Submission in response to the

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

Discussion Paper

1 May 2017
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1 Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Australian Health Minister’s Advisory Council discussion paper on the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.

The AHHA is Australia’s national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

The AHHA submission therefore focuses on issues raised under the following two areas:

- Producing the future health workforce; and
- The relevance and responsiveness of health education in achieving this.
2 Producing the future health workforce

2.1 Setting health workforce reform priorities

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

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

AHHA advocates for health reforms that maintain and improve health outcomes, and support equity, accessibility and sustainability of the broader Australian health system to the benefit of the whole community. There is therefore particular interest in the manner in which the National Registration and Accreditation Scheme achieves the objectives1 of:

- Facilitating access to services provided by health practitioners in accordance with the public interest; and
- Enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in service delivery by health practitioners.

Meeting the current and future health workforce needs of the community is challenging. The former Health Workforce Australia reported2 that a ‘business as usual’ approach to the health workforce is not sustainable, with a need for co-ordinated, long-term reforms by government, professions and the higher education and training sector for a sustainable and affordable health workforce.

The key elements of proposed solutions, as identified in major studies, include:

- refocusing on service delivery to develop a workforce that meets the health care needs of consumers, rather than focusing on practitioners
- a move from acute models of care to a community driven population and primary health care approach
- retention of existing workforce and increased productivity with an emphasis on expanded scopes of practice and generalist roles
- use of technology, role redesign and greater flexibility and inter-professional training
- improved distribution of the health workforce particularly to rural and remote areas and to populations of extreme disadvantage, and
- increased participation rates of Aboriginal and Torres Strait Island people in the health workforce.3

The policy lever identified as having most promise was innovation and reform measures, with potential solutions being changing models of care, adjustments to skills mix, expanded scope of

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1 National Regulation and Accreditation Scheme. At: www.coaghealthcouncil.gov.au/NRAS
practice, use of assistants or increased use of technology. Other levels included immigration, training capacity and efficiency and workforce distribution.  

There is limited research and little international experience to inform a national, coordinated approach to such innovation and reform within the health workforce. Since the early 2000s, various proposals aimed at changing scope of practice of the health workforce have been discussed in Australia, yet there has been limited sustained change. ‘Many of the difficulties in adapting the workforce are created by existing legislation and regulation, the funding models for health professional services, and entrenched professional cultures.’

To address this:

- Scope of practice changes within the health workforce must be included as a standing item on the national, and state and territory health policy agendas, with the goal of developing national policy directions for the health workforce.
- Effective workforce planning must be data driven. Limitations in the systems and processes that currently provide workforce data have been acknowledged. Modelling can be improved with improvements in the quality of existing national data sets; identifying and linking additional datasets; and clarity about the potential for scope of practice changes (e.g. through a central repository of scopes of practice within the Australian health workforce, interdisciplinary agreement on essential work roles in priority settings; prioritisation of health services research directed at evaluating scope of practice changes).
- Stakeholder engagement must be strategic. It should reach beyond existing professional silos, be patient-centred and encourage cross-profession discussion. Engagement with service providers and Primary Health Networks (PHNs), health and hospital services or local hospital districts/networks, Aboriginal Community Controlled Health Organisations (ACCHOs), and Aboriginal Medical Services (AMS) is critical. Their contribution should not be limited to their role as employers of health practitioners, but encompass their responsibility for identifying and responding to local needs.

The linkages with PHNs is important given health workforce has been identified as a priority area for targeted work by them. A number of areas of focus emerge in this context, including their role in:

- Improving access in response to local need
  PHN service planning decisions are underpinned by comprehensive needs assessments of current and future health care needs in their catchments, which will identify service and workforce gaps. PHNs have at their disposal a number of ways to address these needs, including commissioning, with workforce development elements (e.g. clinical placements and supervision) potentially able to be specified in requirements when commissioning.
- Boosting productivity through innovation

In meeting the needs of their communities, they have the opportunity to identify, pilot and commission services with models of care that challenge traditional scopes of practice through extended or new roles.

Similarly with ACCHOs or AMS, who have had a lead role in building local health workforce capacity, e.g. training of Aboriginal staff, local workforce development and mentoring of staff, as well as having progressed innovative models of care for the Aboriginal and Torres Strait Islander population through workforce redesign.

2.2 Governance of accreditation authorities

Issue 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

Issue 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?

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

Issue 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?

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

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

The optimal governance model for carrying out the accreditation functions should be determined by the model that will most effectively and efficiently contribute to the objectives of the National Law. There is no one model that should be considered ideal. Rather, whichever model chosen should:

- Ensure public, not professional, interest, is the primary objective. The independence of accreditation authorities must be upheld, from Government and education providers, but also the profession itself and other professions if innovation and reform are to be progressed. Mechanisms for ensuring the public have adequate opportunity to contribute in a meaningful and relevant way should be pursued; optimal structures, support and training for community members within accreditation authority governance structures that is common across all health professions should be explored.
- Preserve the identity of, and engagement with, professions. While a single accreditation authority may facilitate ‘top-down’ directives and consistency between professions, a greater
effort would need to be invested in retaining professional engagement and input. Genuine engagement by health professionals is critical in sharing the responsibility for mitigating risk of harm to the public, but also to achieving innovation and reform towards common goals.

