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

MAY 2017
1. INTRODUCTORY COMMENTS

Thank you for giving the College the opportunity to submit to this important and timely review.

About the College

The College has a special vision ‘to advance the health of rural and remote communities through access to skilled rural doctors’. It progresses this through the provision of quality vocational training and professional development and education programs; setting and upholding of evidence-based professional standards; and, through the provision of support and advocacy services and resources for medical students, doctors and doctors-in-training.

ACRRM is one of two AMC accredited medical colleges providing vocational training towards Fellowship in the specialty of general practice. The ACRRM programs are specifically designed to prepare Fellows for the broad and advanced scope and special skills required to provide the highest quality care in rural, remote, Aboriginal and Torres Strait Islander communities.

ACRRM represents almost 5000 rural doctor members across the country. It received initial accreditation in 2007 and full accreditation in 2011. It undertook a third full accreditation process in 2014 and will undertake another full accreditation process in August this year.

Community needs embedded into accreditation process

This review presents an opportunity to reconsider how the national accreditation system might support creation of the quality workforce that Australia needs.

- Approximately one-third of Australians live in rural and remote areas. These people use health services less and receive considerably less per capita of the Government's annual spend on health expenditure yet they have significantly poorer health status than their urban counterparts by all key indicators.

- Australian has a higher than OECD average number of doctors per capita and is projected to have a workforce oversupply over the next seven years. From 2008 to 2012 the 'gap' between the number of urban and non-urban practitioners increased and the divergence increased with remoteness. One in five rural people continue to report longer than acceptable waiting times to see a general practitioner.

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• Over this same timeframe the increase in general practice doctors (who are statistically more likely to become rural doctors) fell well behind that of other specialists and within the consultant specialties there has been a clear trend toward ever-increasing levels of sub-specialisation. An oversupply of urban specialists creates a systemic incentive to increase demand for city-based specialist services and there is a risk that this could be progressed through imposition of prohibitive accreditation requirements upon rurally-based generalist services.

The accreditation framework tends to focus on assessing ‘quality of skills.’ The focus is on the capacity of programs to produce professionals able to provide services for a specified skill set. There is minimal consideration given to these skills’ relationship to community needs and to whether the services, the specified skill set, or the individual professionals are actually needed by communities. The framework should allow assessment of whether the programs are delivered in the model best suited to meeting community needs; and/or, if their skilled services come at the opportunity cost of meeting higher priority needs.

The broader context in which health care is delivered must be recognised. Without recognition of this there is a risk that accreditation processes inadvertently obstruct positive community-oriented solutions, facilitate workforce distortions, and by failing to identify the nexus between ‘access to care’ and safe, quality care for rural and remote communities lead to loss of essential local services.

Recommended general principles to be adopted by the review:

The College endorses the Discussion Paper’s contentions that ideally, our accreditation system should provide the community with a quality and safe healthcare workforce and that this should be achieved in a manner which is valid, practicable and which maximally enables innovative approaches, flexibility and responsiveness to a diverse and dynamic sector. Additionally, we would propose the following key principles:

• ‘Implicit’ to the accreditation framework’s responsibility for provision of a high quality and safe workforce is the need for models of care that enables access to health care professionals for all Australians. This broad responsibility should be reflected in the formal objectives of the framework and an implicit element of all accreditation processes.

• The NRAS framework should provide systemic flexibility and adaptability. Flexibility should not be hampered by the desire for consistency and control. With an increasingly dynamic sector, the agility of the professions and healthcare services to respond quickly and continuously to changes is paramount. We see a clear trade-off between proposed initiatives to enhance process centralization/consistency, and systemic capacity for innovation/adaptation and view the latter objectives as the best way to attain efficiency and efficacy.

• That the policy development functions of the National Registration Accreditation Scheme (NRAS) should remain within the remit of governments, based on the Government’s direct interactions with the profession and community. This is essential to ensure community accountability, community responsiveness and relevancy to the professional context of the framework.

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• That the NRAS will best serve national priorities where medical colleges/ professional organisations are ‘required’ to be responsive to broad community needs and are given maximal scope to adopt fit-for-purpose mechanisms to achieve this. The colleges and organisations should then be rigorously assessed to ensure their integrity of process to these ends.

2. RESPONSE TO DISCUSSION PAPER CONSOLIDATED ISSUES: QUESTIONS

The College offers the following responses to a number of the questions raised in the Discussion Paper list of consolidated issues. Only the questions of special pertinence to the College have been included and answers reflect the medical college perspective.

