Combined APHA and CHA Submission

Discussion paper:
Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions
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Introduction

The Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA) would like to thank Michael Woods for the opportunity to comment on the Discussion Paper regarding the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions.

APHA is the peak industry association for the private and day hospital industry, representing around 70% of the private hospital sector in Australia. The members of APHA run both for-profit and not-for-profit private and day hospitals.

CHA represents Australia’s largest non-government grouping of hospitals, aged and community care services, providing about 10% of aged care services in Australia, about 25% of private hospital beds and about 5% of public hospital care.

The private hospital sector in Australia offers a range of services and distinctive learning opportunities. It accounts for 34% of hospital beds and more than 40% of annual hospitalisations in Australia. Whereas it might once have been presumed students and early career clinicians would receive the most comprehensive clinical experience by working in a large public ‘teaching’ hospital, it is now increasingly recognised that exposure to a range of clinical contexts is essential, including exposure to the private hospital sector.

The private hospital sector also employs or contracts with a significant number of clinical staff, many of whom would be required to gain registration through the National Registration and Accreditation Scheme (NRAS).

The private sector employs a large number of health professionals (about 20% of employed FTE of nurses, 8% of employed FTE allied health professionals) and whilst few medical doctors are officially employed in the private sector (3% of employed FTE), employment arrangements are different in the private sector (medical specialists are generally ‘credentialed’ rather than employed, with the ability to admit patients to the private hospital).

Additionally, APHA and CHA research (report forthcoming) has shown the private sector has a strong and continuing commitment to providing education. In 2014-15, the private sector:

- Clinical placements (more than 40,000 days of clinical placements for medical students, 300,000 days of clinical placements for nursing and midwifery students, nearly 30,000 days of clinical placements for allied health students).
- Medical training (nearly 80 FTE in medical internships, nearly 100 FTE in postgraduate years 2 and over, and more than 280 FTE for vocational registrars).
- Nursing and midwifery training (1,400 FTE for graduates, and a limited amount of training for other types of nurses and midwives, including internationally qualified and re-entry).
- Allied health training (could not be extrapolated out to the sector due to limited data).
It is important curricula and clinical experiences include a range of settings for the graduate to have a well-rounded view of the entire health sector, and to meet Government priorities. The forthcoming APHA/CHA report also finds that with the support of Government funding, the private sector has the capacity to do more education and training.

Clinical experience provided in the private sector includes traditional acute hospital services, but also multidisciplinary service provision in the areas of mental health, chronic diseases and conditions and palliative care. As a significant provider of psychiatric and rehabilitation services, it would be remiss to exclude the private sector from training opportunities for students and future graduates.

This submission only addresses a select number of questions raised by the Discussion Paper.

The Independent Reviewer should not hesitate to follow up with the APHA or CHA regarding this submission, should he have any queries.
1. **What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?**

The potential benefits of greater consistency and commonality in the development and application of accreditation standards may be found in cost savings due to less duplication and streamlining of processes.

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?**

Australian education providers would be either a university or a registered training organisation (RTO) and should therefore adhere to either TEQSA or ASQA standards. The accreditation authorities should therefore incorporate decisions from these organisations as part of their reviews.

Ideally failure to adhere to either TEQSA or ASQA standards should immediately trigger a question as to whether their status under the NRAS should be retained.

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

If open-ended and risk managed accreditation styles were more widely adopted, it would be important to note an accredited education provider might actually be subject to more frequent reviews than under a periodic review scheme.

It would be important to establish an agreed framework for risk management so risk assessment could be applied in a consistent manner. It would be important for employers and other stakeholders as to have input into the development of such a framework.

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?**

It is important assessors meet relevant skills and experience and participate in training. Even more importantly, it is essential assessors participate in the provision of assessments regularly in order to maintain currency in their skills and knowledge. The Australian Commission on Safety and Quality in Health Care (ACSQHC) is currently implementing a number of measures to address similar issues in relation to accreditation of health service providers against the National Safety and Quality Health Service Standards.
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

It is desirable assessors include a range of stakeholders. It is also desirable that in addition to drawing together the requisite skills, assessment teams combine a range of experience including health care professional with current clinical experience in a range of settings including hospitals.

Hospitals either employ or contract with many of the professions that are accredited through the National Boards of NRAS including: Medical, Medical Radiation, Nursing and Midwifery, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Psychology and Dental.

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?

If a profession is prioritised by the Australian Government for the purposes of skilled migration, it would indicate the Government is either recognising or anticipating a shortage of that profession within Australia. If the Government has decided these are the types of professionals Australia wants to encourage, it would not be in the national interest for these overseas trained people to pay a higher rate for assessment and thereby cross-subsidise local students.

In fact, in the skilled visa submission (dated 9 May 2014) APHA stated cost was already deterring lower remunerated professions from coming to Australia (highlighting added):

The APHA is concerned that the fees associated with the programme may deter some applicants from coming to Australia. The occupations that can attract 457 visas in the health sector range from highly skilled and well-remunerated occupations (such as medical specialists) to skilled but lower remunerated occupations (such as nursing and medical technicians). For the latter, fees and barriers to entry are prohibitive, especially if the nominees have dependents.

For the applicant, there is:

- A visa fee ($1,035 per applicant over 18 and $260 per applicant under 18)
- Possible health assessment fees (depending on country of origin)
- Police certificates
- Charges by assessing authorities to verify the qualifications of the candidate.