- Apply a consistent framework across accreditation functions, while recognising that profession-specific aspects exist and need to be accommodated. A consistent framework has many benefits, including facilitating consistent performance monitoring of accreditation authorities and education providers; achieving efficiencies for stakeholders working with accreditation authorities across multiple professions; supporting shared understandings of quality assurance across professions, cross-professional accreditation teams and common accreditation team training; and allowing identified health priorities to be disseminated, discussed and incorporated into accreditation requirements in a coordinated and consistent way.

Roles and responsibilities of different entities within the governance of accreditation functions should be transparent to ensure the role aligns with the mission, objectives, skills and expertise of that entity, and to minimise unnecessary duplication. For example, the Ministerial Council’s interest in accreditation standards is expected to be related to ensuring workforce needs are met and public safety is assured. However, it would be reasonable for them to delegate the review and approval according to specific, relevant and transparent criteria to an independent entity with the required skills and expertise.

2.3 Accountability and performance monitoring

Issue 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?

Outcomes are the ultimate measure of success. However, there is little research to inform the development of performance measures for the outcomes of accreditation functions.

Reforms to improve performance information and reporting should therefore be guided by evidence from other contexts. Reforms should be cautious in the selection of measures, in particular in the use of indirect surrogate measures of outcome. Process measures, such as time targets are unlikely to accurately reflect desired outcomes or drive improvements, and risk producing unintended consequences.

As such, action should be taken to identify outcomes to target performance measures (aligned to the objectives of the National Law), identify how to measure performance together with any considerations in interpretation of such measures, and develop a standardised system for data collection and reporting.

Obtaining the necessary data is likely to be challenging as it must be in the right format, timely and of sufficient quality for decision makers to discern critical relationships. There will need to be consideration of the variables (measures, completeness and context); observations (population or sample; time and setting); and quality and integrity (process and technical), and these will also influence who should be responsible for measuring and monitoring performance.
3 Relevance and responsiveness

3.1 Competency frameworks

Issue 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?

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

Currently, there is significant variation in the way different health professions define the knowledge, skills and attributes expected of graduates and the competencies/capabilities of practising professionals. There is also variation in the ‘ownership’ of such frameworks between health professions.

A common approach would have value if the frameworks could be used together to provide a tool that can guide and inform workforce design on the basis of skills mix. However, work progressed by the former Health Workforce Australia\(^{10}\) identified the challenges of this, in particular the considerable number of variables that influence knowledge and skills requirements within a workplace.

Instead, ensuring a competency framework (or equivalent) has been defined for each profession is what is of most value. 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.

3.2 Education accreditation standards

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

Issue 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 requirement of the current and future workforce?

Issue 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?

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

There are considerable benefits to high-level commonality across accreditation standards for health professional education programs, including consistent and comparative expectations across all registered professions; improved clarity and efficiency for those interpreting and applying them (e.g.

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education providers, accreditation team members); and improved capacity for shared learnings cross-professionally of educational and professional approaches to meeting standards.

For accreditation authorities to be able to respond to identified workforce needs in a timely manner, these need to be communicated to accreditation authorities in a manner that reflects the priority accorded to them. There will then need to be transparency and agreement (between regulatory bodies, accreditation authorities and education providers) about expected responses, as influenced by the priority assigned and with consideration of existing processes and the workload being imposed, which may incorporate:

- Actions taken (e.g. change in standards, communication with education providers)
- Timeliness
- Monitoring and reporting requirements.

### 3.3 Clinical experience and student placements

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<th>Issue 15: How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?</th>
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<td>Issue 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?</td>
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Education practices used by providers should be guided primarily by the knowledge, skills or attitudes that are to be acquired or demonstrated. Consideration must be given to such things as the extent to which skills can be learned and assessed adequately in a simulated environment versus the practice environment, the availability of appropriate and varied practice environments, and the evidence that supports the approach selected.

Contemporary education practices may best be incorporated through sharing experiences and learning between professions, involving researchers, education providers, accreditation authorities and health services. This could be supported by a web portal that collates evidence and cases about best practice cross-professionally, dedicating time at existing forums to discussing current and emerging practices, and holding collaborative workshops that bring together all stakeholders (e.g. the workshop progressing interprofessional learning for interprofessional practice in June 2015\(^{11}\)).

The rationale for requiring periods of supervised practice varies between professions. Public interest should be the foremost consideration; variations in requirements may be influenced by the types of activities performed by each profession and the settings in which practitioners typically practice post-registration (and the existence of adequate supervision or oversight within those settings). As mentioned under 3.1, where multiple steps exist towards becoming registered, competency frameworks (or equivalent) identifying the expectations at each step may be used to defend or reject the need for the different requirements.

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\(^{11}\) Workshop report: Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice. At: www.healthprofessionscouncils.org.au/files/7c4d0b610f2d2161ec0828fcd57372350e0f0f0_original.pdf