**Improving Efficiency**

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<th>Accreditation standards</th>
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<td>1. <strong>What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?</strong></td>
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<td>There is value in constructive engagement between these organisations to provide a whole-of-sector agreement on guiding principles and priorities. We see considerable potential cost and would not support any initiatives which would:</td>
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<td>• Limit respective professions’ capacity to take a flexible approach to its own accreditation operations and to nimbly respond to their respective professional requirements over time, and/or</td>
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<td>• Create an additional level of compliance effort and administrative duplication.</td>
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<td>2. <strong>Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?</strong></td>
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<td>The College supports constructive interaction between these authorities which minimizes compliance effort and inflexibility. It is noted that a Memorandum of Understanding is already in place between TEQSA and AMC.</td>
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<td>3. <strong>What are the relative benefits and costs associated with adopting more open-ended and risk managed accreditation cycles?</strong></td>
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<td>The AMC accreditation process in its current form already involves an open-ended and risk managed accreditation cycle approach which incorporates ongoing requirements throughout the accreditation cycle to report on all significant developments as well as on areas subject to conditional accreditation or recommendations for improvement. The College considers this general approach to be appropriate.</td>
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Training and readiness of assessment panels
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

The College would recommend that representation in all accreditation teams includes at least one representative of the profession who is rurally-based, one representative of the profession who provides primary care services, and community representative/s specifically responsible for representing the rural, remote and Aboriginal and Torres Strait Islander perspective. The College would highlight that without an explicit policy to achieve this representation - it is numerically likely that these interests will be either under-represented or unrepresented.

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?

Fees and levies should be set on a cost-recovery basis.

It should be recognised that time and resources dedicated to accreditation processes come at the opportunity cost of service delivery and a general principle should also be adopted that accreditation authorities are required to consider and implement the most time and cost effective mechanisms for assessment.

Our College’s experience since its inception in 1997 has been that it has been required to undertake a full accreditation every 3 years including this year, to provide approximately 100-page annual reports and to undertake any additional reporting requirements as and when required. Past full accreditations have included submission of an approximately 1000 page report and convening approximately 30 meetings involving around 100 members and professional colleagues from across the country. These efforts have had to be financed by our relatively small membership in addition to the approximately $400,000 that have had to be paid to the AMC for their services over this time.

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

All accreditation should be outcomes based. This makes clear the appropriate role of the professional organisation as the expert in their field of practice and the role of the accrediting authority as an arbiter of their organisational and process integrity. Input-based assessment affectively puts decisions regarding the ideal shape of training and professional development further away from the organisations closest to its delivery and necessarily stifles the capacity of those organisations for innovation and to find fit-for-purpose best practice approaches.

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

- Accreditation defined by accordance with community needs: As outlined above accreditation authorities should require education providers to demonstrate that all their undertakings meet community needs and priorities. In this way, accreditation processes could take a less
prescriptive approach to ‘how this is being achieved’ and focus instead on ensuring that it is being achieved. This empowers colleges to find the best possible mechanisms to serve their communities’ needs and to optimize their capacity to respond to rapid change in the sector.

- **Outcomes-based standards need to be applied using outcomes-based assessment**: There is a need for clarity and rigour in the application of outcomes-based standards. While the AMC applies an outcomes-based assessment process, our experience has been that it is often in effect input based, as assessment teams determinations commonly assign conditions of accreditation which mandate a process or process change that must be implemented.

### 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?**

The College would see value in such an approach only on the understanding that this provided a joint-representative forum to agree on broad guiding principles:

- that was led by government and the professional organisations/medical colleges and included strong community representation
- that did not create an additional layer of bureaucracy and administrative duplication
- that did not create an additional layer of systemic inflexibility and barrier to responsive accreditation frameworks within each profession

Should this be developed it would be essential that all determinations included sufficient representation of the perspective of rural and remote communities. This should include representation from rural and remote communities and their Aboriginal and Torres Strait Islander members, representation from the rurally-based medical and other health professions and representation from Rural Generalist medical practitioners.

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

See Q.10 above.

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?**

Accreditation processes need to minimise the obstruction they may present to professional organisation’s capacity to undertake organisational change responsively to changing needs and circumstances. An important component of this is outputs-based assessment and more generally an approach which rewards innovation and which accredits professional organisations/colleges on their bespoke solutions to meeting their own community-oriented organisational goals.
Clinical experience and student placements

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

It is important that professional organisations/colleges be more explicitly challenged to demonstrate how they have embedded health priorities throughout their educational and professional development efforts as part of their accreditation assessment. Specific standards in major priority areas could be included, such as the Aboriginal and Torres Strait Islander Health standards recently included in the AMC guidelines, and additionally the College should demonstrate its performance against its own community-oriented goals.

Initiatives to address health priorities should be delivered in a manner and to a degree that is best fit to each profession. To prescribe the mechanisms by, and extent to which these should be achieved not only creates an unnecessary level of compliance but also takes decision-making about what is likely to be the most effective approach for each profession out of the hands of that profession. The approach also needs to be flexible across professions to recognise that different professions will have different levels of responsibility and capacity to address different priorities.

