment that national examination wouldn’t, but it needs to be supported and funded adequately.
  - Note that Midwifery programs include Continuity of Care Experiences that provide students with an appreciation of consumers’ experiences of health (maternity) care.
  - Further the costs of implementing and maintain a national examination need to be considered before implementing.
- Education providers need an effective mechanism to prevent flailing students from progressing if results do not meet required standards.
- The concept of student exchanges as part of broadening skills, particularly between regional and remote areas, and experience has the potential to produce graduates with an appreciation for other professions and working in multidisciplinary teams.
- There is a need to review simulation based training to contribute to clinical practice hours, especially in the cases of emergency situations. Simulation training is a worthwhile education practice that not only incorporates emergency situations but also students working as a multidisciplinary team.
Need for greater alignment between practice and education standards identified – should accrediting bodies have greater involvement with development of practice standards?

There needs to be an understanding of what is meant in all professions by interdisciplinary and reach a common definition.

Input and outcome based accreditation standards

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

Response: Outcome focussed standards allow for greater flexibility and innovation, which is to be supported however learning outcomes & assessments, especially clinically based, also need to demonstrate a clear association with midwifery practice standards.

Note it is important to consider discipline based differences which currently are not factored in, but will impact assessment method.

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

Response: This is where the decision concerning practice experiences and/or practice hours needs to be included – differences between midwifery & nursing are significant here.

Key Messages

The differences between nursing and midwifery must be factored/considered when determining whether input or outcome based standards are warranted.

Health program development and timeliness of assessment

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

Response: This would be beneficial with the ACM as the professional association taking the lead and involving women as consumers rather than the current process of external tender usually to a university.
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Education accreditation standards

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

Response: Risk of losing specific focus on professional identity however would depend on how the profession-specific requirements were included.

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

Response: Need for greater clarity in determining what changes, minor and major, need to be reported. A more streamline application process for accreditation. The current process is extremely time consuming due to the submission of responses/evidence according to the standards that can be repetitive.

Increased evidence of involvement of professional association and health service providers in changes made by education providers.

Interprofessional education, learning and practice

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

Response: Discussion paper identifies challenges with resourcing and sustainability of IPE – supported for midwifery as long as shared with appropriate disciplines but not sure how to address these challenges. Not sure that making these elements any more 'compulsory' would be achievable.

Clinical experience and student placements

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

Response: Midwifery already uses a range of clinical settings – limited only by models of care available.
Funding for clinical placements needs further negotiation between education providers and health services – consider mutual benefits.

Most public health services do not charge fees but may negotiate funding for clinical facilitations costs. Some private facilities charging unreasonable fees given benefits to workforce recruitment.

The cost of placements is very expensive and is believed to be inequitable across Australia and is a major issue that needs attention.

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

Response: Simulation based learning is effective and could be part of any contemporary curriculum. It is however difficult to designate a percentage for replacement of clinical hours. Funding for resources and technological developments and support needed to progress meaningful simulation.

Key Messages

- Secure funding for clinical placements is required to ensure students gain access to the full breath of experiences/areas of practice as possible.
- Review of fees charged could be considered to enable greater access by students to private health care facilities for clinical hours (education of private institutions as to benefits of students needs to be increased/undertaken).
- Increased funding for resources and technological developments and support needed to progress meaningful simulation.

The delivery of work-ready graduates

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

Response: Graduate programs in midwifery appear beneficial however not essential. A level of supervised practice should be an expectation for any new
practitioner however could argue that anything more than this should not be necessary if initial registration course meeting all standards.

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

Response Concept of novice to expert may address this with beginning practitioner entering profession as a novice. Support for mentoring needs to be progressed with funding for adequate preparation of mentors and recognition of this role being an important part of the working day – staffing levels to reflect this.

Key Messages
- If a graduate year is to be required then funding is required to ensure that all graduates have access to such a program.
- Standards for supervised practice programs would benefit the employers. ACM are well placed to advise or lead this work.

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

Response: National assessment should not be required if the education provider has demonstrated appropriate assessments linked to learning outcomes. Not sure that there is any evidence to support benefits of national examinations as happened for many years in midwifery and nursing in the UK for example.

The role of TEQSA is to ensure compliance by the education provider. What is the evidence to support a national assessment? This leads to many questions such who, what and how this would be managed?

Producing the future health workforce

- The emerging workforce will need to manage interactions with disadvantaged and Indigenous patients in rural and remote settings. To develop consistency
of health providers in remote communities, they have to ‘want to be there’ and need to stay long enough to immerse themselves into community life.

- Need a more comprehensive & integrated approach to health care that is promoted through initial preparation.
- There are currently a number of differences in how professions behave in relation to a range of Board activities, e.g. complaints, poor performance.
- Concerns that the National Boards are potentially overly risk averse – does this limit acceptance of innovation in education programs that are ultimately approved by them...

Independence of accreditation and registration

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

Response: National Boards do not appear to have been set up to ensure appropriate expertise related to accreditation functions. Midwifery poorly represented on NMBA therefore limited understanding of midwifery specific issues without separate Board being identified.

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

Response: Would appear to have this potential – involvement of professional associations important if this model was to be pursued.

Key Message
- All professions need equitable representation on governing boards (eg Midwifery) and all accrediting authorities related to their profession

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?
Response: Community members require more support and preparation in order to contribute most effectively to committees. Need to reduce risk of tokenism amongst health consumer representatives.

The unique needs (funding and support) of the community representatives also need to be recognised and met.

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

Response: The current process is submission of an application to ANMAC with a CV. Perhaps there needs to be a reference from the employer to ensure increased expertise of applicants

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

Key Messages

- Community and consumer representatives should be included but their unique requirements (funding and support/training) must be considered and met to make their contribution meaningful

Role of accreditation authorities

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

What other governance models might be considered?

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

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.
Response: Obvious financial benefit with both options – would be concerned about loss of profession specific requirements being acknowledged.

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

Response: Currently the process is submission of an application to ANMAC with a CV. Perhaps there needs to be a reference from the employer to ensure increased expertise of applicants.

Accountability and performance monitoring

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

Response: Annual reviews including both quantitative and qualitative measures. For example, quantitative data supplied could include number of completions. Qualitative items could include for example, identifying whether or not there have been any major changes. Obviously, a definition of what is meant by a ‘major’ needs to be included.

Setting health workforce reform priorities

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

Response: To identify that each discipline has differing practice requirements.

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

Response: Focus on workforce recruitment is reasonable however not sure what benefit further expansion and consequent delay in process would have.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
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- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?

**Response:** ACM believes that for nursing and midwifery this is the role of the NMBA in its random audits of those for example, registered as a 'midwife' for evidence of continuing education.

- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

**Response:** It can be argued that universities already have this in place with key stakeholders. This could be an overlap on the TEQSA requirements.

### Specific governance matters

#### The roles of specialist colleges and post-graduate medical councils

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

**Response:** Would appear to be an unwieldy and costlier process. Questions need to be asked as to why medicine continues to be so different to other health professions.

#### Assessment of overseas health practitioners

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

**Response:** Current two assessment process for nursing and midwifery has not been effective and has resulted in confusion for migrants who fulfil requirements for skilled migration however subsequently not considered suitable for registration.

33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?
34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

Response: Yes.

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

Response: Yes.

### Key Messages

- Streamlined (standardised) process for internationally qualified migrants should be implemented across all professions.

### Grievances and appeals

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

Response: It is not obvious statement of availability on the ANMAC website

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

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

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