The combination of these fees and associated costs will cause good candidates for lower-paid jobs to seek opportunities elsewhere in a global labour market.

In terms of the assessment of offshore competent authorities, it is important these are appropriately accredited. The fee setting structure for this would have to be determined by the accrediting authorities taking into account the full costs of off-shore accreditation.
Relevance and responsiveness

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

The primary focus of an accreditation program should, according to best international practice, move towards a focus of outcomes and competency, allowing flexibility in delivery methods. In the case of accrediting health professionals, it is important that competencies include both hard and soft skills relevant to reasonable expectations for a graduate in each profession in their first week of registration or provisional registration.

The provision of adequate clinical placements and access to simulated learning environments should remain part of accreditation criteria. However, it is not acceptable to rely on simulated learning as a substitution for adequate clinical placement.

The focus on outcomes and competencies should also aim to reduce variability in the quality of graduates from accredited training programs and courses. Accredited programs should ensure graduates qualifying for registration possess a core set of skills and competencies (both hard and soft) relevant to their profession.

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 development of professional competency frameworks should be done in consultation with a wide range of stakeholders, including employers. The focus on outcomes and competencies should also aim to reduce variability in the quality of graduates from accredited training programs and courses. Accredited programs should ensure graduates qualifying for registration possess a core set of skills and competencies (both hard and soft) relevant to their profession.

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

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.
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?

A period of supervised practice addresses the real concern employers have regarding variability in university graduates, and ensures a graduate’s skills are developed fully prior to general registration.

Despite this benefit, supervised practice requires a sufficient number of people willing and able to provide supervision, and there are generally more graduates available than supervised positions. This means there is effectively a hard barrier to entry into these professions and it may create bottlenecks where graduates are either not able to practice, or will have to wait for an internship to become available. The costs of creating graduates who are unable to qualify for general registration is significant, both to the individual, the health system and the Government. It is thus essential that enough supervised positions are made available across the board.

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

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. In fact, induction training was specifically excluded from the most recent private hospitals education and training survey (survey report is due to be published shortly), as it was seen as part of what all private hospitals provide on a routine basis. The survey did find, however, that private hospitals invest heavily in multidisciplinary training as well as continuing professional development.

Registration requirements must define a minimum expected set of outcomes and competencies a graduate in any profession will have at the outset.

The recommendations from the National Medical Intern Review on work ready graduates (pp43-45) should be considered for Medical graduates, and may also be useful more broadly in its recommendation to develop Entrustable Professional Activities (EPAs) for graduates. If a list of EPAs similar to the one available for American medical graduates (p44 of the Medical Internship Review Report) were to be developed for all professions and with employer input, it would ensure graduates are work ready through the NRAS.
Producing the future health workforce

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?

It is important employers are represented on these boards, and private hospital employers where practicable.

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

Employers should always be involved in key accreditation decisions.

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?

It is essential.

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 Ministerial Council would also be able to issues directions where it considers a proposed accreditation standard may have a substantive and negative impact on:

- the cost of training to students such that they are deterred from applying in sufficient numbers to meet workforce requirements
- cost barriers to Australian and overseas applicants (and their sponsors) to identified areas of workforce shortage (including people seeking to re-enter the profession)

Such impact assessments should specifically evaluate the impact on the public and private sectors.
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?

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.

### Specific governance matters

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?

There are two reasons alignment of approval for skills migration visas and registration is desirable:

- First, a single process reduces cost for applicants and their sponsors (including private hospitals) and wastage of resources.
- Second, a single process avoids the risk of individuals finding themselves approved for entry into Australia but unable to work in their chosen profession.

The processes for assessing qualifications for skilled migration visas and those for registration under NRAS should be as closely aligned as possible. The example listed in the draft discussion paper (p67) of accreditation of nurses and midwives demonstrates these functions not being aligned will in fact create a two-tiered process of requirement for entry into Australia, which is not a defensible position for professions flagged as a priority by the Australian Government, due to existing or expected workforce shortages.

Overseas trained nurses not holding university degrees of the requisite length and level because they qualified for registration at a time before the introduction of such academic requirements are unfairly disadvantaged. Such people must complete expensive formal training in order to meet Australian registration requirements even when their work history demonstrates they have extensive experience working at the required level. This anomaly has been particularly
detrimental to the private hospital sector when seeking to address skill shortages that can only be met by experienced nurses. The APHA and CHA are of the view a smooth and efficient pathway to registration must be provided for such professionals.

At the same time, however, there may be some professions where applicants may meet academic/training qualifications based criteria but lack experience of the way in which clinical services are provided in Australia. In this instance, it is important to ensure such professionals have access to appropriate supervision before they enter independent practice in Australia. This requirement is particularly important for clinicians who upon registration are able operate independently and are not employed by a health service provider. While hospitals are required to undertake their own credentialing processes, these processes are predicated on the existence of an adequate and appropriate process of registration. For these professions, there may be justification in maintaining a difference between visa and open/full registration requirements.

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

Consistency should be encouraged if it means better efficiency and cost reductions for the individual professional as well as employers. However, in creating better consistency, it is essential quality and safety are not compromised, and this should not be done for the sake of doing it.

See also the comment above regarding the relevance of supervision requirements for some professions prior to full/open registration.

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? (p69)

See the comment above regarding the relevance of supervision requirements for some professions prior to full/open registration.