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. For example, based on an agreement with the Commonwealth government, the College is currently developing a *Tackling Domestic Violence* education module and undertaking a curriculum revision to ensure its incorporation of all key education issues and latest knowledge in this area.

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

The strongest mechanism by which innovations such as these can be encouraged is to ensure accreditation systems explicitly encourage and reward innovation and prevent an inexorable creep by assessment teams toward input-focused assessment (i.e. by imposing conditions on accreditation which mandate a required course of action).

There is value in an accreditation organisation positively promoting the value of specific approaches but only in so far as these are mechanisms to meet the mission and graduate outcomes of each training organisation.

It should be noted that training organisations are inherently subject to a wide range of push factors which motivate them to engage with emergent technologies and approaches. These include cost and resource constraints, the need to meet their trainee’s expectations for quality, state-of-the-art education, the need to meet trainees need for convenient education delivery, and the competitive pressure of keeping up with other training organisations. Our College for example, by necessity of its commitment to providing training for doctors in rural and remote communities has from inception been a leader in innovation in remote and online education delivery and digital health.

It is important that accreditation frameworks do not act as an inhibitor to innovative approaches. Our College experience of attempting to establish workplace based assessment for doctors in remote locations provides and instructive example. The program used digital technology-assisted assessment to enable doctors to undertake assessment within their communities rather than having
to travel to major centers. This would deliver cost-savings and prevent loss of medical services in those communities (while doctors undertook assessment in cities). Several years were invested in developing and testing the pilot program and it was fully-endorsed by an independent evaluation. It was never adopted however, as the intrinsic conservatism of the accreditation process led to successive additional requirements for compliance which rendered the program financially unviable.

Producing the future health workforce

**Governance of accreditation authorities**

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

Appropriately, all AMC accreditation teams include community representatives and all medical colleges are now assessed against an accreditation standard for community representation within their governance processes.

The process would be further strengthened by including rural, remote and Aboriginal and Torres Strait Islander representatives specifically on these teams. It is important that rural and remote communities and Aboriginal and Torres Strait Islander people living in these communities have input into this process and their voices are not overwhelmed by the perspectives or metropolitan doctors. It should be noted that most consultant specialties have a negligible workforce in rural and remote Australia and typically by virtue of numbers, these doctors represent a majority of voices in medical forums.

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

The accreditation team selection process should exclude members with clear competing interests; additionally, there should also be clearly articulated processes with respect to declaring an interest which should include the requirement for declared interests to be recorded in accreditation reports at all levels of reporting.

Accreditation selection process need to recognise that there are competing agendas across medical colleges and as such there is considerable capacity for team selection in perception or in fact to bring into question the integrity of accreditation decisions. Our College in previous accreditation cycles for example has been assessed by team members from the Australian College of Emergency Medicine who among other things have been required to make judgements regarding the appropriate scope of the ACRRM curriculum which has direct competitive implications for that college.

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

The College would see value in establishment of clear regulatory arrangements to ensure that accreditation activities are not compromised by alternative institutional priorities.
What other governance models might be considered?

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

- expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards
- establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

The College would support establishing a representational reference group to develop broad policy and principles and which delegated adaption of these principles to the needs of the various professions to their respective accreditation bodies.

The College would not support establishment of an additional administrative body which we consider would duplicate administration and reduce systemic capacity to respond to change and be flexible to meet the diversity of circumstances across the sector.

The College would not support expansion of the remit of the AHPRA as a policy body and would view this as an inappropriate function for this organisation. Policy development if it is to best represent and reflect community priorities should occur at the interface between government and the profession (colleges and organisations) and include community representation at all levels. This approach ensures the community accountability of policy and its continuing connectedness to the realities of the field of practice. Assigning responsibility for policy development to AHPRA would disarticulate policy development from this process.

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

As outlined above, the College would recommend establishing a representational reference group to develop joint policy and principles which could be adapted by the relevant accreditation authorities for the purposes of their profession.

Accountability and performance monitoring

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

The NRAS should take a project logic approach and measure its progress against process outcomes as well as specific workforce outcomes which are aligned with national health priorities.

The assessment should include measurement of the NRAS progress (both in terms of process and outcomes) against:

- The Closing the Gap principles and targets
- Addressing the growing workforce maldistribution this should include measures of skilled/credentialled rural and remote workforce provision and retention
- Realigning the number of doctors within various medical specialties with community needs.
Specific governance matters

**The roles of specialist colleges and postgraduate medical councils**

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

The College is confident that its accreditation through the AMC process is sufficiently rigorous.

**Assessment of overseas health professionals**

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?

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?

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

The College sees no justification for a change to the current arrangements which deliver some degree of process simplicity. As outlined at Q.25 above we would support the establishment of interprofessional forum to identify common approaches and principles but would see the establishment of a designated interprofessional agency as either creating systemic rigidities and/or bureaucratic double-up as its work would not preclude the need to adapt overarching guidelines to each individual profession.